Targeting healthy weight? How the ideologies and discourses underpinning the policies addressing South Australia's Healthy Weight Target (2007) affect health equity.

Louise Townend

BA, Ass. Dip. Court & Parliamentary Reporting, B Soc Admin.

Southgate Institute for Health, Society and Equity
Flinders University of South Australia

July 2015

TABLE OF CONTENTS

List of figures viii
Summary ix
Declaration xi
Acknowledgements xii
Glossary xiii
CHAPTER 1: INTRODUCTION 1
1.1 Overview of this study 1
1.2 Research questions 3
1.3 Research approach 3
1.4 Context and contribution of this research 5
1.5 Key concepts 7
1.6 Outline of chapters 8
CHAPTER 2: LITERATURE REVIEW — EVIDENCE FOR THE OBESITY 'PROBLEM' 9
2.1 Overview 9
2.2 Literature search strategy 9
2.3 The obesity 'problem' 9
2.3.1 Establishing obesity as a health problem 9
Obesity globally *9*
Obesity in Australia *11*
Obesity in South Australia *12*
Health risks *13*
2.3.2 Establishing obesity as an inequity problem 14
Population distribution of obesity in Australia *14*
Equity in health — the social gradient *14*
The social gradient of obesity *16*
CHAPTER 3: EXPLANATIONS AND POLICY RESPONSES TO THE OBESITY 'PROBLEM' 20
3.1 Overview 20
3.2 Literature search strategy 20
3.3 Contested concepts: 'Energy Equation' and 'BMI' 21
3.4 Explanations for the social gradient in obesity 22
3.5 Explanations for the obesity epidemic and its distribution 24
3.5.1 Health promotion framework: three approaches to obesity 25
3.5.2 The medical frame 25
3.5.3 The behavioural frame 26
Moral deficit discourse *27*
Lifestyle discourse *29*
Market choice discourse *30*
3.5.4 The socioenvironmental frame 31

Critique of market choice discourse *31*
Development of the socioenvironmental frame *37*
Variants within the socioenvironmental frame *38*

3.5.5 The role of ideology in framing obesity 43

3.6 The policy response to obesity 47

3.6.1 Global obesity policies 47
3.6.2 National obesity policies for Australia 48

The context of Australian governance *48*
National policies *49*

3.6.3 South Australian obesity policies 51

3.7 The neoliberal ideological context of obesity policy 53
3.8 Conclusion 57
CHAPTER 4: METHODOLOGY 58
4.1 Overview of chapter 58
4.2 Philosophical foundations 58

4.2.1 Social constructionism 58
4.2.2 Critical theory and key concepts: ideology, discourse and equity 60

Power: Productive or oppressive *61*
Ideology *62*
Hegemony *63*
Discourse *64*
Equity *66*

4.3 Methodology 66

4.3.1 Qualitative research 66
4.3.2 Research design 67

4.4 Research methods 67

4.4.1 The What's the Problem Represented to be? (WPR) approach 67

WPR approach — transparency and reflexivity *72*

4.4.2 Sampling strategy 72
4.4.3 Healthy weight policy document analysis 73

First stage: Familiarisation with the data *73*
Second stage: Descriptive account *73*
Third stage: Interpretive stage — Discourse analysis and identification of themes *73*
Fourth stage: Interpreting the themes: synthesised discourse analysis *74*

4.4.4 OPAL program document analysis 75

Selection of documents *75*
OPAL program data analysis *76*

4.4.5 OPAL interview analysis 77

Interview schedules *77*
Ethics and recruitment *78*

Analysis of interview data ... *80*
4.4.6 How the research methods chosen relate to the purpose of this study ... 81
4.4.7 Data generation ... 81
Multiple methods of data generation ... *82*
4.4.8 Research rigour ... 83
Credibility ... *83*
Transferability ... *83*
Dependability ... *84*
Confirmability ... *84*
4.5 Conclusion ... 85
CHAPTER 5: FRAMING OF OBESITY IN HEALTHY WEIGHT STRATEGY DOCUMENTS ... 86
5.1 Overview of chapter ... 86
5.2 Descriptive accounts of Healthy Weight Strategy documents ... 86
5.2.1 Eat Well Be Active Healthy Weight Strategy for South Australia 2006–2010 (EWBA) ... 86
Background and context ... *87*
Evidence and consequences ... *87*
Principles, aims and objectives ... *87*
Strategic directions ... *88*
5.2.2 Eat Well South Australia Public Health Nutrition Action Plan 2006–2008 Summary (EWSA) ... 88
Background and context ... *89*
Evidence and consequences ... *90*
Principles, aims and objectives ... *90*
Strategic Directions ... *91*
5.2.3 Be Active Physical Activity Strategy for South Australia (BA) ... 91
Background and context ... *92*
Evidence and consequences ... *92*
Principles, aims and objectives ... *92*
5.2.4 Eat Well Be Active Healthy Weight Strategy for South Australia: Priorities as at November 2009 ('Priorities') ... 94
Background and context ... *94*
Evidence and consequences ... *95*
Principles, aims and objectives ... *95*
Strategic directions ... *96*
5.3 Discourse analysis ... 97
5.3.1 Overview ... 97
5.3.2 Representation of the problem of obesity: Primary problematisations ... 98
5.3.3 Representation of the problem of obesity: Secondary problematisations ... 102
5.3.4 Shared characteristics of the problem representations ... 103
5.3.5 Representation of the causes of this problematisation ... 108
5.3.6 Representation of the solution to this problematisation ... 109

The public *111*
Government *113*
Corporate sector *115*

5.3.7 Framing of responsibility in this problematisation 118
5.3.8 Implications for health equity 119

Eat Well Be Active *119*
Eat Well South Australia *120*
Be Active *121*
Priorities *121*

5.4 Summary of chapter 122
CHAPTER 6: FRAMING OF OBESITY IN OPAL DOCUMENTS 124
6.1 Overview of chapter 124
6.2 Selection of OPAL and OPAL documents 124
6.3 Descriptive accounts of OPAL 125

6.3.1 National Partnership Agreement on Preventive Health 125

Origins, funding, targets and theoretical underpinnings *125*
Structure and implementation *128*
Evaluation *130*

6.3.2 OPAL in public presentations 130

Summary of changes in research design from 2009 to 2011 .... *135*

6.3.3 Website and social marketing materials 136

6.4 Discourse analysis of documents 138

6.4.1 Representation of the problem 138
6.4.2 Representation of the causes of this problematisation 138
6.4.3 Representation of the solution to this problematisation 139
6.4.4 The framing of responsibility in this problematisation 139
6.4.5 Implications for health equity 139

6.5 Themes from discourse analysis 140

6.5.1 Construction of responsibility through the commercial sphere in OPAL public presentations 141
6.5.2 Construction of responsibility through the commercial sphere in OPAL website and social marketing themes 142
6.5.3 Principle of positivity 144
6.5.4 Construction of responsibility through the principle of choice 147
6.5.5 Summary of themes and chapter 148

CHAPTER 7: FRAMING OF OBESITY BY KEY ACTORS IN OPAL 149
7.1 Overview of chapter 149
7.2 Introduction: How OPAL represents a solution to unhealthy weight 149
7.3 Descriptive account of the community-based component of OPAL 150

7.3.1 Overview 150
7.3.2 OPAL as a complex community-based program 150

A complex response to a complex problem *150*

Working through local government and existing stakeholders *151*
7.3.3 OPAL as a program premised on a socio-ecological approach 153
Environmental and individual change *153*
The role of the commercial environment *156*
7.3.4 Equity and OPAL 162
Selection of project sites *162*
Perspectives on equity *165*
7.4 Descriptive account of the social marketing component of OPAL 169
7.4.1 Overview 169
7.4.2 Background to strategy of changing norms through social marketing 169
OPAL as a program based on the French EPODE franchise *169*
Applicability of EPODE to South Australia *171*
EPODE's private partnership model *172*
7.4.3 Implementing the strategy of changing norms via social marketing 175
Changing the normative environment *175*
Using a social marketing strategy *177*
Changing the normative environment in the home *179*
Not stigmatising any product or industry *184*
7.5 Discourse analysis of interviews 185
7.5.1 Representation of the problem 186
7.5.2 Representation of the causes of this problematisation 186
7.5.3 Representation of the solution to this problematisation 186
7.5.4 Representation of the framing of responsibility in this problematisation 187
7.5.5 Implications for health equity 188
7.6 Summary of chapter 190
CHAPTER 8: DISCUSSION 191
8.1 Overview 191
8.2 How the problem is represented 192
8.2.1 How unhealthy weight is problematised in the data 192
8.2.2 Comparison with how unhealthy weight is problematised in the literature192
8.3 Causes of this problematisation 194
8.3.1 How the causes of unhealthy weight are represented in the data 194
8.3.2 Comparison of how the causes of unhealthy weight are represented in the literature 195
8.4 Solutions to this problematisation 198
8.4.1 The solutions to unhealthy weight identified in the data 198
8.4.2 Comparison to how the solutions to unhealthy weight are identified in the literature 198
Social marketing *199*
Targets *201*
Partnerships and community *201*
Regulation *202*

8.5 The framing of responsibility in this problematisation 202
8.5.1 How responsibility is framed in the data 202
8.5.2 Comparison with how responsibility is framed in the literature 204
Self-responsibilisation 207
Making sense of my observation 210
How individual responsibilisation is evident in the findings 213
How the ideology of individual responsibility takes the focus off corporate responsibility 214
8.6 How this framing is likely to affect health equity 218
8.6.1 How health equity is represented in the discourses and ideologies identified in my data 219
8.6.2 Comparison between the representation of health equity in my data and in the literature 220
A more equity-centred paradigm 220
An environment that is healthy weight-promoting by default 221
Equity-centred policy 221
8.7 Insights for public health 223
8.8 Strengths, limitations, and suggestions for further research 224
8.9 Conclusion 226
8.9.1 Embedding healthy weight in policies beyond the health sector 227
8.9.2 Materially supporting individuals to make healthy weight enhancing changes 227
8.9.3 Prioritising organisational and environmental level changes 228
Appendix A: National diet and physical activity guidelines and strategies 229
Appendix B: WPR template for healthy weight analysis applied to EWBA 230
Appendix C: Policies related to the Healthy Weight Target 232
Appendix D: Interview schedules 238
Appendix E: Letters to participants 256
Appendix F: Example of analysis of interviews using WPR framework 260
Appendix G: Synthesis of main findings 265
References 268

LIST OF FIGURES

Figure 2.1: Increasing obesity among adults in OECD countries, 2000 and 2011 (or nearest year) 10
Figure 2.2: Persons aged 18 years & over: BMI scores 1995 & 2011–12 11
Figure 2.3: Adults 15 years and above who are obese by SES (SEIFA), 2007–08 17
Figure 3.1: Relationships between 'healthy weight' policy documents in SA 55
Figure 4.1: Research design 68
Figure 4.2: WPR template for the healthy weight analysis 71
Figure 4.3: Research questions and data sources 82
Figure 6.1: OPAL genealogy and timeline 126
Figure 6.2: Summarised changes in OPAL research design 2009–2011 136

SUMMARY

This thesis examined the ideological framing of obesity within a government strategy designed to promote healthy weight to explore how ideologies can influence the goal of achieving equity in health. Frame theory and critical theory were used to examine policies addressing the Healthy Weight Target set in the South Australian Strategic Plan, and one of the associated programs, OPAL (Obesity Prevention And Lifestyle).

Evidence suggests that obesity follows a general, increasingly steep social gradient. This means obesity is not only a health problem but also an equity problem. This dual nature of the 'obesity problem' lies at the core of this study and drives the three research questions. First, what are the ideologies and discourses underpinning policies designed to contribute to achieving the Healthy Weight Target of the 2007 South Australian Strategic Plan? Second, what are the ideologies and discourses underpinning one of the community programs and its practice? Finally, to what extent is the aim of achieving health equity embedded within the ideologies evident in the policies and program?

Critical theory facilitates an analysis of power, ideology and hegemony, which is crucial to understanding how dominant discourses construct responsibility for problems and their solution, and what the implications are in terms of equity. Qualitative methods were used to investigate these questions. The discourses and ideologies evident in policy and program documentation were identified using discourse analysis. In-depth interviews were then conducted with key informants from the OPAL program to gain insight into which discourses and ideologies were reflected in their perspectives.

The data illustrated how the ideological framing of problems in documents and interviews did not always align with the framing of solutions, and that while obesity was often framed as a socioenvironmental problem requiring socioenvironmental solutions, in practice solutions often also reflected behavioural discourses making individuals responsible for solving their own obesity 'problem'. It is suggested that this may be one way through which neoliberal governance is practiced as it diverts attention from obesogenic products, production and producers on to consumption and consumers. While capitalist forces of production were not problematised in the documents, they were problematised by some of the respondents, and the social-cultural

norms flowing from capitalism were problematised by most; the dominant ideology of individual responsibilisation was also challenged at times. The complex picture painted by the findings supports Gramsci's theory that hegemony is both culturally pervasive and simultaneously resisted.

Equity is identified in both the policies and program as primarily conceptualised as consisting of specific disadvantaged groups. It is argued that this can inadvertently result in blaming individuals who 'have' the problem as being responsible for their own disadvantage. In contrast, viewing equity as distributed along a gradient and thus affecting everyone problematises the whole system and social relations of production, making it harder to individualise responsibility. It is suggested that augmenting the current obesity-centred paradigm with one that is equity-centred might support the socioenvironmental framing of obesity, counterpointing the individualising of responsibility in policy that is an ideological pillar of neoliberal capitalism.

DECLARATION

I certify that this thesis does not incorporate without acknowledgment any material previously submitted for a degree or diploma in any university; and that to the best of my knowledge and belief it does not contain any material previously published or written by another person except where due reference is made in the text.

………………………………………………………………………………………………

ACKNOWLEDGEMENTS

There are many, many people who have helped me complete this long journey and who have made it a rich and rewarding one, to whom I owe my sincere thanks.

I would like to thank everyone associated with OPAL and the Eat Well Be Active Healthy Weight Strategy for South Australia who generously gave me their time and shared their insights and experiences.

I have been privileged to have had the support and guidance of an exceptional team of supervisors whose input has been essential at every stage of this thesis. Firstly, the patience, wisdom and kindness of Professors Fran Baum and John Coveney, and Dr Lareen Newman, my supervisors, continue to astound me. I am indebted also to my early mentors, Professors Peter Travers and Fiona Verity, for their faith and vision in setting me off along this path.

The camaraderie of the other students in the Hot Room and elsewhere, past and present, has helped make this journey fun: Ali Barr, B-J Dee Price, Clare Phillips, Georgia Panagiotopoulos, Jane Fitzgerald, Janet Adkins, Jo Flavel, Julia Anaf, Kathryn Browne-Yung, Kingsley Whittenbury, Lori Baugh-Littlejohns, Ruth Campbell and Sabitra Kaphle. I am grateful too for the encouragement and assistance of my co-workers at the Southgate Institute for Health, Society and Equity and in Health Sciences at Flinders University — Catherine Mackenzie, Helen Scherer, Julie Henderson, Katy Osborne, Kaye Mehta, Marlene Weise, Patricia Lamb, Paul Ward, Paula Lynch and Trish Clark. I am also indebted to Tina Thornton, Principal of Academic Editorial Services, for her invaluable technical assistance.

Finally, my deepest thanks to my friends Susan O’Toole and Susan Williams, who have walked the journey with me; to June Alexander, Kirsty Turner, Liz Denborough and Marie Norris, and to my family — Mum, who is at my side still; Dad, for his unwavering belief in me and now his cheering from Heaven with my brother Carl; to my long-suffering husband David, and my son Tim, who has grown along with my thesis, from child to man. Thank you all!

GLOSSARY

ABS	Australian Bureau of Statistics
AC	Advisory Committee
AIHW	Australian Institute of Health and Welfare
ANGELO	Analysis Grid for Environments Linked to Obesity
BA	Be Active Physical Activity Strategy 2004–2008
BMI	Body Mass Index
CSDH	Commission on Social Determinants of Health
EDNP	Energy Dense Nutrient Poor
EPODE	Together Let's Prevent Childhood Obesity
EWBA	Eat Well Be Active Healthy Weight Strategy for SA 2006–2010
EWBA (2011)	Eat Well Be Active Strategy for SA 2011-2016
EWSA	Eat Well SA Public Health Nutrition Plan 2006–2008
HAES	Health At Every Size
HE	Healthy eating
HiAP	Health in All Policies
HWT	Healthy Weight Target
LGA	Local Government Area
MP	Member of Parliament
MONICA	Monitoring Trends and Determinants in Cardiovascular Disease
NCD	Non-communicable disease
NGO	Non-governmental organisation
NHPA	National Health Performance Authority
NPAPH	National Partnership Agreement on Preventive Health
NPHT	National Preventative Health Taskforce
OECD	Organization for Economic Cooperation and Development
OPAL	Obesity Prevention And Lifestyle
PA	Physical activity
PRIORITIES	Eat Well Be Active Healthy Weight Strategy Priorities November 2009
SA	South Australia
SAC	Scientific Advisory Committee
SACOSS	South Australian Council of Social Service
SAMSS	South Australian Monitoring and Surveillance System

SASP	South Australian Strategic Plan
SEIFA	Socio-Economic Indexes for Areas
SES	Socioeconomic status
STAC	Strategic Advisory Committee
UK	United Kingdom
US	United States
W	Worker
WHO	World Health Organization
WPR	What’s the Problem Represented to be?

CHAPTER 1: INTRODUCTION

1.1 Overview of this study

Obesity rates are increasing globally, and in Australia almost 4 million adults — more than a quarter of the population — are now obese (National Heart Foundation 2012; World Health Organization [WHO] 2014). Obesity is also distributed increasingly unevenly across the population, being higher in those groups that are more disadvantaged (Commonwealth of Australia 2009a; Loring & Robertson 2014). This makes obesity a problem of health inequity as well as a health problem.

This thesis examines how different ideological understandings of obesity and healthy weight influence health equity. The central question explored is how the goal of health equity described in healthy weight policies is influenced by the ideologies underpinning them. This is explored in this study by examining the South Australian government's policy response to its Healthy Weight Target (HWT), itself a response to the increasing incidence of obesity in South Australia (SA). The discourses that frame obesity as a problem in policy, and how this affects the solutions developed in response, are considered. Critical theory and frame theory inform this study, and a *problematising* approach to policy analysis is followed (Bacchi 2009; Fischer 2003).In SA, the Eat Well Be Active Healthy Weight Strategy for South Australia 2006–2010 (SA Department of Health 2006a) policies and the associated program, OPAL (Obesity Prevention And Lifestyle), aim to increase the number of South Australians in the healthy weight range in an equitable manner. This research seeks to contribute to the knowledge base from which public policy is generated by investigating the extent to which the ideologies underpinning the policies and program influence this goal. While the ideologies influencing understanding of causes of the obesity problem at a general level have been examined elsewhere (e.g. Henderson et al. 2009), investigation of the ideologies apparent in the specific solutions — that is, in policies and programs themselves — are rarely studied, and the research exploring ideologies does not focus on equity (Gard 2011a, 2011b; Gard & Wright 2005). Although there is considerable scholarship concerning obesity as a problem of health inequity, this study seeks to link these two fields by focusing on the way that ideologies which permeate policy solutions

to obesity impact on the goal of health equity, and thus to make a contribution to equitable obesity policy.

The importance of this aim is underlined by the gravity of the problem. Obesity is widespread and increasing, with serious implications for health (WHO 2014). It is also distributed unequally, in general following the social gradient. That is to say, obesity is higher in those groups that are more disadvantaged and lower in those groups in the population that are more affluent (Loring & Robertson 2014). This is especially true for women and children (Commonwealth of Australia 2014; Sobal & Stunkard 1989). Evidence suggests that the social gradient for obesity is also becoming steeper, with the rate of obesity increasing relatively faster at the lower end of the social gradient (Loring & Robertson 2014). This makes obesity a problem of injustice in health, that is, a health inequity, as well as a health problem per se (Loring & Robertson 2014).

Additionally, evidence suggests that the effects of obesity and associated discrimination can have a compounding impact on the disadvantages resulting from and, in turn, causing obesity, for example, reducing opportunities for upward social mobility through marriage and occupation (Bacon & Aphramor 2011; Sobal & Stunkard 1989). In other words, obesity is both an outcome and a cause of low socioeconomic status (Ball & Crawford 2005). Both these features add to the importance of policy responses addressing the (increasingly) unequal distribution of obesity as well as its general increase. These issues will be explored further in Chapters 2 and 3. People low on the social gradient already bear a disproportionate burden of obesity and associated ill health (Loring & Robertson 2014). If policies designed to address this in practice fail, then increasing inequities and injustice may result.

Obesity rates in Australia and in the state of South Australia are some of the highest in the world (Organisation for Economic Co-operation and Development [OECD] 2013). The national- and state-level government responses to the rise in obesity have resulted in a range of strategies, guidelines, policies and programs. In South Australia, obesity has been perceived as sufficiently serious a problem to warrant being set a specific health target within the South Australian Strategic Plan (Government of SA 2007a).

1.2 Research questions

The overall aim of this study was to examine how the ideological framing of the Healthy Weight Strategy (HWS) policies and the OPAL program influenced their goal of increasing the proportion of South Australians with healthy weight in an equitable manner.

This thesis specifically addresses the following research questions:

1. *What are the ideologies and discourses underpinning policies that are designed to contribute to achieving the Healthy Weight Target of the 2007 South Australian Strategic Plan?*

2. *What are the ideologies and discourses underpinning one of the community programs and its practice?*

3. *To what extent is the aim of achieving health equity embedded within the ideologies evident in the policies and program?*

By addressing these questions it is anticipated that insights will be gained about how the problem of obesity can best be addressed in a way that will make the bigger improvements in those populations who currently bear the greater burden of ill health. The research approach followed in this study will now be described.

1.3 Research approach

A critical approach is taken to the issue of obesity, applying a method of policy analysis that examines how issues are constructed as policy problems, and how responsibility for their solution is represented. The use of critical theory enables an analysis of power, ideology and hegemony, which is crucial to understanding how dominant discourses construct responsibility for problems and their solution, and what the implications are in terms of equity.

One of the ways to draw out ideological framing is to analyse the discourses employed in texts. The identification of discourses was thus fundamental to my analytic purpose. Discourse analysis was considered to be the most appropriate method of analysis as discourse provides a link between what is said (such as policy texts) and what is unsaid (ideology). Because my focus was to elucidate the ideological framing of policy,

program and interview transcript ‘texts’, a method of discourse analysis designed specifically to facilitate policy analysis was chosen: namely, the approach outlined by Bacchi’s (2009) *What’s the problem represented to be?*. This provides a framework of questions with which to interrogate data, and was customised to my purpose by incorporating the three health promotion frames identified with distinct ideological positions, with the addition of a question specifically focusing on equity (Labonte 1993). This enabled the ideological framing of data to be identified and provided an opportunity for an in-depth exploration of reflections on practice.

In this thesis, explanations for obesity as a health problem and as an inequity problem are reviewed. The evidence and arguments drawn on in supporting these two problematisations will be outlined here, and are covered in greater depth in Chapters 2 and 3. They are given this attention because the way a problem is represented — or problematised — has a profound impact on the kinds of solutions proposed in response, that is, in policy (Bacchi 2009). From this review, the three frames for health promotion interventions (*medical, behavioural* and *socioenvironmental*; Labonte 1993) and the discourses associated with each are identified and described. This provides an analytic framework that is used to inform the method of discourse analysis and which is also used in this study to interrogate policy and program data. This is explained in detail in the following chapters.

Of the three frames, the medical frame accepts the narrowest range of causes: biological, genetic or metabolic. With the exception of body mass index (BMI) categories, which have their origin in the positivist medical frame, this frame is less visible in the policies studied here than are the behavioural and socioenvironmental frames. The behavioural frame problematises the issue as health and economic, drawing on moral deficit, lifestyle and market choice discourses to do so. The problem is conceived very narrowly and excludes any but the most proximal causes. This narrow view of health tends to focus on the individual and then easily shifts to what the individual does to cause the problem they experience. In effect, this becomes what is a focus on the obese person/body — the outcome, rather than the cause of weight-gaining behaviours. A focus on immediate causes of weight gain tends to exclude the causes of the weight-gaining behaviours (Kwan 2009).

In contrast, the socioenvironmental frame casts a wide net of factors that influence weight-gaining behaviours, problematising environmental factors and, at its most encompassing, the distal influences known as the social determinants of health (Friel 2009; Swinburn 2009). Critiquing the market choice discourse in particular and invoking instead an environmental discourse, the socioenvironmental frame adopts a much broader view than the medical or behavioural frames; a wider range of factors are included as influencing weight and thus relevant to the problem. The breadth of this view enables the broad patterning of obesity to be seen, with the result that this perspective problematises inequity. This frame tends to be destigmatising as it identifies that weight is not simply a result of 'poor' behavioural choices. While researchers from this perspective generally acknowledge that differences in behaviour, though socially and environmentally driven, account for some of the differences in weight, they argue that there is more to it than this. In Chapter 3 many explanations are proffered to account for the social gradient in obesity.

The framework derived from the literature review was then incorporated into the methodology of the discourse analysis and through which the identification of the discourses and ideologies that underpin the policies and program was made. Drawing on the insights offered by Gramsci's conceptualisation of how hegemony can be simultaneously strengthened and challenged, a series of incongruences were identified. These included incongruences within and between policies and program; between policy and program documentation and practice; between the ideological framing of problem, cause and solution; and, most importantly, incongruences in the construction of responsibility and the implications for equity.

1.4 Context and contribution of this research

A number of contributions to the field may arise from this study's findings. The possible role played by ideology that leads to unintended policy outcomes in the field of healthy weight is illuminated. This is achieved by illustrating a process for comparing the implicit ideological framing of a policy intervention in practice with its framing in policy documentation. Differences thus disclosed may be useful for future healthy weight policy planning.

In this study reflections on whether equitable intentions expressed in healthy weight policy and program documentation assure equitable practice are offered. Suggestions are also made about how the representation of obesity as a certain kind of problem can affect policy and practice. This study illustrates the value that a problematisation approach can have in destabilising assumptions; in situations where policy may not be having its intended effect, this might be particularly useful.

The question as to whether the aim of improving population health is compatible with a political–economic system that privileges profits over health has been posed numerous times (e.g. Freudenberg 2014; Harvey 2007). My study aims to contribute to the field of knowledge that will help answer this question by drawing and building on the insights from critical scholarship (e.g. Crawshaw 2013; Freudenberg 2014; Guthman 2011; Monteiro and Cannon 2012; Moodie et al. 2013) to offer insights into one instance of policy intended to deliver improvements in population health 'in a way which is equitable' (SA Department of Health 2006a, p. 9). The aims of this research locate it within a broader context of research and policy action reflecting a socioenvironmental discourse that is supportive of the social determinants of obesity and health inequity, and challenging of individualist ideology (Baum et al. 2014; Commission on Social Determinants of Health (CSDH) 2008; Loring & Robertson 2014; Newman et al. 2014; WHO 2004, 2009, 2012a, 2012b; WHO Regional Office for Europe 2015). Chapter 3 describes the policy context in detail.

This research raises the question of whether ideology might be a missing link in the chain of logic between health, policy and inequity, explaining how socioenvironmental, equity-focused intentions become behavioural interventions; that is, it offers insight into the 'lifestyle drift' phenomenon identified by previous public health researchers (Popay et al. 2010). In this study I draw attention to the profound effect the ideological context in which policy is developed and executed has on the aims of a policy, thus making a contribution to the field of public policy.

Other researchers (e.g. Swinburn & Egger 2002) have adopted an obesity-centred paradigm positioned on the core problematisation of obesity as a health problem (this paradigm currently underpins the policy approach to healthy weight in SA). In contrast, this research draws attention to how this can lead to a focus of attention which, while much broader than that apparent in a behaviourist frame, is still possibly narrower than

required to fulfil the policy aim of addressing obesity in a way that also promotes equity. In this study I suggest that the equity-centred focus evident in the work of some other researchers (e.g. Friel 2009) would expand the range of factors identified as relevant targets for change and could thus inform the policy response.

1.5 Key concepts

It is useful to first define a number of concepts used in this thesis that are crucial to this analysis. *Ideology* is understood in this research in the sense inherited by Gramsci from earlier Marxist writings — as a 'system of ideas' (Gramsci 1975a, p. 175) — and also in the sense he developed as encompassing social and cultural institutions (Gramsci 1971). Ideology can thus be used as a means of class domination to secure hegemony (that is, the winning of consent to rule), and also as influencing the construction of identity (Abercrombie et al. 1988; Eagleton 1994; Gramsci 1975a; Kincheloe & McLaren 2000). *Hegemony* is understood in this thesis as the particular ideology held and propagated by the dominant group, making their worldview seem natural and working through both what is said and what remains unsaid (Gramsci 1971; Kincheloe & McLaren 2000). This understanding informed my analysis of discourse in this research. *Discourse* refers to language that represents a particular way of thinking and talking about an issue (Abercrombie et al. 1988). *Policy* is a particular kind of language text, and policy discourse is one way that ideology is practised by government (Fischer 2003). One of the ways this happens is through the construction of issues as particular policy 'problems', that is, as *problematisations*; I use this concept to guide my analysis (Bacchi 2009; Rose & Miller 1992). *Discourse analysis* seeks to make explicit what is implicit in a text and is thus the most appropriate method for my objective of identifying ideologies that are embedded within health policy discourses. The conceptualisations of equity are guided by the WHO (CSDH 2008), which describes health inequities as differences in health that are both systematic and avoidable, noting that the latter quality also renders them unjust. Detailed definitions will be provided in Chapter 4.

Fundamental to a discussion of obesity is an examination of what is meant by healthy or unhealthy weight. I use the term *healthy weight* when referring to SA Health policies as it is the term generally used there, in line with best practice recommendations (King et al. 2011) as it is considered less stigmatising than *obesity*. I use *obesity* at other

times, however, as it refers to a precise range of weights relative to heights calculated using body mass index (BMI) that enables international comparisons to be made with some confidence. WHO classifications for BMI are used in this study; thus the *normal* weight range 18.50–24.99 kg/m^2; *overweight* 25–29.99 kg/m^2; and *obese* 30 kg/m^2 or greater (WHO 2014). Aspects of BMI are highly contested in the literature and are explored at some length in Chapter 2, along with the usage of *healthy* and *unhealthy weight.*

1.6 Outline of chapters

The following chapter reviews evidence for the 'problem'. Explanations for the problem and policy responses to it are then considered in Chapter 3. In Chapter 4 I explain the design of the study, the research approach, theoretical perspective and methodology, the choice of qualitative research methods and a description of how the data were generated and analysed. Background information about the policies and program are provided in Chapters 5–7, followed by analysis of the findings from the policy and program document reviews and interviews with 10 respondents from the program. In Chapter 8 I bring together and discuss the key findings and conclusion in the context of the literature, concluding with reflections on the study limitations and potential insights and recommendations for public health.

CHAPTER 2: LITERATURE REVIEW — EVIDENCE FOR THE OBESITY 'PROBLEM'

2.1 Overview

This chapter and the next review the literature relevant to this thesis, exploring the evidence for obesity, setting the context for this study and identifying how it will contribute to existing research. In this chapter, literature establishing obesity as a health problem is reviewed. By focusing on obesity's distribution, as well as its prevalence, a social gradient in obesity is noted, highlighting the issue of health inequity.

2.2 Literature search strategy

Data on rates of overweight and obesity by country and by state in Australia were sourced from a variety of reports from global organisations commissioned by, for example, the WHO and the OECD. Australian data were sourced from national bodies, such as the Australian Bureau of Statistics (ABS) and the National Heart Foundation. South Australian data were taken from reports of the South Australian Monitoring and Surveillance System (SAMSS – operated by Population Research and Outcomes Studies, University of Adelaide, on behalf of SA Health) and similar organisations.

2.3 The obesity 'problem'

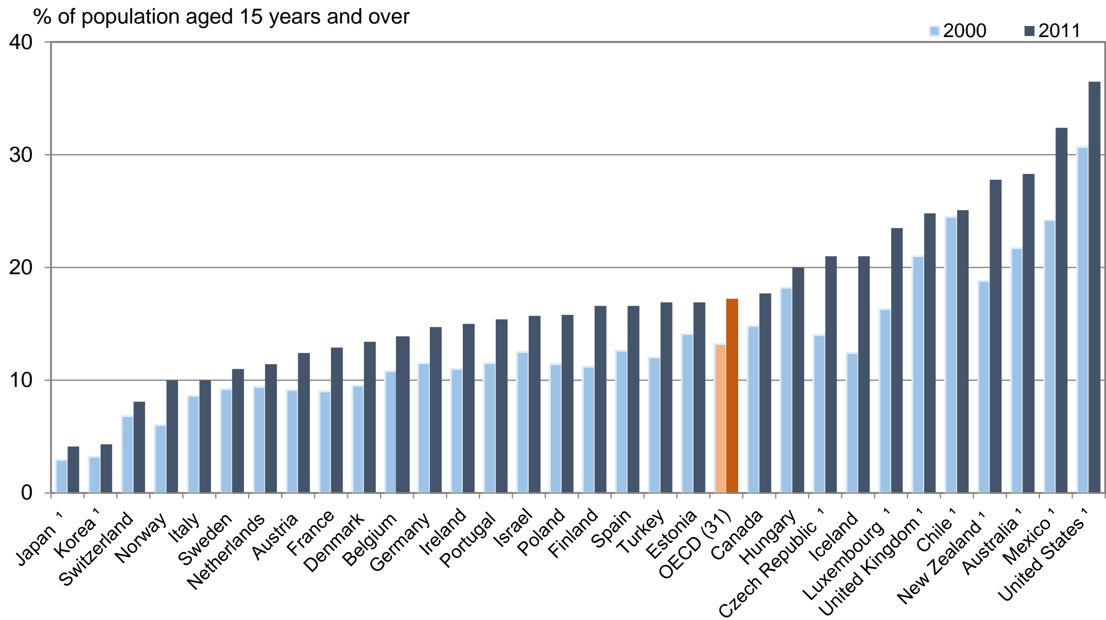
2.3.1 Establishing obesity as a health problem

Obesity globally

Epidemiological evidence overwhelmingly suggests that obesity is a problem for health systems, policymakers and governments. Although the term 'obesity and overweight' is often used to refer to one condition, they will be regarded separately in this thesis as their health implications can be quite distinct and are highly contested (Australian Institute of Health and Welfare [AIHW] 2003; Flegal et al. 2005, 2007, 2013; Heymsfield & Cefalu 2013). The prevalence of obesity is high and on the increase globally, having almost doubled between 1980 and 2008, with 11% of adults over the age of 20 now considered obese (WHO 2014).

The following graph, Figure 2.1, demonstrates the extent of the increase in obesity across OECD countries between 2000 and 2011, with Australia experiencing a slightly greater increase than the United States (US).

Figure 2.1: Increasing obesity among adults in OECD countries, 2000 and 2011 (or nearest year)



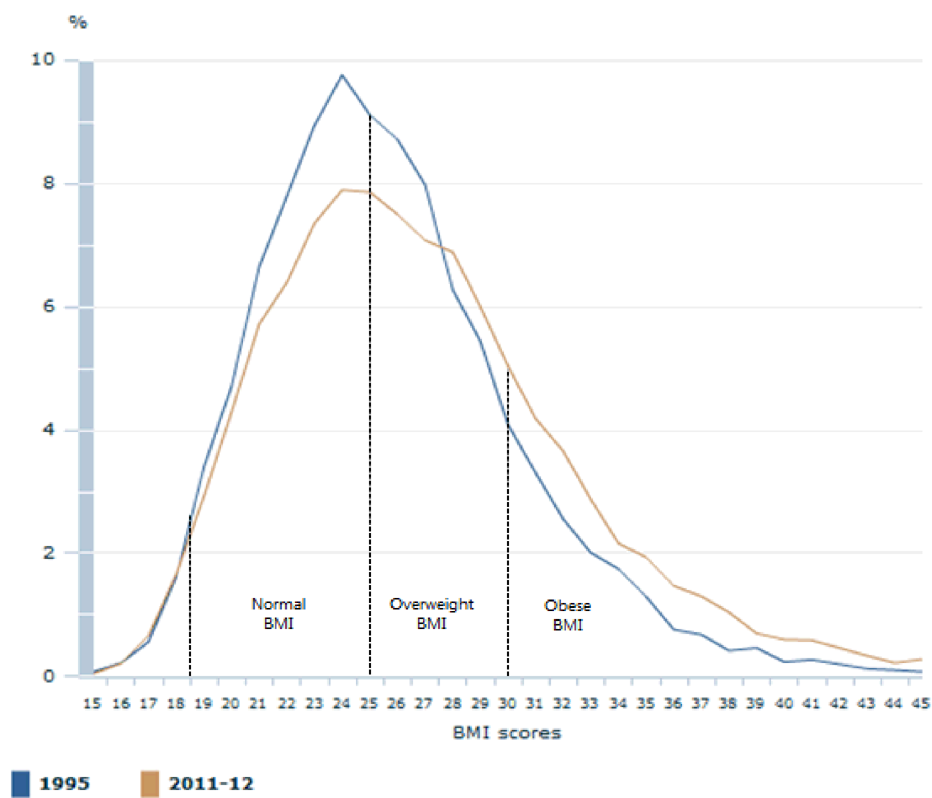
Source: OECD 2013, Health-at-a-glance, Figure 2.7.2 (p.61)

The impact of obesity on health is wide-reaching. For example, being obese increases the risk of developing a number of serious non-communicable diseases (NCDs) that can reduce both current health and life expectancy (Lobstein et al. 2004; WHO 2012a, 2012b). In 2011 the United Nations General Assembly issued the UN Political Declaration on Non Communicable Diseases, which 'recognises the scale of the NCD crisis, including obesity, and the urgent need for global action' (WHO 2012a, p. 14), the WHO (2012b, p. 9) describing the situation as 'one of the most serious health challenges of the early 21st century'. Obesity is often framed as an economic as well as a health risk as the associated NCDs impose additional costs on the health care system and reduce labour force productivity (McCormick et al. 2007; Wang et al. 2011). The unequal distribution of obesity and its health consequences across populations is less often described, with obesity thus rarely framed as an issue of health inequity.

Obesity in Australia

The 2011–12 Australian Health Survey revealed that the prevalence of obesity in adults over the age of 18 years continues to rise, increasing from 18.7% in 1995 to 28.35% obese in 2012, an increase of 47% (National Heart Foundation 2012). This means that almost 4 million Australians are now obese, with slightly more men (28.4%, or just over 2 million) than women (28.2%, just under 2 million) in this category. The increases in combined 'overweight and obesity' that have occurred in Australia over this time have mostly been in the category of obesity, with overweight remaining relatively stable (National Health Performance Authority [NHPA] 2013, p. 1). This is illustrated in Figure 2.2 below.

Figure 2.2: Persons aged 18 years & over: BMI scores 1995 & 2011–12



Source: ABS, Profiles of health, Australia 2011/13

Given the contestation about the impact being overweight has on health for individuals, society and health systems, and its stability over time, it seems accurate and purposeful to refer to an 'obesity problem'. Obesity has increased dramatically, and particularly the percentage of people with very high BMIs. Between 1995 and 2011–12, the ABS

reports that the number of Australian adults with a very high BMI (>35) almost doubled, going from 5% to 9.6% (ABS 2013a). This is of concern, as weight-related health problems are most serious at the highest weights (AIHW 2003).

That ‘Australia has among the highest rates of adult obesity in the world’ at 28.3% (OECD 2013) is of national concern (see Figure 2.1). Indeed, the Council of Australian Governments has set a target ‘to increase the proportion of the population in the healthy weight range by five percentage points over the 2009 baseline, from 37% to 42%’ by 2018 (NHPA, 2013, p. 2).

The percentage of Australian children aged 5–17 who are obese is now reported to be ‘stable’, with 6.9% children aged 2–17 years being obese. Although this represents an increase over the 1995 figure of 5% - a figure which itself has been reported to represent a steep increase over the rate reported for the two decades earlier (Booth et al. 2003; see also Magarey et al. 2001) - it shows a decrease from the 8% reported in 2007–08 (ABS 2013b). A literature review conducted by Rokholm et al. (2010) that examined 52 studies in 25 countries between 1999 and 2010 identified a similar pattern of levelling off in obesity rates among children in Europe, Japan and the US as well as Australia (see also Jackson et al. 2014). The authors caution, however, that plateaus in the past have been followed by further increases, and the fact that rates remain very high causes the authors to postulate that the ‘obesogenic environment … maintains its pressure’ (Rokholm et al. 2010, p. 844).

Obesity in South Australia

The results from the Australian Health Survey 2011–13 indicate that South Australia (SA) has the equal-highest obesity rate of any state at 30% obesity, which is 2% above the national average of 28% (NHPA 2013, p. 4; ABS 2013). Within the state, the SAMSS (2013 p. 2) indicates that in 2012–13, 23.8% of South Australians were obese. An increase in obesity prevalence was reported each year from 18.2% in 2003–04 to 23.8% in 2012–13 (SAMSS 2013a, p. 4). Also apparent in this data was a clear social gradient, with obesity steadily increasing as socioeconomic status decreases (SAMSS, 2013a, p. 10) For the period 2012–13, 6.8% of South Australian children were identified as obese (SAMSS 2013b, p. 2), which is very slightly lower than the national average of 6.9%. Unlike the situation for adults, children’s obesity rates have fluctuated in the period 2004–05 (7.4%) to 2011–12 (6.8%), with a high point of 10.1% reported

in 2005–06 and a low of 4.6% in 2008–09 (SAMSS 2013b, p. 3, although the figure reported in 2004-05 itself follows an earlier apparent doubling of the rate of obesity in school age children between 1985 and 1997 (Boothe et al. 2003; Vaska & Volkmer 2004).The social gradient in unhealthy weight (obesity is not isolated from overweight) is also evident for South Australian children (SAMSS 2013b, p. 8).

Health risks

Scientific evidence suggests the health risks associated with obesity, and to a lesser extent overweight, include 'hypertension, high cholesterol, diabetes, cardiovascular diseases, respiratory problems (asthma), musculoskeletal diseases (arthritis) and some forms of cancer' (Sassi 2010, in OECD 2013, p. 58; see also Lobstein et al. 2004). Life expectancy also reduces as BMI increases beyond the normal range (Commonwealth of Australia 2009a, 2009b; OECD 2013).

The *Obesity in Australia* report (Commonwealth of Australia 2009a, p. 9) explains how life expectancy is reduced 'by an average of around four years for obese Australian adults'. The report continues:

> For Australian children, it has been estimated that if current obesity trends continue, the life expectancy for children alive now will fall two years by the time they are 20 years old. This would represent a loss of five to 10 years in life expectancy gains and a return to life expectancy values seen in 2001 for males and in 1997 for females.

Due to the perceived direct and indirect costs associated with obesity because of its impact on health (McCormick et al. 2007; Wang et al. 2011), economic modelling and cost predictions have become an integral part of the way obesity is reported (Wisniewski 2011). For example, the 2007 Foresight Programme study estimated that total costs linked with overweight and obesity in England in 2015 could increase by as much as 70% relative to 2007 and could be 2.4 times higher in 2025 (Foresight 2007). This is also evident in Australia's *Healthy Weight 2008* report (Government of Australia 2008, p. 8), where obesity is framed as a 'problem … of enormous health, social and economic concern', with costs to health inevitably linked to their economic costs:

> Overweight and its associated illnesses also create a huge financial burden for governments and society as a whole. Latest estimates suggest that the true costs of obesity may now be as high as $1.3 billion per year and rising fast.

This figure has since been revised upwards, with the NHPA (2013) stating that in 2008 obesity had directly cost Australia's health system an estimated $2 billion.

The unequal distribution of obesity will now be described.

2.3.2 Establishing obesity as an inequity problem

Population distribution of obesity in Australia

The *Obesity in Australia* report (Commonwealth of Australia 2009a, p. 6) notes that 'Obesity is particularly prevalent among men and women in the most disadvantaged socioeconomic groups, people without post-school qualifications, Aboriginal and Torres Strait Islander peoples, and among many people born overseas'. Indigenous Australians are identified as being three times as likely as other Australians to be morbidly obese (that is, having a BMI greater than or equal to 40), with all its associated health risks (Commonwealth of Australia 2009a). Based on data from national health surveys, the report further notes that 'the most striking differences between the most and least disadvantaged socio-economic groups were observed in the prevalence of obesity rather than overweight', with 'women in the most disadvantaged socioeconomic group' having 'nearly double the rate of obesity (22.6%) of those in the most advantaged group (12.1%)' (Commonwealth of Australia 2009a, p. 7). Though the differences are less marked for men, the same pattern was noted, with men in the most disadvantaged group 'significantly more likely to be obese than those in the most advantaged group (19.5% compared with 12.7%)' (Commonwealth of Australia 2009a, p. 7).

Equity in health — the social gradient

Whitehead (1992, p. 5) has explained inequities in health as 'differences which are unnecessary and avoidable but, in addition, are also considered unfair and unjust'. They do not just exist between the 'least' and the 'most' disadvantaged in society but concern relative wellbeing distributed along the 'social gradient'. Sadana et al. (2011, p. 8) further explain:

> The relationship between socioeconomic standing and health is on a continuous gradient at all income levels rather than a gap simply between the rich and poor. This phenomenon occurs whether health differences are measured by income, employment, education, or other markers of social stratification.

The ‘unequal distribution of power, prestige and resources’ are identified as key elements in creating health inequities (Marmot, 2007, p. 1159). Marmot (2010, p. 10) explicates how these ‘fundamental drivers … underpin the determinants of health: the range of interacting factors that shape health and well-being’. He describes how the most proximal influences on individual health — such as material, social, behavioural and biological factors — are in turn influenced by education, occupation, income, gender, ethnicity and race. Finally, all these influences are described as ‘affected by the socio-political and cultural and social context in which they sit’. As I relate in Chapter 4, critical theorist Gramsci (1971) theorised that ideology is diffused through the social and political world, suggesting that ideology is also likely to be among the ‘fundamental drivers’ of health, including healthy weight. Marmot (2007, p. 1156) clarifies the role played by behaviour in this social determinants approach, stating that unless the ‘causes of the causes’ are addressed — that is, ‘the structural drivers of inequity in behaviour’ — government action ‘will not tackle the contribution of these behaviours to health inequities’ (2007, p. 1159; see also Baum 2008; Baum et al. 2009; CSDH 2008; Sadana et al. 2011; Marmot 2005; South Australian Council of Social Service 2008; Wilkinson & Marmot 2003).

Of particular significance to my study is the argument made by writers from this social determinants perspective that inequities in behaviours, which are the proximal causes of some ill-health, have distal roots — the ‘causes of the causes’ — which must be addressed if the behaviours and their inequitable health outcomes are to be altered. The focus of the ‘problem’ thus shifts from behaviour to the structural and social determinants of health, the alteration of which falls beyond health policy and into the realm of social and economic policy.

Finally, health is constructed as a matter of social justice, the steepness of the social gradient displaying the fairness with which health is distributed. As the Rio Political Declaration on Social Determinants of Health (WHO 2011) made clear, the social determinants lie within the field of public policy and government action; so to neglect their uneven impact — to allow inequities to remain through policy inaction — implies an injustice. The connection between the social determinants and health equity and the central role of empowerment is explained by Friel (2009, p. 8), ‘The combination of

structural factors and daily living conditions — the social determinants — are the determinants of empowerment, freedom and ultimately health and health equity'.

The recognition of health as distributed along a social gradient means that universal, as well as targeted, policy responses are required, with 'proportionately more impact further down the social hierarchy' (Friel 2009, p. 34). That a social gradient in health exists is thus an inequity, an injustice requiring remedy; this study will now explore evidence for there being a social gradient in obesity, its dimensions, explanations and proposed solutions.

The social gradient of obesity

The seminal work on the association between socioeconomic status (SES) and obesity is Sobal and Stunkard's (1989) review of the literature that revealed a strong inverse relationship for women and an inconsistent relationship for men and children in industrialised countries. That the distribution of obesity and overweight loosely follow the social gradient, and most strongly for women, has been demonstrated many times since (AIHW 2003, 2004, 2014; Ball et al. 2002; Brunner at al.1997; Clarke et al. 2008; Commonwealth of Australia 2014; Devaux et al. 2011; Foresight 2007; King et al. 2006; Molarius et al. 2000; Robertson et al., 2007; Wilkinson & Picket, 2009). As Loring and Robertson (2014, p. 8) state in their policy brief to the WHO Regional Office for Europe,

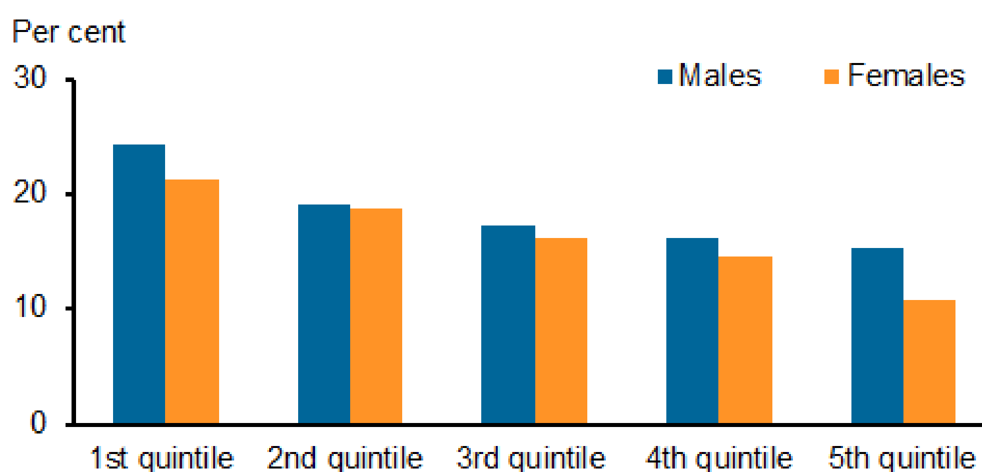
> It is not only the most disadvantaged who suffer a disproportionate burden of obesity. A social gradient exists, especially in women and children, whereby each socioeconomic group is relatively more obese than the next group above them in the social spectrum.

The social gradient in obesity also exists in Australia (O'Dea 2003), as illustrated by Figure 2.3. The differences in weight by SES is also greater in the obese than in the overweight category: women in the most disadvantaged socioeconomic group are almost twice as likely to be obese as women in the least disadvantaged socioeconomic group (Commonwealth of Australia 2009a). In contrast, as Ball and Crawford (2005, p. 1987) note, in developing countries, higher SES is associated with higher weight.

The relationship between obesity and SES is not straightforward. Molarius et al., (2000) posit that SES and relative weight are associated in a complex way, and one which is most likely bidirectional. This means that, as well as weight being influenced *by* a person's SES, it can also impact *on* a person's SES, as described in Chapter 1. Ball and

Crawford (2005, p. 2007), in reviewing longitudinal studies tracking weight change in adults over time, argue that obesity does not lead to low SES through ‘downward social mobility’, finding that high levels of obesity originate in people with already low SES. Reviewing 333 obesity studies, McLaren (2007) updated Sobal and Stunkard’s review, in general confirming their findings. McLaren (2007, p. 38) found that education level and occupation level in women correlated most closely with obesity, negatively in developed countries and positively in developing ones, but that the results for men were less consistent.

Figure 2.3: Adults 15 years and above who are obese by SES (SEIFA), 2007–08



Note: 1st quintile = lowest SES; 5th quintile = highest SES

Source: AIHW (2013) analysis of the 2007–08 National Health Survey

Examining data from the WHO MONICA (Monitoring Trends and Determinants in Cardiovascular Disease) study, which collected data from 39 centres in 26 countries, Molarius et al. (2000) also found that educational level was linked to obesity. In contrast, based on their literature review of 34 studies assessing the relationship of various dimensions of SES with weight change over time, Ball and Crawford (2005, p. 1988) found little association between weight gain and income. Findings from King et al.’s (2006 p.281) study of ‘Weight and place’ in Australia suggested a link between ‘area disadvantage’ and BMI, while Friel and Broom (2007), reviewing the evidence in Australia, found inverse relationships between obesity and higher education, employment status and income — with the strongest link being to education. They also noted that the only data available about ethnicity concerned indigenous populations who experience not only higher levels of obesity, but rates that are rising more quickly than for other Australians.

Martikainen and Marmot (1999), analysing data from the Whitehall II study of UK civil servants between 1985 and 1993, also found that gains in BMI increased more the lower the civil service grade, and a similar trend is illustrated in the 2010 Marmot Review (2010, Figure 2.15, p. 58). Pickett et al. (2005), using data from the MONICA project that surveyed populations in 1979–89 and again in 1989–96, also conclude that the social gradient in obesity increases as rates of obesity increase. In their analysis of this data, Molarius et al. (2000) predicted that this would increase the unequally distributed health consequences associated with obesity in many countries. Rokholm et al.'s recent review of studies from 25 different countries reporting obesity prevalence since 1999 have also noted that there is less evidence of a levelling off of the 'obesity epidemic' among lower-SES groups (2010).

A steepening of the social gradient in obesity has been reported in Europe (Loring & Robertson 2014), among children in the US (Singh et al. 2010) and in Australia (Commonwealth of Australia 2009a). Loring and Robertson (2014) note that in some European countries, such as France, people in lower socioeconomic groups who are already obese are gaining weight faster than people of higher SES, resulting in a steeper gradient over time. Charafeddine et al. (2009) report a steepening of the social gradient in obesity for males and a persistence of the gradient for women in Belgium from 1997 to 2004. Reviewing US National Survey of Children's Health data between 2003 and 2007, Singh et al. (2010) report an increase in the prevalence of obesity two to three times greater for children from low-education and low-income households than for children from other households.

In Australia, the picture seems similar, though less marked. The *Obesity in Australia* report prepared for the National Preventative Health Taskforce (Commonwealth of Australia 2009a, p. 8) reported that the disparity is increasing, 'Between 1995 and 2001, the gap (rate ratio) between the highest and lowest socioeconomic quintiles for obesity slightly increased in conjunction with the absolute increases seen for adults of both sexes'.

The AIHW also reports that, although rates of obesity are increasing in an absolute sense, evidence suggests that the increases in weight are occurring at the higher end of BMI, which carries more serious health risks (AIHW 2003). This is consistent with tends noted in analysis of earlier data from the Bogalusa Heart Study in Europe (Booth

et al. 2003). The only alternative view seems that expressed by Swinburn and colleagues (Swinburn 2009; Swinburn et al. 2013). A study of the weights of children in Victoria, Australia aged 4–5 years from 1999 to 2007, of which Swinburn was part (Nichols et al. 2011, p. 921), found that there had been a flattening of the socioeconomic gradient in obesity in this age group, although the gradient remained significant. Reporting on the results of the *Be Active Eat Well* program in Victoria, Swinburn et al. (2013) similarly found that the program had more impact in children from households that were more disadvantaged. In light of the potentially compounding effects on health inequalities that a steepening of the social gradient in obesity could have on the already greater risks to health faced by people of lower SES (Ball & Crawford 2005), this is positive news.

In this chapter I have reviewed the data on obesity and its distribution, noting that it is both a health and an inequity problem. In the next chapter I review explanations for this distribution, and policy responses to the 'problem'.

CHAPTER 3: EXPLANATIONS AND POLICY RESPONSES TO THE OBESITY 'PROBLEM'

3.1 Overview

In Chapter 2 I reviewed evidence for the obesity 'problem'. In this chapter, literature offering explanations for this problem and its distribution — and thus how much equity is considered — is reviewed under the framework of the three approaches to health described by Labonte (1993). These are the *medical*, *behavioural* and *socioenvironmental* frames. Policy responses to the obesity problem are then reviewed in order to provide the context in which this study takes place. Finally, the role of ideology in framing the problem of obesity, and the policy responses this engenders, is examined thus establishing the gap in research that this study aims to fill. I begin this chapter with an outline of the search strategy undertaken and an exploration of two concepts that underpin obesity literature, namely the *energy equation* and *BMI*.

3.2 Literature search strategy

The Web of Science, SCOPUS, CINAHL, INFORMIT and PAIS databases were identified as either comprehensive or relevant to public health and searched for peer-reviewed papers and reviews available in English. For information on policy and practice, the search terms (obesity OR obese OR overweight) AND 'ideolog* AND (policy OR policies) were used. The results were scanned, with articles rejected if their titles were clearly irrelevant, for example biomedical studies, or those not primarily focused on obesity; otherwise, abstracts were downloaded and read. If still judged as relevant, the whole article was downloaded and scanned for my key terms and incorporated as appropriate into this review. Key references cited in these papers were also followed up and the sources analysed and incorporated if relevant.

No sources linking all my fields of obesity, equity, ideology and policy were found. There is a substantial literature discussing obesity and equity, some of this being linked to ideological causes; and some discussion of ideologies underpinning policies contributing to the obesity problem, but nothing about ideologies underpinning the policies that address obesity, so nothing about the impact of such ideologies on equity.

3.3 Contested concepts: ‘Energy Equation’ and ‘BMI’

The concepts of the ‘energy equation’ and BMI that underpin the medical frame are challenged by other representations of obesity. The energy equation is the principle that weight is the result of the difference between energy consumed and energy expended, individuals gaining weight when they consume more calories or kilojoules than they expend (e.g. Australian Bureau of Statistics [ABS] 2013; WHO 2004). Representations differ in the number and range of factors they acknowledge or construct as contributing to either side of the equation, from the medical frame that limits influences to individual biology (e.g. Prentice & Jebb 1995) to the socioenvironmental frame’s identification of environmental factors both influencing these choices and independently influencing people’s health (and weight) due to social and structural determinants (Patterson & Johnston 2012).

Rayner et al. (2010, p. 3) offer what seems a reasonable guide to the usefulness of the ‘energy equation’ with which to proceed:

> It is a metabolic rule that when we consistently overeat we put on weight: it therefore follows that dietary intake and physical activity matters. However, changes in diet and levels of physical activity always occur in historical and social context, a fact which is often ignored. The result is that behavioural and biomedical discourses emphasise proximate causation and individual responsibility, which, in turn, limits the possibilities of public health action.

The second aspect of obesity that is highly contested is the use of BMI as a measurement of unhealthy weight, as prefaced in Chapter 1. The way the BMI categories are calculated, and the significance of the categories to health, are both challenged. To recap, a BMI below 18.5 kgm^2 is regarded as *underweight*; from 18.5 to 24.9 kgm^2 as *normal*; between 25 and 29.9 kgm^2 as *overweight*, and 30 kgm^2 and above as *obese* (WHO 2015). However, the frequent conflation in literature of ‘overweight’ and ‘obesity’ (Carter et al. 2011) creates confusion and unwarranted construction of risk. Much of the questioning of the conventional association of higher than normal weights with illness is based on the research findings of Flegal et al. (2013) who suggest that the association between BMI categories and health is less certain than their representation in much of the medical literature and the health policy it gives rise to. The inaccuracies in disease risk classification arising from the over-application of BMI is articulated by Prentice and Jebb (2001), while Evans (2006, p. 262) claims that BMI is used ‘as a proxy for ill-health’ rather than simply as a diagnostic tool, with the result

that weight is constructed as 'risk' and leads to victim-blaming. The main criticisms are that while health and weight may be closely associated at the extremes, this is less so in the mid-ranges (Campos et al. 2006; Guthman 2011; Rich & Evans 2005; Saguy & Riley 2005); that numeric classification systems are vulnerable to statistical exaggeration (Kuczmarski & Flegal 2000); and that BMI does not measure adiposity, which is more closely associated with increased risk than is weight (Guthman 2011). These reservations notwithstanding, both concepts are sufficiently supported in the literature to provide common ground for discussions such as this. Explanations for the social gradient in obesity described in Chapter 2 will now be considered.

3.4 Explanations for the social gradient in obesity

There seems some consensus in the literature that the general social gradient in obesity results, at least in part, from a social gradient in weight-gaining behaviours (e.g. Dykes et al. 2004; Knai et al. 2012; Marmot 2010) but disagreement about the way this happens and to what extent other factors are involved (e.g. Molarius et al. 2000). For example, in their analysis of evidence from the Whitehall II study, Brunner et al. (1997, p. 1341) found that 'little of the social patterning of metabolic syndrome' (which includes obesity) could be attributed to behaviours. Martikainen and Marmot (1999) drew similar conclusions from the same study. Similarly, in their review of the literature, Ball and Crawford (2005, p. 2008) conclude that weight-related behaviours associated with differences in SES explain only some of the SES differences in obesity, and question *why,* if behaviours do 'mediate the relationship between SES and weight gain', they vary by SES. This will be discussed at greater length below when explanations for the obesity epidemic are described. The main focus here is on explaining the stronger, and at times opposite, association between obesity, education and income in women and men.

Many researchers seek to explain the gender differences in the social gradient of obesity. The focus of this study, however, is on the social gradient itself, so this review will be restricted to examining the socioeconomic pattering of obesity. It is the obesogenic environment and the structural forces that shape it, and whether these are mediated by behaviours or not, which form the crux of most contemporary explanations for the general social gradient in obesity. Friel and Broom (2007) describe obesity as one of the health inequalities that are caused by social determinants, with people's

chances of becoming obese affected by distal factors working through proximal influences on eating and physical activity. There is some evidence for there being a 'socioeconomic gradient in diet' in Australia (McLaren 2007, p. 37) and there is considerable evidence of the impact of income on food choices (Barosh et al. 2014; Burns 2004; Caraher et al. 1998; Drewnowski 2009; Drewnowski & Darmon 2005; Drewnowski & Specter 2004; Friel 2007; Kettings & Sinclair 2009; Ward et al. 2013). The Australian Institute for Health and Welfare (AIHW) (2012) acknowledges the complex relationship between equity and food choices and behaviours, and the existence of locational disadvantages. This report also notes the higher incidence of both weight-gaining behaviours and of chronic diseases among people living in lower socioeconomic status areas. As Ball and Crawford (2005) observe, this in turn is likely to lead to further increases in health inequalities.

Pickett et al. (2005) argue that obesity is one of the ways income and social inequalities are played out in the body, suggesting that behaviour is not always or necessarily the link between the social determinants and unequal health outcomes. They further hypothesise that the psychosocial effects of living in an unequal society might cause nutritional problems. Analysing the MONICA project (Molarius et al. 2000) and their own study, they link income inequality with the social gradient in obesity, with the US having the steepest gradient and greatest income inequality, and Sweden the least (Pickett et al. 2005). Pickett et al. (2005, p. 673) suggest that the 'psycho-social effects of inequality' may underpin other pathways to obesity such as physical activity, energy intake and food choices, and the way that stress affects the body. The same result was found by Wilkinson and Pickett (2009) who, using data from the International Obesity Task Force (2002), demonstrate that obesity rates are highest in those countries with the greatest inequalities in income, an observation confirmed by the latest OECD data (2013).

One explanation Wilkinson and Pickett offer is the role of stress, premised on evidence of stress and anxiety being higher among people who perceive themselves as having lower social status. They suggest that stress might play a dual role, both increasing calorie intake and altering biological functioning, affecting the way that food is metabolised and stored by the body, and also changing brain functioning so that appetite is increased. Harvey's (2007) critique of the rise of neoliberalism since the

1980s describes in detail the global changes in labour markets and social support systems that have increased the stresses both on workers and those unable to work. Egger and Swinburn (2010) also argue that stress may be a pivotal pathway through which the experience of inequality influences weight. Additionally, Wisman and Capehart (2010, p. 936) posit that the insecurity and 'sense of powerlessness' generated through laissez-faire economic policies triggers consumption of high sugar and high fat foods thus driving obesity, particularly among economically vulnerable groups. Loring and Robertson (2014) also note that chronic stress over the course of life may compound other pathways to obesity.

Friel et al. (2007, p. 1242) argue strongly for the direct impact of environments on the unequal distribution of obesity and state that:

> Unequal exposure to health protecting or health damaging aspects of these environments adds health disadvantage to disadvantages of wealth, power, and prestige. These underlying structural inequities are likely to be responsible for the unequal distribution of obesity.

They advocate that only action at all levels of governance to ensure a more equal distribution of the material and psychosocial determinants of obesity will effectively change this.

Explanations as to why obesity is also an inequity problem have been presented in this section, with explanations for the social gradient in obesity being reviewed. Explanations for the obesity epidemic itself and its distribution will now be considered.

3.5 Explanations for the obesity epidemic and its distribution

As discussed, there is a social gradient in obesity that makes it both a health problem and a problem of inequity. The way obesity is represented in the literature, that is, what kind of a problem it is represented as, what solutions are generated by such representations, and who is cast as responsible, are thus important for policy-making. In presenting this review I use Labonte's (1993) health promotion framework to group the literature according to the way it problematises the obesity epidemic, that is, as medical, behavioural, or socioenvironmental.

3.5.1 Health promotion framework: three approaches to obesity

Labonte's (1993) classification of health promotion as medical, behavioural, and socioenvironmental was selected as a framework as it helps foreground the ideological underpinnings of the various frames and the discourses on which they draw. This is necessary as the aim of this research is to explore how the ideologies evident in obesity policies and programs are likely to impact on health equity. This framework also accords with the biological, behavioural, and environmental frames that Lawrence (2004) identifies in the media debates about obesity. As Lawrence (2004) observes, it is important to note that proponents and critics of a problem draw on different frames to argue their case; for instance, the fast-food industry frames the 'problem' as behavioural, while critics frame it as environmental. Worth noting here is the link between frames and the ideologies that underpin them which Lawrence (2004, p. 57) draws attention to when she says 'it is useful to think of individualizing and systemic frames as anchoring opposing poles of a continuum of discourse'. These classifications are also not discrete but have 'fuzzy' boundaries, as Labonte (1993, p. 31) observes, describing the three approaches as 'ideal types' rather than 'fully self-contained practices'.

3.5.2 The medical frame

The medical frame is one of the most dominant and earliest obesity frames identified in the literature (Kwan 2009; Lawrence 2004). Lang and Rayner (2005), in their overview of obesity in European policy, date its emergence as a medical problem of global significance from 1948 when, according to the International Association for the Study of Obesity, the classification of obesity and its analysis were the subject of international medical meetings.

A series of WHO reports related to obesity and strategies to address it in the past four decades has confirmed this position (WHO Europe 1988; WHO, 2000, 2003, 2004, 2009, 2012, 2012). Data — primarily based on BMI — is used to support the claims of this frame, and a multiplicity of biological, behavioural and environmental factors are identified as causal, with the 'energy equation' occupying a central place. Policy recommendations centre on prevention, namely, slowing the epidemic in order to improve population health.

Lawrence (2004, p. 62) notes that the medical frame, by locating the cause and cure of obesity ‘at the molecular level’, does not attribute blame to the individual, though it also deflects attention from the role of the environment in causing or solving the problem; others note that its medical status obscures the role played by the food industry in contributing to it (Berkeley 2013). Kwan (2009, pp. 42 & 27) notes that the medical frame’s narrow definition of health (health corresponding to being within normal BMI range) ‘has the potential to legitimize social inequality’ and ‘health disparities’ and to support the censure of fatness, thus potentially stigmatising people who are obese. It can be argued that this lays the basis for stigmatisation and the various moralised framings of obesity. Kwan (2009, p. 43) also highlights how the health risks of being of normal weight but unfit are occluded by this frame, and how the focus on healthy lifestyles endorsed by the medical frame can legitimise ‘moral judgments of fat individuals’ as it locates responsibility for body size on the individual. This constructs people who are obese as sick, with the most immediate cause of their sickness being their poor lifestyle choices (Patterson & Johnston 2012). The core concepts of BMI and the energy equation on which the medical frame rests are contested in some of the discourses that can be classified as behavioural; this frame will now be considered.

3.5.3 The behavioural frame

The behavioural approach to obesity falls within the general behavioural approach to health dated by Labonte (1993, p. 5) to the 1970s, when the focus broadened from physiology to include behavioural risk factors for disease, which were thus constructed as ‘health determinants’ (see also Wisniewski, 2011). I have included here those representations of obesity that frame individuals as primarily responsible for their own weight and health through the choices they make about eating and physical activity behaviours. These include a range of representations that draw on two specific discourses: obesity as a moral deficit (and its refutation); and/or as the result of lifestyle or market choice (Kwan 2009). While other representations and frames also draw on moralised, healthist and lifestyle constructions of obesity, these discourses are most prominent in the behavioural frame.

Moral deficit discourse

Kwan (2009, p. 28) credits Sobal (1995) with identifying a 'moral deficit' model that characterises obese people as immoral subjects, and its antithesis, the 'political discrimination' model drawn on by activists to challenge discrimination based on body size (2009, p. 30). This moral construction of obese people builds on the long history of the moralising of health ('healthism') recounted by Crawford, among others, itself a permutation of individualism as it seeks to explain health in terms of individual characteristics and behaviours (Crawford 2006; Fitzpatrick 2001; Jones 1994; Leichter 2003). It also underpins other obesity discourses (Coveney 2006). In this representation of obesity, although the biomedical premise that obesity is the result of biological variants is generally accepted, the medical frame's equating of health with BMI is challenged, highlighting the injustices that flow from such a frame.

Crawford argues that the practice of self-discipline (with its roots in Protestantism) results in health being seen as the rightful outcome of self-control (2006, 1994). Just as a thin body signifies self-discipline, Crawford (1984, p. 71) reflects that 'fat is a confirmation of the loss of control, a moral failure, a sign of … self-indulgence, and sloth'. Once illness is thus equated with failure rather than ill-fortune, it can be constructed as deserved (Jamrozik 2009). Saguy and Riley (2005) argue that obesity's high visibility makes it easily located within the healthist discourse, being constructed as evidence of the failure to care for one's health, which in turn is taken as a sign of civic irresponsibility, as doing so has incurred public health costs (see also Gard 2011a).

The potency of the moral deficit discourse can be illustrated by Guthman and DuPuis's (2005, pp. 444–445) observation that, ironically, even the framing of obesity as the result of socioenvironmental causes can diminish the moral status of obese people because:

> Those who can achieve thinness amidst this plenty are imbued with the rationality and self-discipline that those who are fat must logically lack.... Thinness, then, separates the deserving from the undeserving by favouring those who exercise self-denial.

By thus equating body size with moral status, Guthman (2011) argues that healthism exacerbates the inequalities that arise from and lead to obesity in two ways. Firstly, it further socially and economically marginalises population groups that do not conform

to the ‘healthy = thin’ ideal. Secondly, it denies determinants of health other than individual attributes and behaviour, justifying inaction on them such as the effects of transnational market forces — and global governance structures — on traditional diets, as argued by Kwauk (2011).

Other critics of the moral deficit construction of obesity are the ‘Health At Every Size’ (*HAES*) movement (Bacon & Aphramor 2011; Brady et al. 2013), building on the ‘fit not fat’ arguments dating back to the 1990s (Blair & Brodney 1999), and the Size Acceptance movement that encompasses work by the anti-discriminatory and body diversity movements, active since 1969 (Kwan 2009), and the burgeoning area of critical fat studies. While both of these movements view obese bodies as simply a mark of natural diversity (Cooper 2010; Saguy & Riley 2005) and focus on combatting stigma and its negative impact on obese individuals (Patterson & Johnston 2012), they differ in their focus on health.

Proponents of HAES argue that body size indicates natural variation and is not necessarily pathological (Bacon & Aphramor 2011; Guthman 2011), and that the poor health of people of size results from their stigmatisation and exclusion from appropriate health care (Bacon & Aphramor 2011; Kwan 2009; Saguy & Riley 2005). Such discrimination can have a material and social impact on obese people, compounding their exclusion by limiting job and marriage prospects (Loring & Robertson 2014). HAES advocates draw on numerous studies that suggest overweight may be protective of health (e.g. Flegal et al. 2005, 2007, 2013), especially for people with chronic disease (Heymsfield & Cefalu 2013), and argue that evidence suggesting weight loss improves health is scanty compared with evidence that ineffective attempts at weight loss are harmful (Bacon & Aphramor 2011; O’Reilly 2011). Instead, scholars advocate for public health to ‘promote healthy eating and movement for all people regardless of size’ (O’Reilly & Sixsmith 2012, p. 98).

Size Acceptance and critical fat studies scholars reject the central focus on health the HAES perspective enjoins, promoting psychological as well as physiological wellbeing (Kwan 2009). Drawing on feminist critiques of science (Gard 2011), they argue that fat is used as a means of intervening in women’s lives, particularly single and marginalised mothers, under the guise of managing the ‘risk’ they create through their weight, so that they can be ‘brought under the gaze of this deeply punitive medico-moral discourse’

(McNaughton 2011, p. 187; see also Warin et al. 2008). McNaughton (2011, p. 186) suggests that invocation of the fat-as-risk discourse means that attention is diverted from 'structural and contextual factors that create risks to health in the first place such as poverty, racism, disenfranchisement, poor housing, etc.' Further structural influences that have been suggested include class and gender oppression (Colls & Evans 2009; Warin et al. 2008), Bell et al. (2009, p. 163) also noting that 'discourses on childhood obesity and over nutrition are loaded with racist and classist assumptions', while LeBosco (2004) and Townend (2009) highlight the coalescence of the stigmatising of poverty and fat. Equity in health depends on changing this focus, the individualising of risk being both unfair and unethical; as O'Reilly and Sixsmith (2012) conclude, a 'weight-neutral' (p. 99) frame is 'morally imperative' (p. 108).

Lifestyle discourse

The lifestyle discourse, like the healthist discourse, promotes the notion that obesity is fundamentally explained by behaviour, and is premised on the energy equation and on the primacy of *choice* as the mechanism through which energy balance is achieved, specifically, by choices around eating and physical activity that are constructed as volitional. These tenets of lifestyle discourse are apparent in much of the popular media representations of obesity (Henderson et al. 2009).

As Lawrence (2004) observes, framing the problem as one of individual consumption choices casts government in the role of providing information to support responsible choices. This may include industry regulation, but it 'fundamentally leaves the solution in the hands of citizens-as-consumers' (Lawrence 2004, p. 62), and is a frame employed by industry to abrogate responsibility (Jenkin et al. 2011). In Australian nutrition policy, Bastian (2011) draws attention to the continued emphasis on altering individual health behaviours, despite a cultural shift towards a population health approach. Rayner et al. (2010) critique the solutions that a lifestyle understanding of obesity logically entails, which is to alter behavioural choices through educational means despite, as Guthman (2011) observes, there being no evidence that telling people what to eat actually works.

Lifestyle solutions thus accord with neoliberal notions of individual responsibility (Gard 2011). The policy and equity implications of such a framing were noted by Doyal in 1979 (p. 35) who suggested that a focus on the individual 'effectively obscures the

social and economic causes of ill health', thus acting as a kind of smokescreen, an effect also noted by Freudenberg (2014). As Friel and Broom (2007, p. 169) caution, 'Continuing the strong emphasis on individual responsibility through educational interventions and mass campaigns is likely to perpetuate or even exacerbate inequalities in obesity'.

Many reasons for the appeal of the lifestyle discourse have been proposed, including its implicit assumption that slimness indicates self-control and, due to its association with the affluent classes, implies higher social status than heavier weights. This maintains the status quo and affirms neoliberal notions of responsibility, while making invisible the political economy that produces ill-health, a focus with devastating results for the social determinants. Milio's criticisms of the lifestyle explanation for health led to her 'ecological health framework', which fed into the Ottawa Charter for Health Promotion (WHO 1986):

> From this perspective [of the ecological health framework], personal behaviour patterns are not simply "free' choices about "lifestyle", isolated from their social and economic context. Lifestyles are, rather, patterns of choices made from the alternatives that are available to people according to their socioeconomic circumstances and to the ease with which they are able to choose certain ones over others. (Milio 1981, p. 76)

This recasting of choice is fundamental to the socioenvironmental frame, which is discussed shortly.

Market choice discourse

One of the most influential aspects of the behavioural approach to obesity is that promoted by the food, beverage and marketing industries, the 'market choice' discourse (Kwan, 2009, p. 30). Like the moral deficit discourse, the market choice discourse rejects BMI as a valid measure of health (Kwan 2009). This challenges the medicalising of consumption (see Broom 2007) on the grounds that the right to consume transcends the obligation to be healthy. However, it goes explicitly further, representing health regulation and food taxation as interference in the consummate right of individuals to choose from an untrammelled marketplace (e.g. Henderson et al. 2009). Although this is most explicit in industry discourse, it also underpins much of the choice discourse evident throughout the behavioural frame, making the implications of such choice narratives clear.

In market choice discourses, obesity is constructed as a problem only for the individual because it is seen as the result of individual choices. By privileging research that focuses on energy expenditure rather than consumption, thus linking weight gain to sedentary behaviours, this discourse absolves and quarantines the powerful food and marketing industries from blame (Jenkin et al. 2011). Most tellingly, as Brownell and Warner (2009) and Patel (2012) identify, this position emphasising personal responsibility is the one consistently promoted by the food industry. It is one of many assumptions underpinning the behavioural approach and that are critiqued in the socioenvironmental approach to obesity. It is to this final approach to health that we now turn.

3.5.4 The socioenvironmental frame

Critique of market choice discourse

Dating from the start of this century, there is an extensive body of literature critiquing the role of industry in contributing to the 'obesity epidemic' that forms part of the socioenvironmental approach to health. Included are popular works such as Schlosser's *Fast Food Nation* (2001) and Spurlock's film *Super Size Me* (2004). Nestle's *Food Politics* (2002) details a fuller picture of the commercial interests and behind-the-scenes politicking underlying ostensibly 'free' choices. Moodie et al. (2006) propose that commerce itself is driving increases in obesity, appealing to government regulation to counterbalance and restrain market forces. Guthman (2011), examining the theoretical basis of the market choice position, argues that neoliberalism purports to champion the freedom of individuals, but in fact champions the freedom of the marketplace, trade, and enterprise, arguing that neoliberal government policies have contributed to many aspects of the obesogenic environment.

Taking such analysis further still, Freudenberg (2014, p. 95) has posited the influence of a 'corporate consumption complex' (analogous to the military–industrial complex in terms of entrenched interests and influence) that induces overconsumption to increase corporate profits, controlling not only the food and marketing industries but also the public policy and regulatory processes designed to protect public health (see also Harvey 2007). Freudenberg (2014) argues that disparate corporate interests are united by neoliberal ideology revolving around individual responsibility and the primacy of the market. Under neoliberal logic, he argues, responsibility for health falls on

individuals, with lifestyle — through the exercise of choice — constructed as the main determinant of health; parents are rendered responsible for ensuring children make healthy choices and society's responsibility is fulfilled by providing education about those healthy choices. Choice is maximised by a freely operating and expanding market (promoting increased consumption) that is constructed as both fair and the best way to provide prosperity for all, with minimal government regulation of individuals or industry.

The analysis of these critics suggests that choice is invisibly constrained by industry's overwhelming interest in profit making, thus allowing it to maintain its employment of libertarian rhetoric and its appeal to core libertarian values (Harvey 2007). As Coveney (2008, p. 205) notes, 'the freedom to choose … is embedded in the modern free market ethos', because profits increase as the range of choice options are maximised. The defence of 'consumer sovereignty', Wymer (2010, p. 101) suggests, is thus used by industry to deny responsibility for the obesity epidemic and to oppose regulation.

While the concept of 'free' choice under neoliberalism will be revisited in the final chapter, some of the main objections to choice made by critics of behaviouralism will be noted here. This approach is still widespread and, although choice discourse is most prominent in the behavioural approach, as a fundamental tenet of neoliberalism (Harvey 2007) it influences all representations of obesity. One of the assumptions that underpins 'choice' discourse is that people are unproblematically able to implement positive choices, unconstrained by circumstances (Crawshaw 2013).

Whitehead (1992) makes an important point regarding the role of choice in the construction of responsibility for ill health. She argues that if healthy eating and physical activity are construed as the result of freely made personal choices, that is, that healthy choices are within people's control, it is not unreasonable that responsibility for the consequences of such choices, such as obesity, should fall on the individuals concerned. This is important because it affects whether obesity is represented as a public issue necessitating a public response, or a private matter of choice. If obesity is depicted as within people's control, that is, the result of their personal choices, then it is unlikely to be regarded as unfair. The kind of policy responses such a problematisation warrants are thus unlikely to address the drivers of health inequities.

The assumption of control that underpins choice contradicts evidence that it is sometimes precisely the opposite that is happening: people's ill health and obesity can be the result of their *lack* of control over their circumstances and the choices that are feasible, that is, that lack of resources or structural factors proscribe choices (Ayo 2012). Critiquing this notion, Hoggett reinserts the importance of context, contending that people are actually 'reflexive but powerless … surrounded by real demands and real constraints' (2001, p. 45). This has important ramifications for how equitable interventions are likely to be, as Crawshaw (2013, p. 619) reflects, suggesting that, for 'socio-economically disadvantaged groups', contexts are 'more characterized by constraint than opportunities for the self-determination and actualization required by behavioural change models'.

Freudenberg (2014, p.6) constructs a compelling case that the overconsumption of obesogenic foodstuffs is the result of deliberate strategising by corporate food manufacturers and marketers to induce overconsumption of the most profitable — and obesogenic — foods, by making them 'hyperpalatable' to stimulate craving, and then marketing them in ways which weaken the ability of potential consumers to make rationally evaluated choices. Freudenberg's thesis thus challenges two of the core claims of neoliberalism: that choice expresses individual liberty, and that the market provides the fairest opportunity for such expression.

While an exhaustive list of industry practices that contribute to obesity is impossible, Nestle (2002) describes a long list of the most prevalent and harmful. These include:

- the denial of links between Energy Dense Nutrient Poor (EDNP) products and obesity, and their promotion as part of a balanced diet, despite single meals at some fast-food restaurants exceeding the recommended daily energy intake
- the non-disclosure of financial interests or any links between public health programs and industry (see also Moodie et al. 2013)
- the benefits gained by corporate sponsorship of EDNP products
- invisible influencing of consumer choices by marketing practices such as industry lobbying of regulatory agencies, courts, universities and professional organisations and particularly politicians (also see Brownell 2012; Daube 2010; Dixon 2003; Freudenberg 2014; Jenkin et al. 2011; Moodie et al. 2013; Miller & Harkins 2010; Miller & Mooney 2010) which outweighs the input of nutritional advice to these decision-and opinion-makers from public health agencies. This imbalance in input was noted by Egger and Swinburn (2010, p. 97) also in the

‘consultative process’ leading up to the *Weighing it up* report (Commonwealth of Australia 2009a).

Other industry practices identified as problematic are:

- the direct funding of research into nutrition (Stuckler & Nestle 2012 p. 2)
- the use of bogus research organisations (Moodie et al. 2013)
- the manipulation of scientific evidence to show the food industry in a more positive light (Ludwig & Nestle 2008, p.1809; Moodie et al. 2013)
- the co-option of policy makers and health professionals to give an air of credibility (Moodie et al. 2013)
- input into policy-making regulatory processes designed to protect public health (Freudenberg 2014)
- ‘cause marketing’ (Dorfman et al. 2012) and manipulation of public discourse (Chan 2013)
- inappropriate partnerships and sponsorships of health agencies (Freudenberg 2014) and
- the shifting of personnel between industry, public health agencies, and government (Freudenberg 2014; Townend 2009).

Numerous researchers argue that the food and marketing industries contribute extensively to the consumptogenic environment through practices such as the increased availability of EDNP food, increased portion sizes, and the low cost of high-fat, high-calorie foods (Grier & Kumanyika 2008; Harris et al. 2009). However, the marketing of EDNP products, most particularly to children, has received the attention of policymakers and critics, both internationally and in South Australia (Handsley et al. 2009; Harris et al. 2009; Henderson et al., 2009; Hoek & King 2009; Nestle 2002; Government of SA 2008;WHO 2004; Wymer 2010). This is an area of government regulation that has extensive support, compared with the direct regulation of the food industry (Shill et al. 2011). As several critics point out, while industry proponents argue that advertising does not influence consumer choice, the sums invested in doing so suggest otherwise (Hoek & Gendall 2006; Story & French 2004). There is also an increasing body of evidence showing that limiting the advertising of EDNP products is effective in reducing their consumption (Friel 2009; Handsley et al. 2009; Lobstein 2006; Loring & Robertson 2014; Stead et al. 2007; Wymer 2010).

It is through practices such as these that critics (Egger & Swinburn 2010; Guthman & DuPuis 2005) surmise that the owners of capital benefit from both creating the problem of obesity and from commodifying its solution, effectively a kind of corporate double-dipping. Other writers allude to the way the marketing industry creates anxiety, which the pharmaceutical industry then assuages, to the profit of both (Coveney 2008; Rayner et al. 2010).

In contrast, Friel (2009, p. i) argues that the overabundance of food might be viewed as a 'commercial success', but is in fact a 'market failure' (see also Gard 2011b) as 'the outcome is not good for both parties — the seller and buyer'. She argues for greater intervention by government, constructing market failure as actually government failure in its duty to protect its citizens' health. Furthermore, she suggests that not only is more corporate accountability and regulation needed, but that public goods — including health — need to be removed from private provisioning and returned to the public sector. This argument for the effective decommodification of social goods is made most strongly by those who promote a social determinants approach to obesity, namely, that obesity is best — or will only be — addressed by action on the social and structural drivers of health. The primary goal of these critics is equity in health, with obesity constructed as one aspect of this broader vision (Friel 2009; Loring & Robertson 2014).

Capitalism's drive to maintain and increase profitability (Fischer 2003) can be achieved domestically by increasing advertising (Nestle 2002); by increasing portion sizes and marketing these, for example, by super sizing (Nestle 2002, pp. 21, 26; Guthman & DuPuis 2005, p. 430), and by inventing new 'needs' (Guthman & DuPuis 2005, p. 441) and food products (Nestle 2002). However, the problem is also 'solved' — or shifted — by the creation of new geographical markets in middle-income countries, with transnational corporations offering diets high in saturated fats, salt and sugar as alternatives to traditional diets. These are made economically possible by a combination of subsidies to primary producers that drives down the costs of basic ingredients, and increases in portion size and EDNP foods (Brownell & Warner 2009; Freudenberg 2014; Monteiro & Cannon 2012; Patel 2012; Rayner et al. 2010; Stuckler & Nestle 2012).

The inordinate power wielded by the food industry and the inherently conflicted goals and interests of public health and industry are highlighted by public health advocates on

the international stage (e.g. Chan 2013) and locally (Daube 2010). As Daube notes, the food industry is 'under pressure from shareholders and others to act aggressively in the pursuit of profit' (2010, p. 445; see also Freudenberg 2014; Ludwig & Nestle 2008; Moodie et al. 2013; Nestle 2002).

At the heart of the conflict are the contradictory messages about consumption that are promoted by public health — to 'eat less' — and industry — to 'eat more' (Nestle 2002, p. 3). Processed foods are generally more profitable than unprocessed foods, as they contain high levels of fat, sugar and salt that are cheap and extend their shelf-life and palatability, and thus assist their sale (Freudenberg 2014). As Brownell (2012, pp. 1–2) observes, 'companies must sell less food if the population is to lose weight, and this pits the fundamental purpose of the food industry against public health goals'.

The imbalance in resources and power between commercial marketing and public health social marketing is well documented (Daube 2010; Hastings 2012; Wymer 2010). One of the results is the imbalance in voice between industry and those who would speak against it. Bastian (2011, p. 138) identifies this in her analysis of the portrayal of childhood obesity in popular and academic literature in Australia as a means by which the 'ideology and interests' of industry come to dominate. This is apparent in the reluctance of government to regulate industry in practice, despite scientific evidence and moral pressure to do this (Moodie et al. 2013). For example, the National Preventive Health Strategy 2008–2011 (Commonwealth of Australia 2009b, p. 16) includes the objective of phasing out 'the marketing of energy-dense nutrient-poor (EDNP) food and beverage products' to children; however, industry is given four years to establish the success of self-regulation, during which time it will be monitored and evaluated, before a legislative pathway is adopted. Professor Rob Moodie (Moodie et al. 2013), who was Chair of the National Preventative Health Taskforce (NPHT) at the time this strategy was written, has since stated that partnerships with industry can lead to delaying tactics by industry to avoid regulation. He also argues that there is a lack of evidence supporting the effectiveness of partnerships, recommending public regulation instead and intervention in the market as the only strategy backed by strong evidence (Moodie et al. 2013; see also Brownell 2012). Some critics go further, suggesting that industry actively undermines external regulation (Freudenberg 2014; Stuckler & Nestle 2012). Maximum profitability is logically better achieved in the absence of external

regulation, so it is not surprising that the processed food industry vehemently supports self-regulation. As Friel argues (2009), the decision to intervene is a political one, a matter of replacing the economic bottom line with one of population health and wellbeing.

Development of the socioenvironmental frame

The behavioural view of health has been extensively critiqued by the health promotion field, and provides the basis for the development of the socioenvironmental representation of obesity. Labonte (1993, p. 5) argues that it was the rise of social action movements in the 1980s, coupled with recognition that the behavioural approach had failed to help everyone, which led to the substitution of a broader 'sociological and ecological analysis of health and disease'. Such an analysis recognised the importance of social and material risk factors as determinants of health. Health promotion was identified as a key concept in the strategy for 'health for all' at the WHO Primary Health Care conference at Alma-Ata in 1977 (Tsouros 1990). This found expression in the 'Ottawa Charter for Health Promotion' (WHO 1986) that broadened the prerequisites of health to include 'peace, shelter, education, food, income, a stable ecosystem, social justice and equity' and control, the latter taking shape in the goal of community empowerment recognising that control over one's life is crucial to health. Several of the principles and strategies outlined in the Ottawa Charter are evident in current obesity literature and policy; although now, as then, their statement as goals does not ensure their enactment nor their survival in the face of political expediency. These included:

- the inseparability of health and equity;
- the fundamental link between people and environments, which provides the foundation for a socioecological approach to health;
- a settings approach to health;
- the provision of supportive environments, skills and opportunities for making healthy choices; and
- the need for healthy public policy, to move beyond the health sector and to work with all levels of government and civil society, most specifically to 'make the healthier choice the easier choice for policy makers as well' (WHO 1986).

Labonte (1993, p. 9) suggests that the already dominant 'neoliberal economic ideology' was problematic to the realisation of the Ottawa Charter, with health promotion carried out within state bureaucracy beneath the twin spectres of co-option and commodification, the latter being where Labonte saw social marketing situated. Three ideas fundamental to the development of non-individual-based explanations of obesity and that characterise health promotion come from Milio's work. These are: the relationship between health and environment; the embedding of choice in environments; and the role of public policy in providing environments in which healthy choices are the easy option, and are health-promoting by default (Milio 1981). Milio (1981) argued that, because health was the result of the positive impact of environments on people, the task of public policy was to create appropriate environments. This is the approach explicitly espoused in the policies and program that form the subject of this research.

By explicitly embedding choice in environments, Milio (1986) shifts the responsibility for healthy choices from the individual to the collective, stressing the role of political choices in determining personal wellbeing. However, Milio (1976, p. 438) also envisaged that making 'health-promoting choices easier' should be the starting point, arguing for environments being made passively supportive of health, distancing the attainment of health even more from individual responsibility and choice-making. She advocated for environments that were themselves actively health-promoting so that individuals could remain 'passive' — that is, not required to make continuous consciously healthful choices — and yet be healthy (Milio 1981 p. 82).

The socioenvironmental frame seeks to minimise the repercussions of non-healthful choices by making health as non-volitional as possible, that is, by removing the need for choices (e.g. via regulatory and legislative changes) and minimising the likelihood of people making non-healthful choices (e.g. by making healthy choices the easy choices through altered settings).

Variants within the socioenvironmental frame

There are several different reflections of the socioenvironmental approach to obesity. These include Dixon and Broom's consumptogenic environment frame (2007); the toxic environment frame (exemplified by Brownell, for instance — Brownell & Warner, 2009; see also Barry et al. 2009); a focus on food insecurity (espoused, for

example, by Drewnowski (2009; Drewnowski & Darmon 2005; Drewnowski & Specter 2004); and, more recently, Guthman's work (2011) advocating more fundamental structural change. However, the model that is the most extensively iterated and influential is Egger and Swinburn's obesogenic environment model.

Egger and Swinburn's largest contribution to obesity scholarship is in applying to obesity the tenets of the socioenvironmental approach to health, proposing that the influences on the 'energy in' and 'energy out' parts of the central medical–behavioural energy balance model should include environmental factors. The resulting 'obesogenic environment' thesis explains the distribution of obesity as resulting from differential access to opportunities for healthful eating and physical activity. It also contends that the passive environment has become one which, unless actively resisted, will lead to population weight gain. By contending that obesity is a 'normal response to an abnormal environment' (Egger & Swinburn 1997, p. 477), and that the default environment is now such that simply leading an ordinary life damages one's health, Swinburn and Egger (2002; Egger and Swinburn 2010) reframe obesity as essentially environmental in origin. This in effect re-moralises obesity as a population health issue, distancing weight gain from the 'gluttony or sloth' characterisation evident in early medical accounts of the obesity epidemic (Prentice & Jebb 1995). I argue that the focus of solutions thus also logically switches from individual behaviours to environments. In line with the principles of health promotion (WHO 1986) it also lays the groundwork for a conceptualisation of obesity as a matter of health equity — of the distribution of those social and structural factors that lead to obesity related ill-health. This focus becomes increasingly clear in the development of the obesogenic environment model itself over the 17 years of its history in numerous publications (Egger & Swinburn 1997; Gibbs et al. 2011; Sacks et al. 2008, 2009; Swinburn 2008; Swinburn et al. 1999; Swinburn & Egger 2002; Swinburn & Egger 2004). This reframing of the problem underpins contemporary recognition of the need for comprehensive policy with community-wide focus (Kirk & Penney 2013; Lobstein 2006) and also underpins the actual, formal policy responses of the SA government that are considered in the following chapters.

The obesogenic environment model becomes increasingly comprehensive over time. The 'ANGELO' framework ('Analysis Grid for Environments Linked to Obesity'), a

systematic method for identifying areas for change (Swinburn et al. 1999), draws on the settings approach of health promotion (WHO 1986; St Leger 1997), which was also applied in OPAL. ANGELO has been adopted by the WHO as one of three process tools used in developing its guide for implementing childhood obesity strategies (WHO 2012b). As Swinburn et al. acknowledge, the framework draws on concepts iterated in the Ottawa Charter such as health-enhancing environments, healthy public policy and intersectoriality (Swinburn et a1. 1999; Tsouros 1990; WHO 1986). The authors call for coordination across all levels of government in policy development and implementation, echoing principles from contemporary health promotion such as those advanced the Commission on Social Determinants of Health (CSDH 2008; Sacks et al. 2008).

The obesogenic environment model has had a wide uptake in Australia and elsewhere, and the literature frequently features calls from its authors, among others, for non-health policies to address the upstream drivers of obesity and the need for coordinated action (e.g. Gortmaker et al. 2011; Sacks et al. 2008, 2009; WHO 2012a, 2012b). However, very few practical examples are written about. While Allender et al. (2011) conducted a study interviewing key informants from local government about their support for various interventions addressing obesity, and Shill et al. (2011) explored support for regulatory intervention at state government level, these were essentially hypothetical and exploratory in nature. In contrast, Newman et al. (2014) detail how a 'Health in All Policies' (HiAP) approach to health promotion can be applied to the issue of obesity. The HiAP approach aims to improve population health and health equity by promoting cross-sectoral action on the social determinants of health, and has been implemented in SA since 2007 (Newman et al. 2014). In the 'SA Health in All Policies Healthy Weight Project', health promotion staff worked with non-health departments to identify common ground, helping policymakers understand how addressing the determinants of obesity aligned with their core business, thus providing a reason for them to take action. The outcome was policy commitments by ten departments included in the next iteration of SA's *Eat Well Be Active Strategy* (2011–2016) (SA Department of Health 2011). This approach would complement the obesogenic environment model.

As more factors come within the scope of what is defined as the obesogenic environment, that is, they are recognised as causal to the problem of obesity, a parallel recognition of the problem of obesity as an inequitable health phenomenon becomes evident. This is reflected in an increasing focus in the model on the need for the outcomes of changes to be equitable. Targets for change simultaneously become more upstream, and the fundamental role played by the social determinants of health in creating healthy environments and population health is increasingly acknowledged in later iterations of the model (Swinburn 2008). This can be seen clearly in Swinburn’s commentary (2009, p. 510) on how to close ‘disparity gaps’ in obesity, where equity forms the focus. In this, Swinburn (2009, p. 510) expresses a ‘social determinants’ approach of recommending policy actions on ‘upstream’ factors like employment and income as well as policies that influence the immediate environments in which health behaviours occur. This accords with current research on the connection between equity and health such as the Marmot Review (2010, p. 14), which identifies the need for ‘equality and health equity’ to be considered across all government departments, not just health.

Finally, the model also increasingly identifies the obesogenic role of industry — ‘the powerful commercial drivers promoting obesity and vested interests in maintaining the status quo’ — and what is required of government, observing that leaving individuals to solve obesity while industry remains unregulated and free to profit is ‘patently failing’ (Moodie et al. 2006, p. 137). This reaches its fullest expression in *Planet Obesity* (2010) where Egger and Swinburn identify the unrestricted growth of capitalism as causal to the problem of obesity. Nevertheless, they fail to take account of one of the fundamentals of capitalism — the principle of diminishing returns, whereby profits decline over time as markets become saturated; capitalism thus requires constant expansion of markets, and thus consumption, in order to just maintain profitability (Harvey 2007).

In contrast, a number of researchers such as Friel and Broom (2007), Moodie et al. (2013), and, most comprehensively, Guthman (2011), reflect a socioenvironmental view more fundamentally challenging to capitalism, creating a political–economic variation in this approach that continues the work of 19th century researchers such as

Engels. The latter linked disease to social and material deprivation and ultimately to capitalist relations of production (Tesh, 1988).

Friel and Broom (2007, p. 161) make accounting for the 'obesity gradient' central to their study. Casting a health inequalities lens across obesity, they find, 'the unequal distribution of the more distal and intermediate drivers of obesity add health disadvantage to those groups who are already disadvantaged in terms of wealth, power and prestige' (p. 149). This explains how distal factors, in turn, influence proximal factors like diet and physical activity. It is these distal factors that the political–economic scholarship is best able to explain. In her report to the NPHT, Friel (2009, p. ii) advised that the NPHT agenda is only realisable through 'action that tackles the underlying social drivers of these behaviours — the social determinants'. She explains the link between environment and behaviour, which offers an explanation for why obesity is distributed along the social gradient, stating that: 'what, and how much, people eat, drink, smoke and how they expend energy are responses to their socio-political, socio-economic, socioenvironmental and socio-cultural environments' (Friel 2009, p. 10). She further argues that the social inequities in people's living conditions lead to inequities in their health outcomes, in part because the capacity to choose healthy options declines with decreasing social status. Therefore, unless the healthy option is 'physically, financially and socially the easier and more desirable choice relative to the less healthy option', she argues that the healthy option is not in reality easier and thus is no more likely to occur (Friel 2009, p. i). This core issue of control is raised by Wisman and Capehart (2010, p. 939) who argue that the social gradient in obesity suggests there is a link between insecurity, stress, and obesity because the incidence of obesity is greater among those who experience the greatest disadvantage and least control over the most significant aspects of their lives.

Friel (2009, p. ii) advises placing equity rather than obesity at the centre of policy, as a 'central overarching goal of government … not just one of a list of issues, which can be ticked off by targeting poor and marginalised groups'. She suggests that applying a social determinants approach to health and health equity would profoundly challenge current policymaking, arguing compellingly for a collective rather than an individualistic approach to health, necessary if equity in health is to be achieved.

Reaching a similar conclusion, Moodie et al. (2013) in effect reframe the 'obesity epidemic' as an 'industrial epidemic', in which 'the vectors of spread are not biological agents, but transnational corporations' (2013, p. 671), recasting the core problem as corporate profit making, of which obesity is an effect or symptom, an argument developed in Freudenberg's (2014) problematising of neoliberalism. Cannon (2004) and Kwauk (2012) also position obesity as an end product of unjust economic relations, as a symptom of imperialism and colonialism respectively. Cannon (2004, p. 374), using the example of the sugar industry, problematises the pursuit and exercise of power by transnational corporations and 'imperialist' governments as undermining the WHO's Global Strategy on Diet and Physical Activity (2004) that would protect the health of low-income countries. An alternative view is propounded by Kwauk (2012, p. 50), who proposes that such documents are themselves instruments of hegemony and governmentality through which the powerful exercise control over smaller nations, reinforcing market inequalities in power.

Guthman's thesis, that the obesity problem is essentially a problem of the inequalities arising from capitalism, is also in this political–economic tradition. She argues that obesity emanates, in part, from capitalism's reliance on its production of cheap food that enables the rate of profit to be maintained through paying low wages, the toxic properties of cheap food and degraded land leading to weight gains among poor workers. However, by constructing the problem of the inequalities of obesity as a gap between the environments of the rich and the poor, Guthman does not address the existence of the gradient in obesity. Nevertheless, Guthman distances obesity from behavioural explanations rooted in consumption and highlights the critical role of production in creating obesity. This is at odds with neoliberal individualist ideology and the moralised accounts embedded deep within behavioural explanations. Through her explicit critiquing of the ideological nature of production and consumption in which obesity is materially based, Guthman provides the platform for a de-moralising of obesity discourse which, as noted above, underpins all discourses.

3.5.5 The role of ideology in framing obesity

Although equity is thus discussed in the socioenvironmental framing of obesity literature as both a driver and an outcome of obesity, Clark et al. (2009, p. 2) note after examining findings from 20 systematic reviews and one meta-analysis of obesity

prevention interventions conducted between 2004 and 2009: 'No reviews considered equity directly when examining the prevention of obesity in children and adolescents although some reviews did consider equity in their methods and interpretation of findings'. As established in this literature review, outside the socioenvironmental literature, the implications for equity are treated obliquely; the role performed by ideology is treated even more tangentially.

In their exploration of opportunities to influence obesity policy, Allender et al. (2011, p. 262) describe the policymaking process at some length, and while they identify the pertinence of 'competing human values, interests and belief', ideology is not identified as a relevant factor. The value base of policies is usually implicit. However, a recent document prepared for the WHO (Loring & Robertson 2014) explicitly states that the current WHO 'Health 2020′ policy framework is based not only on evidence but on values such as sustainability and equity in health and wellbeing. Kwauk's (2012) critique of the ideological function performed by the WHO's 2004 Diet and Physical Activity Strategy document, which she argues reinforces colonial power, is also an exception. Kwauk (2012, p. 44) suggests that the Strategy's disease focus, 'by directing our attention to the growth of obesity as a problem rather than a symptom', obscures the unfair global trade that has driven population-level weight gains. The same can be said of those discourses that place obesity rather than equity at the centre, as they similarly draw attention to medical or bio-health rather than political–economic-social solutions.

There is some discussion in the literature about the role of neoliberal ideology on health and on obesity via policy, such as Henderson et al. (2009), who explore the impact of neoliberalism on food and food marketing regulation. Similarly, Shill et al. (2011) consider the constraints on policy options exerted by the neoliberal climate, and Wisman and Capehart (2010) identify neoliberalism as driving economic policies that in turn drive obesity. Nevertheless, these critique the causes of obesity and do not consider the ideologies beneath the policy responses to obesity, that is, the solutions.

In contrast, Alvaro et al. (2010) explore the ideological underpinnings of Canadian obesity policy, identifying neoliberal ideology and specifically the dominant discourse of individual responsibility as key influences on policymakers. They argue that this contributes, in large part, to what they suggest is an overwhelming focus on change at

the individual level, despite evidence of the role played by structural determinants in creating health problems, including obesity. Using critical theory to analyse the power imbalance between government departments, they offer an explanation for how individualist policies dominate, suggesting that those departments directly linked to maintaining free market operation have greater power than those departments charged with promoting health. Like my research focus, Alvaro et al. (2010) also identify the need for policy to address the 'structural injustices' of the obesogenic environment. My focus, however, differs in that in addition to considering policy, my focus is also on the enactment of policy intentions via program implementation — that is, what ideologies are evident in practice.

Freudenberg's (2014, p. 95) analysis accounts for the inequitable impact of neoliberal pro-market policies and the distribution of ill-health and obesity that result from the domination of the 'corporate consumption complex'. Most of all, Freudenberg considers ideology as of central explanatory importance, as he argues that it is what connects the activities of the various corporate elements. This supports my decision to focus my research on how the ideologies embedded in healthy weight policies influence equity in health, although my examination is far more concentrated, substituting a focus on program implementation at the local level for consideration of policy at a national or global level.

Gard and Wright (2005) and Gard (2011a, 2011b) provide the only systematic examination of ideology within obesity debates and, while their work broadly relates to policy, it treats equity only peripherally. Their interest is primarily in how truth claims are made. They explore the nature of ideology — 'a moral position [which] generates a particular way of reading and interpreting science' — and how it is used to parcel up scientific evidence in pursuit of dominance in obesity discourse (Gard & Wright 2005, p. 146). They argue that every truth claim in the obesity debate has an ideological dimension, the implications of which are not explicit, but have far-reaching implications in practice.

While Gard (2011b, p. 45) acknowledges that there are 'many obesity researchers who argue in favour of fighting obesity precisely on the grounds of addressing health inequalities', the relationship between inequalities and ideology is not specifically explored. Gard and Wright (2005, p. 181) do, however, examine the relationship

between ideology and policy, suggesting that 'particular regimes of truth or "ideologies" provide resources for the ways in which bodies can be understood' and thus the ways they are treated (governed and regulated) by institutions like law, medicine, health and education and which are apparent, for example, in BMI classifications. After surveying the field of obesity discourse claimants, they conclude that the dominant ideology of the obesity epidemic is highly moralised and individualistic, arguing that 'the ideology of the "obesity epidemic" allows us … to construct those who are overweight as lazy and morally wanting' (Gard & Wright 2005, p. 182) resulting in the marginalisation of — and ultimately the discrimination against — large groups of people whom obesity policies are ostensibly designed to help.

In contrast, the core of Kwauk's critique (2012) is the inequitable impact on obesity of the maintenance of the power imbalance that forms part of the ideological underpinnings of international institutions. Analysing the construction of responsibility in documents of international governance, including the 'international development community', and drawing on Crawford's concept of healthism (1980), Kwauk (2012) argues that the dominant neoliberal discourse reconstructs the economic and political struggle that characterises obesity as a problem of individual behaviour and poor choices.

Kwauk (2012) thus illustrates how complex political problems are turned into simple lifestyle problems, with corresponding individual responsibility for solutions. She illustrates her argument with the example of Australian corporations selling EDNP products to Pacific Islanders who are then castigated for consuming the products and getting fat, thus becoming a 'burden to … Australian taxpayers' through the provision of international aid. Kwauk's analysis demonstrates how the moral deficit discourse surfaces through the individual responsibility discourse. In addition to highlighting Australia's complicity in cultural imperialism and in solving domestic market (and obesity) problems by exporting them to less-powerful countries, Kwauk's case study (2012, p. 41) illustrates how 'whole communities' are ascribed with lesser moral status, assigned 'positions along a social hierarchy of those who are worthy citizens and those who have failed', through moralising discourse.

This section has described how the problem of obesity is represented in the three health promotion frames, and then how ideology influences the framing of obesity as a problem and the solutions that logically arise from this. The solutions represented by obesity *policy* will now be considered.

3.6 The policy response to obesity

In this section, policy responses to the increasing problem of obesity are discussed. Policy documents were sourced from references in the literature (described above), from the WHO website, and from national and South Australian health department websites.

3.6.1 Global obesity policies

At a global level, the WHO has played a lead role in responding to the obesity epidemic, publishing a series of technical and strategic papers, most importantly the Global Strategy on Diet, Physical Activity and Health (WHO 2004), which laid the groundwork for the more recent series of evidence-based strategy documents developed following the WHO Forum on Childhood Obesity held in 2009. The Global Strategy (WHO 2004) explicitly recognises the need to focus on disadvantaged populations and focuses on the behaviours that may result in obesity; obesity is thus implicitly problematised as the product of behaviours.

The 2012 strategy documents provide a comprehensive guide to interventions, using a settings approach, and promoting the goal of reducing overweight and obesity in an equitable fashion. These documents (WHO 2012b) adopt the obesogenic environment model of obesity, identifying the significant role the private sector can play in creating environments that support or hinder healthy eating and physical activity behaviours. Core responsibilities are spelled out and specific actions identified regarding food formulation and marketing. This issue is highlighted here as the focus in local policy and programs, which also draw on the obesogenic environment model, are at times less clear about the responsibility of this sector, focusing more on individual consumption than corporate production.

All the WHO documents examined (2004, 2009, 2012a, 2012b) include the equitable distribution of improved health outcomes as a goal. The WHO's main action-oriented policy document (2012b, p.23) identifies social marketing and health promotion as

interventions that can potentially exacerbate inequalities as they rely on ‘end-user engagement and uptake’. To mitigate against this it is recommended that interventions target communities with high needs and provide them with additional support. Particular mention is made of the more equitable impact of ‘regulatory interventions, such as restrictions on food marketing to children’ (WHO 2012b, p. 23). This document (WHO 2012b, p. 69) also incorporates the ‘three public health promotion approaches for tackling the issue:

- ‘Socioecological (Upstream) approach: Policies that shape the economic, social and physical (built and natural) environments’
- ‘Lifestyle (Midstream) approach: Policies that directly influence behaviour (reducing energy intake and increasing physical activity)’
- ‘Health Services (Downstream) approach: Policies that support health services and clinical interventions’.

These definitions will be adopted in this thesis.

The WHO European Office recently released a report, *Obesity and Inequities*: *Guidance for Addressing Inequities in Overweight and Obesity* (2014)*,* indicating the significance obesity-associated inequity has attained. This report is also drawn on in Chapter 8 as it specifically focuses on obesity as part of the issue of inequity.

3.6.2 National obesity policies for Australia

The context of Australian governance

Australia is a federation with three levels of government: national, state and local council level. Most taxes are levied nationally and redistributed through the federally funded welfare system and state-administered but federally funded health and education programs. Local councils have authority for land usage such as development approval, and in South Australia have responsibility for administering the South Australian Public Health Act (2011). They also take over some of the functions in community health which prior to this Act were the responsibility of the state Department of Health, in addition to hosting locally delivered programs such as the Healthy Communities Initiative and OPAL. As Allender et al. (2011) note, however, local government in Australia has only limited direct responsibility for factors relevant to obesity. This might curtail the apparent opportunities brought with the new Act. In addition to their

powers being defined under state government legislation, the capacity of local government to act can also be proscribed by the exact nature of funding provided by state government (Allender et al. 2009). Australia's tripartite system of government is complex, with jurisdictional issues often making changes difficult and responsibility unclear. One example of this is the difficulties faced by South Australia's Minister for Health in trying to protect children's health (a state responsibility) by restricting television advertising of EDNP products to children (SA Department of Health, 2008) while lacking the authority to implement broadcasting controls or consumer protection from misleading advertising as these fall within federal jurisdiction (Henderson et al. 2009; Sacks et al. 2008). As Henderson et al. (2009, p. 1404) explain, while consumers are protected in theory by a system of co-regulation between government bodies and industry, '[i]n practice, responsibility for regulation of food advertising largely falls upon industry in Australia'.

National policies

When this study commenced in 2007, responses in Australia to the perceived 'obesity epidemic' abounded at all levels of governance, with a National Obesity Task Force, parliamentary inquiries at federal and state level, and a range of documents and programs detailing the policy responses of different government departments (Commonwealth of Australia 2003, 2006, 2009a; National Obesity Task Force 2005; Government of SA 2004a; SA Department of Health 2006a). The chief national policy response to overweight and obesity in children and families was *Healthy Weight 2008 — Australia's Future — The National Action Agenda for Children and Young People and their Families* (Commonwealth of Australia 2003) and in adults[1] was *Healthy Weight for Adults and Older Australians*: *A national action agenda to address overweight and obesity in adults and older Australians 2006–2010* (Commonwealth of Australia 2006). These were supported by a series of clinical diet and physical activity guidelines and strategies (Appendix A) and, more recently, *Clinical Practice Guidelines for the Management of Overweight and Obesity in Adults, Adolescents and Children in Australia* (National Health & Medical Research Council 2013). Food

[1] Healthy Weight 2008: Australia's Future — the National Action Agenda for Children and Young People and their Families is the overarching policy for children and young people (0–18 years, p. 1) Although this policy statement precedes Healthy Weight for Adults and Older Australians, I concentrate on the latter as the Healthy Weight Target, which is the focus of my proposed study, includes South Australians 18 years and older.

Standards Australia and New Zealand continue to provide guidance about food labelling.

Since *Healthy Weight 2008*, two framework documents relevant to obesity have been released: *Australia: The Healthiest Country by 2020, Technical Report 1, Obesity in Australia: a need for urgent action* (Commonwealth of Australia 2009b), and *Australia: The Healthiest Country by 2020, National Preventative Health Strategy — the roadmap for action* (Commonwealth of Australia 2009c), in which obesity is one of three priority areas targeted for behaviour-related intervention. A socioenvironmental approach is advocated, acknowledging that making healthy choices requires supportive environments: 'the healthy choice must be physically, financially and socially the easier and more desirable choice than the less easy option' (Commonwealth of Australia 2009b, p. 58). This document draws directly on Friel (2009). In terms of addressing inequalities in the distribution of obesity, both *Healthy Weight* documents (2003 & 2006) and *Obesity in Australia* (2009b) acknowledge the unequal distribution of obesity, highlighting that people of lower SES (particularly women) and Aboriginal and Torres Strait Islander people are more likely than other Australians to be obese. They advocate a 'combination of environmental and behavioural changes' (Commonwealth of Australia 2006, p.2) to address the issue, targeting groups with higher rates of obesity for additional help. The 2003 document includes among its aims the desire to 'Help those most in need and close the health gap between different population groups as a result of geography, ethnicity, and socio-economic status' (Commonwealth of Australia 2003, p. 4) and recognises that more than local changes will be required to achieve this. However, it contains only a few interventions targeting the social determinants of the inequalities in health, such as housing quality for Indigenous people, and food supply, access and security, and has a mainly proximal focus on healthy eating and physical activity. This was the document current at the time this study took place, and was prior to the WHO Commission on the Social Determinants of Health (2008), which raised awareness of the need to address structural drivers if equity in health outcomes was to be achieved.

There have also been two relevant Commonwealth parliamentary inquiries which resulted in the *Protecting Children from Junk Food Advertising* (*Broadcast Amendment*) *Bill* 2008; and *Weighing it up*: *Obesity in Australia* (the House of

Representatives Standing Committee on Health and Ageing 2009a). The second of these, and the process behind it, has drawn considerable criticism (e.g. Egger & Swinburn 2010), Olsen et al. (2009) noting that its terms of reference did not acknowledge obesity's unequal distribution, despite ample evidence from government-sponsored research, with the result that few of the 95 submissions reviewed addressed this evidence. Like Friel (2009), they reflect that obesity is unlikely to be reduced until the inequalities behind it are addressed, and suggest that:

> While the notion of 'health for all' is fundamental to public health and health promotion in Australia and implies a commitment to equity, unambiguous attention to it is required to ensure that health policy and practice does not unintentionally produce greater inequality. In the absence of politically sanctioned, overt attention to the drivers of inequitable health risks, exercises such as this obesity inquiry may exacerbate inequity because (correctly, from a pluralist perspective) they attempt to balance competing perspectives. (Olsen et al. 2009, p. 171)

Olsen at al. (2009) also observe that the inequality dimension can be rendered invisible by other arguments, despite there being a commitment to equity at a rhetorical level; this will be pertinent to the following section and to later chapters where I examine and describe state-level responses to the 'obesity epidemic'.

3.6.3 South Australian obesity policies

This section describes the policy context at the time this study began, 2007, as it is these policies and related programs, and key informants' responses to them, which form the subject of the analysis in Chapters 4, 5 and 6.

South Australia has had a Strategic Plan (SASP) since 2004, updated three times, which aims to provide both future directions and a framework for action for government, business and community sectors (Government of SA 2011a). The one pertinent to this thesis is the second iteration, SASP 2007. It has six overarching objectives, within which sit 98 specific targets. One is a Healthy Weight Target (Target 2.2), which sits under Objective 2, 'Improved wellbeing' (Government of SA 2007a, 2007b).

SA's strategic plans are updated annually with progress reports, and reflect a *joined up* approach by and to government, which has significance for the HWT. This target — with related strategic policies — reaches across several departments, with the South Australian Department of Health (SA Health) designated the lead agency (SA Department of Health 2008a). The for-profit and not-for-profit sectors are included to

varying degrees. A Healthy Weight Coordinating Group had responsibility for facilitating ‘a strategic and coordinated approach across SA Health’ (SA Department of Health 2009, p.4).

Healthy Weight Target 2.2 in the SASP was stated as: ‘Increase the proportion of South Australians 18 and over with healthy weight by 10 percentage points by 2014’ (Government of SA 2007a, p. 19). This target was modified from the earlier target in the original State Strategic Plan of 2004, ‘to reduce the percentage of South Australians who are overweight or obese by 10% within 10 years’ (SA Department of Health 2006a, p.3). The revised target limits its focus to adults and extends the timeframe. The 2007 target also expresses the goal in positive terms, as an increase in people with ‘healthy weight’, rather than a reduced number of people who are ‘overweight or obese’. While other targets potentially affect achievement of the HWT (see Chapter 8), my research has focused on policies directed towards families, including the adult population, parents, and children by implication.

Plans to address the SA Health-led targets in the SASP are specified in more detail in the SA Health Strategic Plan 2008–2010 (SA Department of Health 2008a), a document that links the SASP to the detailed planning document, the *SA Health Care Plan 2007–2016* (Government of SA, 2007c). The relationship between SA Health and the *SA Strategic Plan* is expressed thus: ‘South Australia’s Strategic Plan is an overarching framework for all SA Health activities, contributing either directly towards specific targets, or more broadly, to South Australia’s Strategic Plan objectives’ (SA Department of Health, 2008a, p. 2).

The HWT can be viewed as the initial response of the SA government to the ‘obesity epidemic’; the Eat Well Be Active Healthy Weight Strategy for South Australia 2006–2010 (EWBA) (South Australian Department of Health 2006a) is the SA government’s strategic response for meeting this target (Government of SA 2006a). While Healthy Weight Target 2.2 encompassed both the fields of nutrition and physical activity in the role they play contributing to weight, there was an additional independent target in the State Strategic Plan that to some degree overlapped this target: Target 2.3, Sport and recreation, which aimed to ‘exceed the Australian average for participation in sport and physical activity by 2014’ (Government of SA 2007a, p. 19).

The activities of The South Australian Health Department, SA Health, are also governed by the *SA Health Care Plan 2007–2016* (Government of SA, 2007c). Also contributing to EWBA are the Eat Well SA Public Health Nutrition Plan 2006–2008 (EWSA) (SA Department of Health, 2006b) and its predecessor, the Eat Well SA Project 1996 (preceding the Health Weight Target and thus independent of its aims – Smith et al. 2004), and the Be Active Physical Activity Strategy 2004–2008 (BA) (Government of SA 2004b). A further document, Eat Well Be Active Healthy Weight Strategy Priorities (*Priorities*, Government of SA 2009a), details 26 programs prioritised under the EWBA.

In terms of health equity, the Eat Well Be Active strategy and *Priorities* acknowledge the higher incidence of unhealthy weight in populations on low income (SA Department of Health 2006a, p. 9), and the EWBA objectives include: 'to make the greatest gain in those population groups who have the highest burden of overweight and obesity and poorest health outcomes' (p. 8). Although the unequal distribution of obesity is recognised, it is, however, represented more as a gap than a gradient, for example as a 'disparity between rich and poor' (p. 19). A commitment to 'Health Equity Actions', for instance to 'support policy initiatives which make healthy choices the easier choices for all but with benefit to disadvantaged communities' links the SASP to the SA Health website (SA Department of Health website 2015, accessed 23 May 2014). Likewise, EWSA (SA Department of Health 2006b, p. 3) also 'aims to … contribute to addressing health inequalities', while BA — a non-health document — does not. The relationships between these various policy documents are set out in visual form in Figure 3.1 below. The shaded boxes indicate the documents that are analysed in Chapter 5.

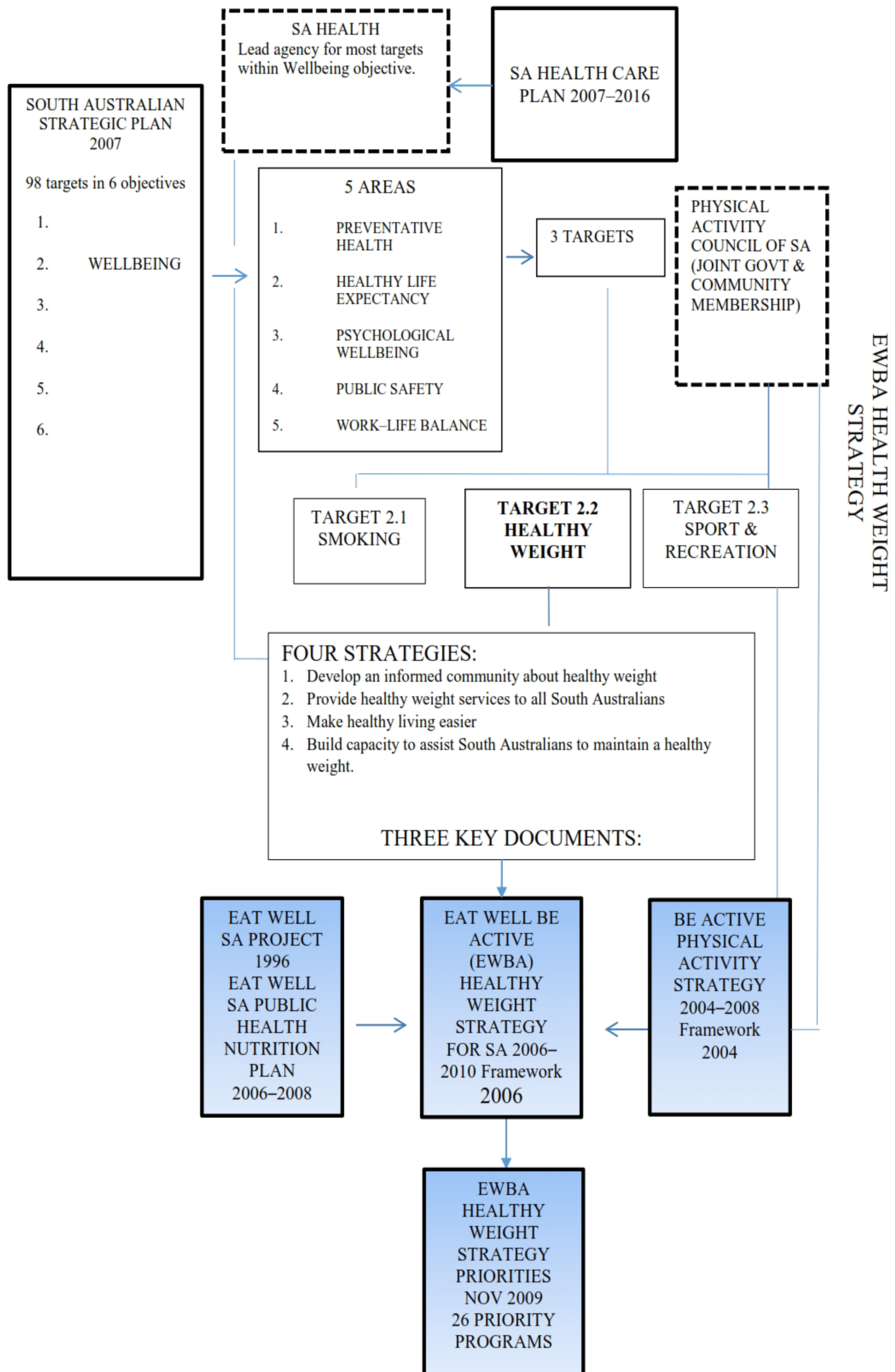
3.7 The neoliberal ideological context of obesity policy

Policy is situated within a political, economic and social context which, in the case of South Australia, is a minimalist '"liberal" welfare state', subject to the same forces of neoliberal market and cultural forces as the rest of the world (Esping-Andersen 1990, p.26; McDonald & Marston 2005), and is part of that global context often inimical to equity in health (CSDH 2008; Freudenberg 2014). Alvaro et al. (2010) note how the commitment of neoliberal welfare states to maintaining the dominance of the free

market leads to a failure to prioritise health interests through addressing the structural drivers of health problems such as obesity.

As Wisniewski (2011, p. 361) argues, the 'medical discourse on obesity' is historically 'expressed in ways that often support the prevailing political ideology expressed in public health approaches'. While the dominance of neoliberal discourse has been described as hegemonic (e.g. Bambra et al. 2007; Fischer 2003; Harvey 2007), Baum argues (2008) that the neoliberal construction of responsibility for health, though dominant, is not hegemonic. It is challenged by the social view of health that sees risks as emanating from social and structural determinants underlying behaviours, that is, apparent risky behaviours are responses to risk-creating environments (Baum 2008). Nevertheless, the ascendancy and pervasiveness of neoliberalism, which Jamrozik (2009, p. 36) refers to as an 'homogenisation of political systems and ideologies', means that civic and social goals (such as health and wellbeing) compete with the economic goals of government (Baum 2008). As policy sits within this context, neoliberalism may be viewed as one of the social determinants of obesity.

Figure 3.1: Relationships between 'healthy weight' policy documents in SA



Source: compiled by the author from Government of SA 2007c and 2007d

Among the features of neoliberalism which, 'since the 1980s', have 'increased the availability, affordability, and desirability of less healthful foodstuffs' and thus contributed to obesity (e.g. see also Smith & Signal 2008), Friel (2009, pp. 20–21) includes 'market integration, trade liberalisation, the growing influence of foreign direct investment, and the continuation of non-health focussed food subsidies'. She also includes global labour markets, extensive privatisation, the scaling back of the state, foreign investment, global advertising, and lack of corporate accountability.

Freudenberg (2014, p. 35) argues that fundamental changes in the way capitalism has functioned in the US since this time have led to 'hyperconsumption' to which he attributes much of the chronic disease burden in the world. Freudenberg (2014, p. 95) theorises that a 'corporate consumption complex' effectively dictates global food, alcohol, tobacco, pharmaceutical, car and gun production, marketing and distribution, and that this complex — united by the ideology of neoliberalism — is overwhelmingly motivated and positioned to maintain its profitability. It does so, he argues, by willingly sacrificing global population health and democracy, for example, through the corporate capture of regulatory processes — Gramsci's (1975a) political and economic institutions by which ideological dominance is secured.

Of particular relevance to this review is Freudenberg's (2014) identification of the integral role played by corporate consumption *ideology* in driving obesity and other chronic illnesses, as he suggests that its pervasiveness makes it seem unassailable and simply how things are. This makes it an instance of Gramsci's (1975b, pp. 334, 369) concept of hegemony as the 'common sense' ideology of a whole social order — so diffuse and embedded in institutional practices that it is not easily made visible and thus the object of challenge (Gramsci 1971; Harvey 2007; McLellan 1986). Freudenberg (2014) effectively does so by problematising the ideology of corporate consumption, making it visible and thus disruptible.

In this section I have described how obesity policy is influenced by the neoliberal ideological context in which it is largely embedded. The next section will conclude this chapter by summarising how the literature reviewed provides the basis for the research focus of this thesis.

3.8 Conclusion

When I began this research in 2007 the literature on obesity was already vast, and while a socioenvironmental approach was gaining ground, much of the framing was still behavioural and medical. Then, as now, discussion of obesity's distribution and the health inequities arising from this was found mostly in public health literature (e.g. Friel et al. 2007). While there was, and is, some recognition of the importance of addressing equity in obesity policy, and recognition of the role played by ideology in influencing policy, there remains relatively little literature exploring the link between ideology, inequity and obesity, especially at a program level. This review revealed that ideology is rarely highlighted in the literature, and that equity is omitted from many of the obesity frames and from the discourses that frame the literature and provide the evidence base from which policy is drawn. Research exploring which ideologies underpin obesity policies and programs, and how these influence the aim of achieving health equity, is thus lacking. This research addresses this gap by considering how much the aim of achieving health equity is embedded in the ideologies evident in the policy strategy designed to address SA's Healthy Weight Target and what ideologies concerning obesity underpin them and in a community-based program that forms part of this strategy.

The three health promotion frames outlined earlier in this chapter were incorporated into the framework (Bacchi 2009) used to conduct the discourse analysis, providing a means for interrogating the data and identifying the ideological framing of the policies and program. This will be outlined fully in the next chapter, which provides information about the research design and methodology of this study.

CHAPTER 4: METHODOLOGY

4.1 Overview of chapter

In this chapter I describe my research design which is underpinned by social constructionist epistemology and a qualitative paradigm, and is informed by critical theory. Schwandt (2000, p. 191), suggests that the relationship of theory to the practice of qualitative research is one where 'acting and thinking, practice and theory, are linked in a continuous process of critical reflection and transformation'. The iterative process Schwandt relates describes my own research journey as I found my understanding of the problems I was researching profoundly altered by reflecting on my findings and consequently seeking further theoretical insight to help understand and explain them. A description of the philosophical foundations of this research is followed by a description of the data generation and analysis methods, and an account of how research rigour was achieved.

4.2 Philosophical foundations

This section explains the epistemological and theoretical basis of this study, and how the key terms — *obesity, power, ideology, hegemony, discourse* and *equity* — are understood and used.

4.2.1 Social constructionism

This research takes a critical perspective. Patterson and Johnston (2012, p. 279), following Bhaskar, posit obesity as a 'hybrid construct that arises out of intersecting forces that are both natural and social'. Obesity described as a heavy weight clearly exists independently of an observer, and is objectively measureable (and thus positivist). However, in this study I explored its broader usage since obesity has multiple and highly nuanced meanings beyond the mere physical; these meanings are constructed by people who are obese, by their critics, by researchers, and by health practitioners (Kwan 2009; Lawrence 2004).

Constructionism implies a realist ontology as it assumes the existence of objects independent of the observer, although their meaning is socially derived from the cultural understandings and preconceptions which the observer brings to the interpretation (Crotty 1998; Patterson & Johnston 2012). Schwandt's (2000, p, 198)

elaboration — that social constructionism assumes that knowledge is 'in some sense ideological, political, and permeated with values' — accords with my approach.

This research uses a moderate or weak version of social constructionism that Alvesson and Skoldberg (2009, pp. 34-5) describes as an 'epistemologic variant' that contends that 'knowledge is socially constructed', rather than the ontological version in which 'reality itself is a social construction'. This 'epistemologic variant' of social constructionism is compatible with critical realism in that it acknowledges a reality existing beyond the observer, but which can only be known socially, that is, through the observer. This variant of social constructionism is compatible with the method of policy discourse analysis described by Fischer (2003, p.54), which considers that 'the very objects of inquiry are constituted through a mix of physical objects and social interactions'. Sayer (1997, p.466) describes a weak form of social constructionism as one which regards knowledge and institutions as social constructions, noting that 'Realists can happily accept weak social constructionism, while noting that the social character of knowledge does not mean that it cannot successfully identify real objects (including social constructions) which exist independently of the researcher.' As Crotty (1998, p.63) notes, 'Social constructionism is at once both realist and relativist.'

As Baum (2008) reflects, qualitative research methods are most useful for the in-depth study of the broad social and structural factors which influence health, into which description my study fits. 'Interpretative methods, generally based on qualitative techniques, are well suited to studying such complex situations and offer much to the study of public health.' (1995, p.459). Discourse analysis sits within the interpretivist tradition (Baum 2008, p.196). Discourse analysis as a research method is logically compatible with social constructionism (Bacchi 1999, p.49). Fischer (2003, pp.13-14) advocates combining a 'social constructionist view of social inquiry with the role of discourse in the shaping of social explanation and understanding' to explicate 'policy questions and … the ways normative presuppositions operate below the surface to structure basic policy definitions and understandings' (p.14). His description of his focus as being on the 'vocabularies and concepts' used to describe and represent objects rather than on objects and their properties themselves (2003, p.130) describes the moderate form of social construction followed in this research. The aims of this research also align it with those described by van Dijk in his 'Principles of critical

discourse analysis' (1993, p.252), that is, 'to get more insight into the crucial role of discourse in the reproduction of dominance and inequality' (p.253).

4.2.2 Critical theory and key concepts: ideology, discourse and equity

Selection of a research methodology should be guided by its ability to shed light on the research objectives, while a theory needs to be able to explain the research findings (Patton 2002; Punch 2000). The key concepts at the heart of this thesis — *ideology*, *discourse* and *equity* — presuppose a theoretical perspective that recognises both the validity of these terms and the importance of research objectives based on them. I have chosen to use critical (social) theory as my research perspective because it helps explain the issues I am most concerned with — ideology; power, both material and discursive; and equity.

I use the term critical theory in the broad, intentionally inclusive sense employed by Kincheloe and McLaren (2000, p. 291) who describe it thus: 'A critical social theory is concerned in particular with issues of power and justice [equity] and the ways that the economy, matters of race, class and gender, ideologies, discourses and cultural dynamics interact to construct a social system'. It thus provides a theoretical basis from which to critique the impact of capitalism on policy, and particularly neoliberal capitalism-based domination, which influences how ideology can become hegemonic (Kincheloe & McLaren, 2000). Jackson et al. (2014) draw on critical theory to examine the influence of integrated marketing communication in contributing to the obesogenic environment. The authors argue that hegemonic processes 'help to reinforce and expand the powerful position of the food and beverage industry within western society' (p.490). They consider hegemony as one of the "'enabling processes' of power" (p.491) that is, one of the ways by which power imbalances in capitalist society are maintained, here, through dominance of cultural institutions and content, bringing about cultural consensus. This conceptualisation of hegemony will inform the analysis of my findings.

Kincheloe and McLaren (2000) present the critical theorising of power in three ways: as productive and/or oppressive, expressed discursively; as ideology; and as hegemony. These are core concepts to my research, so they will be briefly discussed in turn.

Power: Productive or oppressive

In the analysis of policy and discourse, power is commonly used in two distinct senses. The Marxist conception of power is as a force exerted on a person from outside, that is, as oppression. In conjunction with this stands Foucault's conceptualisation of power as the ability to enable subjects to conduct themselves appropriately, which includes the concept of empowerment, with power conceptualised as diffused throughout society and apprehensible to everyone (Petersen 2003). Power used in both senses is relevant to this study, and critical theory offers insight into both understandings. Chapter 3 described the link between self-determination, which is one form of empowerment, and the social gradient in health and obesity. Researchers have noted this from data as varied as the Whitehall II cohort study of London-based civil servants (Martikainen & Marmot 1999), data gathered for the Commission on Social Determinants of Health (Marmot 2007), and data drawn from the US National Center for Health Statistics (Wisman & Capehart 2010), that weight and poor health increase as SES and control over one's circumstances decreases. Critical theory exposes how power can be used oppressively, and by whom, to curtail the power of others to control their own life (self-determination). It provides a framework for seeing how such power is not random but is entrenched through social and economic relations, so that the power to rule oneself is undermined by the exertion of (oppressive) power by the ruling class acting in its own interests, that is, to maintain the status quo under which it dominates. Kincheloe and McLaren (2000, p. 283) suggest that critical theory is 'intensely concerned with the need to understand the various and complex ways that power operates to dominate and shape consciousness'. The tools for making such an analysis are essential for my research.

Most of all, critical theory aims to identify 'who gains and who loses' in 'particular social arrangements and the processes by which such power plays operate' (Kincheloe & McLaren 2000, p. 281). Public policy is one such process that can either challenge or reinforce inequalities in the distribution of power and the benefits associated with it. Critical theory can thus help identify the interests at stake and hence, for my purposes, how responsibility for change might be ascribed. Two associated concepts — ideology and hegemony — will now be examined.

Ideology

While I agree with the observation, derived from Gramsci (1975a), by Kincheloe and McLaren (2000, p. 303) that 'The dominant ideology is the expression of the dominant social group' it is necessary to elaborate on how ideology was understood and used in this research. Ideology has a number of meanings, the most basic being a 'system of ideas' (Gramsci 1975a, p.175). This general meaning underpins the more specific and political uses of the term that I employed in this study. I used ideology in the sense developed by Gramsci who built on Marx's proposition that ideologies are founded on economic structures and relations, though accepting Marx's notion that these are distorted by class interests (Abercrombie et al. 1988; Gramsci 1975a). Two aspects of Gramsci's theory of ideology, laying the basis for his concept of hegemony, were important for my research.

Firstly, Gramsci (1975a, 1975b) argued that class domination required the operation of ideological apparatus as well as economic factors. He theorised that the beliefs which favoured the ruling class and secured its domination were embedded in and propagated through institutions such as schools, courts, the media, church and family, through 'a multitude of … so-called private initiatives and activities … which form the apparatus of the political and cultural hegemony of the ruling classes' (Gramsci 1971, p. 258) to which can be added 'medicine' (Waitzkin 1989, p.223).

Secondly, Gramsci (1975b, p. 330) proposed that ideology was able to operate independently of economics as it drew on 'two theoretical consciousnesses': the beliefs imposed by the dominating capitalist class that controls the economy, and people's own experiences as a working class, which he theorised generated independent beliefs through which the dominant beliefs could be challenged. This understanding of ideology is essential to my analysis as it highlights instances of resistance to dominant neoliberal ideology; it is also the basis for many ideas underpinning both Marxism and empowerment, as it theorises the possibility that people can change their circumstances by struggle (thus privileging agency over structure), meaning that hegemony is never complete (Abercrombie et al. 1988; Gramsci 1971, 1975a).

My understanding and usage of ideology was also influenced by three ideas developed by Althusser (1994, p. 136): his conceptualisation of ideology as a practice for securing class domination, as well as a set of beliefs; his notion that ideology is imposed without

being consciously apprehended, and can thus in turn be expressed without intention, 'subjects' believing they act 'all by themselves'; and his argument that ideology plays a role in constructing individuals' identities and allotting them a role in society ('interpellation' ; Althusser 1994, p. 130; McLellan 1986).

Bambra et al. (2007, p.572), in their 'politics of health glossary', note the usefulness of analysing the ideological influences on health which, they observe, are frequently identified but seldom explored: 'Ideology is a system of inter-related ideas and concepts that reflect and promote the political, economic and cultural values and interests of a particular societal group.' Following Bercovitz's (2010) use in their analysis of health promotion, I have drawn on Hall's (1995) explanations and usage of 'ideology' which further elucidates Althusser's work. Hall argues that we speak through ideologies as part of our sense making of experience, at an unconscious (or 'taken-for-granted' - van Dijk 2001, p.355) level, that is, we draw on ideological premises without knowing we do so. This is the way I have understood ideology to operate, for example in my analysis of OPAL respondents (Chapter 7).I drew on these understandings of ideology to examine both how the neoliberal capitalist context in which healthy weight policy is situated influences the impact of such policy, and how such policy itself can perform an ideological function in constructing responsibility for weight, while the concept of ideology as unconsciously held beliefs underpins the rationale of discourse analysis.

Hegemony

Gramsci's concept of hegemony is thus a broader and more dynamic concept than ideology, and plays an instrumental role in how he theorised power. Gramsci (1975a, p. 183) refers to the 'struggle for hegemony', representing hegemony as a means of eliciting consent to rule — of establishing 'a certain equilibrium' — rather than as a means to 'subordinate' the interests of the working class. Kincheloe and McLaren (2000) further clarify the relationship between ideology and hegemony. While they describe ideology as the expression (a 'discursive regime') of certain groups, which may or may not be dominant, they note: 'Hegemony refers to conventions and constructs that are shared and naturalized throughout a political community. Hegemony works both through silences and repetition in naturalizing the dominant worldview' (Kincheloe & McLaren 2000, p. 303).

Gramsci's (1975a, p. 180) description of hegemony as one set of ideas — or the worldview — of the ruling class which 'tends to prevail, to dominate, to spread across the entire field, bringing about, in addition to economic and political unity, intellectual and moral unity … on a universal level' is especially important for this research. It helps explain how one's own interests can seem identical to, and inseparable from, those of the dominant group, making alternative thinking — and challenge — difficult. The significance of this pervasiveness and effective invisibility of hegemony is summarised by Eagleton (1994, p. 198): 'Once power nakedly reveals its hand, it can become an object of political contestation'; it is the task of critical analysis to contribute to this goal. These understandings informed my analysis of discourse.

Recent work in critical public health offers further insights into how an exploration and understanding of the concepts of ideology and hegemony can help explicate public health issues and policy. Scott-Samuel et al. (2009, p.289), drawing on Bambra et al. (2007) in their application of Connell's (1987) concept of 'hegemonic masculinity' to explain health inequalities, express the concept of hegemony well, as a 'process whereby popular beliefs or ideologies are adapted and incorporated into establishment values and ideologies and reinforced by those with political and cultural power to the extent that they become perceived as both natural and inevitable.' They argue that hegemony is a dynamic but subtle process that can undermine explicit attempts to create public policy which is non-patriarchal. This understanding of hegemony is relevant to my own analysis, particularly my suggestion (6.5.3 Principle of positivity, paragraph 7, p.144) that neoliberal ideology exerts a gravitational pull on the framing of policy, whereby explicitly stated intentions not to hold individuals primarily responsible for their weight are undermined by the pervasive but subliminal neoliberal doctrine of individual responsibility, sometimes resulting in behavioural interventions.

Discourse

The critical perspective also offers insight into the role of discourses in expressing power. While Foucault rejected the concept of ideology for discourse (Barrett 1991), his conceptualisation of 'discursively based' power as dispersed throughout social practices and institutions (Fischer 2003; Petersen 2003; Rose et al. 2006) builds on Gramsci's work. Fischer's (2003, p. 73) suggestion that 'discourses represent specific systems of power and the social practices that produce and reproduce them' illustrates

the closeness in meaning of the terms ideology and discourse. Discourse is understood here as referring to language that represents a particular way of thinking and talking about an issue (Abercrombie et al. 1988).

In the field of discourse analysis, Lupton (1992, p. 145) describes discourse as 'a patterned system of texts'. Policy can be viewed as one particular kind of language text. Policy discourse is a means for propagating the aspirations of government. Writing from the perspective of policy analysis, Fischer (2003, p. viii) notes that 'discourses both frame and carry knowledge', reflecting the constitutive, and powerful, nature of discourse. He further suggests that policies 'reflect and sustain particular beliefs and ideologies', recommending that 'to understand how a particular condition becomes constructed as a problem, the range of social constructions in the discourses and texts about it need to be explored' (Fischer 2003, p. 62). This is what this research does, using Bacchi's (2009) guided discourse analysis framework.

Bacchi's (2009) concept of problematisations can be understood as containing the core ideological framing of issues. My discourse analysis is informed by frame theory (Fischer 2003; Rein & Schoen 1993). Rein and Schoen (1993, p. 146) describe framing as 'a way of selecting, organizing, interpreting, and making sense of a complex reality to provide guideposts for knowing, analyzing, persuading, and acting'. Frames are thus essentially mental principles of organisation, simplifications that influence how a problem can be though about, as they highlight some aspects of an issue and exclude others (Fischer 2003, p. 143). Frame theory proposes that how an issue is represented as a problem influences the kind of solutions that will be adopted. Frames are signified by particular discourses, which in turn indicate certain ideological positions. Goffman (1974, p. 564) theorises that analysing frames provides a means through which 'What is implicit and concealed can … be unpacked, unravelled, revealed' and thus laid bare and potentially disrupted, which is the aim of research conducted from a critical perspective (Crotty 1998).

Bacchi (1999, p.40) notes the 'multiple and contradictory' nature of discourses, later (2009, p. 35) describing them as 'socially produced forms of knowledge that set limits upon what it is possible to think, write or speak about', as 'powerful fictions' that 'make things happen, most often through their truth status' (p. 35). Kincheloe and McLaren (2000, pp. 284, 299) define discourse as 'a set of tacit rules' regulating what

can and cannot be said, and who may speak and who remain silent, with the powerful constructing ‘truth’: ‘Critical research traditions have arrived at the point where they recognise that claims to truth are always discursively situated and implicated in relations of power’.

Lupton (1992, p. 145) argues that discourse analysis is ‘pertinent to the concerns of public health’ as it involves the critical analysis of how language reproduces dominant ideologies. Discourse analysis seeks to make explicit what is implicit in a text and is thus the most appropriate method for my objective of identifying ideologies embedded within health policy discourses.

Equity

In Chapter 3 I presented evidence and explanations arguing that the unequal distribution of obesity across the population constitutes a health inequity. One of the concepts my analysis explored was *equity,* a concept that includes a normative element in that it describes something claiming a moral basis (Whitehead 1992). The methodology I chose to use is one that has ‘an explicitly normative agenda’ (Bacchi 2009, p. 44; see also vanDijk 1993) as it aims to examine how problem representations contained in policies impact on people.

4.3 Methodology

4.3.1 Qualitative research

Qualitative methods were chosen for this study as they lend themselves to the exploration of meanings (Crotty 1998). The kind of questions I was seeking answers to were not quantitative in nature. As Denzin and Lincoln (2000, p. 13) explain, qualitative research is concerned with ‘the socially constructed nature of reality’. Qualitative methods allow us to examine in depth and in detail the meanings that are not possible using quantitative approaches, thus facilitating the study of specific and contextualised phenomena (Guba & Lincoln 1994; Patton 2002) such as the HWS and OPAL program in this research. In discussing research methods applicable to public health, Baum (2008, p. 180) suggests that qualitative research methods are better suited to cope with ‘complexity and naturalistic settings’, allowing the in-depth study and explanation of influences on health that includes economic, political, social and cultural

factors. These characteristics make qualitative methods suited to my study, and will now be described.

4.3.2 Research design

This was a mixed methods study of SA Health's response to the SA government's Healthy Weight Target (HWT). Using qualitative data, in this research I explored the ideologies and discourses underpinning the policies addressing the HWT of the 2007 South Australian Strategic Plan and one of the associated community programs, and the extent to which health equity was embedded in the ideologies identified. The design had three stages, comprising: (1) an analysis of Healthy Weight Strategy (HWS) policy documents, (2) an analysis of OPAL program documents, and (3) interviews with OPAL program workers and Advisory Committee members. The research design is expressed diagrammatically at Figure 4.1.

The research was conducted in this way so that analysis of data from each stage could inform the next stage of the study. This happened in two ways. The method of analysis was refined each time it was applied in order to meet the particular research requirements of each stage in accordance with the requirements of the data, thereby producing increasingly nuanced results. At the same time, and most importantly, there was a gradual accumulation of broad data that provided the foundation for the analysis and final discussion of the findings.

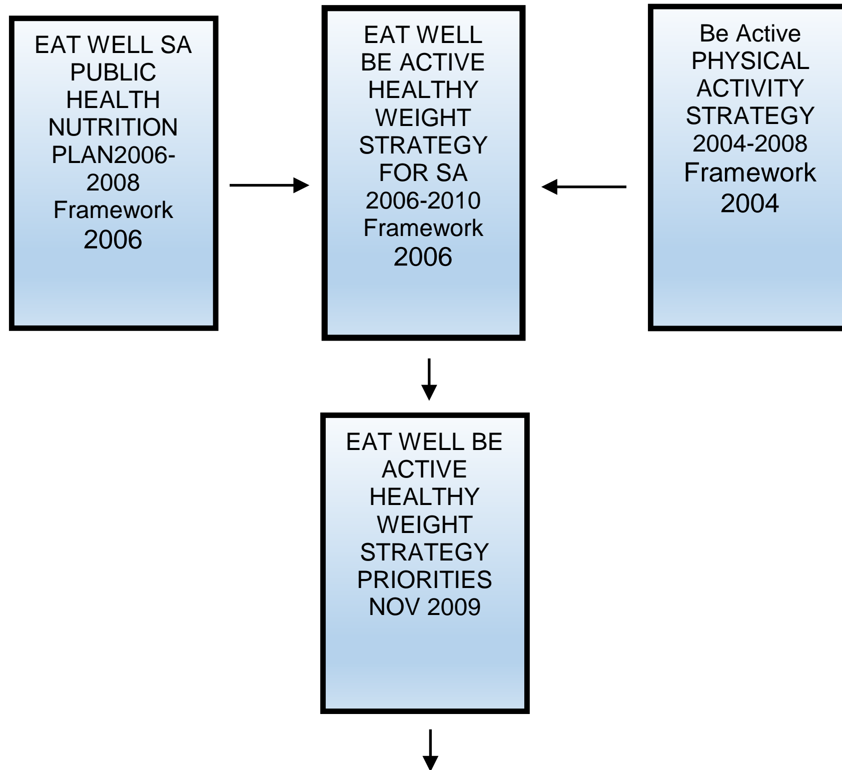
4.4 Research methods

4.4.1 The What's the Problem Represented to be? (WPR) approach

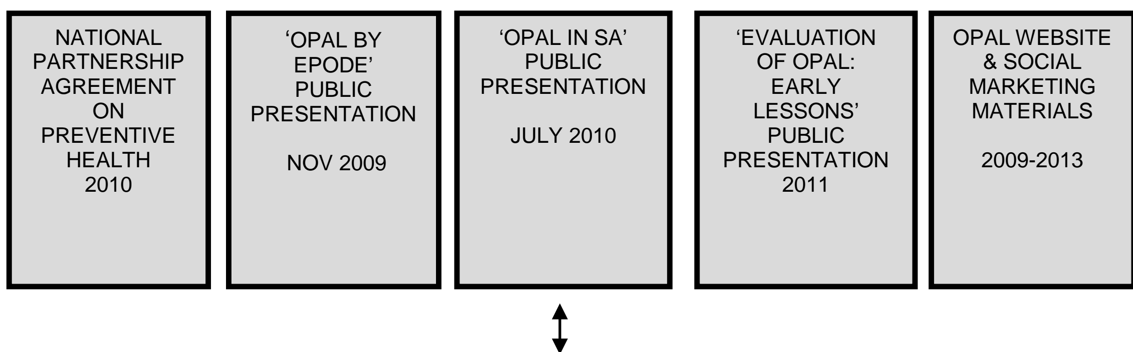
Governmentality scholarship posits that 'Government is a *problematizing* activity' (Rose & Miller 1992, p. 181) [emphasis in original]. Building on this notion, Bacchi (2009, p. 25) argues that 'We are governed through problematisations' rather than through policies. Bacchi developed the WPR approach to facilitate the analysis of these problematisations. The WPR approach provides a framework of questions for interrogating policies so as to uncover problematisations embedded in the policy discourse (Bacchi 2009).

Figure 4.1: Research design

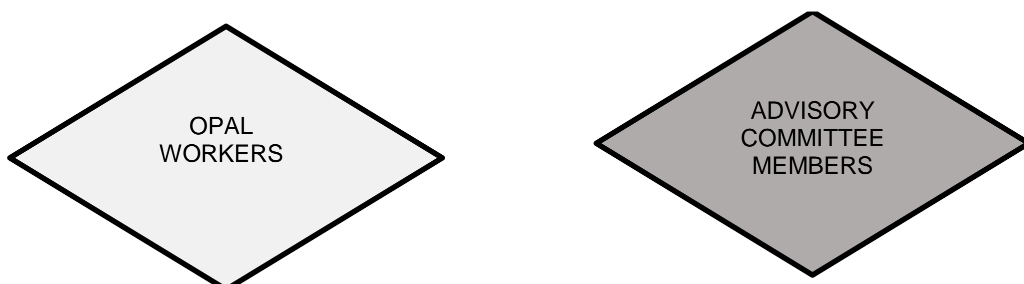
(1) ANALYSIS OF HEALTHY WEIGHT STRATEGY DOCUMENTS: Addressing *Research questions 1 & 3*



(2) ANALYSIS OF OPAL PROGRAM DOCUMENTS Addressing *Research questions 2 & 3*



(3) OPAL PROGRAM INTERVIEWS Addressing *Research questions 2 & 3*



Bacchi's (2009, p. 48) original six WPR questions are as follows:

1. *What's the problem of obesity represented to be in a specific policy?*

This asks us to consider how the issue at hand is constructed.

2. *What presuppositions or assumptions underlie this representation of the 'problem'?*

   This question explores the 'conceptual logics and political rationalities' that underlie the 'problem' representation identified at WPR 1.

3. *How has this dominant representation of the 'problem' come about?*

This question explores the history of this problem representation, that is, what led to this representation becoming dominant?

4. *What is left unproblematic in this problem representation? Where are the silences?*

At this point, the focus changes to explore what is left out by this representation of the problem, that is, what is not problematised. Focusing on the 'silences' is a way of speculating about other ways to present the problem.

5. *What effects are produced by this representation of the problem?*

This question invites us to evaluate problem representations in policies by examining their effects, to critically assess the implications that flow from this way of representing the 'problem'. Bacchi draws attention to three kinds of effects: 'discursive', 'subjectification' (that is, how people are created as subjects), and 'lived' or material effects. This question highlights power — who wins and who loses as a result of the problem representation, and in what way, and who is held responsible for it.

6. *How/where is this representation of the 'problem' produced, disseminated and defended?*

This question considers how the problem representation is propagated. By examining how problem representations 'secure their authority', 'opportunities for disruption' and resistance can also be identified (Bacchi 2009, p. 45).

I modified and extended Bacchi's original six questions to include a more nuanced version of a seventh question that she devised specifically for analysing health policy, and added my own eighth question to draw out the implications of the analysis for health equity, based on my research focus. Other researchers have described their tailoring of the WPR approach to meet the purposes of their particular research focus (e.g. Cort 2011). Bacchi (1999, p. 13) introduces her approach as 'providing the conceptual tools to interrogate [problem] representations', and recommends using the WPR questions as a 'starting place … to initiate a What's the Problem? approach of any selected issue'. The WPR questions thus form a guide rather than a prescription for conducting interrogations aimed at elucidating problem representations. I created and applied the abbreviated form of the WPR template for healthy weight analysis illustrated at Figure 4.2.

Bacchi (2009, p. 128) suggests including a seventh question specifically for health policy analysis on the grounds that health is a 'slippery concept rather than a fixed idea'. However, I modified Bacchi's (2009, p. 140) inclusion of two health paradigms — the 'biomedical' and the 'social' — to incorporate the three health approaches (Baum 2008; Labonte 1993) of biomedical, behavioural and socioenvironmental that I had identified in my literature review. I felt that separating Bacchi's 'social' into 'behavioural' and 'socioenvironmental' would provide the nuanced result my research focus demanded.

Thus, the extra modifications (italicised) were:

7. *Does the document:*

   a. represent the 'problem' of *obesity-related* 'ill health' to be biomedical, *behavioural or socioenvironmental*

   b. represent the 'problem' *of obesity-related* 'ill health' to be either a curative or a preventive 'problem'

   c. represent 'prevention' to be a biomedical, *behavioural or a socioenvironmental* 'problem'

d. represent ‘prevention’ to be an individual (*i.e. biomedical and/or behavioural*) or socioenvironmental ‘problem’?

My second modification was to extend the Bacchi method by adding an eighth question. This highlighted the effects of the problematisation on equity, which was integral to answering my third research question.

8. *Is equity a consideration? How is it represented? Is it inherent or added on?*

As I analysed each section of a document or each theme in an interview (see below), I documented the analysis in the template. An example of applying this process to Section 3 of the *Eat Well Be Active Healthy Weight Strategy*, ‘Box 3: Influences that affect weight’, ‘Food Supply’ setting (SA Department of Health 2006a, p. 10) is included at Appendix B.

Figure 4.2: WPR template for the healthy weight analysis

Q1: What’s the dominant problematisation in this section of the document?
Q2: What are the underlying assumptions, logic?
Q3: How did this come about?
Q4: What remains unproblematised? What is missing? Who is silent?
Q5: What effects are produced; what are the implications (and for whom) of this problematisation in this policy? What is changed and what stays the same? How is power distributed? (Who wins/loses?) What are the subjectifications? Who is responsible for solving the problem? Who is blamed?
Q6: How and where is this problematisation produced and spread?
Q7: How is the ‘problem’ framed? a. Is the problem of obesity framed as a biomedical, behavioural or socioenvironmental problem? b. Is the problem of obesity framed as curative or preventive? c. Is the prevention framed as biomedical, behavioural or socioenvironmental? d. Is this framed as the responsibility of the individual or socioenvironment?
Q8: Is equity a consideration? How is it represented? Inherent or added on? Does the resulting policy present an upstream, midstream or downstream approach to the ‘problem’?

WPR approach — transparency and reflexivity

The WPR approach promotes transparency and assists the researcher to be reflexive as it calls for 'detailed introspection' as a 'political practice' (Bacchi 2009, p. 45), most particularly through Bacchi's final injunction to problematise one's own problematisation. This is a highly iterative process in which tabulated analyses were repeatedly examined and recategorised so they could be synthesised into a meaningful and also manageable problem representation. It helped generate new insights into both the text under consideration and into how — and to what purposes — discourses are employed.

4.4.2 Sampling strategy

As described in the literature review, an updated HWT was included in SA's Strategic Plan of 2007, and aimed to 'Increase the proportion of South Australians 18 and over with healthy weight by 10 percentage points by 2014.' (Government of SA 2007a, p. 19). Because SA Health was designated the lead agency for the HWT, my research focused on identifying and then analysing the policies developed or adopted by SA Health in its *Eat Well Be Active Healthy Weight Strategy for SA* (EWBA) (SA Department of Health 2006a). These consisted of the *Eat Well South Australia Public Health Nutrition Action Plan* (EWSA) (SA Department of Health 2006b), the *Be Active Physical Activity Strategy for South Australia* 2004–2008 (BA) (Government of SA 2004b), and the *Eat Well Be Active Healthy Weight Strategy Priorities* November 2009 (*Priorities*) (Government of SA 2009a).

To ensure comprehensive coverage, internet searches were also conducted of databases and the grey literature, and government websites searched for documents that related in some way to the HWT. References listed in these documents were also followed up. This yielded over 50 documents that related broadly to the HWT (see Appendix C). They provided background context to this study but were not analysed. Finally, key informants were asked to review the resulting policy lists for any omissions.

The four documents — EWBA, EWSA, BA and *Priorities* — were taken to comprise the policy response of the SA government to the HWT; although the EWBA, as the most direct expression of government intent regarding the HWT, formed the pivotal focus of this study.

The *Priorities* document (Government of SA 2009a) described SA Health's 'priority programs' within EWBA. From these the community-based childhood obesity program OPAL (Obesity Prevention And Lifestyle) was selected for study as it represented the most visible and largest financial commitment by the SA government to any single program in the EWBA. This, by inference, made it a significant part of how the government conceived obesity might be best addressed. All publicly available documentation for OPAL was scrutinised and five documentary sources were analysed, namely: the *National Partnership Agreement on Preventive Health* (Council of Australian Governments August 2010), which provided an overview of OPAL; three public presentations; and OPAL's website and social marketing material. The selection of interview participants is described below.

4.4.3 Healthy weight policy document analysis

Once the above listed policies were identified they were analysed as follows.

First stage: Familiarisation with the data

This stage consisted of repeated readings of policy documents and making notes, as recommended by Braun and Clark (2006). Documents were also scrutinised for references to other policies and to the academic literature, and these sources followed up. A similar approach has been described by other researchers as part of their interrogation of policy texts and processes, combining Bacchi's WPR approach with that of content analysis (e.g Carson & Edwards 2011; Cort 2011; Hagberg et al. 2013; McDonald 2014).

Second stage: Descriptive account

Comprehensive descriptive accounts were produced for each of the four core policy documents. Initially, these accounts closely reflected each policy document in terms of content and format, but in order to maximise their manageability they were then summarised, producing descriptive accounts of the most significant attributes, which then provided the basis for the next stage of analysis.

Third stage: Interpretive stage — Discourse analysis and identification of themes

A discourse analysis using the 'What's the Problem Represented to be?'(WPR) approach described above was then conducted on each descriptive account. This

accords with what Patton (2002, p. 453) describes as 'deductive analysis where the data are analysed according to an existing framework'. Analysis at this level seeks to explain rather than describe the content of the data (Patton 2002). As I systematically examined the descriptive accounts of each policy, tables were created for each policy with notes entered against the WPR questions, although reference back to the original policy documents was frequently made to cross-check for accuracy.

Examining the WPR-coded data from all four policy document tables, three themes were identified that explained the data in terms of my research focus: how the *problem* — of obesity/inadequate nutrition/inadequate physical activity — was represented; how the *causes of the problem* of obesity were represented; and how the *solution to the problem* was represented. These themes span Bacchi's original six WPR questions, reflecting the logical stage of analysis to which they corresponded and which they best illuminated, making explicit those questions eliciting the 'problem' and those eliciting the 'solution' that are implicit in Bacchi's original framework. The WPR questions were thus grouped as follows to provide a thematic framework: Theme 1: Representation of the problem (WPR Question 1); Theme 2: Representation of the causes of this problematisation (WPR Questions 2 & 3); and Theme 3: Representation of the solution to this problematisation (WPR Questions 4, 5 & 6).

Data were accordingly organised under these themes. Amalgamating and simplifying the six original WPR questions into three themes helped clarify how the final two (additional) question-groups, WPR7 and WPR8, related to the data and became Theme 4: The framing of this problematisation; and Theme 5: Implications for health equity respectively.

Fourth stage: Interpreting the themes: synthesised discourse analysis

This final stage involved producing a single synthesised account of the findings. Data from the four separate policy analyses were merged under the three themes of *problem*, *causes* and *solutions* to produce composite representations. These included primary and secondary problematisations to account for as much of the data as possible, and to also highlight any incongruences between the four policy documents. Synthesised accounts of the final two themes — the framing of the problem and the implications for equity — were then produced by applying the relevant WPR questions to the composite representations.

A single synthesised account of how the HWS represented the problem, its causes and solutions, its framing and the implications for equity was thus produced.

4.4.4 OPAL program document analysis

Selection of documents

OPAL (Obesity Prevention And Lifestyle) is an obesity prevention program that supports children and young people through their families and communities (SA Department of Health website 2015, OPAL, accessed 2009-2015). While drawing on expertise from similar South Australian community-based obesity prevention programs, OPAL is formally an adaptation of the methodology belonging to the French program EPODE — Together Let's Prevent Childhood Obesity — which was purchased by the South Australian Government from EPODE's parent company, Proteines Pty Ltd. Under the terms of its licence agreement, only documentation that was publicly available could be accessed for this study (Council of Australian Governments 2010, pp. 6–7).

These documents comprised:

- National Partnership Agreement on Preventive Health (August 2010)
- public presentations showcasing OPAL
    - 'OPAL by EPODE' (November 2009)
    - 'OPAL in SA' (July 2010)
    - 'Evaluation of OPAL: Early lessons' (December 2011)
- OPAL website and social marketing materials (2009–2014).

Ministerial press releases at the time of OPAL's launch in 2009 were also drawn on to provide additional background.

National Partnership Agreement on Preventive Health (August 2010).
Because OPAL received commonwealth and state funding, it was described in the National Partnership Agreement on Preventive Health (Council of Australian Governments August 2010). This document provides an official record of OPAL's origins, funding, targets, theoretical underpinnings, structure, implementation and evaluation and thus forms an invaluable source of background information.

Public presentations showcasing OPAL (November 2009, July 2010 and December 2011)

The public presentations were selected because they provided ‘snapshots’ of OPAL’s evolving research design over two years, from its inception as a derivative of the EPODE model in 2009 to its evaluation two years later as a fully-fledged and locally contextualised program embedded in 17 communities (Cobiac et al. 2011; SA Department of Health 2009). The evolving research design entailed changes in the relative prominence of the community development and social marketing components that were significant to my research focus as they reflect different ideological assumptions (e.g. Crawshaw 2013). The presentations were delivered to significant audiences, so it can be inferred that they were accurate representations of the program. However, as I could only access the visual component of the ‘text’, which would have also had a significant oral component, the richness of the data generated would have been reduced (Mason 2002).

OPAL website and social marketing materials (2009–2014)

The selection of the OPAL website and social marketing materials (SA Department of Health website 2015, OPAL, accessed 2009–2014) as data sources for analysis was made because they represent the OPAL ‘product’ directly accessed by members of the public and thus offer a different perspective to the other textual sources. Due to the finite quantity of official material available about OPAL, all relevant material available on their website on 6 April 2013 was analysed, supplemented by website social marketing material until 12 November 2014. The methods of analysis followed will now be described.

OPAL program data analysis

(a) The first and second stages of analysis.

The production of the descriptive accounts and discourse analysis of the separate documents followed the same process as described above for the policy document analysis.

(b) Third stage: Interpretive stage — Discourse analysis and identification of themes.

Bearing in mind Bacchi's (2009) injunction to problematise one's own analysis, I used the three themes from the policy document analysis to guide my analysis of program documentation. I was thus able to build on the framework of *problem*, *cause* and *solution* to move my analysis forward, identifying one central motif running through the data. This was 'whose is the problem represented to be?', or more specifically, who is constructed as responsible for making the changes required by the program? This resulted in three themes found in the OPAL program document analysis. These were the construction of responsibility through i) the commercial sphere; ii) the principle of positivity; and iii) the principle of choice.

(c) Fourth stage: Interpreting the themes: synthesised discourse analysis.

Data were then organised under these themes, and a composite analysis produced. By analysing the construction of the problem of obesity, its causes and solution, this secondary WPR analysis explored the issue of *responsibility for change* implicit in these constructions. Rather than simply being the seventh step in the WPR framework (WPR 7d), *responsibility* became the lens through which the previous answers to the WPR questions are viewed. The final step was to draw out the implications for health equity (WPR 8). Lastly, the findings from the two document reviews were compared.

4.4.5 OPAL interview analysis

Interview schedules

Drawing on the themes arising from the document analysis and in conjunction with my supervisors, a draft interview schedule was developed that was adapted to the three different groups of informants by varying the specific questions asked, based on their area of expertise. As Mason (2002) discusses, even when one's intention is to elicit the same information from different interviewees, it is often necessary to ask different questions. The schedule was piloted with colleagues familiar with the field and was then further refined. The schedules each consisted of approximately ten main questions, along with prompts and probes (McCracken 1988) (see Appendix D).

Ethics and recruitment

Approval to conduct the interviews was granted by the Flinders University Social and Behavioural Research Ethics Committee (Project Number 4617). Recruitment of SA Health staff was arranged with the manager of the Health Promotion Branch at SA Health. I requested that a list of names and contact details of potential participants be given to me to follow up as I considered this maximised confidentiality by concealing the identity of those who agreed to participate. Potential participants were then contacted by email as this accorded greater privacy than phone and enabled participants to respond at their convenience. Participants who agreed to participate were then sent an interview schedule, a letter of permission to participate from SA Health, a letter of introduction from my principal supervisor that also outlined confidentiality, and an information sheet about my research and myself. Participants were thus fully informed about the research and its aims, and what their involvement would be. Anonymity was preserved as far as possible by using pseudonyms in place of participants' names, and by not identifying their role in the program or the site at which they were located (Mason 2002). Copies of these letters can be viewed in Appendix E.

Ten key informants from OPAL were interviewed, five each from workers and Advisory Committees. Workers and Advisory Committee members were selected to represent a range of roles and perspectives. Workers included all senior professional staff within OPAL's central State Coordination Unit at the time. The other workers were managers selected from two of the six Local Council Teams (community sites) that were then operational; these sites were chosen because their longevity provided the opportunity to fully roll out the program. All coordination roles were thus represented, resulting in five of the nine OPAL workers at that time being interviewed. Five members from the two Advisory Committees were interviewed in order to provide a range of perspectives. These people were selected on the basis of their backgrounds and area of expertise and represented practice, university, policy and local government. This provided maximum variation or heterogeneity which, as Patton (2002, p. 235) notes, is useful when the researcher can only study a 'small sample of great diversity', as from it one can identify both 'unique characteristics and common patterns', both of which are informative. Because the interviews were designed to provide insight into the implementation or practice of the OPAL program, supplementary to the document

analysis, and given the restricted pool of potential respondents, ten was deemed a sufficient sample size for providing heterogeneity.

Workers and roles were identified through the SA Health website and by contacting the Health Promotion Branch of SA Health and the OPAL manager. Advisory Committee members were identified through public documents that provided the membership of the Scientific Advisory and the Strategic Advisory Committees.

Ten potential participants (workers and AC members) were emailed and invited to participate, and all accepted. At the conclusion of each interview participants were asked whether there was anyone they thought was essential for me to talk to, while not disclosing whether I had already or intended to interview them, in order to maintain confidentiality as far as possible. No participants suggested anyone additionally.

Interviews were conducted between November 2010 and January 2011, one by telephone and nine face-to-face; each taking 1–1.5 hours in locations chosen by the participants (usually their workplace). The exception was a follow-up interview necessitated by a participant needing to cut the original interview short and that was later conducted in their home at their request.

All participants agreed to the interview being recorded. Interviews were audiotaped and fully transcribed by a transcription editor, corrected by me after listening to/comparing transcripts with recordings, then sent to the interview participant for verification and amendment. While most participants reviewed their transcript and made only minor changes, one person made significant changes due to the political sensitivity of their situation (OPAL was frequently under attack in the media by an Opposition MP). Three participants trusted the use I would make of the transcript and chose not to review it.

Analysis of interview data

(a) First stage: Familiarisation with the data.

I immersed myself in the data by actively reading and re-reading the transcripts and listening to the audio recordings of the interviews several times, comparing them with the transcripts and making notes (Braun & Clarke 2006; Green et al. 2007).

(b) Second stage: Descriptive account.

A decision was made to also apply a process of open coding to the interview transcripts to complete the process described by Braun and Clarke (2006, p. 96) as needing to be 'thorough, inclusive and comprehensive'. The interviews were therefore downloaded into NVivo software (QSR International, Version 8, 2008) for initial coding. Braun and Clarke (2006, p. 89) note that coding all data results in a long list of different codes, which the researcher then starts to analyse, thinking about how to merge them to produce 'overarching' themes. Accordingly, similar nodes were then manually collapsed into categories using a colour key. From these categories, two overarching categories were identified, corresponding to the two components of OPAL. These categories were still descriptive rather than explanatory. As Green et al. (2007) describe, this was an iterative process, involving moving backwards and forwards checking and modifying codes for their accuracy.

For presentation and further analysis, the results were split into two groups: *workers* who were based in local OPAL communities, implementing the program, and coordinators who fulfilled various roles in the central management unit); and *Advisory Committee* (*AC*) *members*. The whole process was repeatedly discussed with my supervisors (as Mason, 2002, recommends). Descriptive accounts of the data were then prepared and presented under the two broad categories: the community-based and the social marketing components, with workers' comments preceding Advisory Committee members, to enable comparisons to be made more easily.

(c) Third stage: Discourse analysis and identification of themes.

Open coding of the interviews resulted in the identification of five themes: *complexity*, *socio-ecological approach*, and *equity* under the community-based component; and under the social marketing component, *origins in EPODE*, and *social marketing in*

practice. This coded material was then transposed onto the 5-part WPR tables devised during analysis of the policy documents. This enabled a vertical reading of the data contained in the four tables (workers' and advisors' accounts of the community-based and the social marketing components), highlighting significant attributes of the descriptive theme being analysed. An example has been included in Appendix F.

(d) Fourth stage: Interpreting the themes: synthesised analysis.

The four tables were then synthesised into one, with material from each of the four tables set side-by-side against the five main categories/representations of WPR 1: problem; WPR 2 & 3: causes; WPR 4, 5 & 6: solution; WPR 7: frame; and WPR 8: implications for equity. This enabled a 'horizontal' reading in which tensions and incongruences between accounts of responsibility for the problem and its solution to be highlighted. A summary of the policy approach or frame that problem representations corresponded to was elicited, and a projection of how the ideological underpinnings of such a framing of obesity were likely to impact on health equity, which corresponds to my fourth research question and is the ultimate purpose of this study.

4.4.6 How the research methods chosen relate to the purpose of this study

As outlined in Chapter 1, the purpose of this study was to consider the impact on health equity of the different ideological understandings of healthy weight that underpin South Australia's response to the Healthy Weight Target (that is, the EWBA Healthy Weight Strategy) and one of the associated community programs. The research questions, and the methods, data source and analysis that were used to answer them are set out in Figure 4.3.

4.4.7 Data generation

A number of theorists argue that the term 'data generation' is more consistent with a social constructionist epistemology than 'data collection' because it acknowledges the active role the researcher plays in producing (rather than discovering) the data (e.g. C Baker 2004, p. 163; Mason 2002, p. 52; Schwandt, 2000). I will adopt this terminology because I approach the policies themselves — the object of my study — as socially constructed, the result of the interaction of people (policy writers) with the 'obesity problem'.

Multiple methods of data generation

While multiple methods of data generation increase the rigour of a study (Mason 2002; Yin 2003), Mason also stresses the importance of being clear about how they integrate. In this research, analysis of the data generated from healthy weight policy documents was used as the basis from which to conduct analysis of program documents. This is apparent in the identification of themes during the critical phase of analysis, when the themes identified in program documentation built on and explored the findings from the policy analysis.

Figure 4.3: Research questions and data sources

RESEARCH QUESTION	METHODS	DATA SOURCE	DATA ANALYSIS
1: *What are the ideologies and discourses underpinning policies that are designed to contribute to achieving the Healthy Weight Target of the 2007 South Australian Strategic Plan?*	Policy document review	'Healthy Weight Strategy' Policy documents: *Eat Well Be Active Healthy Weight Strategy for SA 2006–2010; Eat Well Be Active Healthy Weight Strategy Priorities Nov 2009; Eat Well SA Public Health Nutrition Plan 2006–2008; Be Active Physical Activity Strategy 2004–2008.*	Descriptive analysis WPR approach
2: *What are the ideologies and discourses underpinning one of the community programs and its practice?*	Program document review Interviews with key stakeholders from program	OPAL program documents: National Partnership Agreement on Preventive Health; Public presentations showcasing OPAL — 'OPAL by EPODE' (November 2009), 'OPAL in SA' (July 2010), and 'Evaluation of OPAL: Early lessons' (December 2011); and OPAL website and social marketing materials (2009-2014). OPAL program interviews with workers and Advisory Committee members.	Descriptive analysis WPR approach, building on thematic framework from policy document review. Descriptive analysis Open coding WPR approach
3: *To what extent is the aim of achieving health equity embedded within the ideologies evident in the policies and program?*	Comparison of findings from analyses of documents and interviews	'Healthy Weight Strategy' Policy documents; OPAL program documents; and OPAL program interviews as above.	Comparative analysis

Analysis of data generated from program documentation both preceded and was contemporaneous with analysis of data generated from interviews with key program

informants. What I learned from the program document analysis informed the interview schedule I prepared; analysis of interview transcripts led me to source further social marketing materials referred to by participants and to review those I had already analysed.

4.4.8 Research rigour

Guba (1981, p. 79) outlines a range of criteria for ensuring qualitative research addresses the 'four major concerns relating to trustworthiness': *credibility*; *transferability*; *dependability*; and *confirmability*. Guba (1981) further argues that trustworthiness can be enhanced both during the research process and after the research has been completed, so a range of criteria, or what Morse et al. (2012, p. 9) call 'verification strategies', are presented. Only those pertaining to my research will be described here.

Credibility

For research to be credible, Guba (1981, p. 83) recommends undertaking 'peer debriefing', 'member checks' and triangulation. I was able to test my developing ideas and be exposed to searching feedback through monthly debriefings with my supervisors, in addition to informal interactions with colleagues undertaking research in similar fields. 'Member checks' relate to testing one's data and its interpretation with the people who helped generate it (Guba 1981, p. 85). The accuracy of my interview transcripts was verified by respondents. Triangulation of my study was established by using a variety of data sources and methods, as illustrated in Figure 4.3 (Research questions and data sources), as Guba (1981, p. 85) suggests, in order to 'cross-check data and interpretations'.

Transferability

Guba (1981) describes transferability as the degree to which research findings are applicable between contexts. The criteria that promote transferability include thick description and purposive sampling. The concept of thick description derives from Geertz (1973) for whom the term included description of social context and meaning as well as physical, observable facts. Thick description, Guba (1981) posits, enables the researcher to discern whether a new context is sufficiently similar to that which has been studied to allow for the transfer of working hypotheses from one to the other. In

my research, both the data collected and the descriptive accounts of each data source contained a wealth of contextual detail that would enable an assessment of transferability. As described above, purposive sampling was undertaken when selecting the healthy weight policies and the OPAL program for study to maximise the range of data that could be generated in relation to my research questions, which accords with Guba's requirement.

Dependability

Guba (1981, p. 86) advocates overlapping the methods used to analyse one's data as one way of improving its 'stability'. As described earlier, two complementary methods of coding were used in this study (thematic and open) to maximise the reliability of the findings. Codes and coding frames were also discussed with my supervisors. As recommended by Guba (1981, p. 87) an 'audit trail' was also created throughout the research process whereby I fully documented the processes of data collection, analysis and interpretation. This enables the dependability of the procedures used to be assessed.

Confirmability

Confirmability refers to the credibility or neutrality of the data, as well as to accounting for the influence of researchers as instruments of their research (Guba 1981). Triangulation — collecting data from a variety of sources and a variety of perspectives — was undertaken, as recommended by Guba (1981). Interview respondents were selected to provide as diverse a range of experience and perspective as possible within the community program so that no single perspective would dominate the data and reduce the likelihood that my own perspective would unduly colour my interpretation. Materials aimed at a variety of audiences, such as members of the public, policymakers and health practitioners, were also selected for the OPAL document review in order to gain a range of perspectives. This meets the definition Stake (2000, p. 443) proposes of triangulation as 'a process of using multiple perceptions to clarify meaning'. Guba (1981) suggests that reflexivity — 'the process of reflecting critically on the self as researcher' (Lincoln & Guba 2000, p. 183) can increase the confirmability of one's findings as the researcher seeks to understand and make transparent their own thoughts regarding their research. This was practised rigorously throughout the study. In addition to the specific reflexive tasks undertaken as part of the WPR approach and described elsewhere, detailed accounts of observations, emerging interpretations and theories

were kept, and meetings with supervisors provided regular opportunities to test and reassess my ideas.

4.5 Conclusion

In this chapter I have described how this research was undertaken. Details have been provided about how a discourse analysis of data derived from a study of healthy weight policy and program documents, and of transcripts from interviews conducted with program workers and advisors, was conducted. The reasons behind the choice of a research design, the 'What's the Problem Represented to be?' methodology and the critical theoretical perspective were also described. The next chapter will present the findings of the policy document analysis.

CHAPTER 5: FRAMING OF OBESITY IN HEALTHY WEIGHT STRATEGY DOCUMENTS

5.1 Overview of chapter

This chapter examines how obesity is framed in the core documents that comprise the response of the SA Government to the Healthy Weight Target (HWT), which was set in South Australia's Strategic Plan in 2007 (SASP) (Government of SA 2007). To recap, the target ('T2.2') was to 'increase the proportion of South Australians 18 and over with healthy weight by 10 percentage points by 2014' (Government of SA 2007, p. 19).

As described in the previous chapter, these documents are:

- the Eat Well Be Active Healthy Weight Strategy for South Australia 2006–2010 (EWBA) (SA Department of Health 2006a)
- the Eat Well South Australia Public Health Nutrition Action Plan (EWSA) (SA Department of Health 2006b)
- the Be Active Physical Activity Strategy for South Australia 2004–2008 (BA) (Government of SA 2004b)
- Eat Well Be Active Healthy Weight Strategy *Priorities* November 2009 (*Priorities*) (Government of SA 2009a).

A descriptive account of each of the documents is followed by a single discourse analysis of these four accounts through which the framing of obesity is identified, and the ideological underpinnings and their implications for health equity explored.

5.2 Descriptive accounts of Healthy Weight Strategy documents

5.2.1 Eat Well Be Active Healthy Weight Strategy for South Australia 2006–2010 (EWBA)

Written in 2006, the EWBA Strategy is a relatively short document that provides a framework for the Government of South Australia's response to the problem of increasing obesity among its population and which is identified in South Australia's Strategic Plan (2007) in its HWT. Specifically, this framework document outlines state-level strategies and responsibilities for promoting healthy weight for all South Australians. It was written by the South Australian Department of Health, with the SA

government taking a lead role in implementing the strategy but with a range of partners identified as also playing key roles. The document outlines a settings approach with a preventative focus, emphasising the provision of environments that can support healthy eating and physical activity, structured around ten 'strategic directions.'

Background and context

The document describes the epidemiological and policy background behind the setting of the HWT in the 2007 SASP, and the response of the SA Government that culminated in its development and the supporting strategies of Eat Well South Australia (EWSA) and the Be Active Physical Activity Strategy of South Australia (BA). EWBA (p. 5) states that it is situated within national and international healthy weight policy directions, specifically *Healthy Weight 2008*: *The national action agenda for children and their families; Eat Well Australia* and *Be Active Australia* and WHO policy documents.

Evidence and consequences

Quantitative evidence of the problem of 'overweight and obesity' in terms of its increasing prevalence in SA is presented, with a detailed explication of the 'consequences of overweight', both social and emotional as well as physical. The chronic disease risks that are described are, however, explicitly ascribed to obesity rather than overweight. The document relates the negative impact on wellbeing, as well as on health, of not increasing population-wide rates of healthy weight, and the economic consequences for individuals, communities and government.

Principles, aims and objectives

EWBA's guiding principles are stated, followed by its aim and objectives. The aim is couched in terms of the HWT:

> To improve the health and wellbeing of South Australians by working towards achieving the target identified in the SA Strategic Plan, that is, to reduce the percentage South Australians who are overweight or obese by 10% within 10 years. (p. 8)

The five objectives focus on and enlarge some of the guiding principles; details of how EWBA will be monitored are included in the form of indicators against them. The objectives include are:

- to slow, stop and then reverse the current rate of weight gain and support all South Australians in achieving a healthy weight
- to increase the number of people whose diet is consistent with the Australian Dietary Guidelines
- to increase the number of people who are physically active in line with the Physical Activity Guidelines and Recommendations
- to make the greatest gain in those population groups with the highest burden of overweight and obesity and poorest health outcomes
- to create environments that encourage healthy eating and physical activity behaviours. (p. 8)

The complexity of the problem of obesity and the concomitant comprehensiveness required in response is highlighted, with collaboration, partnerships and the necessity for multiple strategies stressed. Both individual and environmental influences on weight are identified for change, with public policy supporting 'healthy eating and physical activity' (p. 11) the core to EWBA's settings approach.

Strategic directions

Ten 'strategic directions' identify key areas of influence, namely: Neighbourhoods and communities; Schools, preschools and childcare; Workplaces; Primary Health Care; Maternal and child health; Food supply; Media and marketing; Regulatory and fiscal policy; Government policy and leadership; and Research, surveillance and evaluation. Outcomes and strategies for achieving them are listed against each of these Strategic Directions.

Appendices list complementary strategies and plans at the state and national level, SA's Healthy Weight Taskforce membership (responsible for preparing the EWBA — p. 5) and the groups who provided feedback during the consultation, and references.

5.2.2 Eat Well South Australia Public Health Nutrition Action Plan 2006–2008 Summary (EWSA)

The EWSA is a brief overview document that presents a summary of South Australia's Public Health Nutrition Plan 2006–2008. It sets out the purpose, guiding principles, objectives, and strategies for achieving its aim of improving 'the health and wellbeing of all South Australians through improving nutrition and reducing the burden of

preventable diet-related disease' (p. 3) by 'taking positive steps to improve the community's access to and consumption of healthy food' (p. 2). Like EWBA, the EWSA expresses health and economic concerns, addressing them through socioenvironmental as well as individual objectives.

EWSA also provides a framework for action that outlines the core role of the SA Department of Health, while inviting 'government agencies, non-government organisations and the business sector' to assist in its implementation (p. 2). Where EWBA takes a settings approach, EWSA outlines six 'action areas' that cover different aspects of community nutrition and include fourteen objectives with specific outcomes and indicators.

Background and context

Eat Well South Australia has a longer history than the EWBA Strategy, arising from the Eat Well SA project of 1996, the goal of which was to 'increase the consumption of healthy food by children, young people and families in South Australia (Smith et al. 2004, p. 327). Rather than positioning EWSA under the mantle of EWBA, the Minister's Foreword locates EWSA in South Australia's Strategic Plan: '*Eat Well South Australia* will contribute to achieving several of the Plan's goals' (p. 2). This will be explored later in this chapter.

Although EWSA does not name the EWBA strategy here, its reference to 'an across government strategy to promote healthy weight' (p. 3) in the Introduction clearly places this policy document alongside EWBA, though not beneath it, as the wording below makes clear. In the context of EWSA:

> Annual priorities as well as plans in specific action areas will be developed. So far there are three plans: an action plan to increase breastfeeding rates, an action plan to increase fruit and vegetable consumption and an across government strategy to promote healthy weight. (p. 3)

The link between eating well and weight is thus still only implicit — it is not directly stated that eating well will reduce/influence weight.

The 'Eat Well Be Active Healthy Weight Strategy' is actually only mentioned once by name (in the fine print below Section 8, Action Area 3), compared with the prominent references to national and international healthy eating protocols, effectively tying

EWSA's genealogy more closely to other healthy eating plans than to the local healthy weight strategy.

Evidence and consequences

Unlike EWBA, which has to establish the existence of the problem it seeks to address, EWSA's purpose of *improving* South Australians' nutritional status is self-justifying; however good nutritional status currently is, it can presumably be made better. The consequences of poor nutrition are outlined succinctly in the introductory sections, linked to its chronic disease risks: 'It is well recognized that good nutrition is fundamental to achieving good health. . . . and what we eat in childhood can help prevent diseases such as cancer, diabetes and heart disease when we grow older' (p. 2).

The economic consequences are also outlined: 'By working together we can optimize healthy eating by all South Australians and eventually reduce the social and economic burden of diet-related chronic disease' (p. 2). The economic consequences are not enlarged upon and improving health (through nutrition) becomes the sole focus of the document.

Principles, aims and objectives

The 'Purpose' section provides an overview of the role of EWSA, which is to identify 'priorities for action'; coordinate a collaborative approach to promoting nutrition; provide guidance for outside groups to plan their own nutrition activities; and to support consistency at national, state and local levels in public health nutrition (SA Department of Health 2006b).

EWSA's 'Guiding Principles,' like those of EWBA, stress their scientific evidence base and their commitment to advancing this and to fostering partnerships; they also state a commitment to equity, specifically recognising the health needs of Aboriginal groups. Both policy documents also include a focus on lifestyle — on the aspects of health that individuals can influence through their chosen behaviours, though EWSA prefaces this with an explicit recognition of the social determinants of health. EWSA also explicitly acknowledges the cultural dimensions of food.

Whereas EWBA's five objectives are quite general and precede — and thus appear to drive — its ten 'Strategic Directions' at an ideological or theoretical level, EWSA's

fourteen objectives are very specific and are embedded in the six action areas and are linked to outcomes and indicators. The objectives are:

> Improving nutrition for mothers, infants and children; Increasing consumption of fruit and vegetables; Promoting healthy weight in children and young people and preventing weight gain in adults; Improving nutrition for older people; Improving food supply and food security; and Building capacity to promote healthy eating and good nutrition for all South Australians. (p. 5)

Strategic Directions

EWSA's 'Strategies' section describes six general approaches that include:

- improve knowledge and awareness of healthy eating
- develop partnerships and coalitions
- promote effective practice
- foster strategic activities which address healthy eating and improved nutrition
- support workforce development
- food and nutrition monitoring.

The two documents share many of the approaches and arenas for action, as will be discussed later.

5.2.3 Be Active Physical Activity Strategy for South Australia (BA)

The 'Be Active Physical Activity Strategy for South Australia 2004–2008' (BA) was compiled by the Physical Activity Council of SA, led by the Ministerial Physical Activity Forum with the Minister for Recreation and Sport at its head, on behalf of the Government of SA in November 2003 (p. 2). Its purpose was to provide strategic direction for 'increasing South Australia's participation rates in sport and physical activity,' specifically to help 'achieve the target set in the State Strategic Plan, of increasing participation rates to exceed the national average' (p. 2). 'The aim of this strategy is to increase the number of South Australians regularly participating in physical activity' (p. 5).

Like the other policy documents being examined, BA is overtly linked to other related documents and bodies. The BA later states that it 'will link with other initiatives that impact on physical activity such as the State Strategic Plan and the work being conducted by the Healthy Weight Taskforce' (p. 5).

The Ministerial Physical Activity Forum largely shared a common membership with the Healthy Weight Taskforce, which had responsibility for overseeing the EWBA, suggesting that the problems addressed in the two policy documents share common features.

Aimed at an audience of partners and the public, BA is a short, framework document: 'This Strategy sets the direction to achieve a more active South Australia. . . . It provides the framework from which a detailed implementation and action plan will be developed' (p. 4).

Background and context

The BA devotes considerable space to providing epidemiological evidence establishing the extent of the problem of lack of physical activity and the need for the strategy. A detailed picture of the environmental causes of declining physical activity in 'most western countries' is painted in BA before focusing on South Australia and on individuals. Statistics are provided and finally chronic disease ramifications cited. Insufficient physical activity is thus linked to 'poor health and increased incidence of obesity', which will have a 'major impact on our quality and length of life' (p. 4).

Evidence and consequences

Like the other policy documents, BA stresses its robust evidence base: 'The Strategy will … strive to make decisions based on information generated through sound evaluation and research' (p. 5). However, BA has noticeably less academic citation than EWBA and EWSA.

Principles, aims and objectives

While the BA does not devote a section to spelling out its principles or objectives, it does outline four National Physical Activity Guidelines with which it states it is aligned.

Strategic Directions

Seven goals with associated strategies comprise the remainder of the document (pages 6–12) and will be described in some detail as they give a similar indication of the

policy approach of this document as that covered by the principles, aims and objectives in EWBA and EWSA.

Goal 1 — Targeted Programs and Services: Four strategies for developing and implementing programs 'designed to increase physical activity' within the populations targeted by BA are described. The need to overcome the barriers and respond to the motivations and needs of different target groups are emphasised.

Goal 2 — Research and Evaluation: Following evidence-based approaches to increasing participation in physical activity is emphasised (p.7).

Goal 3 — Coordination: A coordinated and cross-sectoral approach to the planning and delivery of physical activity initiatives is emphasised, and several allied policies and documents are cited, locating this document within broader policy directives, such as the SASP: 'Strategy 3.5 Embrace the objectives in the State Strategic Plan as they relate to physical activity' (p. 8).

It is interesting that the obesity target (as it was then) is not referenced; weight, in fact, is not mentioned in BA (beyond the title of the Healthy Weight Taskforce), and 'obesity' is only mentioned once. These issues will be taken up in later analysis.

Goal 4 — Policy, Planning and Legislation: Strategies ensuring that physical activity participation is written into all relevant government policy, planning and legislation are outlined, echoing the 'health in all policies' approach, representing what amounts to 'physical activity in all policies' (p. 9).

Goal 5 — Supportive Environments: Strategies to alter physical environments to make both purposeful and incidental physical activity easier and more likely are outlined.

Goal 6 — Awareness and Promotion: In contrast, this goal stresses the importance of awareness raising to 'motivate individuals to be active and experience the multiple benefits associated with participation in physical (p. 11).

Goal 7 — Education and Training: The final goal relates to professional development, curriculum development and provision of resources to fill identified gaps (p. 12).

5.2.4 Eat Well Be Active Healthy Weight Strategy for South Australia: *Priorities* as at November 2009 (‘*Priorities*’)

This document primarily describes initiatives that contribute to achievement of the HWT (‘Priority Programs that Department of Health invests in to achieve the South Australian Strategic Plan Target 2.2’, Government of SA 2009a, p. 11) and, as these change over time, it is emphasised that this is an evolving document reflecting current priorities. At 58 pages the November iteration contains considerably more detail than the EWBA, and is focused on the implementation of that strategy. It thus differs in purpose from the previous documents described, which were strategies in and of themselves, and its format — and this description — differ accordingly.

Background and context

In 2009, the Government of South Australia developed Eat Well Be Active Healthy Weight Strategy *Priorities* as an adjunct to EWBA, to be ‘read in conjunction with the Eat Well Be Active Healthy Weight Strategy for South Australia 2006 — 2010′, setting out the ‘priority initiatives under this Strategy’ (p. 3). It is a significant document as it clearly indicates the focus of government investment and action.

The policy context of *Priorities* is clearly stated and locates this document within broader policy directions, including the South Australian Strategic Plan, specifically the ‘very ambitious’ *Target 2.2 Healthy Weight* and the ‘closely aligned’ *Target 2.3 Sport and Recreation*, ‘to exceed the Australian average for participation in sport and physical activity by 2014’, with another four relevant targets cited (p. 3). It is also noted that, ‘the Eat Well Be Active Healthy Weight Strategy for South Australia 2006 — 2010 supports *South Australia’s Health Care Plan 2007 — 2016* by adopting a population health approach to promote healthy lifestyles and disease prevention’ (p. 3).

It is noteworthy that this emphasises ‘healthy lifestyle’ over ‘healthy weight’; as will be discussed shortly, despite its name, the EWBA (and EWSA and BA) place more emphasis on promoting healthy behaviours than on weight.

The ‘Governance’ section of the *Priorities* document also highlights a number of linkages: between EWBA and the Health Promotion Branch, which has a central leadership role in EWBA; with the Be Active Physical Activity Strategy and working in partnership with the Office for Recreation and Sport; and with other government

departments and areas of work, with examples provided of activities undertaken which promote EWBA's goals.

Evidence and consequences

Whereas the other documents have cited epidemiological statistics to establish the problem they were addressing, *Priorities* instead references McLeroy et al.'s (1988) 'ecological model' on which the overall EWBA intervention — the solution to the problem — is based. A comprehensive and detailed breakdown of the multiple factors that influence weight and the corresponding points of intervention are provided in the 'Evidence Base' section. These include individual and sociocultural factors (such as norms); structural, physical and contextual environments; organisational factors; and public policy, thus spanning the individual, socioenvironmental and structural levels. Later in the document, 'Prochaska's Transtheoretical Model' of behaviour change is also cited in some detail as the source for, and providing the scientific credentialing for, the reliance on the strategy of social marketing (pp. 4, 12).

In general, the various SASP targets are more visible in this *Priorities* document than in other documents and, unlike them, *Priorities* focuses only on the solution to the 'problem' of unhealthy weight, not to establishing the need for intervention.

Principles, aims and objectives

The goal of EWBA is described in terms of needing to achieve population-level transformation through individual behavioural changes on a large scale in order to reduce 'the long-term risk of chronic disease' (p. 3). Links are drawn between individuals and socioenvironmental factors, with achieving 'healthy weight at a population level' described as requiring a solution that is 'comprehensive', consisting of 'multiple strategies' addressing 'behaviour, knowledge and attitudes as well as environments, policies and program delivery' (p. 3).

Reinforcing this socioenvironmental framing, the links between disadvantage and poor health are also spelled out:

> Disadvantage correlates strongly with poorer health outcomes and higher rates of overweight, obesity and lifestyle related diseases. Evidence points to interactions between individual, social and environmental factors that must be addressed through a suite of strategies to have an impact. (*Priorities*, p. 3)

Again, in contrast to the other documents, a sizeable section is dedicated to explicating equity. The document links SES to risk factors, but also later refers to the social determinants of health and acknowledges that people's lifestyle options are impacted by factors outside their control: 'the broader social determinants have a profound effect on individuals' lifestyle behaviours and access to healthy lifestyle (e.g. those of lower socioeconomic status, migrants, and Indigenous Australians) and therefore require targeted intervention where appropriate' (pp. 5–6).

The view of equity reflected is a comprehensive one: not only are the 'most disadvantaged' groups targeted, but the distribution of health outcomes are also monitored and an intention to make 'equity concerns, strategies and measurement integral to all aspects of work is expressed (p. 4). The centrality of equity to EWBA is evident in the 'Program Logic' flow charts (*Priorities*, pp. 7–8), where 'Ultimate Outcomes' include 'increased equity' as well as 'increased healthy weight'.

Strategic directions

The 'four action areas' in the *Priorities* document (p. 6) and associated strategies, under which EWBA (and the main body of this document) are organised are summarised in the 'Framework for Action'.

Two flow charts ('Healthy Eating', p.7, and 'Physical Activity', p.8) spelling out the logical connection — or 'causal pathway' — between components of the EWBA strategy (approximating the four action areas) and their ultimate outcomes are provided in the 'Program Logic' (p. 6). A comprehensive evaluation commitment is also outlined.

The remainder of the *Priorities* document consists of overviews of the programs that will contribute to the HWT — 26 'priority programs' that are funded by the Department of Health, and seven 'related initiatives' (p. 6).

The focus of the remainder of this descriptive account will be on OPAL, as described in the 26 priority programs, in preparation for the case study that will follow. The description of OPAL itself consists largely of EPODE's credentials, possibly to distinguish it from the local pre-cursor to OPAL:

> In South Australia a similar model to the French EPODE methodology has been piloted; the Eat Well Be Active Community Programs in Morphett Vale and Murray Bridge have been running since 2005. OPAL will build on this program through additional social marketing methodologies and community mobilisation techniques across 20 communities by end 2014. (p. 28)

In addition to highlighting the new elements of social marketing and community mobilisation, the description claims that: 'The EPODE program is . . . internationally transferable (e.g. to Spain, Belgium and Greece)' (p. 28). This issue will be revisited later in this thesis.

OPAL's aim is 'To improve eating and activity patterns of children, through families and communities in OPAL regions and thereby increasing the proportion of 0–18 year olds in the healthy weight range' (p. 28). Although the HWT specifically targets adults — those '18 and over' (p. 3) — evidence supports the prioritisation of children in EWBA 'to prevent long term exacerbation of the current problems' (p. 3).

OPAL is then described as:

> A community-based childhood obesity prevention program involving comprehensive social marketing, along with a variety of programs and activities to support healthy eating and physical activity through a range of settings including schools, local government, health services, community organisations etc. (p. 28)

5.3 Discourse analysis

5.3.1 Overview

As the focus of this thesis is healthy weight policy, greater attention will be given to the two core healthy weight policy documents, the *Eat Well Be Active Healthy Weight Strategy of South Australia 2006-2010* (EWBA), and *Eat Well Be Active Healthy Weight Strategy for South Australia 2006-2010: Priorities as at November 2009* (*Priorities*). As well as providing details of actual interventions, where one might logically expect to get the clearest impression of how the EWBA Strategy embodies the solution to the problem of unhealthy weight, *Priorities* also contains clear accounts of two essential elements that throw light on how unhealthy weight is framed: the theoretical foundations of the strategy and an explication of equity. A synthesis of the findings from the discourse analysis of the four policies, using the WPR approach, is presented in the following sections.

5.3.2 Representation of the problem of obesity: Primary problematisations

EWBA, EWSA and BA share several common elements in their core problem representations. The encompassing aim of all three is to improve the wellbeing or quality of life of the South Australian population. EWBA and EWSA state this in near-identical terms, with 'health' preceding 'wellbeing':

> The aim of the *Eat Well Be Active Strategy* is: To improve the health and wellbeing of South Australians. (EWBA, p. 8)
>
> and
>
> *Eat Well South Australia* aims to improve the health and wellbeing of all South Australians. (EWSA, p. 3)

This is reversed in BA, which actually lists enjoyment as the primary benefit to be gained by physical activity, with 'social' and only then 'health' benefits ensuing:

> There are many reasons we are encouraging South Australians to become physically active. Physical activity is something that everyone can enjoy and by participating regularly we can achieve a range of social, health and economic benefits. (BA, p. 2)

Within this broad common direction, each policy document addresses a specific core problem. Unsurprisingly, the *Eat Well Be Active Healthy Weight Strategy* (EWBA) aims to increase the number of South Australians with healthy weight; *Eat Well South Australia* (EWSA) to increase the number eating a nutritious diet; and the *Be Active Physical Activity Strategy* (BA) to increase the number participating in physical activity. On the surface, these three aims would seem to converge, the aim of healthy weight being realisable through the achievement of the two apparently subsidiary policies, as EWBA's title clearly implies. It is notable that inadequate nutrition and physical activity were both problematised before unhealthy weight in policy in SA. Although the EWSA document was written after the EWBA Strategy, the *Eat Well SA* project preceded it by almost a decade, having been established in 1996 (Smith et al. 2004), and work on BA began in 2003. This explains why unhealthy weight features little in EWSA and BA, and suggests that while the obesity 'problem' led to the HWT and the 'Healthy Weight Strategy', it led to the adoption and union of the 'Eat Well' and 'Be Active' elements in the *Eat Well Be Active Healthy Weight Strategy* rather than to the development of these policies themselves.

Although the causes of unhealthy eating and physical activity are the means by which the problem of EWBA is addressed, it becomes apparent that the concept of ‘healthy weight’ is itself problematic. While healthy weight is the objective of *Priorities*, as it is of EWBA, unlike these other three documents it does not contain a distinctive problematisation, with the exception of the observation — echoing EWBA — that small population-wide behavioural changes will ‘. . . reduce the long-term risk of chronic disease’ (p. 3). The focus is thus on the whole population, problematising systemic practices, rather than ‘high risk’ groups. In contrast to the very complex problematisation of unhealthy weight in EWBA, EWSA and BA, because *Priorities* represents current existing programs addressing unhealthy weight, the existence of an unhealthy weight problem is assumed.

Neither EWSA nor BA give much attention to weight — it is very secondary in EWSA, and in BA almost peripheral, with only two references in the entire document linking physical activity to weight. In EWSA, the emphasis on good nutrition being the pathway to good health, rather than to a healthy weight, is constructed by multiple references (and thus implicit genealogical ties) to national nutrition policies and documents. There are only very occasional references to EWBA or the Healthy Weight Target, and with weight being the focus within only one of its six action areas.

Population-wide healthy weight might be achieved almost unconsciously as a bi-product of achieving good nutrition and physical activity, but it might not. This possibility is allowed for in the expression of EWBA’s intent as being to: ‘Promote the benefits of healthy eating, active living *and* healthy weight in a positive way, avoiding individual blame’ [emphasis added] (EWBA, p. 8).

All four policy documents promote the independent benefits of healthy eating and physical activity as unequivocal. The concept of healthy weight is explored further in EWBA: ‘The healthiest weight for an individual is the weight that they can achieve through living a healthy lifestyle — being physically active and eating a healthy diet’ (EWBA, p. 9). This statement constructs weight as subjective. Although EWBA does not define healthy weight, it seems implicitly equated with the medical ‘normal’ weight range as in the section ‘Overweight and Obesity: The Evidence’ (EWBA p. 6), increasing BMI rates in SA from 1991 to 2004 are used to establish the extent of the *problem.*

It is possible that the more generalised term of healthy weight is used to distinguish the goal of this strategy from the Obesity Target as it then was, which was tied to reducing the percentage of South Australia's population who were overweight or obese. This was an achievement that had, and remains thus far, extremely elusive for any government in Australia. EWBA is described as providing 'guiding principles' (EWBA p. 8), and EWSA and BA as 'framework' documents (BA p.2; EWSA p. 3), so it is not surprising that what exactly constitutes 'healthy' or 'active' is not stipulated. The construction of health as both subjective and paramount and the emphasis on not blaming or stigmatising unhealthy weight mean that these policies align with the 'Health At Every Size' frame outlined in Chapter 3.

When describing the problem that needs to be solved — that is, when the argument justifying the need for the policy intervention is being set up — medical and behavioural frames are drawn on. Problem representations are constructed through the use of language (Bacchi 2009). Like frames, they are simplifications that leave out certain ways of thinking about the problem. A medical frame draws the focus inwards to individual biology or genetics, emphasising the pathology and medical risks of a large weight, poor nutrition, or inadequate physical activity, logically justifying the parameters of the solutions that follow and which largely exclude macro-level factors such as governance or corporate interests. For example, the medical frame's BMI categories and their associated health and economic implications are stated in 'Overweight and Obesity: The Consequences' (EWBA p. 7). The extent of the health implications is used to underline the economic costs to individuals and the state.

However, because weight on one level represents the difference between calories consumed and expended, obesity, nutritional and physical activity status have behavioural antecedents and are frequently framed to reflect this, leading to implications for lifestyle changes. Both frames are apparent in EWBA, EWSA and BA in their chronicling of the biomedical conditions associated with each problem, and their behavioural associations:

> Overweight is associated with a range of chronic conditions such as diabetes, hypertension, cardiovascular disease and some cancers. (EWBA p. 4)
>
> It is well recognized that good nutrition is fundamental to achieving good health. . . . and what we eat in childhood can help prevent diseases such as cancer, diabetes and heart disease when we grow older. (EWSA p. 2)

and

> Increased physical activity has the potential to contribute to length and quality of life, to reduce the risk of heart disease and stroke and even lower the risk of contracting some forms of cancer. (BA p. 4)

The *solution* in EWBA is framed as being about ‘healthy weight’, an ambiguous term used in two ways in EWBA, as a synonym for ‘normal weight’ (e.g. EWBA p. 7), that is, as a range of BMI, which accords with how it is defined on the SA Department of Health website (SA Department of Health website 2015, accessed 15 March 2015), and at other times as a more subjective term that allows for some degree of self-definition of what one deems to be ‘healthy’ for oneself, as described earlier. Healthy weight is not defined in either the SASP (2007), or the *Priorities* (2009) document. Even where data sources are described and healthy weight associated with BMI in *Priorities* (Government of SA 2009a, Appendix C p. 56), what level of BMI is not stated. The effect is to frame healthy weight as behavioural rather than medical.

The solution as represented in *Priorities* consists of both the framing text, that is, the introductory and concluding sections, from which an overall construction of the solution can be surmised, and the 26 individual ‘priority programs’ that furnish the detail as they constitute the actual initiatives within the EWBA Strategy. In the framing text of *Priorities*, the core problem is embedded in the solution: the solution is framed as the presence of healthy weight and the problem as its absence, thus enabling positive expression of both. This framing is apparent in the explication of the HWT: ‘In 2006 42.5% of adults were in the healthy weight range with the target requiring 52% by 2014’ (*Priorities* p. 3).

Healthy weight is represented as being promoted by state interventions (e.g. *Priorities* p. 3), and as a goal to be maintained by individuals (*Priorities* p. 6). The focus on health in general — ‘making healthy living easier’ (p. 35) takes the framing even farther from the medical framing device of the term obesity, drawing attention beyond the individual as a biological entity to their behaviours, and to the socioenvironmental in its inclusion of environmental influences on the individual.

Within *Priorities*, each of the different priority programs contains its own representation of the problem and the solution; the presence of the problem is flagged by the use of the medical term obesity. This is a framing device, and its use in *Priorities*

reinforces the other discursive devices that frame the problem as both individual and collective, and the solution as socioenvironmental. Of specific interest, the title is 'Healthy Weight' as it is about the actual strategy, that is, the solution.

5.3.3 Representation of the problem of obesity: Secondary problematisations

Having thus established the problem as largely individual, EWBA, EWSA and BA elide this construction with the economic implications of the problem, making these appear both logical and inevitable, and the result of individual abrogation of responsibility. These economic implications further strengthen the implicit justification of the policy solution. For instance, having detailed the 'chronic conditions' associated with overweight, EWBA continues: 'While this [overweight] has serious consequences for the individual, it is also a major public health issue, as well as a financial burden on the government and the community as the costs of health care escalate' (EWBA p. 4).

The most consistent secondary problematisation in these policy documents is their reference to the shared economic impact resulting from their core problem, although (in contrast to EWBA) BA and EWSA frame the economic issues positively, in terms of the financial benefits to be gained by addressing the problem rather than the consequences should they not. For example, EWSA states: 'By working together we can optimise healthy eating by all South Australians and eventually reduce the social and economic burden of diet-related chronic disease' (EWSA p. 2).

This problematisation, by extending the negative consequences of the problem from those who are obese or inactive or poorly nutritioned to the whole of society, effectively collectivises the gains that can be made by reducing the problem, which should widen the support base for each policy. It also leads into the socioenvironmental construction of obesity, nutrition and physical activity that becomes apparent when solutions become the focus, as the solution to each problem is represented as relying on changes being made more widely than just by those who themselves directly experience the problem: responsibility is collectivised. The foundation for this can be seen in EWBA, where obesity becomes everybody's problem: 'The South Australian Government . . . recognizes the role that different groups play in creating environments that promote healthy eating and physical activity and support healthy choices' (EWBA p. 4).

In contrast to the biomedical framing of the problem, when describing the solution to the obesity crisis EWBA presents an ecological representation of the individual as impacted by their environment, rather than as a self-contained biological entity. It states that ‘A comprehensive public health response is essential to achieve sustained behavioural and social change’ (p. 9). Milio’s (1976) classic health promotion concept that healthy choices must be easy to make if behaviours are to change is touched on, although it is not a dominant theme in this document: ‘Social and built environments have a huge influence on the foods people choose and how easy it is to be active and thus influence weight’ (EWBA p. 9).

In contrast, this concept recurs frequently within the 26 priority programs, indicating a slippage to a wider environmental focus in the programs. The problem of obesity has now become one of unhealthy environments and settings, which encompass non-material as well as material elements. For example, ‘family values’ help shape health behaviours and ‘feelings of safety in local areas . . . will make it easier for everyone to enjoy healthy eating and be physically active’ (p. 9). Environments span the macro-level (such as the mass media), which constructs the problem as structural, to the meso-level (where people ‘live, work, are educated, cared for and spend their leisure time,’ p. 9), that is, a socioenvironmental framing; and the micro-level (the home). The problem is thus framed here as, to a small degree, structural, with policies being supportive or unsupportive of health; socioenvironmental (local settings), and individual, with factors like knowledge deficits implicit in the focus.

Although in EWSA the use of the biomedical consequences of imperfect nutrition constructs the problem (of sub-optimal nutrition) as individual, and strategies to promote healthy eating construct it as socioenvironmental, and very occasionally as structural, on the whole the representations of problem, cause and solution, and the relationship between them, differ in these three policies, and will be discussed in detail later.

5.3.4 Shared characteristics of the problem representations

Although the EWBA represents the problem as unhealthy weight, EWSA as inadequate or sub-optimal nutrition, and BA as insufficient physical activity, these problems are represented as sharing core characteristics. They are represented as important; as having health, social and economic consequences at an individual and group level

(discussed above); with EWBA and BA also presenting the problem as complex, difficult and urgent.

All three documents construct the solution as needing to be comprehensive, EWBA and BA deriving this from the problem's representations as complex and challenging:

> The factors which affect the weight of the population are myriad and complex and the solutions are not simple. (EWBA p. 9)
>
> The issue of decreasing levels of physical activity is complex. (BA p. 2)
>
> There are no easy solutions to this issue. (BA p. 5)

While the solution in *Priorities* is represented as comprehensive, implying that the problem is multifactorial and complex, the absence of a specific construction of the problem as part of an epidemic (as in the other documents) means that the solution is not constructed as overwhelmingly urgent, but is instead a matter for well-considered and evidence-based — and theory-based — intervention.

Unlike these policy documents, *Priorities* is distinguished by the high visibility of the various SASP targets, with a total of six targets — and the supplementary measure of the weight of 4-year-olds (p. 3) — being referenced. This creates the impression that EWBA is tightly linked to achievement of the targets, making the government seem in control and having the 'problem' under control. This is an effect compounded by the absence of an explication of the 'problem' or its justification in terms of severity and urgency, which feature in the other policy documents. The resulting tone of *Priorities* is businesslike, with the status of the government as a responsible leader enhanced.

EWBA, having established the severity of the problem faced by the public, with 'more than half the adult population' and 'one in every four children' personally at 'risk of health, emotional and social problems', adds an element of urgency: obesity has 'risen alarmingly'(EWBA p. 3). This constructs the problem as a crisis that needs immediate remedy, by inference requiring urgent intervention. For example, BA, exhorts 'us' thus: 'We must act now . . . the issue is too important not to' (BA p. 5). The implications for how this positions the various subjects in the policies will be discussed later.

A tendency to focus on the positive is evident in EWBA, EWSA and BA. The positive tone, however, is less apparent in *Priorities,* which devotes most space to describing

current interventions in the form of programs. Sometimes the focus on the positive is explicit, as in EWBA, which aims to, 'Promote the benefits of healthy eating, active living and healthy weight in a positive way' (EWBA p. 8); or in EWSA, where the aim of improving South Australians' nutrition will be achieved by 'taking positive steps to improve the community's access to and consumption of healthy food' (EWSA p. 2). In BA, the emphasis throughout the document is on the benefits of participating in physical activity, which is normalised as natural and overwhelmingly positive — the word 'enjoy' appears three times on one page (p. 4) — and is explicitly reframed 'as an opportunity, not an inconvenience' (p. 5, quoting National Physical Activity Guidelines).

This positive framing is also implicit, the focus on the positive manifesting in the tendency to add to what is there, rather than to remove a barrier to its uptake. In EWBA and BA, for instance, 'active transport' (EWBA p. 11; BA p. 10) is encouraged, and both documents describe creating 'safe and supportive environments' (BA p. 10) and options like 'off-road paths, on-road bicycle lanes and back street routes' (EWBA p. 11), yet no mention is made in either document of discouraging or restricting the use of cars in order to make cycling a safer and thus more appealing option. In a similar way, EWSA reflects a conceptualisation of nutritional status deriving from under-nutrition due to the foods that are *not* consumed, rather than over-nutrition due to consumption of other foods in excess of nutritional needs. This means that EWSA's focus is almost solely on adding missing foods or nutrients to the diet, rather than reducing the consumption of non-nutritious foods. This has clearly positive repercussions for the food industry. When 'food supply' is discussed in EWBA, a similar focus is apparent, with only one of the six strategies outlined (food regulation) implicating the general nutritional content of food rather than focusing on simply increasing the supply of undisputedly high nutrient food such as fruit and vegetables (EWBA p. 15). Nevertheless, there is evidence suggesting that increasing people's intake of fruit and vegetables automatically reduces their intake of energy-dense, nutrient poor (EDNP) foods (see Epstein et al. 2001).

While there is evidence supporting the efficacy of 'positivity' in the behavioural sciences — such as the self-reinforcing and thus inherent sustainability of promoting behaviours that are pleasurable (see Seligman & Csikszentmihalyi 2000) — it is

apparent that a positive focus in policy can (inadvertently) reinforce the status quo by implying that ‘all is well’. The effect here is to turn the spotlight away from any corporate financial interests that would be impacted by a more critical stance. This effectively quarantines the corporate sector from being identified as part of the problem and thus the focus of change. Further analysis of this is provided below when the role of the corporate sector is discussed in detail.

Another aspect of this positive construction is the stance evident in all policy documents of not blaming individuals who bear the problem. In EWBA this is explicit: ‘It is vital that “victim blaming” is avoided’ (EWBA p. 7). In EWSA the construction is more implicit and is achieved through the introduction of explanations for food choices, which draw responsibility away from the individual. This is achieved, for example, through its acknowledgment of cultural factors, and through its implicit recognition of the existence of material and structural barriers to healthy food consumption in acknowledging ‘the nutrition-related health needs of disadvantaged groups’ and the ‘social determinants of health’ (EWSA p. 3). However, this is not necessarily sufficient safeguard, as the following analysis suggests.

Unlike these three documents, *Priorities* explicitly utilises theory to support strategy, for example, citing ‘Prochaska’s Transtheoretical Model’ of behavioural change to ground the use of social marketing (*Priorities* p. 12), and identifying its overall approach with the ecological model: ‘SA Health . . . acknowledges the need to work in the ecological model (1) [McLeroy] addressing multiple levels and factors that affect lifestyle behaviour (*Priorities* p. 5).

Reinforced by the extensive references to a range of related policies, this referencing to academic work constructs the solution as particularly compelling, although in doing this other problems are raised as these models then become potentially problematic.

The ‘transtheoretical therapy’ model (Prochaska & Di Clemente 1982, p. 276) is a wholly individual behavioural change model into which environment only enters as a stimulus for individual response modification. Its aim is to help individuals change their ‘troublesome’ behaviours (Prochaska & Di Clemente 1982, p. 280). As a source for the EWBA Strategy, it would seem likely to focus on the ‘individual’ aspect of the

‘individual-in-the-environment’ focus, which is the hallmark of the ecological model. The two models are thus possibly incongruent.

McLeroy et al. (1988) note the limitations as well as the strengths of the ecological model. Although acknowledging that an ecological approach encourages the use of a variety of change strategies beyond the individual, they identify that its tendency to focus intervention on the proximal rather than distal causes of ill health, leaves structures unaffected: ‘Even viewing behavior within an ecological perspective will not adequately address many of the sources of ill health, such as economic inequities, discrimination, genetics . . . except as they effect behaviour’ (McLeroy et al. 1988, p. 368).

Nevertheless, the ecological model does provide a solid theoretical foundation to those programs which, like OPAL, focus on changing social norms, as this model identifies them as part of the environment layer or sphere surrounding the individual and influencing their behaviour. OPAL, like the EWBA Strategy as a whole, also attempts to avoid victim blaming at a discursive level; however, problems and solutions are at times represented in ways that cast the individual as responsible for either creating or causing the problem besetting them. While this is not ‘victim blaming’ it can create the opening for discourses of blame, through the lifestyle focus, to attach.

McLeroy et al. (1988) also suggest that the high visibility of social marketing campaigns can lead members of the public to overlook the less-visible concomitant environmental change programs underpinning interventions like OPAL. This can lead to the erroneous conclusion that the government ‘believes’ that individuals cause their own illness or obesity as it can apparently be corrected by messages. To avoid this problem, an alternative strategy for changing social norms might be to change the drivers that support the anti-health norm, such as the corporate interests that counter socially marketed messages with messages promoting consumption, irrespective of their health effects. The constraints on such policies will be taken up in the final chapter.

The full application of the ecological model, identifying the focus of change as environmental as well as behavioural, should highlight the role played by the commercial sector in influencing the environments surrounding individuals, and in

which they must exercise choice. The virtual absence of this sector from all solution representations in these documents is itself problematic and will form the focus of analysis later in this thesis.

5.3.5 Representation of the causes of this problematisation

The causes of the problems represented in the documents share some characteristics — for instance, that the causes are complex and multiple. At its simplest, EWBA constructs the immediate cause of obesity as unhealthy eating and physical activity levels, though these risky individual behaviours are often represented as mediated through risk-generating environments. Structural factors are occasionally implicated. EWSA similarly constructs the immediate cause of sub-optimal nutrition as the inadequate consumption of healthy food. However, consumption is framed as determined by factors largely beyond individual control, such as the 'community's access to and consumption of healthy food' (EWSA p. 2), that is, as due to structural and socioenvironmental factors. Underpinning the whole EWSA policy document are two critical assumptions, one of which was discussed above and relates to the policy's focus on advocating the inclusion of more nutritious food, rather than less non-nutritious food, as the solution to the problem of sub-optimal nutrition. The second assumption is that the factors influencing people's food selections are within the purview of a policy of this nature. This will now be examined more closely.

In acknowledging the 'social and cultural' value of food, that 'food is more than a source of fuel and nutrients' (p. 3), EWSA constructs people's reasons for eating the food they do as complex, and that by doing so, tacitly indicates its own limitations. If meanings other than health drive people's food choices, there is only so much that an 'eat well' policy can do: government only has jurisdiction in some of the areas that influence food selection, such as its supply, access, and affordability: its role is to ensure the availability of healthy food for everyone. The construction of food choice as socially and culturally driven implies that it is not necessarily desirable (or perhaps democratically and ethically possible) to influence foods selected for their cultural or social value. Thus, if EWSA 'fails', and the nutritional status of South Australians remains less than optimal, it might not be due to the shortcomings of the policy, but to the rationale underpinning it in the first place; that is, that government can do more than

set up the preconditions for a healthy population-wide diet. This indicates a potential misalignment between what the policy is being required and what it is able to deliver.

BA frames the cause of inadequate physical activity differently again, summarising it as the increasingly technical and sedentary nature of modern life:

> Decreasing levels of physical activity is an increasing concern in most westernised countries and is the result of multiple factors such as the increased influence of technology, urban planning which restricts opportunities for physical activity, increased reliance on motorised transport, increased working hours, increasing demand on public open space, increased demands on the education curriculum and changing leisure patterns. (p. 4)

The cause of the problem is thus overtly identified as structural, with flow-on socioenvironmental effects.

Just as the problem is not defined in *Priorities*, its cause remains nebulous, the only direct reference to a cause being the necessity of a multi-level solution in order, 'to address the myriad of [*sic*] complex factors which contribute to overweight' (*Priorities* p. 3). Like the problem, its causes must be inferred from the solution which comprises the bulk of the document.

5.3.6 Representation of the solution to this problematisation

The construction of obesity, sub-optimal nutrition and insufficient physical activity as interconnected problems, or as different sides of a core problem, is established through the identification of common characteristics shared by the problem representation in EWBA, EWSA and BA (e.g. common medical consequences). This common problematisation is reinforced by the sharing of many of the same settings as sites for potential intervention, suggesting that there are common points of change or leverage for achieving their goals.

The core representation of the solution in EWBA, EWSA and BA is a healthy lifestyle — healthy eating and physical exercise. This representation has a number of core characteristics that have implications for the roles assigned to the different policy players. The more comprehensive representation of the solution includes the idea that a healthy lifestyle requires environmental supports; it also requires changes to the structures that create an obesogenic world, but these are just touched on in EWBA.

The framing of the solution in the *Priorities* document spans structural, socio-environmental and individual elements in a causal chain. Individuals and environments are conceived as influencing each other ('reciprocal determinism' — Glanz & Mullis 1988, p.399; or 'reciprocal causation' — McLeroy et al. 1988, p. 354), thus it might be assumed that changing sufficient individuals' healthy eating and physical activity behaviour will eventually alter the normative environment. Such an effect, however, is countered constantly by sections of the advertising and food industries pushing social norms and expectations — and sales — in the opposite direction. The relative absence and unaccountability of this sector from problematisations in these policy documents suggests that such activity may not be predicted, with the result that policy interventions are less influential in nudging (Thaler & Sunstein 2009) population weight in the desired direction.

The four action areas under which priority programs are organised in *Priorities* — 1) Community Education; 2) School and Community Programs, 3) Policy and Legislation; and 4) Workforce Development, Research and Evaluation — represent a steadily expanding conceptualisation of the factors influencing healthy choices or healthy lifestyles. The descriptions of these action areas reflects the multi-level approach outlined earlier, grouped around the health promotion concept of 'making the healthy choice the easy choice', a concept present in EWBA but more articulated here. 'Community Education' (Strategy 1) describes how the provision of information and the use of social marketing strategies will enable people to make 'healthy lifestyle choices'; although the language is about 'community', these strategies all have as their goal individual behaviour change. The 'School and Community Programs' (Strategy 2), however, acknowledges that: 'Adults and children need support to make healthy choices', and describes how 'microenvironments' such as schools and communities, 'provide a means to influence many of the factors impacting on food choice and physical activity participation' (*Priorities*, p. 17).

This reflects a more socioenvironmental framing of the solution. This section also reflects the commitment to equity discussed earlier in noting that programs must be available to all in the community, particularly 'those who are most disadvantaged' (*Priorities* p. 6).

‘Policy and Legislation’ (Strategy 3) — described as ‘a critical part of the solution’ — identifies that environmental and structural support is necessary to support people ‘to be active, eat well and maintain a healthy weight, making the healthy choice the easy choice’. ‘Workforce Development, Research and Evaluation’ identifies that capacity building of the workforce is necessary to ‘support populations to eat well, be active and maintain a healthy weight’ (*Priorities* p. 6). The focus of the first strategy area on individual change has thus been enlarged to encompass a focus on environmental and policy change — as far as these support ‘healthy choices.’

At ‘Healthy Food and Drink Choices for Staff and Visitors in South Australian Health Facilities Policy’ (Strategy 3), what is actually meant by ‘healthy choices’ is defined thus: ‘Healthy choices are those that are in line with the Dietary Guidelines for Australians and the Australian Guide to Healthy Eating’ (*Priorities* p. 37).

It is at the solution stage that the EWBA, EWSA and BA policy documents fit logically together (although the problematisations do not coincide); as the solution to the problem constructed in EWBA is healthy eating and physical activity, it is apparent that this logically aligns with the goals and solutions of EWSA and BA.

The effect of the construction of the problem in each policy document is to set up certain roles for each ‘player’ affected by the policy, that is, the state or government as author and organiser of the policy; the public as the intended recipient or beneficiary of the policy; and various other sectors such as the community and private sector. Althusser’s concept of interpellation is helpful here as it offers insight into the effects of the construction of different roles. Althusser (1994) argued that one of the processes by which ideology is promulgated is by defining the roles that people can perform, that is, that *roles* have ideological functions. These roles will now be examined.

The public

The emphasis on motivation apparent in the solution representation in EWBA, EWSA and BA implies that the problem is a lack of motivation. This is incongruent with the environmental representation of the cause of the problem in these documents. ‘Motivation’ is far less discernible in the representation of the 26 priority programs in *Priorities*, suggesting that the problem can no longer be inferred as lack of motivation in the individual. This is congruent with the more thorough incorporation of the

ecological model where environments rather than individuals' failings are the cause of the problem. However, the first four programs are social marketing initiatives. *Priorities* introduces these programs by quoting Andreasen (1995):

> . . . social marketing has been defined as 'the application of commercial marketing technologies to . . . programs designed to influence the voluntary behaviour of target audiences in order to improve their personal welfare and that of their society'. (*Priorities* p. 12)

This constructs social marketing as a mechanism, not only for supplying deficits in individual knowledge or awareness, but as a way of establishing the 'good citizenship' discourse by linking healthy behaviours with societal benefits. By making participation a civic duty, participation in healthy weight interventions becomes the marker of a good citizen. This will be discussed in more detail shortly. The corollary of the state being constructed as powerful and responsible is that the public is correspondingly, at times, positioned in EWBA, EWSA and BA as irresponsible, a financial burden. It is also positioned as passive, in a mental even if not always necessarily physical sense, its role that of receiving or carrying out what the state has designed. Fischer (2003, p. 66) suggests that policies constitute both 'citizens and politicians' — or, in this case, policymakers — by specifying 'which players are virtuous and which are dangerous, which actions will be punished or penalized, and which will be encouraged and rewarded'. Paradoxically, in order to be valorised and fulfil the objective of policymakers, the policy audience here must be simultaneously active citizens — increasing their physical and mental activity regarding food and activity choices — while being constructed as the passive recipients of policy imperatives.

The logical corollary of collectivised responsibility is civic duty. As in BA, participation has been made part of good citizenship: in order to achieve the state vision of a 'prosperous, strong and environmentally sustainable State' (p. 2), the public must be healthy, which EWSA implies can be achieved in great part by eating healthily; this will reduce the 'social and economic burden of diet-related chronic disease' (p. 2). What individuals eat is thus constructed not just as putting their personal health at risk, but as endangering state wellbeing; what people eat is thus re-made as no longer a private decision but a civic duty. Although no blame is ascribed here, such subject positioning nevertheless makes blame possible which can lead in turn to stigmatisation.

Although in BA physical activity is presented as an invitation to participate — as something intrinsically enjoyable as well as beneficial on a range of levels — it is simultaneously implicitly constructed as serious and obligatory:

> The Government is committed to increasing South Australia's participation rates in sport and physical activity, which are currently among the lowest in Australia. As Minister for Recreation and Sport, I am committed to ensuring this situation is addressed and we achieve the target set in the State Strategic Plan, of increasing participation rates to exceed the national average. (Michael Wright MP, Chair, Ministerial Physical Activity Forum, BA p. 2)

This sets up a tension with another characteristic — the strong appeal to a collective spirit that resonates throughout BA; though it is also apparent in EWBA and EWSA, it is expressed more powerfully here and is entwined with additional obligations of good citizenship — that one must participate for the benefit of the current and future collective:

> We must all take up the challenge to be physically active, to assist others to enjoy activity and ensure that we have more people, more active, more often. For future generations and the future of our State, we must act now and we must all take some responsibility. (p. 4)

This appeal is premised on the assumption that everyone is actually able to participate, and will experience participation as positive: 'Physical activity is something that *everyone* can enjoy' (p. 2). As this is logically not the case — because age, illness or disability may prevent some people from being physically active, or from enjoying being active — this appeal to inclusiveness paradoxically automatically excludes a proportion of the public. To the extent that good citizenship has been defined as participating in physical activity, people who do not participate are by default ascribed with lesser moral status.

In short, while participation is framed (in overwhelmingly positive terms) as beneficial, this can hide its obligatory nature and the ramifications of this: if participation is obligatory, then not to participate is not to be a good citizen, and thus to have diminished moral status. In the case of BA, what is notably missing is an acknowledgment that physical participation is not possible for everybody.

Government

Partnerships: The appeal to the collective spirit is also evident in all four policy documents, though it is most marked in BA (see above), created by the abundance of

words expressing collectivity, such as: 'coordinated and collaborative approach' (EWBA p. 4); 'partnerships and coalitions' and 'partners in collaborative and co-ordinated action' (EWSA p. 6); and 'collaborative and cooperative efforts' and 'coordination and commitment' (BA p. 5). Like the other policy documents, the language of *Priorities* is that of 'joined-up' government: 'partnerships,' 'coordinated responses,' 'complementary policy' (*Priorities* p. 4), constructing the government as expert and as part of modern governance. This is further emphasised by inclusion of a table detailing 'government sectors contributing' to EWBA. Overall, the solution of successfully 'promoting healthy weight at a population level' is constructed as requiring a solution that is 'comprehensive,' consisting of 'multiple strategies' addressing 'behaviour, knowledge and attitudes as well as environments, policies and program delivery' (*Priorities* p. 3).

The cooperative principle extends to all policy players:

> Reversing the problem requires a co-ordinated and collaborative approach involving all levels of government, as well as non-government organisations, communities and individuals. (EWBA p. 4)
>
> Implementation at all levels will require partnerships with other government, non-government organisations and the community. A co-ordinated statewide approach to implementation will be fostered. (EWSA p. 3)
>
> The aim of this Strategy is to establish a framework that will foster strong partnerships between Government, community and private sector organisations. (BA p. 2)
>
> To achieve the healthy weight target, SA Health actively fosters partnerships across government, regional health services, non-government agencies and the community. Increasingly, it will pursue new partnerships . . . (*Priorities* p. 4)

In each document this approach also expresses a strategic principle of practice (Guiding Principle 3.1 in EWBA; Strategy 2 in EWSA; Goal 3 in BA; and apparent in the Logic Models of Priorities, pp. 7–8) and corresponds to the representation of the solution as complex and comprehensive, logically demanding joined-up governance.

The state: The solution to the problematisation(s) in each of the four policy documents constructs the role of the state in similar terms. Fischer (2003 p. 62) suggests that the 'policies designed to deal with social problems are important determinants of which actors will have the authority and power to deal with the issues they raise.' Here, the state is positioned as powerful and responsible, as a leader, a good coordinator, well

organised and informed, an expert, a collaborator, and as quintessentially *active,* even heroic (EWBA, BA).

In EWBA and BA, the problem is constructed as an urgent and serious crisis, logically making the role of the state that of rescuer or hero in its enabling of citizen participation, effectively reinforcing the power of the state apparatus. This takes various forms. In EWBA and EWSA emphasis is on socioenvironmental strategies supporting individuals to adopt healthy practices, although an exhortatory element is still apparent. In BA this element dominates, and the major role ascribed to the state is as a motivator to participation. This is both explicitly stated: 'the Strategy will. . . . attempt to increase individuals' motivation to be active' (BA p. 5) and present at an implicit level. The combination of exhortation and urgency discussed above — 'It is time to act!' (p. 4) — gives BA the flavour of a call to action as much as a policy framework.

This contrasts with the representation of the state in *Priorities*, which is matter-of-fact and well considered, though it shares the representation of the state as leader and expert.

Corporate sector

The third logical major player, in terms of the degree of influence exerted on the factors that render environments supportive of healthy eating and physical activity, is the corporate sector. It is identified in each of the policy documents as an integral player, for example: 'EWBA Guiding Principle 3.1: Build partnerships that value and support the role that individuals, families, communities, government, non-government and industry can and should play in addressing the issue' (EWBA p. 8). However, apart from similar allusions in the other documents, the corporate sector is allotted a very minor role. Its absence at the level of detailed program implementation in particular is significant as this is where outcomes and indicators measure effectiveness and provide a degree of accountability.

In EWBA, EWSA and BA, the corporate sector is implicated in the solution to the problem, not in its causation, again sequestering this sector from accountability for contributing to or solving the problem. As Eagleton (1994, p.198) observes, power that remains 'conveniently invisible' works better as it is hard to critique or challenge. From a critical perspective, then, this quarantining process is part of the obfuscating of

ideology — it is one of the ways that ideology permeates the state apparatus, reinforcing neoliberal principles and logic (Althusser 1994). In EWBA, the food industry, though not identified as contributing to the problem of obesity, was able to provide input into how the problem was initially defined, that is, with themselves not being held accountable. EWBA states that it ‘reflects the feedback received from the consultation process’ (p. 5). Groups that provided feedback include the Australian Food and Grocery Council (p. 21), the peak industry body and a very powerful lobby group (Daube 2010). It is precisely by such means that Freudenberg (2014) suggests the corporate consumption complex gains power over democratic processes, using them to further their own ends; in this case, to avoid the food industry being implicated in contributing to obesity and thus being liable for doing more to help its resolution. More importantly still, this construction of blamelessness strengthens the food industry’s argument for avoiding government regulation, a core principle of neoliberal ideology. It also illustrates the Althusserian notion that ideology exists in material practices such as industry consultation and the resulting influence on public policy (Althusser 1994).

The corporate sector is primarily absent from EWSA. Following the Minister of Health’s deferential invitation: ‘I invite government agencies, non-government organisations and the business sector to work with the Department of Health to implement *Eat Well South Australia*’ (p. 2) — the corporate sector is not identified again until the final section of EWSA, which outlines strategic solutions, ‘Develop partnerships and coalitions,’ quoted above.

It is apparent that the corporate sector — unlike other sectors — is constructed as part of the solution to the problem, not as contributing to it. Given that the vast majority of our food is supplied via this sector, this seems incongruent. When considered along with the non-problematisation of the food that *is* consumed (rather than what is *not* consumed) in the primary problematisation, the effect is that the functioning (and profit-making) of the commercial sector is likely to remain unaffected. The focus on the consumption rather than production of food shifts responsibility for obesity to the individual, reinforcing another fundamental tenet of neoliberal ideology.

The closest either EWBA or EWSA get to a structural problematisation is concerning food supply. EWSA devotes greater space to it than EWBA, which has a much broader remit. In EWSA, the problem representation of the food supply as inadequate rather

than inappropriate focuses attention away from the forces that support a system of unhealthy food production and promotion. It focuses attention instead on consumption, and local barriers to good nutrition. The structural driver of the problem thus sidestepped, the solutions offered are, logically (though incongruently), individual and socioenvironmental rather than structural.

The corporate sector is barely present in the BA strategy, whereas several programs and policies described in *Priorities* have direct implications for the corporate sector, which is congruent with its more comprehensive representation of the influences on individual behaviour. For example, the 'Healthy food and drink choices for staff and visitors in South Australian Health Facilities Policy' lists one of its outcomes as the 'decreased availability and promotion of energy-dense, nutrient poor food and drinks' (*Priorities* p. 37).

Similarly, the 'Crunch& Sip'® program (p. 23) highlights the contribution that EDNP food makes to children's poor nutrition, explicitly identifying that:

> Many children are eating too many foods that contain too much added fat, salt and sugar and drinking sugar-containing beverages. One way to improve children's overall food intake then is to encourage them to replace sugary drinks with water and unhealthy snack foods with fruit and/or vegetables. (*Priorities* p. 23)

The introduction to the Policy and Legislation action area specifically identifies 'banning marketing of unhealthy food to children and adolescents in the media' (*Priorities* p. 35) as a 'promising area', stating that 'It has been argued that there are strong causal links between food promotions and children's food preferences, household purchases and children's consumption patterns (*Priorities* p. 35).

In contrast to the potentially far-reaching consequences envisaged in this introductory section of *Priorities*, suggesting the more upstream drivers of the obesogenic environment might be influenced, the actual policy initiatives that follow are quite narrow. This is possibly because, whereas SA Health can ensure that the narrow policy changes can happen, it requires political support for legislative changes to be passed by parliament, even when the desired changes are within state jurisdiction. To date, this political support has been lacking, with a consultation paper entitled, 'Eat Well Be Active: Television advertising and the consumption of unhealthy food and drinks by children', released in August 2008, not progressing any further (Government of SA

2011b). Although the move to restrict the advertising of junk food during children's television viewing is noted in the Program Logic (p. 7), and referenced in the Appendices (p. 56), presaged in this section of *Priorities*, it does not appear in the policy descriptions that follow.

Gramsci (1971; 1975a) theorised that hegemony is won through the diffusion of ideology via political and economic institutions — such as public policy — thereby helping cement the domination of the ideas that benefit the ruling class. The success of the fast food and marketing industries in resisting government regulation is an illustration of how this happens in practice. However, the ongoing contestation over food and marketing regulation (Government of SA 2011b) also illustrates another concept proposed by Gramsci (1975a, 1975b) — that hegemony is inherently fragile and unstable, and that it must be repeatedly won. Although dominant, neoliberal individualist ideology is not the only ideological position apparent in these policies. Collectivism and shared responsibility is apparent in the government's commitment to address the issue of children and junk food in another way, by attempting to remove junk food from SA schools. This is the subject of one of the 'related initiatives' — 'Right Bite Food and Drink Supply Strategy for South Australian Schools and Preschools' — for which the Department of Children's Services rather than Health is the lead agency and which '. . . supports schools and preschools to meet the State Government deadline of removing 'junk' food (least healthy choices which are energy-dense and nutrient poor) from school canteens and vending machines from the beginning of 2008' (*Priorities* p. 47).

5.3.7 Framing of responsibility in this problematisation

As described above, the framing of responsibility is both individual and collective, with members of the public and the government and partner agencies — though not the private sector — sharing responsibility for carrying out the changes that are framed as likely to solve this problematisation of unhealthy weight. Discourses invoked are similarly mixed, for instance the 'civic duty' discourse (BA) suggesting an individualisation of responsibility, at the same time as the strategies are described in environmental terms. The 'making the healthy choice the easy choice' maxim from health promotion (Milio 1976) does not feature in either EWSA or BA, but forms a recurring, fundamental notion in EWBA and particularly *Priorities*. In the latter it

draws on discourses of both individual responsibility (for choosing) and collective provisioning (the responsibility for providing healthy, easy options). How practitioners reflect this concept will become apparent in Chapter 7, which describes interviews with OPAL respondents, and it will be analysed in depth in Chapter 8 where the pivotal nature of *choice* is scrutinised.

While the framing of the solution represented by the EWBA, EWSA and BA policies is both individual and socioenvironmental, as described above, that of *Priorities* also includes recognition of the social determinants of healthy weight and the causal chain of policy → environments → individual behaviour. That current default environments are obesogenic, and have an unequal impact on different populations, is also recognised: ‘In industrialised nations . . . the social and physical environments tend to create conditions for choosing unhealthy options. . . . this creates population detriments and health inequalities. . . .’ (*Priorities* p. 35). How this problematisation is likely to affect health equity will now be considered.

5.3.8 Implications for health equity

Eat Well Be Active

EWBA explicitly acknowledges the health and weight-related health disparities in the South Australian population. The higher incidence of overweight and obesity among Indigenous Australians, and the relationship between increasing weight and decreasing SES, are clearly outlined in language that avoids attributing blame by emphasising the inequality inherent in the distribution of the negative effects of a large weight:

> In South Australia the lowest SES groups have double the rate of obesity of the highest SES group, thus disproportionately bearing the burden of the associated health risks. Indigenous Australians are also more likely to be overweight or obese when compared with non-Indigenous persons. (p. 6)

In its section ‘Focus on Inequalities’, the language is again non-blaming, identifying the cause of poor health as (only) economic disadvantage, with the addressing of health disparities in this policy implying that such things are bad:

> In order to reduce the disparity between rich and poor it is necessary to pay particular attention to psychosocial, environmental, educational, economic and occupational determinants which make it more difficult for South Australians on low incomes to maintain a healthy weight. (p. 9)

Interestingly, weight is still framed here as behavioural, that is, as the result of individual behaviours, but not as volitional, people's circumstances dictating the range of options from which they can choose.

An awareness of the effect whereby absolute improvements in an indicator such as overweight and obesity or health can also represent a relative worsening for some groups (see Baum 2007), is also apparent in several places in EWBA and reflects a nuanced conceptualisation of equity. The Guiding Principles aim to: 'Help those most in need and close the health gap between the most and least advantaged groups' (p. 8), while the fourth objective also hopes: 'To make the greatest gain in those population groups who have the highest burden of overweight and obesity and poorest health outcomes' (p. 9).

Finally, Section 3.5: 'Focus on Inequalities,' states: 'It will be essential that population-based strategies do not exacerbate the already existing inequalities in this area' (p. 9).

Eat Well South Australia

In contrast, health equity is more implicitly represented in EWSA, expressed in general terms such as the Health Minister's proclamation that 'The health and wellbeing of individuals, families and communities is fundamental to achieving our State's vision of creating opportunity for all' (p. 2). Equity is more clearly expressed in the Guiding principles, with three of the seven principles pertaining to equity. These are:

> (1) Take a population health focus that embraces a public health approach . . .;
>
> (2) Contribute to reducing health inequalities by focusing on the nutrition related health needs of disadvantaged groups, including Aboriginal South Australians; and
>
> (4) Acknowledge the social determinants of health as well as the relationship between nutrition, physical activity, smoking and alcohol consumption on health. (p. 3)

The 'population' and 'public health' approach are potentially favourable to equity as they focus on environmental rather than individual-level health needs, though they are not clarified any further in this document and no indication is given as to how it is envisaged that these principles will be applied. The focus on 'reducing health inequalities' through addressing the 'nutrition related health needs of disadvantaged groups,' while promoting equitable outcomes, obviously does so only narrowly. While it is unreasonable to expect a policy of this nature to address the causes of

disadvantage, the acknowledgment the determinants of health are social as well as individual is at least an indication of awareness that current health inequities have structural causes. This is reassuring as the policy elsewhere is somewhat ambiguous about which ‘specific population groups’ are to have strategies tailored to them (p. 4). The explicit acknowledgment of the disparities in health experienced by Aboriginal South Australians (as in EWBA) also suggests that this significant inequity may be prioritised in the policy.

Be Active

Unlike EWBA and EWSA, BA makes no mention of health inequities, nor of disadvantages systemically accruing to population groups according to their SES, Aboriginal status, or disability. If an understanding of equity underpins this strategy, it would seem to be conceived as an add-on or by-product rather than part of the inherent nature of the social-economic system in which people are located.

That ‘The [BA] Strategy aims to target population groups’ (p. 5), with Goal 1 being dedicated to this object, suggests an awareness that different population groups are differentially able to take up physical activity options. However, the actual population groups are unspecified: the fact that the first strategy under this goal consists of identifying these populations suggests that there is no fundamental analysis of inequity underpinning this policy document. Statistically, the disproportionate burden of ill health and disadvantage borne by Aboriginal groups should alert policymakers to the needs of this group, as is the case in EWBA and EWSA — it is a predictable inequity. Disability is similarly absent. This silence suggests a more rudimentary conception of targeting than that evident in EWBA, with no sense of health being distributed along a gradient.

Priorities

The commitment to equity expressed in *Priorities* — reinforced by quoting EWBA’s Objective 4 — is attributed to SA Health, which has the effect of locating EWBA within SA’s overall health planning, possibly to distinguish it from the SASP, which is elsewhere extensively referenced: ‘SA Health has nominated its strategic commitment to produce positive and equitable health outcomes for all South Australians’ (SA Department of Health 2008a, p.3).

In its general discussion of equity — which itself is unique among the four policies — *Priorities* details the monitoring of interventions on 'the distribution of health outcomes,' and identifies a twofold approach to equity: as well as embedding the principle of equity within strategies aimed at the population level, specific interventions seek to 'tackle the health inequities facing the most disadvantaged members of the community' (p. 4). Finally, it is conceded that 'more work needs to be done to integrate equity concerns' into actual interventions 'to ensure that equity considerations are made central to planning and resource allocation' (p. 4).

This commitment is operationalised to the degree that, as discussed above, eight of the 26 priority programs target populations identified as experiencing disadvantage, including Aboriginal populations, Culturally And Linguistically Diverse populations, migrants, and people of low SES. Some programs are specifically designed to promote healthy weight in one of these populations, such as 'Healthy Ways' (*Priorities* p. 27) and Community Foodies (*Priorities* p. 21) while other initiatives, like Healthy Weight Coordinators, include 'closing the equity gap' among its aims (p. 30).

5.4 Summary of chapter

This chapter provided descriptive and analytic accounts of the policies comprising SA's Healthy Weight Strategy. Core problematisations of unhealthy weight, its causes and solutions were identified. The discourses through which responsibility for solving these problematisations was constructed were then identified and ideological associations noted, before finally considering how equity was represented in the policies and in the ideologies that underpin them, threads that will be taken up at Chapter 8. While EWBA contains a clearer expression of commitment to health equity than EWSA or BA, it is in *Priorities* where it receives its clearest expression as an embedded conceptualisation.

Equity is a normative concept, that is, it expresses a certain value base — one which is committed to fairness. The explicit commitment of the EWBA Strategy to equity is supported by its socioenvironmental framing of what changes need to happen to improve population level healthy weight. However, as intimated above, the maxim of 'making healthy choices easy choices' can in practice privilege choice, so that whether healthy weight is increased in an equitable manner can depend on the extent to which healthy choices really have been made easier for those experiencing constrained

circumstances. The way in which the ideology of neoliberal individualism interacts with the commitment to equity expressed in these policy documents will be examined in Chapter 8 when analyses of policy and program documents, and interviews, are brought together.

CHAPTER 6: FRAMING OF OBESITY IN OPAL DOCUMENTS

6.1 Overview of chapter

In this chapter the way that obesity is framed in the OPAL (Obesity Prevention And Lifestyle) program documentation is considered. The ideologies and discourses underpinning OPAL are identified, thus addressing Research Question 2. The previous chapter examined the framing of obesity in the Healthy Weight Strategy (HWS) policies, and the following chapter will complete the analysis component of this thesis by examining how obesity is framed in interviews with key informants from OPAL.

The previous chapter outlined the global health promotion context within which the Healthy Weight Strategy was developed. As the SA Government noted at the time of OPAL's launch, OPAL was part of the broader Healthy Weight Strategy; specifically, OPAL was introduced as a

> ... new program ... in addition to other measures by the State Government to combat childhood obesity, including... banning junk food in public school canteens; working with preschools and schools to encourage children to swap soft drinks and junk food snacks for water and fruit; introducing the Premier's 'be active' Challenge; introducing the 'Start Right Eat Right' healthy food in childcare services … [and] recruiting ten healthy weight co-ordinator positions across the state. (Government of SA 2009b, p. 2)

As part of the Healthy Weight Strategy, which addresses one of the South Australia's Strategic Plan (SASP) targets, OPAL is located within a policy environment committed to furthering equity in health by influencing the determinants of health that lie outside the health sector.

6.2 Selection of OPAL and OPAL documents

Occupying a substantial section within the SA Health website, OPAL is introduced as 'a program that supports children, through their families and communities, to be healthy now, and stay healthy for life' (SA Department of Health website 2015, OPAL, accessed 14 March 2013).

The OPAL community-based childhood obesity program was selected as a case study from the EWBA *Priorities* document as it represented the most visible and largest financial commitment by the SA Government to any single program in EWBA, implying that the government considered it to be a significant component of this

strategy. The range and depth of expertise represented on OPAL's Scientific Advisory Committee also made it reasonable to suppose that it would also reflect current best practice.

The following documents were selected for study, as described in Chapter 3:

1. National Partnership Agreement on Preventive Health (Council of Australian Governments, August 2010)
2. Public presentations showcasing OPAL
    a. 'OPAL by EPODE' (SA Department of Health November 2009)
    b. 'OPAL in SA' (SA Department of Health July 2010)
    c. 'Evaluation of OPAL: Early lessons' (Cobiac et al. December 2011)
3. OPAL website and social marketing materials (SA Department of Health website, OPAL, viewed 2009–2014).

The relationship between these documents, the policy documents described in Chapter 5, and OPAL's origins in the French program, EPODE ('Together Let's Prevent Childhood Obesity'), are illustrated in Figure 6.1 below.

6.3 Descriptive accounts of OPAL

6.3.1 National Partnership Agreement on Preventive Health

Background information on OPAL was obtained from the National Partnership Agreement on Preventive Health (NPAPH) (Council of Australian Governments 2010), supplemented by the SA Health OPAL website. OPAL featured in the NPAPH as it was partially funded by the Commonwealth.

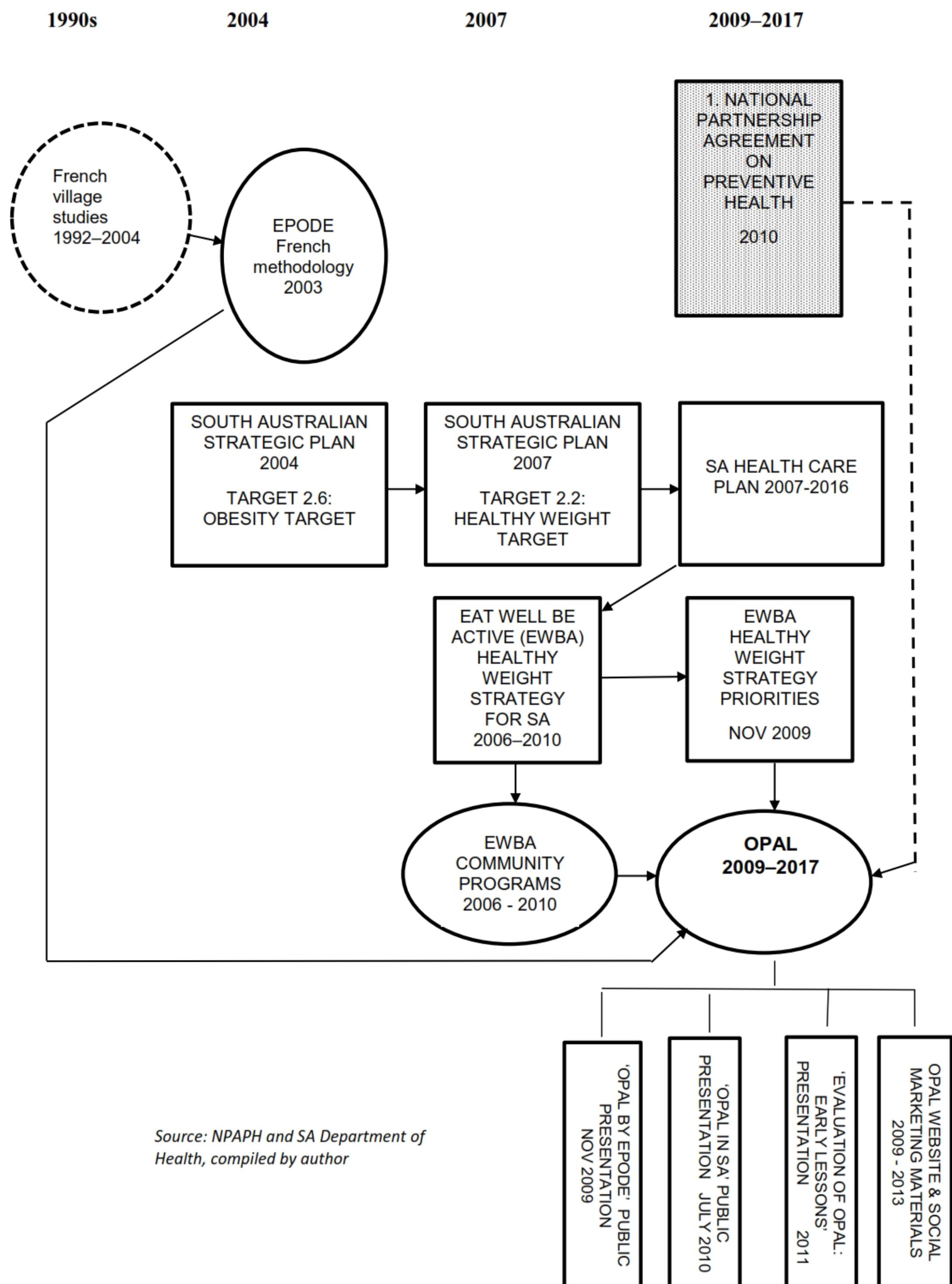
Origins, funding, targets and theoretical underpinnings

The NPAPH (2010, p. 6) describes how the South Australian Government came to acquire the EPODE methodology as a solution to the 'unacceptably high' levels of overweight and obesity among 0–18-year-olds in South Australia. EPODE is described as having 'demonstrated promising results' in 'bringing about weight change in populations', further describing it as one of the 'few community interventions that is scaleable and transferable – being relevant to different sizes and types of populations' (NPAPH 2010, p. 6).

Launched in March 2009, OPAL is described as applying the 'four pillars' of the EPODE methodology — 'political support, innovative social marketing, excellent

evidence base, and partnerships' — while adapting to local circumstances (NPAPH 2010, p. 6). The most immediately visible departure is OPAL's funding source, which is 'all three tiers of government', unlike the privately funded EPODE (NPAPH 2010, p. 4).

Figure 6.1: OPAL genealogy and timeline



Source: NPAPH and SA Department of Health, compiled by author

Funders include the Commonwealth and South Australian health departments and the local governments within which the 20 OPAL projects are located (NPAPH 2010, p. 4). OPAL is described as working across multiple sectors and settings, employing 'a wide range of strategies to bring about healthy lifestyle changes' at a community and individual level, focusing on 'those in greatest need — for example those of lower SES, Indigenous, culturally diverse, regional and remote communities' (NPAPH 2010, p. 4). Rather than targeting children directly, OPAL specifically targets families, with its objective being to increase the number of 0–18-year-olds in the healthy weight range through increasing healthy eating and physical activity (NPAPH 2010, pp. 3,4).

In terms of its policy context, OPAL falls within the South Australian *Eat Well Be Active Healthy Weight Strategy* (SA Department of Health 2006a) as previously explained, and thus contributes to the achievement of the Healthy Weight Target (HWT) of the SA Strategic Plan 2007 (NPAPH 2010, p. 9). OPAL is also identified as contributing to national objectives for addressing 'the rising prevalence of lifestyle related chronic diseases' under the Commonwealth Healthy Children Initiative (Government of SA, 2007; NPAPH 2010, pp. 1,4). Under the NPAPH funding agreement, half of this funding is received upfront, with the other half dependent on OPAL's satisfactory reporting against a range of quantitative benchmarks for healthy weight, including number of serves of of fruit and vegetables consumed, and number of people participating in 'moderate physical activity' (NPAPH 2010, pp. 17–18). As this agreement makes clear that the state will have to cover any shortfall in funding if benchmarks are not met, that is, the 'reward payments' are not forthcoming (NPAPH 2010, p. 2), they operate in practice as additional targets.

The NPAPH (2010, p. 6) describes the issues OPAL addresses as not simply 'overweight and obesity', but the behaviours that lead to overweight and obesity. '… low levels of fruit and vegetable consumption and insufficient physical activity … As weight mediators, these behaviours and the social norms that underpin them must be addressed'. In addition, it identifies the uneven distribution of the 'health risks' associated with overweight and obesity, which are not '… evenly spread across the population–increased weight, unhealthy eating and less physical activity are skewed to those people experiencing greater disadvantage' (NPAPH 2010, p. 6).

Ecological theory is identified as underpinning OPAL, combining community development principles to target the physical and policy environments that support healthy eating and physical activity, and social marketing to change the social norms that influence choice and individual behaviour (NPAPH 2010, pp. 4,6).

Structure and implementation

OPAL was described as consisting of a central State Co-ordination Unit with a manager and social marketing and evaluation coordinators, with administrative support, and Local Council Teams comprising a manager and support officer (NPAPH 2010, p. 4). OPAL is guided by two independent bodies: a Scientific Advisory Committee (SAC) with representatives from all three local universities chaired by Professor Boyd Swinburn (WHO Collaborating Centre for Obesity Prevention and Related Research and Training); and a Strategic Advisory Committee (STAC) consisting of industry and non-governmental organisation (NGO) representatives, which provides advice and feedback and champions the OPAL cause (NPAPH 2010, p. 4).

There have been 21 OPAL project sites, each funded for five years. At the time this part of the research began in 2009, six OPAL projects were being piloted in metropolitan and regional Local Government Areas (LGAs) (Government of SA 2009b). Fourteen more projects were rolled out from 2010 to 2012, and one site was established in the Northern Territory, administered by SA. Most projects are located in different LGAs following processes of tender and invitation; project location is thus dependent on LGA interest. After cuts to SA's health promotion work and the loss of Commonwealth funding that had threatened OPAL's continuation, the SA Health website (SA Department of Health website 2015, OPAL, accessed 15 March 2015) notes that OPAL will continue until 2017. This date being when the last of the projects completes its five-year term, with state funding and continued support from local government (McCann 2012, p. 27).

OPAL project sites are described as consisting of communities of up to 40,000 residents within the host LGA, and include rural, regional and urban locations. Selection between and within LGAs is based on a combination of percentage of people in the unhealthy weight range, disadvantage (using the Australian Bureau of Statistics (ABS)'s Socio-Economic Indexes for Areas [SEIFA] index), Aboriginal population, and council readiness and support for wellbeing (e.g. finance, infrastructure, energy)

(NPAPH 2010, p. 4). OPAL is presented as potentially directly influencing about 400,000 people — approximately a quarter of South Australia's population — by the conclusion of the program in 2017 (NPAPH 2010, pp. 4,7).

OPAL managers based in local government locations (but employed by the SA Department of Health) are portrayed as engaging with and working through existing community-based agencies in a range of settings where there is opportunity to influence the environments that enable or constrain healthy eating and physical activity. According to the NPAPH (2010), OPAL's responsiveness to local needs is facilitated by its location at the local government level and by its collaborative processes. These are captured in the 'process indicators' established in the NPAPH document on which OPAL will report and which highlight partnerships and collaborations, community engagement and 'equity and cultural inclusiveness' (NPAPH 2010, p. 14). Although a template-style program would contradict the community development principle of working from the bottom up, rather than the top down (Kenny 2011), the NPAPH specifically notes that,

> Each OPAL community is unique and dynamic. The tailoring of the OPAL approach for Indigenous and cultural groups happens at the local level. Most OPAL communities have developed OPAL Local Advisory Groups with representations from stakeholder groups including migrant and Indigenous groups. (NPAPH 2010, p. 11)

The NPAPH notes the flexibility of the OPAL model, which means that OPAL managers can be responsive to the particular needs of their different local communities: they 'generate, partner and promote' as appropriate, that is, they build on and augment existing community programs and capacity (NPAPH 2010, pp. 9,11).

An illustration of how social marketing themes are tailored around the needs of a particular community also shows the connection between social marketing and other activities conducted by OPAL teams (a manager and assistant) in their OPAL communities. The process by which a new social marketing theme is generated every six months is described (NPAPH 2010). After the SAC identifies a specific aspect of healthy eating and physical activity (not weight), market research is conducted and the theme is reviewed by the STAC, OPAL managers and the state government's central Health Promotion Branch. The theme is then turned into a specific and positive marketing message, with further advice about implementation from the health sector, the STAC and OPAL Local Advisory Groups (NPAPH 2010, pp. 11–12). Various

materials are produced for distribution to the public, and training provided to OPAL managers.

The NPAPH describes the linkage between healthy behaviours and choices, and the role of social marketing in enhancing this process:

> At the heart of trying to make a difference to children in OPAL communities are families, with parents and care givers playing a pivotal role in decision making around opportunities for healthy eating and physical activity. OPAL's innovative social marketing includes a twice yearly thematic approach to promoting healthy behaviours and environments. (NPAPH 2010, p. 4)

Evaluation

The NPAPH describes OPAL's complex evaluation, designed to capture environmental changes, population-level behaviour changes, and anthropometric changes such as BMI and waist circumference (NPAPH 2010, p. 9). In addition to the extensive qualitative and quantitative evaluation embedded in the design of OPAL (the SAC contributing to the design), an independent evaluation team will be appointed (NPAPH 2010, p. 14). The complexity of the program described by the NPAPH, and OPAL's accountability to the multiple stakeholders and funders, which require reporting against different criteria, are both likely to contribute to this complexity (NPAPH 2010, pp. 9, 17–18).

6.3.2 OPAL in public presentations

Three public presentations of the evolving OPAL program will now be examined:

- 'OPAL by EPODE' (SA Department of Health, 2009), presented on 21 November 2009 at the seminar, *How Early Is Too Early For Good Nutrition?* organised by the SA Nutrition Network, in partnership with the Health Promotion Branch of SA Health, in Adelaide, SA.
- 'OPAL in SA' (SA Department of Health, 2010) presented on 26 July 2010 to the first 'Reducing Obesity in our Communities' Symposium, in Sydney, Australia, organised by the Centre for Health Innovation and Partnership (CHIP), Sydney West Area Health Service (SWAHS) and the International Life Sciences Institute South East Asia region (ILSI SEA).
- 'Evaluation of OPAL: Early lessons' (Cobiac et al., 2011), presented on 7 December 2011 to the second 'Reducing Obesity in our Communities' Symposium, in Sydney, Australia, organised by CHIP, SWAHS and ILSI SEA.

> (OPAL's evaluation is being conducted by a team led by Professor Lynne Cobiac, from Flinders University and the CSIRO Food and Nutritional Sciences.)

How OPAL has been represented in public presentations changed considerably during the period since the first six OPAL sites were rolled out in South Australia. A discernible fully and locally contextualised OPAL emerged over the two years between the first (2009) and third (2011) presentations. The following analysis will specifically examine at how these presentations represent the onus of change falling — on environments or individuals — explored or apparent through the roles accorded to social marketing, environmental change and changing social norms.

OPAL's ten principles remain unchanged in the three presentations. OPAL is 'equity focussed' — it 'reaches all parts of the community [via families] with a focus on the disadvantaged', and it 'adopts community development principles'. These attributes are presented as 'consistent with EPODE methodology' and local 'HE & PA [Healthy Eating and Physical Activity] guidelines'. OPAL is also identified as working 'in partnership with others across multi-sites and multi-settings', adopting 'a multi-strategy portfolio approach', which is 'evidence based', at the same time addressing 'broad structural change in conjunction with individual change', while being 'positive and non-stigmatising' (2009, p. 9; 2010, p. 9; 2011, p.4).

The first (2009) presentation introduces EPODE and its methodology to the SA audience. In this presentation OPAL was still largely represented as part of EPODE and was not fully differentiated from it: references are to 'EPODE (OPAL)' (SA Department of Health 2009, p. 2) or 'OPAL (EPODE)' (p. 3), and while 'OPAL' featured in the overview, the details were still those of EPODE.

By July 2010, although OPAL was still presented as OPAL by EPODE (possibly due to franchise requirements), 'A French childhood obesity prevention program in South Australia' (SA Department of Health 2010, p. 4), the detailed description is specifically about OPAL, a 'joint program of Australian, State and Local Governments' (p. 24), the aim of which was: 'To improve eating and activity patterns of children, through families and communities in OPAL regions and thereby increase the proportion of 0-18 year olds in the healthy weight range' (SA Department of Health 2010, p. 8).

In the earlier 2009 presentation (SA Department of Health 2009, p. 5), this phrasing had been identified as an Scientific Advisory Committee ‘refinement’, presumably of the original aims as derived from EPODE that had been represented earlier in the presentation thus: ‘EPODE’s (OPAL’s) over-riding aim is to change the social norms around healthy eating and physical activity making them the preferred option. This is done by working with whole communities’ (SA Department of Health 2009, p. 2).

Behavioural changes are identified as being the aim of the program in both the 2009 and the 2010 representations, although there are two key differences in how this is envisaged as happening. First, ‘social norms’ were omitted in the 2010 iteration. Second, whereas in 2009 ‘community’ was represented as the site where the changes will occur, in 2010 ‘community’ — not ‘social norms’ — becomes the vehicle through which these changes will occur.

EPODE is additionally represented (in 2009) as, ‘A methodology based on social marketing techniques … to induce individual and collective changes in social norms and thus behaviour changes (SA Department of Health 2009, p. 23). That is, social marketing is envisaged as a strategy for changing social norms and thus behaviours. This is consistent with its representation in the NPAPH document: ‘OPAL’s social marketing is … aimed at parents. Information is tailored to encourage parents to make the healthy choice. This, according to the French model EPODE, is the key to changing social norms’ (NPAPH 2010, p. 10).

In the 2010 representation of OPAL, the role of the social marketing approach is reduced from being one of EPODE’s ‘Four Pillars’ (SA Department of Health 2009, p. 24) to one of seven ‘Objectives and Activities’–the seven strategies in the third (2011) presentation (Cobiac et al. 2011, p. 4) — and the logical connection between social marketing and changing social norms is lost. In the 2010 iteration there is no longer any explicit logic linking social marketing to social norms, although changing social norms is retained in the research design — as it is in the 2011 presentation — as a ‘process indicator’ or ‘measure’ towards behavioural changes: ‘Changes in social norms towards healthy eating and physical activity’ (Cobiac et al. 2011, p. 9; SA Department of Health 2010, p. 31). This is the only mention of ‘social norms’ in either the 2010 or 2011 presentations.

Corresponding differences are apparent in the role that 'behaviour' is accorded in the three presentations. In the 2009 presentation, changed (health promoting) 'behaviour' is represented as the actual goal of EPODE, with social marketing (and 'network creation') and then social norms implicitly presented as vectors for achieving this change (SA Department of Health 2009, p. 23), though the HWT is explicated as a local goal for OPAL. In the 2010 presentation, 'behaviour' is represented as only one of several 'impact indicators' to be used in the evaluation research (SA Department of Health 2010, p. 30). In the 2011 presentation, 'HE' [healthy eating] and PA [physical activity] behaviours' have re-emerged as prominent, but are clearly represented as themselves being intermediate vectors for change, located between the proximal targets of environments/agency, and the distal outcomes of changes to 'energy balance', 'healthy body weight' and 'quality of life' (2011, p. 6). Most significantly, environmental change rather than social marketing/social norm changes is now clearly represented as preceding behavioural change (with social marketing contributing to behavioural changes only through its influence on environments and agency) (2011, pp. 4,6,19). The logic underpinning the representation of how OPAL will achieve its aims thus significantly alters between 2009 and 2011.

To summarise, while the same degree of focus on social norms is maintained from 2009 to 2011, the role they are represented as playing decreases in importance from centre stage in 2009 ('EPODE's aim is to change norms', p. 2) to the newly highlighted role played by environmental change. The role given to social marketing also changes markedly, from being a core concept in the EPODE-inspired approach and research design in 2009; to a still prominent, but more peripheral role in 2010; to having a minor role in the research design of 2011, where it is represented as only one of several influences on environments and agency. This contrasts with the prominence the social marketing themes are accorded on the OPAL website.

Reinforcing this increasingly community-focused representation is the 2010 presentation's use of numerous examples from OPAL's community-based projects: a community garden (p. 35); feasibility study for a producers' market (p. 36); a local Physical Activity Council (p. 37); 'Healthy Eating Policy' and 'Transit Plan' to make environments more 'supportive of active transport' (p. 38). Also listed are drinking fountains (p. 39); water tastings (p. 41); and Community Foodies training with

Aboriginal education in Port Augusta' using a 'Peer education model', and providing ongoing support and training, and 'Working to establish an Aboriginal Parent Advisory Group' (p. 42). The 2010 presentation thus describes a more fully South Australian and contextualised program than the 2009 presentation, which still showed strong ties to the French model. It is here that OPAL's community location and approach to work becomes evident, and the claim of being able to be contextually specific, while following a franchise or template approach, becomes visibly supported in practice.

OPAL's evolution from a program centred on changing health-impacting behaviours through the individualised mechanism of social marketing — essentially, telling people what to do — to one centred on making the environments people inhabit more conducive to healthy behaviours, continues from the 2010 to the 2011 presentations. For instance, the 2011 presentation includes for the first time the concept that 'healthy weight' is itself only an intermediate goal, instrumental in contributing to 'Quality of Life' rather than an end in itself, in contrast to the anthropometric measures that had dominated the 2010 presentation with its single and ultimate goal of improved weight status. What is described is still a weight-centred program, but not just a weight-centred program: weight has now been located within the broader context, not even of health, but of wellbeing. This represents a significant move away from the weight-centred paradigm.

The description of the evaluation, which follows reflects these dual outcomes, with primary anthropometric measures now clearly complemented by 'secondary measures' that indicate impact on 'Quality of Life' (Cobiac et al. 2011, pp. 8,9). Whereas in the 2010 presentation, changes in 'skills, knowledge, behaviour and attitudes' are identified as needing to occur at both the individual and stakeholder/organisational/community level (2010, p. 30); in the 2011 presentation they are represented as only needing to occur at the community level, and are portrayed as 'proximal impacts' needing to, 'impact on HE and PA opportunities, environments and policies' (Cobiac et al. 2011, p. 9).

This increasingly visible socioenvironmental perspective implies that the factors listed under healthy eating and physical activity behaviours in the 2011 presentation — such as 'decreases in intake of energy dense food and drinks' (2011, p. 9) — are envisaged as driven by factors external to the individual, that is, that they represent not just

reductions in consumption or individual diets but in the environments with which individuals engage. This interpretation is supported by the identification of the 'Obesity System Map of "Societal influences"', 'Food Production' and the 'Activity Environment' as well as the individual elements of 'Food consumption', 'Individual psychology', 'Individual activity', and 'Biology' (Cobiac et al. 2011, p. 17).

Another new element in the 2011 presentation that further reinforces the focus on environmental influences on weight is the reproduction of an ecological diagram (similar to Dahlgren and Whitehead's 'rainbow' model, 1991, p. 5 in South Australian Council of Social Service [SACOSS] 2008) that is labelled 'Sociocultural context'. This depicts 'The determinants of health and wellbeing in our neighbourhoods' in concentric circles with 'people' at the centre, surrounded respectively by 'lifestyle' then decreasingly local environmental elements, ending up at an outer layer of the 'global ecosystem'. Significantly, however, economic, structural and cultural influences are only depicted in a subtext — as 'add-ons' between the other nested layers, rather than being understood as intrinsic elements in the spheres that influence health, or healthy weight. Their impact is thus implicitly minimised, that is, they are minimally visible. There is nowhere in this diagram, for instance, for influences such as the marketing of energy-dense nutrient-poor (EDNP) foodstuffs to be depicted. The context inhabited by 'people' seems predominantly portrayed as neutral or benign, so that despite the inclusion of environments as well as individuals as targets for change, the scale of change needed is underestimated. As in the analysis of the EWBA, the commercial sphere is underrepresented.

Summary of changes in research design from 2009 to 2011

OPAL's most current (publicly available) program design is distinctively different from the earlier, those more closely EPODE-derived. Detailed consideration of research design is warranted because it represents a distillation of the logic or opens a window directly on the thinking or logic behind the program. Of significance is the introduction of the 'proximal targets' of 'Social and Built Environment' and 'Agency' that mediate social marketing and behaviour change (2011, p. 6), compared with the 2009 research design where social marketing is envisaged as directly creating behaviour change. Figure 6.2 illustrates how these changes can be simply expressed:

Figure 6.2: Summarised changes in OPAL research design 2009–2011

Source: SA Department of Health (2009) & Cobiac et al. (2011) Compiled by author

Although 'social norms' can be conceived as a subset of the social environment, the latter term encompasses more, as well as being itself a subset of 'Social and Built Environment'. This means that OPAL's latest research design reflects a more structural approach to understanding the problem of obesity. The different characteristics highlighted as comprising 'Environment' and 'Agency' also represent some of the essential elements for an equitable program: 'Affordability, Availability, Accessibility, Quality, Social Acceptability of Home Meals, Healthy Outlets and Local Food' as well as 'Knowledge, Attitudes, Beliefs, Skills, Motivation' (Cobiac et al. 2011, p. 6). A program that works on these factors is more likely to enhance equity in health than a program which does not. This reflects a sophisticated conceptualisation of equity.

6.3.3 Website and social marketing materials

After a brief overview of the program, the five social marketing themes, identified as 'health messages', are listed and linked to supporting social marketing materials such as fact sheets. These themes were:

- Water, the original cool drink;

- Give the screen a rest, active play is best;
- Make it a fresh snack;
- Think Feet First — step, cycle, scoot to school;
- A healthy brekky is easy as PEEL. POUR. POP.

  (SA Department of Health website 2015, OPAL, accessed 15 March 2015)

The social marketing materials make it clear that OPAL is aimed both at parents (shopping lists and menu suggestions are provided) and at community 'stakeholders' (action sheets list ways for local organisations to support their OPAL community). The social marketing themes precede the list of 'OPAL communities' (the OPAL projects located in local government), which concludes with instructions on how to find out whether you live in an OPAL community, immediately followed by a list of OPAL's benefits to family health:

> Contact your local OPAL Council Manager to see if you live within the OPAL community in your council.
>
> **Why is OPAL valuable?**
>
> Wouldn't it be great to …
>
> Give your children the best chance to be healthy. (SA Department of Health website 2015, OPAL, accessed 15 March 2015)

The benefits then described are considerable, and include reducing the risk for 'type-2 diabetes, heart disease, high blood cholesterol, high blood pressure and some cancers'. The juxtaposing of this information, immediately following a list of project sites from which parents might have discovered their family was ineligible for these benefits, illustrates one of the key limits to the way OPAL addresses disadvantage — geographically. Although the distribution of OPAL projects is intended to maximise health outcomes for those with the worst obesity-related health, not all people in this category will logically live within an OPAL area. This also reflects a view of equity as a gap between the best and worst off, whereas obesity is distributed along a social gradient.

The rest of the website provides EPODE's credentials, the need for such a program in SA, with OPAL's objectives, and explains how OPAL works and the kind of programs that might be run in the communities in which projects are located and by which they

are driven, stressing that each OPAL project will thus be as different as the community in which it is based. The website makes it clear that OPAL's aim in 'working with a range of communities' is 'to positively change attitudes and behaviours about healthy eating and physical activity' (SA Department of Health website 2015, OPAL, accessed 14 March 2013). OPAL's general approach and the strategies it follows are explained, concluding with its social marketing themes that provide the opportunity to offer detailed information about different issues related to children's health, framed within their developmental needs, and how parents can maximise the benefits and minimise the harms. This information is obviously available to families outside OPAL communities, if they have internet access and literacy skills.

When the term 'obesity' is mentioned on the OPAL website it is mostly in the context of describing EPODE. The focus of the website is overwhelmingly on health and help to adopt a healthier lifestyle, rather than weight.

6.4 Discourse analysis of documents

This section draws together how the OPAL program documents problematise healthy weight, exploring the ideological and discursive underpinnings of this program, addressing the second research question. Particular attention is paid to the role played by the themes describing the role of the commercial sector, and the principles of positivity and choice. The WPR process outlined in Chapter 4 was followed for this document analysis, with the findings presented below.

6.4.1 Representation of the problem

The core problematisation is that people are not eating or exercising well enough to have a healthy weight and thus the best health they can have. This problem is worse among people who experience other disadvantages.

6.4.2 Representation of the causes of this problematisation

The local physical and normative environments in which people live, especially people experiencing disadvantage, are represented as undermining their ability to make healthy choices about eating/drinking and physical activity. People are not choosing enough healthy foods and drinks or being active enough. Although unhealthy products and their marketing are implied as contributing to this problem, this is very secondary to the

emphasis placed on their consumption, which is cast as the result of poor parental choices. While the commercial sector starts to be implicitly viewed as contributing to this problem as OPAL evolves, this is still at the local level. The decision to locate OPAL in local government, while having many benefits, also keeps the focus on proximal rather than distal causes of unhealthy weight.

6.4.3 Representation of the solution to this problematisation

The solution is represented as making the local environments in which people live more supportive of healthy choices — that is, to make them easier, at the same time as raising awareness about what are the healthier choices. The commercial sector has always been part of the formal solution to this problem through the private partnership model of EPODE, on which OPAL was partly based. OPAL's portrayal of the role of the commercial sector is more critical, although the consistent focus on consumption choices keeps the spotlight off manufacturing and marketing practices. Emphasis is explicitly placed on consuming more healthy products, and fewer unhealthy ones by implication, despite limited evidence that healthy products replace unhealthy ones rather than are simply added to them. A similarly positive focus on making local environments more conducive to exercise keeps the focus off upstream drivers of sedentary behaviour such as long working hours and commuting times and distances.

6.4.4 The framing of responsibility in this problematisation

Although OPAL's focus on altering the material and normative environments in which people live implies collective responsibility for healthy weight, the final onus of responsibility is placed on individuals — primarily parents, given OPAL's focus on children and young people — availing themselves of these opportunities by actively choosing the healthier options. This reflects both how the dominant individualising discourse is resisted, and its potency. How the cultural context reinforces the individualising of responsibility will be explored in the final chapter.

6.4.5 Implications for health equity

Social marketing is known to be potentially deleterious for equity (Baum 2011; Swinburn 2008). This may be countered if OPAL projects, targeted to communities with higher levels of disadvantage, are able to achieve significant changes to local environments so that the social marketing messages can be easily implemented by

families. OPAL's influence might thus help level the playing field between communities. The extent to which equity is impacted is likely to be related to how far OPAL is, however, able to make environments healthy weight promoting by *default* (Milio 1981). This is achieved by being passively supportive of the behaviours that promote healthy weight, rather than such behaviours remaining dependent on the active exercise of choice.

Countering the opportunities for improved health represented by OPAL is its limited or targeted roll-out. The OPAL website also makes clear that it is not a universal program, and that not all people who may want OPAL's help to adopt a healthier lifestyle — and thus possibly reduce their weight — will be eligible for it, undermining the equity in access to the program. By delineating geographic communities that can or cannot access OPAL, the assumption seems to be made that obesity is a problem only affecting some people. Evidence shows that obesity is distributed along the social gradient, with weight generally increasing as SES decreases, and that health problems increase as excess weight increases, that is, both the effects of obesity and its distribution are graded, rather than absolute.

The dominant terminology in OPAL, and certainly the language employed in its social marketing messages (NPAPH 2010, p. 10; all OPAL material) is about healthy lifestyle, with the effect of distancing this program from a weight-centred paradigm. However, the context and imposition of the HWT and Commonwealth-funding agreement benchmarks compels OPAL back into the positivist paradigm, which privileges statistics like BMI over environmental process indicators of change (NPAPH pp. 9, 17–18). As discussed above, a focus on weight reduction in the short term can divert the focus from the broad determinants of health (which are also the determinants of healthy weight), changes in which provide the most promising outlook in terms of the equitable distribution of health gains.

6.5 Themes from discourse analysis

A number of themes became apparent during the analysis, centring on the concept of the *construction of responsibility*. These will be discussed in turn as they offer insight into the discourses and ideological underpinnings of the documents studied before some conclusions are drawn about the document analysis.

6.5.1 Construction of responsibility through the commercial sphere in OPAL public presentations

Although the commercial or private sphere is mentioned in the context of 'public–private partnerships' several times in the 2009 presentation, this is never as a potential site of change. The title 'partner' suggests a position of equality, EPODE being represented as being 'designed and managed in collaboration with … private partners' (SA Department of Health 2009, p. 24) — that is, the private partners have input into forming the solution and funding the program. In contrast, public–private partnerships feature in the 2010 presentation only as one of the 'challenges' (SA Department of Health 2010, p. 3).

In the 2010 presentation, in contrast, the commercial sector features as an implicit target for change in some of the case examples; that is, it is constructed as part of the problem, albeit in fairly low key ways. For instance, a 'transit plan' aimed at reducing 'motorised transport' (p. 38) is likely to have negative implications for industry (car industry, oil industry etc.); while providing drinking fountains at another site is likely to have some impact on the sale of drinks, but the small scale of the proposed intervention (only two fountains are initially envisaged) means the effect would be negligible (SA Department of Health 2010, p. 39). Public water tastings in another OPAL community were aimed at demonstrating that tap water was rarely distinguishable from bottled water, and was thus an affordable way to act on the OPAL social marketing message, 'Water, the original cool drink'. This could potentially convince a sizeable number of people to drink tap water and thus reduce the sales of bottled water, potentially impacting the corporate sector. If OPAL had been privately funded, like EPODE, it is possible that even these challenges to corporate profit-making would not have been possible. Projects described at Port Augusta supporting people to prepare healthy meals, such as Community Foodies (2010, p. 42), though making no mention of the private sector, might logically still affect the sales of EDNP food. The private sector is thus differently present in the portrayal of 'OPAL by EPODE' in 2009, where it is represented as part of the solution, and 'OPAL in SA' in 2010, where it is not but, by implication is potentially part of the problem, although it is not explicitly constructed as such.

6.5.2 Construction of responsibility through the commercial sphere in OPAL website and social marketing themes

Unlike the other documentary sources discussed, the OPAL website and social marketing materials are aimed at an audience of parents (as well as stakeholders), the target group of the program. The OPAL website (SA Department of Health website 2015, OPAL, accessed 12 November 2014) makes a clear statement about its goals:

> OPAL is focused on six goals to bring about behavioural change across the community:
>
> Eating well, which means:
>
> 1. healthy food choices available at food outlets
> 2. healthy meals produced in and from homes
> 3. local healthy food production, access and distribution.
>
> Being active, which includes
>
> 1. active travel journeys
> 2. active leisure participation choices
> 3. use of parks, spaces and places.

The wording of these goals explicitly includes the commercial sphere as a target for change (food outlets, food production/distribution), as well as the family home, most significantly moving beyond food consumption to production, as in 'Eating well' point 3 above. Although, as with the determinants diagram in the 'Evaluation of OPAL: Early lessons' (Cobiac et al. 2011), this sphere is posited as 'local', drawing attention away from the economic system and global practices and ownership of (and thus profit from) production, effectively 'de-globalising' it and obscuring its ideological nature. This will be explored in Chapter 8.

The discussion of these six goals concludes by saying, 'Information and activities regarding each theme present a positive, encouraging approach to challenging the social norms and practices which support unhealthy behaviour' (SA Department of Health website 2015, OPAL, accessed 12 November 2014).

This constructs the individual family (and ultimately children) as responsible for adopting and enacting the socially marketed behaviours. This is incongruent with how the most recent public presentation by the external evaluation team represented the

logical flow of the different elements in OPAL, which was that social marketing was mediated by environmental changes that then supported behaviour changes.

References to chronic diseases occur on the OPAL website, not just in establishing the 'need', that is, the health problems (see below) that may strike the population without this program, but in convincing parents of the veracity and wisdom of the social marketing messages; for example, why they should 'make it a fresh snack':

> Setting good habits early in respect to snacks, can help ensure that kids get the best start to life, and do not head down the track towards diet-related diseases like high blood pressure, heart disease, high cholesterol, type-2 diabetes and osteoporosis. (SA Department of Health website 2015, OPAL, accessed 12 November 2014)

Although OPAL avoids targeting children with negative messages, spelling out the dangers of not 'setting good habits' could be interpreted as invoking the polarised and polarising 'neglectful parent/good parent' discourse to spur parents into action. This is because the subtext implies that if one does not start setting good habits early in childhood, one is condemning one's child to a lifetime of serious illness.

The social marketing information about 'fresh snacks' provides practical advice about avoiding packaged foods, though this still places the onus for change on parents, not manufacturers, and does not acknowledge the focus in the public presentation earlier (Cobiac et al. 2011) on affordability: 'When packaged food is prepared or processed, things like salt, sugar, fat, preservatives and colours are usually added and the good bits, like fibre and vitamins, are often reduced' (SA Department of Health website 2015, OPAL, accessed 12 November 2014).

There is no suggestion here that it might be the responsibility of anybody except the 'good parent' to alter the quality of packaged, and highly marketed, children's snacks. Although 'Make it a fresh snack' has indirect ramifications for commercial production, it retains responsibility for children's diets on parents, without fully acknowledging the difficulty that some parents may face in trying to keep their children from consuming these foods, laced with the taste-enhancing additives of 'salt, sugar and fats' that they may be used to in processed snack foods. To some extent, the difficulty of achieving this is addressed under another heading, 'Got fussy eaters? Give these tips a go' (SA Department of Health website 2015, OPAL, accessed 12 November 2014).

However, this simply shifts the blame from parents to their 'fussy' children, the

implication being that such fussiness is unreasonable, which ignores the fact that children may have spent a lifetime being exposed to the marketing of EDNP foodstuffs. OPAL's tips do not address how to placate children whose diets habitually include a great deal more sugar.

One of the supplementary information sheets accessible through the OPAL website — 'Summary of evidence: healthy snacks' — identifies that most children report eating and preferring 'unhealthy food' because it tastes better and is addictive (SA Department of Health website 2015, OPAL, accessed 12 November 2014). Constructing parents as able and responsible to counter this by changing their own behaviours seems unreasonable. Although other programs within the HWS attempt to lessen children's exposure to junk food by altering their food environments, thereby implicitly recognising that the responsibility for children's healthy diets is shared by other institutions, there is little such acknowledgment in the OPAL materials specifically aimed at parents. The tips centre on modelling correct eating habits, involving children in 'healthy' food selections in supermarkets — not by changing the foods offered by supermarkets and advertised at children. Drawing on Gramsci's (1971) concept that ideology is embedded in cultural institutions, it is possible that, as an offshoot of commercial marketing that focuses on selling ideas to individuals to induce them to perform certain desired behaviours (Hastings & Haywood 1991), social marketing as a strategy does not easily support the construction of responsibility as collective. This would help explain why the framing of responsibility slips from the socioenvironmental to the individual.

6.5.3 Principle of positivity

I am critiquing OPAL's principle of positivity as it is one of the ways that the commercial sphere, with its motive of profit-making, appears to be cocooned against being targeted in social marketing campaigns by programs such as OPAL. Positivity is a general principle in social marketing (Hastings & Haywood 1991). OPAL's social marketing campaign, 'Water. The Original Cool Drink', will be examined to illustrate the discordance between OPAL's ability to alter obesogenic environments while being 'non-stigmatising … of food' (SA Department of Health 2009, p. 9).

The 2010 presentation spells out the 'OPAL theme principles', which are that they should be 'framed positively' (2010, p. 18). The scientific evidence base in support of

the ‘Desired outcome: a decreased consumption of sweet drinks’ (2010, p. 19) is then cited: ‘Reducing soft drink consumption is the most highly rated intervention for the reduction of obesity: Professor Boyd Swinburn’s best bets for reducing obesity’ (2010, p. 19).

Despite this, the presentation then states that, ‘The message should not … stigmatize any other drink. They have their place as an “extra” food to be consumed in moderation. (Australian Guidelines for Healthy Eating)’ (SA Department of Health 2010, p. 21). However, it goes on to say that at the same time theme messages, ‘… should not … only focus on increasing water consumption but on replacement of other sweet drinks with water’ (2010, p. 21).

This would seem to place unrealistic restrictions on how OPAL is able to achieve the ‘desired outcome’ of reducing soft-drink consumption without making negative reference to soft drinks. With a privately owned methodology like OPAL, the question arises as to whether such restrictions might have originally derived from the commercial interests of the private partners/owners of EPODE, thus unintentionally serving ends other than health.

Given the unequal budgets and thus unequal power of commercial versus social marketing campaigns, the effect is that social marketing does not just have to fight above its weight, but has to do so with one hand tied behind its back. Witness, for example, the soft-drink industry’s recent defeat of proposed legislation to restrict the size of soft-drink serves to below 16 oz. in New York City, framing the proposal as an infringement on personal freedom (Grynbaum 2014). This means that the final responsibility for choosing wisely, that is, choosing water over a soft drink — the conversations that people will have inside their heads — cannot be rebalanced. Commercial marketing is likely to far outstrip the influence of social marketing, and changes to the proximal environment may make healthy choices easy, but unhealthy options will not actually be changed at all — they will still be there, still highly visible — meaning that internal conversation or debate is therefore still very one-sided and stands to counter the messages coming from OPAL.

The focus on ‘positivity’ constitutes what is effectively a prohibition within OPAL’s ideology against holding the commercial sphere to account and means that this sphere

is rarely directly targeted as part of the obesogenic environment that OPAL's research design so clearly seeks to influence. Scientific evidence suggests that broad environmental changes are the most equitable in their impact on health, those with the highest burden of obesity and ill health having the fewest resources, material and non-material, to counter it (CSDH 2008; Harvey 2007; SACOSS 2008; Swinburn 2009). In contrast, OPAL's focus on positivity can be seen as having an inequitable side by actually avoiding a focus on the changes most likely to have an impact. The effects of the apparent indiscriminate application of the principle of positivity is to privilege the interests of the corporate sphere. This suggests that, like the strategy of social marketing in general, 'positivity' is serving an ideological function, acting — like choice (Freudenberg 2014, p. 135) — as a smokescreen to obscure corporate interests.

This focus on the positive is evident also in the kind of environmental changes identified in the logic model in the 2011 presentation. Under the 'Process' column, 'enabling' factors are listed, such as 'knowledge', 'accessibility' and 'affordability', but there is no concomitant identification of 'constraining' factors such as reducing the high visibility and accessibility of EDNP food. This is indicative of how the assumption is made that 'enabling' and 'constraining' are simply the obverse of each other; that is, that if OPAL's focus and energy is placed on enabling the desired practices, then the undesired practices will consequently be restrained, rather than being sometimes quite separate things that require independent policy action. The effect of this is to make constraining factors invisible and thus able to continue to function unabated. Of more far-reaching significance, this partial analysis seems to stand for the whole; as half the picture is missing, one does not see, or look for, the common element that unites the several factors at a paradigmatic or ideological level. Exerting a gravitational pull in the opposite direction to the strategic strengthening of 'enabling' factors is the vortex of neoliberalism, the ideology that unites and drives the obesogenic environment (see Freudenberg 2014), as potent yet unstable as Gramsci's (1975a) vision of hegemony, reinforcing current power imbalances..

In Milio's (1976) terms, while OPAL's social marketing component promotes (or reminds or reinforces) what are the healthiest choices and how to make them, that is, the *what*, OPAL's community-based component represents, as it were, the *how* of making healthy choices easy.

6.5.4 Construction of responsibility through the principle of choice

The NPAPH document constructs responsibility for enacting the behavioural changes intended by OPAL in apparently contradictory ways. OPAL's immediate target — the 'heart' of its campaign — is identified as parents being the decision makers who set families' healthful behaviours, with OPAL's social marketing goal identified as being to 'encourage parents to make the healthy choice' on behalf of their families (NPAPH 2010, pp. 4,10). Children are specifically identified as not being the target of OPAL's social marketing ('OPAL's social marketing is not directed at children 0–12, rather it is aimed at parents.' (NPAPH 2010, p. 10). However, the NPAPH document then identifies that the OPAL logo and the simple theme messages are designed to specifically appeal to children, with the detailed information available in the printed materials and on the website aimed more at parents:

> Primary aged children (5–12 years) will be aware of OPAL in their community through positive, non-stigmatising healthy lifestyle messages and the bright and engaging OPAL brand. The detailed information behind the messages is, as has been described, aimed at adults. The healthy eating and physical activity programs and policies supported by OPAL and put in place by adults, will however be enacted by children. (NPAPH 2010, p. 10)

Although parents are constructed as the ultimate decision makers, children are constructed as the people ultimately bearing responsibility for making OPAL happen — they are constructed as needing to be active, thus OPAL is 'enacted' by them and not as passive recipients of instructions or injunctions from either OPAL or their parents.

OPAL's use of a social marketing strategy that explicitly corrects consumption implies that it is individual consumption (lack of willpower or knowledge) that creates the problem of obesity. It implies that obesity is caused by unwise individual consumption, not irresponsible manufacturing or marketing: obesity is constructed as being about consumption, not production. Again, the effect is to privilege and protect corporate interests. The focus on social norms is an attempt to address collective consumption and physical activity behaviours, implying that the problem is not simply individual consumption, however, but collective habits. Nevertheless, although delivered at a community level, OPAL's social marketing themes and material can also be accessed individually through the OPAL website, and the ultimate site of change from the above analysis of the website was identified as the private family — namely children. OPAL's social marketing strategy aims to improve health by influencing the choices people

make (SA Department of Health website 2015, OPAL, accessed 14 March 2014). The role of ‘choice’ in the attribution of responsibility will be explored in the final chapter.

6.5.5 Summary of themes and chapter

The result of the way that responsibility is implicitly constructed is that, through individualising discourses such as choice and through the minor role accorded the commercial sector compared with individual families, responsibility for making the changes that are likely to bring about healthy weight often devolves upon the individual. It is important to note, however, that OPAL’s location at the local government level provided limited opportunities to influence the commercial sector compared with programs at a state or national level. Nevertheless, the devolution to individual responsibility is contrary to the explicit socioenvironmental framing and, in light of OPAL’s targeting of disadvantaged communities, is concerning as these communities may be constrained in their capacity to enact the healthy changes. The nature of this analysis has, however, necessarily focused on documentary evidence, meaning that the social marketing component of OPAL received greater scrutiny here than the community-based component. The following chapter will provide some counterbalance as key informants from OPAL reflect on the program and its practice, completing the addressing of Research Question 2.

CHAPTER 7: FRAMING OF OBESITY BY KEY ACTORS IN OPAL

7.1 Overview of chapter

This chapter continues and completes analysis of the OPAL program, identifying the ideologies and discourses underpinning the practice of OPAL, addressing Research Question 2. It explores how obesity is framed within the OPAL program by a group of workers involved in OPAL's administration and delivery, and by a group of advisors from OPAL's two advisory committees. In-depth interviews were conducted with five workers (with the pseudonyms Ian, Millie, Peri, Steven and Tegan) whose comments are designated with the prefix 'W', and five members of the two advisory committees — the Scientific Advisory Committee and the Strategic Advisory Committee (Ben, Donna, Harry, Martha and Rose) — whose comments are designated with the prefix 'AC'. Following the process described in Chapter 4, findings from these interviews were analysed and descriptive accounts of the findings presented, followed by a synthesis of the discourse analysis that was conducted. Material in the descriptive account is presented under OPAL's two component parts, a community-based component in which the physical environment is largely targeted, and a social marketing component targeting the normative environment, with workers' reflections preceding those of Advisory Committee members. The analysis investigates the discourses and evidence drawn on by respondents when discussing OPAL, and through the discourse analysis explores the ideological underpinnings and how these impact on health equity.

7.2 Introduction: How OPAL represents a solution to unhealthy weight

This section provides a descriptive overview of OPAL workers' and Advisory Committee members' (advisors') accounts of how they perceive the OPAL program representing a solution to unhealthy weight. Their description of OPAL's core attributes correspond to OPAL's two component parts:

(a) OPAL as a complex community-based program

(b) OPAL as a program utilising a social marketing strategy.

Although these two components were evident before the interviews were conducted, the interview schedule was not designed to reflect this demarcation so that a 'blank canvas' approach could be maintained as much as possible. After initial coding and categorisation of the interview data, however, it became clear that these two components made the most logical basis for analysis. This dual nature of OPAL foreshadows a tension in approach to the problem and solution of obesity, which the discourse analysis will make clear.

The members of the Advisory Committees, with their academic backgrounds, independent 'expert' status and their more distant relationship with OPAL, presented a more panoramic perspective than that of the workers. On the whole, they voiced more critical reflections on OPAL's background and model and, not surprisingly, tended to theorise about the causes of obesity more than do the workers. Respondents' views of the community-based component of OPAL will now be described.

7.3 Descriptive account of the community-based component of OPAL

7.3.1 Overview

Three core aspects of OPAL's community-based model were highlighted by respondents as characterising its approach to addressing the problem of unhealthy weight in children and young people: OPAL as a complex community-based model that complements existing programs; OPAL as a program premised on a socio-ecological approach; and OPAL as a program targeting populations experiencing disadvantage. The rest of this section details how respondents reflected upon these core aspects.

7.3.2 OPAL as a complex community-based program

This section describes how respondents described OPAL as a complex community-based program, located in local government and working through existing stakeholders, and that advocates environmental change to impact unhealthy weight.

A complex response to a complex problem

Workers described OPAL as a 'multidimensional approach' (Ian, W) to achieving healthy weight through changing the normative and physical environments. For instance, worker Peri observed: 'You're working on social norms and you're working

on environment, you're working on policy and the political commitment, the structure and the tri-level [local, state and federal government]-support'.

The complexity of the government environment was also noted by several workers. Among OPAL's distinctive features, workers identified OPAL's community location and focus — with the local expertise that this brings in through stakeholder interactions — as enabling it to help overcome the fragmentation of current bureaucratic structures. Ian identified how OPAL plays a 'linking' role, describing OPAL as, bringing non-traditional agencies together in a geographical catchment, with OPAL adopting a brokerage role and being able to 'infuse the wellness or health agenda' into services that did not have this as their core business, such as the local Aboriginal Cultural Centre.

As well as joining up different sectors, Ian described how OPAL helps the different levels of government communicate, describing OPAL's role, almost as translators between local council and the state government. He described OPAL helping 'non-health agencies to view the world through a health perspective "lens"', while Millie (W) described OPAL as creating 'mutual outcomes' based on common goals around wellbeing.

Perhaps due to their more distant relationship with OPAL, advisors reflected on the complexity of obesity and the challenge it poses for developing solutions, rather than the complexity of OPAL. Rose encapsulated this notion: 'That's the trouble with obesity … it is a complex situation and there's no one single strategy or one single thing that will change it'.

Working through local government and existing stakeholders

Although state government, 'cross-departmental' and Ministerial support for OPAL were acknowledged as crucial (Tegan, W), locating OPAL in local government ('council') rather than state government was identified as 'a strategic decision based on the EPODE model' (Tegan); Steven enlarged on the advantages this brings:

> I think probably the most important thing for us is that we are actually situated in council. It's the hub of communities; it makes decisions around environments; it can influence environments, and the key people in government, in local government, the Mayor and the CE [Chief Executive], can impact up to a state level.

Beyond the specific role of local government, worker Steven explained how he sees OPAL's intervention approach in concrete terms:

> I say we do three things within OPAL; we promote, partner and generate. The promotion is that our managers go out and promote those things that already exist, the programs that exist, the policies that exist, the legislation, the creative and healthy environments.... Then they partner ... with programs and organisations that might look like they've got capacity or they've got potential but might be falling a little short around human resources or financial [resources].... The last bit of it is to generate … where they see a genuine gap … they would look to fill that gap, whether that's around a program, around awareness raising, around partnerships, coordination around legislation and regulation. Somewhere in there they would be looking to generate new activity of some sort that would lead to change but all of it is about trying to affect those cultural norms, what is acceptable and what's not?

Although structures, including legislative and regulatory ones, are described as potential targets, Steven made it clear that he sees altering structures as instrumental to changing behavioural norms.

Like Steven, Donna, an AC member, used a socioenvironmental discourse to explicate the role that local and state government can play in changing individual behaviour through changing the environment:

> We ['the councils'] want to change not only individual behaviour … because we know that's a really difficult one to change but what you have to do to get that change to happen is to change the environment in which people live, work and play so the idea is that the councils who have actually … developed the streetscapes, the open spaces, do the land use planning — you have to make the changes around that and you have to think about how you make the cities more liveable and walkable, accessible to public transport, bike friendly, so that includes lighting, safety, things that make it attractive for people to want to change what they do and how they get around in their city.

As well as directly making physical activity more likely through their role in governing land uses, Donna described how local government can also support physical activity in the community through community grants to back such things as water safety classes for new migrants at a local swimming pool. She also described how grants can be used in unison with commercial retailers and developers, such as walking groups in a Westfield shopping mall, and how partnerships with retailers and developers can create integrated shopping/recreational spaces that also encourage walking. While Donna was optimistic about the capacity of councils to promote environments that promote more physical activity, she was, however, less sanguine about affecting the food environment: 'The real challenge will be, how do you get into the food cycle, the fast-

food convenience, because that's never, I don't think, going to change with the pace we go at'.

Donna also described in optimistic terms the challenge for the local government host organisation in adopting a health lens:

> Councillors sort of think 'oh we're not into health'. Well, we are. Everything … we do in our community is having an impact on people's health …You're not in the medical illness side of it, you're in the promotion-prevention side. That's a bit of a cultural shift for local government, to start getting its head around.

7.3.3 OPAL as a program premised on a socio-ecological approach

Workers referred to OPAL as following a particular perspective: the 'socio-ecological approach' (Steven). While this term is not found in the OPAL documents analysed above, it features in the literature referenced in the *EWBA Priorities* (Government of SA 2009a) document. It is also fundamental in the history of health promotion as it moved from a behaviourist to a more equity-promoting approach within the 'new public health', best summarised by Milio's phrase, 'making healthy choices the easy choices' (Kickbusch 1986, p. 438; Milio 1981, p. 77; Nutbeam 1986).

This section describes how respondents depicted OPAL as following a socio-ecological approach, how they reflected OPAL focusing on both environments and, in particular, on the commercial environment and individuals, especially as exemplified by healthy weight targets, and the tensions that result.

Environmental and individual change

As used by OPAL workers in reference to unhealthy weight, the socio-ecological approach, although differently understood by different workers, implicates social and environmental elements as causal to the problem of unhealthy weight, and thus — by implicit logic — relevant sites for change in order to address unhealthy weight.

One of the ways workers used the term 'socio-ecological' equated it to making 'healthy choices, easy choices', implying that the purpose of OPAL is to engender environmental change in order to support, not supplant, individual choice: 'Ours is a socio-ecological approach so we're looking for changes in environment and really that is what the 'healthy choices, easy choices' is about, ensuring that you have an environment that is supportive of healthy choices' (Steven).

Steven linked this approach to the concept of ‘nudge’ politics (see Thaler & Sunstein, 2009) and through this, back to EPODE:

> I’ve just been reading about nudge politics in the UK, where that seems to be the flavour, is that provide people with opportunities through environments and nudge them towards better health rather than the Nanny State of telling them what to do and, in fact, identifying all the things you’re doing wrong. EPODE is fitting well with a view that’s been generated out of the UK, I think it is, so that is the direction we’re taking.

Here Steven explains some of the rationale behind OPAL’s emphasis on the positive, particularly in social marketing, which will be described shortly. Advisory Committee member Donna provided a different perspective to Steven’s focus, emphasising collective responsibility for normative change to affect risky environments, rather than focusing on risky individual behaviours. Drawing on the illustration of what it takes to make bike riding feasible, Donna made it clear that it is not only the responsibility of the people whose behaviour is being directly targeted that must change (that is, children/cyclists), but the behavioural norms of the encompassing community (motorists) that must also change to make the targeted change feasible in practice:

> You might think ‘I’ve got a new bike, I’d like to go off and do something but oh there’s only roads and they’re dangerous and I can’t do it’ …‘and I’m not sure about the routes and where it’s safe…’ … I think we’re starting to get there. The motorist has to realise that the car is not king, that the road is to be shared and if you want our kids to be less weighty and more physically active you’ve got to be mindful and keeping a watch out for kids and not thinking they’re just a nuisance on the road.

Different understandings of socio-ecological are reflected by different workers, suggesting that the concept of a unifying and official socio-ecological approach in practice allows for multiple interpretations. For example, Tegan (W) made the point that a socio-ecological approach essentially links individual and environmental change: ‘It’s [OPAL] not just individual change without the environment change… It’s based on social-ecological theory and so it’s combining the two’.

Ian (W) reflected how the socio-ecological approach encapsulates both physical and normative elements in the environment:

> I think that the socio-ecological changes of communities have made it very difficult for families to live healthy lifestyles because their access to food, the changes in transport systems, the open space management, the willingness of parents to let their children experience the public realm and explore and take risks...

He then reflected what characterises the obesogenic environment model (Swinburn et al. 1999), identifying that the default environment in which South Australians now live creates unhealthy weight: '... multiple changes I think have occurred, such that it's not the norm now to eat well and be active, we need to swim against the stream' (Ian).

Ian's observation illustrates the gap between the current environment and Milio's notion that in successful health interventions, '... individuals can remain "passive". People are not required to continuously make conscious choices or to be reminded or supported to continue to make healthful choices. They need not be "active" '(Milio 1981, p. 82).

Millie (W) provided an illustration of how Milio's concept can be operationalised when she explained how OPAL will upgrade the outdoor play space at a domestic violence shelter to make it more inviting to children and mothers. She described how, by manipulating the physical environment so that individuals do not have to consciously choose active options, both the likelihood of the family staying in the safety of the shelter and of children engaging in active play while they are there are increased.

The physical environment is described by respondents as encompassing a range of levels from the micro environment of the home, to the meso-level of schools, to the macro environment of the commercial sphere, accompanied by reflections on OPAL's ability to influence these different spheres.

Although none of the advisors who were interviewed used the term 'socio-ecological' (the term 'social-environmental' is frequently used to describe the same perspective, see McLaren & Hawe 2005), they all reflected what may be termed a socio-ecological perspective towards achieving healthy weight; though as with the workers, these views span a considerable spectrum, as Martha reflected:

> All the different people on the [Advisory Committee] would have their own perspectives of what contributes to these issues [that is, obesity] and what can redress them and they'd come with different views about change and about behaviour or about structure or about the interrelationship between behaviours and structures.

Also echoing Milio's notion of active and passive interventions, Donna (AC) suggested that local government has a role to play in reversing the obesogenic environmental trend noted by Ian, by creating environments that support incidental as well as deliberate or transport oriented physical activity, by:

> shaping the environment to make it one where people can walk and feel space but be able to get off the train and be able to walk … around and feel safe and feel like they're looking at things as they go so they don't really notice that they're walking.

Ben articulated most clearly the evidence upon which he bases his environmental perspective, and how this affects his involvement with OPAL.

> We [the OPAL AC] are concerned with the environment .... That interest arose from doing community intervention and being able to demonstrate relationships between psychosocial factors, behaviour, health outcomes ... [as] really a function of the context of the people.

He continued, explaining his interest in OPAL and again invoking an environmental discourse: 'I'm increasingly interested in demonstrating that health is a function of the environment and that people's risk behaviour arises because of political, economic and social factors'.

Ben, Harry and Martha did not talk about individual behavioural change as a goal; their concern, rather, was to change the determinants or drivers of obesity, which they identified as structural, though they conceded that this is not OPAL's task.

The role of the commercial environment

Workers expressed a range of views regarding the role of the commercial sector in contributing to the obesogenic environment, although in general they did not implicate this sector as responsible for redressing it. This may be related to the limited opportunities (identified in the previous chapter) for OPAL to influence the commercial sector due to its location at the local government level. One exception was Ian's critique of the environment as 'commodified', in which 'everything's got this veneer of marketing', which needs to be challenged: 'we need to wake up'. He goes so far as to identify the culpability of 'the corporate world':

> You think about the thousands of years humans have produced food and enjoyed [it] — and now suddenly it's been ...taken away from us, I think by, to a degree, the corporate world ... You know, there are some products that have unlimited elasticity of price and food is one, you can't do without food, water, oxygen, so they're not stupid, they've cashed in.

Ian is highly critical here of capitalist ideology. Nevertheless, despite individuals not being to blame for creating the problem of the obesogenic world, Ian's account holds them responsible for addressing it — it is the public who must 'wake up'. It is apparent then, that even in the most radical interpretation of OPAL's socio-ecological approach reflected by workers, although the commercial sector is identified as responsible for

contributing to the problem of obesity by making healthy choices difficult, it is not identified as responsible for contributing to its solution. Ian seems to be expressing here what Gramsci theorised as cultural hegemony, involving the simultaneous submission and resistance to the dominant ideology, in this example, that of the individualising of responsibility that denotes neoliberalism. Ian reconciled his analysis of the commodified environment with a view that individuals as members of the public still can — and should — overcome these environmental impediments to health for their family's sake, if not their own: 'Regardless of what I did I would make time to walk with my kids to school and whatever I had to do – and I do it now, I'll get up hours earlier every day and go to bed later'.

Drawing on this discourse of self-responsibilisation (Ayo 2012), Ian proposed this private solution to what he has clearly defined as a public problem. This is not necessarily at odds with the (equity-promoting) systems-wide change that he advocates elsewhere as being necessary to support individual changes. In particular, such changes among those who currently have the lowest rates of healthy weight, as such choices can always presumably be made easier, particularly for those experiencing constrained agency.

In contrast to the workers' accounts, the AC respondents were consistently outspoken in their critique of the corporate sector's contribution to the obesogenic environment, and their allocation of responsibility. In addition to her own expressions of trepidation about altering the fast-food environment, Donna also made it clear that parents, as well as academics, identify commercial interests such as fast food as problematic to children's health: 'Parents will say "no, we don't want a McDonald's over the road from the school" if an application comes in for that'.

Donna is here relating how parents resist neoliberalism's individualising of responsibility: parents seem clear that the public sphere (local councils in SA control land use) has responsibility for controlling the commercial sector. Also reflecting on the commodified food environment, Rose discussed the vulnerability of children (and the resulting pressure on parents) to the advertising and display of energy-dense, nutrient-poor foods. She reflected on the need for legislative change to control the advertising of energy-dense, nutrient-poor food to children: 'I think certainly work's come out of Deakin [University] to show that one of the [strategies] — because it really wouldn't

cost anything — is to ban advertising inappropriate foods in children's television …'. She continued, posing a series of rhetorical questions and answers that illustrate how difficult the regulatory road can be in practice: '… and why hasn't it happened? It's because the corporate sector have fought it tooth and nail. Why have they fought it tooth and nail? Because it's so successful'.

As well as highlighting one of the fundamental premises underpinning the strategy of social marketing — that advertising works — Rose suggested that the commercial sector is beyond the reach of government to control, though she made it clear that it is its responsibility to do so. Harry reflected similar sentiments, expressing scepticism about the efficacy of the regulatory policymaking process that is meant to control industry: 'The big problem I see is industry's role at the policy table, influencing policy. I don't think industry should have a role there because they're too conflicted'.

He was insistent that government regulation is needed, because the food industry 'will play by whatever the rules are …. And they'll push it to the borders'. Even more problematic, he continued, is the grey area where rules do not apply. Harry was outspoken about industry's 'lobbying power and the undermining of public health interventions', which he described as being 'kind of done in the dark, not many rules apply and that's where most of the influence occurs'. Harry's reflections accord with Freudenberg's (2014, p. 95) critique of the usurpation of democratic institutions by the 'corporate consumption complex', which will be explored further in the following chapter, as does Rose's identification below of how profits are prioritised over health.

Rose also suggested that the drive for market share and increased profitability plays an essential role within the food industry and the resulting food environment:

> We have a fabulous food supply in this country, it's called primary produce. We have to process our wheat to turn it into bread but we don't have to turn it into muesli bars, we don't have to turn it into all these cakes and muffins …. The development in the food supply — well, most of it, the large dollars — are about processing … and each company trying to get a little bit more of the market share so we have 20 different sorts of muesli bars.

Again drawing a similar conclusion to Freudenberg (2014), Harry was more directly critical than Rose of industry's role in driving unhealthy consumption, suggesting that capitalism is the ultimate driver of overconsumption:

> They're [the food industry] doing it because they're businesses, because they're corporations and it's how we've set it up. Then you go back to our basic fabric of how we construct economics and capitalism, particularly … how important economic growth is and … from growth comes consumption and overconsumption … and that is creating … an overconsumption of foods.

This concept of 'hyperconsumption' (Freudenberg 2014, p. 35) was also voiced by Martha. In identifying the origins of obesity as lying in the untrammelled consumption and urbanisation of capitalism, Martha, like Harry, identified the drivers of the commercial, commodified environment:

> Go out and buy, go out and buy, have this, have that…. This is just my view but it just makes perfect sense to me that we've got people obese…. It's a logical outcome of 200 years of capitalism…. And urbanisation in the form that we've got it.

Ben reflected a similar view too, linking capitalist consumption and status as contributing to the problem of obesity: 'I think it's [obesity] indicative of a society where people are encouraged to consume, 'having more is better, more money's better, more stuff is better' where you're concerned with social comparisons'.

These reflections by the OPAL advisors indicate that while the neoliberal values of consumption and profits-first are powerful and pervasive, they are at the same time resisted, again reflecting Gramsci's (1975b) notion that hegemony, while embedded in cultural practices, is not totalising (Eagleton 1994). The environmental changes that Martha identified as necessary for people to lead healthful lives require influencing economic structures at the highest level: 'global capital, you know... free trade'. Nevertheless, she expressed hope — 'I'm a hopeful OPAL. HOPAL' — about workers' capacity to 'leverage up', and for '[OPAL] managers to motivate and enable other kinds of groups within the locality to do the same, to sort of lever up to levels of government to drive changes'.

Martha was clear that it is the responsibility of government to push for the changes necessary to make environments less obesogenic; she saw OPAL having a role to play in influencing government. Although both Martha and Harry resisted the dominant discourse individualising responsibility, Martha's optimistic conclusion contrasts with Harry's pessimistic assessment of industry's power to influence government.

Ben, while sharing Martha's analysis of the necessity of such change, suggested OPAL is more likely to target 'the meso system within … intervention sites' than 'broader

factors': 'OPAL, to a degree, is interested in changing the community environment, the nature of schools. Whether it would try to tackle high level influences I can't say'.

OPAL's evaluation design reflects not only the SA Healthy Weight Target (HWT) but the targets that are tied to federal funding (described in Chapter 2): 'We are required to meet those targets as well so we have several masters' (Steven, W).

The complexity that the attempt to meet these targets imposes, as well as the difficulty of achieving such 'incredibly high targets' (Tegan), was reflected on by workers, although OPAL was still predominantly portrayed in terms of promoting general population-wide health and wellbeing. It would seem that the effect of current targets is to reinforce a focus on individual changes and on the dominance of quantitative measurements such as reducing children's BMI.

Tegan (W) also explicitly stated that environmental changes and their capture were an important and integral part of OPAL, despite the fact that this is not reflected in external targets; she suggested they are implied by OPAL's theoretical base. Critiquing the individual targets set by national and state government, she explained,

> For me what's missing from the way these [nutrition, physical activity and weight] are measured and what … [OPAL is] hoping to achieve as part of the evaluation is that yes these are individual factors and … [OPAL is] measuring individuals for a population … level picture — but what's not part of what most of them say … is around the environment and what's changing in the environment, which is a key component of OPAL … so … [OPAL is] looking at ways of measuring those environmental changes.

Tegan is expressing her frustration with a system that seems intent on directing evaluation back to individual changes, despite OPAL's clear focus on environmental change. This appears to be another misalignment between OPAL's conscious and theoretically based framing and focus, compared with its practice in a world where individual changes are habitually tracked and more easily measured. Similarly, where they are required for political purposes to illustrate program success and to justify funding, inexorably skewing OPAL's practice and evaluation away from the environmental and towards the individual.

The challenge of maintaining an environmental focus was also expressed by advisors in relation to meeting targets and satisfying funding requirements. Advisors Rose and Donna reflected on the initial HWT and the processes surrounding its development,

Donna describing the SASP targets overall as ‘a first go effort’, and Rose recalling that in the Healthy Weight Strategy (HWS) consultations ‘everybody said “you won’t meet these, you will not meet these”’. (Interestingly, the new HWT is to increase the number of South Australians with healthy weight by 5 rather than 10 percentage points, Government of SA, 2011a).

Although Rose identified the dominance of commercial interests in the food environment, when asked how changes in the food environment would be identified in OPAL’s evaluation, she reflected, ‘My understanding at the moment is most of the audits will probably be around schools and child care centres so in terms of policy, around canteens, maybe the wider school eating policy’. From Rose’s understanding of the evaluation, measuring the influence of OPAL projects on the commercial sphere in the same way that the non-commercial sphere was being measured was not currently part of OPAL.

Rose expressed some trepidation about whether the short time frame of the targets allows sufficient time for individual changes in behaviour to translate into changes in weight status, noting of EPODE that ‘it was 10 years before they saw any change’ in children’s weights. Martha reflected on the impact of such targets on evaluation design and ultimately program design and practice:

> I come from a community development social science background where there is always that thing about complex social lives or social worlds that I’ve always got issues about the extent to which you can reduce it down to a target at a population level.

Martha acknowledged the value of goals in helping programs to set and stick to their direction: ‘I think it’s good to have goals in terms of where to marshal resources and what you get into … at least it gives you some way to kind of shoot the arrow forward’. She made it clear that it is not targets in general but these particular targets that focus on individuals and isolate weight as the only variable to be measured, which she considered unhelpful (though unsurprising in the current neoliberal context):

> I support targets about health …so to increase the proportion of South Australians who are healthy as expressed in a number of variables, yes, but to just put it as weight as the only measure – I mean it’s just so much part of the kind of contemporary, individualistic neoliberal discourse isn’t it, so it doesn’t surprise me that that’s it.

What Martha would prefer to see is targets for the determinants of weight, that is, the commodified consumptogenic environment that characterises capitalism:

> I think … if in addition to that [HWT] there was a target that was also around the contexts around humans or around capitalism and all the kinds of – you know, the things that people consume, to me it's [the HWT] just taking a speck of dust and focusing on that….

7.3.4 Equity and OPAL

Workers referred to equity most in terms of OPAL's design, in the distribution of OPAL projects across populations experiencing high levels of ill health associated with social and economic disadvantage. They also talked about equity being addressed within project sites by working through community stakeholders who already worked with groups experiencing disadvantage. In doing so they reflected different understandings of equity, though the influence of how equity is defined in OPAL's documentation as akin to disadvantage is evident (see Chapter 5, SA Department of Health 2010, p. 9). Advisors, not surprisingly, reflected more considered and scholarly accounts of the nature of equity. The definition that will be used here is based on the Commission for the Social Determinants of Health (CSDH), as being a state where 'systematic differences in health have been avoided through policy intervention' (CSDH 2008, p. 26).

Selection of project sites

The first six OPAL pilot sites were, depending on size, either Local Government Areas (LGAs) or regions within the LGAs (SA Department of Health 2009). Workers described four elements as being considered in site selection: the population characteristics of obesity rates/weight status, low SES, high proportion of Aboriginal people, and council support.

Workers reflected equity as embedded in the design or model of OPAL — 'addressing disadvantage' is 'at the forefront of our thinking of where we work' (Millie) — and the fundamental mechanism by which OPAL operationalises one of its ten guiding principles: 'OPAL: Is equity focused — OPAL reaches all parts of the community with a focus on the disadvantaged' (SA Department of Health 2010, p. 9). However, while the first three considerations satisfy a 'focus on the disadvantaged', recognising that obesity is distributed disproportionately along the social gradient (Robertson et al. 2007) and among Aboriginal people, this must be balanced against pragmatic considerations. OPAL's restricted roll-out also means it does not reach 'all parts of the community', and thus in practice reflects a targeted rather than gradient view of equity.

Workers described the practice of working with Aboriginal populations as somewhat more problematic than the ideal. Steven described the presence of an Aboriginal population as 'one of the criteria' that is looked at 'long and hard' when choosing an OPAL project site. At the time of interview, however, OPAL's evaluation did not include collection of data on small population groups, such as Aboriginal groups, at about 'two per cent of the population' (Steven), so OPAL's impact on Aboriginal population groups within their sites may not be captured.

In contrast to Ian's positive recollection above, several workers described how one social marketing theme fails to have the intended impact on a rural Aboriginal community (to be discussed later), due to its failure to recognise the prevailing cultural norms of that group.

Ben's reflection was at a more theoretical level, detailing the social determinants of health for Aboriginal people: 'The fundamental issues are about "we are who we are" — some level of respect for their [Aboriginal communities'] self-determination and autonomy as a people; they need an economic foundation and they need some self-determination'.

Working through community stakeholders to access disadvantaged populations

OPAL's partnering with community stakeholders was reflected by workers as being one way to aid the sustainability of OPAL's impact and was also described as a means by which OPAL managers can access those 'disadvantaged' populations that OPAL seeks to target. For example, Peri described managers as working through community-based agencies in order to target the 'hardest to reach' populations within their site. However, in her description of working with one stakeholder, Families SA, Millie reflected the potentially problematic nature of partnering with outside agencies. She described how appropriate healthy weight messages can be delivered to traditionally hard to reach families by working through this agency:

> … Families SA … are coordinating access programs for families who have had their children taken away from them under court order, for them to have the information so that when their families are ready to pick up a fruit and veg message or healthy eating message or water message how can we support that setting to deliver those?

Families SA is the agency in South Australia charged with child protection. As such, the relationship they have with their clients, and their authority over those clients, is not

necessarily one based on respect for client self-determination, one of the principles underpinning community work. At this point, the potential conflict in intentions, interests or goals between OPAL and other agencies, especially those with mandated responsibilities that might place OPAL in a position of meeting an agency's goals rather than meeting clients' needs, is not identified.

However, when she recalled an offer from Families SA: 'Would you be interested in coming and running some healthy cooking, healthy label reading?' Millie expressed scepticism about whether it is Families SA or the clients themselves who have expressed their readiness: 'I sit there and respond "well, I have a sense that Families SA have probably identified their readiness for this, not them"'.

Workers described their work in terms of respect and empowerment, and expressed support for OPAL being driven by community needs rather than ready-made solutions, a hallmark community development and health promotion principle (Nutbeam 1986). Describing OPAL's 'methodology of working with the community from the bottom-up', Millie added: 'We're relevant, we're not condescending, we're not disconnected from people's starting points and that's what a lot of health initiatives don't do'.

In contrast to Millie's experience, Ian described an example of where the community development principles Millie referred to (of starting where people are at) were able to be operationalised in his working alongside Aboriginal families at a domestic violence shelter. Interestingly, respecting the 'starting points' (Millie) of these families precluded introducing healthy weight messages as such. The relative (un)importance of messages about healthy eating and physical activity is acknowledged and reframed in more culturally appropriate ways which would seem to neither deny this population group the opportunity to benefit in health terms nor impose an inappropriate message:

> Another context I'm working in is with Aboriginal women who are escaping domestic violence, so healthy eating and gardening is way down their list because they've kids that don't have houses, they're not going to school, they have no food, they've got nowhere to live within three months, so the work that we're doing with them is in one part building some active play spaces for the kids so that when they come in they've actually got free, liberating leisure for their own release, their own stress management. Children feel what's going on and if we can give them the opportunity and the ability to take mastery of their own active play then that's a really nice thing. If they do it with their parents the bonding and familial relationships are good. If they're doing it with families also living in the shelter then that builds their social networks when they move on. (Ian)

Donna from the AC offers another perspective on OPAL's practice of working through community stakeholders in terms of its capacity to bridge the gap between groups experiencing disadvantage and services from which they are currently excluded. She described how OPAL's 'promote, partner, generate' (see above) process can work in practice as a means of addressing health inequities, by creating a temporary bridge for people whose needs are currently not being met by existing community programs and in the process influence the way agencies engage with groups in disadvantaged circumstances, thereby rendering the agencies' practice more equitable:

> … so when OPAL goes away the things that have always been there in communities are still there and these people are attached to it, and the people running them have learnt about how to connect up with those kinds of people as well.

Advisory Committee members, most notably Ben and Martha, stressed the importance of being driven by the needs that community members themselves identify. Martha was particularly positive about OPAL's potential to effect change due to the combination of having workers skilled in community development and located in local government: 'I'm hopeful because I'm certain we've employed some really good people' with really good CD [community development] skills. And there's some really good stuff happening in local government as well'.

Perspectives on equity

Although most workers spoke about health equity in terms of redressing the negative health effects of the disadvantages experienced by specific population groups, they also expressed support of the way OPAL's impact spread beyond its formal boundaries, suggesting a conceptualisation of health-related disadvantage being distributed throughout society. In doing this they reflected a range of views about equity itself, from representing it primarily as a gap between the advantaged and the disadvantaged, which accurate targeting of programs might address, to something more complex, nuanced and diffuse, and which requires more fundamental, universal changes.

In contrast, advisors reflected overtly and at some length upon general principles of equity and the causes of inequity, and on the determinants of obesity, including where they saw OPAL fitting in as part of the solution to the inequitable distribution of unhealthy weight. When discussing how equity principles can be operationalised in general, and based on her extensive experience on other programs, like Rose, Martha

expressed an awareness of the danger of the potential widening of the health equity gap as a result of health promotion interventions, referring to the,

> … unintended consequence, which is the middle class have got healthier and fitter …. I think it's a lot of work to actually make sure that in practice you're going to have a practice that does do that [i.e., promote equity] because unintended consequences often are that people who benefit from it are the people that you particularly didn't want to target.

Harry also reflected on the worsening of health equity as a result of the *healthy choices* focus: 'Healthier choices worked very well for people who already live pretty healthy'. In identifying the 'unintended consequence' of the middle class benefiting from health interventions, Martha took her analysis of the underlying causes of health inequities further than the other respondents. She identified the challenge of achieving equitable outcomes as resulting from the 'neoliberal landscape' in which programs like OPAL are located; theorising different levels of equity, she concluded that OPAL is not able to impact 'higher order' equity:

> I think that … equity's actually really, really, really difficult to put into practice when we've got this kind of neoliberal landscape, a growing gap between rich and poor… I think … there's a higher order equity, there's a medium order equity, different kind of levels or orders of equity in this context….So I don't think of equity in terms of closing the gap between rich and poor that will have an impact on health, this program obviously isn't going to do that, it's not of that nature.

Martha here clearly identified the determinants of health as related to economic inequities, and concluded that these are beyond OPAL's sphere of influence. This analysis resonates with Ben's earlier reflections on the limits to OPAL's ability to impact factors causing 'population-level ill health'.

Martha then contemplated whether locating OPAL projects in 'disadvantaged areas, so-called' will do any more than maintain a steady-state of the (unequal) distributions of health. At the same time as the government is investing in 'disadvantaged areas' the middle class are investing their greater disposable incomes in their own health promotion such as 'gyms and fitness things' via the market:

> Whether the allocation of resources to disadvantaged areas, so-called, is actually one way — the other thing that's always accounted to it because simultaneously people in middle class areas are spending more and more money on gyms and fitness things, so there's actually mechanisms that are purchased through the market that people are accessing anyway, so what you would have is that a lot of this effort going into lower socioeconomic areas [is] maybe just to hold things.

In contrast, Harry reflected more confidence that interventions like OPAL, which are aimed at entire disadvantaged communities, 'may even reduce inequality'. He reasoned that this is because such interventions alter the default environment, meaning that everyone benefits, but the relatively more disadvantaged sub-populations benefit more ('in the intervention areas the greatest gains were made by those more disadvantaged') as they are more vulnerable to the obesogenic features that have changed.

As Martha continued her exposition, she reversed the usual attribution of the 'consumptive lifestyle choice' label, applying it to those members of the middle class who are able to purchase their own 'individualistic' solutions to the 'obesogenic environment that applies to everybody'. Martha, like Harry, identified why regulatory and environmental changes enhance equity.

Martha's allusion to targeting resonates with Ben's iteration of the 'public health' perspective of the need to target resources where they are most required, implying that public health has an obligation to redistribute resources to equalise outcomes, a view shared by his colleagues, as we have seen: 'I don't think we need to target always the whole spectrum but politically I understand the expediency of targeting the whole spectrum, to be fair, but in public health we need to direct our energies where it's most needed'.

Ben described two perspectives, reflecting two distributive principles here. The first is what might be termed a simple equality perspective, that is, distributing equal resources to the whole of society; the second perspective reflects a targeted view, that is, most resources go to those whose needs are the greatest. Although the first perspective acknowledges that all might benefit from such a distribution (universal provision), it does not acknowledge any difference in circumstances or conditions (that is, the already existing inequalities that result in a gradient in circumstances and health), which would render the result of such even-handed distribution unfair, unlike the second perspective Ben described.

Members of the Advisory Committee (Ben, Harry and Martha most explicitly) reflected a view of OPAL as a (partial) mechanism to redress current inequalities in the distribution of unhealthy weight. The workers interviewed, however, did not express the reasoning behind OPAL's targeting of the 'hardest to reach' (Peri) or the 'most

disadvantaged' (Millie) though they expressed support for it, reinforcing the value of OPAL's Advisory Committee structure.

Following the discussion of how OPAL operationalised the principles of equity, Martha spoke at some length about what she saw as the determinants of obesity, how these might best be impacted, and OPAL's place in doing this. Reflecting on where OPAL fits into the downstream/upstream continuum of primary health care, Martha mused: 'I don't know whether OPAL is downstream because it's not providing … stomach surgery or counselling — behavioural modification counselling, so I'd put them more downstream. I think it's a little bit upstream'.

This part of the interview followed Martha's reflection on how population-wide obesity is a response to the obesogenic conditions of daily life created by capitalism. She continued to use the 'downstream/upstream' frame to reflect on the general conservative turn in the political and social context in which health policy is located:

> I think the stream's shortened in the context of the last ten years, so what constitutes upstream? I think what's happened is there's been a drying upstream so what happens is the stream, the upstream, now is what used to be the midstream….

Martha illustrated what she means by this by describing how although OPAL does influence policy, this is not at the highest level, so is more midstream than upstream:

> I think they're [i.e. OPAL] a bit up midstream but … one conceptualisation of it is if you've got all these enablers in local government, and local government has the capacity to influence a bit more upstream than midstream in terms of land use planning and … policies and regulations; but even so local government is not state government or federal government, it's local government ….

Martha also expressed hope in the broadening of discourses around obesity to include environmental factors that she has observed:

> I've already noticed the discourse is widening all the time because they're now talking about the need to look at social ecology, about micro, meso and macro environments in this context. Debates are being had about how interventions that focus just on the individuals aren't effective. It's actually starting the kind of realisation that — or at least in the policy documents and literature — that this is not going to do the trick.

Martha is suggesting that the discursive environment in which OPAL is embedded, and which forms its context for change, is not static as discourse plays a part in determining which ideas and actions are thinkable, speakable, and do-able. This then opens up

possibilities for OPAL (and other programs) effecting material change in the physical environment in which it is embedded in the future.

7.4 Descriptive account of the social marketing component of OPAL

7.4.1 Overview

Section 7.3 described how respondents reflected upon OPAL's complex and complementary, community-based model, its socio-ecological approach, and its targeting of disadvantage. This section describes respondents' accounts of how they perceived the OPAL program representing a solution to unhealthy weight by influencing the normative environment through social marketing. Their accounts highlighted two key aspects that will be explored here. The first is OPAL as a program based on EPODE, the privately sponsored French childhood obesity prevention franchise that supplied the social marketing methodology (Raffin 2008). The second is how OPAL's social marketing strategy works in practice, as a strategy that is positive and non-stigmatising, and which influences the 'micro-environment' of the home (Raffin 2008). As described earlier, 'social marketing' differs from commercial marketing in its purpose rather than methods and, as such, is a tool increasingly used in health promotion for 'fostering change in community norms by delivering health messages, as well as encouraging individual behaviour change' (Evans et al. 2010, p. S24). The social marketing messages were described in the previous chapter: 'Water, the original cool drink'; 'Give the screen a rest, active play is best'; 'Make it a fresh snack'; 'Think Feet First – step, cycle, scoot to school'; and 'A healthy brekky is easy as PEEL. POUR. POP' (SA Department of Health website 2015, accessed 12 November 2014). The background to this component of OPAL will now be briefly described.

7.4.2 Background to strategy of changing norms through social marketing

OPAL as a program based on the French EPODE franchise

In describing OPAL's background and origins, workers reflected that OPAL combines the methodology of the French EPODE ('Together we can prevent childhood obesity') franchise (see Chapter 6), with local community-based healthy weight programs, though not without some tension. The main concerns raised by workers about EPODE concerned its generalisability (the applicability of a model based on French conditions

to South Australia) and its model of corporate partnership, which is less common in SA than in France. They also hinted at the political nature of EPODE's adoption in SA: 'The Minister went on an educational tour to look for solutions and there's very few out there and EPODE happened to be one' (Millie).

Perhaps due to their extensive familiarity with researching community-based interventions, advisors spoke at greater length than workers about the potential difficulties they perceived might result from adoption of the EPODE model. They also voiced how these shortcomings could be resolved by OPAL, which at least in part is through their own influence. With the exception of Harry, who spoke positively about EPODE's adoption due to what he considered was its success, advisors reflected that the adoption of the EPODE model was precipitate, based on insufficient research — both into the evidence base of EPODE's claims and into comparable locally available programs.

It was reflected that the claims made about EPODE's success in academic journals were not well supported by evidence from their evaluation: 'They actually didn't have much in – virtually no evaluation (Rose)'. 'I felt that … EPODE was perhaps suggesting a strategy that had not been evaluated as effective' (Ben).

It was also suggested that EPODE did not represent any methodologically unique solutions to the problem of obesity:

> I don't …see what EPODE does that is different and unique and allows it to have any claim beyond any other kind of well-structured, thought out community intervention program. EPODE seems to me to have arisen really as an expression of a variety of different attempts to do something good, which is to address weight in school aged children in France, and at some point I suppose someone decided that this could be labelled as something that's unique. Now I don't understand what is unique about it. (Ben)

Again, with the exception of Harry, the purchase of EPODE was framed by advisors as unnecessary and its cost thus wasteful ('We're paying buckets to France', Rose) as there were similar models available locally.

> The disappointing thing is that they took that on without waiting for the outcomes of Eat Well, Be Active Community Programs, which was a home developed project. (Rose)

> We had two projects running, two trial projects running, in Morphett Vale and Murray Bridge which were running through a very similar kind of process. (Donna)

Advisory Committee members also reflected that the model OPAL embodied in practice was very different from EPODE: ‘I’m not even sure that OPAL is representing what EPODE was or what it says it was’ (Ben). ‘They’re [EPODE and OPAL] totally different models’ (Rose).

Applicability of EPODE to South Australia

In reflecting on EPODE’s transposition to OPAL, workers questioned the applicability of the EPODE methodology to local conditions; as Peri reflected, ‘our communities are not as homogeneous as perhaps they are in France’. The issue of trust in a foreign corporate model was raised, and the difference in the roles of the public and private sectors between the two countries were also highlighted by workers. In SA, school lunches are supplied by children’s families or purchased on or off site, whereas in France they are supplied by schools that are under the authority of the Mayor. Mayors in France are core ‘champions’ within each EPODE site, giving EPODE projects more control over changing the environment within which the proximal determinants of weight (nutrition and physical activity) occur than is possible for OPAL projects. As Tegan reflected:

> Their [the French] system is very different and … one example where I think they’ve got a lot more influence … is in relation to school lunches because most schools provide lunches … and if EPODE can influence the provider of the school lunch and what’s provided they influence a third of the [food] intake of the child’s day. Now that’s a kind of powerful thing….And it’s certainly one thing that we don’t have control over because we don’t do school lunches…. So it’s those sort of translations of the model that I think will be interesting to see how it pans out in this environment.

Advisors emphasised that context was critical to any community intervention: ‘The answers were all contextually specific in the enactment of EPODE’ (Ben), making transposition inherently problematic. This raises the question of whether a franchise model is appropriate for a community-based program at all.

Differences between the French and Australian political systems were noted, with EPODE’s utilisation of mayors as local champions highlighted as of particular concern. Rose expressed apprehension about how this part of the model might work in South Australia, where mayors have significantly less power and status.

> Well the French — I mean it’s different. The French version was developed for France.… The Mayor of the community was the pivotal person, was … seen as the champion and I think … that to have champions is really important but generally the

> mayors aren't the champions … certainly not in a big city and I'm not sure to what extent they are even in the regional areas.

Finally, OPAL was depicted as a community-development program embedded in its local context and focused on environmental change to a greater extent than EPODE, the focus of which was considered to be more on 'individual behaviour change' (Donna). Donna described how the OPAL model reflected the 'problem' of obesity as collectively owned, with community consultation, culminating in OPAL's 'bottom-up' approach:

> Our approach certainly was about "this is not about saying you've got a problem", this is saying we as a community, as a society has got to this point where we're seeing two out of four kids are overweight and three out of four adults so what are we going to do to arrest that? And "you've probably got some ideas, we want to work with you. What do you need to know? … If you can identify things about your own life where you think you need more skills or knowledge we can provide that. How would you like to find that out? What do you need?", so it's really trying to be bottom-up.

EPODE's private partnership model

One issue that was raised concerned EPODE's intellectual property rights over OPAL materials that do not form part of its public social marketing campaigns. OPAL is state funded, yet in response to my request for OPAL's 'Roadmaps', that is, practical guides for local OPAL workers for each social marketing theme that had been alluded to in OPAL presentations to the public (SA Department of Health 2009, p. 52), I was informed that, 'We're not actually letting any of that out because I think that's the IP of EPODE. We have a partnership or a contractual arrangement with them and there's a point at which we have to draw a line' (Steven).

Although this was not presented as problematic (to anyone but me), this proprietary arrangement indicates a degree of contradiction between public health objectives (presumably, the free circulation of state-purchased materials should logically enhance health promotion) and the private ownership of a program's methodology. Any potential problems with a for-profit business owning this healthy weight program were not raised by workers.

EPODE is owned by Proteines, a French 'consultancy company specialised in health strategies, network dynamics and social marketing' (EPODE European Network 2011). Its corporate 'founder' partners include Ferrero, Mars, Nestlé and Orangine-Schweppes, companies that produce what is usually regarded as 'energy-dense,

nutrient- poor' (EDNP) or 'junk food' (EPODE European Network 2011, p. 2). The decision by EPODE to partner with McDonalds was framed positively by Millie, although EPODE's decision implies some recognition of the contribution currently made by McDonald's to unhealthy consumption. Reflecting the public health principle (Rose 1985) of the value of small changes across entire populations, Millie reflects:

> They [EPODE] value healthy eating but their attitude was 1.5m meals are sold at McDonald's every day, we'd rather partner with them to make small changes to a large number of meals for a greater population health outcome than to just label them as the devil and lose the battle because they'll always out resource you.

When reflecting on EPODE's commercial partnerships through its parent company, Proteines, Steven similarly acknowledges the potential of working with organisations which have scope for improving population level health due to their reach:

> Proteines is the social marketing company in France that are running it [EPODE] and they generate income through those private industries so they don't have government sponsorship and I think that's pretty impressive, what they've been able to achieve, to get such incredible buy-in from some of the major companies. They're really positive about it, Proteines, they see it as an opportunity to bring about change within organisations that potentially can be less healthful.

Peri's response to product reformulation, however, was uncritical: '[In] their [EPODE's] private partnerships, they do a lot more about product reformulation, so when they provide the partnership they'll also work with that agency about product formulation'.

Similar views were expressed by Advisory Committee member Harry, although he stressed that the possibilities for industry to reformulate food would require the strong guiding hand of government to make it an actuality:

> They [the food industry] have the ability to make changes which are not particularly perceptible, people wouldn't know and wouldn't care, and potentially have quite a significant influence. They clearly have a role in that whole production formulation, reformulation business … If they think about it and they apply themselves … there's a heck of a lot more that the industry can be contributing but it will require serious government action to get it to contribute.

Other advisors reiterated these concerns. Ben firstly questioned whether EPODE's methodology is sufficiently unique to be claimed as intellectual property, that is, privatised, and then whether it is ethical for a private corporation to own and profit from what is essentially a public good arising from the results of publicly funded health promotion interventions and research. We had been discussing an article published by

the Director of EPODE France and Chair of the EPODE European Network's Committee on Public Private Partnerships, Professor Monique Romon, and EPODE founder Jean-Michel Borys (Romon et al. 2008) that presented EPODE's early results, from which their claim to have reversed the upward trend in childhood overweight in two towns in northern France from which EPODE emanated. Ben commented:

> It implies something that is tangible and there's relatively little that's tangible and what's particularly upsetting is that decades of public health literature that EPODE has completely overrode in claiming something that is uniquely theirs and almost patentable. It disregards decades of involvement at the community level.

Continuing his tacit appeal to collectivist values, Ben then outlined his objections to the general concept of methodology being of the order of things that are able to be claimed as private property: 'I struggle with the idea of companies owning methodologies. Methodology is a link between theory and method — it's on a par with owning genes …. I'm morally opposed to the privatisation and claiming of methodologies as proprietary'.

The challenges presented by adopting a health intervention model based on corporate sponsorship, with the concomitant ethical issues this presents, were raised by Donna when she recollected the public reception of the knowledge that OPAL was based on EPODE. The issue being that EPODE's corporate partners include the chocolate conglomerates Ferrero, Mars, and Nestlé, plus Schweppes (which owns the other major chocolate manufacturer, Cadbury), and that Proteines, EPODE's parent company, markets McDonald's. Donna raised the dilemma of whether health programs should partner with businesses that are perceived as having interests anathematic to health and healthy weight in particular, in order to modify that company's unhealthy products:

> I think down the track whilst the government … are wanting to get more buy-in from the corporates…. I know that the Liberal opposition [South Australian conservative party in opposition] did say "oh we're not having this program because they're funded by Nestlé, oh what a joke that is" but you've got to understand Nestlé makes baby formula and a whole range of things, they don't just make chocolate…. I mean chocolate in and of itself is not a bad thing, it's about all things in moderation so do you demonise and you know, do you not partner with McDonald'sor do you partner with McDonald's and say "right, we'll partner with you but as a consequence of that you have to do certain kinds of things and re-badge?" So do you work with the devil, do you get into bed with the devil in the hope that you're going to change something or is the message wrong and kids think "oh well McDonald's is okay" because that's kind of the learning?

The seriousness of the question about whether a partnership with McDonald's might be perceived, particularly by children, as legitimising the whole fast-food company, is such that Donna concluded that, 'These are the things that have got to be thought through … on the part of the Strategic Advisory Committee and the scientific group, about who it is that you partner with'.

Having explored some of the background issues raised by the purchase of the EPODE franchise, this discussion now turns to EPODE's most signature characteristic — its strategy of changing social norms through social marketing — and the issues it raises as OPAL applies this strategy in its quest to increase healthy weight.

7.4.3 Implementing the strategy of changing norms via social marketing

Social marketing is one of the four 'pillars' which comprise EPODE's methodology (EPODE European Network, 2011) and is the aspect of OPAL that distinguishes it from other community-based interventions. The logic behind the social marketing component of OPAL presupposes that messages can change norms; while workers' reflections generally accorded with this position, those of the AC were more mixed. They emphasised social marketing as a means of engagement and consciousness-raising with communities rather than a strategy for targeting individual behaviour.

Changing the normative environment

As well as consisting of the physical and organisational elements discussed previously, 'environment' was also reflected by respondents as consisting of norms or ideas which, by influencing those behavioural choices that affect body weight (individuals' or their children's), influence how individuals interact with the physical environment. In this respect, norms were often described as relating to parenting practices, which will be discussed in detail later.

Respondents identified unwise consumption as a problematic norm, associating it with the influence of marketing and 'brand power' (workers Ian, Millie and Peri, 'The brand is important', Peri) and identity status (advisors Ben and Donna). For example, Ian identified the role the media plays in driving the norms which influence behaviour, though he did not pursue this theme:

> I don't think people are drawn to those [fast-food] places because of the sugar content or the fat content, I think they're drawn to those places because of the way the media has made them feel, that if you eat these brand products that you're more popular.

Conceding OPAL's limited ability to counter such messages, Millie reflected:

> How we change the social norms to get a Red Bull out of a kid's hand ... is not just going to happen. No matter how engaging I might think I am I don't have the power to change 'cool' overnight.

Millie is describing how products are bought for their symbolic meanings, which Donna also described: 'There's a whole range of … capitalist kind of marketing that's got into our heads where we think it's a status, it's about 'I've made it because I've got this'. By suggesting that the popularity of commercial brands is due to their role in establishing identity status, the respondents here affirm Althusser's (1994) notion that ideology fundamentally influences identity formation.

Although Ian (W) critiqued the role of current commercial practices in unwise consumption, his focus was on providing consumers with choice rather than replacing unhealthy practices entirely. The positive framing of even this critique will be discussed more later; here, neither particular kinds of foods and their manufacturers, nor the commercial paradigm that underpins the world OPAL seeks to influence, are directly identified as contributing to the obesity problem, nor seriously identified as a target for change:

> If we're thinking about the commercial sector as it relates to perhaps the convenient food industry ... we need to be very careful about how we engage them.... A lot of what they're doing we know is impacting on the world's health but it's — again OPAL is not about demonising what they [businesses] do it's about asking them to consider other ways of doing their business. Certainly fast food as a concept I think is great, that people can get food quickly, it's inexpensive, it's accessible, but maybe we can improve the quality of the cooking, instead of using these oils, use these oils. Instead of these portion sizes can we have these portion sizes? Instead of just that can we have all these choices around juices and fruits? Can you do the same thing with your product in a healthy way? (Ian)

Ian's tone and optimism about industry's cooperation contrasts starkly with Advisory Committee member Harry's reflection that industry change will only occur if driven by government through regulation.

Donna's description of the role McDonald's 'family restaurants' played in her own family's life supports Ian's assertion that fast food has a legitimate place in time-poor modern family life. She identified the allure of McDonald's to mothers as it provides a

meal solution that appeals on several 'good family' levels. It is seen as a family outing and ritual ('we ate McDonald's every Friday night, it was the big treat') and even a communal one ('They got to see their friends from school there'); it also means there is one less meal to have to plan and cook ('I didn't want to go home and have to cook for myself').

This contrasts with Ben's critique of modern work practices as responsible for driving people towards unhealthy meal solutions:

> We've experienced really truly remarkable changes in the way we live in the sense of far less physical activity than ever before, constraints on time for family and friends which are fundamental to wellbeing and being told to work, work, work …. We're stressed and we know there's an association between fat consumption and stress, whether one perceives it or not, so we have cravings for certain foods, we can easily over consume certain foods and so we have obesity.

Ben's conception of social norms as practices that have a material basis, being embedded in people's environments and arising naturally from their interaction with their material and social world, logically leads to interventions which change the norm/environment interface:

> I think that changing community norms is extremely important. I think we have to conceive of norms as an environmental influence so generally speaking if we're targeting a community I would be working to change norms that are conditioned by a variety of things, sociopolitical influences, by the nature of the built environment. Social environment would consider things like poverty, generations of hopelessness and so on. I would target norms before I ever targeted individuals….

He contrasted this with OPAL's approach which he described as, 'Well they [OPAL] really get into lifestyle …'.

Ben suggested that focusing on individual change will not achieve normative change; this highlights an important point of difference or possibly incompatibility between a community-based 'bottom-up' approach and the more top-down approach of changing social norms that EPODE represents with its centrally generated social marketing themes.

Using a social marketing strategy

OPAL's model of social marketing provides a centrally driven generic theme and message focus. It relies on OPAL workers' knowledge of the particular communities in which they are located, and the cultural norms that prevail in those communities, to

tailor material to their specific populations — in this sense reflecting the context-specific nature of community work.

Workers Millie and Peri identified the failure of the social marketing message, 'Water, the original cool drink', to be taken up in an Aboriginal community within another OPAL project with the mismatch between scientific evidence and specific knowledge of local norms:

> She [OPAL manager] went into an Aboriginal child care centre to talk about water and ... what it meant and the parents straight off the bat said "we won't drink water" and she said "why not?" and they said "well, that's povo [poor person's] drink". Again we could give them all the evidence we want on why it's more affordable but if in their minds only poor people drink water and they don't want to be seen as poor and they see that putting Coke in their child's bottle is a sign of affluence then we shouldn't be surprised that when we keep selling them the scientific message and the evidence about tooth decay. (Millie)

Workers did not reflect directly on why this Aboriginal community might give more value to water's role as an overt marker of social status than to its implied value as health-promoting.

In describing how they saw the role of social marketing within OPAL, workers reflected a range of views. Peri drew explicitly on dominant neoliberal discourses that encompass both economic and social elements in casting the problem as motivational — a current lack of demand for healthy lifestyle, where individuals are identified as the site of problems and their remedies:

> The key thing [is]… to, as a start, get the concept of a healthy lifestyle being something which is aspirational. So for us that's the basis and then … we come in with these other hopefully inspirational messages... framed in a way that has some relevance to them…. Sometimes I talk about it as coming from economics — supply and demand, that we try and create in the communities a demand for healthy lifestyle activities ... kind of create that supply of "well, come and try this, come and do this". (Peri)

Within the logic of her economics frame, social marketing seems like a credible solution.

Workers clearly reflected that social marketing on its own is not sufficient to make the improvements to healthy weight that OPAL is aiming at ('social marketing doesn't save the world', Peri), and reflected that the materials sometimes chosen by OPAL might impact negatively on people whose lives already include disadvantages: 'In a lot of

settings our messages are condescending and irrelevant' (Millie). 'Much of our material does come out looking very glossy' (Peri).

This highlights a contradiction between OPAL's two components, which will be taken up in Chapter 8. A further danger not voiced by workers, however, was that people unable to respond to the messages may feel stigmatised as well as alienated. This unintended consequence is at odds with OPAL's intent to not stigmatise: 'OPAL is positive and non-stigmatising — OPAL … does not demonise food, behaviours or factors connected with healthy weight' (SA Department of Health 2010, p. 9). OPAL's focus on the positive will be explored at greater length shortly.

Advisory Committee respondents expressed a range of views about the likelihood of social marketing changing social norms. While Donna, Harry and Rose were quite positive, Ben and Martha suggested that norms are best changed by changing the environments that give rise to them. Donna explained how the passive social marketing of the OPAL 'brand' works in practice, utilising existing council-funded activities but identifying them with OPAL by hanging up banners, in order to raise community awareness of its healthy weight messages.

Rose also spoke positively about the social marketing side of OPAL, reflecting that repeated exposure to messages can be effective in changing behaviours: 'We see something and think "oh that's a good idea, I should do that", put it aside, you don't do it immediately, but you see it again "oh yes, I was going to do that"'.

Harry spoke positively about social marketing that was narrowly and accurately targeted, such as the tobacco reduction messages aimed specifically at 'lower-income populations'. He suggested that such social marketing could, in fact, reduce health inequalities. However, this is in the context of his reflection that, 'The biggest area of risk [to equity], I think, is where we take an education approach … rather than regulations.… The less regulatory they [interventions] are the more likely they are to be taken up unequally'.

Changing the normative environment in the home

> I don't know whether OPAL's got the answers to changing the home environment. I think we've got the answers for changing the community environment ... and hopefully the school environment, but what happens in people's homes has always been a tricky area. (Tegan).

The family home as a core setting for change was alluded to by all the OPAL workers interviewed. As Ian explained when he described applying the ‘healthy choices, easy choices’ maxim: ‘Wherever we do an OPAL there has to be that ability to transfer into the minutiae of daily life through to systems change. How can you re-jig your house environment?’

OPAL documentation makes clear that interventions to change children’s healthy weight will focus on families and parents, not children. Parenting practices thus become a significant vector for change. How workers described the implementation of one of OPAL’s social marketing messages, ‘Give screens a rest — active play is best’, will be used to explore how responsibility for changing this crucial setting is represented, with particular reference to how the responsible or ‘good parent’ is constructed, a theme that will be explored in Chapter 8.

Ian suggested that a responsible parent severely limits or eliminates TV watching, whatever the norms or ulterior motives for using television:

> **Interviewer**: …if television no longer existed, if you took televisions ... out of the world.
>
> Ian: Yeah, but I found out you know on the bottom of every TV there’s a switch.
>
> **Interviewer:** I know … mum’s magic finger.
>
> Ian: You just push it to put something else there. You know, I truly believe that kids would much rather be hanging out with mum and dad.

He resisted my invitation to place responsibility onto the environment, instead — logically — pointing out that the means to eliminate TV from our own home is always there, we just have to do it. The question of ‘agency’ was omitted, and a number of assumptions made that impact on the implementation of the social marketing message: that children live in two-parent homes; that while children are not watching television parents are free to interact with them; and that such interaction will be positive.

As the conversation continued, Ian made clear that the role of the good parent ‘on one level’ is to switch off the television, whatever the circumstances:

> **Interviewer**: .... and if mum’s stressed, she’s on her own … and it was her normal environment, all of that stuff… and I know you know it’s not just switching it off, it’s ...
>
> Ian: But on one level it is and that’s the ...

> **Interviewer**: And what happens when you switch it off?
>
> Ian: That's it, what do you do? You look at your child and ask them "what do you want to do today? Do you want to go and …"… and that's where I think that we underestimate the inherent abilities we have as people to generate pleasure ....

Though Ian at other times recognised that he spoke from a relatively privileged position ('I sit here well educated, well resourced, I get stressed…'), his construction of responsible parenting here was in marked contrast to the awareness shown by other respondents to the role television can play in maintaining tenuous family peace:

> If we have families who are using the screen to reduce the tension and keep the children apart or you have domestic violence issues or … parental abuse issues and one of the key strategies would be "if you're feeling stressed with your child put them in front of the telly and walk outside"; we wanted to make sure that we weren't contradicting that. (Peri)

The range of views of agency and power expressed reflects the alternating influence of individualist and environmental discourses, and demonstrates the tension that these competing explanatory frameworks exert. At times, both Peri and Ian presented the concept of healthy lifestyles as an option contingent only on effort and volition: ' 'I'm about healthy lifestyle, have you tried to do this, have you tried to do this?' (Peri). 'It's not that difficult …. Easy to do, not hard …' (Ian).

Although Ian's observations about television reflected cognisance of prevailing norms of behaviour and consumption, he suggested that it was a (good) parent's job to resist them. This contrasted with how Millie located responsibility for change — for responding to norms — in the environment: 'The parenting norms have changed. The good parent now doesn't let her child just go to the park or come home when it's dark, so all those norms impact on where we're at'.

How Peri and Ian discussed the norms of their own childhoods illustrates the ease with which behavioural norms can be regarded in isolation from economic and structural factors, leading to an individualised discourse. They described appealing to parents' (assumed) shared memories of 'free range' (Ian) childhoods and backyard cricket that dominated their own childhoods, epitomising an era of greater physical activity. They both represented this idyll as separate from the broader structural and economic context in which it took place, that is, full employment, the sufficiency of one parent in paid employment and thus the presence of a full-time homemaker in most homes, record levels of home ownership and employment stability:

> Just throw your kids outside and here's some ideas for them to entertain themselves and why would they do that rather than watching television? Well, ….do you remember … your backyard cricket game that went all day? Do you remember climbing up that cubby house? .... They really valued their childhood memories of doing that and they want to replicate it for their kids and that's what motivated them… (Peri)

> I've been talking to parents about "what did you do as a kid?" and most of them grew up in that sort of 70s and 80s and we were free range kids and we all tell exactly the same story … until your mum said "come in for dinner" — how I hear that literally everywhere I go. I … say "so why don't you do that now?" "Oh I can't do it now, I'm too busy and I've got this and this and this". I say, "Well, how much TV do you watch?" … I can't see why any family wouldn't just put the telly in a box during summer and leave it ... (Ian)

While advisors did not specifically discuss how OPAL's social marketing themes relate to parenting norms within the home setting, Donna and Rose did discuss in depth how the role of mothers is at the forefront of managing normative change within families, OPAL's demographic target group. The perspectives they offered, like workers, draws on individualist and socio-ecological discourses. In contrast to Ian, Donna critically reflected on the onus placed on parents to consciously resist the food-laden environment:

> Everywhere you go in the shopping centres there's a shop and there's three food shops. Food is around you everywhere… so it's very hard to say "oh no, I won't", whereas at one time it was never offered, it just wasn't available.

Rose reflects a similar analysis of the environment that confronts families when she recalled her work with mothers in a children's healthy weight clinic, also identifying that accomplishing change is ultimately the responsibility of individuals: 'That's what we say [is] ... "you're [mothers] out there, it's a hostile environment. We're here to help you manage that but you have to take responsibility for doing that"'.

Rose also identified the home as the major source of children's food, explicitly identifying mothers as bearing prime responsibility for their children's environment:

> When we're talking in the child area, parents have a responsibility and they are responsible for their child's environment predominantly. Children get most of their food from home…. It is parents', predominantly mother's, role to provide the home environment, the eating environment. She does the shopping, she does the cooking in most cases.

In contrast to the perspective reflected by Ben and Martha that behaviours are largely responses to environmental cues, Rose seemed to represent a more individualist explanation of behaviour, that is, that behaviours seem quite unconnected with

environment: ‘We can change the environment but people have got to change and I don’t know how you get them to do that’.

This highlights a recurring tension in the interviews between a focus on changing environments, which presupposes that environments drive obesity, and focusing on individual change, which presupposes that individual behaviour drives obesity. As described in previous chapters, these tensions are brought together in the notion of making ‘healthy choices, easy choices’, that is, changing environments to make them supportive of healthy weight promoting choices by individuals.

Rose also acknowledged the power dynamics within the home that can undermine efforts to make family diets healthier. Although she constructed mothers as responsible, unlike Ian she explored the agency that mothers may or may not enjoy, when she asks, ‘How can we make mum’s job easier?’ Rose has identified this as essential if the micro environment of the home is to become healthy weight promoting.

Rose reflected on how the deep emotions tied to parenting practices can act as a barrier to their changing, even when a child’s medical need is significant:

> The dietician sat down and weighed and measured and plotted, and says, … “your child is obese, how do you feel about that?” and one woman was in total denial and said “oh no, no” and she said “I couldn’t — there’s no way I’d want to change my daughter, she wouldn’t be my daughter if she changed”.

In contrast, Donna identified instances of how OPAL has been able to challenge parenting norms in a concrete way. She described a community breakfast-cum-workshop led by a visiting celebrity chef, where children,

> worked with [chef] … and did the cooking with him so that was fantastic. They’re great ambassadors, so they then go home to their parents and say “well, come on I’ll cook this or help you” and “we should be buying this sort of food” and ... they can often be ... good change agents really for the family.

It is significant that this example of norm changing came from its community-based component, not as a result of social marketing. However, this still places ultimate responsibility for withstanding the toxic food environment on individual families, and assumes they have the capacity or agency to respond to children’s requests. The notion that it is ultimately up to the individual to choose wisely — regardless of how easy the state has been able to render that choice through policy which creates supportive physical, social and normative environments — recurs throughout the interviews.

Not stigmatising any product or industry

All workers framed the OPAL intervention positively, several citing OPAL's non-stigmatising stance; for instance, Millie described OPAL as, 'a strengths-based initiative which is positive and non-stigmatising'. This is one of the core precepts of OPAL, discussed in the documents section previously and extends to the content of the the social marketing messages, Steven noting that, '"water, the original cool drink" … is a non-stigmatising and positive way of addressing the issue of sugar sweetened beverages and decreasing them'. It is apparent, however, that only addressing the positive aspects of a norm leads to a very partial focus on what is targeted as needing to change — here, the actual behaviour or choice of drinking — not the commercial interests or the profit-focused paradigm underlying the development of the problematic norm, which does not accord with the spirit of health promotion tradition. This kind of positivity will be explored in Chapter 8.

The extension of the non-stigmatising framing was evident in how workers described both the products, which are generally framed as contributing to unhealthy weight, and the corporations that produce them:

> We think of it is as, yeah, every product in its place … We just say "everything in moderation". (Peri)
>
> So not saying, "please don't sell these evil items". (Millie)
>
> Another really fantastic part about OPAL is that it upfront is non-stigmatising. You never hear OPAL staff talk about "let's get the car industry or the fast-food industry" — we don't control them, we're not trying to control them. (Ian)

However, stressing the positivity of the environment — including the commercial environment — necessarily lays blame for unwise or immoderate consumption at the feet of the individual after all.

Unlike the workers interviewed, advisors also spoke about the importance of not stigmatising people. As Donna described the adoption of OPAL into a host LGA she highlighted the steps taken to avoid stigmatising the target population as the problem:

> We were really clear that we didn't want people marching in and saying "you're in the OPAL area because you're all fat and we're going to work on you". We had to approach this that we were wanting to work on ourselves as a community, as a council area. How can we make our community and the environment that we provide for you one that helps you to be more active principally?

Like the OPAL workers interviewed, Donna also expressed support for OPAL's principle of not 'demonising' specific foods, explaining that to do otherwise casts OPAL in the role of 'the fun police':

> It's not about demonising food, which is good because I think sometimes the messages can be it's all about the fun police, the food police, and trying to make everyone boring and you can only eat a lettuce leaf and a piece of celery or something like that.

Rose reflected critically upon OPAL's principle of only using positive messages, 'I think OPAL's certainly all about positive messages, every message has to be positive like drink more water, but the underlying is "okay, well, we want the water to replace all the sweetened beverages"'. She then suggested that obesogenic behaviours can be framed so positively in health promotion interventions that they lose their point. Discussing the approach to 'healthy weight' in general, Rose commented, 'I feel very much that there's been too much pussy footing around and that we actually don't confront it [obesity] head on'.

The descriptive accounts of interviews with workers and members of OPAL's Advisory Committees foreshadowed a number of elements, which the following discourse analysis develops.

7.5 Discourse analysis of interviews

As described in Chapter 4, open coding of the descriptive accounts of the interviews from the two groups of respondents identified three themes in the community-based component — *complexity*, *socio-ecological approach* and *equity* — and two in the social marketing component — *origins in EPODE*, and *social marketing in practice*. Coded material was then subjected to the five-stage analysis of the customised 'What's the Problem Represented to be?' (WPR) approach, described in Chapter 4. An example of the WPR analysis is included in Appendix F. Once this process had been completed, the results were then tabulated and synthesised, the findings being presented below. This completes the analysis started in Chapter 6 addressing the second Research Question, *What are the ideologies and discourses underpinning one of the community programs and its practice?*

7.5.1 Representation of the problem

The problem of obesity was primarily represented by respondents as a complex, worldwide population-level problem that is embedded in local environments and manifested in contextually unique ways. This problematisation explains respondents' concerns with EPODE's transposition to South Australia.

7.5.2 Representation of the causes of this problematisation

The causes of obesity were predominantly represented by all respondents as environmental in origin. The environment was represented as impacting on individuals both directly through physical environments, including organisational and structural environments, and indirectly, through normative environments, mediated by behaviour. Although behaviours were represented as driven by environments (physical and normative), they were represented as manifested in the individual.

Advisory Committee members mostly framed the problem of obesity in socioenvironmental terms, being driven by distal environmental factors — including commercial or market drivers — and to a lesser extent by proximal factors, constructing the norms that give rise to particular behaviours as embedded in environments. Workers, conversely, framed obesity in behavioural as well as socioenvironmental terms, attributing proximal rather than distal causes. This may reflect the fact that they are daily faced with implementing OPAL at the local level, while advisors (distant from OPAL both geographically and by occupation) maintained a more upstream focus, reflecting a social and structural determinants approach, although they represent addressing these distal drivers as outside OPAL's scope. Both groups, nevertheless, expressed views that challenge the dominant ideology of individual responsibility. This theme will be discussed in the following final chapter.

7.5.3 Representation of the solution to this problematisation

As the focus of this analysis shifts to how OPAL is represented as a 'solution' to the problem of obesity, incongruences between workers' and advisors' representations become more visible. The solution to obesity as embodied in the two components of OPAL is consistently represented by advisors as influencing the local physical, organisational and normative environment in which people live. In contrast, while workers represented the solution of the community-based component this way, they

characterised the solution implied in the social marketing component as more behavioural, specifically targeting parenting practices. Workers' representations closely reflected the representations in the documentation. As suggested in the previous chapter, Gramsci's (1971) insights about ideology being diffused throughout, and propagated through, cultural institutions and practices may help explain the workers' more individualised attribution of responsibility when describing the social marketing component. Developed from commercial marketing, which is premised on eliciting behavioural change to create profit (Hastings & Haywood 1991), it is possible that social marketing is a vector for spreading the ideology of individual responsibility as well as a means of promoting health. As Fischer (2003, p. 45) notes, this embedding of 'hegemonic discourses … in the existing institutions', among which he includes 'the theories and practices of liberal capitalism', makes the construction of alternative discourses very difficult.

In representing obesity as caused by upstream environmental factors, both groups of respondents expressed resistance to the dominant individualist discourse of responsibility. Neither group represented the solution embodied by OPAL as able to influence these factors. If correct, the effect of this is that the solution may not address the problem. If the causes of obesity lie in the macro sphere of social and structural factors, then changes to the local- or meso- level environment, and particularly to the micro-level of the individual or family, seem unlikely to bring about improvements in obesity rates. As described in previous chapters, however, OPAL is part of the EWBA Healthy Weight Strategy (SA Department of Health 2006a), itself a part of a broader policy approach by the SA Government to address health through actions undertaken in the non-health sector (Kickbusch et al. 2008). These are actions that may impact upstream drivers of obesity, though, as Baum (2013; Baum et al. 2014) notes, the policy environment has become less supportive of health promotion in recent years.

7.5.4 Representation of the framing of responsibility in this problematisation

Workers framed the community-based component as socioenvironmental and then individual, with responsibility shared between the state, the not-for-profit sector and individuals. They framed the social marketing component as primarily individual, with responsibility falling on individuals to implement changes advised by the state through its social marketing campaigns. Advisors, in contrast, framed both components as

socioenvironmental, though framing the social marketing component as additionally relying on individual change. It is apparent that even the representations of OPAL that begin by framing the problem and solution as socioenvironmental, in the final instance they frequently construct the solution as individual. This suggests that there is both resistance and acquiescence to the dominant neoliberal ideology that individualises responsibility. For example, Ian was seen to simultaneously recognise the commodification of the natural, health-promoting environment, yet to construct individuals as able and responsible for overcoming its health-diminishing effects. This seems a prime example of *self-responsibilisation*, the process — or 'technology' (Rose et al. 2006) — of neoliberalism by which individuals take on the task of governing themselves.

This instance of self-responsibilisation can be interpreted as either a positive or negative expression of power. It can be seen as an instance of what Petersen (2003), drawing on the work of Foucault, describes as opportunities for empowerment created by neoliberal rule whereby individuals can express their agency by making choices that benefit them. However, Ian's reflection can also be taken as one of those instances of what Rose et al. (2006, p. 90) more critically describe as the modern citizen's obligation to be free — to 'conduct themselves responsibly' — by taking on the role of governing themselves. Rose et al. (2006, p. 90) build on the work of Althussser, whom they credit with identifying the role of ideology as being 'to constitute individuals who took themselves to be autonomous subjects and who enacted their subjection as if it were a matter of their free will', a description that seems to fit Ian's response.

The pervasive nature of hegemony, as theorised by Gramsci and Althusser, means that ideology is, as it were, imbibed unconsciously: one can hold ideas without being aware that one holds them. It is therefore possible that respondents expressed relatively unrehearsed or spontaneous views, reflective of dominant norms, in contrast to documentation, which is the end product of careful consideration and scrutiny. The comparison of the findings in the final chapter will consider the implications of this dichotomy.

7.5.5 Implications for health equity

To recap, health equity was defined as a situation where 'systematic differences in health' (CSDH 2008, p. 26) have been avoided through policy or practice intervention.

Whether OPAL's impact is equitable or not depends on whether the 'playing field' has been effectively levelled (or its tilt reversed) by the provision of healthy choice-making opportunities, though as suggested above, like most of the determinants of obesity, this is beyond OPAL's remit. OPAL's restriction to 20 sites means that it cannot be expected to influence all people in all environments.

Respondents framed the solution of OPAL as the responsibility of both individuals and the collective (mainly the state). The environmental framing of the community-based component highlights the importance of material changes to those factors that influence weight-related behaviours and make health-promoting behaviours easier for people. As OPAL is located in communities with less healthy weight, this part of the solution would be expected to make the distribution of healthier weight more equitable. However, whether these changes are able to make it sufficiently easy for people in these communities to take up the social marketing messages — framed as the responsibility of individuals [workers] as well as the collective [AC] — is crucial. Social marketing is a motivational approach, helpful where the availability (range, affordability, etc.) of healthy options has increased but people are unaware of this (Milio 1976); otherwise, it is ineffective. As the community members most likely to benefit from this approach are those who are better resourced (WHO 2012b), this part of the OPAL program may worsen the health inequities that result from unhealthy weight (Alvaro et al. 2010).

Rather than focusing on the drivers of norms, this analysis suggests that social marketing focuses on the individual behaviours that are the result of norms. Such marketing draws attention away from those environmental factors over which people have no control (and which were previously identified as significant), and focuses attention on the narrow band of activity that is ostensibly within individual control — the home environment and the behaviours within it. This isolates what is targeted for change (behaviours) — that is, what is identified as the immediate and targeted cause of the problem — from any environmental context that might give it meaning and validity (Milio 1981, p. 3), and makes the resulting individualising of responsibility for achieving change seem logical. Where a focus on individual consumption and the reinforcement of the commercial sector as a solution were identified in the community-based component (for instance, via product reformulation and strengthened market

relations through increased reliance on commercial products), this is also likely to further marginalise those who are already economically marginalised. These findings will be considered in light of the literature in the next and final chapter.

7.6 Summary of chapter

This chapter explored how OPAL workers and members of OPAL's Advisory Committees framed the problem of obesity and the solution to obesity represented by the OPAL program. Using the WPR approach to interrogate their representations of OPAL, incongruences between respondents' framings and the ideological underpinnings of the frames were identified. Competing discourses framing obesity as socioenvironmental and individual–behavioural were evident. It was noted that even where OPAL was framed as socioenvironmental, individuals often became implicitly constructed as responsible for achieving those changes that would reduce population-level unhealthy weight. From respondents' framing, OPAL — whether by design (social marketing) or by default (community-based component) — was seen to often privilege the individualist discourse and paradigm, one of the chief characteristics of which is the process of 'individual responsibilisation', which will now be explored.

CHAPTER 8: DISCUSSION

8.1 Overview

This chapter discusses the findings of the thesis in light of the literature and the research questions that this thesis addresses:

1. *What are the ideologies and discourses underpinning policies that are designed to contribute to achieving the Healthy Weight Target of the 2007 South Australian Strategic Plan?*

2. *What are the ideologies and discourses underpinning one of the community programs and its practice?*

3. *To what extent is the aim of achieving health equity embedded within the ideologies evident in the policies and program?*

Chapter 5 identified the ideologies and discourses underpinning SA's Healthy Weight policies, that is, the policies that contribute to achieving the Healthy Weight Target (HWT) of the 2007 South Australian Strategic Plan, which addressed Research Question 1. Chapters 6 and 7 identified the ideologies and discourses underpinning the OPAL program, addressing Research Question 2. In this chapter, the findings from these analyses will be brought together and the final research question — the extent to which the aim of achieving health equity is embedded within these ideologies — will be explored.

To this end, the key findings from the analysis of each dataset will be reprised under five themes: the problematisation of unhealthy weight, its causes, its solution, how this problematisation frames responsibility, and the likely impact on health equity. These findings will then be discussed in light of the literature. Finally, the ideologies identified in the solution represented by the healthy weight policies and OPAL program will be examined to determine how equity is represented in them, and some conclusions will be drawn.

8.2 How the problem is represented

8.2.1 How unhealthy weight is problematised in the data

My analysis of the Healthy Weight Strategy policies (that is, Eat Well Be Active: EWBA; Eat Well South Australia: EWSA; Be Active Physical Activity Strategy: BA, and EWBA *Priorities*) showed that the primary problematisation is that an increasing number of people are at risk of poor health as a result of unhealthy eating and physical activity, particularly as these manifest in unhealthy weight. A secondary problematisation present in some of the policies was that this is bad for the economy as well as for people's health. Although the primary problematisation represents the problem as lifestyle or behavioural, behaviours are framed as non-volitional, with environments driving those behaviours that lead to unhealthy weight.

The focus of the policies is on eating well and being active, rather than on (unhealthy) weight. Where weight is the focus, it is represented in subjective terms as being the healthiest weight a person can achieve through a healthy lifestyle, and emphasis is placed on not blaming or stigmatising people because of their weight. While analysis of the policies showed a focus on individual circumstances, as well as environment, analysis of the program revealed greater attention to environmental influences on weight-gaining behaviours.

8.2.2 Comparison with how unhealthy weight is problematised in the literature

The literature review identified three main ways that obesity was problematised: as a medical, a behavioural and a socioenvironmental problem, with some variations noted within these frames. The discourses drawn on in framing obesity were also described in both the policies and program document and interview analysis. My analysis of the policies and program suggested that the construction of the problem used the medical discourse to frame the problem as serious and likely to result in multiple chronic diseases. It also used economic rationalist arguments to frame the problem in terms of the economic costs that rising obesity levels would impose. The effect was to construct obesity as an issue of such seriousness, medically and economically, that it justified the state taking a lead role in addressing the issue, collectivising responsibility for the solution to the problem. Thus, although the problem is described in EWBA as directly caused by unhealthy eating and physical activity behaviours, the fact that this is

occurring at a population as well as individual level logically requires that these behaviours are most effectively addressed collectively.

It was interesting that neither EWSA nor BA problematised weight at all, though they did construct the consequences of poor nutrition and inadequate physical activity in similar terms of chronic disease risk to the consequences of unhealthy weight. In contrast to the more serious tone of EWBA, these policies also emphasised the positive benefits of good nutrition and physical activity, independent of weight. Interestingly, this emphasis is reflected in the title of the next iteration of the EWBA with the omission of 'healthy weight': *Eat well be active strategy for South Australia 2011–2016* (SA Department of Health 2011). EWBA is non-stigmatising in its approach to the problem of obesity. Positivity was a recurring theme that was uncovered in my analysis and will be discussed in some detail later.

Policies thus invoked medical and lifestyle discourses when describing the problem, but invoked socioenvironmental discourses when the focus turned to the solutions that were being proposed. This contrasted with my analysis of the OPAL program, which disclosed greater use than the policies of socioenvironmental discourses when describing both the problem and the solution. While unhealthy behaviours were noted in the program, these were framed as having a socioenvironmental context. However, a dual tendency was identified among some respondents whereby behaviours would be explained as driven by norms, and yet these norms — such as family eating practices — would at times simultaneously be decontextualised, with constraints such as affordability excluded from the problematisation. The phenomenon whereby policies initially framed as socioenvironmental revert to a behavioural frame has been described by Hunter et al. (2010, p. 148) as 'lifestyle drift'. The same tendency in *discourse* recurred numerous times in my analysis, most notably in the interviews with OPAL workers.

Representation of the commercial sphere was complex and inconsistent, both between policy and program documentation, and between workers and Advisory Committee (AC) members.

My analysis showed that the policies tended to omit the commercial sector from the problematic environment, including it only as part of solutions to obesity, not as

contributing to the problem. In contrast, program documentation obliquely problematised the commercial sphere, with local food production and distribution identified as needing to change. This was more directly expressed in the advisors' reflections, which were consistently forthright about critiquing the role of industry in driving obesity. This accorded with critiques in the literature from researchers using a socioenvironmental/political economy perspective, described in Chapter 3. Workers' reflections were more mixed, with some critiquing but others protecting the role played by the commercial sector. Of relevance to this latter tendency, Fischer (2003, p. 66) notes that policies can 'construct immunity' by treating certain situations as 'non-problems', which seems to be what is happening here to some extent.

While the EWBA policy was identified as problematising the unequal distribution of obesity, this was most apparent in the program that was geographically located on the basis of low socioeconomic status and higher than average presence of an Aboriginal population, both these factors being associated with a higher risk of obesity (Commonwealth of Australia 2009b). This kind of targeting, although it addresses absolute disadvantage, represents a view of equity as a gap rather than a gradient; that is, that some populations 'have' the problem, rather than it being something experienced by everyone to a different extent, in line with the general social gradient in health. A shortcoming with the 'gap' view is that populations can be constructed as *having* — and thence *causing* — the problem, constructing responsibility as individual rather than shared, as the problem has been made marginal. Inequity can thus be construed as an attribute rather than a cause of obesity.

8.3 Causes of this problematisation

8.3.1 How the causes of unhealthy weight are represented in the data

Based on my analysis, the main cause identified as leading to obesity as problematised in the policies and program was unhealthy eating and low levels of physical activity, which are cast as having strong environmental drivers that constrain choice. Healthy choices are identified in my analysis as not necessarily easy, and as harder for people experiencing disadvantage. Environmental drivers are most explicitly identified as including the commercial sector or products in the problematisations of Advisory Committee members.

8.3.2 Comparison of how the causes of unhealthy weight are represented in the literature

The three frames of medical, behavioural and socioenvironmental apparent in the literature represented the causes of obesity differently. The medical frame represented the problem of obesity as being caused by biology, genetics and behaviour. The behavioural frame represented the problem as caused by poor choices due to a lack of information, understanding or motivation. The socioenvironmental frame represented the problem as caused by the easier uptake of unhealthy than healthy choices, due not only to lack of information and understanding but to environmental constraints. This frame represented obesity as a normal physiological response to unhealthy and weight-promoting 'default' environments. Within this frame, a political-economic discourse was evident, which cast the problem as caused by the fundamental structures and relations of production of late-20th century and early 21st century global capitalism. A number of themes were raised in the findings that will be outlined here and explored in detail later.

My analysis showed that the causation of unhealthy weight, like the problem itself, is framed as both a behavioural and a socioenvironmental problem in the policies and program. The tendency I observed for this dual framing to devolve to a focus on those factors that immediately impact behavioural change has also been noted in the literature for many years. The EWBA *Priorities* document (Government of SA 2009) cites the work of McLeroy et al. (1988) on the ecological model of health promotion, which the authors describe as focusing on individual as well as socioenvironmental factors as targets for intervention. Local environments mediate between individuals and structural drivers, as noted in the social determinants of health literature (CSDH 2008; Marmot 2010) and in the recent *Obesity and inequities* (Loring & Robertson 2014) report prepared for the WHO European Office. This means that interventions aimed at this level in disadvantaged communities — such as OPAL — can improve the unequal distribution of health factors such as unhealthy weight.

My analysis of the OPAL program, however, also noted that a focus on local influences can draw attention from a broad to a narrow perspective. In the same way that Tesh (1988) argued that a focus on lifestyle leaves structural causes of diseases unexamined, McLeroy et al. (1988) suggest that a focus on proximal environments can occlude distal

drivers, meaning that they remain unproblematised. I argue that this is what happens at times with the policies and program I have analysed in this thesis where the commercial sector is rarely identified as playing a part in the obesogenic environment, even when obesity is identified as partly caused by commercial factors. Possible reasons for this, as well as the repercussions and ideological implications, will be discussed under *responsibility* shortly.

One of the ways that the policies and program were identified in my analysis as circumventing criticism of the commercial sector was the tendency (noted in EWSA and in the OPAL documentation) to focus on what was missing from nutritional diets, rather than what was being eaten in excess. This observation has also been made in a critique of national policy where the Australian Dietary Guidelines have been criticised for over-emphasising the health benefits of eating more fruit and vegetables, but not clearly stating the harmful effects of excessive 'treat' foods (Abraham 2014, p. 3). The advice in EWSA and OPAL means that people are advised to eat and drink more (fruit and vegetables and water respectively) rather than to not eat — and therefore not buy — more energy-dense nutrient-poor (EDNP) items. This is one instance of the broader practice that was observed in this study of only framing health messages positively, and illustrates the negative impact this practice can actually have on health. The *eat more* message also means that commercial production is not problematised and therefore is not targeted as needing to change to improve population health.

One of the differences identified between the data and the literature was the way *choice* was represented. *Choice* is fundamental to how the cause of obesity is problematised, as it can provide a means by which individualising discourses can influence the framing of an issue. Choice will therefore be examined in some detail.

Choice is a pivotal concept in the data and the obesity literature, and is represented differently in the two most apparent discourses in the data: as 'free' (the *liber* element of neo*liber*al in Latin, Simpson 1969, p. 344) in individualist discourse, and as constrained in the socioenvironmental discourse. Milio's (1981) concept of needing to make healthy choices easy can be seen as an attempt to highlight the second meaning. Some of the individualist assumptions underpinning neoliberal choice that were apparent in some of the worker interviews were that: choice is empowering (c.f. Peterson 2003); health is high on the list of priorities that drive the choices individuals

make (c.f. Broom 2008; Crawshaw 2012); choices are made as a result of rational decision-making processes (c.f. Broom 2008); and that the right choices by parents will lead to healthy children. This created some of the tensions noted in the analysis of the interviews, with other workers and the advisors identifying choices as primarily driven by the environment.

Also evident in some of the worker interviews and related to choice was the concept of agency — an assumption that individuals are able to choose freely, and that their choices are efficacious and lead to the desired health result, which also characterises neoliberal discourse (Hoggett 2001; Petersen 2003; Rose et al. 2006). Other workers explicitly drew attention to the constraints on parents exerting agency in their choices, reflecting a socioenvironmetal discourse. The concept of *responsibility* was also evident — that parents are responsible for their children, and that individuals (including in their role as parents) are responsible for health. Again, some workers represented responsibility — like choice — as unproblematic, while others, like most advisors, were more openly critical of the concept, drawing on socioenvironmental rather than individualist discourses to highlight the structural features inhibiting people's capacity to fulfil such responsibilities.

One of the most authoritative assumptions identified as underpinning the nutrition discourse, and evident in EWSA and in some of the OPAL social marketing messages, was that people make their food choices based on its nutritional content. By this logic, 'poor' food choices stem from a lack of knowledge about the nutritional content of different foods. By thus problematising poor nutrition as being the result of inadequate nutritional knowledge, education and labelling solutions are logically justified. However, there is a considerable international literature detailing the meanings that food has and which influence food choices, apart from nutritional content (e.g. Bava et al. 2008; Coveney 2006; Hampson et al. 2010; Hoek & King 2008; Jolly 2011; Lee et al. 2013; Rawlins 2008). Some of the other meanings which food has in Australia and which drive food choices include: cost; taste; convenience; availability; advertising pressure; pressure from children; as well as habit, family expectation, trust and ethical considerations such as fair trade, organic, Australian made, cruelty free, and sustainability, as well as religious significance (Barosh et al., 2014; Coveney 2006, 2008 & 2014; Dixon et al. 2006; Kettings & Sinclair 2009; Mohr et al. 2007; Wong et

al. 2011, 2013; White 2007; PG Williams 2011). These reflect the multiple meanings of food and thus the potential reasons behind food choices, which were not evident in either the policies or program analysed for this study. This may reduce the impact of interventions like food labelling and reminders to 'Make it a fresh snack' (SA Department of Health website 2015, OPAL, accessed 12 November 2014) as people may respond to other drivers of their food choices.

8.4 Solutions to this problematisation

8.4.1 The solutions to unhealthy weight identified in the data

Based on the logic outlined above, my analysis suggests that the solution to the problematisation of unhealthy weight in the policies and program is making environments as supportive of healthy eating and physical activity choices as possible. The commercial sector is included as part of the potential solution by being able to offer healthy choices in product lines.

8.4.2 Comparison to how the solutions to unhealthy weight are identified in the literature

As identified in Chapter 3, the medical frame presents pharmacological and surgical intervention at an individual level as being the solution to obesity, while the behavioural frame advocates programs to educate individuals about healthy choices and to motivate them to choose healthy options. The socioenvironmental frame presents the solution as more complex, requiring government intervention to make healthy choices the easy choices by creating environments that are supportive of health, and providing education to encourage healthy choice making. This is represented, in turn, as requiring comprehensive policy intervention at all levels of government and in all sectors and settings, including working with industry to provide joint solutions.

In EWBA, but most markedly in the *Priorities* document, the solution is represented comprehensively, spanning structural, socioenvironmental and individual elements in a causal chain that includes policy, settings, and lifestyle changes. OPAL's design, also reflected in both the documentation and interviews, represents the solution as comprehensive, with an ecological approach encompassing community development elements as well as the social marketing component.

Social marketing

Some incongruences between OPAL's use of a social marketing strategy and its goal of reducing unhealthy weight and its unequal distribution (Cobiac et al., 2011, p. 4; SA Department of Health 2009, p. 9; SA Department of Health 2010, p. 9) became evident during my analysis. Both workers and Advisory Committee members reflected that unhealthy weight is a complex, worldwide population-level problem that is embedded in local environments and manifested in contextually unique ways. However, while the solution represented by the community-based component is congruent with this problem representation, it is less clear whether this is the case for the solution represented by social marketing in the program documentation and interviews.

Firstly, social marketing aims to make it easier to *choose* the healthy option. It does not make the options healthier, and there is evidence that unless it accomplishes significant changes in local norms — in opposition to continued commercial marketing — neither does it make the act of choosing any easier (Evans et al. 2010; Wymer 2010). While social marketing campaigns can be used at a community rather than individual level to promote community mobilisation and coalition formation (Evans et al. 2010), most commentators describe it as aiming to alter individual behaviours (Crawshaw 2012, 2013; Hoek & Gendall 2006; Wymer 2010). This is at odds with the framing of the problem as socioenvironmental.

While social marketing on its own does not address environmental barriers to healthy choices, OPAL's social marketing is, however, supported by its community-based component that has many embedded equitable aspects. These include the targeting of (absolute) disadvantage, which is seen in the selection of sites for OPAL projects; the local community base of activities; and the overall commitment to making environmental changes to support individual changes. Concerns about the equitableness of social marketing in public health and strategies for overcoming these were described in Chapter 3. To recap, it was argued that the easier uptake of social marketing messages in more affluent and better resourced communities (WHO 2012b) could be countered by: (a) customising messages for disadvantaged communities (Stead et al. 2007); (b) accompanying social marketing with additional support to these communities (WHO 2012b); (c) making concomitant structural and policy changes (Baum 2011); and (d) delivering social marketing as part of an ecological approach

(Evans et al. 2010). The social marketing approach described in OPAL documentation and in the interviews, as part of the Healthy Weight Strategy (HWS), would seem to comply with these safeguards.

A further incongruence noted was that while some OPAL respondents represented the problem of obesity as contextually unique, the social marketing *solution* was sometimes described as driven by the context of the communities involved, and sometimes not. OPAL's social marketing component derives from the methodology purchased from EPODE. As an intervention strategy, therefore, it is not derived from an analysis of the problem of obesity in South Australia, although the themes and wording of messages are generated and piloted locally. While OPAL's community-based component is also part of the EPODE methodology, it is a standard health promotion strategy used in many similar Australian programs (e.g. King et al. 2011; Pettman et al. 2010; Swinburn et al. 2013). OPAL differs from most community-based programs in its high profile and its high-resource social marketing methodology. OPAL's social marketing component applies centrally generated, generic messages to OPAL communities, thus its output has mixed contextuality in that it is unique to SA but not to every community where it is implemented. This was illustrated in the vignette recounted by two OPAL workers describing their perception of the failure of the social marketing message, 'Water, the original cool drink' to supplant Coca-Cola in an Aboriginal community child care setting. How the Aboriginal community in this OPAL site understand or prioritise their wellbeing might be broader than the definition implied in the social marketing message, the material about tooth decay or the appeal to thrift that OPAL managers found successful elsewhere. The workers reflected that social status ('water is "povo"[2]', the provision of Coca-Cola thus equating to wealth) within the Aboriginal community was apparently a stronger driver than the aspiration for health promoted by OPAL. As noted in the analysis of the EWBA documents, the multiplicity and depth of social meanings represented in food, its preparation and eating are minimised or rarely acknowledged in dominant discourses.
OPAL's social marketing campaign is directed at families and thus family behaviours, such as consumption, not on the production or marketing of obesogenic products. This focus on the local (the family) rather than the distal (corporate production) also draws

[2] 'Povo' is Australian slang for poverty or being poor (Macquarie Dictionary 2014).

attention to the effects or outcomes rather than the causes of behaviours, thereby reinforcing the individualist paradigm.

Targets

While the policies and program both focus on prevention, several interview respondents expressed consternation at the healthy weight, eating and physical activity targets the strategy and the program were expected to achieve, at a population level, yet over a short timeframe. One respondent suggested weight targets should be supplemented by targets measuring changes in the environments influencing weight. The challenge of meeting weight targets in relatively short time frames was mirrored in the literature, which suggests long time frames are needed to see changes in population-level weight (Gantner & Olsen 2012; King et al. 2011). A critique in the literature suggests that targets need to shift from being aspirational to promoting genuine cultural change (Lang & Rayner 2007).

Partnerships and community

OPAL respondents reflected on the central role played by partnering with different stakeholders in the community, particularly as an aid to sustainability. AC members, but not workers, expressed caution about potential conflicts of interest with commercial partners, an issue also raised in the literature (Freudenberg 2014; King et al. 2011).

My analysis of the OPAL program showed that, like many other obesity prevention interventions, OPAL arrived in a community with obesity prevention as their pre-set aim — the problem had been pre-identified. Although this is related to funding issues and is perhaps unavoidable in the current political and economic climate, it can nevertheless be argued that simply being community-based does not equate to practising core community development processes. The most fundamental of these is the precept of starting where people are at, or naming the problem, which is fundamental to the process of empowerment (Labonte 1993; Kenny 2011) and addressing inequities (Whitehead 1992). While social marketing can be a ‘top-down’ strategy, community-based interventions are not inevitably ‘bottom-up’. The result can be community-based interventions experienced by communities as an imposition rather than something they would prioritise for their own wellbeing. A sense of this was reflected by OPAL workers in the scenario described earlier. Despite the health risks

posed by obesity, this may not be the issue that this community would have prioritised to be addressed.

Regulation

The difficulty of achieving major regulatory changes was noted in my analysis of the policies, and the ineffectiveness of government regulation of industrial practices harmful to public health was identified by several interview respondents, with the usurping of public policy processes by industry specifically identified by one respondent. These examples are akin to the corporate capture of democratic processes described by Freudenberg (2014) in his critique of neoliberal capitalism. The sustainability and equitable impact of regulatory approaches to obesity prevention are identified in best practice (WHO 2012a, 2012b) and by public health advocates, many of whom are strident in advocating for the regulation of industry (Daube 2010; Moodie et al. 2006; Nestle 2002; Swinburn et al. 2011). These advocates suggest that, when compared to educational interventions, a regulatory approach is sustainable. They also assert that it is also equitable in that it targets changes in obesogenic environments and can influence entire populations, is both effective and cost-effective, and is a strategy that has public support (Shill et al. 2011; Swinburn et al. 2011). Its unpopularity in practice may be because, whereas social marketing locates responsibility for changing with the individual and thereby absolves other players of responsibility, regulation requires government to assume responsibility for enforcing industry to shoulder *its* responsibility, as critics have observed (Allender et al. 2011; Shill et al. 2011). The theme of *responsibility* will now be examined.

8.5 The framing of responsibility in this problematisation

8.5.1 How responsibility is framed in the data

My analysis showed that responsibility is constructed in the policies and program as being jointly individual and collective. In the primary problematisation, most evident in policy and program documentation, while the construction is that people will be helped as much as possible, healthy weight-promoting behaviours are also constructed as ultimately up to the individual. Where responsibility is deemed collective, exercising choice responsibly is cast as a civic duty. The secondary problematisation, that distal drivers which directly impact people’s weight also need to change, places all

responsibility at the collective level, stated as shared by all sectors but rarely naming the commercial sector (once each in EWBA and EWSA). This relative absence of the corporate sector from the solution is incongruent with the socioenvironmental framing of the solution and is widely critiqued in the literature by researchers writing from this perspective.

Tensions were evident in the policy and interview analysis between discourses of individual and collective responsibility for health and healthy weight. Of particular interest in the findings was the way that some OPAL respondents, although rarely problematising obesity as caused by behavioural factors, nevertheless represented the solution to obesity as ultimately the responsibility of the individual or individual family unit. (The reverse had been evident in the framing of the problem and solution in the policies, where my analysis showed that the problem had been constructed as largely behavioural, but the solution as socioenvironmental.) Given that populations already bearing the burden of the highest rates of obesity and obesity-related ill health are disadvantaged on socioeconomic status indicators, placing responsibility on them for also solving this problem seems unlikely to work. As the problem of obesity is framed as socioenvironmental in cause, it also seems unjust to require populations not responsible for this problem to fix it. As critics of healthism explain (Crawford 2006; Guthman 2011; Leichter 2003), a further danger with individualising responsibility for health problems is that, once problems are identified as belonging to certain populations they can become stigmatised, invocation of the moral deficit discourse attributing the problem to certain features (apparently) exhibited by that population, further reducing the likelihood of collectivised responsibility and possibly making the problem worse. Behavioural discourses — such as the lifestyle, moral deficit and market choice discourses — individualise responsibility as they only take as their subject the individual, with other factors being outside their scope. The socioenvironmental frame locates responsibility for obesity in social and environmental factors. It is only this frame which, by including a broad array of factors as influencing obesity, enables the patterning of its distribution to be seen — that is, the distribution of obesity along the social gradient that enables obesity to be identified as an issue of inequity, as described in Chapter 2. Socioenvironmental solutions frame responsibility as collective, shared across the whole of society, and these solutions are thus more likely to enhance equity in healthy weight. The gradient conceptualisation of equity within the

socioenvironmental frame, while present in the literature and in best practice outlined in the Loring and Robertson's report to the WHO Regional Office for Europe (2014), was apparent in the program analysis in the reflections of the Advisory Committee members, but not elsewhere. As described above, a sense of equity as involving distinct populations was apparent in EWBA and in OPAL's location.

As the analysis illustrated, the attribution of responsibility was pivotal to the ideological framing of the problem of obesity represented in the HWS and OPAL. The findings in terms of the ideological underpinnings that were identified will now be examined in greater depth by drawing on the literature to consider their significance in influencing these 'solutions' to unhealthy weight.

8.5.2 Comparison with how responsibility is framed in the literature

Analysis of the data revealed an ideological contestation signified by competing discourses of neoliberal individualism and the socioenvironmental perspective underpinning SA's healthy weight policies and the OPAL program. Neoliberal individualism primarily was manifested through the process of *individual responsibilisation*, that is, holding individuals responsible for factors outside their control. The discursive devices constructing this will be examined shortly. Several scholars argue that the ideology of individual responsibility requires people to take personal responsibility for their health, when in fact they may have little control over the factors that influence it (Crawshaw 2012, 2013; McLeroy et al. 1988). The instances of resistance to individualist ideology that were identified in my study share this critical stance. In the following section I discuss the key ways through which neoliberal market relations and individualism are concentrated into the process of individual responsibilisation identified in my data. *Choice* is identified as the predominant mechanism by which individuals are constructed as responsible, obscuring many features of the socioenvironmental frame. Choice is explicated as comprising elements of self-responsibilisation, governmentality and risk; the reflexive, active individual; 'correct' consumption, particularly in the commodified environment and the creation of identity through consumption; and an uncritiqued commercial sphere. The latter was shown by the principle of positivity, the non-demonising of products, private partnerships, and links to EPODE. Social marketing is analysed as a sub-category of governmentality, comprising a series of contradictions that affect OPAL. Localism is

also discussed as an outcome of the narrowed view of responsibility created by individual responsibilisation, and the concept of *making healthy choices easy choices* is critiqued in light of these understandings. Finally, what is made unproblematic by this process of individual responsibilisation is explored, before turning to consideration of the final theme — equity — which will form the focus of the final section.

Neoliberal market relations, individualism and the individualisation of responsibility

As described in Chapter 3, the core ideological framing of responsibility in the neoliberalised world is individual (Harvey 2007). Baum (2008) discusses the role of individualism in underpinning neoliberalist politics and economics, and the implications for health, and health equity in particular. At its core, she argues that individualism constructs individuals as entirely responsible not just for what they do, but for the outcomes of their actions, explaining that the capacity of individuals to make free choices and to control their life is expressed in ethical terms as *autonomy,* literally, 'self-rule' (Baum 2008, p. 74).

The issue of control was identified in my study. In Chapter 5, my findings highlighted the paradoxical construction of the public as needing to be active citizens yet cast as the passive recipients of policy; *Be Active* in particular revealed the obligatory nature of policy compliance as physical activity was represented as a civic duty. Governmentality scholarship offers some insight into this paradox. While Petersen (2003, p. 195) identifies the creation of the 'active decision maker' as necessary under the 'neoliberal strategy' of self-responsibilisation, the circumscribed nature of those choices (Ayo 2012) suggests that autonomy or agency and control — the precondition of choice — may be illusory, effectively disempowering individuals (Rose et al. 2006). This is significant when considering how responsibility was constructed in the documents and interviews studied here. The effect of active citizenship discourse which erroneously assumes a level of agency that often is not present has been identified as a means of depoliticising and obscuring the structural roots of people's marginalisation (Salmon 2011).

While the explicit solutions represented in the policies and programs stress the socioenvironmental changes needed to make healthy choices easier, this analysis has identified that responsibility was nevertheless sometimes constructed as individual.

Such a construction sees choice invoking a lifestyle discourse foregrounding individual change rather than change to the environments that support those behaviours. The lifestyle discourse is most apparent in the behavioural frame where individuals are represented as able and thus beholden to promote their own healthy weight through making prudent lifestyle decisions. All variants within the behavioural frame draw on discourses of choice in their delineation of responsibility.

The effects of this individualist construction were apparent in the analysis of the program documentation and interviews. Several workers in particular represented parents as able to make choices, for example to engage in active play (one of OPAL's social marketing messages) with their children. They had little consideration of time and other constraints, or agency, not identifying changes in material conditions influencing norms and behaviours, with behaviours thus represented as volitional. Once norms are divorced from the environments that engender them, of which and from which they are a natural and logical expression, individual behaviour can likewise be divorced from the environment in which it is embedded. As Beck and Beck-Gernsheim (2002) argue, this decontextualising of behavioural 'choices' in this way is how individual responsibility can become individual blame. This was implicit in one worker's contrasting of their own engagement in active play with their children, whatever the cost to themselves. Broom (2008) argues choice can be a vehicle by which moral status is imposed. In this instance, the workers' unintentional moralisation of parents is in opposition to what they had explicitly stated about people not being to blame for their weight, as well as contrasting with the explicitly stated policy intent of avoiding victim blaming (SA Department of Health 2006a). Drawing on Gramsci, Eagleton (1994) theorised that ideology comprised not simply ideas but was the lived practice of cultural habits, from which comes the possibility, articulated by Althussser (1994), that ideology can therefore be imposed without people's conscious awareness of it. It seems logical that ideology can also be expressed without intention, which is what seems to be happening here, with some workers consciously holding and expressing views challenging individual responsibility, but unconsciously echoing it. The key features of this individualised responsibilisation will now be examined.

Self-responsibilisation

As explained in Chapter 3, Crawford (1980) identified the operation of a healthism discourse within individualism that acknowledges the source of problems as being beyond the individual but locates the solution within the individual. The outcome of such a process is that political problems are rendered as problems of individual lifestyle (Kwauk 2012). The literature (Ayo 2012; Petersen 2003; Rose et al. 2006) describes how this process of individual responsibilisation undergoes a further transformation whereby people render *themselves* responsible.

This comes about because being seen to be responsible is valorised under neoliberalism, and the way this is expressed is through making 'responsible' lifestyle choices. As was established in my analysis earlier, the lifestyle discourse in which responsibility is cast as individual is pervasive, and permeates the cultural and political context in which the HWS and OPAL are situated. While data were presented in which responsibility for obesity was framed as individual, instances were also cited where this was challenged and the framing was socioenvironmental, with obesity constructed as a collective responsibility.

The increasing construction of the individual as primarily responsible for themselves under neoliberalism is widely attested (Crawshaw 2012; Elliott & Lemert 2006; Freudenberg 2014; Harvey 2007; Hoggett 2001; Petersen 2003; Rose et al. 2006). Following the concept developed by Gramsci (1971) and Althusser (1994) that ideology is diffused throughout society and embedded in cultural practices and institutions, I suggest that choice is one such vehicle through which the ideology of neoliberal individual responsibility is enacted, as illustrated in worker interviews.

Self-responsibilisation underpins the social marketing observed in OPAL; the issuing of messages by a governmental health authority such as OPAL directing people what to do (however positively and thoughtfully worded, as OPAL's social marketing messages are) carries with it the implicit assumption that people *can* carry out the directive: they can, in the words of Rose at al. (2006, p. 91) 'conduct themselves responsibly'. Althusser's (1994) theory that ideology unconsciously shapes people's understanding again helps explain the somewhat uncritical attitude to social marketing reflected by some workers, in contrast to their socioenvironmental framing (and certainly that of the program documentation) of the problem of obesity at other times in our interviews.

In his analysis of corporate involvement in childhood obesity programs, Powell (2014, p.229) posits that neoliberal ideology is itself a form of governmentality: 'Neoliberalism is … a dominant political rationality that problematises the welfare state and re-organises the rhetoric and programmes of government into alignment with rationalities of competitiveness, autonomy (of individuals and institutions), choice, enterprise and responsibility.' Neoliberalist governmentality can thus be seen as a means by which individual responsibilisation is enacted, becoming how children are influenced to act and think: it is possible to view this as one way that hegemony happens, and neoliberal power relations are actualised. Powell's analysis of neoliberal forms of governmentality such as 'public/private/voluntary partnerships' (2014, p.230), reflects my own: that corporations render themselves present as solutions to – not causes of - the 'problem of obesity'. This is how neoliberal ideology becomes hegemonic. Herrick (2009, p.51) further suggests that the positioning of corporations as solutions to obesity via Corporate Social Responsibility in turn problematises the role of the state in addressing "its own 'public health' crisis".

Governmentality theory, as described in Chapter 3, helps explain the popularity within neoliberal governments of social marketing as a health promotion strategy as it is a prime means by which people are made responsible for their own health (Crawshaw 2012, 2013). In this study, self-responsibilisation which underpins social marketing was seen to be off-set by the emphasis in OPAL on concomitant environmental changes which frame responsibility as collective.

The *lifestyle choice* discourse that underpins self-responsibilisation thus shifts responsibility, such as for health, to the individual. By invoking the *free market choice* discourse, self-responsibilisation also benefits the commercial sector by transferring to the individual consumer responsibility for the negative effects of consuming the products from which it has profited. While this would absolve industry of responsibility for its obesogenic products, this discourse is challenged by many lobby groups. The influence that the market choice discourse exerts is evident in my analysis of the way some OPAL workers described the benefits to consumers of a fast-food chain increasing their range of products, framing this as an appropriate contribution to public health. This contrasted with the dissonant framing they expressed elsewhere, which will shortly be explored.

In their privileging of choice, the lifestyle choice and market choice discourses act to reinforce each other and to embed the assumption that individuals should be responsible for themselves. One instance of the individualising of responsibility is the 'good citizen' discourse that was identified in my analysis as reverberating through the policies, where healthy weight-promoting behaviour was constructed as a civic duty (for a similar analysis of official lifestyle discourse in the UK, see Rawlins 2008). Baum (2008) argues that there is an individualising of collective responsibility in neoclassical economics through which, rather than a collective sharing of responsibility *between* individuals, civil society and the state, individuals are understood as responsible *for* collective good. Responsibility, but not necessarily the power that is needed to convert it into agency, is thus shifted to the individual. It has profound implications for the way equity is considered. This will be explored in greater detail shortly.

Dissonant voices to the dominant lifestyle discourse of individual responsibility were identified in my data. Interview respondents clearly identified environmental influences on the behaviours that influence weight, and related their conscious opposition to stigmatising explanations for obesity. They described their own awareness of and resistance to the promotion of junk food, and that of members of the public, offering insights into the reasons for its appeal. Industry practices influencing the public policy process and fighting government regulation was openly critiqued, and several respondents alluded to the way capitalism encouraged overconsumption (Freudenberg's 'hyperconsumption — 2014, p. 35) to the detriment of health. While capitalist forces of production were not problematised in the documents, they were problematised by some of the respondents, and the social–cultural norms that flow from capitalism were problematised by most respondents.

The literature review also identified a number of perspectives in the field of obesity studies that challenge different aspects of the dominant neoliberal-individualist construction of obesity. While the socioenvironmental perspective reframes the problem of obesity as caused by social and environmental factors, to be solved collectively, the Health At Every Size and Size Acceptance movements destabilise the moral element underpinning the behaviourist construction of obesity as self-created, which supports neoliberal arguments blaming individuals for their lifestyles. Taken

together, this suggests that the ideology of individual responsibilisation, though pervasive, is not hegemonic.

As suggested in Chapter 4, if discourse is taken to be constitutive this means that it has the power to define problems (Fischer 2003); the problem of obesity can thus be understood as simultaneously constituted as predominantly socioenvironmental (explicitly) and individual (implicitly) in the HWS and OPAL documentation and interviews. The instances of dissonance summarised above can thus be seen as attempts to create new discourses, to challenge the ideology of neoliberal/individual responsibility by reframing responsibility as collective. This matters because, as Fischer (2003, p. 143) observes, 'when people who see the world differently act on their views, the world itself changes'.

In summary, in presenting obesity as a behavioural problem, three discourses were invoked in the policies and program to represent individuals as responsible for the problem and its solution: moral deficit, lifestyle and market choice. (The moral deficit discourse was mainly evident as a default background presence, unspoken but implicit in the framing of individuals as responsible for choices, the negative consequences of which reverberate beyond themselves; Broom 2008; Petersen 2003.) Conversely, when the policies and program presented obesity as a problem best solved by socioenvironmental means, individuals were represented as *not* responsible for unhealthy choices, as the socioenvironmental frame constructed the government, the not-for-profit, and the for-profit sectors as responsible for making healthier choices the easy ones. As explained in Chapter 3, in the socioenvironmental frame (and particularly in the structural variants of this), the behavioural discourses are critiqued and explanations proposed that identify features of the social, political, economic and physical environments as causal to the problem and pivotal to its solution. These two predominant frames — Lawrence's (2004, p. 57) ideologically 'opposing poles' — that focus attention and locate responsibility in opposing directions were frequently evident within the same policy and program beneath the discursive contestation.

Making sense of my observation

The two frames evident in the policies and program take into consideration a different range of causative factors. The behavioural frame narrows or restricts the range of factors identified as influencing weight or obesity, concentrating its focus on what the

individual does. In contrast, the socioenvironmental frame has, over time, expanded the range of possible causes from the immediate environment surrounding an individual and directly influencing their behaviour, to the distal and indirect causes — the social and structural determinants of health. Where this frame includes a conceptualisation of equity as inclusive, affecting everyone, such as in the gradient concept, I suggest it is easier to see inequity as a cause as well as an attribute of obesity. By making equity core to obesity, this could have the effect of making the socioenvironmental model less vulnerable to capture by individualist discourse; equity, being a relational concept, insists on a broader frame than does the individual behavioural frame.

In contrast, the narrowness of the behavioural frame, as observed and described in my analysis of the policies and program, relentlessly drives attention back on individuals and the choices they make about eating and physical activity. One of the interview respondents commented, however, on the evolution of the socioenvironmental framing of obesity, expressing hope in the changing policy and academic discourse that they saw as moving beyond individualist explanations.

How wide the net of cause and responsibility is cast is an ideological decision. For instance, the difference between the role played by inadequate fast-food marketing regulation and that played by the direct consumption of fast food in contributing to an obesity epidemic is their distance from (or proximity to) the consumer — that is, their visibility, which depends on the breadth of the frame in use. Social determinants evidence is excluded from all but the socioenvironmental frame, meaning that what precedes the final visible consumption 'choice' remains outside the picture or focus of policy. As I have described, this latter frame with a 'gradient' conceptualisation of equity is not dominant in the policies and program studied here.

A number of discursive practices that were identified in the findings as contributing to this narrowing effect and which reinforce each other will be outlined shortly. A narrow focus precludes the unequal distribution of obesity from being apparent, so that inequity is not included as an integral part of the *problem.* This means that solutions can deviate from their intended equitable effects as inequity is seen as a feature rather than driver of the problem of obesity. The overall effect was to give the ideology of individual responsibility a prominence that was surprising given the socioenvironmental framing of the documents and some of the interviews. It is important to remember that this

analysis applies only to the OPAL social marketing materials viewed on the website, and to some parts of the interviews with some workers. The discourse was in fact contested, and the following breakdown is offered as an attempt to understand how — if not why — individualist ideology had become as evident as it did.

- The effect of the focus on individual behaviour change in the social marketing documentation and its resonance in some of the interviews with some of the workers was that the relationships *between* individuals was less visible. This could draw the focus in both the policies and program away from the distribution of obesity, taking inequity out of focus, as inequity expresses the relative relationship between many individuals.
- Where the individual became foregrounded, the focus was on consumption, as production became peripheral. This was reinforced by the positivity discourse that was consistently invoked in both the policies and program, and which constructed products as potentially good and choice as inherently good; by implication, the consumer can easily be constructed as being at fault if they make the 'wrong' choice. The use of a social marketing strategy that implies people can operationalise health messages can reinforce this effect.
- By primarily seeing the individual, the focus was on outcomes of behaviours embodied in their person. This made behavioural interventions seem logical. This was evident in the way some of the workers and Advisory Committee members reflected on parenting practices leading to children becoming obese.
- This led to the goal of 'making healthy choices easy choices' at times apparently becoming about lifestyle choices rather than enabling environments, thereby legitimating social marketing as an appropriate intervention for OPAL, one of the 'flagships' of the Healthy Weight Strategy Priority Programs. Although evident in both policies and program, the lifestyle discourse was most evident in the program interviews and in the documentation where, for instance, despite supplementary information on the OPAL website acknowledging that taste and addiction drive children's food choices, the most visible aspect of the website — its social marketing messages — simply advise eating fresh food and drinking water. Underpinning this and countering the framing, however, are the changes to environments catalogued among the 4000 projects OPAL was involved with and which were not the focus of this study (M Williams 2013).

- Where the focus was on the individual, attention became concentrated on the final choices they made. This focus decontextualised those choices, enabling them to be constructed as ‘free’. By diverting attention away from factors that influenced the choices, concealing the commodified and consumptogenic environment, the focus on consumption and the consumer, not production and the producer, was reinforced. This made the individual the main source of risk, and thus the focus of its resolution, because in practice, risk-generating environments were often excluded from a field of vision that foregrounded the individual.
- Only the most proximal factors in environments remained visible; distal factors were often beyond the field of vision, whether as parts of the problem or in terms of potential solutions. This resulted in an effect of localism. This was most evident in the program documentation and interviews where the point of consumption — but rarely production — was problematised.

In brief, this narrowing of vision effectively decontextualised the individual, so that interventions that were socioenvironmental in their intended effect — as described in the policies and program documentation — were countered to some extent by this individualising, narrowing gaze. Most importantly for this study, by making the relationships between obese individuals invisible, this effect obscures inequity, making it more marginal to the problem of obesity. The final product in terms of the problematisation of obesity is thus imprinted by the individualist as well as the socioenvironmental explanation.

How individual responsibilisation is evident in the findings

Risk was identified in my study, in the EWBA Strategy and most markedly in the Be Active (BA) strategy, as a way of making a situation seem urgent so that action must be taken immediately, in this case by members of the public. Risk has been noted in the literature as a pathway by which people are being rendered responsible (McNaughton 2011), that is, as part of the process of individual responsibilisation (Ayo 2012). In BA, one of the contradictions that flowed from the invocation of the risk discourse is that the target of the policy document — members of the public — were simultaneously constructed as passive in comparison with the active role of the state, but needing to become heroically active, like the state, as described earlier. This contradictory

construction has been identified in the literature, with risk simultaneously constructing the target of action as passive and in need of management (Guthman & DuPuis 2005) but required to become active and agentic (Beck & Beck-Gernsheim 2002; Fieldhouse 2011; Petersen 2003).

This complex construction of the risky individual draws on the notion, described in Chapter 3, that Hoggett (2001) proposes of the reflexive, active individual underpinning neoliberal rationality. Hoggett (2001) highlights the gendered and classed nature of the concept of the reflexive self, drawing attention to women's typically multiple and conflicting roles in which their breadth of obligations means that every course of action lets somebody down, and this is what I found in my study. One of the OPAL Advisory Committee members related a situation in which the mother of an obese child is caught between the conflicting pressures of different family members. The respondent implied that parents' feelings need to be over-ridden for the sake of their child's health. Although they appeared aware that doing so was disempowering to the mother (they identified the mother's discomfort), the respondent did not reflect awareness of how this contradicted her expectation that parents need to be highly empowered or agentic to resist the 'hostile' external environment, and the highly challenging home environment, which they then described. What apparently misled the respondent was the decontextualisation of the mother's behaviour, the invisibility of what drove her to choose foods that apparently maintain her child's obesity. My study identifies how the discourse of reflexivity underpinning public policy exerts an immense moral weight on women, placing them in a state of permanent, imminent dilemma when faced with the need to exercise *choice*. Guthman and DuPuis (2005) identify how choice and consumption, and overconsumption, are linked under neoliberalism, inducing people to think that the exercise of choice equates to the exercise of freedom (see also Petersen 2003; Rose et al. 2006).

How the ideology of individual responsibility takes the focus off corporate responsibility

Since Milio's seminal work (1976, 1981), proponents of 'healthy by default' environments have sought to obviate the need for active choice, arguing that choice is far from free, being manipulated by marketing in the name of profit (Moodie et al. 2006). Hoggett's (2001) observation that choice implies the presence of an actor who is

independent of any social obligations or constraints, challenging the assumption that agency and choice automatically go together, supports what I found in my data. Specifically, this was where I noted the presence of an ‘invisible woman’ or ‘invisible mother’ implicit in the policy and program background, invisibly — and thanklessly — carrying out the various dictates of governmentality, on behalf of the state as well as her family.

Making healthy choices easier requires development of environments that are passively supportive of healthy weight, where healthy weight promoting options are materially embedded in their physical, organisational and structural elements, and are also actively supportive of healthy weight in that choosing such options has been made easier — through material as well as normative changes — than choosing the unhealthy alternatives. Under current circumstances, choosing healthy options requires active engagement of the individual with their environment (Dixon & Broom 2007; Swinburn & Egger 2010). Because material constraints on choices are excluded from behavioural discourses, people can be blamed for making ‘poor’ choices (Crawford 1980; Elliott & Lemert 2006). Choice thus becomes a vehicle for stigmatising (Broom 2008). Neoliberalism, with its emphasis on personal choice and, through this, responsibility, can legitimate the unequal outcomes and consequent inequalities that inevitably arise from the constrained choices available to people experiencing disadvantage (Harvey 2007). Once inequality is constructed as a choice, it can be written off as inevitable and, I argue, therefore not a ‘problem’ that the government has any logical obligation to fix (Ericson et al. 2000; Whitehead 1992).

As discussed (Chapter 2), a focus on the positive is an integral aspect of the health promotion frame (Nutbeam 1986); however, in OPAL the term seems to have been applied to products in the environment as well as behaviours of individuals. This is not necessarily aligned with the traditional use of the term. OPAL documentation clearly states that OPAL will not stigmatise or ‘demonise’ any food or factor related to weight (SA Department of Health 2010, p. 9). As described above, one of the OPAL social marketing themes was ‘Water, the original cool drink’ (SA Department of Health 2010, p.17). While documentation clearly advises that the aim is to replace soft drink consumption with water (not simply increase the consumption of water), which is supported by a strong evidence base, it also advises that no other drink should be

stigmatised as they all have a place when consumed in moderation, citing the 'Australian Guidelines for Healthy Eating' (SA Department of Health 2010, p. 21). One of the workers affirmed that the 'Water, the original cool drink' message was a non-stigmatising and positive way of decreasing consumption of sugar sweetened drinks. However, the message says nothing about decreasing soft drink consumption, as this would transgress the edict against stigmatising any product. It is not clear that the message, having been rendered this positive and non-stigmatising of any commercial product, can actually deliver its objective. One Advisory Committee member was especially critical of this practice, describing the general insistence on positivity as meaning that target groups might entirely miss the point of social marketing messages. Being required to say only positive things about all foodstuffs means that the market saturation of EDNP foods cannot be criticised which, by default, focuses attention away from production and from the relations of production that underpin the commercial sphere.

Applied indiscriminately, positivity can end up acting like blinkers, narrowing what can be viewed and obscuring that which cannot be influenced by positive action alone. This can result in underestimating the potency of forces that place the profitability of overconsumption above its negative effects on health. In policy terms, it would be possible to do everything right in framing the desired changes positively, and yet still fail to halt the rise of obesity as this approach has not curtailed the obesogenic force of profit-first capitalism, or the fact that where forces are in direct opposition to the changes desired by policy makers, that regulatory policy must have authority to restrain as well as 'enable' (for example, SA Department of Health 2010, p. 28). To do this is to collude at injustice by not impacting those forces — the social and structural determinants of health — that might help deliver equitable outcomes.

Quotes presented from workers in Chapter 7 show very clearly how emphasising the positivity of the environment — including the commercial environment — can lay blame for unwise or immoderate consumption at the feet of the individual after all. This contradicts the commitment stated elsewhere by workers and in OPAL documentation not to do so, but rather to follow a socio-ecological approach. This appears to be in line with what Labonte (1993) suggests is a way of individualising blame, and is also contrary to what the health promotion literature states worked with 'tobacco' in

replacing the focus on smoking or smokers (Frieden et al. 2010). I argue that the result of this focus is that corporations are left free to pursue profits while the government restructures the physical and organisational environment, and individuals practice ‘healthy choices’ in an unrelenting commercial environment. The benign approach to the commercial sector implied in this stance is at odds with evidence about the harmful impact on health of the marketing of EDNP products, especially at children (Hoek & Gendall, 2006; Wymer 2010; also see Stead et al. 2007), whereas the reality of providing healthy food choices requires a change in food production as well as in behaviours (Marmot 2010). The imperative to frame everything positively that is evident in OPAL documentation and some interviews is another vector for the individualising discourse, reinforcing its narrowing effect.

Localism was also identified in my study as another means by which the commercial sector is sequestered from scrutiny. The foreshortened view created by individual responsibilisation can result in a concentration on locally based interventions that do not challenge upstream drivers. The tendency to focus on proximal rather than distal factors has been noted above. There is a danger that the concentration of resources at the community, local government level where OPAL projects are located risks localising a problem that is actually driven by more upstream factors. Labonte (1993) suggests that focusing on the local can hide the fact that economic and social policies are mostly made at the national and even the transnational level, where local government lacks the authority to influence, and this is what may be happening here. Labonte (1993) cautions that devolving responsibility to the local level can be a neoliberal trick for shifting blame, and that the de facto decision-making authority that will fill the gap will be private economic interests.

While strategies like social marketing promote choice and thus can potentially promote individual responsibility for health and healthy weight, changes to environments and government regulation represent a collective response to the same problem. They do this by seeking to remove the need for individuals to choose wisely in order to enjoy good health or healthy weight. Minimising reliance on choice is likely to maximise the equitable distribution of health, as the constraints to healthy choices are experienced more by those who live on the economic or social margins. Epitomising this approach

and diametrically opposite to the neoliberal world of infinite choice is the concept of the ‘healthy by default’ environment.

Last century, Milio (1976, 1981) recognised that poorer populations suffered more of the negative effects of the industrially advanced way of life in the United States and fewer of the positive resources with which to counter these than did better-off populations. Her argument that if equitable health outcomes are to occur, public policy would have to intervene to equalise the risks that environments create, is made today by many researchers (Baum 2008; Friel & Broom 2007; Friel et al. 2007; Marmot 2007).

The underestimation of the potential burden represented by choice was apparent in the findings. The maxim that every product has a place, voiced by one of the OPAL workers, assumes that the overall playing field of daily life is healthy — a ‘neoliberal presumption’ (Harvey 2007, p. 68) — so that the consumption of any one particular item that is not healthy is immaterial against a diet consisting of 99% well-chosen, healthy items. This ignores the logic that, if *every* food choice, every day is chosen in the same physical and normative circumstances, with the same pressures and meanings, in the same environment of obligations, responsibilities and needs, then this assumption is unjustified. Whereas our gaze is continually being directed narrowly, policy makers need to look at the whole, broad picture — the sum total of a lifetime of food ‘choices’.

As it stands, people who experience disadvantage and a disproportionate burden of ill health also experience a disproportionate burden of choice-making. A wealthy person need not think hard about buying fresh, healthy (and expensive) food — their wealth cushions them from the repercussions of a poor choice, as they can simply go and buy something else. In contrast, a person on a low income has to weigh up myriad factors as a poor choice could mean a family goes hungry as well as undernourished. When such decision-making is repeated at every juncture of life, the disproportion burden is significant. Making environments healthy by default can thus be framed as simply rebalancing this burden more equitably.

8.6 How this framing is likely to affect health equity

This thesis will now draw these arguments together to directly address the final Research Question: *To what extent is the aim of achieving health equity embedded within the ideologies evident in the policies and program?* The ideologies identified in

the solution represented by the healthy weight policies studied and OPAL program will be examined in order to determine how equity is represented in them. Scholarly literature will be drawn on during such discussion.

8.6.1 How health equity is represented in the discourses and ideologies identified in my data

My analysis shows that there is an explicit commitment to equity in the policies and program. However, despite the overt socioenvironmental framing of the solutions represented by the policies, responsibility for healthy weight has been demonstrated to be sometimes implicitly constructed as positioned with the individual.

In OPAL documentation too, addressing equity issues is an integral part of OPAL's vision and planning and underpins the location of OPAL projects, as described in my analysis. However, in practice, in terms of OPAL and the broader 'making healthy choices easy choices' frame, my analysis, informed by the literature, suggests that the result is only likely to impact positively on health equity if substantial material changes to local environments are achieved in the disadvantaged communities in which OPAL projects are located. Where social marketing is implemented without material change, the effect on equity is likely to be negative because those with sufficient agency are the most likely to respond. An incongruence is evident between the two components of OPAL that target changing environments to make them healthier (the community-based component), and encouraging people to make healthier choices (the social marketing component). The former is underpinned by a socioenvironmental frame that recognises material conditions influence health and health promoting — and healthy weight-promoting — behaviours. The latter is influenced by a behavioural frame, drawing on lifestyle and market choice discourses that decontextualise choices from the conditions that influence them, and is rooted in the ideology of individual responsibility. As the discussion has argued, equity is a casualty rather than a goal of this ideology. Social marketing, as described here, has been identified in my analysis as a prime example of an intervention premised on the ideology of individual responsibilisation; its prominence in OPAL therefore seems unlikely to help deliver OPAL's goal of reducing obesity in an equitable way.

8.6.2 Comparison between the representation of health equity in my data and in the literature

Taking a socioenvironmental perspective, the *Obesity and inequities* (Loring & Robertson 2014) report to the WHO specifically focusing on addressing inequities in obesity emphasises that solutions need to alter the unequal impact of the social determinants of health. This includes those that impact directly on obesity such as food pricing and availability, and those that have a more global effect such as income support. OPAL's location in local government means it is potentially able to address some of the intermediate factors through which the determinants of health influence communities. These include factors such as local access to fresh food and the availability of healthy food alternatives in public entertainment venues, and interview respondents reflected their involvement with such interventions. However, as one advisor observed, OPAL is clearly not positioned to influence things like food composition or cost, which directly influence obesity, nor the more distal drivers such as adequate income, which create the inequities that in turn lead to a heightened risk of obesity. While the policies comprising the HWS are also, on the whole, not positioned to influence these drivers, they are better positioned, as one advisor said, to influence the intermediate environment, with their policies promoting healthy food in workplaces and in children's services and schools, for example. Building on the findings of this research, three suggestions will now be outlined that could help meet the goal of increasing the proportion of South Australians with healthy weight in an equitable manner.

A more equity-centred paradigm

The obesogenic environment model has helped reframe obesity from a medical to a public health problem (Bacchi 2009) by using the socioenvironmental frame of health promotion. I suggest that augmenting the current obesity-centred paradigm with an equity-centred focus might support the socioenvironmental framing of obesity, providing a counterpoint to the individualising of responsibility, which is an ideological pillar of neoliberal capitalism. Equity was identified in both the policies and program as primarily conceptualised as consisting of specific disadvantaged groups. This can inadvertently result in blaming individuals who 'have' the problem as being responsible for their own disadvantage. In contrast, viewing equity as distributed along a gradient and thus affecting everyone problematises the whole system and social relations of

production, making it harder to individualise responsibility and blame. I suggest that inclusion of this view of equity as a core element in the obesogenic environment model would be a useful next step. Such a focus on equity insistently highlights the wider picture, which might help maintain the broad focus of the socioenvironmental perspective, in opposition to the narrowing effect of the background individualist paradigm.

An environment that is healthy weight-promoting by default

For the Healthy Weight Strategy's and OPAL's goal of making 'healthy choices, easy choices' to become a reality for all people requires the structural factors producing unequal risks and 'choice-making' opportunities to be addressed by policy, both public and corporate (Milio 1976; Swinburn 2009). The likelihood of the HWS and OPAL achieving equitable gains in healthy weight thus depends on how far they are able to make environments passively supportive of the behaviours that promote healthy weight - healthy weight-promoting by default - and how far such behaviours remain dependent on the active exercise of choice. With a local program of OPAL's nature, much of this is beyond its control. As the issue of junk food advertising also illustrated, regulatory changes may also be beyond the scope of the HWS despite its location at the state rather than local government level, as responsibility for it still resides with the Department of Health. However, other policy options drawing on the expertise and power of non-health departments are possible, and will now be described.

Equity-centred policy

As described in Chapter 2, the goal of making the default environment less obesogenic is being acted on around OPAL and the HWS as well as through them, in the form of South Australia's 'healthy public policy' approach of Health in All Policies (HiAP) — which casts a health lens across other departments — and the joined-up governance of the SA Strategic Plan (SASP).

SA's Strategic Plan (Government of SA, 2007a), which provides a framework for the integrated involvement of SA government, business and community, has a number of targets which could affect health inequity, in addition to the Healthy Weight Target (HWT) , including improving the wellbeing of groups which currently experience high

levels of obesity and obesity-related ill-health; for example, there are targets for increasing Aboriginal employment, life expectancy and leadership.

The ‘SA Health in All Policies Healthy Weight Project’ identified opportunities for non-health departments to help address the HWT and the ‘social determinants of obesity’, while meeting their own goals, and making policy commitments that became part of the 2011–2106 iteration of the *Eat Well Be Active Healthy Weight Strategy* (Newman et al. 2014, p. 4; SA Department of Health 2011). This is thus a concrete and feasible way forward, despite — or perhaps because of — the virtual dissolution of health promotion in SA following the McCann Review (McCann 2012).

The approach to healthy public policy represented by the SASP and HiAP commitments in SA are also part of a larger global movement promoting equity in health by addressing determinants of health, which are the responsibility of the non-health sector (Kickbusch et al. 2008). The work of the Commission on Social Determinants of Health (2008) represents an alternative ideological perspective to neoliberalist individualism, highlighting the necessity of addressing the structural factors that create health inequity. This vision is evident in the current health policy framework for Europe, *Health 2020: the European policy for health and well-being* (WHO Regional Office for Europe 2015) that aims to reduce health inequalities. In the field of obesity, the perspective reflected in WHO documents has become increasingly socioenvironmental in the past decade (WHO 2004; 2009; 2012a; 2012b), and this perspective is also evident in the policy brief on tackling health inequity while addressing the ‘public health challenge’ of obesity prepared for the WHO in collaboration with the European Union (Loring & Robertson 2014, p. v).

The SASP and a HiAP approach (as mentioned on page 40, and the latter of which has expanded further — SA Department of Health 2011 — since the work undertaken for this thesis) amount to embedding the most upstream facets of obesity policy within a broader, comprehensive commitment to making the social determinants of health (and hence also of obesity) more equitable in their impact. Evidence suggests that this would improve a range of health indicators, obesity among them. Such a re-visioning could deliver much more than healthy weight, while also possibly being our best bet for delivering healthy weight in SA’s current political climate.

8.7 Insights for public health

In order to gain insights for increasing healthy weight equitably, this study explored how the problem of obesity was ideologically framed in the some of the policies and one of the programs – OPAL - addressing the Healthy Weight Target set in South Australia's Strategic Plan (2007). After analysing documents and interviewing program respondents, it was found that, although responsibility for causing the 'obesity problem' was rarely framed as lying with individuals, responsibility for solving the problem sometimes was, reflecting dominant neoliberal ideology.

As argued in this thesis, the ideology of individual responsibility is integral in justifying the logic of the operation of neoliberal capitalism. The fact of its (unconscious) presence in these findings is therefore perhaps less surprising than the degree to which it is challenged, which is in itself a cause for optimism and which supports Gramsci's theorising that hegemony is both culturally pervasive and simultaneously resisted. These findings also reinforce the importance of including an examination of ideology when analysing policy as, while less visible than other factors, the influence it exerts was seen to still be significant.

This was perhaps most evident in the 'blinkering' effect which was an insight from my research. It will be discussed here as it is relevant to the current policy context. I posited that a strictly positive perspective can narrow one's field of vision, meaning that problems may not be 'named' and only the most proximal influences observed. This means that all relevant influences might not be identified, which can imperil the success of an intervention if there are distal factors exerting pressure in the opposite direction. An example of this was the way that consumption was extensively problematised in my analysis, but production only occasionally. The blinkering effect can mean that individuals may end up bearing a greater share of responsibility for addressing the problem than distal players. This was illustrated in my study regarding the quarantining of the commercial sector from responsibility for contributing to the solution of a problem that the evidence overwhelmingly suggests it helped create. Evidence suggests that making healthy choices easy requires changes in production as well as consumption, meaning that responsibility needs to be shared between individuals and the commercial sector (Marmot 2010). This is recognised in the current EWBA policy (SA Department of Health 2011), which identifies the need for the

greater involvement of the private sector, including the food industry and the need for changes in processed food production as a necessary change to support healthy eating (EWBA 2011, pp. 9, 22). The current iteration of EWBA (2011, p. 9) also maintains the commitment to positivity.

My identification of the quarantining of commercial producers through positivity and through the narrowing effect of underlying individualist discourse reinforces the difficulty of this task. By examining the ideological level that lies beneath and around policy, my study contributes to explanations for why the commercial sector continues to be protected from accountability for its role in the 'obesity problem', and may thus support actions to challenge such 'immunity' (Fischer 2003, p. 66).

8.8 Strengths, limitations, and suggestions for further research

This study has a number of strengths. The focus of the research — how the ideologies that underpin the way healthy weight are addressed in policy are likely to influence equity — is somewhat unusual both in its specificity and in the combination of these areas of research. While several studies have considered the unequal distribution of obesity, and some scholars have considered how ideology may influence the causes of obesity, my literature searches revealed none that considered how ideology influenced the solutions to obesity that were proposed in the form of policies. While it is probably not uncommon for equity-focused researchers to look into ideology, as the link is well established, my literature search revealed that it is less common to do this at specific healthy weight policy and program level; specifically, to look at ideology at the ground level in the way that the practice of a policy and program is experienced by those involved with its delivery. This study thus fills a gap in scholarship in this field. It is important that it does so, as inequities in health remain significant despite having been the focus of international attention for some years (CSDH 2008), and because evidence suggests that inequalities in the distribution of healthy weight are increasing.

Another strength is the research design that I developed, modifying and applying the 'What's the Problem Represented to be?' (Bacchi 2009) methodology to interrogate data from two documentary (policy and program) and two interview (workers and Advisory Committee members) sources, and also using two forms of coding, allowing rich comparisons to be made and strengthening the dependability of my findings. The

practice of viewing policy problems as *problematisations,* that is, deliberate constructions with implied causes and solutions, and implications regarding responsibility, seems an extremely useful and practical tool to bring to policy analysis. A further strength was my adherence to high levels of research rigour, manifested through a constant critical appraisal of my fieldwork, analysis and findings. I also shared my analysis with my supervisors to gain better insight into my own interpretations. Finally, I was mindful of practising reflexivity, which Popay et al. (1998) suggest as a defining feature of rigorous qualitative research.

It is important to acknowledge that this study took place in the beginning stages of OPAL's implementation and, given OPAL's commitment to comprehensive and ongoing evaluation, it is reasonable to suppose that the insights and learnings that were related to me by workers would have informed their later practices. Although OPAL has not reached every disadvantaged community in South Australia, it has implemented over 4000 individual community-based projects in the past five years, effecting myriad changes to the local environments of these communities (M Williams 2013, p. 38). OPAL will conclude in 2017 as planned when the last OPAL site will have completed its five years, though in a reduced format due to loss of federal funding (SA Department of Health website 2015, OPAL, accessed 15 March 2015).

Based on this experience, a more open-ended research design where I had started data collection and analysis and then gone back into the field to interview more respondents may have yielded further insights. Although a variety of views were expressed by the different workers and Advisory Committee members, the similarities between each group were greater than the differences. I would also have liked to have revisited OPAL in its maturity. Due to the inclusion of a program document analysis, the community-based element of OPAL was less visible than its social marketing arm. Although I made every attempt to account for this in my analysis, it was only with time that I realised how significant this was. In hindsight, I would have spent time in the field with workers, and asked to do an audit of their community work documentation (as I have done in other programs), which I suspect would have provided a more holistic perspective.

I would also like to have done follow-up interviews with OPAL practitioners, exploring my finding of contested discourses, as I think this would have both surprised and

interested them. I would also have liked to learn more about the 4000 projects OPAL had a hand in during what will be its eight-year history.

The group I would most like to have met and interviewed are the members of the communities in which OPAL was working. More interviews would have strengthened the credibility of my data and added another dimension to the analysis. Most of all, I would like to have spoken to members of the Aboriginal communities with whom OPAL was working, such as described in the children's centre vignette. First-hand stories of their experience of OPAL's social marketing and community capacity building approach — the *solution* to the *problem* — and comparison of their identification of the 'problem' and the policy and program's representation of it, would have deepened my analysis.

Beyond this, further research to ascertain people's experience of interventions that aim to make healthy choices easier would be beneficial to policymaking. My analysis of the perniciousness of the ideology of individual responsibilisation behind SA's Healthy Weight Strategy and the OPAL program suggests that individuals can unintentionally be, and feel, responsible for solutions to a problem that is socioenvironmental in origin. It would be helpful to know, and I think very valuable, whether their choices have in practice been made easier, if this has this reduced their weight, and their self-perceived health and wellbeing.

Finally, after reviewing the current state of healthy weight policy for this final chapter, I would especially like the opportunity to update my research, analysing the current EWBA strategy and future directions of healthy weight promotion in South Australia.

8.9 Conclusion

This thesis identified the ideologies and discourses underpinning policies comprising South Australia's Healthy Weight Strategy (SA Department of Health 2006a) and one of the community programs and its practice, and the extent to which the aim of achieving health equity was embedded within these ideologies. The aim of this research was to gain insights into how the problem of obesity might best be addressed to make the bigger improvements in those populations currently bearing the greater burden of ill health.

The contribution of this research to state governments addressing healthy weight in the current policy climate will now be considered. Based on the findings of this study, and building on the equity-centred suggestions outlined previously, the three recommendations regarding healthy weight policy that I would make and which are of most relevance to the current policy context are: embedding healthy weight in policies beyond the health sector; materially supporting individuals to make healthy weight enhancing changes; and prioritising organisational and environmental level changes. These will now be considered in turn.

8.9.1 Embedding healthy weight in policies beyond the health sector

An overview of current healthy weight promotion in SA will show that the first recommendation in fact reflects the direction taken by the current government. Over the duration of this study a number of changes to policies influencing healthy weight have occurred. While EWBA (SA Department of Health 2011) still spearheads the promotion of healthy weight in South Australia, it will expire in 2016, and in 2017 the last OPAL projects will complete their five-year missions (SA Department of Health website 2015, OPAL, accessed 15 March 2015). The introduction of the overarching SA Public Health Act 2011 and the attendant State Public Health Plan 2013 (SA Department for Health and Ageing 2013) means that responsibility for healthy weight has been devolved, to a great , upon local government (SA Department for Health and Ageing 2013, p.5). The HiAP approach and the 30-Year Plan for Greater Adelaide (SA Department of Planning and Local Government 2010) are also identified as vehicles for promoting health through the non-health sector, in keeping with a social determinants of health approach (SA Department of Health 2011).

8.9.2 Materially supporting individuals to make healthy weight enhancing changes

Making healthy choices easier remains a focus of current policy (EWBA 2011). My study found that the neoliberal ideology of individual responsibility was both pervasive and pernicious, and was apparent in some of the assumptions about individual agency which some respondents revealed when reflecting on choice. If the degree to which the exercise of choice can be constrained by circumstances is not acknowledged it can be experienced more as an imposition than as empowerment. The provision of material

support to alleviate some constraints would serve as recognition of this and might mitigate against the inequitable potential of behavioural change interventions.

8.9.3 Prioritising organisational and environmental level changes

While in the past few years OPAL and EWBA (2011) both contributed to the development of organisational policies promoting healthy eating in the workplace and in fundraising in local government, their work with private organisations is more embryonic. While EWBA (2011) reflects recognition of vested interests potentially undermining the cooperation of the processed food sector, opposition from the food industry is strong, as evidenced by the recent failed attempt at the national level to alter the food environment by introducing front-of-pack labelling: the food industry won a two-year self-regulation trial (Australian Government, Department of Health website 2015, accessed 29 June 2015).

EWBA (2011) is also about to finish, meaning that South Australia will lack a specific focus and policy driving healthy weight. Given the weight of industry pushing against regulation, and the potency and reach of individualist ideology which my research reflected supports it, this is not positive in terms of the likely impact on equity. More optimistic for the aim of achieving health equity is the endurance of HiAP, which has scope for addressing some of the social determinants of obesity; amidst other cuts it remains, and remains the best hope for delivering equitable improvements in healthy weight across the South Australian population.

Appendix A: National diet and physical activity guidelines and strategies

Bauman, A, Bellew, B, Vita, P, Brown, W & Owen, N, 2002, *Getting Australia active: towards better practice for the promotion of physical activity*, National Public Health Partnership, Melbourne, Australia.

Commonwealth of Australia 1998, *Australian guide to healthy eating,* Department of Health and Family Services, Canberra.

Commonwealth of Australia 2004a, *Australia's physical activity recommendations for 5–12-year-olds*, Department of Health and Ageing, Canberra.

Commonwealth of Australia 2004b, *Australia's Physical Activity Recommendations for 12-18 year olds*, Department of Health and Ageing, Canberra.

Commonwealth of Australia 2006, *A national chronic disease strategy*, Department of Health and Ageing, National Health Priority Action Council, Canberra.

Commonwealth of Australia, 2013, *Eat for health: Australian dietary guidelines 2013,* Department of Health and Ageing and NHMRC, Canberra.

Commonwealth of Australia 2003a, *Australian dietary guidelines for children and adolescents in Australia, incorporating the infant feeding guidelines for health workers,* National Health & Medical Research Council, Canberra.

Commonwealth of Australia, National Health & Medical Research Council 2003b, *Dietary guidelines for Australian adults,* Canberra

Commonwealth of Australia, National Health & Medical Research Council 2003c, *Clinical practice guidelines for the management of overweight and obesity in adults,* Canberra.

National Public Health Partnership 2005, *Be active Australia: a framework for health sector action for physical activity 2005–2010,* Canberra.

Strategic Inter-Government Nutrition Alliance 2001, *National Aboriginal and Torres Strait Islander nutrition strategy and action plan 2000–2010,* National Public Health Partnership, Canberra.

Strategic Inter-Governmental Nutrition Alliance 2011, *Eat well Australia: an agenda for action for public health nutrition 2000–2010,* National Public Health Partnership, Canberra.

Appendix B: WPR template for healthy weight analysis applied to EWBA

The following template demonstrates how the WPR ('What's the problem represented to be?' Bacchi 2009) approach was followed to facilitate discourse analysis of documents and interviews. The material analysed here is from EWBA (Eat Well Be Active Healthy Weight Strategy for SA) Section 3, 'Box 3: Influences that affect weight', 'Food Supply' setting (SA Department of Health 2006a, p. 10).

WPR EWBA, Section 3, Box 3, p.10; Food Supply setting **CONTEXT**: 'There are a myriad of [sic] influences, both positive and negative, that affect weight. These influences are social, cultural, environmental, economic and ecological. For the purposes of this Strategy these influences are described as they relate to the "settings" in the Strategic Directions for action, outlined in Section 4 (see page 11), and include … Neighbourhoods and Communities … **Food Supply** … Schools, Preschools and Childcare … Maternal and Child Health … Primary Health Care … Workplace … Media and Marketing…'. **TEXT FOR ANALYSIS:** 'Food regulations and pricing policies • Food procurement policies and practices • Food availability and access to healthy foods, including locally grown foods • Costs of food • Ready availability of energy dense, low nutritional value foods • Promotion of fast and pre-packaged foods • Food safety'
Q1: What's the dominant problematisation in this section of the document? That there are many influences on food choice, including the food supply, i.e. that the food supply influences healthy eating (food choices) and by implication, healthy weight.
Q2: What are the underlying assumptions, logic? That these aspects influence food choices, i.e. availability of healthy vs unhealthy (EDNP) food; cost; ENDP food marketing. That food can be regulated, and this will be effective. That government has a role here. That altering these influences will improve people's diets and thus their weight. That food choices are rational, and that their drivers can be logically and methodically addressed by policy.
Q3: How did this come about? Pretty social view of health — influenced by SA's strong tradition/history of health promotion.

Q4: What remains unproblematised? What is missing? Who is silent? What is missing? More distal influences on the food supply: the production side of food — ownership, distribution, subsidising of crops (and reverse), trade agreements, profit element and its contrary direction to some of the items that are listed, i.e. all the big picture stuff. Also its interaction with households and the food purchaser and preparer in particular — convenience is up-side of presence of fast-food outlets; if these are removed, what will be the impact on children's nutrition, for instance? Other reasons for food choices, like taste, family preferences, culture — emotion… So, two areas missing: economic systemic picture and this 'family facilitator' picture.
Q5: What effects are produced; what are the implications (and for whom) of this problematisation in this policy? What is changed and what stays the same? How is power distributed? (Who wins/loses?) What are the subjectifications? Who is responsible for solving the problem? Who is blamed? Increase in undernourishment? For the policy areas listed to have a positive impact, need to have understanding of barriers at household level in terms of constraints on time etc., as well as 'food culture' or 'family values' identified earlier. Upstream issues are explicitly itemised, which gives the feeling that these are being addressed, whereas in reality the government may not have power or political will to do so, e.g. the EDNP food marketing (they would but can't) or profit (could but won't), so nothing necessarily changes. The government constructs itself as explicitly responsible, but the shadow of 'invisible woman/mother' is always there, making the final selections for her family. The result is continued but hidden focus on downstream issues.
Q6: How and where is this problematisation produced and spread? In policies like this, though probably not read much by public. In food regulation, e.g. food safety. This latter, though very good on one level as far as helping ensure safe food, can have a hidden impact, again on the invisible food preparer — e.g., must now get a local Council Food Handling certificate to cook for anyone (even if it's just the family members you normally cook for) in a council-owned facility like a camp. (No doubt an unintended effect but real all the same.)
Q7: How is the 'problem' framed? **a. Is the problem of obesity related ill health framed as a biomedical, behavioural or socioenvironmental problem?** **b. Is the problem of obesity related ill health framed as curative or preventive?** **c. Is the prevention framed as biomedical, behavioural or socioenvironmental?** **d. Is this framed as the responsibility of the individual or socioenvironment?** a. Explicitly socioenvironmental–behavioural frame implicit; b. Preventive; c. socioenvironmental; d.socioenvironmental.
Q8: Is equity a consideration? How is it represented? Inherent or added on? Does the resulting policy present an upstream, midstream or downstream approach to the 'problem'? Yes. It is represented through the identification of 'food supply' including a 'pricing policy; the identification of availability and access to healthy and unhealthy foods, costs, and promotion of EDNP food' all indicate that equity is embedded in understanding of healthy weight. These factors have clear impact on equity, and are listed near the top of the seven settings listed in detail here. Upstream.

Appendix C: Policies related to the Healthy Weight Target

National policies and documents of relevance to this thesis were outlined in Appendix A. The following list comprises South Australian and national polices relevant to the Healthy Weight Target and to equity in health. Policies listed below were sourced largely from the grey literature, from government websites and from the policies referenced therein. The resulting list below consists of 50 policies, and was reviewed by key informants for comprehensiveness. (More than 125 policies were initially surveyed, but many have become unobtainable in the years since this study commenced and have been omitted.)

Core policies

Government of South Australia 2004, *Ministerial physical activity forum, be active physical activity strategy 2004–2008,* Adelaide, Australia.

Government of South Australia 2009, *Eat well be active healthy weight strategy for South Australia 2006–2010: priorities* as at November 2009, SA Health, Adelaide, Australia.

South Australian Department of Health 2006a, *Eat well be active healthy weight strategy for South Australia 2006–2010,* Government of South Australia, Adelaide, Australia.

South Australian Department of Health 2006c, *Eat well South Australia: public health nutrition plan 2006–2008*, Government of South Australia, Adelaide, Australia.

Policies supporting core policies

South Australian Department of Health 2004, *Eat well South Australia public health nutrition action plan 2004–2008*, Government of South Australia, Adelaide, Australia.

South Australian Department of Health 2006b, *Eat well be active healthy weight strategy for South Australia 2006–2010*: Summary, Government of South Australia, Adelaide, Australia.

South Australian Department of Health 2006d, *Eat well South Australia priorities 2006-2007 summary*, Government of South Australia, Adelaide, Australia.

Documents and policies referenced in core policies

Government of South Australia 2005, *Physical activity in South Australian adults 2004*, Physical Activity Council and the Physical Activity Council Research Panel, Adelaide, Australia

Government of South Australia 2007, *South Australian Food Plan 2007–2010*, Premier's Food Council Executive, Adelaide, Australia, Primary Industries and Resources SA, Adelaide, Australia

Government of South Australia 2007, *South Australia's strategic plan.* Department of the Premier and Cabinet, Adelaide, Australia, viewed 12 February 2015, <http://saplan.org.au/media/BAhbBlsHOgZmSSIhMjAxMS8wOS8wNy8wM181OF80M18xMDBfZmlsZQY6BkVU/03_58_43_100_file>

Government of South Australia 2008, *Right bite healthy food and drink supply strategy for South Australian schools and preschools,* Department of Education and Children's Services, Adelaide, Australia.

South Australian Department of Health 2008b, *Eat well be active television advertising and the consumption of unhealthy food and drinks by children*, Consultation Paper, August, Department of Health, Adelaide, Australia.

South Australian Department of Health 2008c, *Go for 2 & 5 fruit and vegetable campaign information bulletin*, South Australian Fruit & Vegetable Coalition, Adelaide, Australia

Parliamentary inquiries

Of particular relevance are the following:

Commonwealth of Australia 2009a, House of Representatives Inquiry into Obesity, *Weighing it up–report on obesity in Australia,* House of Representatives Standing Committee on Health and Ageing, May 2009, Canberra

Government of South Australia 2004, Social Development Committee Inquiry into Obesity, *Nineteenth report of the Social Development Committee*, May 2004.

Government of South Australia 2007, Social Development Committee Inquiry into Fast Foods and Obesity, *Twenty-fifth report of the Social Development Committee*, March 2007.

Government of South Australia 2008, *Submission to the House of Representatives Standing Committee on Health and Ageing's Inquiry into Obesity*, May 2008, Adelaide, Australia.

Government of South Australia, Department of Health, and the Across-Government Healthy Weight Taskforce 2009, *Eat well be active: measuring our success progress report on: The Social Development Committee's Inquiry into Obesity—reported to Parliament May 2004; Fast food and obesity inquiry—reported to Parliament March 2007; and Eat well be active healthy weight strategy for South Australia 2006–2010*, Adelaide, Australia, viewed 13 February 2015, <http://www.sahealth.sa.gov.au/wps/wcm/connect/05a06f80465f0429868afe2e504170d4/SDC+2011+FINAL-+HPB-02-03-2011.pdf?MOD=AJPERES&CACHEID=05a06f80465f0429868afe2e504170d4>

Relevant state plans

Government of South Australia 2004, *South Australia's strategic plan*, Department of the Premier and Cabinet, Adelaide, Australia, viewed 12 February 2015, <http://saplan.org.au/media/BAhbBlsHOgZmSSIhMjAxMS8wOS8yOC8yMV8yNF8zOF83OTlfZmlsZQY6BkVU/21_24_38_799_file>

Government of South Australia 2006, South Australia's Strategic Plan Audit Committee, *South Australia's strategic plan progress report 2006,* Adelaide, Australia.

Government of South Australia 2007b, *South Australia's strategic plan: summary of targets,* Department of the Premier and Cabinet, Adelaide, Australia, viewed 12 February 2015, <http://saplan.org.au/media/BAhbBlsHOgZmSSIhMjAxMS8wOS8wNy8wNF8wMF8yN185NjRfZmlsZQY6BkVU/04_00_27_964_file>

Government of South Australia 2007c, *South Australia's health care plan 2007–2016,* SA Health, viewed 6 February 2015, <http://www.sahealth.sa.gov.au/wps/wcm/connect/Public+Content/SA+Health+Internet/Health+reform/South+Australias+Health+Care+Plan/>

Government of South Australia 2007d, *SA strategic plan target fact sheets 2.2*, Department of the Premier and Cabinet, viewed 6 February 2015, <http://saplan.org.au/fact_sheets/178>

Government of South Australia 2007e, South Australia's strategic plan … *through a health lens,* Department of the Premier and Cabinet, Adelaide, Australia, viewed 12 February 2015, <http://www.health.gov.au/internet/nhhrc/publishing.nsf/Content/458/$FILE/458%20-%20O%20-%20SA%20Health%20-%20SASP%20...through%20a%20health%20lens.pdf>

Government of South Australia 2008, South Australia's Strategic Plan Audit Committee, *South Australia's strategic plan progress report 2008*, Adelaide, Australia.

Government of South Australia 2011a, *South Australia's Strategic Plan*, Department of the Premier and Cabinet, Adelaide, Australia, viewed 31 December 2014, <http://saplan.org.au/media/BAhbBlsHOgZmSSIhMjAxMS8xMS8wNC8wMV8wMl8xNF8yMjNfZmlsZQY6BkVU/01_02_14_223_file>

Hensgen, S 2009, *Planning for health: a study on the integration of health and planning in South Australia, Report for SA Health*, viewed 12 February 2015, <http://www.upv.es/contenidos/CAMUNISO/info/U0559149.pdf>

South Australian Department of Health 2007, *SA Health Public Health Directorate Strategic Plan 2007–2009*, Adelaide, Australia, viewed 12 February 2015, <http://www.health.sa.gov.au/pehs/publications/07-public-hlth-strat-plan.pdf>

South Australian Department of Health 2008a, *SA Health strategic plan 2008–2010, extended to 2014,* Adelaide, Australia, viewed 12 February 2015, <http://www.sahealth.sa.gov.au/wps/wcm/connect/a1b9198042602f06b8debeb44d317729/Strategic_Plan_Revised2_2013.pdf?MOD=AJPERES&CACHEID=a1b9198042602f06b8debeb44d317729>

South Australian Department of Health, 2008c, *SA Health strategic plan summary 2008–2010* Adelaide, Australia, viewed 12 February 2015, <http://www.sahealth.sa.gov.au/wps/wcm/connect/69314c004852c756b855fc7675638bd8/2008-10-strategic-plan-summary.pdf?MOD=AJPERES&CACHEID=69314c004852c756b855fc7675638bd8>

South Australian Department of Health, 2009 *SA strategic plan: health equity actions*, viewed March 2011, <http://www.sahealth.sa.gov.au/wps/wcm/connect/public+content/sa+health+internet/about+us/about+sa+health/state+strategic+plan/strategic+plan+health+equity+actions>

South Australian Department of Health 2009, *Chronic disease action plan for South Australia 2009–2018,* Adelaide, South Australia, viewed 12 February 2015, <http://www.ibrarian.net/navon/paper/Chronic_Disease_Action_Plan_for_South_Australia.pdf?paperid=15276309>

Other relevant policies and documents

Centre for Health Equity Training, Research and Evaluation 2008, *Equity focused HIA* [Health Impact Assessment] *report*: *South Australian ABHI* [Australian Better Health Initiative] *school and community initiatives*, University of New South Wales, Sydney, Australia, viewed 13 February 2015, <http://hiaconnect.edu.au/wp-content/uploads/2013/04/SA_EFHIA_of_ABHI.pdf>

Commonwealth of Australia 2003, *Healthy weight 2008: Australia's future—the national action agenda for children and young people and their families*, National Obesity Taskforce, Department of Health and Ageing, Canberra.

Commonwealth of Australia 2006, *Healthy weight for adults and older Australians: A national action agenda to address overweight and obesity in adults and older Australians 2006–2010*, Department of Health and Ageing, Canberra.

Commonwealth of Australia 2008, *Australia: the healthiest country by 2020, A discussion paper*, prepared for the National Preventative Health Taskforce, Canberra.

Commonwealth of Australia 2009b, *Australia: the healthiest country by 2020, technical report 1, obesity in Australia: a need for urgent action*, prepared for the National Preventative Health Taskforce by the Obesity Working Group, Canberra.

Commonwealth of Australia 2009c, *Australia: the healthiest country by 2020, national preventative health strategy—the roadmap for action*, prepared for the National Preventative Health Taskforce, Canberra.

Commonwealth of Australia 2011, *Department of Health, National Obesity Taskforce Membership*, [website last updated 4 July 2011], viewed 13 February 2015, <http://www.health.gov.au/internet/publications/publishing.nsf/Content/healthy-weight-2008~healthy-weight-2008-notm>

Council of Australian Governments 2006, *Better health for all Australians action plan*, Canberra, viewed 13 February 2015, <http://archive.coag.gov.au/coag_meeting_outcomes/2006-02-10/docs/attachment_d_better_health.pdf>

Council of Australian Governments 2010, *National partnership agreement on preventive health, attachment 1: implementation plan for the healthy children initiative*, OPAL, South Australia, viewed 2 March 2015, <http://www.federalfinancialrelations.gov.au/content/npa/health_preventive/healthy_children/SA_IP_2013.pdf>

Council of Australian Governments 2010, *Implementation plan for social marketing: measure up,* South Australia, viewed 2 March 2015, <http://www.federalfinancialrelations.gov.au/content/npa/health_preventive/social_marketing/SA_IP.pdf>

Government of South Australia 2004, *Eat well SA schools and preschools healthy eating guidelines*, Department of Education and Children's Services, Adelaide, Australia.

Government of South Australia 2010, *South Australian food strategy 2010–2015*, Premier's Food Council Executive, Adelaide, Australia.

Government of South Australia 2011b, *Measuring our success: progress report two on: the Social Development Committee's Inquiry into obesity* (reported to Parliament May 2004) and the *Fast food and obesity inquiry* (reported to Parliament March 2007); and *Eat well be active healthy weight strategy for South Australia 2006–2010,* viewed 10 January 2015, <http://www.health.sa.gov.au/pehs/branches/health-promotion/measuringoursuccess-pehs-sahealth-090923.pdf>

Kickbusch, I 2008, *Healthy societies: addressing 21st century health challenges*, Government of South Australia, Department of the Premier and Cabinet, Adelaide, Australia, viewed 12 February 2015, <http://www.thinkers.sa.gov.au/lib/pdf/Kickbusch_Final_Report.pdf>

Menadue, J, Chair of South Australian Generational Health Review 2003, *Better choices better health, final report of the South Australian Generational Health Review* April 2003, Government of South Australia, Adelaide, Australia, viewed 13 February 2015, <http://www.sahealth.sa.gov.au/wps/wcm/connect/f2f26480428ddf2ab41fb6e7eece1070/generationalhealthreviewreport-ce-0304.pdf?MOD=AJPERES&CACHEID=f2f26480428ddf2ab41fb6e7eece1070>

National Obesity Taskforce, 2005, *2004 overview*, Canberra, Australia, viewed 13 February 2015, <http://www.health.gov.au/internet/healthyactive/publishing.nsf/Content/activities_2004.pdf/$File/activities_2004.pdf>

National Obesity Taskforce 2005, *2005 overview,* Canberra, Australia, viewed 13 February 2015, <http://www.health.gov.au/internet/healthyactive/publishing.nsf/Content/publications>

Smith, A 2002, *Eat well SA project 1997–2002: Promoting healthy eating for South Australian families*, Government of South Australia, Department of Human Services, Adelaide, Australia.

South Australian Department of Health 2006, *Department of Health priorities for action 2006–07,* SA Health, Adelaide, Australia.

South Australian Department of Health 2008, *Department of Health annual report 2008–09*, SA Health, Adelaide, Australia.

South Australian Department of Human Services 2004, *Chronic disease prevention and management opportunities for South Australia,* Adelaide, Australia, viewed 12 February 2015, <http://www.sapo.org.au/pub/pub2143.html>

Appendix D: Interview schedules

FLINDERS UNIVERSITY OF SOUTH AUSTRALIA

SOUTHGATE INSTITUTE FOR HEALTH, SOCIETY AND EQUITY

‘Targeting Healthy Weight’

INTERVIEW SCHEDULE for OPAL

Operations

My name is Louise Townend, and I am a PhD candidate in the Southgate Institute for Health, Society and Equity at Flinders University.

The title of my research project is ‘Targeting Healthy Weight’, in which I look at the different understandings of healthy weight in the SA Healthy Weight Strategy, how these impact on health equity, and how this translates into a community program. This research will eventually lead to a doctoral thesis and possibly other publications.

Your name and contact details were obtained from material on public websites or SA Health documents and your choice to participate or not in my research will not be passed on to anyone from your organisation.

I’m going to ask you a series of questions about your knowledge of the OPAL Obesity Prevention and Lifestyle program. You may skip any question or stop the interview at any time.

I’d like to tape record the interview to ensure accuracy. If this is okay would you mind signing these two consent forms—I’ll leave one with you.

First name:

Section:

Interview date/time:

Transcribed:

Edited:

Sent:

Comments:

Introduction: OPAL

1. Can you explain what your role in OPAL is?

Can you tell me something about your own background [years & type of experience] in:

- health promotion?
- weight? Prevention or management?

Can you tell me something about the history of OPAL from where you stand?

Your experiences? Frustrations? Successes?

2. Focus

What do you see as the focus of OPAL?

3. Values and assumptions

What values do you think underpin the OPAL program? What do you think about this?

The term 'obesity' is often used. Does this have any impact, do you think?

4. Healthy Weight Target

OPAL is part of the policy response to the Healthy Weight Target in the SA Strategic Plan—part of the Healthy Weight Strategy which addresses the problem of unhealthy weight.

What place do you think OPAL has in addressing the Target?

5. The problem of unhealthy weight

What kind of a 'problem' do you think unhealthy weight is? What problem do *you* think underpins OPAL? Who do you think has this problem? Who do you think it's a problem for?

6. Equity

One of the objectives of the *Eat Well Be Active* Strategy—and of SA Health—is health equity: '4. To make the greatest gain in those population groups who have the highest burden of overweight and obesity and poorest health outcomes'.

How are the 'population groups who have the highest burden of unhealthy weight and poorest health outcomes' being helped? (Is evidence on this available yet?) Will some people miss out? Who?

To what extent does equity feature in OPAL do you think? To what extent do you think health equity is incorporated within OPAL/the different programs?

How does this accord with your understanding of health equity (in this context)? If it doesn't, in what ways?

Looking at T2.2, should it be achieved, do you think this program intervention will contribute to the equitable distribution of the 10% increase in people with healthy weight?

I understand that the selection of council sites included measures of—SES, Aboriginal population—can you tell me more? What happens on the ground?

Is there any feedback identifying groups who feel they are being excluded or overlooked?

How do you see the social marketing approach impacting on equity?

The public presentations have talked about 'adapting levers' (social marketing messages?) for different socioeconomic groups… If you are familiar with this, are you able to enlarge on this?

7. Roles of different sectors

Can you explain the roles played in OPAL by the:

- government sector
- community sector
- public—individuals/families/community
- private sector?

Community consultation and engagement of the government sector with community groups is also mentioned. Can you run through how this works in practice? Who? How? What is the response of community groups?

How do the OPAL Council Managers go about deciding which programs to work with?

Regarding the private sector, the EPODE model is based on four pillars, one of which is private sector partnerships. The program here in SA, however, is government funded. How do you think you might achieve sustainability without private sector partners?

8. Model

OPAL is informed by two committees, the Scientific Advisory Committee and the Strategic Advisory Committee. What is your understanding of:

- the role played by these committees?
- the roles played by the different groups represented on these committees?

The job description for OPAL Council Managers makes it very clear that behaviour change is a priority. Although 'environments for healthy lifestyles' are mentioned in the broad program descriptions which I have, behavioural and lifestyle change seem to feature more prominently. Where do you see lifestyle and behavioural changes fitting in to OPAL? What examples can you give?
How do the different elements get balanced?

To what extent can OPAL make healthy choices the easiest choices?

- Do you think there is a role for industry in helping with this?
- Are there any changes you can think of which might help empower families and communities to make wise choices?
- What might help to make healthy choices the easy choices?

What is your experience of trying to influence the environment? What factors do you think influence this environment? Do you think OPAL is able to impact these? Are there any factors which you can identify as important but which you feel OPAL hasn't been able to influence? Which? Any thoughts on why?

9. Social marketing

What do you see as the strengths and weaknesses of the social marketing approach?

What evidence do you draw on?

Who comes up with the messages for OPAL? How does this process unfold?

How do you tell whether it's working? (Messages themselves and method.) How IS it going?

I understand that different materials and information resources have been produced for different stakeholders like parents and health professionals? May I see them? How do they work?

In what ways have the material and the messages been tailored to different cultural and language groups?

Some questions have been raised about how well the link between social marketing and obesity reduction stands up in the original evaluation of the first two EPODE communities. This is obviously important as the EPODE model highlights - and relies heavily on – social marketing. Do you have any thoughts on this?

10. Evaluation

I understand there is an Evaluation Coordinator, but I'm interested in your perspective on this too.

OPAL is already established in10 sites, and I understand that there will eventually be 20. Can you explain how and what will be evaluated?

How will the different types of work be evaluated?

What is your understanding of how success will be measured regarding:

- individual change
- organisational change
- normative change?

What are your thoughts about this?

I'm aware that measuring children's BMI marker drew a strong audience response at health worker information sessions and was discussed in the local press, raising concerns about privacy, stigmatisation and duty of care/provision of follow up help to families. I believe that the issue was referred to the SAC—can you tell me how it has been resolved?

11. Is there anything you'd like to add?

FLINDERS UNIVERSITY OF SOUTH AUSTRALIA

SOUTHGATE INSTITUTE FOR HEALTH, SOCIETY AND EQUITY

‘Targeting Healthy Weight’

INTERVIEW SCHEDULE for OPAL

Council

My name is Louise Townend, and I am a PhD candidate in the Southgate Institute for Health, Society and Equity at Flinders University.

The title of my research project is ‘Targeting Healthy Weight’, in which I look at the different understandings of healthy weight in the SA Healthy Weight Strategy, how these impact on health equity, and how this translates into a community program. This research will eventually lead to a doctoral thesis and possibly other publications.

Your name and contact details were obtained from material on public websites or SA Health documents and your choice to participate or not in my research will not be passed on to anyone from your organisation.

I’m going to ask you a series of questions about your knowledge of the OPAL Obesity Prevention and Lifestyle program. You may skip any question or stop the interview at any time.

I’d like to tape record the interview to ensure accuracy. If this is okay would you mind signing these two consent forms—I’ll leave one with you.

First name:

Section:

Interview date/time:

Transcribed:

Edited:

Sent:

Comments:

Introduction: OPAL

1. **Can you explain what your role is in connection with OPAL?**

   Can you tell me a little about your own background [years & type of experience] in the field of:

   - community programs
   - health promotion?
   - weight? (Prevention or management?)

   Can you tell me something about the history or background of OPAL from your perspective?

   Your experiences? High points? Frustrations?

2. **Focus**

What do you see as the focus of OPAL?

3. **Values and assumptions**

What values do you think underpin the OPAL program? What do you think about this?

The term ‘obesity’ is often used. Does this have any impact, do you think?

4. **Healthy Weight Target**

OPAL is part of the policy response to the Healthy Weight Target in the SA Strategic Plan – part of the Healthy Weight Strategy which addresses the problem of unhealthy weight.

What place do you think OPAL has in addressing the Target?

5. **The problem of unhealthy weight**

What kind of a ‘problem’ do you think unhealthy weight is? What problem do you think underpins OPAL? Who do you think has this problem? Who do you think it’s a problem for?

6. **Equity**

One of the objectives of the Eat Well Be Active—and of SA Health—is health equity: ‘4. To make the greatest gain in those population groups who have the highest burden of overweight and obesity and poorest health outcomes’.

How do you see the 'population groups who have the highest burden of unhealthy weight and poorest health outcomes' being helped? (Is evidence on this available yet?) Will some people miss out? Who?

To what extent does equity feature in OPAL do you think? To what extent do you think health equity is incorporated within OPAL/the different programs?

Does this accord with your understanding of health equity (in this context)? If not, how?

Looking at T2.2, should it be achieved, do you think this program intervention will contribute to the equitable distribution of the 10% increase in people with healthy weight?

I understand that the selection of council sites included measures of disadvantage—SES, Aboriginal population—can you tell me more? What happens on the ground?

Is there any feedback identifying groups who feel they are being excluded or overlooked?

What impact do you think the presence of OPAL has on health equity in your region? What impact do you think OPAL has on those parts of SA—particularly disadvantaged population groups—which don't have an OPAL program?

How do you see the social marketing approach impacting on equity?

What is your awareness of different 'levers' or approaches being utilised with different socioeconomic groups?

7. Roles of different sectors

What do you think about the roles played in OPAL by the:

- government sector
- community sector
- public—individuals/families/community

- private sector?

Community consultation and engagement of the government sector with community groups is also mentioned. From your perspective, how does this work in practice? Who? How? What is the response of community groups?

What do you think are the considerations that influence which programs OPAL works with in a council area?

Regarding the private sector, the EPODE model is based on 4 pillars, one of which is private sector partnerships. The program here in SA, however, is government funded. How do you think OPAL might achieve sustainability, after the five year funding period, without private sector partners?

8. Model

OPAL is informed by two committees, the Scientific Advisory Committee and the Strategic Advisory Committee. What is your understanding of:

- the role played by these committees?
- the roles played by the different groups represented on these committees?

The job description for OPAL Council Managers makes it very clear that behaviour change is a priority. Although 'environments for healthy lifestyles' are mentioned in the broad program descriptions which I have, behavioural and lifestyle change seem to feature more prominently. Where do you see lifestyle and behavioural changes fitting in to OPAL? What examples can you give?

How do you think the different elements get balanced?

To what extent can OPAL make healthy choices the easiest choices?
Do you think there is a role for industry in helping with this?
Are there any changes you can think of which might help empower families and communities to make wise choices?
What might help to make healthy choices the easy choices?

What is your experience of trying to influence the environment? What factors do you think influence this environment? Do you think OPAL is able to impact these? Are there any factors which you can identify as important but which you feel OPAL hasn't been able to influence? Which? Any thoughts on why?

9. Social marketing

What do you see as the strengths and weaknesses of the social marketing approach?

Who comes up with the messages for OPAL? How does this process unfold?

How do you tell whether it's working? (Messages themselves and method.) How IS it going?

I understand that different materials and information resources have been produced for different stakeholders like parents and health professionals? How do they work?

In what ways have the material and the messages been tailored to different cultural and language groups?

Some questions have been raised about how well the link between social marketing and obesity reduction stands up in the original evaluation of the first two EPODE communities. This is obviously important as the EPODE model highlights - and relies heavily on – social marketing. Do you have any thoughts on this?

10. Evaluation

I understand there is an Evaluation Coordinator, but I'm interested in your perspective on this too.

How will the different types of work OPAL is involved with be evaluated?

What is your understanding of how success will be measured regarding:

- Individual change
- Organisational change
- Normative change?

What are your thoughts about this?

I'm aware that measuring children's BMI marker drew a strong audience response at health worker information sessions and was discussed in the local press, raising concerns about privacy, stigmatisation and duty of care/provision of follow up help to families. I believe that the issue was referred to the SAC – can you tell me how it has been resolved?

11. Is there anything you'd like to add?

FLINDERS UNIVERSITY OF SOUTH AUSTRALIA

SOUTHGATE INSTITUTE FOR HEALTH, SOCIETY AND EQUITY

'Targeting Healthy Weight'

INTERVIEW SCHEDULE for OPAL

Evaluation & Scientific Advisory Committee

My name is Louise Townend, and I am a PhD candidate in the Southgate Institute for Health, Society and Equity at Flinders University.
The title of my research project is 'Targeting Healthy Weight', in which I look at the different understandings of healthy weight in the SA Healthy Weight Strategy, how these impact on health equity, and how this translates into a community program. This research will eventually lead to a doctoral thesis and possibly other publications.
Your name and contact details were obtained from material on public websites or SA Health documents and your choice to participate or not in my research will not be passed on to anyone from your organisation.
I'm going to ask you a series of questions about your knowledge of the OPAL Obesity Prevention and Lifestyle program. You may skip any question or stop the interview at any time.
I'd like to tape record the interview to ensure accuracy. If this is okay would you mind signing these two consent forms—I'll leave one with you.

First name:

Section:

Interview date/time:

Transcribed:

Edited:

Sent:

Comments:

Introduction: OPAL

1. **Can you explain what your role in OPAL is?**

   Can you tell me something about your own background [years & type of experience] in:

   - health promotion?
   - weight? Prevention or management?

   Can you tell me something about the history of OPAL from where you stand?

   Your experiences? Frustrations? Successes?

2. **Focus**

   What do you see as the focus of OPAL?

3. **Values and assumptions**

   What values do you think underpin the OPAL program? What do you think about this?

   The term 'obesity' is often used. Does this have any impact, do you think?

4. **Healthy Weight Target**

   OPAL is part of the policy response to the Healthy Weight Target in the SA Strategic Plan—part of the Healthy Weight Strategy which addresses the problem of unhealthy weight.

   What place do you think OPAL has in addressing the Target?

5. **The problem of unhealthy weight**

   What kind of a 'problem' do you think unhealthy weight is? What problem do *you* think underpins OPAL? Who do you think has this problem? Who do you think it's a problem for?

6. **Equity**

One of the objectives of the *Eat Well Be Active* Strategy – and of SA Health – is health equity: '4. To make the greatest gain in those population groups who have the highest burden of overweight and obesity and poorest health outcomes'.

How are the 'population groups who have the highest burden of unhealthy weight and poorest health outcomes' being helped? (Is evidence on this available yet?) Will some people miss out? Who?

To what extent does equity feature in OPAL do you think? To what extent do you think health equity is incorporated within OPAL/the different programs?

How does this accord with your understanding of health equity (in this context)? If it doesn't, in what ways?

Looking at T2.2, should it be achieved, do you think this program intervention will contribute to the equitable distribution of the 10% increase in people with healthy weight?

I understand that the selection of council sites included measures of disadvantage – SES, Aboriginal population – can you tell me more? What happens on the ground?

Is there any feedback identifying groups who feel they are being excluded or overlooked?

How do you see the social marketing approach impacting on equity?
The public presentations have talked about 'adapting levers' (social marketing messages?) for different socioeconomic groups. If you are familiar with this, are you able to enlarge on this?

7. **Roles of different sectors**

Can you explain the roles played in OPAL by the:

a. government sector
b. community sector
c. public – individuals/families/community
d. private sector?

Community consultation and engagement of the government sector with community groups is also mentioned in the OPAL presentations. What is your awareness of how this works in practice? Who? How? What is the response of community groups?

Regarding the private sector, the EPODE model is based on 4 pillars, one of which is private sector partnerships. The program here in SA, however, is government funded. How do you think you might achieve sustainability without private sector partners?

8. Model

OPAL is informed by two committees, the Scientific Advisory Committee and the Strategic Advisory Committee. What is your understanding of:

- the role played by these committees?
- the roles played by the different groups represented on these committees?

The job description for OPAL Council Managers makes it very clear that behaviour change is a priority. Although 'environments for healthy lifestyles' are mentioned in the broad program descriptions which I have, behavioural and lifestyle change seem to feature more prominently. Where do you see lifestyle and behavioural changes fitting in to OPAL? What examples can you give?

How do the different elements get balanced?

To what extent can OPAL make healthy choices the easiest choices?

- Do you think there is a role for industry in helping with this?
- Are there any changes you can think of which might help empower families and communities to make wise choices?
- What might help to make healthy choices the easy choices?

What is your experience of trying to influence the environment? What factors do you think influence this environment? Do you think OPAL is able to impact these? Are there any factors which you can identify as important but which you feel OPAL hasn't been able to influence? Which? Any thoughts on why?

9. Social marketing

What do you see as the strengths and weaknesses of the social marketing approach?

What evidence do you draw on?

Who comes up with the messages for OPAL? How does this process unfold?

How do you tell whether it's working? (Messages themselves and method.) How IS it going?

In what ways have the material and the messages been tailored to different cultural and language groups?

Some questions have been raised about how well the link between social marketing and obesity reduction stands up in the original evaluation of the first two EPODE communities. This is obviously important as the EPODE model highlights - and relies heavily on – social marketing. Do you have any thoughts on this?

10. Evaluation

OPAL is already established in10 sites, and I understand that there will eventually be 20. Can you explain how and what will be evaluated?

The public information sessions have given an overview of some of the evaluation methods which will be used. Are you able to elaborate on the following please?

- 'statewide monitoring'
- 'mixed methods' …
    - 'Sociological surveys'—interviews with different stakeholders? What else? Will changes in healthy behaviours (eating habits, physical activity) etc. be measured?

Can you explain about the control groups you are using?

How will success be measured regarding:

- individual change
- organisational change
- normative change?

What are your thoughts about this?

How will the different types of work be evaluated?

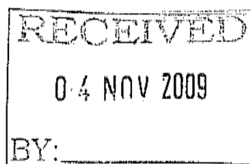
What are the program outcome markers?

- Qualitative c.f. quantitative?
- Why these? (T2.2?)
- What are your thoughts about these markers.

I'm aware that measuring children's BMI marker drew a strong audience response at health worker information sessions and was discussed in the local press, raising concerns about privacy, stigmatisation and duty of care/provision of follow up help to families. I believe that the issue was referred to the SAC—can you tell me how it has been resolved?

11. Is there anything you'd like to add?

Appendix E: Letters to participants



Government of South Australia
SA Health

Statewide Service Strategy
Health Promotion Branch

Citi Centre Building
11 Hindmarsh Square
Adelaide SA 5000

PO Box 287
Rundle Mall
Adelaide SA 5000
DX243

T (08) 8226 6329
F (08) 8226 6133

www.health.sa.gov.au

ABN 976 433 565 90

Professor Fran Baum
Director
Southgate Institute for Health Society & Equity
Level 2
Health Sciences Building
Registry Road
BEDFORD PARK SA 5042

Dear ~~Professor~~ Fran Baum

Thank you for your letter regarding Ms Louise Townend seeking approval to interview Health Promotion Branch Staff regarding the "Eat Well Be Active Healthy Weight Strategy".

We are pleased to be able to assist with this research.

Please advise Louise that she may contact the Health Promotion Branch staff regarding these interviews.

Yours sincerely

Michele Herriot
Director
Health Promotion Branch
Department of Health

16 October 2009

Cc Dr David Panter, Executive Director, Statewide Service Strategy

Southgate Institute for Health, Society and Equity

South Australian Community Health Research Unit

Level 2, Health Sciences Building
Registry Road, Bedford Park SA 5042

GPO Box 2100
Adelaide SA 5001

Tel: +61 8 7221 8444
Fax: +61 8 7221 8424
patricia.lamb@flinders.edu.au

som.flinders.edu.au/FUSA/SACHRU

Dear Sir/Madam

This letter is to introduce Ms Louise Townend who is PhD candidate in the Southgate Institute for Health, Society and Equity at Flinders University. She will produce her student card, which carries a photograph, as proof of identity.

The title of Louise's project is 'Targeting Healthy Weight', in which she will be examining the different understandings of healthy weight in the South Australian Healthy Weight Strategy response to the Healthy Weight Target of the SA Strategic Plan 2007, focussing particularly on how these impact on health equity. Her project will consist of an overview of the policies and an in-depth case study of one program, and will eventually lead to a doctoral thesis and possibly other publications.

Louise would be most grateful if you would volunteer to assist in this project by granting an interview which covers certain aspects of this topic. No more than one to one and-a-half hours would be required at a location of your choice.

Be assured that any information provided will be treated in the strictest confidence and neither the participants nor the agency will be named in the resulting thesis, report or other publications. Every attempt will be made to ensure that participants are not individually identifiable. You are, of course, entirely free to discontinue your participation at any time or to decline to answer particular questions.

Since she hopes to make a tape recording of the interview, Louise will seek your consent, on the attached form, to record the interview, to use the recording or a transcription in preparing the thesis, report or other publications, on condition that your name or identity is not revealed. It may be necessary to make the recording available to secretarial assistants for transcription, in which case you may be assured that such persons will be advised of the requirement that your name or identity not be revealed and that the confidentiality of the material is respected and maintained.

If you wish you will be sent a copy of your interview transcript as soon as it is available which you may amend and return, and a final copy of the relevant section of her thesis summarising and analysing interview data at the conclusion of Louise's candidature.

Any enquiries you may have concerning this project should be directed to me at the address given above or by telephone on 72218410, by fax on 72218424 or by email (fran.baum@flinders.edu.au).

Thank you for your attention and assistance.

Yours sincerely

Fran Baum

Prof Fran Baum
Director, Southgate Institute

This research project has been approved by the Flinders University Social and Behavioural Research Ethics Committee. For more information regarding ethical approval of the project the Secretary of the Committee can be contacted by telephone on 8201 3116, by fax on 8201 2035 or by email human.researchethics@flinders.edu.au..

inspiring achievement

INFORMATION SHEET FOR POLICY STAFF

'TARGETING HEALTHY WEIGHT' RESEARCH PROJECT

My name is Louise Townend, and I am a PhD candidate in the Southgate Institute for Health, Society and Equity at Flinders University.

The title of my research project is 'Targeting Healthy Weight', in which I look at the different understandings of healthy weight in the South Australian Healthy Weight Strategy, which is the Government's response to the Healthy Weight Target of the SA Strategic Plan (2007), and how these impact on health equity. This research will eventually lead to a doctoral thesis and possibly other publications.

I have been given permission to contact staff members by Dr David Panter, Executive Director of the Statewide Service Strategy. Your name and contact details were obtained from material on public websites or SA Health documents and your choice to participate or not in my research will not be passed on to anyone from your organisation.

The part of my project that I am seeking your help with is the policy background to the Healthy Weight Target 2.2 of the SA Strategic Plan 2007 and the *Eat Well Be Active Healthy Weight Strategy for South Australia 2006-2010* (SA Department of Health, 2006). I would be most grateful if you would volunteer to assist in this project by granting an interview of no more than one to one-and-a-half hours, at a location of your choice, covering certain aspects of this topic. A copy of the interview schedule will be sent to you if you choose to participate.

Any information you tell me will be treated in the strictest confidence and neither the names of participants nor the program will be used in the resulting thesis, report or other publications. Every attempt will be made to ensure that you are not individually identifiable. You are, of course, entirely free to discontinue your participation at any time or to decline to answer particular questions. You may also withdraw consent to let me use your information at any stage.

I would like to make a tape recording of the interview so that I can ensure I accurately represent your views, so I will seek your consent, on the attached form, to record the interview, to use the recording or a transcription in preparing the thesis, report or other publications, on condition that your name or identity is not revealed. It may be necessary to make the recording available to secretarial assistants for transcription, in which case you may be assured that such persons will be advised of the requirement that your name or identity not be revealed and that the confidentiality of the material is respected and maintained.

inspiring achievement

If you would like, I will send you a copy of your interview transcript as soon as it is available which you may edit for clarification before returning to me. At the conclusion of my candidacy (approximately June 2011) if you would like, I will also send you the relevant section of my thesis summarising and analysing interview data.

Although I do not anticipate that the content of the interview will be distressing, as an employee of SA Department of Health you have access to confidential counselling services that you may utilise if you wish.

My research is supported by a scholarship from the Australian Health Inequities Program but I receive no other funding and have no conflicting interests.

I hope that this research will provide insights which can help policy makers design policies which have the fairest health outcomes possible.

Thank you very much for your time and assistance.

My contact details and those of my principal supervisor are as follows:

Researcher:
Ms Louise Townend
Email: louise.townend@flinders.edu.au
Telephone: 72218460; 0414 954 960

Supervisor:
Professor Fran Baum, Principal Supervisor
Director, Southgate Institute
Email: fran.baum@flinders.edu.au
Telephone: 72218410

Appendix F: Example of analysis of interviews using WPR framework

***Problematisation* WPR 1: Problem representation**	***OPAL program***
Workers' reflections on the community-based component of OPAL	*Complex* Obesity is a complex problem (requiring a complex, multifaceted solution). *Community-based and following community development principles* Obesity is a worldwide population-level problem but is manifested in particular, local ways. OPAL's community-based rollout implies that the environments in which people live impact obesity. *Project sites located in disadvantaged populations* The problem of obesity impacts more heavily on populations that experience disadvantage, here, low SES and Aboriginal populations. This suggests obesity is related to population characteristics. *Works through local councils, community organisations and stakeholders* Obesity is the kind of problem that can be addressed through policy and planning, and service provision at a local level; obesity is the kind of problem that councils and local organisations and NGOs can deal with—not disconnected from their ordinary business. Obesity is not just about health but is a broad policy problem. *Follows socio-ecological theory* Obesity is a problem that is best understood through a socio-ecological perspective, that is, a perspective which proposes that behaviours are best understood by considering the individual-in-the-environment. *Environments and individuals are focus of change* Obesity is a problem embedded in the environment (physical, structural, legislative, organisational, ideational and normative). OR Could say, Obesity is a problem embedded in the environment and in social norms. *Commercial environment* Obesity is a problem that is caused, at least in part, by the commercial environment and thus by the corporate sector that drives the commercial environment; however, it is not a problem that is appropriately addressed or possibly, it is not appropriate to be addressed, by the corporate sector. *Aiming to meet Health Weight Targets* Healthy Weight Targets (HWTs) and funding construct population-level obesity as an aggregate of obese individuals.
AC members' reflections on the community-based component of OPAL	*Complex* Obesity is a complex problem (requiring a complex, multifaceted solution). *Community-based and following community development principles* Obesity is a worldwide population-level problem but is manifested in particular, local ways. OPAL's community-based rollout implies that the environments in which people live impact obesity. As obesity is represented as the kind of problem that is best dealt with by upholding the principles of community development, such as self-determination, it can be inferred that for results to be effective, interventions must adhere to these principles also,

Problematisation WPR 1: Problem representation	*OPAL program*
AC members' reflections on the community-based component of OPAL	that is, be community-driven and 'bottom-up'. *Project sites located in disadvantaged populations* The problem of obesity impacts more heavily on populations that experience disadvantage, here, low SES and Aboriginal populations. This suggests obesity is related to population characteristics. *Works through local councils, community organisations and stakeholders* Obesity is not simply a health problem or problem *for* health—it is the kind of problem that can be addressed through policy and planning, and service provision at a local level; obesity is the kind of problem that councils and local organisations and NGOs can deal with—not disconnected from their ordinary business. *Follows socio-ecological theory* Obesity is a problem that is best understood through a socio-ecological perspective, that is, a perspective which proposes that behaviours are best understood by considering the individual-in-the-environment. *Environments and individuals are focus of change* Obesity is a problem embedded in the environment and in social norms; social norms are environment-specific, that is, they are embedded in their particular environment. *Commercial environment* Obesity is a problem that is caused, at least in part, by the commercial environment and thus by the corporate sector which drives the commercial environment; the process of the commodification of ordinary practices of life contributes to the obesogenic nature of multiple environments; the corporate sector is implicated as responsible for contributing to both the problem and solution of obesity. *Aiming to meet Healthy Weight Targets* Healthy Weight Targets (HWTs) and funding construct population-level obesity as an aggregate of obese individuals. This represents the problem of obesity as residing in individuals rather than in environments.
Workers' reflections on the social marketing component of OPAL	*A program based on EPODE, a privately sponsored French franchise* This aspect of the EPODE model constructs obesity as a worldwide phenomenon that shares common causes rather than being locally embedded in unique ways (as a worldwide franchise is a solution). This is at odds with the problematisation identified in the community-based component: Obesity is a worldwide population-level problem but is manifested in particular, local ways; the existence of a franchise suggests that obesity can be addressed generically, suggesting that the solution is possibly mismatched to the problem. The corporate sponsorship of the EPODE model suggests that it is not government's job to fix the problem. The problem is just like any other need

Problematisation WPR 1: Problem representation	*OPAL program*
Workers' reflections on the social marketing component of OPAL	that can be supplied by the market, in the same way. Workers agreed that private sponsorship did not sit well with cultural expectations here, highlighting the difference in roles played by the private sector in France and SA. Workers did not represent EPODE's commercial solution to obesity as problematic; however, their acknowledgement that its 'methodology' is IP and is purchased with the franchise implies that obesity (the problem) or healthy weight (the solution) are viewed through a commercial lens. There seems to be a major contradiction between this and the deliberate omission of the commercial environment from the targets of change identified in the DA of the community-based component. *Changing the normative environment…* Workers problematised norms as caused by global forces (Tegan), and commodification of daily life (Ian), which does not line up with social marketing being the solution, nor with omitting the commercial sector from the environment that needs to be changed as it implies a view of the 'problem' as fundamental to the economic and social system in which we are situated. Their personal explanations though were not 'OPAL's' problematisation, i.e. workers identified norms as being driven by global forces (Tegan) and by the commercial sector and branding (Ian, Millie and Peri) that is, they see OPAL's goal of impacting norms within this construction, but this was not necessarily so for the model (reflected in the documentation). OPAL's focus on changing behavioural norms makes individualising responsibility (such as Ian's 'just do it' reflections) easy and natural: it problematises the cause of obesity as individual failings in knowledge or moral fortitude. *Changing the normative environment using a social marketing strategy* This model suggests that obesity is a behavioral problem that can be solved by telling people to behave differently. This is at odds with how workers identify norms as globally driven. It is also at odds with the problematisation of obesity identified in the community-based component: 'Obesity is a problem embedded in the environment and in social norms' as it ignores the 'environment' part. *Positive and non-stigmatising of any product or industry* Workers represented products and their producers as basically good; the involvement of these producers as EPODE program sponsors and the identification of the corporate sphere through its explicit quarantining from criticism (evident in program documentation and in worker interviews) implies their products play a role in obesity. Logically, if they are constructed as doing the right thing, then it must be the consumers at fault. Obesity is thus represented as being about consumption, not production; it is constructed as nothing to do with the products people consume—with the product-laden environment they live in, nor with the economic system that supports it. Workers' reflections and the program documentation did not

***Problematisation* WPR 1: Problem representation**	***OPAL program***
Workers' reflections on the social marketing component of OPAL	conflict here. *Changing the normative environment in the home* Again, both workers and program documentation represented obesity as the outcome of unhealthy changes to family lifestyle.

Problematisation **WPR 1: Problem representation**	***OPAL program***
AC members' reflections on the social marketing component of OPAL	*A program based on EPODE, a privately sponsored French franchise* This aspect of the EPODE model constructs obesity as a worldwide phenomenon that shares common causes rather than being locally embedded in unique ways (as a worldwide franchise is a solution). This is at odds with the problematisation identified in the community-based component: Obesity is a worldwide population-level problem but is manifested in particular, local ways; the existence of a franchise suggests that obesity can be addressed generically, suggesting that the solution is possibly mismatched to the problem. AC members noted fundamental contradictions between a ready-made franchised solution being applicable to a complex and contextually unique problem. The corporate sponsorship of the EPODE model suggests that it is not government's job to fix the problem. The problem is just like any other need that can be supplied by the market, in the same way. AC members represented EPODE's commercial solution to obesity as problematic, specifically questioning the status and applicability of its 'methodology' and critiquing its profiting from what they represented was a public health promotion intervention. *Changing the normative environment* In contrast to workers, AC members represented norms as emanating from and embedded in the environments (social and material) people inhabit. This problematisation is consistent with that of the community-based component. *Changing the normative environment using a social marketing strategy* AC members were thus predominantly cautious about the extent to which social norms can be altered by social marketing. *Positive and non-stigmatising of any product or industry* Unlike workers, AC members were highly critical of the role played by industry in contributing to the obesogenic environment. Favouring environmental explanations of obesity, AC members represented legislative curtailment of the food and marketing industries (rather than product reformulation) being necessary to alter the obesogenic environment. Although unwise consumption was alluded to, they predominantly constructed the problem lying with production rather than consumption. *Changing the normative environment in the home: the 'good parent'* AC members represented the home environment as a potent influence on parenting practices; rather than seeing parenting norms as isolated, they saw them as responsive to environmental pressures, though parents were sometimes constructed as individually responsible for needing to change, particularly when children's health was represented as at risk from permissive parenting practices.

Appendix G: Synthesis of main findings

	EWBA documents	OPAL documents	OPAL interviews	Composite
Problematisation	Primary Unhealthy eating and physical activity behaviours, leading to unhealthy weight.	Primary Unhealthy eating and physical activity behaviours, leading to unhealthy weight.	Primary Local environments are causing weight gain in individuals.	Primary Unhealthy eating and physical activity behaviours, leading to unhealthy weight.
	Secondary Poor health to individuals and economic costs to society.	Secondary This problem is worse among people who experience other disadvantages.	Secondary Obesity is a complex, worldwide population-level problem that is manifested in contextually unique ways.	Secondary Structural drivers of unhealthy weight can impact directly on individuals.
Its causes	Primary Unhealthy eating and physical activity levels: risky behaviours.	Primary Physical and normative environments make healthy choices difficult, especially for people experiencing disadvantage.	Primary Environments impact on individuals both directly through physical environments, and indirectly, through normative environments,	Primary Environmental drivers constrain choices, meaning that unhealthy eating and physical activity behaviours are not entirely volitional.
	Secondary Behaviours are mediated by risky environments. The foods that are *not* eaten are a problem, but not the foods that *are* eaten. The food supply is a problem but not food production. The problem has complex drivers but the commercial sector is not explicitly identified as one of them.	Secondary Behaviours are the result of choices. Poor consumption choices are driving unhealthy weight; commercial products and sector only implicitly problematised, and then at a local level.	Secondary Environmental impact is mediated by behaviour. Workers: norms are partly decontextualised as free choices; proximal drivers are identified; commercial products are not problematised. AC members: norms are seen as materially based; distal drivers are identified; the commercial commodified environment is problematised.	Secondary Healthy choices are not easy, especially for people experiencing disadvantage. Environmental drivers are rarely identified as including the commercial sector or products.
Its solution	Primary Behavioural change—healthy eating and physical activity: participation in healthy lifestyle opportunities.	Primary Local environments (physical and normative) need to be more supportive of healthy choices, i.e., make them easier.	Primary OPAL is a meso-level solution to a problem that has macro- as well as meso-level causes. OPAL as a ‘solution’ thus addresses intermediary rather than ultimate causes of the problem. Its efficacy is thus questionable.	Primary Make environments as supportive of healthy eating and physical activity choices as possible…

	EWBA documents	OPAL documents	OPAL interviews	Composite
Its solution (cont'd)	Secondary Supportive local environments that make healthy choices easier. Structural changes are also necessary. The commercial sector has a role in this. Positive	Secondary The commercial sector has always been part of the formal solution through the EPODE partnership model, although OPAL's stance is more circumspect. The focus is still on consumption not production, and on increasing healthy consumption. Positive and local.	Secondary As most workers see norms as separate from their material environment, a social marketing strategy is congruent with achieving behavioural change. For AC members, however, OPAL's success depends much more on achieving environmental changes. Positive and local (workers); distal as well as local (AC).	Secondary … while focusing on positive changes. The commercial sector can be a part of this solution by offering healthy choices in its product lines.
How this problematisation frames responsibility	Collective: Although behavioural change is the core solution, responsibility is framed as shared between the state as the leader.	Collective: Environmental change to provide healthful opportunities is a collective responsibility.	Collective: Socio-environmental seen as needing to drive.	Collective: People will be helped as much as possible through environmental and structural change.
	Individual: with the public having a civic duty to follow. Mixture of behavioural/socio-environmental, with joint collective and individual responsibility.	Individual: The final onus of responsibility is placed on individuals availing themselves of these opportunities by actively choosing the healthier options. Mixture of behavioural/socio-environmental, with joint collective and individual responsibility	Individual behavioural change. A mix of individual/behavioural (workers) and socio-environmental (AC and workers). Mixture of behavioural/socio-environmental, with joint collective and individual responsibility.	Individual: Ultimately, however, healthy weight-promoting behaviours are up to the individual. The secondary problematisation of distal drivers directly impacting people's weight places all responsibility at the collective level, shared by the state and the private for-profit sector (policy documents). Mixture of behavioural/socio-environmental, with joint collective and individual responsibility.
How this is likely to affect health equity **How this is likely**	Explicit commitment to equity; environmental changes likely to be equity enhancing to a degree, but the minimal focus on structural changes is likely to limit their impact to the intermediary level	Commitment to equity via targeting OPAL projects to communities experiencing disadvantage, undermined by inclusion of social marketing strategy which is known to have deleterious effect on equity (	Commitment to equity via targeting OPAL projects to communities experiencing disadvantage, undermined by inclusion of social marketing strategy that is known to have deleterious effect on equity If environmental	While equity is likely to be enhanced most if the regulatory and other structural changes identified in the policy documents occurs, this is a minor focus of the HWS and has a history of not happening.

	EWBA documents	OPAL documents	OPAL interviews	Composite
to affect health Equity (cont'd)	of supporting volitional behaviour changes. These are less likely to be equitable unless communities that experience high levels of disadvantage receive most assistance.	If environmental changes in these communities are significant, so that the social marketing messages can be easily implemented by families, OPAL might enhance equity in terms of healthy weight.	changes in these communities are significant, so that the social marketing messages can be easily implemented by families, OPAL might enhance equity in terms of healthy weight. The belief expressed by some workers that OPAL's commitment to equity had been fulfilled by targeting projects, in conjunction with their decontextualisation of social marketing messages, might undermine equity.	Addressing equity issues is an integral part of OPAL, which recognises that the environments in which some people live their lives create more risks for health, including healthy weight, than do the environments in which others live. In terms of OPAL and the broader 'making healthy choices easy choices' frame, the result is only likely to impact positively on health equity if substantial material changes to local environments are achieved, especially in communities experiencing disadvantage. Where social marketing is implemented without material change, the effect on equity is likely to be negative.

References

Abercrombie, N, Hill, S & Turner, BS (eds) 1988, *The Penguin dictionary of sociology*, 2nd edn, Penguin Books, London.

Abraham, J 2014, 'The Dietary Guidelines: a tool to tackle obesity with Professor Amanda Lee', *intouch* newsletter of the Public Health Association of Australia Inc., vol. 31, no. 7, pp. 3–4

Allender, S, Gleeson, E, Crammond, B, Sacks, G, Lawrence, M, Peeters, A, Loff, B & Swinburn, B 2009, 'Moving beyond 'rates, roads and rubbish': how do local governments make choices about healthy public policy to prevent obesity?' *Australia and New Zealand Health Policy*, vol. 6, no. 20, viewed 19 April 2014, <http://anzhealthpolicy.com>.

Allender, S, Gleeson, E, Crammond, B, Sacks, G, Lawrence, M, Peeters, A, Loff, B & Swinburn, B 2011,'Policy change to create supportive environments for physical activity and healthy eating: which options are the most realistic for local government?' *Health Promotion International*, vol. 27, no. 2, pp. 261–274.

Althusser, L 1994, 'Ideology and ideological state apparatuses' (Notes towards an investigation) in Slavoj, Z (ed.), *Mapping ideology*, Verso, London, pp. 100–140.

Alvaro, C, Jackson, LA, Kirk, S, McHugh, TL, Hughes, J, Chircop, A & Lyons, RF 2010, 'Moving governmental policies beyond a focus on individual lifestyle: some insights from complexity and critical theories', *Health Promotion International*, vol. 26 no. 1, pp. 91–99.

Alvesson, M. and Skoldberg, K. (2009) *Reflexive methodology: new vistas for qualitative research*, 2nd edition, Sage Publications Inc., London.

Ang, I 2003, 'Culture and communication: toward an ethnographic critique of media consumption in the transnational media system' in L Parks & S Kumar (eds*), Planet TV: a global television reader*, NYU Press, New York, pp. 363–375.

Australian Bureau of Statistics 2013a, *Profiles of health, Australia, 2011–13 Overweight and Obesity*, Cat No. 4338.0 (Last updated 7 June 2013), viewed 3 January 2015 <http://www.abs.gov.au/ausstats/abs@.nsf/Lookup/by%20Subject/4338.0~2011–13~Main%20Features~Overweight%20and%20obesity~10007>.

Australian Bureau of Statistics 2013b, *2011–12 Australian health survey*, Cat. No. 1301 (Last update 21 January 2013), viewed 10 November 2014, <http://www.abs.gov.au/AUSSTATS/abs@.nsf/Lookup/1301.0Chapter11062009%E2%80%9310>.

Australian Government 2015, Department of Health website, last updated 12 June 2015, viewed 29 June 2015, http://www.health.gov.au/internet/main/publishing.nsf/Content/foodsecretariat-front-of-pack-labelling-1.

Australian Institute of Health and Welfare 2003, ‘Are all Australians gaining weight?’ *Bulletin,* no. 11 (December), pp.1–17 .

Australian Institute of Health and Welfare 2004, *Risk factors Data Briefing Number 2*, *Risk factor monitoring, a rising epidemic: obesity in Australian children and adolescents,* viewed 23 June 2008, <http://www.aihw.gov.au/WorkArea/DownloadAsset.aspx?id=6442471181>.

Australian Institute of Health and Welfare 2012, *Australia's food & nutrition 2012*, Canberra, viewed 21 January 2014, <http://www.aihw.gov.au/WorkArea/DownloadAsset.aspx?id=10737422837>.

Australian Institute of Health and Welfare 2013, *Who is overweight*? Viewed 4 January 2015, <http://www.aihw.gov.au/who-is-overweight/>.

Australian Institute of Health and Welfare 2014, *Australia's health 2014, The 14th biennial health report of the Australian Institute of Health and Welfare*, Australia's health series no. 14, Canberra, viewed 17 February 2015, <http://www.aihw.gov.au/WorkArea/DownloadAsset.aspx?id=60129548150>.

Ayo, N 2012, ‘Understanding health promotion in a neoliberal climate and the making of health conscious citizens’, *Critical Social Policy*, vol. 22, no. 1, pp. 99–105.

Bacchi, CL 1999, *Women, Policy and Politics*, Sage Publications, London.

Bacchi, C 2009, *Analysing policy: what's the problem represented to be?* Pearson Australia Frenchs Forest, NSW Australia.

Bacon, L & Aphramor, L 2011, ‘Weight science: evaluating the evidence for a paradigm shift’, *Nutrition Journal*, vol. 10, no. 9, viewed 11 March 2013 <http://www.nutritionj.com/content/10/1/9>.

Baker, C 2004, ‘Membership categorization and interview accounts’ in D Silverman (ed.), *Qualitative research: theory, method and practice*, 2nd edn, Sage Publications, London, pp. 162–176.

Ball, K & Crawford, D 2005, Socioeconomic status and weight change in adults: a review’, *Social Science & Medicine*, vol. 60, pp. 1987–2010.

Ball, K, Mishra, G, & Crawford, D 2002, ‘Which aspects of socioeconomic status are related to obesity among men and women?’ *International Journal of Obesity*, vol. 26, pp. 559–565.

Bambra, C, Fox, D and Scott-Samuel, A 2007, ‘A politics of health glossary’, *Journal of Epidemiology and Community Health*; vol. 61, pp.571–574.

Barosh, L, Friel, S, Engelhardt, K & Chan, L 2014, ‘The cost of a healthy and sustainable diet – who can afford it?’ *Australian and New Zealand Journal of Public Health*, vol. 38, no. 1, pp. 7–12.

Barrett, M 1991, *The politics of truth: from Marx to Foucault*, Stanford University Press, Stanford, California.

Barry, CL, Brescoll, VL, Brownell, KD & Schlesinger, M 2009, ‘Obesity metaphors: how beliefs about the causes of obesity affect support for public policy’, *The Milbank Quarterly*, vol. 87, no. 1, pp. 7–47.

Bastian, A 2011, ‘The future of public health nutrition: a critical policy analysis of Eat Well Australia’, *Australian and New Zealand Journal of Public Health*, vol. 35, no. 2, pp. 111–115.

Baum, F 2007, ‘Cracking the nut of health equity: top down and bottom up pressure for action on the social determinants of health’, *Promotion & Education*, vol. 14, no.2, pp. 90–95.

Baum, F 2008, *The new public health*, 3rd edn, Oxford University Press, Melbourne, Australia.

Baum, F 2011, ‘From Norm to Eric: avoiding lifestyle drift in Australian health policy’, *Australian and New Zealand Journal of Public Health*, vol. 35, no. 5, pp. 404–406.

Baum, F 2013, 15 October 2013, ‘A backward step for community health in South Australia’, *The conversation*, viewed 23 January 2015. <https://theconversation.com/a-backward-step-forcommunity-health-in-south-australia-18889>

Baum, F, Begin, M, Houweling, TAJ & Taylor, S 2009, ‘Changes not for the fainthearted: reorienting health care systems toward health equity through action on the social determinants of health’, *American Journal of Public Health*, vol. 99, no. 11, pp. 1967–1974.

Baum, F, Lawless, A, Delaney, T, MacDougall, C, Williams, C, Broderick, D, Harris, E, McDermott, D, Kickbusch, I, Popay, J & Marmot, M 2014, ‘Evaluation of health in all policies: concept, theory and application’, *Health Promotion International*, vol. 29, no. S1, pp. i130–i.142.

Bava, CM, Jaegerb, SR & Park, J 2008, ‘Constraints upon food provisioning practices in ‘busy’ women’s lives: Trade-offs which demand convenience’, *Appetite*, no. 50, pp. 486–498.

Beck, U & Beck-Gernsheim, E 2002, *Individualization: institutionalized individualism and its social and political consequences,* Sage, London.

Bell, K , Salmon, A & McNaughton, D 2009, ‘Alcohol, tobacco, obesity and the new public health’, *Critical Public Health*, vol. 21, no. 1, pp. 1–8.

Bercovitz, KL 2007, ‘A critical analysis of Canada's ‘Active Living’: Science or politics?’, *Critical Public Health*, vol. 10, no. 1, pp. 19-39.Blair, S & Brodney, S 1999, ‘Effects of physical inactivity and obesity on morbidity and mortality: current evidence and research issues’, *Medicine and Science in Sports and Exercise*, vol. 31(11 Suppl.), pp. 646–662.

Booth, ML, Chey, T, Wake, M, Norton, K, Hesketh, K, Dollman, J and Robertson, I 2003, ‘Change in the prevalence of overweight and obesity among young Australians, 1969–1971’, *American Journal of Clinical Nutrition*, vol. 77, no. 1, pp. 29-36.

Brady, J, Gingras, J and Aphramor, L 2013, ‘Theorizing health at every size as a relational–cultural endeavour’, *Critical Public Health*, vol. 23, no. 3, pp. 345–355.

Braun, V & Clarke, V 2006, ‘Using thematic analysis in psychology’, *Qualitative Research in Psychology,* vol. 3, pp. 77–10.

Broom, D 2008, ‘Hazardous good intentions? Unintended consequences of the project of prevention’, *Health Sociology Review*, vol. 17, no. 2, pp. 129–140.

Brownell, KD 2012, ‘Thinking forward: the quicksand of appeasing the food industry’, *PLoS Medicine*, vol. 9, no. 7, e1001254. doi:10.1371/journal.pmed.1001254, viewed 25 September 2012, <http://www.plosmedicine.org>.

Brownell, KD & Warner, KE 2009, ‘The perils of ignoring history: big tobacco played dirty and millions died. how similar is big food?’ *The Milbank Quarterly*, vol. 87, no. 1, pp. 259–294.

Brunner, EJ, Marmot, MG, Nanchahal, K, Shieply, MJ, Stansfield, SA, Juneja. M & Alberti KGMM, 1997, ‘Social inequality in coronary risk: central obesity and the metabolic syndrome. Evidence from the Whitehall ii study’, *Diabetologia,* vol. 40, pp. 1341–1349.

Burns, C 2004, *A review of the literature describing the link between poverty, food insecurity and obesity with specific reference to Australia*, Victorian Health Promotion Foundation, Vic Health, Melbourne, Australia, viewed 4 March 2009, <http://www.vichealth.vic.gov.au>.

Campos, P, Saguy, A, Ernsberger, P, Oliver, E & Gaesser, G 2006, ‘The epidemiology of overweight and obesity: public health crisis or moral panic?’ *International Journal of Epidemiology*, vol. 35, pp. 55–60.

Cannon, G 2004, ‘Why the Bush administration and the global sugar industry are determined to demolish the 2004 WHO global strategy on diet, physical activity and health’, *Public Health Nutrition*, vol. 7, no. 3, pp. 369–380.

Caraher, M, Dixon, P, Lang, T and Carr-Hill, R 1998, ‘Access to healthy foods: part i. Barriers to accessing healthy foods: differentials by gender, social class, income and mode of transport, *Health Education Journal*, vol. 57, pp. 191–201.

Carson, L and Edwards, K 2011, ‘Prostitution and sex trafficking: what are the problems represented to be? a discursive analysis of law and policy in Sweden and Victoria, Australia’, *Australian Feminist Law Journal*, vol. 34, June 2011, pp. 63–87, viewed 1 March 2015, <http://search.informit.com.au/documentSummary;dn=331289524394682;res=IELHSS>.

Carter, SM, Rychetnik, L, Lloyd, B, Kerridge, IH, Baur, L, Bauman, A, Hooker, C & Zask, A 2011, ‘Evidence, ethics, and values: a framework for health promotion’, *American Journal of Public Health*, vol. 101, no. 3, pp. 465–472.

Chan, M 2013, *Opening address at the 8th Global Conference on Health Promotion*, Helsinki, Finland, 10 June 2013, viewed 2 January 2015, <http://www.who.int/dg/speeches/2013/health_promotion_20130610/en/index.html>.

Charafeddine, R, Van Oyen, H, & Demarest, S 2009, ‘Trends in social inequalities in obesity: Belgium, 1997 to 2004’, *Preventive Medicine*, vol. 48, no. 1, pp. 54–58.

Clark, R, Waters, E, Armstrong, R, Conning, R & Petrie, R 2009, *Evidence summary: achieving equity in community-based obesity prevention interventions for children and adolescents*, CO-OPS Secretariat, Deakin University, Geelong.

Clarke, P, O’Malley, PM, Johnston, LD & Schulenberg, JE 2008, ‘Social disparities in BMI trajectories across adulthood by gender, race/ethnicity and lifetime socio-economic position: 1986–2004’, *International Journal of Epidemiology*, vol. 38, pp. 499–509.

Cobiac, L, Daniel, M, Cargot, M & Jones, M, 2011, *Evaluation of OPAL: early lessons*, Commonwealth Scientific and Industrial Research Organisation, presented on 7 December 2011 to the second ‘Reducing Obesity in our Communities’ Symposium, in Sydney, Australia, organised by the Centre for Health Innovation and Partnership (CHIP), the Sydney West Area Health Service (SWAHS) and the International Life Sciences Institute Southeast Asia Region (ILSI SEA). Viewed 23 February 2015, <http://www.google.com.au/url?sa=t&rct=j&q=&esrc=s&source=web&cd=1&cad=rja&uact=8&ved=0CCIQFjAA&url=http%3A%2F%2Fswahs.elcom.com.au%2FArticleDocuments%2F925%2FLynne%2520Cobiac%2520OPAL.pdf.aspx&ei=6g7rVNL1HomK8QWkzID4BA&usg=AFQjCNGZF-kCGCycFrLbxdJoRBAkE2QEPQ&sig2=htOKKpw5Be4lZxYQEkwj8w>.

Colls, R and Evans, B 2009, ‘Critical Geographies of Fat/Bigness/Corpulence; Introduction: Questioning Obesity Politics’, *Antipode*, vol. 41, no. 5, pp. 1011–1020

Commission on Social Determinants of Health 2008, *Closing the gap in a generation: health equity through action on the social determinants of health*, final report of the Commission on Social Determinants of Health, Geneva, World Health Organization.

Commonwealth of Australia 2003, *Healthy Weight 2008: Australia's future–the national action agenda for children and young people and their families*, National Obesity Taskforce, Department of Health and Ageing, Canberra.

Commonwealth of Australia 2006, *Healthy Weight for Adults and Older Australians: A national action agenda to address overweight and obesity in adults and older Australians 2006–2010*, Department of Health and Ageing, Canberra.

Commonwealth of Australia 2009a, House of Representatives Inquiry into Obesity, *Weighing it up - Report on Obesity in Australia*, House of Representatives Standing Committee on Health and Ageing, May 2009, Canberra.

Commonwealth of Australia 2009b, *Australia: the healthiest country by 2020, technical report 1, obesity in Australia: a need for urgent action*, prepared for the National Preventative Health Taskforce by the Obesity Working Group, Canberra.

Commonwealth of Australia 2009c, *Australia: the healthiest country by 2020, national preventative health strategy – the roadmap for action*, prepared for the National Preventative Health Taskforce, Canberra.

Commonwealth of Australia 2014, *Evidence brief: obesity prevalence trends in Australia, promoting a healthy Australia*, Australian National Preventive Health Agency, Canberra.

Cooper, C 2010, 'Fat Studies: Mapping the Field', *Sociology Compass*, vol. 4, no. 12, pp. 1020–1034

Cort, P 2011, 'Taking the Copenhagen process apart: critical readings of European vocational education and training policy', PhD dissertation, The Danish School of Education, Aarhus University.

Council of Australian Governments 2008, *National partnership agreement on Closing the Gap in Indigenous Health Outcomes,* Canberra.

Council of Australian Governments August 2010, *National partnership agreement on preventive health* (NPAPH)*, attachment 1: implementation plan for the healthy children initiative, South Australia, OPAL*; Canberra.

Coveney, J 2006, *Food, morals and meaning: the pleasure and anxiety of eating*, Routledge, Abingdon, Oxford.

Coveney, J 2008, 'The government of girth', *Health Sociology Review*, vol. 17, no. 2, pp. 199–212.

Coveney, J 2014, *Food*, Routledge, London.

Crawford, R 1980. 'Healthism and the medicalization of everyday life', *International Journal of Health Services*, vol. 10, no. 3, pp. 365–388.

Crawford, R 1984, ‘A cultural account of “health”: control, release and the social body’, in JB McKinlay (ed.), *Issues in the political economy of health care*, Routledge and Kegan Paul, London, pp. 60–103.

Crawford, R 1994, ‘The boundaries of the self and the unhealthy other: reflections on health, culture and AIDS’, *Social Science and Medicine*, vol. 38, no. 10, pp. 1347–1365.

Crawford, R 2006, ‘Health as a meaningful social practice’, *Health*, vol. 10, no. 4, pp. 401–420.

Crawshaw, P 2012, ‘Governing at a distance: social marketing and the (bio) politics of responsibility’, *Social Science & Medicine*, vol. 75, pp. 200–207.

Crawshaw, P 2013, ‘Public health policy and the behavioural turn: the case of social marketing’, *Critical Social Policy*, vol. 33, pp. 616–637.

Crotty, M 1998, *The foundations of social research: meaning and perspective in the research process,* Allen & Unwin, St Leonards, Sydney, Australia.

Daube, M 2010, ‘Health and vested interests’, Editorial, *Australian and New Zealand Journal of Public Health*, vol. 34, no. 5, pp. 444–445.

Denzin, N, & Lincoln, Y 2000, ‘Introduction’, in N. Denzin & Y. Lincoln, Y (eds), *Handbook of qualitative research*, SAGE Publications Inc., Thousand Oaks California, pp. 1–28.

Devaux, M, Sassi, F, Church, J, Cecchini, M & Borgonovi, F 2011, ‘Exploring the relationship between education and obesity’, *OECD Journal: Economic Studies*, vol. 2011/1, pp. 1–41, viewed 4 January 2015, <http://dx.doi.org/10.1787/eco_studies-2011–5kg5825v1k23>.

Dixon, J 2003, ‘Authority, power and value in contemporary industrial food systems’, *International Journal of Sociology of Agriculture and Food*, vol. 11, no. 1, pp. 31–39.

Dixon, J & Broom, D 2007, Preface and conclusion, in J Dixon and D Broom (eds), *The seven deadly sins of obesity: how the modern world is making us fat,* University of New South Wales Press, Sydney, pp. x–xii and 172–187.

Dixon, JM, Hinde, SJ & Banwell, CL 2006, ‘Obesity, convenience and “phood”’, *British Food Journal*, vol. 108, no. 8, pp. 634-645.

Dorfman, L, Cheyne, A, Friedman, LC, Wadud, A & Gottlieb, M 2012, ‘Soda and tobacco industry corporate social responsibility campaigns: how do they compare?’, *PLoS Medicine*, vol. 9, no. 6, e1001241, doi:10.1371/journal.pmed.1001241, viewed 25 September 2012 <http://journals.plos.org/plosmedicine/article?id=10.1371/journal.pmed.1001241>.

Doyal, L with Pennell, I 1979, *The political economy of health*, Pluto Press, London.

Drewnowski, A 2009, 'Obesity, diets, and social inequalities', *Nutrition Reviews*, vol. 67 (Suppl. 1), pp. S36–S39.

Drewnowski, A & Darmon, N 2005, 'Food choices and diet costs: an economic analysis', *Journal of Nutrition*, vol. 135, no. 4, pp. 900–904.

Drewnowski, A & Specter, SE 2004, 'Poverty and obesity: the role of energy density and energy costs', *American Journal of Clinical Nutrition*, vol. 79, pp. 6–16.

Dykes, J, Brunner, EJ, Martikainen, PT and Wardle, J 2004, 'Socioeconomic gradient in body size and obesity among women: the role of dietary restraint, disinhibition and hunger in the Whitehall II study', *International Journal of Obesity Related Metabolic Disorders*, vol. 28, no. 2, pp. 262–268.

Eagleton, T 1994, 'Ideology and its vicissitudes in western Marxism' in Slavoj, Z (ed.), *Mapping ideology,* Verso, London, pp. 179–226.

Egger, G & Swinburn, B 1997, 'An "ecological" approach to the obesity pandemic', *British Medical Journal*, vol. 315 (23 August), pp. 477–480.

Egger, G & Swinburn, B 2010, *Planet obesity*, Allen & Unwin, Sydney, Australia.

Elliott, A & Lemert, C 2006, *The new individualism: the emotional costs of globalization,* Taylor & Francis, London.

EPODE European Network 2011, *Preventing childhood obesity: Epode European Network recommendations,* JM Borys, Y Le Bodo, S De Henauw, LA Moreno, M Romon, JC Seidell, & TLS Visscher (eds), Lavoisier Publishing, Lavoisier, France, available from <http://www.epode-european-network.com>.

Epstein, LH, Gordy, CC, Raynor, HA, Beddome, M, Kilanowski, CK & Paluch, R 2001, 'Increasing fruit and vegetable intake and decreasing fat and sugar intake in families at risk for childhood obesity', *Obesity Research*, vol. 9, no. 3, pp. 171–178.

Ericson, R, Barry, D & Doyle, A 2000, 'The moral hazards of neo-liberalism: lessons from the private insurance industry', *Economy and Society*, vol. 29, no. 4, pp. 532–558.

Esping-Andersen, G, 1990, *The three worlds of welfare capitalism*, Princeton University Press, Princeton, New Jersey.

Evans, B 2006, 'Gluttony or sloth: critical geographies of bodies and morality in (anti)obesity policy', *Area*, vol. 38, no. 3, pp. 259–267.

Evans, WD, Christoffel, KK, Necheles, JW & Becker, AB 2010, 'Social marketing as a childhood obesity prevention strategy', *Obesity*, vol. 18, Supp 1, pp. S23–S26.

Fieldhouse, P 2011, 'Critical dietetics', *Journal of Critical Dietetics*, vol. 1, no. 1, p. 10.

Fischer, F 2003, *Reframing public policy: discursive politics and deliberative practices*, Oxford University Press, Oxford.

Fitzpatrick, M 2001, *The tyranny of health: doctors and the regulation of lifestyle,* Routledge, London.

Flegal, KM, Graubard, BI, Williamson, DF & Gail, MH 2005, 'Excess deaths associated with underweight, overweight, and obesity', *Journal of the American Medical Association*, vol. 293, no. 15, pp. 1861–67.

Flegal, KM, Graubard, BI, Williamson, DF & Gail, MH 2007, 'Cause-specific excess deaths associated with underweight, overweight, and obesity', *Journal of the American Medical Association*, vol. 298, no. 17, pp. 2028–2037.

Flegal, KM, Kit, BK, Orpana, H & Graubard, BI 2013, 'Association of all-cause mortality with overweight and obesity using standard body mass index categories: a systematic review and meta-analysis', *Journal of the American Medical Association*, vol. 309, no. 1, pp. 71–82.

Foresight Programme 2007, *Tackling obesities: future choices – project report, October*, UK Government Office for Science, London.

Freudenberg, N 2014, *Lethal but legal: Corporations, consumption, and protecting public health*, Oxford University Press, New York.

Frieden, TR, Geetz, W & Collins, J 2010, 'Reducing childhood obesity through policy change: acting now to prevent obesity', *Health Affairs*, vol. 29, no. 3, pp. 357–363.

Friel, S 2009, *Health equity in Australia: A policy framework based on action on the social determinants of obesity, alcohol and tobacco*, report prepared for the Australian National Preventative Health Taskforce, 27 May. Preventative Health Taskforce, Canberra, viewed 6 November 2014, <http://www.preventativehealth.org.au/internet/preventativehealth/publishing.nsf/Content/0FBE203C1C547A82CA257529000231BF/$File/commpaper-hlth-equity-friel.pdf>.

Friel, S & Broom, D 2007, 'Unequal society, unhealthy weight', in J Dixon & Broom, D (eds), *The seven deadly sins of obesity: how the modern world is making us fat,* University of New South Wales Press, Sydney, Australia, pp. 148–171.

Friel, S, Chopra, M & Satcher, D 2007, 'Unequal weight: equity oriented policy responses to the global obesity epidemic', *British Medical Journal,* vol. 335, pp. 1241–1243.

Gantner, LA & Olsen, CM 2012, 'Evaluation of public health professionals' capacity to implement environmental changes supportive of healthy weight', *Evaluation and Program Planning*, vol. 35, pp. 407–416.

Gard, M 2011a, *The end of the obesity epidemic*, Routledge, London.

Gard, M 2011b, ‘Truth, belief and the cultural politics of obesity scholarship and public health policy’, *Critical Public Health*, vol. 21, no. 1, pp. 37–48.

Gard, M & Wright, J 2005, *The obesity epidemic: science, morality and ideology*, Routledge, London.

Geertz, C 1973, *The interpretation of cultures: selected essays*, Basic Books, New York.

Gibbs, L, Waters, E, St Leger, L, Green J, Gold, J, & Swinburn B 2011, ‘A settings-based theoretical framework for obesity prevention community interventions and research’, *Australian and New Zealand Journal of Public Health*, vol. 35, no. 2, pp. 104–106.

Glanz, K & Mullis, RM 1988, ‘Environmental interventions to promote healthy eating: a review of models, programs, and evidence’, *Health Education & Behavior*, vol. 15, no.4, pp.395–415.

Goffman, E 1974, *Frame analysis: an essay on the organization of experience*, Harvard University Press, Cambridge, Massachusetts.

Gortmaker, SL, Swinburn BA, Levy, D, Carter, R, Mabry, PL, Finegood, DT, Huang, T, Marsh, T & Moodie, ML 2011, ‘Changing the future of obesity: science, policy, and action’, *Lancet*, vol. 378, pp. 838–847.

Government of South Australia 2004, *Inquiry into obesity, Nineteenth Report of the Social Development Committee*, Legislative Council Social Development Committee, Adelaide, Australia

Government of South Australia 2004, *Ministerial Physical Activity Forum, Be Active Physical Activity Strategy 2004–2008,* Adelaide, Australia.

Government of South Australia 2007a, *South Australia’s Strategic Plan.* Department of the Premier and Cabinet, Adelaide, Australia, viewed 28 March 2011, <http://saplan.org.au/pages/archives>

Government of South Australia 2007b, *South Australia’s Strategic Plan: summary of targets* Department of the Premier and Cabinet, Adelaide, Australia, viewed 28 March 2011, <http://saplan.org.au/pages/archives>

Government of South Australia 2007c, *South Australia’s Health Care Plan 2007–2016,* SA Health, viewed 6 February 2015, <http://www.sahealth.sa.gov.au/wps/wcm/connect/Public+Content/SA+Health+Internet/Health+reform/South+Australias+Health+Care+Plan/>

Government of South Australia 2007d, *SA Strategic Plan Target Fact Sheets 2.2*, Department of the Premier and Cabinet, viewed 6 February 2015, <http://saplan.org.au/fact_sheets/178>

Government of South Australia 2008, *Submission to the House of Representatives Standing Committee on Health and Ageing’s Inquiry into Obesity*, May 2008, Adelaide, Australia.

Government of South Australia 2009a, *Eat Well Be Active Healthy Weight Strategy for South Australia 2006–2010: priorities* as at November 2009, SA Health, Adelaide, Australia.

Government of South Australia 2009b, *OPAL – A lifestyle revolution for SA families*, Premier Mike Rann, News Release, 4 March 2009, Adelaide, Australia, viewed 15 October 2012, <http://decd.sa.gov.au/mediacentre/files/.../OPAL>.

Government of South Australia 2011a, *South Australia's Strategic Plan*, Department of the Premier and Cabinet, Adelaide, Australia, viewed 31 December 2014, http://saplan.org.au/media/BAhbBlsHOgZmSSIhMjAxMS8xMS8wNC8wMV8wMl8xNF8yMjNfZmlsZQY6BkVU/01_02_14_223_file>.

Government of South Australia 2011b, *Measuring our success: Progress report two on: the social development committee's inquiry into obesity* (Reported to Parliament May 2004) and the *Fast food and obesity inquiry* (Reported to Parliament March 2007); and *Eat Well Be Active Healthy Weight Strategy for South Australia 2006–2010* <http://www.health.sa.gov.au/pehs/branches/health-promotion/measuringoursuccess-pehs-sahealth-090923.pdf>.

Gramsci, A 1975a, *Prison notebooks*, Volume II, European Perspectives, edited and translated by JA Buttigieg, Columbia University Press, New York.

Gramsci, A 1975b, *Prison notebooks*, Volume III, European Perspectives, edited and translated by JA Buttigieg, Columbia University Press, New York.

Gramsci, A 1971, *Selections from the Prison Notebooks*, edited and translated by Q Hoare and GN Smith, Lawrence & Wishart, London.

Green, J, Willis, K, Hughes, E, Small, R, Welch, N, Gibbs, L & Daly, J 2007, 'Generating best evidence from qualitative research: the role of data analysis' , *ANZ Journal of Public Health*, vol. 31, no. 6, pp. 545–550.

Grier, SA and Kumanyika, SK 2008, 'The context for choice: health implications of targeted food and beverage marketing to African Americans', *American Journal of Public Health,* vol. 98, issue 9, pp 1616-29.

Grynbaum, M 2014, 'New York's ban on big sodas is rejected by final court', *New York Times,* 26 June 2014, viewed 18 January 2015 <http://www.nytimes.com/2014/06/27/nyregion/city-loses-final-appeal-on-limiting-sales-of-large-sodas.html?_r=0>.

Guba, EG 1981, 'Criteria for assessing the trustworthiness of naturalistic inquiries', *Educational Communication and Technology*, vol. 29, no. 2, pp.75–91.

Guba, EG & Lincoln, YS 1994, 'Competing paradigms in qualitative research' in N Denzin & Y Lincoln (eds), *Handbook of Qualitative research*, 1st edn, Sage Publications, Thousand Oaks, California, pp. 105–117.

Guthman, J 2011, *Weighing in: obesity, food justice, and the limits of capitalism*, University of California Press, Berkeley and Los Angeles, California.

Guthman, J & DuPuis, M 2005, ‘Embodying neoliberalism: economy, culture, and the politics of fat’, *Society and Space*, vol. 24, pp. 427–448.

Hagberg, A, Horodinca, A, Hedelund, S and Hillerup, I 2013, ‘Kurdish minority rights: What’s the problem represented to be?’, student thesis, Malmö högskola/Kultur och samhälle, Malmo University, Sweden, viewed 1 March 2015, <http://hdl.handle.net/2043/15158>.

Hampson, SE, Tonstad, S, Irgens, LM, Meltzer, HM & Vollrath, ME 2010, ‘Mothers’ negative affectivity during pregnancy and food choices for their infants’, *International Journal of Obesity*, vol. 34, pp. 327–331.

Handsley, E, Mehta, K, Coveney, J & Nehmy, C 2009, ‘Regulatory axes on food advertising to children on television’, *Australia and New Zealand Health Policy*, vol. 6, no. 1, pp. 6–1, viewed 10 April 2014, <http://www.anzhealthpolicy.com/content/6/1/1>.

Harris, JL, Pomeranz, JL, Lobstein, T & Brownell, KD 2009, ‘A crisis in the marketplace: how food marketing contributes to childhood obesity and what can be done’, *Annual Review of Public Health*, vol. 30, pp. 5.1–5.15.

Harvey, D 2007, *A brief history of neoliberalism*, Oxford University Press, Oxford.

Hastings, G 2012 ‘The marketing matrix’, *Journal of Social Marketing*, vol. 2, issue 3, pp. 222–226.

Hastings, G & Haywood, A 1991, ‘Social marketing and communication in health promotion’, *Health Promotion International*, vol. 6, no. 2, pp. 135–145.

Henderson, J, Coveney, J, Ward, P & Taylor, A 2009, ‘Governing childhood obesity: Framing regulation of fast food advertising in the Australian print media’, *Social Science & Medicine,* vol. 69, pp.1402–1408.

Herrick, C 2009, ‘Shifting blame/selling health: corporate social responsibility in the age of obesity’, *Sociology of Health & Illness*, vol. 31, no. 1, pp. 51-65.

Heymsfield, SB & Cefalu, WT 2013, ‘Does body mass index adequately convey a patient’s mortality risk?’, *Journal of American Medicine*, vol. 309, no. 1, pp. 87–88.

Hoek, J & Gendall, P 2006, ‘Advertising and obesity: a behavioral perspective’, *Journal of Health Communication*, vol. 11, pp. 409–423.

Hoek, J & King, B 2009, ‘Food advertising and self-regulation: A view from the trenches’, *Australian and New Zealand Journal of Public Health*, vol. 32, no. 3, pp. 261–265.

Hoggett, P 2001, ‘Agency, rationality and social policy’, *Journal of Social Policy*, vol. 30, no.1, pp.37–56.

Hunter, DJ, Popay, J, Tannahill, C & Whitehead, M 2010, ‘Getting to grips with health inequalities at last?: Marmot review calls for renewed action to create a fairer society’, *British Medical Journal*, vol. 340 (c684), pp. 323–324.

Jackson, M, Harrison, P, Swinburn, B and Lawrence, M 2014, ‘Unhealthy food, integrated marketing communication and power: a critical analysis’, *Critical Public Health*, vol. 24, no. 4, pp. 489-505

Jamrozik, A 2009, *Social Policy in the post-welfare state: Australian society in a changing world*, 3rd edn, Pearson Education Australia, Frenchs Forest, NSW, Australia.

Jenkin, GL, Signal, L & Thomson, G 2011, ‘Framing obesity: the framing contest between industry and public health at the New Zealand inquiry into obesity‘, *Obesity Reviews*, vol. 12, pp. 1022–1030.

Jolly, R 2011, ‘Marketing obesity? Junk food, advertising and kids’, Research Paper no. 9 2010-2011, 12 January 2011, Parliamentary Library, Parliament of Australia, Department of Parliamentary Services, Canberra, viewed 16 January 2015, <http://www.aph.gov.au/About_Parliament/Parliamentary_Departments/Parliamentary_Library/pubs/rp/rp1011/11rp09>.

Jones, H 1994, *Health and society in twentieth-century Britain*. Longman, Harlow, England.

Kenny, S 2011, *Developing communities for the future*, 4th edition, Cengage Learning Australia, Melbourne, Australia.

Kettings, C & Sinclair, AJ 2009, ‘A healthy diet consistent with Australian health recommendations is too expensive for welfare-dependent families’, *Australian and New Zealand Journal of Public Health*, vol. 33, no. 6, pp. 566–572.

Kickbusch, I 1986, ‘Health promotion: a global perspective’, *Canadian Journal of Public Health*, vol. 77, pp. 321–326.

Kickbusch, I, McCann, W & Sherbon, A 2008, ‘Adelaide revisited: from healthy public policy to Health in All Policies’, *Health Promotion International,* , vol. 23, no. 1, pp. 1–3.

Kincheloe, JL & McLaren, P 2000, ‘Rethinking critical theory and qualitative theory’, in N. Denzin & Y. Lincoln, Y (eds), *Handbook of qualitative research*, SAGE Publications, Thousand Oaks California, pp.279–313.

King, L, Gill, T, Allender, S & Swinburn, B 2011, ‘Best practice principles for community-based obesity prevention: development, content and application’, *Obesity Reviews,* vol. 12, no. 5, pp. 329–338.

King, T, Kavanagh, AM, Jolley, D, Turrell, G and Crawford, D (2006) ‘Weight and place: a multilevel cross-sectional survey of area-level social disadvantage and overweight/obesity in Australia’, *International Journal of Obesity*, vol. 30, pp. 281–287.

Kirk, SFL & Penney, TL 2013, 'The role of health systems in obesity management and prevention: problems and paradigm shifts', *Current Obesity Reports*, vol. 2, pp. 315–319.

Knai, C, Lobstein, T, Darmon, N, Rutter, H and McKee, M 2012, 'Socioeconomic Patterning of Childhood Overweight Status in Europe', *International Journal of Environmental Research and Public Health*, vol. 9, pp.1472–1489.

Kuczmarski, RJ & Flegal, KM 2000, 'Criteria for definition of overweight in transition: background and recommendations for the United States', *The American Journal of Clinical Nutrition*, vol. 72, pp. 1074–81.

Kwan, S 2009, 'Framing the fat body: contested meanings between government, activists, and industry', *Sociological Inquiry*, vol. 79, no. 1, pp. 25–50.

Kwauk, CT 2012, 'Obesity and the healthy living apparatus: discursive strategies and the struggle for power', *Critical Discourse Studies*, vol. 9, no.1, pp. 39–57.

Labonte, R 1993, 'Health promotion and empowerment: practice frameworks', *Issues in Health Promotion*, Series HP-10–0102, Centre for Health Promotion and ParticipACTION, University of Toronto, Canada.

Lang, T & Rayner, G 2007, 'Overcoming policy cacophony on obesity: an ecological public health framework for policymakers', *Obesity Reviews*, vol. 8 (Suppl. 1), pp. 165–181.

Lawrence, RG 2004, 'Framing obesity: the evolution of news discourse on a public health issue', *Press/Politics*, vol. 9, no. 3, pp.56–75.

LeBosco, K 2004, *Revolting bodies? The struggle to redefine fat identity*, University of Massachusetts Press, Amherst, Massachusetts.

Lee, A, Mhurchu, CN, Sacks, G, Swinburn, B, Snowdon, W, Vandevijvere, S, Hawkes, C, L'Abbé, M, Rayner, M, Sanders, D, Barquera, S, Friel, S, Kelly, B, Kumanyika, S, Lobstein, T, Ma, J, Macmullan,J, Mohan,S, Monteiro, C, Neal, B & Walker, C 2013, 'Monitoring the price and affordability of foods and diets globally', *Obesity Reviews*, vol. 14 (Suppl. 1), pp. 82-95.

Leichter, HM 2003, '"Evil habits" and "personal choices": assigning responsibility for health in the 20th century', *The Milbank Quarterly*, vol. 81, no.4, pp. 603–626.

Lincoln, YS & Guba, EG 2000, 'Paradigmatic controversies, contradictions, and emerging confluences', in N. Denzin & Y. Lincoln, Y (eds), *Handbook of qualitative research*, SAGE Publications, Thousand Oaks California, pp.163–188.

Lobstein, 2006, 'Comment: preventing child obesity – an art and a science', *Obesity Reviews*, vol. 7 (Suppl. 1), pp. 1–5.

Lobstein, T, Baur, L and Uauy, R for the IASO International Obesity TaskForce (2004), 'Obesity in children and young people: a crisis in public health', *obesity reviews,* vol. 5 (Suppl. 1), pp. 4–85.

Loring, B & Robertson, A 2014, *Obesity and inequities: guidance for addressing inequities in overweight and obesity*, WHO, Regional Office for Europe, Copenhagen.

Ludwig, DS & Nestle, M 2008, 'Can the food industry play a constructive role in the obesity epidemic, *Journal of the American Medical Association*, vol. 300, no. 15, pp. 1808–1811.

Lupton, D 1992, 'Discourse analysis: a new methodology for understanding the ideologies of health and illness', *Australian Journal of Public Health*, vol.16, no.2, pp. 145–150.

Macquarie Dictionary 2014, *Australian Word Map*, viewed 1 March 2015, <https://www.macquariedictionary.com.au/resources/aus/word/map/search/word/povo/Adelaide%20Region/>.

Magarey, AM, Daniels, LA and Boulton, CJ 2001, 'Prevalence of overweight and obesity in Australian children and adolescents: reassessment of 1985 and 1995 data against new standard international definitions', *Medical Journal of Australia*, vol. 174, no. 11, pp.561-564.

Marmot, M 2005, 'Social determinants of health inequalities', *Lancet*, vol. 365, pp. 1099–104.

Marmot, M 2007, 'Achieving health equity: from root causes to fair outcomes', *Lancet*, vol. 370, pp.1153–63.

Marmot, M 2010, *Fair society, healthy lives: The Marmot Review, Full Report, Strategic Review of Health Inequalities in England post-2010,* UCL [University College London] Institute of Health Equity, The Marmot Review, London.

Martikainen, PT & Marmot, MG 1999, 'Socioeconomic differences in weight gain and determinants and consequences of coronary risk factors', *American Journal of Clinical Nutrition*, vol. 69, pp. 719–726.

Mason, J 2002, *Qualitative researching*, 2nd edn, Sage Publications, California.

McCann, W 2012, *Review of non-hospital based services*, Report to the Minister for Health and Ageing, October 2012, SA Government, Office of Public Employment and Review, Adelaide, South Australia.

McCormick, B, Stone, I & Corporate Analytical Team, Department of Health, London 2007, 'Economic costs of obesity and the case for government intervention', *Obesity Reviews,* vol. 8 (Suppl. 1), pp. 161–164.

McCracken, G 1988, *The long interview*, Sage, Newbury Park, California.

McDonald, C & Marston, G 2005, 'Workfare as welfare: governing unemployment in the advanced liberal state', *Critical Social Policy*, vol. 25, no. 3, pp. 374–401.

McDonald, D 2014, '*What's the drug driving problem represented to be*?', presentation at ATODA [Alcohol Tobacco and Other Drug Association] ACT [Australian Capital Territory] Annual Conference 24 September 2014, National Portrait Gallery of Australia, Parkes, Canberra, viewed 1 March 2015, <http://www.atoda.org.au/>.

McLaren, L 2007, 'Socioeconomic status and obesity', *Epidemiologic Reviews*, vol. 29, pp. 29–48.

McLaren, L & Hawe, P 2005, 'Ecological perspectives in health research', *Journal of Epidemiology & Community Health*, vol. 59, no. 1, pp. 6–14.

McLellan, D 1986, *Ideology*, Open University Press, Milton Keynes, England.

McLeroy, KR, Bibeau, D, Steckler, A & Glanz, K 1988, 'An ecological perspective on health promotion programs', *Health Education Quarterly*, vol. 15, no. 4, pp. 351–377.

McNaughton, D 2011, 'From the womb to the tomb: obesity and maternal responsibility', *Critical Public Health,* vol. 21, no.2, pp. 179–190.

Miller, D & Harkins, C 2010, 'Corporate strategy, corporate capture: Food and alcohol industry lobbying and public health', *Critical Social Policy*, vol. 30, no. 4, pp. 564–589.

Miller, D & Mooney, G 2010, 'Corporate power: Agency, communication, influence and social policy', *Critical Social Policy*, vol. 30, no.4, pp. 459–471.

Milio, N 1976, 'A Framework for Prevention: Changing Health-Damaging To Health-Generating Life Patterns', *American Journal of Public Health*, vol. 66, no.5, pp.435–439.

Milio, N 1981 *Promoting health through public policy*, F.A.Davis Co., Philadelphia, USA.

Milio, N 1986, 'Multisectoral policy and health promotion: Where to begin?' *Health Promotion*, vol. 1, no. 2, pp. 129–132.

Mohr, P, Wilson C, Dunn, K, Brindal1, E & Wittert, G 2007, 'Personal and lifestyle characteristics predictive of the consumption of fast foods in Australia', *Public Health Nutrition*, vol. 10, no. 12, pp. 1456–1463.

Molarius, A, Seidell, JC, Sans, S, Tuomilehto, J & Kuulasmaa, K 2000, 'Educational level, relative body weight, and changes in their association over 10 years: an international perspective from the WHO MONICA project', *American Journal of Public Health*, vol. 90, no. 8, pp. 1260–1268.

Monteiro, CA & Cannon, G 2012, 'The impact of transnational ''big food'' companies on the south: a view from Brazil', *PLoS Medicine*, vol. 9, no. 7, e1001252, doi:10.1371/journal.pmed.1001252, viewed 25 September 2012, <http://journals.plos.org/plosmedicine/article?id=10.1371/journal.pmed.1001252>.

Moodie, R, Swinburn, B, Richardson, J & Somaini, B 2006, 'Childhood obesity a sign of commercial success, but a market failure', *International Journal of Pediatric Obesity*, vol. 1, no. 3, pp. 133–138.

Moodie, R, Stuckler, D, Monteiro, C, Sheron, N, Neal, B, Thamarangsi, T, Lincoln, P & Casswell, S 2013, 'Profits and pandemics: prevention of harmful effects of tobacco, alcohol, and ultra-processed food and drink industries', *Lancet*, vol. 381, pp. 670–679.

Morse, JM, Barrett, M, Mayan, M, Olson, K & Spiers, J 2002, 'Verification strategies for establishing reliability and validity in qualitative research', *International Journal of Qualitative Methods*, vol. 1, no. 2, pp. 13–22.

National Health & Medical Research Council 2013, *Clinical practice guidelines for the management of overweight and obesity in adults, adolescents and children in Australia,* Commonwealth of Australia, Canberra.

National Health Performance Authority 2013, *Healthy communities: overweight and obesity rates across Australia, 2011–12 (In Focus)*, Commonwealth of Australia, Canberra.

National Heart Foundation of Australia 2012, *Factsheet: overweight and obesity statistics*, viewed 10 November 2014 <http://www.heartfoundation.org.au/SiteCollectionDocuments/Factsheet-Overweight-and-obesity.pdf>.

Nestle, M 2002, *Food politics: how the food industry influences nutrition and health*, University of California Press, Berkeley and Los Angeles, California.

Newman, L, Ludford, I, Williams, C, & Herriot, M 2014, 'Applying health in all policies to obesity in South Australia', *Health Promotion International*, Advance Access, published August 1, 2014, viewed 5 August 2014, <http://heapro.oxfordjournals.org>.

Nichols, MS, de Silva-Sanigorski, AM, Cleary, JE, Goldfeld, SR, Colahan, A & Swinburn, BA 2011, 'Decreasing trends in overweight and obesity among an Australian population of preschool children', *International Journal of Obesity*, vol. 35, pp. 916–924.

Nutbeam, D 1986 'Health promotion glossary', *Health Promotion*, vol.1, no. 1, pp. 113–127.

O'Dea, JA 2003, 'Differences in overweight and obesity among Australian schoolchildren of low and middle/high socioeconomic status', *Medical Journal of Australia*, vol. 179, Vol.1, p.63.

Olsen, A, Dixon, J, Banwell, C & Baker, P 2009, 'Weighing it up: the missing social inequalities dimension in Australian obesity policy discourse', *Health Promotion Journal of Australia*, vol. 20, no. 3, pp.167–171.

O'Reilly, CJ 2011, 'Weighing in on the health and ethical implications of British Columbia's weight-centered health paradigm', Master of Public Policy thesis, Faculty of Arts and Social Sciences, Simon Fraser University, British Columbia.

O'Reilly, C and Sixsmith, J 2012, 'From theory to policy: reducing harms associated with the weight-centered health paradigm', *Fat Studies: An Interdisciplinary Journal of Body Weight and Society,* vol. 1, no. 1, pp. 97–113.

Organisation for Economic Co-Operation and Development 2013, *Health at a Glance 2013*: *OECD Indicators*, OECD Publishing, viewed 9 December 2013, <http://dx.doi.org/10.1787/health_glance-2013-en>.

Patel, RC 2012, 'Food sovereignty: power, gender, and the right to food', *PLoS Medicine,* vol. 9, no. 6, e1001223, doi:10.1371/journal.pmed.1001223, viewed 25 September 2012, <http://journals.plos.org/plosmedicine/article?id=10.1371/journal.pmed.1001223>.

Patterson, M & Johnston, J 2012, 'Theorizing the obesity epidemic: health crisis, moral panic and emerging hybrids', *Social Theory & Health*, vol. 10, no. 3, pp. 265–291.

Patton, MQ 2002, *Qualitative research and evaluation methods*, 3rd edn, Sage Publications, London.

Petersen, A 2003, 'Governmentality, critical scholarship, and the medical humanities', *Journal of Medical Humanities*, vol. 24, no. 3/4, Winter 2003, pp. 187–201.

Pettman, T, McAllister, M, Verity, F, Magarey, A, Dollman, J, Tripptree, M, Stanley, S, Wilson, A & Mastersson, N 2010, *Eat well be active community programs final report*, SA Department of Health, Adelaide, Australia.

Pickett, KE, Kelly, S, Brunner, E, Lobstein, T & Wilkinson, RG 2005, 'Wider income gaps, wider waistbands? An ecological study of obesity and income inequality', *Journal of Epidemiology and Community Health*, vol.59, pp. 670–674.

Popay, J, Rogers, A & Williams, G 1998, 'Rationale and standards for the systematic review of qualitative literature in health services research', *Qualitative Health Research*, vol. 8, no. 3, pp. 341–351.

Popay, J, Whitehead, M & Hunter, DJ 2010, 'Injustice is killing people on a large scale - but what is to be done about it?', *Journal of Public Health*, vol. 32, no. 2, pp. 148–149.

Powell, D 2014, 'Childhood obesity, corporate philanthropy and the creeping privatisation of health education', *Critical Public Health*, vol. 24, no. 2, pp. 226-238.

Prentice, AM & Jebb, SA 1995, 'Obesity in Britain: gluttony or sloth?' *British Medical Journal*, vol. 311, pp. 437–9.

Prentice, AM & Jebb, SA 2001, 'Beyond body mass index', *Obesity Reviews*, vol. 2, pp. 141–147.

Prochaska, JO & Di Clemente, CC 1982 'Transtheoretical therapy: toward a more integrative model of change', *Psychotherapy: Theory, Research and Practice*, vol. 19, no. 3, Fall, pp.276–288.

Punch, KF 2000, *Developing effective research proposals*, Sage Publications, London.

Raffin, S 2008, 'EPODE: Social marketing approach and network creation to prevent childhood obesity in a sustainable way', presentation at World Social Marketing Conference, Brighton & Hove City, England, 29–30 September 2008.

Rawlins, E 2008, 'Citizenship, health education and the obesity "crisis"', *ACME Editorial Collective, ACME: An International E-Journal for Critical Geographies*, vol. 7, no. 2, pp. 135–151.

Rayner, G, Gracia, M, Young, E, Mauleon, JR, Luque, E & Rivera-Ferre, MG 2010, 'Why are we fat? Discussions on the socioeconomic dimensions and responses to obesity', *Globalization and Health*, vol. 6, no. 7, viewed 13 December 2013, <http://www.globalizationandhealth.com/content/6/1/7>.

Rein, M & Schoen, D 1993, 'Framing in policy discourse' in F Fischer & J Forester (eds), *The argumentative turn in policy analysis and planning*, Duke University Press, Durham, North Carolina, pp. 145–166.

Rich, E & Evans, J 2005, '"Fat ethics": the obesity discourse and body politics,' *Social Theory & Health*, vol. 3, pp. 341–358.

Robertson, A, Lobstein, T & Knai C 2007, *Obesity and socioeconomic groups in Europe: Evidence review and implications for action*, viewed 4 October 2014, <http://eurohealthnet.eu/sites/eurohealthnet.eu/files/publications/Focusing-on-obesity-through-a-health-equitylens>.

Rokholm, B, Baker, JJ & Sørensen, TIA 2010, 'The levelling off of the obesity epidemic since the year 1999 – a review of evidence and perspectives', *Obesity Reviews*, vol. 11, pp. 835–846.

Romon, M, Lommez, A, Tafflet, M, Basdevat, A, Oppert, JM, Bresson, JL, Ducimetie, P, Charles, MA & Borys, JM 2008, 'Downward trends in the prevalence of childhood overweight in the setting of 12-year school- and community-based programmes', *Public Health Nutrition*, vol. 12, no. 10, pp. 1735–1742.

Rose, G 1985, 'Sick individuals and sick populations', *International Journal of Epidemiology*, vol. 14, no. 1, pp. 32–38.

Rose, N & Miller, P 1992, 'Political power beyond the state: problematics of government', *The British Journal of Sociology*, vol. 43, no. 2, pp. 173–205.

Rose, N, O'Malley, P & Valverde, M 2006, 'Governmentality', *Annual Review of Law and Social Science*, vol. 2, pp. 83–104.

Sacks, G, Swinburn, BA & Lawrence MA 2008, 'A systematic policy approach to changing the food system and physical activity environments to prevent obesity', *Australia and New Zealand Health Policy*, vol. 5, no. 13, doi: 10.1186/1743–8462–5-13, viewed 22 May 2014, <http://www.anzhealthpolicy.com/content/5/1/13>.

Sacks, G, Swinburn, BA & Lawrence MA 2009, 'Obesity policy action framework and analysis grids for a comprehensive policy approach to reducing obesity', *Obesity Reviews*, vol. 10, pp. 76–86.

Sadana, R, Simpson, S, Jennie, P, Albrecht, D, Hosseinpoor, AR & Kjellstrom, T 2011, 'Strengthening efforts to improve health equity', in JH Lee & R Sadana (eds), *Commission on social determinants of health knowledge networks*, *improving equity in health by addressing social determinants,* World Health Organization, Geneva, pp. 7–22.

Saguy, AC & Riley, K 2005, 'Weighing both sides: morality, mortality, and framing contests over obesity', *Journal of Health Politics, Policy, and Law*, vol. 30, no. 5, pp. 869–921.

St Leger, L 1997, 'Health promoting settings: from Ottawa to Jakarta', *Health Promotion International*, vol. 12, no. 2, pp. 99–101.

Salmon, A 2011, 'Aboriginal mothering, FASD prevention and the contestations of neoliberal citizenship'*,* *Critical Public Health*, vol. 21, no. 2, pp. 165-178.

Sayer, A 1997, 'Essentialism, Social Constructionism and Beyond', *The Sociological Review*, vol. 45, no. 3, pp. 453–487.

Schlosser, E 2001, *Fast food nation: the dark side of the all-American meal*, Houghton Mifflin Harcourt, New York.

Schwandt, TA 2000, 'Three epistemological stances for qualitative inquiry', in N. Denzin & Y. Lincoln (eds), *Handbook of qualitative research*, SAGE Publications, Thousand Oaks California, pp.189–213.

Scott-Samuel, A, Stanistreet, D and Crawshaw, P 2009, 'Hegemonic masculinity, structural violence and health inequalities', *Critical Public Health*, vol. 19, no. 3-4, pp. 287-292.Second International Conference on Health Promotion 1988, 'The Adelaide recommendations: healthy public policy', *Health Promotion*, vol. 3, no. 2, pp. 183–186.

Seligman, MEP & Csikszentmihalyi, M 2000, 'Positive psychology: an introduction'; *American Psychologist,* vol. 55, no. 1, pp. 5–14.

Shill, J, Mavoa1, H, Allender, S, Lawrence, M, Sacks, G, Peeters, A, Crammond, B & Swinburn, B 2011, 'Government regulation to promote healthy food environments – a view from inside state governments', *Obesity Reviews*, vol. 13, pp. 162–173.

Simpson, DP 1969, *Cassell's New Latin-English English-Latin Dictionary*, Cassell, London.

Singh, GK, Siahpush, M & Kogan, MD 2010, 'Rising social inequalities in US childhood obesity, 2003–2007', *Annals of Epidemiology*, vol. 20, no.1, pp.40–52.

Smith, A, Coveney, J, Carter, P, Jolley, G & Laris, P 2004, 'The Eat Well SA project: an evaluation-based case study in building capacity for promoting healthy eating', *Health Promotion International*, vol. 19, no. 3, pp. 327–334.

Smith, MB & Signal, L 2009, 'Global influences on milk purchasing in New Zealand – implications for health and inequalities', *Globalization & Health*, vol. 5, no.1, viewed 18 May 2014, <http://globalizationandhealth.com>.

Sobal, J 1995, 'The medicalization and demedicalization of obesity', in D Maurer & J Sobal (eds), *Eating agendas: food and nutrition as social problems*, Aldine de Gruyter, New York, pp. 67–90

Sobal, J & Stunkard, AJ 1989, 'Socioeconomic status and obesity: a review of the literature', *Psychology Bulletin*, vol. 105, pp. 260–275.

South Australian Council of Social Service 2008, *The social determinants of health*, SACOSS [South Australian Council of Social Service] Information Paper, December, South Australian Council of Social Service, Adelaide, Australia.

South Australian Department for Health and Ageing 2013, *South Australia: A Better Place to Live* (State Public Health Plan), Government of South Australia, Adelaide, Australia.

South Australian Department of Health 2006a, *Eat Well Be Active Healthy Weight Strategy for South Australia 2006–2010,* Government of South Australia, Adelaide, Australia.

South Australian Department of Health 2006b, *Eat Well South Australia: Public Health Nutrition Plan 2006–2008*, Government of South Australia, Adelaide, Australia.

South Australian Department of Health 2008a, *SA Health Strategic Plan 2008–2010,* Government of South Australia, Adelaide, Australia, viewed 6 February 2015, <http://www.health.sa.gov.au/DesktopModules/SSSA_Documents/LinkClick.aspx?tabid=46&table=SSSA_Documents&field=ItemID&id=864&link=T%3a%5c_Online+Services%5cWeb+Admin%5cIndividual_site_correspondence%5cProject+Correspondence%5cSASP%5cStrategic-P>.

South Australian Department of Health 2008b, *Eat Well Be Active Television advertising and the consumption of unhealthy food and drinks by children*, Consultation Paper, August, Department of Health, Adelaide, Australia.

South Australian Department of Health 2009, *OPAL by EPODE*, presented on 21 November 2009 at the seminar, How Early Is Too Early For Good Nutrition? organised by the SA Nutrition Network, in partnership with the Health Promotion Branch of SA Health, in Adelaide, Australia.

South Australian Department of Health 2010, *OPAL in SA*, presented on 26 July 2010 to the first 'Reducing Obesity in our Communities' Symposium, in Sydney, Australia, organised by the Centre for Health Innovation and Partnership (CHIP), Sydney West Area Health Service (SWAHS) and the International Life Sciences Institute South East Asia region (ILSI SEA).

South Australian Department of Health 2011, *Eat Well Be Active Strategy for South Australia 2011–2016*. Government of South Australia, Adelaide, Australia.

South Australian Department of Health website, *OPAL*, SA Health, updated 5 March 2015, viewed 2009–2015, last viewed 15 March 2015, <http://www.opal.sa.gov.au>.

South Australian Department of Planning and Local Government 2010, *The 30-Year Plan for Greater Adelaide,* Government of South Australia, Adelaide, Australia. Department of Planning, Transport and Infrastructure website, updated 13 April 2015, viewed 29 June 2015, <http://www.dpti.sa.gov.au/planning/30_year_plan>.

South Australian Monitoring and Surveillance System 2013a, *Unhealthy weight trends in South Australian adults, July 2002 to June 2013*, Government of SA, Adelaide.

South Australian Monitoring and Surveillance System 2013b, *South Australian Summary Target Report 2012/13:01 FY Body Mass Index: State, Metropolitan, Country and Local Health Networks, Adults aged 18 years and over, July 2012 to June 2013,* SAMSS, Adelaide.

South Australian Monitoring and Surveillance System 2013c, *South Australian Summary Target Report 2012/13:02FY Body Mass Index: State, Metropolitan, Country and Local Health Networks, Children aged 5 to 17 years, July 2012 to June 2013,* SAMSS, Adelaide.

Spurlock, M 2004, *Super Size Me*, documentary film, Kathbur Pictures, Dublin, Ohio, USA.

Stake, RE 2000, 'Case studies', in N. Denzin & Y. Lincoln, Y (eds), *Handbook of qualitative research*, SAGE Publications, Thousand Oaks, California, pp. 435–449.

Stead, M, Hastings, G & McDermott, L 2007, 'The meaning, effectiveness and future of social marketing', *Obesity Reviews*, vol. 8 (Suppl. 1), pp. 189–193.

Story, M & French, S 2004, 'Food advertising and marketing directed at children and adolescents in the US', In*ternational Journal of Behavioral Nutrition and Physical Activity*, vol. 1, p. 3, viewed 20 January 2015, <http://www.ijbnpa.org/content/1/1/3>.

Stuckler, D & Nestle, M 2012, 'Big food, food systems, and global health', *PLoS Medicine,* vol. 9, no. 6, e1001242, viewed 25 September 2012, <http://journals.plos.org/plosmedicine/article?id=10.1371/journal.pmed.1001242>.

Swinburn, B 2008, 'Obesity prevention: the role of policies, laws and regulations', *Australia and New Zealand Health Policy*, vol. 5, no. 12, viewed 19 July 2008, <http://www.anzhealthpolicy.com/content/5/1/12>.

Swinburn, BA 2009, 'Closing the disparity gaps in obesity', *International Journal of Epidemiology*, vol. 38, pp. 509–511.

Swinburn, B & Egger, G 2002, 'Preventive strategies against weight gain and obesity', *Obesity Reviews*, vol. 3, pp. 289–301.

Swinburn, B, Egger, G & Raza, F 1999, 'Dissecting obesogenic environments: the development and application of a framework for identifying and prioritizing environmental interventions for obesity', *Preventive Medicine*, vol. 29, pp. 563–570.

Swinburn, B, Malakellis, M, Moodie, M, Waters, E, Gibbs, L, Millar, L, Herbert, J, Virgo-Milton, M, Mavoa, H, Kremer, P & de Silva-Sanigorski, A 2013, 'Large reductions in child overweight and obesity in intervention and comparison communities 3 years after a community project', *Pediatric Obesity*, vol. 9, no. 6, pp. 455–462.

Tesh, S, 1988, *Hidden arguments: political ideology and disease prevention policy*, Rutgers University Press, New Brunswick, New Jersey.

Thaler, RH & Sunstein, CR 2009, *Nudge: Improving decisions about health, wealth and happiness,* Penguin, Harmondsworth, England.

Townend, L 2009, 'The moralizing of obesity: a new name for an old sin?' *Critical Social Policy*, vol. 29, no. 2, pp. 171–190.

Tsouros, AD (ed.) 1990, *World Health Organization healthy cities project: a project becomes a movement, review of progress 1987 to 1990,* WHO Regional Office for Europe, Copenhagen.

Van Dijk, T 1993, 'Principles of critical discourse analysis', Discourse & Society, vol. 4, no. 2, pp. 249-283.

Vaska, VL and Volkmer, R,2004) 'Increasing prevalence of obesity in South Australian 4-year-olds: 1995–2002', *Journal of Paediatrics and Child Health*, vol. 40, pp. 353–355.

Waitzkin, H. 1989, 'A Critical Theory of Medical Discourse: Ideology, Social Control, and the Processing of Social Context in Medical Encounters', *Journal of Health and Social Behavior,* vol. 30, no. 2, pp. 220-239.Wang, YC, McPherson, K, Marsh, T, Gortmaker, SL & Brown, M 2011, 'Health and economic burden of the projected obesity trends in the USA and the UK', *Lancet*, vol. 378, pp. 815–825.

Ward, PR, Verity, F, Carter, P, Tsourtos, G, Coveney, J & Wong, KC 2013, 'Food stress in Adelaide: the relationship between low income and the affordability of healthy food', *Journal of Environmental and Public Health*, vol. 2013, viewed 26 February 2013, <http://dx.doi.org/10.1155/2013/968078>.

Warin, M, Turner,K, Moore, V and Davies, M 2008, 'Bodies, mothers and identities: rethinking obesity and the BMI', *Sociology of Health & Illness*, vol. 30, no. 1, pp.97-111.

White, M 2007, 'Food access and obesity', *Obesity Reviews*, vol. 8 (Suppl. 1), pp. 99-107.

Whitehead, M 1992, *A fair chance for all: the concepts and principles of equity and health*, discussion paper prepared for WHO Regional Office for Europe, Copenhagen.

Wilkinson, RG & Marmot, MG (eds) 2003, *The solid facts: social determinants of health*, 2nd edition, Centre for Urban Health, World Health Organization, Copenhagen.

Wilkinson, R & Picket, K 2009, *The spirit level: why more equal societies almost always do better*, Allen Lane, Penguin Books, London.

Williams, M 2013, *Game changer: OPAL*, presented on 29 November 2013 to the 'Game changer: Evolving our approach to prevention' symposium, an Official Academic Symposium of the 2013 World Diabetes Congress 2013, Melbourne, Australia.

Williams, PG 2011, 'Can the poor in Australia afford healthy food?' *Nutrition & Dietetics* 2011, vol. 68, pp. 6–7.

Wong, KC, Coveney, J, Ward, P, Muller, R, Carter, P, Verity, V & Tsourtos, G 2011, 'Availability, affordability and quality of a healthy food basket in Adelaide, South Australia', *Nutrition & Dietetics*, no. 68, pp. 8–14.

Wisman, JD & Capehart, KW 2010,' Creative destruction, economic insecurity, stress, and epidemic obesity', *American Journal of Economics and Sociology*, vol. 69, no. 3, pp. 936–982.

Wisniewski, AE 2011, 'The weight of communication: The Canadian Medical Association Journal's discourse on obesity', *Public Understanding of Science*, vol. 22, no. 3, pp. 351–364.

World Health Organization, 1986, *Ottawa charter for health promotion*, WHO, Geneva.

World Health Organization, 2000, Technical report series 894, *Obesity: Preventing and managing the global epidemic, report of a WHO consultation*, WHO, Geneva.

World Health Organization, 2003 Technical Report Series 916, *Diet, nutrition, and the prevention of chronic diseases, report of a joint WHO/FAO expert consultation*, WHO, Geneva.

World Health Organization 2004, *Global Strategy on Diet and Physical Activity*, WHO, Geneva.

World Health Organization 2009, *Interventions on diet and physical activity: what works: summary report*, WHO, Geneva.

World Health Organization 2011, *World conference on social determinants of health, Rio political declaration on social determinants of health*, Geneva, viewed 4 January 2015, <http://www.who.int/sdhconference/declaration/en/>.

World Health Organization 2012a, *Population-based approaches to childhood obesity prevention*, WHO, Geneva.

World Health Organization 2012b, *Prioritizing areas for action in the field of population-based prevention of childhood obesity: a set of tools for Member States to determine and identify priority areas for action,* WHO, Geneva.

World Health Organization 2014, *Media centre: obesity and overweight*, [LM: stats about increases 1980 – 2008] Geneva, last updated August 2014, viewed 10 November 2014, <http://www.who.int/mediacentre/factsheets/fs311/en/#>.

World Health Organization 2015, *Global database on body mass index – BMI classification*, Geneva, last updated 2 January 2015, viewed 2 January 2015, <http://apps.who.int/bmi/index.jsp?introPage=intro_3.html>

World Health Organization Regional Office for Europe 2015, *Health 2020: the European policy for health and well-being*, Copenhagen, viewed 14 January 2015, <http://www.euro.who.int/en/health-topics/health-policy/health-2020-the-european-policy-for-health-and-well-being>.

Wymer, W 2010, 'Rethinking the boundaries of social marketing: Activism or advertising?' *Journal of Business Research*, vol. 63, pp. 99–103.

Yin, RK 2003, Case study research design and methods, 3rd edn, Sage Publications, Thousand Oaks, California.