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Weighing Status: Obesity, Class, and Health Reform

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In March 2010, Congress passed and President Obama signed two bills¹ intended to reform the nation's troubled health care system. That success follows almost a century of failed efforts. During that century, almost every other nation with significant economic resources, and many without, constructed a national health care system that provides universal or near-universal coverage. This Article considers a set of factors, grounded in the nation's peculiar socioeconomic hierarchy, that helps explain a long string of failed attempts to reform the health care system and that also explain a number of significant limitations of the reform now being implemented pursuant to the 2010 legislation.

Other determinants—some political,² some economic,³ and some social⁴ or cultural⁵—have also shaped the nation's ambivalent response to health care reform. The factors on which this Article focuses lie beneath society's radar. These factors stem from the nation's longstanding and deep-seated anxiety about class status and the use made, in an unselfconscious effort to assess and maintain class status, of stigmatizing images of socioeconomic "Others." More specifically, the opacity of class in the United States has rendered such stigmatizing images more powerful than they might be were class and relative class status transparent. Such stigmatizing images reinforce a barrier coveted by those who are, or who view themselves (or yearn to view themselves) as, relatively well situated on the nation's hierarchy of social status and economic well-being, but who

¹ Patient Protection and Affordable Care Act (Affordable Care Act), Pub. L. No. 111-148, 124 Stat. 119 (2010); Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029 (companion bill to the Affordable Care Act).

² See John B. Judis, *Tea Minus Zero: The Tea Party Menace Will Not Go Quietly*, NEW REPUBLIC, May 27, 2010, at 18, 19–21 (describing the political roots of Tea Party movement); see also *infra* Part I.B.1.

³ Those opposing the Affordable Care Act call attention to states' increasing concern about the potential cost of health care reform. *The Appeal of Repeal: Health Care*, ECONOMIST, June 24, 2010, http://www.economist.com/node/16438612?story_id=16438612.

⁴ Tea Party movement members, who widely opposed health care reform, mostly come from the lower segments of the middle class and generally blame those lower than they are on the socioeconomic hierarchy for their economic and social difficulties. Judis, *supra* note 2, at 20–21. Judis refers to an earlier *New York Times*/CBS poll that characterized those affiliated with the Tea Party as more wealthy. *Id.* at 20. Judis explains that the poll surveyed people who supported the Tea Party "but don't necessarily have anything to do with" it. *Id.*

⁵ See *infra* notes 66–70 and accompanying text.

fear displacement. That barrier separates them, at least psychologically, from those below them. More specifically, within the highly competitive American class system, groups and individuals concerned about the fragility and uncertainty of their own status may seek to buttress that status by forging images of the less fortunate “Other” and differentiating those images from images of “Self.”

In this competitive and uncertain socioeconomic setting, large groups of Americans—especially those struggling to sustain middle-class status—have long feared that expanding health care coverage and extending it to larger groups of people will blur the boundaries between those at the lower reaches of the middle class and those even less well-off. The fear has not generally been directly or expressly acknowledged. The implications are stunning and discomfiting.

Among the physical attributes associated with poverty in the United States, obesity is perhaps the most significant and the most complicated. This Article focuses on the association between poverty and obesity and the implications of that association for attitudes toward health care reform. It suggests that alongside the nation’s putative efforts to “fight” obesity sits a far less explicit attempt to undermine that effort. And it suggests that a similar conflict underlies the effort to mitigate poverty. These conflicts and the social tensions they reflect must be revealed and examined in order to understand fully the nation’s longstanding refusal, and its continuing reluctance, to provide adequate health care coverage for everyone.

Part I considers America’s peculiar class system, comparing the myth with the reality. It then explores the significance of that system in explaining the nation’s hesitation about providing health care coverage for everyone. Part II compares social assumptions about poverty with social assumptions about obesity. This Part suggests that the nation’s putative interest in ameliorating poverty and “fighting” obesity is undermined by conflicting interests. Part III then summarizes and offers an explanation of the 2010 health reform law’s limited response to obesity discrimination and to discrimination based on class. Finally, Part IV examines the implications of the nation’s ambivalent response to expanding health care coverage, both before *and after* passage of the 2010 health reform law. That ambivalence is illustrated through reference to conflated images of poverty and obesity.

I

THE AMERICAN IDEOLOGY OF CLASS: SOCIOECONOMIC STATUS AND ITS IMPLICATIONS FOR HEALTH

The United States has long adhered to a myth that presumes bridgeable gaps among classes and that promises great social mobility to those at the bottom.⁶ The myth teaches that those who work hard and make the right choices will succeed and, concomitantly, that poverty signals a lack of personal responsibility and a penchant for laziness.⁷ This myth—sometimes referred to as the Horatio Alger myth—lies deeply entrenched in the American psyche. However, it only tangentially reflects reality.⁸

The first section of this Part further delineates the ideology of relative classlessness in the United States as well as the reality, which largely belies that ideology. The next section reviews the significance of the ideology for understanding the nation's reluctant responses to health care reform.

*A. Socioeconomic Status in the United States**1. The Ideology of Class*

Among nations, the United States scores poorly on measures of both social mobility and socioeconomic equality. Of eight nations (Britain, Canada, Denmark, Finland, Norway, Sweden, the United States, and West Germany) studied by three British economists, the United States (on a par with Britain) had the lowest social mobility.⁹ Moreover, the United States has a very high level of income inequality compared to other nations.¹⁰ Measures of social mobility

⁶ See, e.g., STANLEY ARONOWITZ, FALSE PROMISES: THE SHAPING OF AMERICAN WORKING CLASS CONSCIOUSNESS 141 (1973); Richard Delgado, *The Myth of Upward Mobility*, 68 U. PITT L. REV. 879, 879–80 (2007).

⁷ Erika Blacksher, *Healthcare Disparities: The Salience of Social Class*, 17 CAMBRIDGE Q. HEALTHCARE ETHICS 143, 144 (2008) (class is a “suppressed” concept in the United States).

⁸ Martin J. McMahon, Jr., *The Matthew Effect and Federal Taxation*, 45 B.C. L. REV. 993, 1011 (2004) (noting the “inescapable conclusion that the Horatio Alger myth is exactly that, a myth”).

⁹ JO BLANDEN ET AL., INTERGENERATIONAL MOBILITY IN EUROPE AND NORTH AMERICA: A REPORT SUPPORTED BY THE SUTTON TRUST 3 (2005), available at <http://cep.lse.ac.uk/about/news/IntergenerationalMobility.pdf>.

¹⁰ RICHARD WILKINSON & KATE PICKETT, THE SPIRIT LEVEL: WHY GREATER EQUALITY MAKES SOCIETIES STRONGER 17 fig.2.1 (2010).

speak to the extent to which one's socioeconomic status during childhood determines one's status later in life and, conversely, the extent to which responsible choices, talent, and perseverance result in achieving a higher status than that of one's parents.¹¹ People along the socioeconomic hierarchy are distinguished by income, education, and health status, and they are far less likely to rise in the hierarchy than popular beliefs about class mobility suggest.

Yet, Americans have long assumed an open future for everyone with the presumptive intelligence to grasp, and the willpower to actualize, a set of cherished values. As a group, Americans presume that social mobility is achieved through hard work and responsible choices.¹² The nation has long deemed those at the bottom of the socioeconomic hierarchy to bear responsibility for their own plight.

Thus, Americans mask the consequences and blur the inequities of class status. Though long accustomed to denying the consequences of class, Americans have, at the same time, exerted significant energy in assessing differences in class status. They seek signs of class distinction everywhere. They attempt, often not quite self-consciously, to assess their status in comparison to that of others. And they disparage those whom they presume sit below them in the nation's socioeconomic hierarchy¹³—thus, perhaps reaffirming the fragility of assessments about class status in a nation that has assiduously denied the importance of class, at least for those in the “middle,” even as it has focused on assessing class status.

Americans—in this, reflecting their government—distinguish a class of very poor people from all others, but they are far less certain about whether and how to discern class divisions above that level.¹⁴

¹¹ BLANDEN ET AL., *supra* note 9, at 4. Blanden et al. looked specifically at the correlation between parental income and that of sons (born sometime between 1954 and 1973). *Id.* at 5–7.

In addition, increasing geographic segregation has accompanied the widening of differences between rich and poor in the United States. WILKINSON & PICKETT, *supra* note 10, at 162 (citing PAUL A. JARGOWSKY, *POVERTY AND PLACE: GHETTOS, BARRIOS, AND THE AMERICAN CITY* 71–73 (1997)); Paul A. Jargowsky, *Take the Money and Run: Economic Segregation in U.S. Metropolitan Areas*, 61 AM. SOC. REV. 984, 984–88 (1996).

¹² Blacksher, *supra* note 7, at 144.

¹³ See WILKINSON & PICKETT, *supra* note 10, at 164–66.

¹⁴ See Hans Kuttner & Matthew S. Rutledge, *Higher Income and Uninsured: Common or Rare?*, 26 HEALTH AFF. 1745 (2007), <http://content.healthaffairs.org/cgi/content/full/26/6/1745>. Kuttner and Rutledge remark, “Although the government has an official definition of who is poor, there is none for who is well-off. The line where higher income begins is subjective.” *Id.* at 1746.

The absence of express delineations of class beyond the separation between those in poverty and all others safeguards the belief that individual effort can result in a rise from rags to riches for virtually anyone adequately committed.¹⁵ This reflects and deepens the opacity of class in the United States.

2. Assessing Class Status

Even before the deep recession that began in 2008, social mobility was largely a myth except for a few “high achievers” who often attained great wealth.¹⁶ For most people, relative, if not absolute, living standards had been stagnant for decades.¹⁷ Since 2008, the middle class and those less fortunate have been threatened with a fall in their absolute standards of living, even as many of those at the very top have fared well.¹⁸ Millions of American workers are now without jobs, and many of those who have jobs have agreed to lower pay.¹⁹

Consequently, large segments of the nation are deeply anxious about safeguarding class status and the future generally. Fear of tumbling into poverty has now found its way into the middle classes.²⁰ Concern is not misplaced. While the greatest impact of the current recession has been on households with annual incomes of less than \$50,000,²¹ many in higher income groups have been affected.

¹⁵ The myth goes back to the nation’s founding. Benjamin Franklin explained in the late eighteenth century that “[l]aziness travels so slowly, that Poverty soon overtakes him.” SIMON P. NEWMAN, *EMBODIED HISTORY: THE LIVES OF THE POOR IN EARLY PHILADELPHIA* 143 (2003).

¹⁶ Janny Scott & David Leonhardt, *Shadowy Lines That Still Divide*, N.Y. TIMES, May 15, 2005, <http://www.nytimes.com/2005/05/15/national/class/OVERVIEW-FINAL.html>.

¹⁷ *Id.*

¹⁸ Robert Reich, *The Root of Economic Fragility and Political Anger*, SALON.COM (July 13, 2010, 10:14 AM), http://www.salon.com/news/great_recession/index.html?story=/news/feature/2010/07/13/reich_economic_anger.

¹⁹ *Id.* Reich reported that weekly pay for Americans decreased at an “annualized rate of 4.5 percent” in June 2010. *Id.*

²⁰ Benjamin Schwarz, *Life in (and After) Our Great Recession*, ATLANTIC, Oct. 2009, at 91 (noting the economic fragility of the “lower-upper-middle class and upper-middle class”).

²¹ PEW RESEARCH CTR., *A BALANCE SHEET AT 30 MONTHS: HOW THE GREAT RECESSION HAS CHANGED LIFE IN AMERICA*, at ii (2010), available at <http://pewsocialtrends.org/assets/pdf/759-recession.pdf> (noting that this group is most likely to say it is “in worse shape” than it was before the start of the recession).

Indeed, the level of long-term unemployment among American workers is now at its highest since the Great Depression.²²

Thus the peculiar American effort to assess relative class status is even tenser and more weighted with emotion than was the case a decade ago. It is played out through reference, among other things, to matters of “taste” (preferences in music, art, and reading material, for instance), homes of a certain kind in particular neighborhoods, clothing by named designers, and cars produced by certain manufacturers that may provide markers of class status. At any point, however, specific markers of socioeconomic status²³ may disappear, to be replaced by others of equal significance in the effort to assess one’s own and other people’s relative class status. Thus, in assessing socioeconomic status, people look to a shifting set of material objects and costly services. But the enterprise is almost never clear-cut because the particular objects and purchased experiences that reflect class status change over time.²⁴ And, in the context of the nation’s economic decline since 2008, the entire enterprise is far more worrisome for broader groups of people than it once was.

In light of that heightened anxiety, modes of seeking to assess status other than those evident through an examination of the material goods and luxury services of others have become more important. In particular, in assessing their own relative status, Americans also look to one another’s bodies for signs of class rank. In seeking to assess comparative socioeconomic status, Americans look to the embodiment of class status—in posture, weight, hair, dental condition, and overall health. These traits—though their meaning also may shift over time—are more permanent markers of status than specific consumer goods and services. Thus, Americans look to various physical embodiments of class—many correlated with good

²² William A. Galston, *America May Never Be the Same*, BROOKINGS (July 2, 2010), http://www.brookings.edu/opinions/2010/0702_america_galston.aspx.

²³ See WILKINSON & PICKETT, *supra* note 10, at 164–66.

²⁴ Especially in the years before the Great Recession, when high-status consumer goods were within the reach of many middle-class people, many of them participated actively in the effort to demonstrate higher class. Jennifer Steinhauer, *Class Matters: When the Joneses Wear Jeans*, N.Y. TIMES, May 29, 2005, <http://www.nytimes.com/2005/05/29/national/class/CONSUMPTION-FINAL.html>. As the middle class attempted to compete with each other in claiming higher class status through ownership of fancy automobiles, McMansions, and electronic devices, wealthy people purchased ever more expensive services such as personal chefs, exotic vacations, and tutors for their children that cost many hundreds of dollars an hour. *Id.*

health—in order to discern each other’s socioeconomic status. They assess each other’s physicality much as they assess each other’s material goods, in order to gauge relative status, and, in that, to safeguard their own perceived status relative to others.

3. *Class Status and Health*

The relationship between class status and health status is compelling and complicated, especially in societies such as the United States with a steep gradient separating people by socioeconomic status. Correlations between health and class are multiple.²⁵ Each, in some part, causes the other. Better health expands opportunities for higher income and more education.²⁶ At the same time, higher income increases access to resources (e.g., housing, food, medical care) that contribute to good health.²⁷ In addition, higher levels of education may facilitate more effective use of available resources.²⁸

a. *Sickness, Class, and Access to Care*

Sick people without health care coverage and without personal resources are unlikely to receive adequate care.²⁹ They will thus not fare as well as people with similar ailments who do have access to health care. Further, the progressive slope downward in health status as socioeconomic status decreases pertains whether socioeconomic status is measured through reference to income or through reference to education or occupation.³⁰ Moreover, social perceptions of

²⁵ Stephen L. Isaacs & Steven A. Schroeder, *Class—The Ignored Determinant of the Nation’s Health*, 351 N. ENG. J. MED. 1137, 1137 (2004). Isaacs and Schroeder note, for example, an inverse relationship between early death and class status. *Id.*

²⁶ Isabelle Joumard et al., *Health Status Determinants: Lifestyle, Environment, Health Care Resources and Efficiency* 27–28 (Org. for Econ. Cooperation & Dev., Working Paper No. 627, 2008), available at <http://www.oecd-ilibrary.org/content/workingpaper/240858500130>.

²⁷ *Id.* at 28.

²⁸ *Id.* at 27–28.

²⁹ Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010), and its companion bill, Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029, will significantly decrease the number of people in the United States with no health care coverage. However, these acts do not provide universal coverage. In particular, dozens of millions of undocumented immigrants will not be assured health care coverage beyond that offered for emergencies under the Emergency Medical Treatment and Active Labor Act (EMTALA), 42 U.S.C. § 1395dd (2006).

³⁰ Isaacs & Schroeder, *supra* note 25, at 1137.

differences in class status lead to presumptions about differences in health, and perceived differences in health lead to conclusions about differences in socioeconomic status.

A 2005 *New York Times* feature article documented the aftermath of a heart attack in three people who ranged in class status from wealthy to poor.³¹ “Class,” the author of the article reported,

informed everything from the circumstances of their heart attacks to the emergency care each received, the households they returned to and the jobs they hoped to resume. It shaped their understanding of their illness, the support they got from their families, their relationships with their doctors. It helped define their ability to change their lives and shaped the odds of getting better.³²

Further, healthier lifestyle choices are more likely to be available to people with adequate resources.³³ Smoking, unhealthy eating patterns, and a lack of physical activity all correlate with poor health.³⁴ Moreover, low socioeconomic status, especially within a society characterized by significant socioeconomic inequality, is an independent factor responsible for ill-health. This last explanation of the association between socioeconomic status and poverty is detailed and considered in subsection (c) of this section.

b. The Embodiment of Poverty

In the United States, people assume that discrepancies in health status correlate with differences in socioeconomic status even if they do not understand the factors underlying that correlation. In assessing each other’s class status, Americans look for and assess visible markers of the diseases and disabling conditions associated with low socioeconomic status. In short, they appraise each other’s physicality for markers of class status. Such assessments are generally not self-conscious. Rather, people respond quickly to subtle cues in reaching conclusions about other people.³⁵

³¹ Janny Scott, *Class Matters: Life at the Top in America Isn’t Just Better, It’s Longer*, N.Y. TIMES, May 16, 2005, <http://www.nytimes.com/2005/05/16/national/class/HEALTH-FINAL.html>.

³² *Id.*

³³ Isaacs & Schroeder, *supra* note 25, at 1137.

³⁴ *Id.* at 1138.

³⁵ The Face Research Laboratory at the University of Aberdeen in Scotland has done significant research on the use of subtle cues on which people rely to make quick assessments about other people. See, e.g., Lisa M. DeBruine et al., *The Health of a Nation*

Mark Peel's study of early twentieth century case records of the Australia Charity Organisation Society (COS) in Melbourne offers a detailed look at how such assessments occur and their power in consequent categorizations of people's character and status.³⁶ The COS interviewers, whose case records Peel studied, were charged with assessing applicants' eligibility for COS assistance. Case accounts often began with descriptions of applicants' bodies, and in particular, their physical frailties. Applicants suffered from the disabling conditions and diseases of poverty. They had bad teeth, bad eyes, signs of a meager diet, and cold homes. They had bronchitis and diabetes, they suffered from chronic pain, and their children failed to thrive.³⁷

Among these applicants, COS workers attempted to separate the so-called "deserving" poor from those deemed "undeserving."³⁸ Case workers found clues in applicants' bodies that led them to decide who should be offered aid and who should be turned down; even more, they assumed that applicants' moral worth was manifest in their bodies—in "gestures, expressions, dress and physical surroundings."³⁹ Although some caseworkers sought rational grounds on which to distinguish those worthy of assistance from those less worthy, others relied on indeterminate insights. Peel reports one among the latter group to have openly reported about one applicant, found unworthy of help: "She did not impress me favorably, but I could not tell why."⁴⁰

In the United States today, rich and poor alike resemble the Australian caseworkers whose records Mark Peel studied, in widely assuming that poor people are less likely to be healthy and less likely to look healthy than those presumed to be middle or upper class. Like the Australian caseworkers, Americans today read inchoate marks of

Predicts Their Mate Preferences: Cross-Cultural Variation in Women's Preferences for Masculinized Male Faces, 277 PROC. ROYAL SOC'Y B 2405 (2010).

³⁶ Mark Peel, *Imperfect Bodies of the Poor*, 4 GRIFFITH REV. 83 (2004). Peel hoped to show the "ebb and flow of compassion and truth" by examining case workers' characterizations of poor people's bodies. However, his essay is suggestive of a much wider use people make of one another's physicality in assessing the "Other" and themselves in relation to the "Other."

³⁷ *Id.* at 5–6.

³⁸ *Id.* at 7.

³⁹ *Id.* at 7–8.

⁴⁰ *Id.* at 7.

status embodied in one another's physicality—in their shape and size; teeth; posture; movements; and, to use Peel's phrase, in their "gestures, expressions, dress and physical surroundings."⁴¹

Such assessments—both in early twentieth century Australia and in the contemporary United States—presume to gauge moral worth. Moreover, they presume that class status reflects autonomous choices, freely rendered. However, that is not the case. Class status follows in large part from parental class status; in turn, class status determines health status in some part. Low socioeconomic status affects health, and poor health further diminishes economic productivity. Beyond this, those sitting at the lower end of a society's socioeconomic hierarchy are less likely than others to be healthy *even if* differential access to health care is discounted.⁴² The next subsection considers the implications of these findings.

c. Relative Socioeconomic Status and Health

The interrelated presumptions that individual choices determine class status and play a large role in determining health status are challenged, if not belied, by a body of research that locates many of the determinants of each in society's socioeconomic hierarchy and in the relative status of individuals within that hierarchy. Research conducted by Michael Marmot and colleagues, linking the health of British civil servants with their rank in the system (the so-called "Whitehall studies"), offers a remarkable challenge to the presumption that class and health can largely be determined felicitously by anyone adequately motivated and appropriately willful.⁴³ Results of the Whitehall research are especially compelling because everyone in the British civil service system enjoys high job security. And everyone enjoys national health coverage. Compared to the society at large, the system is homogeneous. The system's employees do not include Britain's richest or poorest people. Yet, status gradients in the system are plentiful and clear.

⁴¹ *Id.* at 7–8.

⁴² WILKINSON & PICKETT, *supra* note 10, at 163 (noting that the increased "stress, deprivation and difficulty" for poor people in segregated neighborhoods, includes "increased commuting times . . . increased risk of traffic accidents, worse schools, poor levels of services, exposure to gang violence, pollution, and so on").

⁴³ See MICHAEL MARMOT, THE STATUS SYNDROME: HOW SOCIAL STANDING AFFECTS OUR HEALTH AND LONGEVITY 38–45 (2004). The first Whitehall study involved men only. *Id.* at 38. Whitehall II included women and men among those studied. *Id.* at 53.

In the first of two Whitehall studies, Marmot and colleagues found that men between forty and sixty-four years of age at the lower end of the civil service hierarchy were at a four-fold risk of dying compared to men in the same age group at the top.⁴⁴ It is crucial, in interpreting these results, to remember that these men had essentially similar access to health care as men at the higher end of the system. Moreover, there was a gradient in mortality rates among civil servants that echoed socioeconomic status. Indeed, mortality rates and rank in the civil service paralleled each other from the top of the system to the bottom.⁴⁵ More astonishing still, lifestyle choices—choices that clearly *do* correlate with health outcomes—explained only a small part of the gradient in health. More people at the lower end of the civil service hierarchy engaged in behaviors harmful to health (e.g., smoking, getting little exercise, eating a poor diet), but even when the gradient was adjusted to account for such unhealthy behaviors, differences in health between those at the top of the system and those at the bottom remained.⁴⁶

A smoker who is low employment grade has a higher risk of heart disease than a smoker who is higher grade. A nonsmoker who is lower grade has a higher risk of heart disease than a nonsmoker who is higher grade. . . . For mortality as a whole, taking all causes together, the social gradient in mortality was nearly as steep in nonsmokers as it was in smokers. A similar conclusion applied to other risk factors.⁴⁷

Marmot follows this description with two pivotal questions:

The first is why smoking and other features of lifestyle should be more and more common as the social hierarchy is descended. The finding is not unique to Whitehall but is clearly evident in national data from the United Kingdom and the United States. . . . The second is, if these aspects of lifestyle account for less than a third of the social gradient in mortality, what accounts for the other two-thirds?⁴⁸

Marmot's answer to both questions is essentially the same. People—whether those of the British civil service or those of an entire nation—respond differently (both in behavioral choices and in

⁴⁴ *Id.* at 39.

⁴⁵ *Id.*

⁴⁶ *Id.* at 44–45.

⁴⁷ *Id.* at 45.

⁴⁸ *Id.*

physiological processes) depending on their relative place in the system's hierarchy and also depending, more specifically, on the level of social control that they enjoy within the hierarchy. In Marmot's words, "[S]ocial conditions affect the degree of autonomy and control individuals have and their opportunities for full social engagement. These needs, for control and participation, are more adequately met the higher your social position. As a result, health is better."⁴⁹

Those at the lower edge of a status hierarchy command less autonomy and personal control than those with higher statuses. The decision to engage in behaviors harmful to health, such as smoking, may well provide a unique avenue for a personal "indulgence" for people who spend almost all of their income providing for basic needs.⁵⁰ In that situation, "exhortations" not to smoke are not likely to be effective.⁵¹

The pathways through which health is compromised as the result of low socioeconomic status are more complicated and less certain. Marmot offers a few possibilities. Perhaps the most compelling of these explanations points to stress. Those without a sense of control over their everyday lives are more likely than others to experience stress—what Marmot describes, more specifically, as "sustained, chronic, and long-term stress."⁵² Marmot then suggests, mostly on the basis of animal studies, that this sort of stress—as opposed to acute stress that abates with time—decreases HDL cholesterol, increases triglycerides, and increases fasting glucose and insulin.⁵³ These measurements are associated with a set of diseases (e.g., coronary disease, diabetes) that are also linked to obesity.

Even more, low HDL cholesterol levels and high triglyceride, glucose, and insulin readings are associated with the development of central body fat. A disproportion of abdominal fat in combination with excess weight is particularly suggestive of diseases and disabling conditions associated with obesity.⁵⁴ Marmot concludes that stress

⁴⁹ *Id.* at 46.

⁵⁰ *Id.*

⁵¹ *Id.*

⁵² *Id.* at 107.

⁵³ *Id.* at 116–18.

⁵⁴ OBESITY EDUC. INITIATIVE, NAT'L INSTS. OF HEALTH, CLINICAL GUIDELINES ON THE IDENTIFICATION, EVALUATION, AND TREATMENT OF OVERWEIGHT AND OBESITY IN ADULTS, at xiv-xv (1998), available at <http://www.ncbi.nlm.nih.gov/books/n/obesity/pdf/TOC.pdf>. The report defines "abdominal fat" as follows: "Fat (adipose tissue) that is

may “play a part in the development of the pattern of obesity that is linked to heart disease and diabetes.”⁵⁵

Marmot’s work reinforces the conclusion that, in significant part, low socioeconomic status and its correlates (including poor health status) lie outside the control of those at the lower end of the socioeconomic hierarchy. Further, it provides an explanation for the association between low socioeconomic status and health that is independent of people’s comparative access to resources, including health care. The Whitehall findings hold true for whole societies and for subgroups within societies (such as the British civil service). Moreover, people living in nations with sharp differences in socioeconomic status, such as the United States, have poorer health overall than other nations.⁵⁶

Within the context of the American class system, the embodiment of low socioeconomic status provides an independent reference for gauging status. Conclusions about social and economic status, formed (though often not self-consciously) through reference to evidence about health status, have far-reaching consequences. These conclusions and the social processes that undergird them safeguard the class system while masking its significance and force. They further support powerful stereotypes that reinforce social inequality.⁵⁷

Even more, Americans whose socioeconomic status situates them above, but not securely above, those at the lower edge of the nation’s hierarchy seek to identify traits presumed to mark those below them and seek to distinguish themselves from that group. They prize, and thus elaborate, differences that separate them from those at the bottom. And, to the extent that traits that identify low status can be found in Others’ diseased or disabled bodies, many Americans have

centrally distributed between the thorax and pelvis” *Id.* app. VIII at 168. The definition further notes that abdominal fat “induces great health risk.” *Id.*

⁵⁵ MARMOT, *supra* note 43, at 119.

⁵⁶ See WILKINSON & PICKETT, *supra* note 10, 162–69.

⁵⁷ Parts III and IV of this Article analyze how perceptions of obesity serve to reinforce America’s competitive, opaque class system. Other marks of class that serve a similar function include dental condition (ranging from the obvious consequences of untreated decay to evidence that orthodontic work was needed but not received); posture and physical energy—an appearance of “fitness” rather than lethargy or the reverse; evidence of smoking (such as yellowed fingers); and the condition of head hair. Gary Tuabes, *Do We Really Know What Makes Us Healthy?*, N.Y. TIMES, Sept. 16, 2007, <http://www.nytimes.com/2007/09/16/magazine/16epidemiology-t.html> (poorer people are more likely to smoke and to be overweight than higher-income people).

long been and remain disgruntled about efforts to provide more universal health care. They are, to say it bluntly, concerned—again, not self-consciously—that such a concession will jeopardize their own place on the nation’s socioeconomic hierarchy.

Much, though certainly not all, of the recent history of opposition to health care reform in the United States finds its roots in the implicit conviction that the status of the presumed middle classes would be undermined should the nation provide health care to everyone.⁵⁸ The next section of this Part considers that conviction in the context of the effort to reform the nation’s health care system.

B. Relevance to Debate About Health Care Reform

The consequences of the conviction and of the fear that attends it can be discerned in the 2010 health care reform laws.⁵⁹ Moreover, several state and local initiatives, aimed at controlling behaviors and ameliorating conditions (such as obesity) associated with poor health, are as likely to stigmatize the behaviors and conditions at issue as to limit or eviscerate them.

The first subsection of this section briefly reviews the social parameters of opposition to universal or near-universal health care in the United States as the country moved toward the Affordable Care Act in 2010. Subsection two describes a set of provisions in the Affordable Care Act that provide for so-called “wellness programs” set up by employers,⁶⁰ and suggests that these programs—expressly aimed at encouraging personal efforts to prevent and respond to disabling conditions and risk factors associated with them—may also be less sanguine than the presumptive motive behind the programs might suggest. Finally, subsection three considers state and local programs with goals similar to those said to motivate “wellness programs” pursuant to federal law. This subsection, in particular,

⁵⁸ In addition, Americans who opposed health care reform in 2009 and 2010 focused on the high cost of reform, the added control that reform would likely give the federal government, the distribution at taxpayer expense of presumptively unearned largesse, and the evisceration of choice they feared from health care reform. See, e.g., Peggy Noonan, *The Town Hall Revolt: One Year Later*, WALL ST. J., July 10, 2010, <http://online.wsj.com/article/SB10001424052748704111704575355403205238916.html>.

⁵⁹ Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010); Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029.

⁶⁰ Affordable Care Act § 2705.

focuses on programs intended to encourage overweight and obese⁶¹ people to slim down.

1. *Opposition to Expanding Health Care Coverage*

Opposition to health care reform in the year leading up to the Affordable Care Act and in the months following its passage echoed long-standing antagonism in the United States to broadening federally funded health care to cover those without health insurance.⁶² In the twentieth century, seven American presidents tried, and failed, to reform the nation's system of health care coverage.⁶³ During the same years, the United States developed many other social welfare programs,⁶⁴ and other nations constructed systems delivering universal or near-universal health care.⁶⁵ A concatenation of political,⁶⁶ social,⁶⁷ and economic⁶⁸ factors coalesced that effectively prevented the United States from providing health care for its

⁶¹ The health care community defines “overweight” and “obese” in terms of body mass index (BMI). See *infra* note 152 and accompanying text. This article assumes that the meaning of these terms, as well as that of the term “fat,” shift over time and that to call someone “obese,” “overweight,” or “fat” is to make a social, as well as a medical, judgment.

⁶² When health care reform was enacted in 2010 almost 50 million people in the United States were without coverage. See, e.g., Paul Krugman, *Health Care Excuses*, N.Y. TIMES, Nov. 9, 2007, <http://www.nytimes.com/2007/11/09/opinion/09krugman.html> (noting that about 47 million people were without coverage and that about one-third of people in the United States under age sixty-five had no health care coverage at some period of time during 2006 and 2007).

⁶³ The seven presidents include Calvin Coolidge, Franklin Roosevelt, Harry Truman, Lyndon Johnson, Richard Nixon, Jimmy Carter, and Bill Clinton. COLIN GORDON, *DEAD ON ARRIVAL: THE POLITICS OF HEALTH CARE IN TWENTIETH-CENTURY AMERICA* 41–44, 269–71 (2003) (noting the roles of Roosevelt, Truman, and Clinton); PAUL STARR, *THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE* 394–96, 411 (1982) (noting the roles of Carter and Clinton); Wendy K. Mariner, *The Road to Health Reform*, 10 DEPAUL J. HEALTH CARE L. 543, 555 (2007) (reviewing JULIUS B. RICHMOND & RASHI FEIN, *THE HEALTH CARE MESS: HOW WE GOT INTO IT AND WHAT IT WILL TAKE TO GET OUT* (2005) (noting Johnson's role); Vicki Kemper, *What's Blocking Health Care Reform?*, 18 COMMON CAUSE MAG. 1, Jan.-Mar. 1992, at 8 (noting Coolidge's role).

⁶⁴ GORDON, *supra* note 63, at 1.

⁶⁵ *Id.* at 147.

⁶⁶ RICK MAYES, *UNIVERSAL COVERAGE: THE ELUSIVE QUEST FOR NATIONAL HEALTH INSURANCE* 17–19 (2004) (Roosevelt abandoned a program to provide health insurance because of opposition of special interests groups).

⁶⁷ GORDON, *supra* note 63, at 3 (noting the faith of Americans in “private solutions”).

⁶⁸ See generally *id.* (considering economic and political parameters of responses to health care reform in the United States).

citizenry.⁶⁹ In addition, the nation's abiding commitment to the presumptive virtues of autonomous individuality and a highly competitive, though often obscured, social hierarchy deterred attempts to deliver a new social benefit aimed at leveling discrepancies in health.⁷⁰

By 2009 and 2010, the nation had reached a tipping point. The number of people without health care coverage had become an unavoidably blatant sign of national failure.⁷¹ The explosive cost of health care screamed for some sort of reform.⁷² The Great Recession that began in 2008 offered a social setting that welcomed major change, and the nation had just elected a new president who made health care reform a central goal of his administration's first year.⁷³ Consequently, Congress passed and the President signed two bills, resulting in significant reform. Even so, that reform, which does not become fully effective until 2014, leaves millions of people outside the system⁷⁴ and provides wide loopholes for those who decide not to pay for health insurance.⁷⁵

⁶⁹ *Id.* at 147 (commenting that “by the 60s . . . every first- and second-world country except [the United States and] South Africa” had national health care).

⁷⁰ Janet L. Dolgin, *Class Competition and American Health Care: Debating the State Children's Health Insurance Program*, 70 LA. L. REV. 683, 716–21 (2010).

⁷¹ Krugman, *supra* note 62.

⁷² DONALD L. BARLETT & JAMES B. STEELE, CRITICAL CONDITION: HOW HEALTH CARE IN AMERICA BECAME BIG BUSINESS—AND BAD MEDICINE 12–27 (2006) (reporting comparatively high costs and low success of the American health care system compared with systems of other nations).

⁷³ *Obama: Staff Had No Idea of Ill. Scandal*, NAT'L PUB. RADIO (Dec. 11, 2008), <http://www.npr.org/templates/story/story.php?storyId=98150826> (newly elected President Barack Obama asked “how can [the nation] afford not to” enact health care reform).

⁷⁴ For example, estimates suggest that almost 12 million undocumented immigrants live in the United States. Adrienne Ortega, Note, . . . *And Health Care for All: Immigrants in the Shadow of the Promise of Universal Health Care*, 35 AM. J.L. & MED. 185, 186 (2009). It was widely agreed early in the debate that led to the Affordable Care Act that expanded coverage would exclude undocumented immigrants. *Senator Says Health Insurance Plan Won't Cover Illegal Immigrants*, HEALTHLEADERS MEDIA (May 22, 2009), <http://www.healthleadersmedia.com/content/HEP-233509/Senator-says-health-insurance-plan-wont-cover-illegal-immigrants.html> (reporting that Max Baucus (D-Mont.), then Chair of the Senate Finance Committee, announced that including “undocumented aliens [and] undocumented workers” in a national health care system was simply “too politically explosive”); see also Michael Scherer, ‘You Lie!’: Representative Wilson's Outburst, TIME (Sept. 10, 2009), <http://www.time.com/time/politics/article/0,8599,1921455,00.html>.

⁷⁵ See Sara Hansard, *Employee Benefits: Extent to Which Employers May Drop Coverage Under PPACA Unclear, Lawyer Says*, Health Care Daily Rep. (BNA) (July 14,

Moreover, even after passage of the Affordable Care Act, opposition to its implementation was strong and widespread. A significant percentage of the public—by some counts over half—opposed the new law, even months after its passage. That level of opposition after passage of major legislation is unusual.⁷⁶ According to a Rasmussen Poll, “[s]upport for repeal is strongest among middle income Americans.”⁷⁷ A group of congressional representatives called for repeal of the Act in the name of “the principles of freedom and individual choice.”⁷⁸ And by May 2010, twenty states⁷⁹ had joined a lawsuit questioning the constitutionality of the law.⁸⁰ The suit,⁸¹ initiated by Florida in March 2010, challenges the individual mandate, which requires citizens and legal residents to have health care coverage or pay a “penalty tax,” and the imposition of significant new Medicaid costs on the states.⁸²

2010). Employers will be able to save significant funds if they elect to pay penalties (\$2,000 per employee) rather than finance health care coverage. And individuals may decide to save money by paying penalties that cost less than health insurance. More specifically, healthy people may choose not to pay for health care coverage. If they become ill, they can then seek coverage. If healthy people do not pay for coverage, premiums will likely rise. See *Obamacare Passes*, NAT’L REV., Apr. 19, 2010, at 14.

⁷⁶ James Regions, Opinion, *Patch Wouldn’t Like ObamaCare Details*, SPRINGFIELD NEWS-LEADER (Missouri), June 12, 2010, at B5 (citing Rasmussen poll reporting that 56% of the public opposed the health care reform law). In July 2010, the Rasmussen poll found that 53% of voters continued to oppose the health care reform law and favored efforts to repeal it. *53% Favor Repeal of Health Care Law*, RASMUSSEN REPORTS (July 12, 2010), available at http://www.rasmussenreports.com/public_content/politics/current_events/healthcare/july_2010/53_favor_repeal_of_health_care_law.

⁷⁷ *53% Favor Repeal of Health Care Law*, *supra* note 76.

⁷⁸ Michele Bachmann, *Return GOP, Repeal and Replace Law*, HILL (Apr. 27, 2010), <http://thehill.com/special-reports/healthcare-april-2010/94665-return-gop-repeal-and-replace-law>.

⁷⁹ The states, in addition to Florida, include Alabama, Alaska, Arizona, Colorado, Georgia, Idaho, Indiana, Louisiana, Michigan, Mississippi, Nebraska, Nevada, North Dakota, Pennsylvania, South Carolina, South Dakota, Texas, Utah, and Washington. In addition, the National Federation of Independent Business and two individuals joined the suit. Drew Douglas, *NFIB, Seven More States Join Lawsuit, Challenging Federal Health Care Reform Law*, Health Care Daily Rep. (BNA) (May 17, 2010).

⁸⁰ Opinion, *Health Care: Prescribed Preparations*, ATLANTA J.-CONST., July 9, 2010, <http://www.ajc.com/opinion/health-care-prescribed-preparations-567775.html>.

⁸¹ Complaint, Florida *ex rel.* McCollum v. U.S. Dep’t of Health & Human Servs., 716 F. Supp. 2d 1120 (N.D. Fla. 2010) (No. 3:10-cv-91 RV/EMT), 2010 WL 1038209.

⁸² *Id.*; see also Douglas, *supra* note 79.

2. *Prevention Efforts: Federal, State, and Local*

This subsection considers some potentially harmful consequences of governmental programs constructed, presumably in good faith, to prevent or limit various risk factors associated with disease and disabling conditions. This subsection begins by examining “wellness programs” established by the Affordable Care Act. It then considers some state and local programs aimed at helping people lose, or at least not gain, weight.

a. *“Wellness Programs”: The Affordable Care Act*

This subsection addresses one parameter of the federal health care reform law—encouraging “wellness programs.” While ostensibly aimed at facilitating public health, these programs have a less obvious and less fortuitous side. They may well further stigmatize people with a variety of health concerns associated with poverty. The next subsection considers programs at the state and local level that have similar consequences.

The analysis here should not be read to suggest an intentional effort on the part of the federal legislature to undermine efforts to minimize disparities in health status (while, ironically, expanding opportunities for health care).⁸³ However, even programs that, on their face, are responsive to the health needs of a wide segment of the American public may reinforce the status quo or even exacerbate existing inequalities. Although such consequences are likely not intentional, neither are they accidental. The programs at issue are grounded on the presumption that individuals bear significant responsibility for their own health status. Americans in general, and liberals in particular, excuse those who do not exercise or eat well to the extent that such failures are perceived as due to a lack of resources. But that excuse largely evaporates in the context of governmentally sanctioned “wellness” programs.

⁸³ Evidence of good faith is found, for instance, in interim final regulations, announced on July 14, 2010, that require insurers to offer preventive services (e.g., screenings for cancer, blood pressure tests, and weight-loss counseling) without the imposition of copayments, deductibles, or coinsurance. Sara Hansard, *Rules Require New Health Plans to Cover Preventive Services Without Cost Sharing*, Health Care Daily Rep. (BNA) (July 15, 2010).

The Affordable Care Act (echoing provisions in the 1996 Health Insurance Portability and Accountability Act⁸⁴) authorizes group health plans (beginning in 2014) to provide premium discounts to employees who participate in “wellness programs.” The discounts can be as much as 30% of the cost of premiums and may eventually rise to 50% of the cost; the Act allows premiums of employees’ dependents to become eligible for similar discounts if the dependent(s) in question participate in the employers’ wellness program.⁸⁵ The law also provides for “rewards” in the form of waivers of other cost-sharing fees, such as deductibles, copayments, coinsurance, relief from surcharges, and provision of a benefit the plan does not otherwise provide.⁸⁶

The statute defines a “wellness program” as one “offered by an employer that is designed to promote health or prevent disease.” “Wellness programs” must be voluntary and cannot be a “subterfuge for discriminating based on a health status factor.”⁸⁷ Small businesses without “wellness programs” will become eligible for grants to develop them.⁸⁸ Employers receiving funds from such grants must agree to develop “wellness programs” that include “health awareness initiatives”;⁸⁹ work to “maximize employee engagement”;⁹⁰ include programs to “change unhealthy behaviors and

⁸⁴ Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191, § 262, 110 Stat. 1936, 2021–31 (codified at 42 U.S.C. §§ 1320d-1 to 1329d-8 (2006)).

⁸⁵ Affordable Care Act, Pub. L. No. 111-148, sec. 1201, § 2705, 124 Stat. 119, 156–60 (2010). The provision permits the Secretaries of Labor, Health and Human Services, and the Treasury to increase the discount up to 50% of the cost of premiums if that increase is deemed “appropriate.” *Id.* The limit before passage of the Act for premium adjustments offered to those participating in wellness programs was 20%. Roni Caryn Rabin, *Could Health Overhaul Incentives Hurt Some?*, N.Y. TIMES, Apr. 12, 2010, <http://www.nytimes.com/2010/04/13/health/13land.html?scp=1&sq=Could%20Health%20Overhaul%20Incentives%20Hurt%20Some?&st=cse>.

⁸⁶ Affordable Care Act sec. 1201, § 2705(j)(3)(A).

⁸⁷ *Id.* § 2705(j)(3)(B). The law also requires “a reasonable alternative standard (or waiver of the otherwise applicable standard) for obtaining the reward for any individual for whom, for that period, it is unreasonably difficult due to a medical condition to satisfy the otherwise applicable standard” and for a person for whom “it is medically inadvisable to attempt to satisfy the otherwise applicable standard.” *Id.*

⁸⁸ *Id.* § 10408, 124 Stat. at 977–78.

⁸⁹ *Id.* Health awareness initiatives are defined to include “health education, preventive screenings, and health risk assessments.” *Id.*

⁹⁰ *Id.*

lifestyle choices”;⁹¹ and provide workplace environments that support good health, replete with policies encouraging “healthy life-styles, healthy eating, increased physical activity, and improved mental health.”⁹²

In this set of provisions, the health reform law pays obeisance to the notion that individuals bear responsibility for their own health but can be guided through a system of rewards and penalties to make the “right” choices. These notions receive wide support among the American public, generally, and among health care providers, more specifically.⁹³ Yet, as Dr. Sandeep Jauhar explains, although lifestyle choices (including decisions about what and how much to eat) play a role in health, they are only one set of factors. Other essential factors—not addressed by “wellness programs”—include socioeconomic status and genetics.⁹⁴ Jauhar opines that good health should be encouraged, but those who make choices deemed “wrong” by the health care system should not be punished—especially insofar as punishing those who make choices associated with poor health does not work.⁹⁵

The provisions of the Affordable Care Act that reduce health care coverage costs for people who participate in “wellness programs” are framed as creating a reward program. In truth, they have a punitive dimension. Existing “wellness programs” suggest the character of that dimension. Certain people, including those who smoke, weigh too much, have high blood pressure, or decide not to be part of a screening or health management program, pay higher premiums and other costs than others.⁹⁶ The sickest people are likely to be excluded from “wellness programs” (even if the programs appear to provide options for them).⁹⁷ And poorer people are less likely to have the

⁹¹ These programs can take the form of “counseling, seminars, online programs, and self-help materials.” *Id.*

⁹² *Id.* The provision authorizes the appropriation of \$200,000,000 for 2011 through 2015 to finance grants to employers setting up “wellness programs.” *Id.*

⁹³ Sandeep Jauhar, *No Matter What, We Pay for Others’ Bad Habits*, N.Y. TIMES, Mar. 29, 2010, <http://www.nytimes.com/2010/03/30/health/30risk.html?ref=health>.

⁹⁴ *Id.*

⁹⁵ *Id.*

⁹⁶ See Rabin, *supra* note 85.

⁹⁷ *Id.*

luxury of participating fully in such programs.⁹⁸ Something as simple as transportation costs may limit participation. Law professor Timothy Stoltzfus Jost has expressly described the “wellness programs” created pursuant to the Affordable Care Act as a surrogate for insurers “to continue to underwrite based on health status.”⁹⁹

That the “wellness programs” incorporated in the Affordable Care Act may be less useful to—or may even disadvantage—poorer and sicker people is essential to this Article’s claim that, even as the nation passed a health reform law, after a century of struggle, it failed to address the most basic socioeconomic disparities—disparities that make the poor sicker and keep them sick. In consequence, those disparities will continue to result in significantly different health outcomes, depending on socioeconomic status.¹⁰⁰

b. Prevention: State and Local Efforts

This subsection considers a variety of state and local responses to ill-health. In tune with the focus of the next Part of this Article, it addresses laws and regulations aimed at preventing and responding to obesity. The resulting programs—such as the “wellness programs” created by the Affordable Care Act—are of less value than might be suggested by the presumptive good intentions behind them.

Most basically, there is significant evidence suggesting that public efforts to “fight obesity” are misguided. First, fatness—short of extreme obesity—is less concerning as a risk to health than popular accounts claim. Moderate obesity does not seem to cause ill-health. One explanation for the correlations between obesity and poor health is that obesity is often accompanied by unfit. And lack of fitness correlates at least as strongly with ill-health as does obesity.¹⁰¹ In particular, people who are thin and unfit are more likely to suffer from ill-health and die prematurely than people who are fat and unfit.¹⁰² Second, public responses to obesity are largely

⁹⁸ Jauhar, *supra* note 93. Jauhar describes the dubious results of a 2006 West Virginia initiative to reward patients in the state’s Medicaid program who enrolled in wellness programs and followed the orders of their physicians. *Id.*

⁹⁹ Rabin, *supra* note 85.

¹⁰⁰ See *infra* Part II.C.

¹⁰¹ Katherine Mayer, Note, *An Unjust War: The Case Against the Government’s War on Obesity*, 92 GEO. L.J. 999, 1023–24 (2004).

¹⁰² *Id.* at 1030 tbl.1.

ineffective.¹⁰³ On the whole, programs aimed at weight reduction have limited neither obesity nor rates of mortality.¹⁰⁴ And third, focusing on obesity as a central health risk inevitably emphasizes personal responsibility for obesity and a host of illnesses associated with obesity, thus creating shame and reinforcing prejudicial, social stereotypes of those who are overweight and obese.¹⁰⁵ Indeed, many public responses to obesity (including aspects of the “wellness programs” created by the Affordable Care Act)¹⁰⁶ are more likely further to stigmatize overweight people (especially poor, overweight people) than to result in significant weight loss for anyone.

Most legislation that responds to public concern about Americans’ weight is grounded on a set of stereotypic assumptions.¹⁰⁷ Such legislation generally presumes that people become fat through a failure of self-control and personal responsibility. This subsection examines two modes of state and local response to the perception that Americans are too fat.¹⁰⁸ One response prohibits people from eating certain foods or prohibits restaurants and other food vendors from

¹⁰³ See Rebecca M. Puhl & Chelsea A. Heuer, *Obesity Stigma: Important Considerations for Public Health*, 100 AM. J. PUB. HEALTH 1019, 1021 (2010). Studies of a variety of weight-loss interventions show a 5–9% loss after six months and no more than a 6% loss after a year. *Id.*

¹⁰⁴ See Mayer, *supra* note 101, at 1018; see also *id.* at 1018 n.135 (noting that drug treatment and surgery may be exceptions to the general failure of weight loss programs).

¹⁰⁵ See *infra* Part III (delineating stereotypes and stigma linked with overweight and obesity).

¹⁰⁶ See *infra* Part III.A.

¹⁰⁷ This Article uses the terms “fat,” “obese,” and “overweight” to describe those who are deemed to weigh too much by the health care community, or by some other segment of society, or by both. The terms “obese” and “overweight” are used by health care providers and are defined through reference to height and weight comparisons. See *infra* notes 170–71 and accompanying text (defining BMI). “Fat” is the term preferred by most advocacy groups that focus on precluding, or at least limiting, discrimination against fat people. See, e.g., NAT’L ASS’N TO ADVANCE FAT ACCEPTANCE, <http://www.naafaonline.com/dev2/> (last visited Apr. 9, 2011).

¹⁰⁸ A 2010 Robert Wood Johnson Foundation report notes that, among other things, twenty states and Washington, D.C., set standards for nutrition in school lunch programs stricter than those set by the U.S. Department of Agriculture; twenty-eight states and Washington, D.C., set standards of nutrition for vending machine and other foods sold in schools; thirty-three states tax the sales of soda; and five states require menu labeling. ROBERT WOOD JOHNSON FOUND., *F AS IN FAT: HOW OBESITY THREATENS AMERICA’S FUTURE* 7 (2010), available at <http://healthyamericans.org/reports/obesity2010/Obesity2010Report.pdf>.

selling certain foods. The other sort of response would actually prohibit people deemed fat from eating in restaurants.¹⁰⁹

The first response is illustrated by efforts (in New York City,¹¹⁰ Philadelphia, and elsewhere¹¹¹) to ban or limit the use of trans fats and by the effort (in parts of Los Angeles) to impose zoning bans on fast-food restaurants in certain neighborhoods.¹¹² New York City's ban on trans fats unilaterally prohibits the use of trans fats in restaurants. The ban presumes openly that consumers are unprotected by either their own capacity to choose healthy foods or by the willingness of industry to sacrifice its economic interests by making healthy, though more expensive, choices in food preparation.¹¹³ The ban seems equitable insofar as it applies to all restaurants and their customers. And yet, an increase in restaurant prices caused by the use of more costly products in place of trans fats differentially affects poor people. In general, bans on unhealthy, but comparatively inexpensive, food products would serve health *and* justice were bans combined with the subsidization of more expensive substitutes for banned products.¹¹⁴

Limitations on fast-food restaurants in poor neighborhoods raise additional issues. In 2008, the Los Angeles City Council approved a one-year zoning ban on new fast-food restaurants in South Los Angeles.¹¹⁵ The provision aimed to facilitate healthy eating in an area in which over a quarter of the residents had incomes below the

¹⁰⁹ This response has been proposed in state legislative bills; none has passed. *See infra* notes 120–26 and accompanying text.

¹¹⁰ N.Y., N.Y., RULES tit. 24 § 81.08 (2010), available at http://24.97.137.100/nyc/rcny/title24_81_08.asp. The New York City ban covers only artificial trans fats, not those found naturally in food products such as meat and dairy products. *Id.* § 81.08(a)–(b); *see also* Katherine Kruk, Note, *The Constitutionality of the New York City Trans-Fat Ban*, 18 WM. & MARY BILL RTS. J. 857, 874 (2010).

¹¹¹ Kruk, *supra* note 110, at 857 n.4 (listing Philadelphia; California; Boston; and Montgomery County, Maryland among places in which trans-fat bans have been promulgated or are under consideration).

¹¹² Molly Hennessy-Fiske & David Zahniser, *Council Bans New Fast-Food Outlets*, L.A. TIMES, July 30, 2008, <http://articles.latimes.com/2008/jul/30/local/me-fastfood30>.

¹¹³ *See* Kruk, *supra* note 110, at 864–67.

¹¹⁴ Anne Kingston & Nicholas Kohler, *L.A.'s Fast-Food Drive-by*, MACLEAN'S (Aug. 13, 2008), http://www.macleans.ca/science/health/article.jsp?content=20080813_34253_34253.

¹¹⁵ *Id.* The legislation provided for two extensions of six months each. *Id.*; *see also* Hennessy-Fiske & Zahniser, *supra* note 112.

federal poverty line¹¹⁶ and almost one-third of children were obese.¹¹⁷ This provision differs, at least on its face, from New York City's trans-fat ban because it applied transparently to people living in poor neighborhoods but not to others. It can thus be perceived, in William Saletan's phrase, to "treat[] poor people like children."¹¹⁸ "[T]elling certain kinds of restaurants," explained Saletan, "that they can't serve certain kinds of people is just plain wrong, even when you think it's for their own good."¹¹⁹

An astonishing legislative proposal to control obesity appeared in the Mississippi legislature in 2008.¹²⁰ The bill, offered in seriousness by its sponsor,¹²¹ would have prohibited "certain food establishments" from serving "any person who is obese based on criteria prescribed by the state health department."¹²² It resembled the Los Angeles zoning ordinance in that it aimed at precluding certain people from eating fattening restaurant foods. However, it discriminated against all fat people rather than poor, fat people. The bill was also surprisingly straightforward in stereotyping and stigmatizing obese people. One blog devoted to discussions about food, health, and weight bluntly commented on the bill's stigmatizing implications by illustrating a news item about the bill with what appears to be the window of a public establishment, presumably a restaurant, featuring a sign reading, "We cater to white trade only."¹²³

¹¹⁶ Kingston & Kohler, *supra* note 114.

¹¹⁷ Hennessy-Fiske & Zahniser, *supra* note 112 (noting that about 25% of children in Los Angeles as a whole were obese).

¹¹⁸ William Saletan, *Food Apartheid: Banning Fast Food in Poor Neighborhoods*, SLATE, (July 31, 2008), <http://www.slate.com/id/2196397>.

¹¹⁹ *Id.*

¹²⁰ Lisa Stein, *Fat? No Food for You!*, SCI. AM. (Feb. 7, 2008), <http://www.scientificamerican.com/article.cfm?id=fat-no-food-for-you> (discussing Mississippi State House Bill 282).

¹²¹ Sandy Szwarc, *No Fat People Allowed: Only the Slim Will Be Allowed to Dine in Public!*, JUNKFOOD SCI., (Jan. 31, 2008), <http://junkfoodscience.blogspot.com/2008/01/no-fat-people-allowed-only-slim-will-be.html> (reporting that lead sponsor of the bill, Representative Mayhall, explained that the bill was offered as a serious piece of legislation even though he did not believe it would pass).

¹²² *Id.*; see also Julie Kent, *Mississippi Legislature Introduces Bill That Would Ban Restaurants from Serving the Obese*, CLEVELAND LEADER (Feb. 2, 2008), <http://www.clevelandleader.com/node/4524>; *Miss. Considers Restaurant Ban for Obese*, CBS NEWS (Feb. 5, 2008), <http://www.cbsnews.com/stories/2008/02/05/national/main3790418.shtml>.

¹²³ Szwarc, *supra* note 121.

One of the bill's sponsors, answering a blogger's question, confirmed the seriousness of the bill.¹²⁴ It was, of course, impractical and quite likely unconstitutional. As a news item in *Scientific American* explained, waiters with the task of winnowing out fat customers would face a grim and thankless task.¹²⁵ The bill died in committee.¹²⁶

Genuine ambivalence about obliterating disparities in health and socioeconomic status underlies the "prevention" efforts delineated in this section. The remainder of this Article aims to explain that ambivalence and its far-reaching implications for America's still-fragile commitment to providing universal or near-universal health care. In exploring these claims, the Article will now focus on social, political, and medical responses to obesity.

II

EMBODIED POVERTY: OBESITY AND CLASS

The ideology of poverty and the ideology of obesity in the United States share a set of assumptions that stigmatize poor people and overweight people in a similar fashion. As a result, each can signal the other. First and most important, American society has long attributed fault to those in poverty; it now attributes a similar understanding of fault to those deemed too heavy. Society denigrates those who are poor and those who are obese and then blames them for their presumptive plight.

Section A of this Part briefly reviews the history of social responses to weight in the United States. Next, section B attempts to distinguish popular beliefs about obesity from contrasting evidence about its actual causes and consequences. Section C addresses the conflation of images of obesity with images of poverty, and it specifically considers the consequences of obesity and low socioeconomic status for health.

¹²⁴ *Id.* (naming Representative Mayhall as the sponsor who described the bill as serious).

¹²⁵ Stein, *supra* note 120.

¹²⁶ *Id.*

A. *Social Responses to Weight in the United States*

Until recently in human history, material circumstances dictated what and how much most people ate.¹²⁷ Choices were limited. People ate when food was available. By the eighteenth century, food supplies became more secure.¹²⁸ That had far-reaching consequences both for society's responses to food and body size, and for the association between those two and socioeconomic status.

The first subsection of this section summarizes the history of responses to fatness in the United States. The second subsection describes the so-called moral panic that now surrounds discussions of weight.

1. *History of Obesity in the United States*

By the start of the Industrial Revolution, Western society began to connect status with the quality, as well as the quantity, of foods eaten.¹²⁹ Yet, in the United States, large body size remained a source of pride, especially for men, until the late nineteenth and early twentieth centuries. As late as 1866—by which time the details of dieting programs had already begun to provide popular reading¹³⁰—a group of wealthy businessmen proudly created the Fat Man's Club.¹³¹ For these men, large size reflected authority and power.¹³² The Club lasted until the first decade of the next century.¹³³

By the end of the nineteenth century and the start of the twentieth century, Americans, especially those in the middle and upper classes, had begun to prize slimmer bodies and more controlled eating habits. Michael Carolan correlates the later trend with a more general effort

¹²⁷ Michael S. Carolan, *The Conspicuous Body: Capitalism, Consumerism, Class and Consumption*, 9 *WORLDVIEWS* 82, 85 (2005) (noting that “[o]nly a privileged few ate lavishly” until the modern period).

¹²⁸ *Id.* at 86.

¹²⁹ *Id.*

¹³⁰ Buck Wolf, *Belly Laughs at Early Fad Diets: Tasty Morsels from Weight-Loss History*, ABC NEWS (Jan. 10, 2005), <http://abcnews.go.com/Entertainment/WolfFiles/story?id=1537630>. (noting the publication of William Banting's “Letter on Corpulence” in 1864).

¹³¹ Carolan, *supra* note 127, at 87 (noting the 1866 creation in the United States of the Fat Man's Club).

¹³² *Id.*

¹³³ LYNNE LUCIANO, *LOOKING GOOD: MALE BODY IMAGE IN MODERN AMERICA* 20 (2001) (noting closing of Fat Man's Club in 1903).

to control bodies and bodily emanations.¹³⁴ Overeating began to suggest a failure of control that encouraged visions of obesity as animal-like: “We may refer to [those who are obese or who overeat] as a type of animal—a pig, hog, or cow, perhaps.”¹³⁵ These images continue to provide powerful stigmatizing metaphors for fat people. Focus on personal control—in eating and in living, more generally—became a badge of middle-class existence by the end of the nineteenth century.¹³⁶

Increasingly, society viewed healthy eating as a matter of choice and, thus, almost inevitably, as a moral matter.¹³⁷ By the late nineteenth and early twentieth centuries, a new field of expertise—food science—expressly urged people to make food choices that promoted health.¹³⁸ This science cemented the belief that people bear responsibility for their own physicality. Food choices—including both the quantity and quality of food eaten—were linked with health and ill-health. Society could thus blame fat people—and at least some ill people—for their own presumed plight.

Culture constructs understandings of both fat and health.¹³⁹ Thus, even a half century before the isolation of vitamins¹⁴⁰ and the appearance of nutritional science, people differentiated between fatness associated with health and fatness associated with illness. Sander Gilman noted the distinction in social views of the “healthy ‘stout’” from those of the “unhealthy obese.”¹⁴¹ Thinness was not yet universally extolled. Gilman illustrated the social difference between

¹³⁴ Carolan, *supra* note 127, at 91.

¹³⁵ *Id.*

¹³⁶ PETER N. STEARNS, *FAT HISTORY: BODIES AND BEAUTY IN THE MODERN WEST* 59 (1997) (noting the advent of “allowances” for children intended, among other things, to train them in affecting control over resources).

¹³⁷ *Id.* at 54–55.

¹³⁸ Carolan, *supra* note 127, at 82, 87.

¹³⁹ The notion of disease and obesity as socially constructed does not, of course, mean that these are not real. See SANDER L. GILMAN, *FAT: A CULTURAL HISTORY OF OBESITY* 14 (2008).

Constructing diseases such as obesity does not always mean inventing them. Often real pathological experiences are rethought as part of a new pattern that can be then discerned, diagnosed, and treated. Obesity as a category has been the subject of such a public reconceptualization over the past decades.

Id. at 14.

¹⁴⁰ Carolan, *supra* note 127, at 88.

¹⁴¹ GILMAN, *supra* note 139, at 8.

modes of obesity through reference to Charles Dickens's depiction in *The Pickwick Papers* of the fat boy, Joe.¹⁴² Joe's size is presumed to be mirrored in his lazy, somnambulant character. In fact, almost everyone in Dickens's novel is large. But the size of Samuel Pickwick and his bourgeois friends is portrayed as the fatness of energy. The fatness of Joe, the servant, is of a different order.¹⁴³ Joe's fatness is that of poverty, illness, and servility. Joe's body, suggested Gilman, could be read as "a symptom of his class."¹⁴⁴ By the early twentieth century, Americans similarly bifurcated images of fatness. The fat men of the Fat Man's Club, large in size as in authority, stood in contrast with the fatness the nation had begun to associate with poverty and with a number of newly arrived immigrant groups.¹⁴⁵

Increasingly, in a notable historic irony, Americans came widely to associate thinness with wealth and high socioeconomic status, and obesity with poverty and low socioeconomic status. Indeed, significant numbers of middle-class and wealthy Americans are not thin. However, many, if not most, of them yearn to be thin and, thus, adhere to a moral code that requires a continuing effort to weigh less.¹⁴⁶ That adherence, suggests Peter Stearns, may be at least as important as achieving weight loss. Thus even those who are not thin can express their status by voicing their commitment to the virtues of self-control.

Attacks on sin never eliminated it, even among believers. The same holds true for the American battle against fat, with its religious-like traits. Even when people did not lose weight, the cultural standards could be accepted, even internalized, precisely because they caused moral anxiety. . . . [I]t was a profession of concern about weight, a promise to diet soon, that counted, not necessarily victorious slenderness.¹⁴⁷

Even overweight politicians from states in which many people are categorized as overweight or obese must now claim an interest in becoming thin—or at least an awareness that they *should* claim that

¹⁴² *Id.* at 46–48.

¹⁴³ *Id.* at 47 (citing JULIET MCMASTER, *DICKENS THE DESIGNER* 25, 88 (1987)).

¹⁴⁴ *Id.* at 60 (adding that Joe's body is also "the physiognomy of the primitive that haunts this world of work").

¹⁴⁵ Carolan, *supra* note 127, at 88.

¹⁴⁶ STEARNS, *supra* note 136, at 147.

¹⁴⁷ *Id.* at 147–48.

interest. Governor Haley Barbour of Mississippi—a possible Republican candidate for the Presidency in 2012—has been portrayed as “squat, big-bellied and pink-jowled.”¹⁴⁸ Almost one-third of his state’s adult population is classified as obese.¹⁴⁹ Queried by news reporters about the chances of his entering the 2012 race, Barbour at once acknowledged the importance for politicians to be thin and, in a stunning phrase, challenged the sanity of the preference. In answer to the news media’s question about his political plans, Barbour quipped that were he soon to lose a significant amount of weight, people would be justified in assuming either that he was “running” or that he had cancer.¹⁵⁰

Yet, even as Americans have become obsessed with weight loss—or, more accurately, with a commitment to lose weight—they are becoming larger. At what size someone becomes “fat” is culturally determined.¹⁵¹ However, by contemporary standards, between half and two-thirds of the people in the United States are overweight or obese.¹⁵²

2. *Moral Panic: The Sin of Obesity*

Obesity has become the subject of widespread exhortation, the object of prevention programs, the context for something resembling a national apology, and the stimulus for what can rightly be referred to as a moral panic.¹⁵³ Yet, as the next section of this Part shows, evidence that large size—short of extreme obesity—poses a serious risk to health is less convincing than many popular reports suggest.

¹⁴⁸ Mark Leibovich, *G.O.P. Stalwart Says Come, the Gulf’s Fine*, N.Y. TIMES, June 19, 2010, www.nytimes.com/2010/06/20/US/20barbour.html?_r=1&ref=mark_leibovich.

¹⁴⁹ Stein, *supra* note 120.

¹⁵⁰ Christina Wilkie, *Gov. Haley Barbour’s Waistline Suggests He Will Run in 2012*, HILL (June 28, 2010), <http://thehill.com/capital-living/in-the-know/106005-gov-haley-barbours-waistline-suggests-he-will-run-in-2012>.

¹⁵¹ STEARNS, *supra* note 136, at 129 (noting that nineteenth-century American society approved of “plumpness”).

¹⁵² Jeffrey M. Friedman, *Modern Science Versus the Stigma of Obesity*, 10 NAT. MED. 563, 563 (2004) (defining overweight as a BMI of more than 25). BMI is discerned by dividing height (in meters) by weight (in kilograms) squared. *See infra* note 171 and accompanying text.

¹⁵³ *See* GILMAN, *supra* note 139, at 13 (declaring that “the moral panic about obesity has reinforced the very notion of excess weight as morally repugnant, unhealthy, and socially irremediable”).

The nation's horror about obesity must thus be understood, at least in part, as misguided—as a displacement of other concerns.

A decade ago, then Secretary of Health and Human Services, Tommy Thompson, exclaimed that “[o]verweight and obesity are among the most pressing new health challenges we face today.”¹⁵⁴ “Our modern environment,” Thompson added, “has allowed these conditions to increase at alarming rates and become a growing health problem for our nation.”¹⁵⁵ Thompson's concern has been widely echoed during the ensuing decade.¹⁵⁶

In February 2010, Michelle Obama launched “Let's Move,” a campaign to “solve the problem of childhood obesity.”¹⁵⁷ The cover of *Newsweek's* March 2010 issue portrayed Mrs. Obama—smiling broadly, a string of pearls around her neck and one apple on the table at which she sat—announcing a national campaign to combat childhood obesity.¹⁵⁸ Mrs. Obama characterized obesity as a national epidemic and a national security threat.¹⁵⁹ Another *Newsweek* article

¹⁵⁴ News Release, Office of the Surgeon Gen., U.S. Dep't of Health & Human Servs., Overweight and Obesity Threaten U.S. Health Gains (Dec. 13, 2001), available at http://www.surgeongeneral.gov/news/pressreleases/pr_obesity.htm.

¹⁵⁵ *Id.*

¹⁵⁶ Two years later, Surgeon General David Satcher issued a “call to action,” urging people to take note of a national “obesity epidemic.” OFFICE OF THE SURGEON GEN., DEP'T OF HEALTH & HUMAN SERVS., THE SURGEON GENERAL'S CALL TO ACTION TO PREVENT AND DECREASE OVERWEIGHT AND OBESITY (2001), available at <http://www.surgeongeneral.gov/topics/obesity/calltoaction/CalltoAction.pdf>; see also Michael T. Heaney, Book Review, 32 J. HEALTH POL. POL'Y & L. 131, 132 (2007) (reviewing J. ERIC OLIVER, FAT POLITICS: THE REAL STORY BEHIND AMERICA'S OBESITY EPIDEMIC (2006)). Soon thereafter, an article published in the *Journal of the American Medical Association* announced that 400,000 Americans die each year from “obesity-related” conditions. Jacob Sullum, *Lay Off the Fatties: They're Not Hurting Anybody—Maybe Not Even Themselves*, 38 REASON, Nov. 2006, at 74, available at <http://reason.com/archives/2006/10/30/lay-off-the-fatties> (reviewing J. ERIC OLIVER, FAT POLITICS: THE REAL STORY BEHIND AMERICA'S OBESITY EPIDEMIC (2006) and PAUL CAMPOS, THE DIET MYTH: WHY AMERICA'S OBSESSION WITH WEIGHT IS HAZARDOUS TO YOUR HEALTH (2005)). A year later, according to Sullum, the estimate was dramatically decreased—to 100,000 deaths each year related to obesity. *Id.*; see also Daniel Engber, *The Fat and Short of It*, N.Y. TIMES, Oct. 15, 2009, <http://www.nytimes.com/2009/10/18/magazine/18fob-essay-t.html> (noting Centers for Disease Control and Prevention estimate of 112,000 obesity-related deaths each year).

¹⁵⁷ Michelle Obama, *Michelle on a Mission*, NEWSWEEK (Mar. 14, 2010), <http://www.newsweek.com/2010/03/13/michelle-on-a-mission.html>.

¹⁵⁸ *Id.*

¹⁵⁹ Penny Starr, *First Lady Links Childhood Obesity to National Security in Launch of 'Let's Move' Campaign*, CNSNEWS.COM (Feb. 9, 2010), <http://www.cnsnews.com/news>

about Michelle Obama's campaign to combat obesity described America's "Culture of Corpulence" in which obesity should be viewed as a "personal threat," an "epidemic," and a "disease."¹⁶⁰

How Americans frame fatness largely determines how they respond to the claim that, as a nation, they have become too large. "Fat acceptance advocates and researchers" employ a political frame in responding to obesity.¹⁶¹ Accordingly, they view fatness as an instance of body diversity and advocate acceptance, tolerance, and nondiscriminatory responses to fat people.¹⁶² Others, in contrast, medicalize obesity, suggesting that tolerance should, in this context, be replaced with public health responses that monitor weight and urge weight-conscious eating choices.¹⁶³ And still others see fatness as the inevitable consequence of a widespread failure of self-control—a vision that blames the putative victim for his or her plight. Here, fatness becomes a moral flaw.

B. The "Facts"¹⁶⁴ and Ideology of Obesity: Contrasting Evidence About Obesity's Causes and Consequences

The social debate about obesity is punctuated with statistics and presumptions about healthy (or "normal") weights. Such presumptions are conditioned by shifting culturally determined preferences. Yet, information about weight trends in the United States shows a nation whose residents have become increasingly large. This information is generally, but should not necessarily be, understood in evaluative terms.¹⁶⁵ The evidence that being

/article/61157. Mrs. Obama explained that obesity threatened the nation's security because "obesity is now one of the most common disqualifiers for military service." *Id.*

¹⁶⁰ Claudia Kalb, *Culture of Corpulence*, NEWSWEEK (Mar. 14, 2010), <http://www.newsweek.com/2010/03/13/culture-of-corpulence.html>.

¹⁶¹ Abigail C. Saguy & Kevin W. Riley, *Weighing Both Sides: Morality, Mortality, and Framing Contests over Obesity*, 30 J. HEALTH POL. POL'Y & L. 869, 873, 899 (2005).

¹⁶² *Id.* at 873.

¹⁶³ *Id.* at 873, 899–900.

¹⁶⁴ See BARBARA J. SHAPIRO, *A CULTURE OF FACT: ENGLAND, 1550–1720*, at 1 (2000) (noting that the concept of "fact" has become problematic in contemporary culture).

¹⁶⁵ Law professor Paul Campos suggests that large size may, at least in part, be related to good health. He notes that Americans' increasing size occurred during a century in which Americans have also enjoyed better health. During the last several generations, he notes, Americans, on average, have "gone from being thin and sickly to being fat and healthy." Paul Campos, Op-Ed, *Fat Doesn't Equal Unhealthy*, ROCKY MOUNTAIN NEWS

overweight (short of being extremely overweight) causes ill-health is inconclusive.¹⁶⁶ There is significant evidence suggesting, in fact, that fat discrimination and its consequences pose a significant risk to health.¹⁶⁷ The first subsection of this section summarizes claims about Americans' larger size and the link between increases in weight and ill-health. The next subsection then delineates three theories about the causes of obesity.

1. The Relation Between Obesity and Health in the United States

During the last four decades, the percentage of people in the United States classified as overweight has increased from about half to three-quarters of the population.¹⁶⁸ As many as 130 million adults in the United States are overweight or obese according to guidelines established by the National Heart, Lung and Blood Institute.¹⁶⁹ Obesity is said to cost the nation \$147 billion each year in medical expenses.¹⁷⁰

Moreover, Americans, on average, have a higher body mass index (BMI) than people in many other comparatively wealthy countries.¹⁷¹

(Aug. 1, 2006), <http://www.rockymountainnews.com/news/2006/aug/01/bcampos-fat-doesnt-equal-unhealthy/>.

¹⁶⁶ Paul Campos et al., *The Epidemiology of Overweight and Obesity: Public Health Crisis or Moral Panic?*, 35 INT'L J. EPIDEMIOLOGY 55, 56–58 (2006).

¹⁶⁷ Gina Kolata, *Whether a Child Lights Up, or Chows Down*, N.Y. TIMES, July 10, 2010, <http://www.nytimes.com/2010/07/11/weekinreview/11kolata.html>. Kolata reports that one expert, when asked to compare the health risks of smoking and obesity, referred to the negative consequences of the stigma attached to obesity, while recognizing that nothing presents a greater risk to health than smoking. *Id.*

¹⁶⁸ WILKINSON & PICKETT, *supra* note 10, at 89. The authors report that the percentage of obese people in the U.S. population during the same years (1970–2009) has increased from 15% to one-third of the population. *Id.* at 89; *see also* B. Jarrett et al., *The Influence of Body Mass Index, Age and Gender on Current Illness: A Cross-Sectional Study*, 34 INT'L J. OBESITY 429, 429 (2010) (noting an increase of about one-third in the percentage of people in the United States categorized as obese).

¹⁶⁹ Nadia N. Ahmad & Lee M. Kaplan, *It Is Time for Obesity Medicine*, 12 VIRTUAL MENTOR 272, 273 (2010), *available at* <http://virtualmentor.ama-assn.org/2010/04/pdf/medu1-1004.pdf>. In 1998, 97 million adults in the United States were categorized as overweight or obese. OBESITY EDUC. INITIATIVE, *supra* note 54, at xi.

¹⁷⁰ ROBERT WOOD JOHNSON FOUND., *supra* note 108, at 107. The report notes that \$147 billion in medical costs is 10% of the nation's medical spending. The data were from 2006. *Id.*

¹⁷¹ BMI is calculated by dividing a person's weight in kilograms by his or her height in centimeters squared (i.e., weight/height²). The non-metric conversion formula is weight in pounds divided by height in inches squared, multiplied by 703 (i.e., (weight/height²) x 703). OBESITY EDUC. INITIATIVE, *supra* note 54, at 1.

In 1998, the World Health Organization reported that 20% of American males and 25% of American females between twenty and seventy-four years of age were obese (identified as those with a BMI of 30 or higher).¹⁷² Contemporaneously, 15% of men and 17% of women in England were considered obese, and 5% of men and 9% of women in Sweden and 2% of men and 3% of women in Japan were categorized as obese.¹⁷³

Obesity has been associated with hypertension, dyslipidemia (high total cholesterol), type 2 diabetes, cardiovascular disease, certain forms of cancer,¹⁷⁴ and sleep apnea,¹⁷⁵ among other conditions. However, evidence that being overweight generally causes these conditions or that losing weight generally cures them is equivocal.¹⁷⁶ Research shows that only significant obesity (a BMI of 35 or more) poses a higher risk of death.¹⁷⁷ Even more, people with a

BMI is widely relied on by the government and health care providers to identify obesity. However, it is controversial and less accurate as a predictor of diseases and disabling conditions linked with obesity than other measures (e.g., waist:hip ratio). See SUSIE ORBACH, *BODIES* 123 (2009).

¹⁷² Rodolfo Valdez & David F. Williamson, *Prevalence and Demographics of Obesity*, in *EATING DISORDERS AND OBESITY* 417, 420 tbl.75.3 (Christopher G. Fairburn & Kelly D. Brownell eds., 2d ed. 2002). A BMI of 25 to 29.9 is considered overweight, a BMI of over 30 is considered obese, and a BMI of 40 or more suggests “extreme obesity.” OBESITY EDUC. INITIATIVE, *supra* note 54, at xii, xvii tbl.ES-4.

¹⁷³ Valdez & Williamson, *supra* note 172, at 420 tbl.75.3. Samoa had more obese men (42% for rural Samoa and 58% for urban Samoan men), and more obese women (59% for rural and 77% for urban Samoan women) than any other nations described in the study. *Id.*

¹⁷⁴ OBESITY EDUC. INITIATIVE, *supra* note 54, at 18 (noting relation between obesity and colon, endometrial, and gallbladder cancer and to death from breast cancer, especially among postmenopausal women, though obesity is inversely associated with premenopausal cancer).

¹⁷⁵ *Id.*

¹⁷⁶ Gina Kolata, *Still Counting on Calorie Counting; Study Aside, Fat-Fighting Industry Vows to Stick to Its Mission*, N.Y. TIMES, Apr. 29, 2005, <http://query.nytimes.com/gst/fullpage.html?sec=health&res=9804EEDB1131F93AA15757C0A9639C8B63&fta=y&sc p=2&sq=still%20counting%20on%20calorie%20counting&st=cse>.

¹⁷⁷ Paul Campos, Op-Ed., *A Weighty Matter: Latest Study Merely Confirms Fat Haters' Arguments Flabby*, ROCKY MOUNTAIN NEWS, May 14, 2005, at 12C, available at 2005 WLNR 7680430; Kolata, *supra* note 176.

One study that compared data from a National Health and Nutrition Examination Survey done in 1988–1994 with one done in 2003–2004 found an increase in prescribed medication (understood as a surrogate for ill-health) among obese people (as compared with “normal-weight people”) only in older age groups. The authors thus suggested that “an increased BMI requires time before it results in an increased medication load.” Jarrett et al., *supra* note 168, at 433. However, increases in prescription medication do not

comparatively low BMI are at greater risk of developing health problems than those with a high BMI (until one reaches an extremely high BMI).¹⁷⁸ Finally, there is disagreement among researchers about whether losing weight significantly reduces the risk of obesity-related conditions.¹⁷⁹ A decade-long study carried out in Sweden revealed that the blood pressure and cholesterol levels of patients who had bariatric surgery fell after the surgery but then rose to above presurgery levels.¹⁸⁰

A third set of factors may explain the correlation between obesity and ill-health. A general state of unfitness may be important in explaining many instances of obesity and the diseasing and disabling conditions associated with it.¹⁸¹ In addition, diabetes, coronary disease, and hypertension have all been associated with a variety of genetic alterations.¹⁸² Moreover, variants of “the diabetes susceptibility genes” have been associated with coronary disease and high cholesterol, among other conditions.¹⁸³ These findings serve, at the very least, as a reminder that correlations suggest, but do not prove, causative links.

Subsection two of this section considers three common theories about the causes of overweight and obesity. The theories are distinct but not mutually exclusive. In particular, they carry different implications for the accuracy of the presumption that people are fat because they are inadequately motivated to lose weight.

2. *Theories About Obesity*

The most familiar medical paradigm that explains obesity reflects the principle that weight gain results from a surfeit of energy (taking

necessarily indicate increased illness. *Id.* at 434. Other explanations are possible. Health care providers may, for instance, respond differently to patients with similar symptoms and diagnoses but differences in BMI and thus prescribe more medication for the same condition to people with high BMIs. *Id.*

¹⁷⁸ Campos, *supra* note 177.

¹⁷⁹ Kolata, *supra* note 176 (noting that evidence of significant weight loss is not compelling in part because many people who lose weight regain it).

¹⁸⁰ *Id.* Surgery patients in this study included fewer cases of diabetes than a comparison group. *Id.*

¹⁸¹ Mayer, *supra* note 101, at 1023–24.

¹⁸² Tamara Hirsch, *More Genes Linked to Diabetes Found*, BIONEWS (July 5, 2010), http://www.bionews.org.uk/page_65425.asp. Twelve gene variants recently linked with type 2 diabetes raise the total number of such genetic variants to over three dozen. *Id.*

¹⁸³ *Id.* (quoting Dr. Jim Wilson of Edinburgh University).

in more calories than one uses) and weight loss is the consequence of an “energy deficit” (using more energy than one takes in).¹⁸⁴ That truism has been used to support the assumption that anyone, adequately motivated and self-controlled, can lose weight. The conclusion does not necessarily follow from the principle. There is a spectrum of additional explanations of weight gain and loss. Some look to personal control in explaining overweight and obesity. Others temper that view by noting the role of genetics in calibrating individual energy balance. Some focus on the success of corporate advertising in directing food choices. And still others look at socioeconomic status as an independent causative factor. Each of these views is considered below.

a. Weight and Energy Balance

The most basic theory about weight gain and loss¹⁸⁵ provides an accurate, but insufficient, explanation. Traditionally, many scientific researchers, physicians, and members of the public have assumed that obesity follows in a straightforward manner from bad lifestyle choices (e.g., too much food of the wrong sort, not enough physical activity). Most troubling, the traditional understanding of obesity assumes that failed diets and weight gain after a successful diet signaled a failure of will power.

This view of obesity encourages the belief that being overweight or obese is a “characterological flaw”¹⁸⁶ and that, in consequence, those who are overweight are responsible for that fact and could alter it were they only prepared to exert adequate self-control. The model is particularly problematic insofar as virtually no method for losing weight and maintaining weight loss has proved generally successful.¹⁸⁷ And some popular methods—including fad diets, surgery, and diet drugs—carry significant risks of their own.¹⁸⁸

¹⁸⁴ OBESITY EDUC. INITIATIVE, *supra* note 54, at 72. The report explains that “[a] decrease in calorie intake is the most important dietary component of weight loss and maintenance.” *Id.* at 74.

¹⁸⁵ This theory focuses on energy balance. Ahmad & Kaplan, *supra* note 169, at 272.

¹⁸⁶ *Id.* at 273.

¹⁸⁷ Campos et al., *supra* note 166, at 57.

¹⁸⁸ *Id.* at 58 (noting “serious side effects, up to and including death” of “many of the tools that are currently employed” to help people lose weight).

Less moralistic versions of this approach medicalize obesity, opening the way for health care providers to respond successfully to overweight patients, themselves anxious to lose weight. A medicalized approach may envision a concatenation of factors (including psychological, social, nutritional, genetic, and physiologic factors) as the cause of obesity and may thus suggest that patients (defined in some medicalized models as “having obesity” rather than as “being obese”) are best served by “a variety of behavioral, nutritional, pharmacologic, and surgical therapies.”¹⁸⁹

b. Genetics

Such presumptions about weight encourage blame and guilt and are challenged by recent scientific theories that posit differences among people in the rate at which calories are converted into usable energy and the rate at which energy is expended.¹⁹⁰ Theories identifying a genetic component in weight gain and loss minimize, but do not obliterate, the role of individual choice.

Some theorists identify genetics as the largest factor in explaining at least comparative weight within a society. Jeffrey Friedman reports that the genetic component in obesity is as significant as that for height and greater than that for a wide variety of other conditions, including schizophrenia, breast cancer, and heart disease.¹⁹¹ He expressly confronts the presumption that only people with inadequate self-control become and remain fat: “The commonly held belief that obese individuals can ameliorate their condition by simply deciding to eat less and exercise more is at odds with compelling scientific evidence indicating that the propensity to obesity is, to a significant extent, genetically determined.”¹⁹² Researchers have suggested possible loci for genetic alterations associated with obesity on almost every chromosome.¹⁹³

¹⁸⁹ Ahmad & Kaplan, *supra* note 169, at 273.

¹⁹⁰ Louise Townend, *The Moralizing of Obesity: A New Name for an Old Sin?*, 29 CRITICAL SOC. POL’Y 171, 175 (2009).

¹⁹¹ Friedman, *supra* note 152, at 563.

¹⁹² *Id.*

¹⁹³ R. Rosmond, *Aetiology of Obesity: A Striving After Wind?*, 5 OBESITY REVS. 177, 179 (2004). Only the Y chromosome seems not to have a locus associated with obesity. *Id.*

Friedman acknowledges that the availability of ample calories (if not always nutritious calories) for almost everyone might account for weight gain in the U.S. population in approximately the last decade. However, he argues that genetics account for most of the differences in individuals' weight. In supporting this claim, Friedman refers to genetic alterations that make permanent weight loss extremely difficult. Genetics may, for instance, determine physiological responses that maintain weight by balancing weight loss with a decrease in energy expended and an increase in hunger.¹⁹⁴ Thus, for people with certain genetic alterations—and easy access to ample calories—any weight loss will soon be followed by “compensatory responses,” resulting in weight gain.¹⁹⁵

There are a few single-gene defects that account for obesity in a Mendelian fashion.¹⁹⁶ But these are rare.¹⁹⁷ Researchers have identified a number of common, but less influential, genetic alterations associated with obesity.¹⁹⁸ However, the search for the loci of genetic alterations responsible for most obesity is ongoing.¹⁹⁹ In all likelihood, research will prove the contribution of genetics to most obesity to involve a number of loci on various chromosomes, each of which plays a small role in determining weight but which, as a group, may play a more significant role.²⁰⁰

For most obese people, genes favoring weight gain interact with the environment to result in increased weight.²⁰¹ Friedman suggests that, perhaps, during periods of hardship and food scarcity, evolution selected for genes predisposing people to obesity.²⁰² That

¹⁹⁴ Friedman, *supra* note 152, at 563.

¹⁹⁵ *Id.*

¹⁹⁶ *Id.* at 568 (noting that “[t]he frequency of mendelian inheritance of morbid obesity is . . . higher than that of most complex disorders”).

¹⁹⁷ Rosmond, *supra* note 193, at 179.

¹⁹⁸ *Id.* Clear genetic alterations associated with obesity have been located on five or six chromosomes. There are also a variety of suspected loci on all other chromosomes (except Y). *Id.*

¹⁹⁹ *Id.*

²⁰⁰ *See id.*

²⁰¹ Friedman, *supra* note 152, at 568.

²⁰² *Id.* Theorists have hypothesized the existence of a “thrifty gene,” which provides for efficient fat storage in times of adversity. Rosmond, *supra* note 193, at 179. This hypothesis suggests that weight gain may be a consequence of a genome constructed to provide for survival in times of hunger within the context of a modern “sedentary”

supposition finds support in the prevalence of serious obesity among populations that suffered from especially adverse conditions.²⁰³ The notion of a “thrifty phenotype” implicates both genetic and environmental pathways in explaining obesity. For instance, poor nutrition during gestation may correlate with a set of diseases associated with lifestyle patterns; these diseases include diabetes, hypertension, and glucose intolerance.²⁰⁴ An elaboration of the hypothesis posits that stress during pregnancy alters fetal development so as to lower metabolism in the child and thus pose a risk of obesity for that child.²⁰⁵

Still, however, genetic explanations of weight gain and loss, even if accurate, do not fully explain recent shifts in population weight in the United States and much of the rest of the world. That is, even to the extent that genetics (including notions such as those of the “thrifty gene” or “thrifty phenotype”) can explain significant overweight among certain individuals within a population as well as the ease with which individuals gain and lose weight, it does not explain recent increases in population weight overall.²⁰⁶ A few researchers have suggested that an adenovirus may contribute to obesity.²⁰⁷ Many others have focused on the role of environmental and social factors.

c. Social and Environmental Factors

Recent increases in population weight have been attributed to a wide set of social and environmental factors. The explanations noted in this subsection look to social or environmental factors to explain obesity and overweight in the contemporary United States.

A widely accepted socio-environmental explanation of overweight and obesity focuses on a set of lifestyle patterns. These include the comparatively sedentary lives of most Americans, high-calorie food that offers little nutritional value but is comparatively inexpensive,

lifestyle and the availability of comparatively inexpensive, high-calorie, low-nutrition foods. *See id.*

²⁰³ Friedman, *supra* note 152, at 568.

²⁰⁴ I.P. Gray et al., *The Intrauterine Environment Is a Strong Determinant of Glucose Tolerance During the Neonatal Period, Even in Prematurity*, 87 J. CLINICAL ENDOCRINOLOGY & METABOLISM 4252, 4252 (2002).

²⁰⁵ WILKINSON & PICKETT, *supra* note 10, at 100.

²⁰⁶ *Id.* at 90.

²⁰⁷ *See, e.g.*, Frank Greenway, *Virus-Induced Obesity*, 290 AM. J. PHYSIOLOGY: REG., INTEGRATIVE & COMP. PHYSIOLOGY R188 (2006).

corporate greed, and fast-food restaurants.²⁰⁸ The relation between each of these factors and increased calorie intake or decreased energy expenditure is more or less direct. Another familiar, though not unrelated, explanation focuses on the public's putative moral slackness.²⁰⁹ This explanation, which attributes obesity to a widespread failure of moral control, harmonizes with the traditional explanation of obesity described.

A rather different explanation—one that focuses on the role that class status, *per se*, plays in causing obesity—suggests that obesity, especially central-body adiposity, is a consequence of the stresses that fall on those at the bottom of the nation's class hierarchy. This explanation is not considered in detail in this subsection but is the focus of section C of this Part.

(i) Lifestyle and Food

In a country in which almost everyone moves about in mechanized vehicles and spends working time sitting in offices and leisure time in front of televisions and computers, people are far more sedentary than they once were. In responding, for the nation, to a perceived “epidemic of childhood obesity,” Michelle Obama named her campaign “Let’s Move.” In a popular magazine, she explained that “walks to school have been replaced by car and bus rides,” and afternoons of physical play “have been replaced with afternoons inside with TV, videogames, and the Internet.”²¹⁰ In addition, calorie-laden foods—so-called “fast foods”—are cheap and generally not nutritious.²¹¹ Beginning in the eighties, children became the new “consumers.”²¹² At that time, marketing firms began to focus on young consumers. Now fast-food chains spend billions of dollars each year on television and other forms of advertising and marketing directed at children.²¹³ Between 2003 and 2007, the fast-food industry significantly increased its television advertising for foods

²⁰⁸ See, e.g., Campos et al., *supra* note 166, at 58–59.

²⁰⁹ See, e.g., *id.*

²¹⁰ Obama, *supra* note 157.

²¹¹ WILKINSON & PICKETT, *supra* note 10, at 90.

²¹² ERIC SCHLOSSER, *FAST FOOD NATION: THE DARK SIDE OF THE ALL-AMERICAN MEAL* 43 (2001).

²¹³ *Id.* at 47–49.

such as pizza, burgers, and fried chicken.²¹⁴ For low-income families, fast-food restaurants, with inexpensive but calorie-rich food (without significant nutritional value), offer an inexpensive source of calories as well as an opportunity to participate in an American culture. A *Wall Street Journal* series (“Deadly Diet”) quoted one woman, recently arrived in Chicago from Puerto Rico, who explained that taking her children to fast-food restaurants substituted for expensive foods and other things that the family could not afford and made them “feel like . . . Americans.”²¹⁵ After fifteen months in the United States, the woman had gained fourteen pounds, her husband had gained sixteen pounds, and their pre-adolescent twin daughters had gained thirty pounds each.²¹⁶ Certainly, food choices can contribute to obesity among low-income people, as among high-income people.

Even food—especially prepared and canned food—bought in supermarkets and eaten in homes has increasingly included high-calorie additions. In particular, the addition of high-fructose corn syrup to the American diet, beginning in the early seventies, significantly altered the amount of calories people get from sugar.²¹⁷ The consumption of crystalline fructose now accounts for about two hundred of the calories that Americans ingest each day. This is about 10% of the daily average intake of calories and contributes to obesity and poor insulin sensitivity.²¹⁸

Despite more pressures on low-income people to purchase cheaper, high-calorie foods, the factors noted in this subsection do not fully explain why middle- and high-income Americans have gained significantly less weight in recent decades than low-income Americans.²¹⁹ Attributing obesity to a lack of physical activity and a poor diet may be, in Brad Evenson’s phrase, not too different from

²¹⁴ *Study Shows Uneven Progress on Youth Exposure to Food Advertising*, ROBERT WOOD JOHNSON FOUND. (July 6, 2010), http://www.rwjf.org/childhoodobesity/product.jsp?id=65629&cid=XEM_205602 (reporting a decrease in television advertisements for fruit drinks, soda and certain sweets during same period that television advertisements for fast-food restaurants increased significantly).

²¹⁵ *American Junk Food Charms Immigrants*, WALL ST. J., Dec. 18, 1990, at A6.

²¹⁶ *Id.*

²¹⁷ Kate S. Collison et al., *Effect of Dietary Monosodium Glutamate on HFCS-Induced Hepatic Steatosis: Expression Profiles in the Liver and Visceral Fat*, 18 OBESITY 1122, 1122 (2010).

²¹⁸ *Id.* (studying nonalcoholic fatty liver disease and conducting research on rodents).

²¹⁹ WILKINSON & PICKETT, *supra* note 10, at 90–91.

“blaming high unemployment on the number of people watching afternoon television.”²²⁰ Neither adequately delineates “underlying causes.”²²¹

Another factor is relative class status. Lower status correlates with, and may be a cause of, obesity, especially within heterogeneous populations with significant income inequality.²²² Indeed, within the United States, higher rates of obesity among both children and adults are found in states with large disparities in income.²²³ This suggests that low socioeconomic status may be an independent factor that results in obesity. Before examining this thesis in more detail (in section C of this Part), subsection (ii) reviews the popular notion in the United States that obesity resembles poverty in that it reflects a basic characterological or moral failing.

(ii) *Society’s Understanding of Weight and Personal Responsibility*

Social characterizations of poor people in the United States—especially by those who do not see themselves as poor—have long reflected the presumption of an association between self-indulgence and obesity.²²⁴ Society often ascribes laziness, sloth, and diminished willpower to those who are obese.²²⁵ Blaming obesity on the failings of individual people has served a nation anxious to assign responsibility for wider social problems to the ineptitude or bad choices of an identifiable social group. In particular, by attributing the high costs of health care in the United States to obesity, it is possible to displace an unwanted focus on basic social and institutional developments that have resulted in high health care costs.²²⁶

²²⁰ Brad Evenson, *When Rich and Poor Kids Eat the Same Diet, Poor Ones Get Fatter*, PROCOR CONFERENCE ON CARDIOVASCULAR HEALTH (Sept. 15, 2003), <http://procor.healthnet.org/archive/200309/msg00004.php>.

²²¹ *Id.*

²²² WILKINSON & PICKETT, *supra* note 10, at 91–93.

²²³ *Id.* at 93–95 & fig. 7.3, 7.4; *see also* ROBERT WOOD JOHNSON FOUND., *supra* note 108, at 4.

²²⁴ *See* Mayer, *supra* note 101, at 1014, 1018. A similar association has long been assumed in the United States between self-indulgence and poverty. In the late eighteenth century, Benjamin Franklin ascribed poverty to laziness. NEWMAN, *supra* note 15, at 143 (quoting Franklin’s proclamation that those who are “industrious” will “never starve”).

²²⁵ Mayer, *supra* note 101, at 1014, 1018.

²²⁶ Campos et al., *supra* note 166, at 58. Campos and his coauthors note that this explanation is more likely to attract those on the right half of the political spectrum.

In exploring the imputation of sinfulness to fat people, Louise Townend refers to the medical categorization of obesity as a “moral impairment” and to the “demonization of obese people” by American media.²²⁷ Correlations between moral failings and obesity have been linked to correlations between obesity and poverty. In this, some commentators suggest quite blatantly that the poor are poor and the obese are obese because, similarly, they are ignorant, uncontrolled, and morally inferior to the rest of society.²²⁸ There is ample evidence of the social conflation of presumptions about poverty and obesity in the United States.²²⁹ One commentator, responding to a blogger’s “conjectures” about obesity explained:

Poor people are probably fat for the same reason they’re poor. Plenty of food (government provided, more often than not), not a lot to do but eat. In a lot of cases, it’s pure laziness. In others, it’s a lack of either the intelligence or imagination required to change bad habits. Either way, I don’t think being poor in a developed nation *causes* obesity so much as it co-exists as an effect of other behavioral patterns.²³⁰

In fact, the links between size and class are terribly complicated. In popular discourse, however, it is commonly assumed that poor people are fat and that fat people are poor. And it has become easy to presume that a similar set of character traits underlies both class and weight status. The next section examines these presumptions in more detail.

C. Poverty and Obesity: Cultural and Physiological Links

Various demographic factors correlate with an increased incidence of obesity.²³¹ In wealthy societies, high weight correlates inversely

“Targeting obesity” as a cause of the nation’s health care problems is attractive as well to those on the left side of the spectrum; rather than focusing on individuals’ failings, they focus on the greed of corporate industry. *Id.*

²²⁷ Townend, *supra* note 190, at 179–80.

²²⁸ See, e.g., *id.* at 180–81 (quoting an Australian journalist who described obese people as gluttonous, ignorant, and lazy).

²²⁹ This evidence is provided in more detail *infra* Part II.C.

²³⁰ Anonymous, Comment to *Obesity: A Conjecture*, IDEAS (Apr. 23, 2007, 12:16 PM), http://davidfriedman.blogspot.com/2007/04/obesity-conjecture_19.html.

²³¹ In addition to the factors considered in this section, the rate of obesity is higher in the southeastern United States than elsewhere. Susan Donaldson James, *Critics Slam Overweight Surgeon General Pick, Regina Benjamin*, ABC NEWS (July 21, 2009), <http://abcnews.go.com/Health/story?id=8129947&page=1> (citing to CDC data). African

with class.²³² In the United States, poor people are more likely to be obese than people with more resources.²³³ However, the supposition (common in popular debate and noted in the previous section of this Article) that a deficient moral character causes either obesity or poverty is misplaced. The first subsection of this section reviews correlations between weight and class. It thus provides background for the next subsection, which considers possible explanations of that correlation.

1. *Correlations Between Obesity and Poverty*

In American households earning less than \$15,000 annually, over 35% of adults are obese (with a BMI of over 30).²³⁴ In households earning \$50,000 or more, 24.5% of adults are obese.²³⁵ And among households in which no adult member graduated from high school, 33.6% of adults are obese, while in households in which an adult graduated from college or technical school, 22% of adults are obese.²³⁶ The statistics suggest how observations about weight can serve as metaphors for observations about class; this, in turn, suggests the misuse to which such statistics lend themselves.

Many of the factors invoked to explain the disproportionate number of obese people among poor people in the United States were noted in earlier sections of this Article.²³⁷ Additional factors include the comparatively limited opportunities available to poor children to engage in exercise programs. Low-income parents are less likely than richer parents to be able to afford organized sports for their children.²³⁸ Less physical activity not only results in lower energy expenditure, it also results in larger concentrations of cortisol, a stress

Americans and Hispanics are more often obese than others. *Id.* In almost every state, obesity is more common among blacks and Latinos than among whites. ROBERT WOOD JOHNSON FOUND., *supra* note 108, at 13. Further, African American and Mexican American women are more likely than other people to be categorized as overweight. Saguy & Riley, *supra* note 161, at 871.

²³² Saguy & Riley, *supra* note 161, at 871.

²³³ WILKINSON & PICKETT, *supra* note 10, at 101. Wilkinson and Pickett report that a much higher percentage of the U.S. population is overweight than is poor. *Id.*; *see also* Evenson, *supra* note 220.

²³⁴ ROBERT WOOD JOHNSON FOUND., *supra* note 108 at 20.

²³⁵ *Id.*

²³⁶ *Id.* at 21.

²³⁷ *See, e.g., supra* Parts I.B.2.b, II.B.2.c.ii.

²³⁸ Evenson, *supra* note 220.

hormone associated with the development of central body fat,²³⁹ which has, in turn, been associated with diseases and disabling conditions associated with obesity.²⁴⁰

In addition to various factors such as lifestyle patterns common among people at the bottom of the nation's socioeconomic hierarchy,²⁴¹ researchers have noted a remarkable connection between obesity and *relative*, rather than absolute, low social status.²⁴² Indeed, subjective assessments of socioeconomic status as "low" are more predictive of obesity than actual income or educational levels.²⁴³ More specifically, rates of obesity within a population correlate with the level of income inequality,²⁴⁴ and comparative socioeconomic statuses correlate inversely with obesity. That is to say, obesity is more common in general among groups living in societies in which the socioeconomic gradient is steepest, and those at the bottom of the gradient are obese in disproportionate numbers.

2. *Obesity, Health, and Poverty*

Obesity has become a powerful metaphor for poverty as well as one of its consequences. Explanations that look only to the food and lifestyle choices, whether freely selected or imposed by socioeconomic conditions, do not adequately account for the higher average weight of low-income populations within nations characterized by large income disparities.²⁴⁵ The link between weight status and socioeconomic status is explained only in part by higher calorie intake and lower activity among people living in poverty.²⁴⁶ In understanding the relation between poverty and obesity, it is essential to consider seriously the suggestion that low socioeconomic status is an independent factor responsible for obesity.

There is significant evidence that increased levels of stress that accompany low socioeconomic status play a real and complicated role

²³⁹ See *infra* Part II.C.2; see also Evenson, *supra* note 220.

²⁴⁰ WILKINSON & PICKETT, *supra* note 10, at 95.

²⁴¹ Rosmond, *supra* note 193, at 179.

²⁴² *Id.* at 180; see also WILKINSON & PICKETT, *supra* note 10, at 101.

²⁴³ WILKINSON & PICKETT, *supra* note 10, at 101.

²⁴⁴ See *supra* note 233 and accompanying text.

²⁴⁵ WILKINSON & PICKETT, *supra* note 10, at 95.

²⁴⁶ *Id.*

in explaining the connection between socioeconomic status and weight. A simple, not inaccurate explanation for this connection is that stress plays a role in determining food choices.²⁴⁷ But that is not the full story. Beyond this, and perhaps more surprisingly, socioeconomic status plays a role in the physiological processes through which people experiencing stress become fat. Specifically, research not only suggests links between increased obesity and low socioeconomic status, it also reveals a difference in the type of fat likely to form in people assessing their own social status at the lower end of the socioeconomic spectrum.²⁴⁸ Specifically, central-body fat develops more often than intramuscular or subcutaneous fat in people who assess their socioeconomic status as being comparatively low.

Michael Marmot's Whitehall studies found that the incidence of central body fat, as well as fasting glucose levels, insulin levels, and triglyceride levels, increased as civil servants descended the system's hierarchy.²⁴⁹ Marmot reported:

The lower the grade, the higher the waist:hip ratio. It is important to make the distinction between this central pattern of obesity and simply overweight, where the excess body fat is more widely distributed. Men show little social gradient in obesity—women do—but in both sexes, there is a social gradient in waist:hip ratio. This central adiposity may be the result of a complex series of reactions involving cortisol metabolism.²⁵⁰

A similar pattern is found in other primates. Low-status monkeys are more likely than their higher-status counterparts to develop diseases linked with visceral fat obesity.²⁵¹ One explanatory model connects low status and stress with shifts in the hypothalamic-pituitary-adrenal axis, resulting in elevated circulating glucocorticoids and thus a greater likelihood of visceral obesity.²⁵² As noted, children from comparatively low-income, low-status homes produce

²⁴⁷ *Id.*

²⁴⁸ Rosmond, *supra* note 193, at 180.

²⁴⁹ See *supra* notes 43–53 and accompanying text.

²⁵⁰ MARMOT, *supra* note 43, at 118–19; see also WILKINSON & PICKETT, *supra* note 10, at 95.

²⁵¹ Rosmond, *supra* note 193, at 180.

²⁵² *Id.*

more cortisol than others. Cortisol, a stress hormone, leads to central body fat and depression.²⁵³

Again, these findings are particularly important because central body fat (measured by waist circumference)²⁵⁴ is significant in deciphering correlations between obesity and health; a disproportionately high level of abdominal fat puts people at especially high risk for the health conditions associated with obesity.²⁵⁵ In short, to the extent that central body fat develops among those who are—or, more specifically, who see themselves as being—at the lower end of society’s socioeconomic hierarchy, class status may be at least as important as weight, per se, as a risk factor for diseases and disabling conditions associated with overweight and obesity.

It is not accidental that obesity (especially the type of obesity most often correlated with disease and disabling conditions) is exacerbated by comparatively low socioeconomic status. The physiological processes—not yet fully understood—that contribute to poor health in those struggling with the social and economic limitations produced by low status are likely as well to result in obesity and in a form of body fat most clearly associated with poor health. The next Part of this Article explores in more detail the stereotypes associated with poverty as well as social and legal responses to the prejudice those stereotypes spawn.

²⁵³ Evenson, *supra* note 220. This suggests, in sharp contrast with the commonplace assumption that obesity causes depression, that depression may cause obesity or that the two may follow from similar social and economic conditions. *Id.*; see also Roni Caryn Rabin, *Exploring the Links Between Depression and Weight Gain*, N.Y. TIMES (June 16, 2010, 1:13PM), <http://well.blogs.nytimes.com/2010/06/16/exploring-the-links-between-depression-and-weight-gain/> (reporting that researchers found abdominal fat increased in depressed people).

²⁵⁴ OBESITY EDUC. INITIATIVE, *supra* note 54, at xiv. The report defines a waist circumference of more than forty inches in men and more than thirty-five inches in women (in adults with BMIs between 25 and 34.9) as suggestive of the presence of disease and disabling conditions associated with obesity. *Id.* at xv. The report notes that the waist circumference figures are less suggestive in people with a BMI above 34.9 because such patients “will exceed” the waist-circumstance cutoff points. *Id.*

²⁵⁵ WILKINSON & PICKETT, *supra* note 10, at 95.

III

STEREOTYPES AND STIGMA IN CLASS COMPETITION: IMAGES OF
OBESITY AND OBESITY DISCRIMINATION

Prejudice and, in consequence, poor self-image are significant risks of obesity. Puhl and Brownell describe obese people as “the last acceptable targets of discrimination.”²⁵⁶ Stereotypes of obese people, so often grounded in the presumption that obesity reflects a failure of personal control,²⁵⁷ translate into significant stigma directed toward²⁵⁸ and discrimination against obese people. Discrimination has been reported among employers, health care professionals, friends, family members,²⁵⁹ and potential spouses of overweight and obese people.²⁶⁰ Stereotypic perceptions of people considered too fat presume that they are responsible, through ignorance, laziness, and self-indulgence, for their size. As noted in section II(B), scientific evidence offers an alternative view.²⁶¹ But that has not (yet) limited the stigmatization of fat people. The first section of this Part considers stereotypes of overweight and obese people and the stigma they experience. Then, the second section examines legal responses to obesity and class discrimination against overweight and obese people.

A. *Stereotypes of Overweight People*

Overweight job applicants are hired less often than comparable applicants of lower weight.²⁶² Both overweight men and women are

²⁵⁶ Rebecca Puhl & Kelly D. Brownell, *Bias, Discrimination, and Obesity*, 9 OBESITY RES. 788, 788 (2001).

²⁵⁷ Rebecca M. Puhl & Chelsea A. Heuer, *The Stigma of Obesity: A Review and Update*, 17 OBESITY 941, 941, 949 (2009).

²⁵⁸ Irving Goffman defined stigma in terms of its ability to reduce someone “from a whole and usual person to a tainted, discounted one.” IRVING GOFFMAN, *STIGMA: NOTES ON THE MANAGEMENT OF SPOILED IDENTITY* 3 (1963).

²⁵⁹ Deborah Carr et al., *Perceived Interpersonal Mistreatment Among Obese Americans: Do Race, Class, and Gender Matter?*, 16 OBESITY supp. 2, at S60, S66 (2008) (reporting that the most common teasers of obese people are family members).

²⁶⁰ Puhl & Heuer, *supra* note 257, at 949–50.

²⁶¹ See *infra* Part II.B; see also Puhl & Heuer, *supra* note 257, at 944 (noting physicians’ views that obese patients are not adequately motivated and “misguided”).

²⁶² Rebecca Puhl & Kelly D. Brownell, *Stigma, Discrimination, and Obesity*, in *EATING DISORDERS AND OBESITY*, *supra* note 172, at 108, 108.

more likely to hold lower-paying jobs than others,²⁶³ employees have been fired for being considered overweight,²⁶⁴ and overweight women are paid less than thinner women for the same work.²⁶⁵ Moreover, overweight employees are stigmatized by coworkers.²⁶⁶ One study of human resource professionals' responses to obesity revealed that 50% of those queried saw obese job applicants as less productive than others, and 40% concluded that overweight people are not likely to exhibit self-discipline.²⁶⁷

Several researchers have reported that employers view obese employees as comparatively disagreeable, introverted, and irresponsible compared to their thinner counterparts.²⁶⁸ Unsurprisingly, other studies show that such presumptions do not accurately reflect the personalities of obese people (as compared with thinner people).²⁶⁹ Health care professionals similarly stigmatize overweight patients, ascribing laziness, noncompliance, and lack of control to them.²⁷⁰ These stereotypes almost inevitably result in less respect for patients as partners in the healing process. Interestingly, there is evidence that health care providers and overweight patients differ in their explanations of obesity; the former are more likely to view obesity as a condition amenable to self-discipline, and the latter to attribute obesity to poverty, underlying medical conditions, and other factors outside individual control.²⁷¹ Even more, overweight people experience negative attitudes from friends and acquaintances. Obese schoolchildren are significantly more likely than other children to be bullied by their classmates.²⁷²

²⁶³ *Id.*

²⁶⁴ *Id.* at 109.

²⁶⁵ Puhl & Brownell, *supra* note 256, at 800 (noting that the same does not seem to hold for overweight men but that “overweight men sort themselves into lower-level jobs”).

²⁶⁶ Puhl & Heuer, *supra* note 257, at 941–42.

²⁶⁷ WILKINSON & PICKETT, *supra* note 10, at 98–99.

²⁶⁸ Puhl & Heuer, *supra* note 257, at 943.

²⁶⁹ *Id.*

²⁷⁰ *Id.* at 943–44.

²⁷¹ *Id.* at 944.

²⁷² Roni Caryn Rabin, *Childhood: Overweight Children and Bullying*, N.Y. TIMES, May 11, 2010, <http://www.nytimes.com/2010/05/11/health/research/11child.html> (reporting that obese children have a 60% greater risk of being bullied by classmates than thinner children). A 1961 study by Richardson and colleagues found that ten- and eleven-year-old children ranked pictures of obese children last or next to last when asked to order (according to preference) six drawings. William DeJong, *The Stigma of Obesity: The*

Media's portraits of overweight people create and reinforce prejudicial images.²⁷³ Entertainment media portray large characters as "objects of humor and ridicule" and as involved in "stereotypical eating behaviors."²⁷⁴ Advertisements for the diet industry confirm that people are responsible for their own weight and suggest that, were they only to try harder (presumably by finding the "right" product), they would become thin.²⁷⁵ News media—even media acknowledging that personal choices may not be the only or even the primary cause of obesity—still insist that obesity can be "cured" through personal solutions.²⁷⁶

Even more disturbing, the current U.S. "war on obesity"²⁷⁷ (urging people to eat less and move more) may have an unintended consequence—increased stigma for overweight people who do not or cannot lose weight. To the extent that this is happening, it poses a risk of serious harm to those whom the campaign against obesity is

Consequences of Naive Assumptions Concerning the Causes of Physical Deviance, 21 J. HEALTH & SOC. BEHAV. 75, 75–76 (1980) (citing Stephen A. Richardson et al., *Cultural Uniformity in Reaction to Physical Disabilities*, 26 AM. SOC. REV. 241, 241–47 (1961)). One drawing depicted a child with no apparent disability; one pictured a child with a leg brace; a third showed a child in a wheelchair; a fourth showed a child without one hand; a fifth showed a child with a facial disfigurement, and the sixth showed an obese child. *Id.* at 76.

In a literature review, Young and Powell found that even in the sixties obese children were viewed "as less likable, less likely to be chosen as friends, and more frequently referred to as lazy, dirty, stupid, ugly, forgetful, argumentative, and mean spirited" than other children. Laura M. Young & Brian Powell, *The Effects of Obesity on the Clinical Judgments of Mental Health Professionals*, 26 J. HEALTH & SOC. BEHAV. 233, 234 (1985) (citations omitted).

²⁷³ One study of six fictional television shows on major networks found that overweight "characters were less likely to help with tasks, to demonstrate physical affection, to date, and to have sex. In addition, they were more likely to be seen eating and to be the objects of humor . . ." Bradley S. Greenberg et al., *Portrayals of Overweight and Obese Individuals on Commercial Television*, 93 AM. J. PUB. HEALTH 1342, 1347 (2003).

²⁷⁴ Puhl & Heuer, *supra* note 257, at 951. A possible exception is *Huge*, a television drama set in a weight-reduction camp; *Huge* premiered on ABC-TV during the summer of 2010.

²⁷⁵ *Id.* at 951–52.

²⁷⁶ *Id.* at 952. This point is reflected in a blog post about Jillian Michaels, personal trainer on *The Biggest Loser*. Renee Martin, *Does Jillian Michaels Know What Fat Is All About?*, MS. MAGAZINE BLOG (June 1, 2010), <http://msmagazine.com/blog/blog/2010/06/01/does-jillian-michaels-know-what-fat-is-all-about>.

²⁷⁷ See, e.g., Daniel Engber, *Pork Barrel*, SLATE (July 16, 2010), <http://www.slate.com/id/2260761/>; *Fox Business Happy Hour* (Fox television broadcast Apr. 30, 2010) (transcript available on LexisNexis) (noting the similarity between "war on obesity" and earlier "war on smoking").

presumptively aimed at helping. Social stigmatization of people considered too fat creates far-reaching prejudice that interferes with a wide set of life activities such as employment and health care. In addition, and more startlingly, one of the major health risks of being obese in the United States is the stigmatization of obesity itself.²⁷⁸

B. The Limits of the Law's Responses

In the last half century, the American legal system has been actively crafting laws to prohibit discrimination against stigmatized groups. On the whole, however, fat people have not benefitted. Much antidiscrimination law prohibits discrimination only against “immutable” characteristics such as race. Fatness has generally not been viewed as immutable. More generally, the failure of the nation’s legal system to prohibit obesity discrimination may reflect a need (fostered perhaps by the nation’s competitive class system) to distinguish “us” from “them.” Stereotyping fat people has provided a substitute for other groups that once faced explicit discrimination based on physical traits.²⁷⁹

The first subsection of this section briefly summarizes the limitations of legal responses to obesity discrimination. The second subsection then reviews prejudicial images of fat people who are also poor. It further explores the social power of such images in the context of class competition in the United States, and it considers the relevance of those images in the nation’s long-standing opposition to universal health care. This section provides background for Part IV, which analyzes the uses by those opposed to universal health care coverage of obesity stigmatization and the stigmatization of those at the bottom of the nation’s socioeconomic hierarchy.

²⁷⁸ Puhl & Heuer, *supra* note 103, at 1019 (noting that the “stigmatization of obese individuals poses serious risks to their psychological and physical health, generates health disparities, and interferes with implementation of effective obesity prevention efforts”).

²⁷⁹ Susan T. Fiske, *Are We Born Racist?*, GREATER GOOD, Summer 2008, at 14, 15 (describing the separation of “us” from “them” as “human nature”). Fiske comments, “[c]onditioned by millennia of tribal warfare and fierce competition for limited resources, we are always looking for cues to help us make snap judgments about others.” *Id.* at 16. Fiske then suggests that the tendency to “rely on physical characteristics” to separate “us” from “them” may partly explain racism. *Id.* If she is correct, the increasing reluctance—facilitated by a shifting social ethic and compelled by law—to express racism openly may have encouraged the substitution of other physically recognizable groups (e.g., obese people) as targets of prejudice.

1. *Legal Responses to Discrimination Against Fat People*

Federal law offers little protection to people discriminated against because of weight. No federal law expressly prohibits obesity discrimination,²⁸⁰ and other federal antidiscrimination laws are of very limited use in this regard. In order to qualify for protection under the Americans with Disabilities Act of 1990 (ADA) or the Rehabilitation Act of 1973, an individual must have a qualifying disability or “physical impairment.”²⁸¹ Fat people are not generally eligible for protection unless they are classified as “morbidly obese,” at least 100% above “normal” body weight.²⁸² Title VII of the Federal Civil Rights Act of 1964, which prohibits discrimination based on “race, color, religion, sex, or national origin,”²⁸³ protects against discrimination based on appearance only to the extent that a physical characteristic can be associated with one of the protected categories.²⁸⁴

Only one state—Michigan—and a few cities and counties prohibit discrimination on the basis of weight (or other parameters of appearance, including height). Michigan prohibits employment

²⁸⁰ RUDD CTR. FOR FOOD POLICY & OBESITY, WEIGHT BIAS: THE NEED FOR PUBLIC POLICY 2 (2008), available at <http://yaleruddcenter.org/resources/upload/docs/what/bias/WeightBiaspolicyruddreport.pdf>.

²⁸¹ Rehabilitation Act of 1973, 29 U.S.C. § 705(9) (2006); Americans with Disabilities Act of 1990, 42 U.S.C. § 12102 (2006); 29 C.F.R. § 1630.2(g)–(h) (2010). The Equal Employment Opportunity Commission has opined that significant obesity or obesity linked to an underlying disorder such as hypertension may qualify for protection. U.S. EQUAL EMPLOYMENT OPPORTUNITY COMM’N, COMPLIANCE MANUAL § 902.2(c)(5)(ii), <http://www.eeoc.gov/policy/docs/902cm.html#902.2c5> (last updated Nov. 21, 2009). *But see* 29 C.F.R. pt. 1630 app. § 1630.2(j) (“[E]xcept in rare circumstances, obesity is not considered a disabling impairment.”).

²⁸² *See* Cook v. Rhode Island, 10 F.3d 17–21 (1st Cir. 1993) (considering a job applicant’s severe obesity to have been a disabling impairment under the ADA); Deborah L. Rhode, *The Injustice of Appearance*, 61 STAN. L. REV. 1033, 1078 (2009) (noting that “[o]nly morbid obesity (100% over average weight), caused by a physiological disorder (such as a thyroid dysfunction) will qualify, a limitation that excludes about 99% of obese individuals”).

²⁸³ Civil Rights Act of 1964, 42 U.S.C. § 2000e-2(a) (2006).

²⁸⁴ *See, e.g.*, Bradley v. Pizzaco of Neb., Inc., 7 F.3d 795, 799 (8th Cir. 1993) (holding against the employer’s no-beard policy for an African American employee unable to shave due to pseudofolliculitis barbae, a condition that affects African Americans disproportionately); Craig v. Cnty. of Los Angeles, 626 F.2d 659, 667 (9th Cir. 1980) (finding discrimination in hiring tests for a deputy sheriff position in Los Angeles County and noting that height requirements can have a “devastating effect on Mexican-Americans”).

discrimination based on height or weight, as well as that based on “religion, race, color, national origin, age, sex, . . . or marital status.”²⁸⁵ In *Lamoria v. Health Care & Retirement Corp.*, a Michigan appellate court sided with Barbara Lamoria, a fat woman who claimed that she was discharged from her nursing position at a retirement home because of her weight.²⁸⁶ The court overturned a grant of summary disposition for the defendant, Lamoria’s former employer, giving Lamoria the opportunity to show that her weight was “a determinative factor” in having been fired.²⁸⁷ Other states do not offer the same opportunity to seek legal redress to people subjected to weight discrimination in the employment context.

However, the District of Columbia and a number of cities and counties ban discrimination based on appearance.²⁸⁸ The most well-known of these antidiscrimination laws was promulgated in Santa Cruz, California, in 1992.²⁸⁹ The Santa Cruz ordinance expressly prohibits discrimination based on weight, height, “physical characteristic,” and a number of other factors.²⁹⁰ The ordinance

²⁸⁵ MICH. COMP. LAWS ANN. § 37.2202 (West 2010).

²⁸⁶ *Lamoria v. Health Care & Retirement Corp.*, 584 N.W.2d 589, 594 (Mich. Ct. App. 1998).

²⁸⁷ *Id.* at 594–95.

²⁸⁸ Discrimination on the basis of personal appearance is prohibited in the District of Columbia; San Francisco, California; Urbana, Illinois; Howard County, Maryland; and Santa Cruz, California, among other places. See D.C. CODE § 2-1401.01 (2011) (not expressly prohibiting discrimination on the basis of obesity but prohibiting discrimination “for any reason other than that of individual merit” and expressly including “personal appearance” in a list of non-inclusive characteristics that cannot serve as grounds for decision making); S.F., CAL., ADMIN CODE §12A.1 (2010) (banning discrimination on the basis of height or weight), available at <http://library.municode.com/index.aspx?clientId=14131&stateId=5&stateName=California>; URBANA, ILL., MUN. CODE § 12-37 (1998), available at <http://urbanaillinois.us/citycode/>; COUNTY OF HOWARD, MD., CODE §§ 12.200(II), 12.201(XIV) (2010), available at http://library2.municode.com/default-test/home.htm?infobase=14680&doc_action=whatsnew; SANTA CRUZ, CAL., MUN. CODE §§ 9.83.010–.120 (2010), available at <http://www.codepublishing.com/CA/SantaCruz/>.

²⁸⁹ SANTA CRUZ, CAL., MUN. CODE §§ 9.83.01, 9.83.02(13). See Robert Post, *Prejudicial Appearances: The Logic of American Antidiscrimination Law*, 88 CALIF. L. REV. 1, 6 (2000) (discussing Santa Cruz’s antidiscrimination provision).

²⁹⁰ The provision states:

It is the intent of the city council, in enacting this chapter, to protect and safeguard the right and opportunity of all persons to be free from all forms of arbitrary discrimination, including discrimination based on age, race, color, creed, religion, national origin, ancestry, disability, marital status, sex, gender, sexual orientation, height, weight or physical characteristic.

SANTA CRUZ, CAL., MUN. CODE § 9.83.010.

defines “weight” to include “the actual or assumed weight of an individual”,²⁹¹ and prohibits discrimination by employers,²⁹² educational institutions,²⁹³ business establishments, places of public accommodation,²⁹⁴ and in the context of housing and real estate transactions.²⁹⁵

The Santa Cruz ordinance—especially in its far-reaching protection of obese people from discrimination—is unusual. In particular, it protects against discrimination based on weight regardless of whether or not weight is presumed to be within an individual’s control. Significantly, and in contrast to the provision protecting obese people from discrimination, the ordinance defines “physical characteristic” to include only those traits “outside the control of th[e] person.”²⁹⁶ The ordinance’s broad protection against discrimination against anyone who is presumed to be overweight, especially in contrast with the more limited protection against discrimination based on a physical characteristic, suggests that, although obesity is not an “immutable trait,” neither is it willful in the way that certain other physical characteristics may be.²⁹⁷

The widespread presumption that weight can be controlled by anyone who wills it adequately has facilitated legislative reluctance to prohibit obesity discrimination. Ironically, that presumption is belied far more often than it is confirmed, but it remains central to Americans’ perspectives on weight.

The strength of the presumption as well as the social license it offers people to continue discriminating against others viewed as overweight may reflect a peculiar but deeply ingrained need within society to sustain some form of social hierarchy that allows

²⁹¹ *Id.* § 9.83.020(18).

²⁹² *Id.* § 9.83.030.

²⁹³ *Id.* § 9.83.060.

²⁹⁴ *Id.* § 9.83.050.

²⁹⁵ *Id.* § 9.83.040.

²⁹⁶ *Id.* § 9.83.020(13).

²⁹⁷ See Post, *supra* note 289, at 8–9 (describing “obesity [as] an interesting borderline case”). Obesity is a “borderline case” in a world of antidiscrimination law that prohibits discrimination on the basis of “immutable traits,” such as race and gender, and that prohibits discrimination against some parameters of people’s lives that are not immutable (such as religion and marital status). *Id.*

individuals to assess their relative status and presumptive worth.²⁹⁸ In the quest for stigmatizing categories, society has perhaps selected obesity because, among other things, it is easily identified, can signal class status, is linked (often erroneously) with health, and is attributed (again, often erroneously) to individual choices.²⁹⁹

2. *Stigmatization, Class, and Obesity*

Many of the traits and dispositions Americans associate with obesity are those they also associate with poverty, and in both cases, mainstream society has not responded effectively to the resultant stigmatization.³⁰⁰ Although Americans may be a bit less sanguine about stigmatizing poor people than they are about stigmatizing fat people, society and the law have widely failed to prohibit discrimination against either group.

In addition to the scarcity of statutory responses, noted in the previous subsection, no constitutional amendment offers significant protection to those facing discrimination because of class status or obesity. In general, Fourteenth Amendment jurisprudence presumes that distinctions based on class are constitutional;³⁰¹ only in a limited set of circumstances are the rights of poor people offered Fourteenth Amendment protection from discriminatory state action.³⁰² Similarly,

²⁹⁸ See Natalie Angier, *Why So Many Ridicule the Overweight*, N.Y. TIMES, Nov. 22, 1992, <http://www.nytimes.com/1992/11/22/us/why-so-many-ridicule-the-overweight.html> (quoting an obesity expert to have said, “We’re running out of people that we’re allowed to hate, and to feel superior to.”).

²⁹⁹ See *id.* Angier quotes an eating disorder specialist: “[Fatness is] the only physical trait I can think of which, although it’s talked about in terms of appearance, is associated with so many things other than appearance.” *Id.*

³⁰⁰ Puhl & Heuer, *supra* note 103, at 1019–20.

³⁰¹ *San Antonio Indep. Sch. Dist. v. Rodriguez*, 411 U.S. 1, 40 (1973); see also Trina Jones, *Race, Economic Class, and Employment Opportunity*, 72 LAW & CONTEMP. PROBS., Fall 2009, at 57, 82–83.

³⁰² Indigent criminal defendants, for example, must be provided with counsel appointed by the court. See, e.g., *Douglas v. California*, 372 U.S. 353, 357–58 (1963) (right to counsel on direct appeal); *Griffin v. Illinois*, 351 U.S. 12, 17–18 (1956) (“In criminal trials a State can no more discriminate on account of poverty than on account of religion, race, or color. Plainly the ability to pay costs in advance bears no rational relationship to a defendant’s guilt or innocence and could not be used as an excuse to deprive a defendant of a fair trial.”). Counsel must also be provided if an indigent parent risks losing parental rights. See *M.L.B. v. S.L.J.*, 519 U.S. 102 (1996) (strict scrutiny must be applied to a case in which a parent cannot appeal termination of parental rights because she could not afford to pay record-preparation fees).

state action that discriminates against obese people is likely to survive a Fourteenth Amendment challenge.³⁰³

Society excuses—if it does not fully justify—the law’s sluggish response to discrimination against fat people and poor people because both groups are presumed responsible for their own “plight.” That is to say, society and the law view the stigma associated with poverty and obesity as fitting because both situations are understood to be matters of personal control. More generally, research has shown the intensity of negative attitudes toward those with various illnesses and disabling conditions to correlate with the level of presumed personal responsibility.³⁰⁴ In addition, society and the law seem unprepared to jettison the social inequality implied by and consequent to understandings of obese people and poor people as social “Others.” That hesitation can then be justified through reference to assumptions about the role that individuals play in becoming or remaining fat and poor.

A surprising window into the assumptions underlying social responses to obesity and poverty is offered by the response of patients (and the parents of patients) with type 1 diabetes. They have openly expressed concern that the condition from which they or their children suffer will be conflated in popular thought with type 2 diabetes, a different disease that affects a different population group. Type 1 diabetes (sometimes referred to as juvenile diabetes) affects about a million people each year in the United States.³⁰⁵ Most of them are young; many are thin. Type 2 diabetes, in contrast, affects about 20 million people each year in the United States. Many, though certainly not all, of them are older, poorer, and overweight.³⁰⁶ One mother of a young child with type 1 diabetes explained her concern: “People

³⁰³ Only state policies discriminating against obese people that also interfere with a fundamental right or that create a suspect class are likely to face a successful challenge through reference to the Fourteenth Amendment. See Sayward Byrd, Comment, *Civil Rights and the “Twinkie” Tax: The 900-Pound Gorilla in the War on Obesity*, 65 LA. L. REV. 303, 347–49 (2004).

³⁰⁴ Puhl & Heuer, *supra* note 103, 1020–21 (citing Christian S. Crandall & Dallie Moriarty, *Physical Illness Stigma and Social Rejection*, 34 BRIT. J. SOC. PSYCHOL. 67 (1995)). Indeed, in one study of sixty-six diseases and health conditions, negative attitudes toward the disease or condition correlated with the extent to which the illness or condition was viewed as being under individual control. *Id.*

³⁰⁵ Richard Perez-Pena, *Beyond ‘I’m a Diabetic,’ Little Common Ground*, N.Y. TIMES, May 17, 2006, http://www.nytimes.com/2006/05/17/nyregion/17diabetes.html?_r=1.

³⁰⁶ *Id.* In both forms of diabetes, the patient has elevated blood sugar. *Id.*

think diabetes is about being fat My daughter isn't fat; she's beautiful."³⁰⁷ Another type 1 diabetic—a fifteen-year-old boy—complained that the public's failure to distinguish between the two forms of diabetes drove him "crazy." He explained: "With Type 1 diabetes, there is absolutely nothing tied to my lifestyle, and this is something over which I had absolutely no control. But people suggest that it's because I ate too much sugar or something"³⁰⁸ This boy disavowed any connection to type 2 diabetics "who, in [his] view, brought this on themselves."³⁰⁹

Even though about twenty times more people in the United States are affected with type 2 rather than type 1 diabetes, only slightly more research money is devoted to type 2 studies.³¹⁰ Dr. Robert Rizza, the current President of the American Diabetes Association, explained that type 2 receives a disproportionate share of available research funds because "society considers obesity and sedentary lifestyle a matter of blame, and that does affect the politics and the money."³¹¹

In short, American society has long reprehended those at the lower end of the socioeconomic hierarchy for their poverty and for the presumptive burden that poverty places on others. It has, more recently, understood obesity within a similar frame. Type 1 diabetes patients and their parents are responding to these assumptions when they distinguish their disease, and its causes, from type 2 diabetes. This distinction, writ large, reflects the far more widespread concern among those in the middle classes for distinguishing their class status from those below them on the nation's socioeconomic hierarchy. The next Part expressly considers that concern.

IV

POVERTY, OBESITY, AND HEALTH CARE REFORM

Society associates obesity (especially obesity marked by central body fat) with low socioeconomic status.³¹² In fact, of course, many

³⁰⁷ *Id.*

³⁰⁸ *Id.*

³⁰⁹ *Id.*

³¹⁰ *Id.* (reporting that about one-third of diabetes research money each year is spent on type 1, 40% on type 2, and the remaining amount on matters affecting both conditions).

³¹¹ *Id.*

³¹² Laura Miller, "Fat Land" by Greg Crister, SALON (Jan. 9, 2003), <http://www.salon.com/books/review/2003/01/09/fat/print.html>.

poor people are thin, and many people deemed overweight are well-off. Yet, the links between obesity and relative class status are real. Being poor significantly increases the likelihood of being overweight and of developing central-body fat³¹³ and makes it harder to lose weight or sustain weight loss.³¹⁴ Being fat makes it harder to find and keep employment, decreases the likelihood that one will be paid as much for similar work as thinner compatriots, and makes it less likely that one will get adequate health care because health care providers too often discriminate against obese patients.³¹⁵ Previous Parts of this Article have reviewed the complicated weave of factors undergirding these associations. Furthermore, and of central importance to this Article's thesis, stereotypical responses toward obesity resemble those toward people in poverty. Both poor people and fat people are stigmatized, assumed to evince a set of attributes that society holds in low regard, and are held personally responsible for their situation. More specifically, American society assumes that both people in poverty and people with obesity are lazy and deficient in will power and self-control.³¹⁶ Even more, poor people and fat people are frequent victims of society's readiness to find someone to blame for its social and economic difficulties. More specifically, both obesity and poverty correlate with, and are perceived as marks of, poor health; those correlations facilitate blaming the groups most in need of fundamental changes in the health care system for that system's inadequacies and high cost.

This cycle of self-justifying blame entraps its victims. American society suggests that those who are poor or fat or both bear responsibility for that situation; further, it suggests that they deprive others of resources that should be available to everyone but that are, instead, allocated disproportionately to people whose problems are self-induced. Yet, more disconcertingly, significant segments of the

³¹³ Robert W. Jeffery & Simone A. French, *Socioeconomic Status and Weight Control Practices Among 20- to 45-Year-Old Women*, 86 AM. J. PUB. HEALTH 1005, 1005 (1996) (noting that "inverse association between socioeconomic status (SES) and obesity in US women is striking").

³¹⁴ Miller, *supra* note 312.

³¹⁵ Puhl & Heuer, *supra* note 257, at 941–49; *see also supra* Part III.

³¹⁶ Campos et al., *supra* note 166, at 58. Campos et al. note further that racial and ethnic minorities, including certain immigrant groups, are similarly stereotyped. They suggest that "anxieties about racial integration and immigration" may account in some part for "concern over obesity" in the United States. *Id.*

American public find solace in the continuing (presumptively self-induced) plight of those sitting below them on the nation's class hierarchy. To the extent that those in poverty embody that status in physical traits such as body size and shape, they are more easily recognized and more facily targeted. That serves those struggling to sustain comparative socioeconomic status in the nation's shadowy class system.

The nation's long-standing and explicit political reluctance to construct a system of national health care coverage that provides care to everyone can, in part, be attributed to its much less conscious social reluctance to tackle socioeconomic disparities. The Affordable Care Act and its companion reconciliation bill respond to some, but only some, of these issues. The reform law has a number of limitations and loopholes—some hidden, some more obvious.³¹⁷

Even as the nation adopts a variety of programs to expand health care coverage and tackle more specific issues such as obesity, it faces opposition—often not fully self-conscious—from large segments of the population anxious to preclude those at the bottom of the socioeconomic ladder from displacing those somewhat more comfortably situated. The commitment is unseemly, and, thus, it is often successfully masked. But the commitment is deeply grounded in the nation's highly competitive but opaque class system. The presence of some easily identified “Other” at the lower end of the class hierarchy provides the illusion of protection to those fearful of being displaced.

Although Americans have become less comfortable with openly stigmatizing groups whose presumptive status is based in “immutable traits,” they continue to stigmatize those whose identifying traits they view as self-induced.³¹⁸ Thus, they continue to marginalize obese, poor people. As one specialist in eating disorders explained to a *New York Times* reporter: “We’re running out of people that we’re allowed to hate, and to feel superior to . . . Fatness is the one thing left that seems to be a person’s fault—which it isn’t.”³¹⁹

³¹⁷ See *infra* note 323 and accompanying text.

³¹⁸ See *supra* notes 263–71 and accompanying text.

³¹⁹ Angier, *supra* note 298.

And so, it is unsurprising that when, finally, the nation passed a momentous health care reform law in 2010,³²⁰ it failed to provide universal coverage.³²¹ And it is not surprising that the law includes a significant loophole for those who would rather pay a penalty than pay for coverage.³²² In fact, the law passed by Congress in March 2010 largely institutionalized existing modes of health care provision and coverage. Congress rejected a “public option” as an alternative to reliance on the for-profit insurance industry.³²³ In so doing, it precluded dramatic change.³²⁴ The health care reform law rearranged the pieces of an existing health care system to offer wider coverage but did not transform that system; it thus hardly pretends to significantly minimize existing disparities in health between those at the top and those at the bottom of the nation’s hierarchy.³²⁵

³²⁰ Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010); Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029.

³²¹ A 2010 government report projected that, in 2019, 23 million people in the United States (about 5 million of them undocumented immigrants) would be without coverage. Robert Pear, *Health Care Cost Increase Is Projected for New Law*, N.Y. TIMES, Apr. 23, 2010, <http://www.nytimes.com/2010/04/24/health/policy/24health.html>. Early in the debate about the health reform laws, Congress agreed that undocumented immigrants would not be covered. In Fall 2009, Senator Max Baucus of Montana, then Chair of the Senate Finance Committee, declared that including undocumented immigrants in a system of national health care coverage for “undocumented aliens [and] undocumented workers” would be “too politically explosive.” *Senator Says Health Insurance Plan Won’t Cover Illegal Immigrants*, *supra* note 75.

³²² Among other limitations, the bills allow businesses and individuals to opt out of the system by paying penalty taxes that amount to much less than the cost of health care coverage. Beginning in 2016, individuals who do not have coverage must pay the higher of \$695 or 2.5% of their annual income. I.R.C. § 5000A(c)(3)(D) (West 2010); I.R.C. § 5000A(c)(2)(B) (West 2010); *see also* 1 CCH’S LAW, EXPLANATION AND ANALYSIS OF THE PATIENT PROTECTION AND AFFORDABLE CARE ACT 230–31 (2010); *see also* Pear, *supra* note 321.

³²³ Helen A. Halpin & Peter Harbage, *The Origins and Demise of the Public Option*, 29 HEALTH AFF. 1117, 1117 (2010).

³²⁴ To conservatives, a public option was socialism. To liberals, reform without a public option was insubstantial. *Id.* at 1121. Howard Dean, a former Governor of Vermont, and Richard Trumka, President of the AFL-CIO, ran a powerful but ultimately unsuccessful program to develop a public option. *Id.* at 1121. But by March 2010, neither the House nor the Senate was adequately committed to a public option. *Id.* at 1122.

³²⁵ In the months before passage of the health reform laws, President Obama began to refer to “health insurance,” rather than health care reform. And the promise of “universal” coverage became the promise of coverage for “almost everyone.” Thomas P. Miller, *Analysis & Commentary: Health Reform: Only a Cease-Fire in a Political Hundred Years’ War*, 29 HEALTH AFF. 1101, 1103 (2010).

The reform law's creation of "wellness programs," described in subsection I(B)(2)(a) reflects and symbolizes the opacity at the heart of the reform effort—an opacity that, not accidentally, reflects that of the nation's class system more generally. While presuming to expand coverage and thus equalize inequalities in health care (if not necessarily in health itself), the health care reform fails to adequately serve those at the lower end of the nation's hierarchy; it fails to serve those who are poor, those who are poor as well as fat, and many others.

Examination of the "wellness program" instituted by the grocery store chain Safeway³²⁶ reveals the limitations of such programs for those most in need.³²⁷ Safeway's incentive is particularly important because Democrats and Republicans lauded it in the months before passage of the federal health reform law.³²⁸ Beginning in 2009, Safeway offered rebates on health insurance premiums to thinner, non-smoking employees.³²⁹ In effect, the consequence of the program has been to charge fatter employees more for health care coverage. The program is significantly over-inclusive and under-inclusive.³³⁰ Many people categorized as fat are healthy, and many others, categorized as thin, are not. Even more troubling, such programs may actually increase rates of obesity and other health

³²⁶ The Safeway "Wellness Incentive Program" offered rebates of up to \$800 on health insurance premiums for nonunion, administrative employees who stayed "within limits on four common medical risk factors—smoking, obesity, blood pressure and cholesterol." Fiona Gathright, *Safeway's Wellness Incentive Program*, CORP. WELLNESS INSIGHTS (Jan. 6, 2009), <http://www.corporatewellnessinsights.com/2009/01/safeways-wellness-incentive-program.html>. One Web site explains that "[s]eventy percent of health-care costs are linked to behavior such as smoking, eating too much of the wrong things and not getting enough exercise" *Id.*

³²⁷ In fact, the inclusion of "wellness programs" in the Senate bill was referred to as the "Safeway Amendment." Daniel Engber, *The Fat Premium: Congress Toys with a Silly Plan to Make Americans Lose Weight*, SLATE (Oct. 29, 2009), <http://www.slate.com/id/2234003/>.

³²⁸ David S. Hilzenrath, *Misleading Claims About Safeway Wellness Incentives*, WASH. POST, Jan. 17, 2010, <http://www.washingtonpost.com/wp-dyn/content/article/2010/01/15/AR2010011503319.html>. The company's wellness approach was invoked by President Obama, Senator John McCain (R-Ariz.), and Senate Minority Leader Mitch McConnell (R-Ky.), among others. *Id.*

³²⁹ *Id.*; Engber, *supra* note 327.

³³⁰ Referring to a 2008 study in the *Archives of Internal Medicine*, Engber noted that many obese people were healthy, with normal cholesterol and blood pressure readings as well as other readings suggesting metabolic health. Engber, *supra* note 327. Conversely, about 25% of patients with BMIs classed as normal had abnormal metabolic readings. *Id.*

problems among poorer participants.³³¹ Daniel Engber, writing for *Slate*, argued just that.

[B]eing poor can make you fat, and being fat can make you poor. Rates of obesity and poverty are closely linked. . . .

In other words, the workers most likely to run afoul of Safeway's BMI threshold are those most burdened by the process of losing weight. . . . If you're fat because you're poor, the Safeway penalty makes you poorer still—and that in turn makes it harder to lose weight. This Catch-22 may end up pricing the neediest members out of the system—and it could explain [Safeway's] alleged success at cutting health care costs.³³²

Those who developed Safeway's program may well have done so in good faith, expecting the program to serve employees' health, and in doing that, to cut the company's health-coverage costs. But, in fact, such programs are problematic. They seem as likely to result in obesity discrimination and increased stigmatization as in healthier employees.³³³

The less felicitous implications of such programs can be discerned in the harsher responses of others. Dr. Delos Cosgrove, Chief Executive of the Cleveland Clinic, told a *New York Times* reporter that if he had his druthers, the Cleveland Clinic would refuse to hire fat people.³³⁴ In defending that preference, Cosgrove invoked the role of individual responsibility in determining weight and the economic consequences of obesity for the nation.³³⁵ ““Has anyone ever shown the law of conservation of matter doesn't apply?,” asked

³³¹ *See id.*

³³² *Id.* The Affordable Care Act's “wellness programs” do not allow such programs to serve as a “subterfuge for discriminating based on a health status factor.” Affordable Care Act, Pub. L. No. 111-148, sec. 1201, § 2705(j)(3)(B), 124 Stat. 119, 158 (2010). It seems likely, though far from certain, that employers will not be able to openly penalize people on the basis of weight (only on the basis of not participating in weight-loss or other “wellness programs”).

³³³ *See* Hilzenrath, *supra* note 328 (describing the Safeway wellness incentive as a “myth”).

³³⁴ David Leonhardt, *The Way We Live Now: Fat Tax*, N.Y. TIMES MAG., Aug. 12, 2009, <http://www.nytimes.com/2009/08/16/magazine/16FOB-wwln-t.html>. Cosgrove explained that, were there no legal impediments, he would simply refuse to hire obese people. The comment was offered in a discussion of the fact that the clinic does not hire smokers. *Id.*

³³⁵ *Id.*; *see also* Harlan Spector, *Cleveland Clinic CEO Sends E-mail to Employees Apologizing for Obesity Comments*, CLEVELAND.COM (Sept. 15, 2009, 3:45 AM), http://blog.cleveland.com/metro/2009/09/cleveland_clinic_ceo_sends_ema.html. Cosgrove explained that his aim was “to spark discussion about premature causes of death.” *Id.*

Cosgrove in response to a query about the justice of denying employment to fat people.³³⁶ The presumption underlying Cosgrove's question—that weight loss is a matter of individual control—is widespread. It is, however, accurate only in a limited context—one that discounts genetic, physiological, and socioeconomic factors.

Such factors, taken as a set, challenge, if they do not completely belie, the notion that fat people would be thin were they sufficiently committed to self-imposed reform. That notion (openly undergirding Cosgrove's preference not to hire obese people and more implicitly underlying various "wellness programs") increases obesity stigmatization and fails to serve the nation's health needs. Rather, it serves the needs only of those who benefit from other people's obesity. This group is diverse. It includes of course those who benefit from producing and selling products that make people fat or products that promise to make them thin. And—closer to the central thesis of this Article—it includes those for whom the stigmatization of obesity offers a marker of low socioeconomic status, thereby constructing an identifiable "Other," against whose misfortune the presumptively more fortunate "Self" can be defined.

CONCLUSION

A troubling irony, with far-reaching implications, lies just below the surface of the nation's fight against a presumptive "epidemic" of obesity. That irony is grounded in the nation's competitiveness about class status in a universe that renders class status uncertain and unstable for most people. The irony follows, more specifically, from the conflation of obesity, especially that characterized by central-body fat, and lower class status.

Americans are concerned about increases in population weight. In some part only, that concern is justified. Far less self-consciously, many Americans are almost equally worried that the "fight" against obesity (especially for those at the lower end of the nation's socioeconomic ladder) might succeed. That success would deprive many others of a clear marker that allows them to identify those below them on the nation's class hierarchy. In short, a significant segment of the American public is at best ambivalent about public

³³⁶ Leonhardt, *supra* note 334.

efforts to help “Others” lose weight. In that, they are supported by corporate interests that depend on the public readiness to pay for diet and nutritional aids. The result is an odd combination of conflicting interests—participating in the national “fight” against obesity while ensuring that those who are obese, especially those who are poor and obese, stay fat.

Both the social stigma constructed around obesity and the law’s sluggish response to obesity discrimination bolster a socioeconomic hierarchy that exacerbates ill-health for those at the bottom. Even more, the social conflation of obesity and poverty bolsters the presumption that those at the “bottom” can be distinguished in character and in physicality from others. Obesity is a contemporary equivalent of Hawthorne’s scarlet letter. But it reflects more than the parameters of presumptive sinfulness and irresponsibility; it provides a powerful marker of class status. The assumptions that underlie this vision—and that now result in conflating images of poverty with those of obesity—long stood in the way of health care reform. And they survive, though in muted form, in the limitations and loopholes embedded in the 2010 health reform law. In consequence, they diminish the value of that achievement to the nation as a whole.

