

# Big fat beat up

The obesity industry has diagnosed the wrong problem, and proposed the wrong solution, argues **Louise Staley**.

**A**rnold Schwarzenegger is obese. He's been obese his entire adult life, including the seven times he won the Mr Olympia bodybuilding title.

Despite obesity not impacting his own, clearly excellent, health, Governor Schwarzenegger has introduced many anti-obesity programs in an attempt to combat what he regards as California's obesity epidemic. In doing so, Governor Schwarzenegger becomes just another in a long line of policy makers attacking the wrong problem with the wrong solutions.

Before *any* public policy responses to obesity can even be considered, a single, surprisingly controversial, question has to be answered: when does being fat become a health problem? Only then can the second, also controversial, question be asked: what, if anything, can policy makers do about obesity?

## Carry that weight

According to the World Health Organisation anybody with a Body Mass Index above 30 is considered obese, and anything over a BMI of 25 is classified as overweight. At his bodybuilding peak Arnie was 1.88m (6'2") and weighed 107kg, leaving him with a BMI of 30.2.

So where did the magic number of a BMI of 25 come from? What makes a woman of average height (164cm/5'4½") fat at 67.5kg but normal at 67kg? Has she actually increased her risk of diabetes, cancer, or heart disease by gaining half a kilo? The use of BMI, and the classifications, come from life insurance tables of the 1940s. But the adoption of 25 as the magic number is credited to the International Obesity Taskforce (IOTF) whose members are also prominent on the US National Institute of Health and World Health Organisation obesity panels. It was the adoption of 25 as the cut-off by the WHO that led to that number becoming the international standard of fatness. Eric Oliver in his

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book *Fat Politics* demonstrates that the IOTF is funded by diet drug companies such as Hoffman-La Roche.

The dirty secret of the BMI is that health experts know the BMI is a deeply flawed way to measure whether someone is too fat.

If the classification for overweight was moved to a BMI of 30 then 52 per cent of Australians—some 10 million people—would immediately be classified as having a ‘normal’ weight. And there is considerable evidence that the greatest public policy intervention legislators could make in this area is to do exactly that. When the US moved the obesity goal posts the other way in 1998 and overnight reclassified 37 million previously normal weight Americans as overweight, the immediate impact was to stigmatise many newly overweight women as too fat—for no measured public health benefit.

But the BMI has one big advantage over accurate methods to measure body fat—it’s cheap and easy.

Obviously, diet pill companies have a big incentive to make more people think they are fat—it’s good for business—but the drug companies are by no means alone in creating the ‘obesity epidemic.’ Obesity researchers in Australia have proved highly media savvy

in getting out the message that obesity is killing us. In the crowded bazaar of medical research, where it’s hard to get your message heard above the clamour of competing illnesses and causes, it helps to proclaim, as Access Economics did earlier this year, that your ‘disease’ affects seven in 10 adult Australians and costs the country \$58.2 billion a year.

### **So what’s wrong with being a bit tubby?**

It is therefore surprising to learn the evidence does not support a BMI of 25 as an important marker of health outcomes. In their 2006 book *Diet Nation*, Patrick Basham, Gio Gori, and John Luik demonstrate that the evidence shows higher mortality rates don’t become prominent until beyond a BMI of 35 (about 118kg for a 183cm/6’ man).

It is clear that the extremely fat (those who have a BMI over 40) face a range of health risks and problems and there is some evidence that the relatively fat, (BMI 35–40) face some additional health risks. The very fat (the morbidly obese) and the very thin (the anorexics) have appreciably higher mortality rates than the rest of the population but, according to *Diet Nation*, what is not clear is at what point fatness causes

disease rather than any other factor such as smoking, age, metabolic disorder or family history.

Nevertheless, over and over researchers trumpet links between disease and obesity. Being even slightly overweight is meant to cause diabetes, some cancers, heart disease and strokes. How can it be that the evidence doesn’t appear to confirm the health risks except for the very fat? Researchers are beginning to re-examine the evidence on weight and health, and coming to some dramatically different conclusions than those which obesity lobbyists rely upon.

Critically, health researchers rarely measure health problems ‘caused’ by fatness along the full range of body weights. This approach fails to distinguish whether a BMI of 22, 32 or 42 is the tipping point for whatever disease excess fat is meant to cause. For this reason, the Australian Institute of Health and Welfare, in its report *Burden of Disease and Injury in Australia 2003* notes that its methods inflate the risk attributed to high body weight. Yet the authors continue to assert being even slightly overweight is a cause of a range of medical conditions. This research flaw is found widely in the obesity literature.

## The original definition of a normal weight came from a Belgian astronomer who measured the most common weight for their height of Scottish and French army conscripts—and he did so in the 1830s.

For example, recent research casts significant doubt on the supposed link between obesity and heart disease risks. Research published this year in *The Archives of Internal Medicine* found over half of those classified as overweight have normal blood pressure and cholesterol levels. More importantly though, is that study found weight was *not* the major risk factor. In all weight groups, inactivity, smoking and age were linked with higher risk factors for heart disease than waist circumference. People with normal weight but larger waist circumference had a greater risk than fatter people with smaller waists.

Another paper in the same journal found no difference in insulin sensitivity between a normal weight group and an obese group leading them to conclude that not all obese people face higher risks for developing diabetes. Similar studies exist for all other supposed diseases of fatness. Increasingly researchers are being faced with evidence that being merely overweight does not cause the raft of diseases attributed to it. A key part of that evidence is from Katherine Flegal and colleagues in a paper published in April 2005 in the *Journal of the American Medical Association* which noted the continued increase in life expectancy and the continuation of the fall in deaths from heart disease and stroke despite more than 25 years of increased weight in the US population.

For sure, there is substantial evidence that being very heavy—those with morbid obesity—is correlated with a range of health problems and risks. Hefting around additional weight puts stress on the joints causing increased demand for hip and knee replacements as well as osteoarthritis. The very fat are more likely to suffer from diabetes, heart disease, some cancers and strokes.

Continuing research does point

to one worrying trend, the super fat—the morbidly obese and even fatter—are both getting fatter and increasing in number. However, even the country with the most massive people, the US, only has 4.8 per cent of its population in the morbidly obese or worse category. Yet the very fat are unlikely to be properly targeted for assistance, not least of which because if the money made available to ‘fight the obesity epidemic’ is spread across 70 per cent of the population, it is unlikely the substantial sums required to treat the multiple health and behavioural problems experienced by the extremely obese will be made available.

As Oliver writes in *Fat Politics*, the reason why a majority ‘are overweight is because a nineteenth-century astronomer, a twentieth-century insurance actuary, and a handful of contemporary scientists concocted some ideas about what a normal weight should be.’ The original definition of a normal weight came from a Belgian astronomer who measured the most common weight for their height of Scottish and French army conscripts—and he did so in the 1830s, a time when life expectancy was about 40 as a result of chronic malnutrition and disease.

No wonder their average weight was so low. The other major source of data for what is ‘normal’ came from measuring men to develop life insurance tables in America in the 1940’s. Because of their different physiology, it is likely women gain additional protective benefits from carrying more weight than men yet the ‘ideal’ weight is deemed to be the same for a man and woman of equal height.

Given the increasing evidence that the categories of overweight and mildly obese have fewer elevated health risks, and definitely lower health risks than the underweight, is it not possible that

the healthy ranges are set too low, particularly for women? It is hard to see any benefit in public health terms or for the individuals concerned by stigmatising large swathes of the population as overweight or mildly obese if the huge effort of them losing weight will not appreciably improve their health or life expectancy.

### Neither cause nor cure are correct

The way to reduce fatness is to eat fewer calories and exercise more. This approach has the great advantage of matching common sense. We see the contestants on *Australia’s Biggest Loser* go on a diet and do huge amounts of physical activity and—Hey Presto!—they all lose weight. It is therefore very surprising to learn that the extensive research literature on exercise and dieting shows virtually nobody loses weight through low calorie dieting, that the overweight do not eat more than the lean and exercise is not correlated with weight loss. Although all experts agree imbalance between energy in and energy out causes weight gain, it seems the actual amount of food needed varies so dramatically between people that no general diet recommendation works across the population. Short of locking all the overweight up with an individual dietician and trainer, the obesity industry has no workable way to help most people get to the weight the experts deem ideal.

The obesity industry—that is, those researchers and drug companies that rely on the notion of an ‘obesity epidemic’—therefore face an increasing amount of evidence suggesting that the links between fatness and various diseases are weaker than believed, and that the industry’s proposed solution to obesity—a low calorie/high carbohydrate diet with exercise—does not work. Moreover, if

current definitions of overweight are set too low—so that attaining a ‘normal’ weight requires constant dieting—then this in itself may be leading many people to feel discouraged when the ideal is unattainable.

Survey after survey tells us that most people—including the fat themselves—blame fat people for their size. If only all the fatties could get a grip on themselves, they wouldn’t be fat. Being overweight or obese is typically seen to be a result of lack of control.

This is also the message pushed by the weight loss companies and gyms as well as the writers of diet books and sellers of weight loss additives. Even though weight loss, particularly to the weight range deemed ideal, is recognised as very difficult to achieve, losing weight is still seen by most as a private decision.

Increasingly policy makers and activists are out of step with this response. Increasingly the Nanny State intrudes into obesity policy. Instead of obesity simply being the result of an energy imbalance caused by an individual’s eating patterns it is some unquantified combination of genes, metabolism disorders and an ‘obesogenic’ environment.

Despite the failure of research to identify either that moderate fatness causes other health problems or, more importantly, that there are cures for this supposed health crisis, increasingly a disparate number of researchers and activists think they have the public policy answers to the ‘epidemic.’ Unlike the public’s preference for individual self-control, the obesity activists favour extensive government intervention and a severe restriction of the civil liberties of the entire population, regardless of whether they are too fat or not.

These activists blame processed food companies, modern agricultural methods and fast food companies for obesity. Television watching (especially presumably plasma TV watching), car driving and urban sprawl are also highly cited. Activists argue that modern agriculture and processing has made food very cheap, and that this cheap food is then shovelled out in huge portion sizes at the supermarket and by fast food companies to people who live in suburban fringe estates with no footpaths; who drive their

cars through drive-throughs so they can return to eat in front of the TV; where they watch increasing amounts of advertisements that trick them into repeating the process the next day.

Over all this they have little or no control.

## **Forgive your upsize**

For some obesity activists the public-spirited response to this is to ban junk food advertising, ban suburban fringe development, build new public transport services, increase labelling requirements, ban super-sized servings, tax junk food, and increase the number of bariatric surgeries done on Medicare.

And these are responses to reducing the number of adults who are obese and overweight. There are far more draconian options proposed for childhood obesity.

One commonly seen proposal is the restriction of fast food outlets in low income areas. Supporters of this heavy-handed restriction on civil liberties imply that poor people are incapable of making good food choices, and so the only option is to restrict their choices to good food. Yet recent research shows that while there is a greater preponderance of fast food outlets in low income areas, there are also more supermarkets. The choice is already there.

Another popular proposal is a fat tax—a tax on high calorie dense foods such as soft drinks, confectionary and much fast food.

The idea is if these types of foods are taxed to the point that reduces consumption and the proceeds are used to subsidise ‘too expensive’ healthy foods, then the poor will be able to eat better.

But beyond the practical problems with this idea—do we really want to make food more expensive for poor people? And do we really want to set individual tax rates for every single food type? There is something deeply repugnant about expecting people to vote, to raise their children, to hold a job or to serve on a jury yet at the same time use policy settings to forcibly change what people eat.

Moreover, it is not clear at all that fast food is the culprit of the obesity ‘crisis.’ A number of research studies have failed to find a link between fast food consumption and obesity. Those dreadful news clips of fat people chowing-down on chips, fried chicken and burgers while slurping huge buckets of coca-cola, do not, obviously, tell the whole story.

The studies show people compensate over the day so that overall very few additional calories are consumed compared to people not eating fast food.

Another claim made by supporters of a fat tax is that supposedly the poor live on soft drink and chips because they are much cheaper than a healthy alternative. But it does not stand up to scrutiny. Consider this hypothetical—a one litre bottle of coke from the supermarket costs about \$2.10, a 200g packet of chips \$3.80 or a large fries from McDonalds \$2.75. Total meal cost around \$5 or \$10 for a couple. For much less money, that couple could have purchased ingredients to cook pork chops and vegetables, pasta with tuna, chicken breast and vegetables or risotto with chorizo and peas, or any number of other meals. The argument that the poor—perhaps with the exception of those who live in the most remote locations—cannot afford unprocessed fresh food is simply not true.

Policy makers of all political persuasions like to be seen to be doing something, especially when there’s an apparent crisis, the ‘obesity epidemic.’ Some are open in claiming it is the right and duty of the state to dictate what a good life should look like. Others are more circumspect, hiding behind disputed science and drug company funded reports, to justify a supposed cost-benefit of limiting people’s basic life choices.

In either case, Nanny State proposals to solve a crisis that may not exist, with proposals that are known not to work, embodies the worst excesses of the government interventionism in a democratic society.

