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Who is responsible for addressing obesity?

- How framing obesity limits the interpretation of the problem and affects our understanding of who is responsible -

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Abstract

Obesity is a worldwide epidemic, affecting children as well as adults. Obesity is a major risk factor for number of chronic diseases, it is closely related to premature mortality and other negative effects on health-related quality of life. Obesity places great economic burden on states as well as obese individuals themselves. Addressing obesity seems an urgent matter, but who should be responsible for addressing this epidemic? This thesis discusses obesity from a public policy perspective. It focuses on how a problem representation, or problem framing, limits the interpretation of the problem and affects our understanding of responsibility and policy options. Taking a constructionist and interpretivist epistemological position, document analysis is used to study how obesity is interpreted and represented in documents from the medical journal *The Lancet*, the World Health Organization and the Icelandic parliament. The main findings are that obesity was represented and framed in a number of ways. However, an environmental framing, representing obesity as a result of social changes and as a symptom of unhealthy food and activity environments, was dominant among all the three actors. Addressing obesity was in all cases presented to be mainly a governmental responsibility.

Keywords: obesity, public policy, problem representation, problem framing, responsibility, noncommunicable diseases.

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1. Introduction

A common understanding of a welfare state entails that the state plays a key role in protecting and promoting the social and economic well-being of its citizens. Thus, the concept of a welfare state is usually associated with ideas of equality and shared responsibility, that is, public responsibility for the "less fortunate" ones or those who are unable to provide themselves with a minimal standard of living. Asa Briggs (1961 in Pierson & Castles, 2006, p. 16) defines a welfare state as:

> […] a state in which organized power is deliberately used (through politics and administration) in an effort to modify the play of market forces in at least three directions – first, by guaranteeing individuals and families a minimum income irrespective of the market value of their work or their property; second, by narrowing the extent of insecurity by enabling individuals and their families to meet certain 'social contingencies' (for example, sickness, old age and unemployment) which lead otherwise to individual and family crises; and third, by ensuring that all citizens without distinction of status or class are offered the best standards available in relation to a certain agreed range of social services.

From the above, I conclude that in case of sickness a welfare state has a role to play, usually by providing citizens with health service and/or securing them with a minimum income when sickness restraints their working capacity. Sickness, indeed, relates to all the three parts Briggs mentions as sickness can for sure decrease the market value of people´s work; sickness may be unforeseen and thus a potential crisis for those involved; and at last one would expect certain services to be available for all citizens under such circumstances. But what if sickness is lifestyle related and thus in the opinion of some, self-inflicted, is that the state´s problem or a personal liability? Does it matter how a medical condition is defined and does that affect our understanding of the problem and who is responsible? That is an issue this paper will revolve around, with the focus set on the global obesity pandemic and public responsibility. The research question is twofold:

How does the problem representation of obesity, or the problem framing, limit the interpretation of the problem, and how does that affect our understanding of responsibility and public policy options?

What does the study of documents from three different actors, the medical journal The Lancet, the World Health Organization and the Icelandic parliament, tell us about the framing of obesity?

1.1 Relevance of the study

Noncommunicable diseases (NCDs) are the leading causes of death globally, killing more people each year than all other causes combined. NCDs, also known as chronic diseases, are medical conditions or diseases that are non-infectious, meaning they are not passed from person to person. These diseases are of long duration and generally slow progression. The four main types of NCDs are cardiovascular diseases, cancers, diabetes and chronic respiratory diseases (lung diseases). These four groups of diseases account for around 80% of all NCD deaths and they share four major behavioral risk factors: tobacco use, physical inactivity, the harmful use of alcohol and unhealthy diet. Because of their risk factors, they are often called lifestyle related diseases (WHO, 2011 B, p. vii).

The growing NCDs epidemic is commonly defined as a serious health problem but nowadays also as a development challenge. NCDs entrench or force many people into poverty due to unbearable expenditure for treatment and because of that the NCDs epidemic is seen as an obstacle in the way of reaching the UN Millennium Development Goals. NCDs are considered to be largely preventable through the reduction of their four main behavioral risk factors (WHO 2011, p. 1-3).

1.1.1 Obesity

Another lifestyle related medical condition is obesity, a focal point for this study. Overweight and obesity, defined as abnormal or excessive fat accumulation that presents a risk to health, is a major risk factor for a number of chronic diseases (NCDs) such as diabetes, cardiovascular diseases and cancer[1]. Overweight and obesity is the fifth leading risk for global deaths. Worldwide obesity has more than doubled between 1980 and 2008. In 2008, 1.5 billion adults (20 years and older) were overweight, of these over 200 million men and almost 300 million women were obese. Hence, more than one in ten of the world´s adult population was obese. Bur, obesity also affects children. In 2010 nearly 43 million children under the age of five were obese. Obesity is thus a health risk for the whole population (WHO, 2011 A and WHO, 2011 B, p. 22-24).

Rising prevalence of obesity is a worldwide concern. Obesity is closely related to increased burden from NCDs, premature mortality and other negative effects on health-related quality of life. Obesity creates great economic burden, consisting of different costs borne by governments, employers, health care organizations, insurance companies and the obese individuals themselves. Obesity leads to a loss of productivity and increased medical treatment- and health-care cost (Rosin, 2008, p. 622). Increased obesity, combined with an ageing population, generates a substantial direct cost burden to the health-care system and according to a worldwide study, obesity accounted for 0.7-2.8% of a country´s total health-care cost. Obesity is also expensive for individuals as the study revealed that obese individuals had 30% higher medical costs than those with normal weight (Wang et al. 2011, p. 815). In addition, one must take into consideration indirect cost stemming from obesity, for example in relations to decreased years of disability-

[1] Body mass index (BMI) is commonly used to classify overweight and obesity in adults. BMI is an index of weight-for-height or person´s weight in kilograms divided by the square of his height in meters (kg/m^2). The WHO defines a BMI $\geq$ 25 kg/m^2 as overweight and a BMI $\geq$30 kg/m^2 as obesity (WHO, 2012 A).

free lives, disability pensions, increased mortality before retirement, early retirements and work absenteeism (2011, p. 817). To that list, economists add the cost of weight loss programs, the cost of excess food consumed, marketing and advertising to encourage over-consumption of food and upsizing of public seats (Rosin, 2008, p. 622). Several studies suggest that the monetary value of lost productivity is several times larger than medical costs (Wang et al. 2011, p. 817).

Nowadays, Obesity is obviously considered a growing problem, both for obese individuals themselves and for society as whole. When a problem is detected a common reaction is to find the cause and search for a solution. While writings indicate that obesity is "man made", researches and empirical data also indicate that the current obesity epidemic is driven by environment that promotes obesity by affecting individual lifestyle in the context of society. In other words, the current epidemic is increasingly seen as a socio-demographic phenomenon (Rosengren and Lissner, 2008, p. 260-262). According to WHO data, the prevalence of overweight and obesity is fundamentally different between regions of the world and it is also different between the sexes, as women were more likely to be obese than men (WHO, 2011 B, p. 24). The data show a positive relation between prevalence of raised BMI and the income level of countries, up to upper-middle-income levels. And, there are indications that there is a relationship between education and BMI – in high-income countries the relationship is inverse but in medium- and low-income countries a positive relationship has been observed (*ibid*). Thus, some regions and certain groups within a population are in more danger of developing an obese condition than other. Still, obesity is a pandemic, rising in prevalence in almost all parts of the world (WHO, 2011 A).

From what has been stated, there is no denying that fighting obesity seems an urgent matter. There seem to be many options in framing obesity: As a general health issue; welfare issue; developmental issue; economical issue; modernization issue and individual lifestyle issue, to name few. My main interest is partly related to this fact, as I am interested in how the representation or the framing of obesity

influences our perceptions on who should be responsible for addressing this pandemic and how. As studies state that many countries have made a good progress in reducing some of the risk factors for NCDs – such as smoking, high cholesterol, and hypertension – but still no country can act as a public health exemplar for the reduction of obesity and diabetes type 2 (Swinburn et al. 2011, p. 804) and that there has been little progress in implementation of already available cost effective policy interventions (Pincock, 2011, p. 761), I felt that studying this topic from a public policy perspective would be an interesting as well as an important task.

1.2 Outline of the study

This study is constructed into five parts. The first part provided the reader with an introduction of the research questions and some practical information about obesity and NCD´s, in order to establish the relevance of the study. The second part introduces the theoretical framework and explains the focus of the study. Under discussion, will be issues concerning public- and private responsibility, public policy theories and theories addressing problem representation, as well as a discussion about problem framing and its connection to public policy. The third part introduces the methodological aspect of the study and explains the analytical framework that will be used. The framework is built on two approaches that will be briefly introduced: Carol Bacchi´s (2009) "What´s the problem represented to be?" approach and an approach to framing inspired by an article written by Regina G. Lawrence (2004), *Framing Obesity – The Evolution of News Discourse on a Public Health Issue*. It also discusses choices of actors, documents and methods, and introduces documents that will be analyzed. The fourth part is the analytical part of the study and the fifth part contains the conclusions.

2 Theoretical framework

> Theory is important to the social researcher because it provides a backcloth and rationale for the research that is being conducted. It also provides a framework within which social phenomena can be understood and the research findings can be interpreted.
>
> (Bryman, 2008, p. 6)

The global obesity epidemic has been escalating for four decades and when this study is conducted, this development seems to be out of control. Most countries are searching for answers to the question how the rising prevalence of obesity may be reversed but so far results are limited. There are many possible causes of obesity and a number of suggestions on what to do. Overconsumption of food, combined with lack of physical activity is a commonly held explanation and so is sedentary lifestyle and human metabolism or genetic factors (Rosengren and Lissner, 2008, p. 262; Rosin, 2008, p. 623; UN Media Centre, 2005). However, in recent years the focus has been moving away from individual factors determining obesity on to environmental factors and social changes that are said to drive the obesity pandemic – factors such as urbanization; globalization; increased reliance and access to motorized transport; technological changes and the mechanization of work; nutritional transition towards fatty foods; super-sizing restaurants; and the increased marketing and commercial advertisements of food (Rosengren and Lissner, 2008 and Rosin, 2008). At the same time there seems to be a shift in the discourse regarding who should take responsibility for this development. Some call for more information and responsible individual choices, others for public policy interventions or global political leadership and measures in line with the Framework Convention on Tobacco Control (Lawrence, 2004) and nowadays there seem to be an emphasis on the importance of multisectoral actions (WHO, 2012 A). As there are many possible causes for obesity, there are also different ways to act and to assign the responsibility – with individuals, states or at the global governance level. My aim for the theoretical part is to discuss theories that

address how a representation of a problem, or problem framing, may influence or determine our perceptions and understanding of the problem and who is responsible. Also, how that may affect our normative perceptions about what states should do. To address this, I find it necessary to discuss theories about the role of the state, public policies, policy framing and what could be called agenda setting – how problems become governmental problems – and the importance of how problems are represented.

2.1 Ideas about state responsibility

The role of the state and what should be its legitimate functions has been a matter of debate for centuries, and it still is. Since the 1930´s the idea of the welfare state – the idea that the state plays an important role in the protection and promotion of the economic and social well-being of its citizens – has become popular in most advanced capitalist democracies, but certainly not uncontested. Advocates of *laissez faire,* for example, state that the government should leave the private sector alone and not try to regulate or control private enterprise because unfettered competition will eventually serve the best interests of society. A more modest economic perspective acknowledges that even if markets and private enterprise is the core in a successful economy, government plays an important role as a complement to the market (Stiglitz, 2000, p. 6). Modern economics address six conditions called market failures[2] that provide a rationale for government activity and interventions, in order to promote efficiency. They also admit that even if economies are efficient, competitive markets may result in a highly unequal income distribution and that is why promoting equality and redistributing income has become an important activity of many governments (2000, p. 77-87). This is in line with the general notion of a welfare state that presumably uses its power to

[2] Market failures: Failure of perfect competition; public goods; externalities; incomplete markets; information failure; and macroeconomic disequilibrium such as unemployment and inflation.

modify the play of market forces. Never the less, the exact role governments should play in market economies, is a matter of contention.

In recent times, with the rise of the welfare state, the responsibility for the nation´s social- and environmental conditions and even the quality of life, has become a matter for government. Numbers of various social programs and public policies in what could be called welfare issues bear witness to this development. Nowadays the role of the state is still debated on, and even if there is a general consensus in many countries about the notion of a welfare state, there are on-going debates on how far collective responsibility should go – what should be the responsibility of individuals and their families and what should be considered social responsibility. States seem to be trying to find some balance in their relation to their citizens – between individualism and collectivism – but also between the needs of the community and rights of individuals.

G. A. Cohen (in Rothstein, 1998, p. 11) argues that state responsibility for the welfare of its citizens should be restricted to compensating them for differences that have not arisen from their own choices. The state should only assist citizens with difficulties that were beyond their power to influence – things such as inborn physical handicaps. However, in practice, drawing such a line is not a simple task, as Bo Rothstein points out (1998, p. 11). Should we, for example, deem an unemployed person responsible for his condition and should we treat persons with the same illness, such as high blood pressure, differently based on whether their condition was caused by their individual lifestyles or reasons beyond their control? Obesity is an excellent example of this dilemma as obesity may be seen as a result of one´s lifestyle choices but it may also be caused by reasons beyond one´s control. Obesity thus brings to our attention the importance of how we understand problems or how problems are framed and represented. If one sees obesity as a lifestyle related condition, by first instinct one would probably regard this as an individual responsibility and perhaps question the relevance of social responsibility. However, if one sees obesity as a condition resulting from

environmental- or socio-demographic factors, the picture might look quite different and social responsibility as well as public actions might actually make great sense.

2.2 Public policy theories

Health is an important sector of most economies and a core area of social policy. So far, my discussion about obesity has been related to the question whether or not the state has a role to play in addressing the obesity epidemic. Some might ask why I am even discussing that, the answer should be an obvious "yes" because most states, at least welfare states, assist their citizens in some ways when sickness occurs. But, the fact is that obesity has been in a medical grey zone for a long time, discussed in terms of being a medical condition, a major risk factor for NCDs and other complications but not as a disease. Thus, the responsibility of the state has, by no means, been clear. However, if states are in some way seen as responsible for addressing obesity and reversing the pandemic, this responsibility will in most cases be manifested in public policies. Thus, a short discussion about public policies and the relationship between problems and policies is necessary.

Public policy, developed by governmental bodies and officials, may be defined as a purposive course of action followed by an actor or a set of actors in order to deal with a problem or a matter of concern (Hill & Hupe, 2009, p. 5). Public policies are in this sense a response to a certain situation that is perceived as undesirable or, at least, as a means for social improvements. Policies normally contain specific goals and the means for achieving those goals, they involve behaviour and intentions, actions or inactions and thus one can say that policies are about means and ends. Policies produce outputs or instruments, such as laws and regulations, and outcomes or impacts, such as behavioural changes. Public policies are important as they often provide government and public agencies with legitimacy for actions (Hill & Hupe, 2009, p. 3-5).

According to Paul Sabatier, in a public policy making process, problems are conceptualized and brought to government for solution. After that, governmental institutions formulate alternatives and select policy solutions that are then implemented, evaluated and revised (Sabatier, 2007, p. 3). Taking evaluation and revision into account, one can also see the process as a cycle. What Sabatier describes is a quite common but nowadays generally perceived as a simplistic view of the policy process, often labeled as the rational model. This view sees policy making as a rational process that can be decomposed into a number of successive phases or stages – steps that relate to each other in a chronological order. These stages are usually called agenda setting, policy formation (consisting of policy formulation and decision-making), implementation and evaluation (Hill & Hupe, 2009, p. 115). The rational model is useful as an analytical tool but it does a poor job in describing reality. As John W. Kingdon points out:

> If policy makers were operating according to a rational, comprehensive model, they would first define their goals rather clearly and set the levels of achievement of those goals that would satisfy them. Then they would canvass many (ideally, all) alternatives that might achieve these goals. They would compare the alternatives systematically, assessing their cost and benefits, and then they would choose the alternatives that would achieve their goals at the least cost.
>
> (Kingdon, 2011, p. 77-78)

According to Kingdon (2011, p. 78), this is not a good description of reality. Decision makers face cognitive limitations in making choices and cannot canvass many alternatives, keep them all in their heads and systematically compare them. Also, in his research, Kingdon found that in many cases participants, in the policy process, were not solving problems at all. Their goals had not been specified very precisely and he found that they had not identified their problems with great care. Often, they seemed to push for given proposals, developing information about the problem they were supposed to be solving along the way. He acknowledges that there are indeed different processes but according to him they do not necessarily follow one another in a regular chronological order (*ibid*). Hence, public policy

process is not as clear and straightforward as the rational model assumes. Reality is usually much more complex.

Sabatier also discusses factors that highlight the limitations of the rational model when he discusses the complexities of the policy making process. Generally there are numbers of actors involved in one or more aspects of the process and these actors may have different values and interests, as well as different perceptions of the situation and different policy preferences (2007, p. 3). Politics, power and negotiations may thus play an important role in the processes, but the rational model neglects those aspects. To understand the policy process one needs:

> […] knowledge of the goals and perceptions of hundred of actors throughout the country involving possibly very technical scientific and legal issues over periods of a decade or more while most of those actors are actively seeking to propagate the specific "spin" on events.
>
> (Sabatier 2007, p. 4)

Because of this complexity a policy analyst needs to find a way to simplify the situation if he/she wants to have a chance of understanding it. One cannot analyze everything (*ibid*). Therefore analysts rarely use the whole rational model in analytical purpose, but focus on certain aspects of the model, such as agenda setting (Kingdon, 2011) or implementation (Hill & Hupe, 2009) to name examples.

A number of models or frameworks for public policy analysis are available. Each model and framework tells the analyst what to focus on and where to search for explanations. Because of that there is a real possibility that depending on from where you look at a situation, you will see quite different things. It is therefore necessary for an analyst to be aware of other theoretical perspectives and to be able to use several of them. This fact brings the attention to the purpose of public policy analysis and whether it should be to generate a body of empirical

generalizations – capable of explaining behavior across social and historical contexts, independently of specific times, places or circumstances. Or, if those studying public policies should attempt to explain how social groups construct their understanding of reality and how their understanding affects their social actions and the process of social changes (Fischer in Hajer & Wagenarr, 2003, p. 212-216). These questions will not be settled in this study, but the focus of this study will be in line with the latter approach, focusing on problem representations or framing.

2.2.1 Problem representation

Going back to Hill´s and Hupe´s definition of public policy, one sees a clear emphasis on problems. Public policies are generally seen as responses to specific problems in society. They are supposed to have a purposive character, be related to these problems and are meant to solve them and improve things. This raises questions about what becomes a problem, why and how.

As was said above, Sabatier states that in a public policy making process, problems are conceptualized and brought to government for solution. Hence, problems do not fall from the sky – they are cognitively formulated and brought to government. Carol Bacchi (2009) points out that public policies have a cultural dimension and may thus be thought of as cultural products. Policies are shaped within a specific historical, national or international context. In contrast to the presumptions that the purpose of public policies is to solve or respond to problems, Bacchi sets out to show that policies imply a certain understanding of what needs to change or put differently, what is the problem. Most government policies do not officially declare that there is a problem that the policy will address, rather it is the whole notion of policy, the emphasis on changes that implies there is a problem that needs to be addressed. These implied problems found in public policies and public policy proposals need to be scrutinized according to Bacchi (2009, p. viiii-x). Considering the fact that public policies are

an important tool for governing, Bacchi wants to set the focus on how particular representations of problems play central roles in how we are governed (2009, p. xi). Bacchi sees policies as problematizing activities. Government need to problematize the issue they are addressing because, as common sense tells us, there is no need to fix what is not bent or broken. This points to the fact that the ways in which issues are problematized, how they are thought of and how they are framed as problems, are central to governing processes. The framing sets a focus, and at the same time limits policy options.

I find Bacchi´s arguments convincing and I think her suggestions make great sense and indeed add a new dimension to public policy analysis. I agree with her, that it is a very interesting focus to study the sources or the precursor of a policy, in order to get a clearer picture of how governing takes place and how that affects those being governed. In the case of obesity I think the key to understanding why governments do or do not address obesity, lies in the problematisation, that is, how obesity is framed or represented as a problem. Problematisations are according to Bacchi (2009, p. 263) framing mechanisms that determine what is considered to be significant and what is left out of consideration. The representation of a problem, in public policy documents, indicates where the responsibility for the problem lies and that is crucial if one wants to understand the obesity epidemic from a public policy perspective.

2.2.2 Policy frames and problem framing

Laws and Rein (in Hajer & Wagenarr, 2003, p. 173-174) interpret the concept of frames as a basis for discussion and action. They use frames as:

> […] a particular way of representing knowledge, and as the reliance on (and development of) interpretive schemas that bound and order a chaotic situation, facilitate interpretation and provide a guide for doing and acting.
>
> (Hajer and Wagenarr 2003, p. 173)

Frames are seen as normative-prescriptive stories that focus our attention and they provide structure and stability through a problem-centered discourse. Stories express beliefs that conceptualize situations into a policy problem that names the phenomenon and implies a course of action. These stories unite fact and value into belief about how to act (2003, p. 174).

In certain situations, or when it comes to certain issues, there may either be a dominant frame or frame pluralism involved. A dominant frame implies a certain consensus but pluralism implies there are multiple frames coexisting. These multiple frames may be contradicting or contesting each other and thus inhibiting agreement on a course of action. Both situations are however open to change over time through the development of a change in the definition of the problematic situation or in what course of action to take. This is called reframing. According to Law and Rein, reframing happens in moments of doubts, when accepted stories are challenged. These are the moments when systems are open to new insights, ideas and behavior (2003, p. 175). There are many situations that may lead to a story being challenged and eventually reframing, some examples may be: lived experiences that do not match the story; new evidences and information that challenge it; and of course the will of people to change the story. The important fact is that policy frames are social constructions. In daily lives people tend to take things such as problems and policies for granted, as they were in some sense "natural" or a "reality", when in fact these are products of certain times and certain places. This means that there is always room for challenging dominant frames and there is always room for changes.

In 2004, an article by Regina G. Lawrence, *Framing Obesity – The Evolution of News Discourse on a Public Health Issue*, was published. Her aim was to study the framing of obesity in news discourse in USA and assess whether obesity was being framed in a way that would make it amenable to policy solutions (2004, p. 56). Although our studies are not identical, Lawrence´s focus was very much in line with mine – how the debate on obesity ignites the question of who or what is

responsible for causing and curing this epidemic. Lawrence´s article is a good example of how theories on framing may be operationalized and applied to a study like mine.

According to Lawrence (2004, p. 56), researches suggest that public health problems become amenable to public policy when they can be framed (or reframed) in systemic terms. As has been said before, problems are what they are represented to be and there are usually many ways to look at a problem. Which causal factors to address and where to locate the responsibility is therefore a policy choice. Citing Deborah Stone (1997), Lawrence says that in politics we look for causes, not only in order to understand how the world works, but also to assign responsibility for problems (2004, p. 57). In her study, Lawrence sets up two kinds of frames of causes for the problem: "individualizing" frame and "systemic" frame. These frames anchor opposing poles of a continuum of discourse. The individualizing frame limits the causes of a problem to particular individuals, often those afflicted with the problem. It also limits the governmental responsibility for addressing it. The systemic frame assigns responsibility to government, business and large social forces and generally calls for governmental action (*ibid*).

I find this a good way of looking at things and I think her operationalization could be applied to my study, because public discourse is of course influenced by what other actors such as specialist and politicians are saying, and vice versa. We are not studying two completely different worlds, but different levels that engage in dialogues on many occasions and mutually shape and influence the discourse.
As was stated above, frames are not fixed – they may change over time. Researches suggest that both public opinion and the policy making environment may change when health risks are reframed in particular ways. Reframing can therefore be a crucial factor in agenda-setting and policy changes. Citing Constance Nathanson (1994), Lawerence mentions three key dimensions in how public health risks are framed, all influencing public policy responses: whether

the health risk is described as acquired *deliberately* or *involuntarily*; whether it is described as *universal* risk or *particular* (targeting a group); and whether it is described as arising from within *the individual* or from *the environment* (2004, p. 59). She then adds a fourth dimension stating that when a health risk is accepted as being *real*, whether it was *knowingly created* by others, is often crucial to assign blame (*ibid*). The more an issue is framed in terms of *involuntary-, universal-, environmental- and knowingly created risk*, the more it points in the direction of public responsibility or the responsibility of powerful groups (*ibid*).

Lawrence mentions an excellent example of reframing when she mentions the anti-tobacco movement and the discovery of the health risks of second-hand smoke. This turned nonsmokers into innocent victims of tobacco and also the highly addictive side of smoking made smokers not entirely responsible for their own behavior (2004, p. 59). I am curious to see if there is a somewhat similar development occurring in the discourse on obesity. Eating is by most seen as a private matter and so is the way we take care of our body. One´s eating does not harm another person in any obvious way, so why should overweight and obesity be a matter of public policy? Is obesity perhaps being reframed into something amenable to public solutions? Lawrence´s study strongly suggests that in the past two decades obesity has been reframed in the US news discourse. Popular understanding of the causes of obesity has moved from biology and personal behavior towards environmental causations (2004, p. 69). Whether this reframing can be identified in public policies and policy making processes, is something I hope to find out by following guidelines from Carol Bacchi´s and Regina Lawrence´s way of studying problem representation and framing.

3. Methodology

How is obesity represented or framed and how does this representation affect how we determine the responsibility of the problem? These are the main questions this study addresses. Last section introduced theories about public policies that showed how policies imply a certain understanding of what needs to change and therefore what is the problem. Carol Bacchi (2009), suggested that problems are created within the policy making process and that policies give shape to them. Problems are cognitively formulated and policies may be defined as cultural products. Public policies, with their emphasis on changes, imply there is a problem that needs to be addressed. According to Bacchi these implied problems, need to be scrutinized because they affect how citizens are governed. Thus, it is important to study how issues are problematized, how they are thought of and how they are framed as problems. Understanding how problems are represented is important in order to understand why governments do or do not address an issue or a situation, but also to understand how they address it. Regina Lawrence (2004) discussed how public health problems become amenable to public policy, when they can be framed in *systemic* terms, assigning responsibility to government, business and large social forces. She also pointed out that when an issue is framed in terms of *involuntary-, universal-, environmental- and knowingly created risk* public responsibility or the responsibility of powerful groups becomes relevant.

Given the research questions and the theoretical framework, emphasizing that social problems are constructed by social actors and in a constant state of revision, this study takes a constructionist epistemological position (Flick 2009, p. 69-70; Bryman, 2008, p. 19-20). It takes an interpretivist epistemological stance, since it will not search for objective knowledge but analyze how different actors interpret reality. In fact it is inspired by a hermeneutic-phenomenological tradition, seeking to understand human action and departing from a notion that human behavior is considered a product of how people interpret the world (Bryman, 2008, p. 16-17). The aim is to study how a selected set of actors interpret and represent obesity,

and this will be done by analyzing documents these actors have produced. The aim is not to assess statistics related to obesity or to test hypothesis. This is a qualitative research, emphasizing words (texts) that reveal how actors interpret reality (2008, p. 22-23). In the words of Frank Fisher (in Wagenaar and Hajer, 2003, p. 209-211) this study uses a postempiricist or a post-positivist approach to policy analysis, turning the focus away from the more traditional emphasis on strict empirical proofs and verification, to a discursive and contextual understanding of social knowledge and the interpretative methods of gaining it.

Before selected actors and their documents are introduced, a discussion about the approaches that will be used for analysis is necessary because these approaches somewhat determine the choice of documents and the methods that will be used. The first approach is developed by Carol Bacchi in relation to her public policy approach (see section 2.2.1) and will be applied in order to study the problem representation of obesity. The second approach is inspired by Regina Lawrence's article (in section 2.2.2) that serves as an example of how frames may be defined and classified. After these approaches have been introduced, the ways in which they will be combined and applied to this study will be introduced.

3.1. A "what´s the problem represented to be?" approach to policy analysis

In contrast to many conventional public policy analysis approaches, focusing on reaction to social problems or problem solving, Carol Bacchi (2009) has developed an approach to policy analysis that emphasizes the creation of policy problems, called a *"What´s the problem represented to be?"* approach (WPR approach). The WPR approach emphasizes that how problems are represented matters because the representation influences how the issue is thought about and how people involved are treated and how they think about themselves. The focus is thus on the constructed character of problems and the creative or productive role government plays in shaping particular understandings of problems (2009, p.

1-2). The WPR approach consists of six interrelated questions and a directive to apply these questions to one´s own problem representations (2009, p. 2). These questions will now be introduced:

1. What´s the 'problem' represented to be in a specific policy?
2. What presuppositions or assumptions underlie this representation of the 'problem'?
3. How has this representation of the 'problem' come about?
4. What is left unproblematic in this 'problem' representation? Where are the silences? Can the 'problem' be thought of differently?
5. What effects are produced by this representation of the 'problem'?
6. How/where has this representation of the 'problem' been produced, disseminated and defended? How could it be questioned, disrupted and replaced?

Bacchi (2009) offers a directive to apply these questions. The first question in fact captures the purpose of Bacchi´s approach and encourages the analyst to work backwards from concrete proposals to reveal what is represented to be the problem within those proposals. Since how you feel about something determines what you suggest doing about it, you could also say that by looking at what is proposed as a policy intervention reveals how the issue is being thought about (2009, p. 2-3). In reality, policies are often complicated, they may entail many proposed actions and there may be more than one problem representation within them. The analyst must therefore identify the dominant problem representation and consider related and interconnected policies, as policies are often located within a web of policies (2009, p. 4).

The second and fourth questions are in fact interconnected. They tell the analysis that he/she needs to consider the understanding that underpins the problem representation and ask what is assumed, what is taken-for-granted and what is not questioned. According to Bacchi (2009, p. 6-7), there are certain identifiable

patterns or styles of problematisation exiting in many policies and she mentions, as an example, a current dominant style that creates individuals as primarily responsible for their lives (*ibid*). If we, for example, see a clear emphasis on "individualization" of the responsibility, we may assume that this way is for some reasons being preferred over, lets say, the "socialization" of the responsibility. Thinking about why the responsibility is represented in this way and whether there are other available options is important and that is why the fourth question encourages the analyst to consider a key question: what fails to be problematized? Policies are constrained by the way they represent the problem and the aim is to bring into discussion issues and perspectives that are silenced in the representation (2009, p. 13-14).

The third and sixth questions focus on processes and practices – how a problem took on a particular shape and how a certain problem representation became dominant. The analyst should also consider possible resistance the representations might face (Bacchi, 2009, p. 10-11; 19). The goal of the fifth question is then to identify where and how the problem representation benefits some groups and harms others, and what can be done about this. The analysis focuses on three interconnected and overlapping kinds of effect that may accompany the representation: Discursive effects (how dominant representation limits social analysis and silences competing or different options); subjectification effects (how people become subjects of a particular kind through grouping or targeting, often putting these groups in oppositions); and lived effects (the material impact of the problem representation) (2009, p. 15-18).

These set of questions are applied to a policy, a program or a policy proposal one intends to study. The raw material for the analysis can consist of policy statements, public addresses, parliamentary debates, government reports, pieces of legislation, court decisions and the like (Bacchi, 2009, p. 54). Once a policy is selected the researcher also needs to identify and collect other documents associated with the policy and with the techniques or mechanisms developed to

implement it. This is done in order to get the fuller picture of the problem representation (2009, p. 55). I will use this approach in the analytical part of this study, but it will be combined it with another approach of policy framing (discussed below) and it will be tailored according to this study. How that will be done, will be explained after the second approach has been introduced.

3.2 Framing obesity

As was discussed above, Regina G. Lawrence´s article (2004) will serve as a guideline when it comes to framing identification and classification. Lawrence used discourse analysis in her study to assess the framing of obesity in news coverage in order to determine whether obesity was being reframed in systemic terms and thus becoming amenable to public policy. An opposite framing would assign the main responsibility to individuals and thus the cause of obesity would be blamed on individual behavior. Lawrence identified competing frames of obesity through extensive reading of news article, scholarly articles, books and Web sites through interviews with health experts and advocates.

The competing frames were:

1. *Biological frame*; a "medicalized" understanding of obesity emphasizing impersonal causes – biological disorder that may be understood and possibly cured by science.
2. *Behavioral frame*; obesity is seen as the result of individuals consuming more calories that they burn and are thus urged to make better choices and take responsibility for their health. The emphasis is on individual solutions but government perhaps has a role in ensuring that people have better information about the products they consume.
3. *Environmental frame*; puts individual choice in a larger context of environmental influences and policy choices. Obesity is seen as a symptom of an unhealthy food and activity environment created by

corporate and public policy. The possible solutions would be changed policies from these actors (2004, p. 61-63).

In preparation for this study I did a quite extensive reading on obesity and my conclusions were very much in line with Lawrence´s. The main types of discussions about obesity I could identify, are clearly manifested in her three competing frames, especially the behavioral- and environmental frame. However, after reading economic articles on obesity, I found it important to take some of those discussions into consideration as well.

3.3 Operationalization

When analyzing the documents chosen for this study, my intention is to use a combination of Bacchi´s and Lawrence´s approaches as guidelines and a focus in my study. I will be asking myself all of Bacchi´s questions while analyzing the documents and considering Lawrence´s theories as well. However, I will adjust their approaches to my specific aims and the fact that I am not only analysis one policy document, but number of documents.

I will not go into policy tracing to find out how and why identified problem representations came to be dominant in each case. I will rather focus on the assumptions underlying each representation and what is not being addressed. That will give some indications about contesting views, that are also in some sense historical, meaning that different views may be dominant at different times. I will also adjust the focus of Bacchi´s effects question and put the main emphasis on the effects the representation has on assigning responsibility, asking the questions: *who is likely to be considered responsible for addressing the problem of obesity from this problem representation and how the representation affect the readers perceptions of who is to blame?* I will not put special emphasis on targeting and material impacts but discursive effects are relevant in this study and related to the other questions that are applied.

Before I explain how I intend to operationalize the theories in the analysis, I will explain how question one, aiming to identify the dominant problem representation, will be applied to the texts. If there are more than one problem representations present in the texts, I will search for the dominant one with the help of ideas underlying the content analysis method. According to Tim May (2001, p. 191) content analysis focuses on "[…] the frequency with which certain words or particular phrases occur in selected text as a means of identifying its characteristics." So even if I will not quantify the content of a text in terms of predetermined categories, I will try to search out underlying themes, partly predetermined, in the material being analyzed and establish which theme is dominant (Bryman 2008, p. 274; 529 and May 2001, p. 192).

The operationalization of this study´s theoretical framework first and foremost entails the involvement of Lawrence´s article into the analytical framework. When studying the documents, I will be looking into how the texts reveal theories about the nature of obesity and how that influences who is considered to be responsible for the problem. I will focus on whether the responsibility is individualized or socialized – socialized meaning the texts assigning responsibility to government, business and large social forces.

In Lawrence´s discussion about the competing frames, the *behavioral frame* is obviously an individualization of the problem. Discussions about lifestyle choices, policies encouraging changes in the behavior of individuals and preventions that aim for a reduction of risk factors are examples of how responsibility is assigned to individuals. In contrast, Lawrence´s *environmental frame* is an example of a socialization of the problem of obesity. When the role of culture in shaping behavior is emphasizes in the text, for example by discussing consumerism, the market society, increased sedentary of lives and increased reliance on automobiles, the responsibility is being socialized. This is also the case when the text emphasizes factors such as changed ingredients in food and lack of healthy food choices in workplaces or schools and when preventions are aiming for

different sorts of screening, surveillances and regulations. In between these two ends of a continuum is the *biological frame* that emphasizes impersonal causes of obesity but medicalizes the responses to obesity and in that way socializes the responsibility, at least in welfare states that assist citizens in case of sickness. In addition to this list, I added an *information deficiency frame* that also lies in between the focus on individuals and the environment.

While reading economic articles about obesity and rational choice theories, the discussion about information deficiency caught my attention. Economists usually portray individuals as rational, self-interested and utility maximizing. In explaining obesity economists would look at the demand side of obesity and study individual choices (Mann, 2008, p. 164). Obesity would be seen as an individual matter unless it creates externalities, for example placing extra cost on society, then the state should intervene. But economics also offer an interesting non-rational approach that discusses obesity as an information deficiency problem and then the question becomes: do we underestimate the risk of getting overweight and obese? (2008, p. 167). Obesity might thus be seen as a result of individual miscalculating, as individuals do not understand the consequences of their consumption. Additional or better information might thus lead to a lower obesity rate (2008, p. 168). Contrary to what some might assume, that gaining information is an individual responsibility, economists define information on food consumption and health as a merit good. This means that consumers demand food-relevant information on the market to a lower degree than would maximize their welfare, and thus the state could increase aggregated welfare by providing information about healthy eating or see to it that these information would be made available (2008, p. 169). I think this is an important point and therefore I added this frame. Lawrence (2004, p. 62) mentions, in her definition of the *behavioral frame,* that government perhaps has a role in ensuring that people have better information about the products they consume but defining food-information as a merit good is taking this role a step further – from a vague role to real

responsibility. The *information deficiency frame*, I would argue, places the main responsibility, for providing food-relevant information, on states and businesses.

In addition to the above I will pay attention to certain binaries or key dimensions Lawrence discusses, that are considered to influence public policy responses and whether health issues are perceived as amenable to public policy. These are whether the health risk is described as acquired *deliberately* or *involuntarily*; whether it is described as a *universal* risk or a *particular*; whether it is described as arising from within *the individual* or from *the environment*; and whether an health risk was *knowingly* created by others (2004, p. 59). The more an issue is framed in terms of *involuntary-, universal-, environmental- and knowingly created risk*, the more it points in the direction of public responsibility or the responsibility of powerful groups (*ibid*).

3.4 Documents

This study, relies on documents for the analysis and therefore treats documents as data. Documents are, according to Uwe Flick (2009, p. 255), standardized artifact, as they typically occur in particular formats such as notes, case reports, contracts, statistics, annual reports or expert opinions to name a few types. Documents have the potential to inform and structure people´s decision-making and as Tim May points out (2001, p. 176), document constitute particular readings of social events and tell us about the aspirations and intentions of the periods to which they refer. However it is important to emphasize that documents are not a simple representation of facts or reality. Documents are constructed – they are produced by someone, for some practical purpose and in order to be used in some way (Flick 2009, p. 257). Because of that, the researcher needs to ask himself/herself who produced the document and for what purpose. The researcher also needs to ask who uses the documents in their natural context and how is the access to them (ibid).

Tim May (2001, p. 182), says there are several ways in which researchers may interpret a document. For some researchers documents represent a reflection of reality, while others consider documents as representative of the practical requirement for which they were constructed. In this study, documents are seen as entailing a representation of how their producers interpret reality. The topic of this study is obesity and how the representation of obesity potentially determines the responsibility of the problem. Thus, the main interest lies in documents produced by actors that have the possibility to influence the framing of obesity, act on the problem or are in a position to influence governmental action and public policy. Example of such actors, in addition to governments, are according to John Kingdon (2011, ch. 3), other members of parliaments and political parties, interest groups, researchers, academics, consultants, media and the mass public. As Kingdon focuses on the US political system I would add to his list, supranational unions as the European Union, international governmental organizations such as the United Nations and, international non-governmental organizations and transnational actors. In other words, the documents in this study are purposively selected.

3.4.1 Document selection – actors

In the beginning of the document selection, I chose the actors I wanted to study based on their potential power to influence obesity discussions and then documents that they have produced and address the issue of obesity. My aim was to select different actors: from the international society; a representative from the state level; and then a representative of specialists or experts from the medical society. As a representative of the medical society, I chose a medical journal, *The Lancet*. *The Lancet* is one of the world´s best known, oldest and most respected medical journals. *The Lancet* is rated number two in medical journals impact factors in 2012, in overall medicine (Medical Journal Impact Factors, 2012), but impact factor is a measure reflecting the average number of citations to recent

articles published in science and social science journals. I wanted to have a representative from the medical society because physicians treat this medical condition and because of their expertise, physicians have the potential to influence the framing of obesity with their writings and discussions. They may also influence public policies as advisors and participants in public health policy processes, as specialists participating in steering committees and as an interest group.

I chose The World Health Organization (WHO), the directing and coordinating authority for health within the United Nation (UN) system for the international level. I also considered the European Union but decided on WHO based on their nearly universal membership. WHO is "[…] responsible for providing leadership on global health matters, shaping the health research agenda, setting norms and standards, articulating evidence-based policy option, providing technical support to countries and monitoring and assessing health trends" (WHO, 2012 B). WHO has great influence in the framing of health issues and has influence on most UN countries´ health agenda and health policy choices, thus I felt it was necessary to study their documents.

At last, I chose Iceland to study how a specific state handles the issue of obesity. Iceland was chosen for several reasons. First of all it is my home country and I was interested in how obesity is represented there. Also, there is the benefit of understanding the language, and finally, I thought Iceland was a good candidate to study. Iceland is a member of the United Nations (UN) and thus influenced by the WHO. Iceland is a Scandinavian Welfare State, and even though it deviates from the Scandinavian Welfare State model (Ólafsson, 2004), it has universal public health insurance and the Icelandic health system is characterized by the dominance of the public sector (Halldorsson, 2003, p. 25-26). The health system is perceived to be of high standard (The Icelandic Ministry of Welfare, 2012) and physicians engage in regular continuing education and should thus (within certain specializations) be familiar with recent trends in the discussion and treatment of

obesity. In addition, according to a recent analysis obesity is increasing rapidly in Iceland and is classified as the top risk factor the health system is facing. Thus, this is a relevant issue in Iceland at the moment (The Icelandic Ministry of Welfare, 2012).

3.4.2 Document selection – time frame

I chose documents that were produced within a certain time frame, between October 2007 and March 2012. The time frame was chosen for specific reasons. In many articles I read about obesity, the fact that obesity has doubled in the period between 1980 and 2008 is mentioned. In 2008 the epidemic proportion of obesity seems to be a common knowledge and one would expect some actions in the following. My immediate thought was to begin the time frame in January 2008, but as the parliament in Iceland traditionally begins its session 1 October, each year, I chose to pick that date in the year 2007 to include all documents addressed to the 135 parliamentary session, operating into the mid year 2008.

In 19-20 September 2011 a UN high-level meeting on noncommunicable disease prevention and control was held in New York, USA. Global leaders met to set a new international agenda on NCDs. This was the second time in the history of the UN that the General Assembly met on a health issue (the first time the issue was AIDS) and the aim was for countries to adopt a concise, action-oriented outcome document that would shape the global agenda for generations to come (WHO, 2012 C). I would argue that in 2011 the grave seriousness of NCDs, where overweight and obesity is a major risk factor, had become a well recognized fact, clearly manifested in this high-level meeting. In 2011, anyone interested in health agenda, global health and health policies should be aware of the importance of addressing the NCDs and obesity epidemics. One would therefore expect some actions in the following, but due to my own time limits the documents needed to be available for me in the end of March 2012, at the latest.

3.4.3 Document selection – selected documents

1. ***The Lancet*** – In August 2011 *The Lancet* devoted a whole issue to obesity. Two articles from this issue were selected: *"The global obesity pandemic: shaped by global drivers and local environments"* (Swinburn et al, 2011) and *"Changing the future of obesity: science, policy, and action"* (Gortmaker et al, 2011). These articles were selected because they address the causes of the obesity pandemic and possible actions to reverse the future development of worldwide obesity.
2. **WHO** – WHO has a fact sheet about overweight and obesity published on their website, that was selected for analysis (WHO, 2011 A). This fact sheet states that the *2004 WHO Global Strategy on Diet, Physical Activity and Health* and the *2008-2013 Action plan for the global strategy for the prevention and control of noncommunicable diseases* (WHO, 2008) are WHO´s responses to overweight and obesity. I selected the Action Plan, as it is within my time frame and builds on the Global Strategy, and in addition I selected the *Global status report on NCDs 2010* (WHO, 2011), that partly address obesity in relation to NCDs.
3. **Iceland** – The Icelandic parliament *Althingi* has an on-line database on their webside (www.althingi.is) containing parliamentary documents such as bills, parliamentary resolutions, queries and reports as well as parliamentary speeches related to the documents and in relation to special debates. A keyword search was conducted, entering the Icelandic words for obesity ("offita") and overweight ("ofþyngd") in the search engine, and documents selected from the results that match the time frame:

    a. *Parliamentary resolution proposal on restricting advertisements of unhealthy foods directed at children* (Althingi, 2007 A).
    b. *Parliamentary resolution proposal on physical education in schools* (Althingi, 2007 B).
    c. *Parliamentary resolution proposal on exercise prescriptions in the healthcare system* (Althingi, 2008 A).

d. *Inquiry to the Minister of Health about sugar consumption and prevention* (Althingi, 2008 B).
e. *The Minister´s of Health answer to the inquiry about sugar consumption and prevention* (Althingi, 2008 C).
f. *Parliamentary resolution proposal on regulating the maximum amount of trans fats in food* (Althingi, 2010 A).
g. *Inquiry to the Minister of Health about overweight children* (Althingi, 2010 B)
h. *The Minister´s of Health answer to the inquiry about overweight children* (Althingi, 2010 C).
i. *Parliamentary resolution proposal on the Nordic Health Mark The Keyhole* (Althingi, 2011 A).
j. *Parliamentary resolution proposal on calorie labeling on fast food* (Althingi, 2011 B).

All the documents chosen for analysis are official documents and access to them is open. These documents may be downloaded from the internet but in order to access *The Lancet* you either have to have an access through a database or be registered as a user on the journal´s web site. All documents were collected from selected actors´ websites, they are first hand data meaning they were not interpreted or analyzed by other actors or individuals.

3.4 Discussions about chosen methods

In the previous sections of this study, chosen theories have been explained and attempts made to justify their selection. The topic of obesity and public policy was chosen based on my interest in the topic. Obesity is a problem I was well aware of as the media regularly discusses the rising prevalence, and regularly shows documentaries about people suffering from extreme obesity and how that condition affects their lives and the health care system. As I studied public policy,

my interest developed into questions on whether or not the state should be addressing obesity. And, if the answer was "yes it should", then I asked myself based on what reasons and with what measures? That was when I decided to devote my thesis to obesity and public policy.

There are many different ways to study obesity in relation to the role of the state. Some might even argue that other methods might be more straightforward than to focus on representation of problems or problem framing. My motivation for choosing that way of analysis was that it is a bit unconventional, it was a challenging way to look at public policy and a point of view easily ignored when one talks about obesity and state responsibility. Therefore, it was my impression that this method might add a new dimension to the discussion. It might also raise awareness about the importance of how events, situations and problems are represented. The representation might be a crucial factor in determining responsibility for addressing a certain situation and might have an important explanatory value when it comes to the question why and how states take action, or why they do not act.

The analysis relies on documents that are purposively selected. Documents are neither neutral nor a simple representation of truth and facts. Documents are constructed, they are produced by someone, for someone and with a certain purpose or use in mind. In this study this limitation is of minimal importance as it is the construction I am interested in. This study is not concerned with a truth but the interpretation and beliefs that are, in a sense, presented as knowledge and scientific truth. The aim is not to search for one "true" definition of obesity, to find the "best" way to address the problem or to proof who or what is responsible for addressing the problem. The aim is to study the framing and representation of obesity in terms of responsibility, as they appear in selected documents. Hence, what matters is how chosen actors represent their interpretation of reality and how that affects the determination of responsibility for the problem. Generalization is also not one of the aims of this study and thus the small sample of actors and

documents are not a severe limitation. However, the small number is a limitation in the sense that it restricts the discussions and conclusions to just these cases. It does not allow any conclusions about hegemonic framing or hegemonic discourse.

The analysis of documents, at the end boils down to the interpretation of the researcher. There is always the possibility that people interpret the same thing differently, which is by some regarded as a limitation to the methods that have been chosen. I will throughout the analysis try to increase the validity of my conclusions by quoting the text and in that way illustrate what I base my conclusions on.

4. Analysis

In this part theories and methods discussed in previous sections will be used to analyze documents from three different actors. The aim is to study how obesity is represented as a problem and framed in terms of causes and responsibility. This will be achieved by using theories on policy- and health risk framing, and a *"What´s the problem represented to be?"* approach to policy analysis.

The analysis begins at the medical society level, so to speak, with an analysis of two articles from a highly respected medical journal, *The Lancet*. The articles have more than one author that jointly formulated the major concepts and read and approved the final versions of the papers. Some authors bore the brunt of the writings while others commented on the paper. This is all clearly stated at the end of the articles, along with a declaration that the authors have no conflict of interest in the matter. Supports for these writings are also clearly stated along with a statement that the articles do not represent official views of any funder (Swinburn et al, 2011, p. 811; Gortmaker et al, 2011, p. 845).

The Lancet has a high impact factor, as was discussed earlier, and is highly respected in the medical society. Its discussion is likely to influence the medical discussion about obesity, as well as academic work on the issue. I was not able to assess whether its discussion has real influence beyond the medical society but I am inclined to think so, as physicians and medical staff are often appointed as members on public committees writing laws or discussing legislature, processes etc. But, on the other way around, researches within the medical society are most certainly influenced by the WHO´s agenda (see discussion on p. 29) as well as by those who sponsor medical studies.

4.1 The Lancet´s representation of obesity

The first article I analyzed from *The Lancet*, "*The Global obesity pandemic: shaped by global drivers and local environments*", focuses on factors that contribute to the increased prevalence in obesity (Swinburn et al, 2011). The second article, "*Changing the future of obesity: science, policy and action*" (Gortmaker et al, 2011) discusses actions to change the development of the obesity pandemic. These articles will be analyzed together as they appear in the same series of articles – in one issue dedicated to this topic – and because three authors (out of seven authors in the first article and nine in the second) are among authors of both articles. However, it will be made clear as to which article I am referring each time.

4.1.1 What´s the problem represented to be?

> […] the economic priorities and policies that promote consumption-based growth, and the regulatory policies that promote market and trade liberalisation have produced many benefits but are now increasingly regarded as contributing to the global crises of overconsumption in general. Obesity is but one of these crises, as the private sector becomes ever more effective in its exploitation of basic human biological drives, desires, and weaknesses. Solutions to obesity and to improve health and development cannot be based on the existing framework (consumption- driven growth creating financially-defined prosperity) because this approach has helped to create the difficulties in the first place.
>
> (Swinburn et al, 2011, p. 811)

> Despite the overwhelming evidence showing the need to reduce obesity, no clear consensus on effective policy or programmatic strategies has been reached. Most countries do not have sufficient population monitoring data on physical activity, dietary intake, and obesity prevalence to set meaningful goals and assess progress.
>
> (Gortmaker et al, 2011, p. 839)

The first article represented a number of problems associated with obesity, such as increased risk of NCDs, morbidity, mortality, disability and increased health expenditure. It also discussed most of the factors traditionally thought to influence rising obesity prevalence (national wealth, genes, culture, built environment, development in technology and what could be labeled modernization etc.). It looked at obesity from three aspects: global, local, and individual. All these aspects were said to matter and influence the obesity pandemic but these influences are different in nature – some drive the obesity pandemic globally while others work as moderators or modulators at the local- and individual level. The precondition for a population to develop obesity, according to *The Lancet* is sufficient wealth but the main global driver of the obesity pandemic, is the global food system: the increased supply of more processed, affordable, tasty and energy-dense foods; improved distribution systems to make food much more accessible and convenient; and more persuasive and pervasive food marketing (Swinburn et al, 2011, p. 805-807).

The second article represented a similar view and stated that obesity is caused by a chronic energy imbalance involving both dietary intake and physical activity patterns – a result of previously mentioned changes in the global food system (Gortmaker et al, 2011, p. 838). The main emphasize of this article was, however, the lack of sustained worldwide efforts to monitor, prevent, and control obesity – the lack of real actions to address the problem (*ibid*). The article discussed political problems with implementing already identified health-improving and cost saving interventions – problems such as: the pressure from "political timetables" demanding quick results when in fact it takes a few years for interventions to show results; "freedom of speech issues" limiting regulatory options in case of advertising for example; and "limited budgets" when the effect of many interventions depend on sustained public funding (2011, p. 840-841). Their respond was to call for a more scientific and evidence-based approach to policy making, based on evidences of effective interventions and thus sustained investments in monitoring obesity and scientific researches on the topic.

As these articles discussed many aspects of their topic the question became what was the problem represented to be, as Bacchi would put it. The main problem representation in the first article was "the obesogenic environments individuals find themselves in" (Swinburn et al, 2011, p. 804). According to the authors, these obesogenic environments arise "because businesses and governments are responding normally to the broader economic and political environments that they find themselves in" (2011, p. 806). Put differently, the main problem was the modern market-based economy promoting consumption-based growth, and political culture producing policies that promote market and trade liberalization that support general overconsumption (*ibid*).

> The pressure for market liberalisation means that regulatory approaches, although feasible, are difficult to achieve—as exemplified in the great reluctance of policymakers to regulate reductions in marketing of obesogenic foods and beverages […].
>
> (Swinburn et al, 2011, p. 804)

> […] the priority should be for policies to reverse the obesogenic nature of these environments.
>
> (Swinburn et al, 2011, p. 804)

Although the second article took another angle in looking at obesity it confirmed the view presented in the first one. The thread throughout the discussion is a call for systemic actions, a call for implementations of already available preventive and treatment interventions. The problem represented in the article was that the most beneficial interventions (for the whole population) and cost-effective, do not reach the governmental agenda (Gortmaker et al, 2011, p. 840-841). The main problem was unfavorable political and economic environment that obstructs the agenda settings and creates implementation failures or gaps. In fact, it was highlighted in both articles that those interventions that have the most population

effects, are also most political difficult to implement as they address systemic drivers and environmental drivers – the supply side of the equation.

4.1.2 How does the representation affect the reader?

Bacchi´s approach is concerned with the presuppositions or assumption that underlie the representation of the problem, and also asks where the silences in the representation are, and which effects the representation produces. *The Lancet* emphasized a scientific and evidence-based approach to obesity and interventions, and built the discussion on available data, researches, studies, trials and experiences. The discussion was broad and touched upon most of the factors that are considered important in relation to obesity. There were no obvious silences and nothing was obviously taken for granted in their discussions. However, the discussion clearly assumed that increased obesity is a result of environmental changes that encourages obesogenic consumption and behavior. The first article emphasized the *environmental frame* (Lawrence, 2004, p. 62-63) and put individual choices in a larger context of environmental influences and policy choices, for example by stating that: "Obesity is the result of people responding normally to the obesogenic environments they find themselves in" (Swinburn et al, 2011, p. 804). Thus, obesity was represented to be somewhat an *involuntary acquired health risk* and taking into consideration their discussion about the market-based economy (promoting consumption based growth) and the well-known fact that obesity is a pandemic, it looks as if they see today´s obesity pandemic as a *knowingly created health risk* (Lawrence, 2004, p. 59).

According to Regina Lawrence (2004, p. 62-63), the *environmental frame* views obesity as a symptom of an unhealthy food and activity environment created by corporate and public policy and the possible solutions would be changed policies from these actors. This view was clearly present in *The Lancet´s* discussion and it was apparent that they placed the main responsibility for addressing this problem in the hands of governmental actors. They called for multi-sector actions or a

systematic approach, but identified governments as the most important actors in reversing the pandemic (Gortmaker et al, 2011, p. 843-843)

> Policy interventions for obesity can only be realistically directed at the environment (making healthy choices easier) rather than the individual (compelling them to take the healthy choices).
>
> (Swinburn et al, 2011, p. 804)

> Interventions that aim to reverse obesogenic drivers (and some of the environmental moderators) will almost all be policy-led—mainly government policy (eg, shifting agricultural polices to incorporate health outcomes, banning unhealthy food marketing to children, healthy public sector food service policies) but some could be food industry policies (eg, moving product formulation towards healthier compositions, self-regulation of marketing to children).
>
> (Swinburn et al, 2011, p. 804)

The Lancet´s discussion is quite political – more than I expected from a medical journal. The first article was quite critical towards market liberalism, a dominant global economic and political discourse, and modern capitalism. The second article was also critical towards governmental priorities and I assume they think a more scientific approach, or evidence-based policies towards obesity, is a good ground to build future policy making on – something that brings together the public interest (reduction in obesity) and political interests (cost-effectiveness, for example). In fact, they called for more investments in sustained effort to monitor, prevent and control obesity (Gortmaker et al, 2011, p. 838).

This issue of *The Lancet* was published in August 2011, a few weeks before the high-level meeting of the UN General Assembly on noncommunicable diseases. They mentioned this upcoming meeting in both articles and bluntly called for action in the second one (Gortmaker et al, 2011, p. 842). They stated that the meeting would be a key opportunity to strengthen international leadership in the

matter and stimulate other agencies and states to begin to seriously address the obesity pandemic (Gortmaker et al, 2011, p. 845). They were obviously making an effort to influence this meeting and "state the case for action on obesity" (Swinburn et al, 2011, p. 804).

The Lancet´s discussions produced the discursive affect that the reader feels it is without a doubt the responsibility of governments and governmental actors to address the problem and see to it that the obesogentic environment changes. The individual responsibility was minimal in their presentation and in fact that was the part that I would say comes the closest to being silenced. Individuals were almost represented as puppets on a string, reacting to the environment but not able to shape it or change it.

> Undoubtedly the final decision to consume a particular food or beverage, or to exercise or not, is an individual decision. However, to negotiate the complexity of the environment and the choices it poses, many of these decisions are automatic or subconscious.
>
> (Swinburn et al, 2011, p. 809)

The Lancet´s approach to obesity reduction was mainly preventive, that is, to prevent further rise in the prevalence of obesity. Their main target group was children. The fact that few children are born obese means that each year begins with a new birth cohort and low rates of obesity and there is the opportunity for policy makers to maintain this situation (Gortmaker et al, 2011, p. 839). Most of the cost-effective interventions they discussed targeted the youth (2011, p. 841) so there they saw the greatest hope in reversing the development. However, they also saw children as the main victims of the market (or the market failure, overconsumption) and in great need of social protection (Swinburn et al, 2011, p. 806).

The Lancet represented obesity in a manner that blamed the environment and placed the main responsibility for addressing the problem with governments.

4.2 WHO´s representation of obesity

As was explain earlier (section 3.4.1), WHO is a highly influential actor in global health matters. WHO is the directing and coordinating authority on international health within the United Nations' system. 193 countries and two associate members are members of WHO and they work with many other partners, such as UN agencies, donors, nongovernmental organizations, WHO collaborating centres and the private sector (WHO 2007, p. 2).

WHO experts produce health guidelines and standards, and help countries to address public health issues. They also set a global health agenda – a global framework for a health promoting strategy (WHO 2007, p. 2). The WHO has six core functions (WHO, 2006, p. iii):

1. Providing leadership on matters critical to health and engaging in partnerships where joint action is needed.
2. Shaping the research agenda and stimulating the generation, translation and dissemination of valuable knowledge.
3. Setting norms and standards, and promoting and monitoring their implementation.
4. Articulating ethical and evidence-based policy options.
5. Providing technical support, catalysing change, and building sustainable institutional capacity.
6. Monitoring the health situation and assessing health trends.

Based on the above, it is beyond doubt, that how WHO represents obesity influences the public discourse on obesity as well as policy options, actions and the perception of the problem. However, as Bacchi (2009, p. 19) would point out, at the end it is the states themselves that set law, ratify treaties and implement recommended policies so on that level WHO´s recommendation can, for sure, be contested, questioned and replaced. And just as the WHO influences researches in

various fields, they are themselves influenced by new researches, conducted outside the organization – researches that may produce new evidences etc.

Three documents were selected from the WHO for analysis. Only one of them is a direct obesity document, the other two put obesity in the context of NCDs. I analyzed the WHO documents in two parts. First, WHO´s *Overweight and obesity – Fact sheet N°311* (WHO, 2011 A), an important document for assessing the definition and framing of obesity. And then, under the heading, *Obesity in relation to NCDs*, I analyzed the *2008-2013 Action Plan for the Global Strategy for the Prevention and Control of Noncommunicable Diseases* (WHO, 2008) and the *2010 Global Status Report on Noncommunicable diseases* (WHO, 2011). The Action Plan highlights six key objectives in prevention and control of NCDs, while the Global Status Report provides a baseline for future monitoring of NCDs related trends and for assessing the progress that countries are making to address the epidemic (WHO 2011, p. ix).

These two documents have targeted audiences. The Action plan (WHO, 2008, p. 7) is written primarily for the community of international development partners, governmental- and civil society actors. The Global Status Report, on the other hand, targets policy-makers, health officials, nongovernmental organizations, academia, relevant non-health sectors, development agencies and civil society (WHO, 2011, p. 1). These documents were, in my opinion, important to get a clear picture of how obesity is currently being addressed. I thought that analyzing them together would be a good way to see both the presentation of the problem and proposed actions, but when I started the analysis I ran into a dilemma. I realized that WHO´s discussion did not clearly separate the discussion of NCDs and obesity in these two documents. The discussion did not include obesity as a NCD, but as a major risk factor for NCDs. But, the confusing part was that two major behavioral risk factors for NCDs – unhealthy diet and a physical inactivity – are also major risk factors for overweigh and obesity. So, in some sense, when

NCDs were being addressed, obesity was also indirectly being addressed – even if it was not classified as one of the NCDs.

My conclusions were that WHO see the NCD- and obesity epidemics in one and the same context – as trends moving on the same trajectories. Still, I am also inclined to think that this has something to do with a (possible) lack of consensus on how to define obesity: as a health problem/risk, a disease, a medical condition, a symptom, or perhaps as something else. Whatever the reasons, this lack of clarity affected my analysis because my assumptions were nowhere confirmed. Hence, I could not allow myself to assume WHO was addressing obesity whenever they discussed NCDs. I chose to analyze the Action Plan, as it was clearly stated to be a response to the obesity epidemic (WHO, 2011 A), but after browsing through WHO´s webpages from every angle I could think of, I could not establish a direct link between their obesity discussions and the Global Status Report. Therefore, in order to avoid misinterpretations, I only analyzed those parts of the report that directly discussed obesity.

4.2.1 Overweight and obesity – Fact sheet N°311

The fact sheet (WHO, 2011 A) clearly approached obesity as a serious health problem resulting from abnormal or excessive fat accumulation. I would say that the main emphasis in this document was the pandemic proportion of the problem, as words beginning with "world-" and "global-" were frequently used. The emphasis was also on the rising prevalence in overweight and obesity, and thus the problem appeared to be the globally increasing overweight and obesity. However, by looking at the document backwards – from action proposals to what is represented to be the problem – as Bacchi suggests (2009, p. 3), the problem became a lack of supportive environments and communities that are fundamental in shaping people's choices, making healthier food choices and regular physical activity easy, and therefore preventing obesity (WHO, 2011 A).

The problem of obesity was represented to be a problem in "high-income-", "middle-income-" and "low-income countries", in "developed-" and "developing countries" and as a problem affecting "women", "men" and "children", in other words the whole world´s population is at risk. Looking at Lawrence´s discussion (2004, p. 59), the emphasis on the pandemic proportions framed overweight and obesity as a *universal health risk,* and as the numbers of people suffering from overweight and obesity also played an important role in this document, emphasizing the size of the problem, obesity was framed as a *real health risk.*

Children were targeted in this document as an especially vulnerable group.

> Children in low- and middle-income countries are more vulnerable to inadequate pre-natal, infant and young child nutrition At the same time, they are exposed to high-fat, high-sugar, high-salt, energy-dense, micronutrient-poor foods, which tend to be lower in cost. These dietary patterns in conjunction with low levels of physical activity, result in sharp increases in childhood obesity while undernutrition issues remain unsolved.
>
> (WHO, 2011 A)

As children depend on adults when it comes to food provision, residency and in some sense access to physical activity, they were in some sense "victimized" in this discussion, and thus the emphasis on children, partly framed overweight and obesity as *involuntary health risk* (Lawrence, 2004, p. 59).

Going back to Bacchi (see p. 29), what is not present in a discussion is also important. In this case obesity was mainly addressed in relation to noncommunicable diseases – as a major risk factor for developing these diseases. Hence, obesity was not defined as a disease and there were no talking about possible medical causes such as metabolism, biological disorder, genes or food addiction.

> The fundamental cause of obesity and overweight is an energy imbalance between calories consumed and calories expended.
>
> (WHO, 2011 A)

Reading this sentence, I immediately assumed that I would see a *behavioral framing*, but then further explanation shifted the focus towards "systemic" factors, or *the environmental frame*, as it pointed out that the increased intake of energy-dense foods and a decrease in physical activity was a global trend. And then:

> Changes in dietary and physical activity patterns are often the result of environmental and societal changes associated with development and lack of supportive policies in sectors such as health, agriculture, transport, urban planning, environment, food processing, distribution, marketing and education.
>
> (WHO, 2011 A)

Discussing how overweight and obesity may be reduced, healthy food choices and engagement in physical activity were mentioned, but individual responsibility was in fact "socialized" when the document stated that:

> Individual responsibility can only have its full effect where people have access to a healthy lifestyle. Therefore, at the societal level it is important to: support individuals in following the recommendations above, through sustained political commitment and the collaboration of many public and private stakeholders; make regular physical activity and healthier dietary patterns affordable and easily accessible too all - especially the poorest individuals.
>
> (WHO, 2011 A)

The food industry was mentioned, as playing a significant role in promoting healthy diets and the document ended with a discussion implying that multilevel actions are needed to reduce overweight and obesity. Individuals, along with

public- and private actors were made responsible for acting on the problem. However, in the overall context – looking at the styles of framing; the emphasis on the global nature of the problem; the way individual responses were presented to be dependent the behavior of the public- and private sector – the discursive effect of the text assigned the main responsibility for addressing the problem of obesity to the states (Bacchi, 2009, p. 15-17). States should promote the optimal environment for individuals to make better choices. Hence, this document clearly framed obesity in a "systemic way", emphasizing the *environmental frame* (Lawrence, 2004, p. 62).

4.2.2 Obesity in relation to NCDs

The 2010 Global Status Report on Noncommunicable diseases confirmed what was stated in the previous analysis, that WHO defines obesity as a worldwide epidemic (WHO, 2011, p. v). Overweight and obesity were again presented as a major risk factor for NCDs – here listed as a metabolic/physiological risk factor (2011, p. 21-22). However, overweight and obesity were also represented as metabolic/physiological changes caused by the four major behavioral risk factors underlying NCDs (2011, p. 16). Thus, it looked like obesity is both a cause and a result and I began wondering whether obesity should be defined as a risk factor or if it should be considered a disease.

Supported with numbers and evidences, obesity was framed as a *"real health risk"*, leading to death, disability, and other health problems (WHO, 2011, p. 2). However, different from the fact sheet (analyzed earlier), this document began by stating that we are facing a worldwide epidemic of obesity (2011, p. v) but later identified and discussed differences in obesity prevalence between: regions; countries income levels; sexes; socioeconomic factors within individual countries and education (2011, p. 24). Thus I would say obesity was both framed as an *"universal health risk"* and as a *"particular health risk"* in this document,

meaning we are all at risk, but some more than others.

Carol Bacchi (2009) suggests that proposed actions reveal what the problem is believed to be. In order to analyze how WHO problematizes obesity, studying the 2008-2013 Action Plan for the Global Strategy for the Prevention and Control of Noncommunicable Diseases – stated to be a part of WHO´s response to the obesity epidemic – was a relevant choice.

To my surprise, in the whole Action Plan, obesity was only directly mentioned on two occasions. First, it was mentioned in a discussion about objective 3 that aims to:

> […] promote interventions to reduce main shared modifiable risk factors for noncommunicable diseases: tobacco use, unhealthy diets, physical inactivity and harmful use of alcohol.
>
> (WHO, 2008, p. 19)

It was later mentioned as an example of indicators or measurements that WHO will use in monitoring and reporting on the global status of the prevention and control of noncommunicable diseases (WHO, 2008, p. 29). There was no definition of obesity in this document, no discussion about the nature of obesity or the effect obesity has. Obesity was simply an "associated biological risk factor" to the four major behavioral risk factors (2008, p. 19).

The Action Plan made a strong case for the importance of addressing NCDs, calling them "the world´s biggest killers" (2008, p. 5) and by stating that unless addressed, the mortality and disease burden from these health problems would continue to increase, affecting poor and disadvantaged populations disproportionately and thus contributing to widening health gaps, both between and within countries (2008, p. 5; 9). The Action Plan has a particular focus on low- and middle-income countries, and vulnerable populations and in fact, even thought it revolves around health issues, in a way they were reframed into a developmental issue.

> The Action Plan highlights the pressing need for NCD prevention as an integral part of sustainable socioeconomic developments.
>
> (WHO, 2008, p. 5)

> The global burden of noncommunicable diseases continues to grow; tackling it constitutes one of the major challenges for development in the twenty-first century.
>
> (WHO, 2008, p. 9)

The Action Plan placed minimum emphasis on obesity, even though it was stated to be one of WHO´s main response to the obesity epidemic. The lack of presence in this document and the fact that the Action Plan especially focused on low- and middle-income countries – whereas obesity is still mainly a problem in high-income countries – implied that obesity was of secondary importance in this document. Obesity was framed as a risk factor for NCDs, and as NCDs are largely preventable by eliminating their major risk factor, combating obesity became a stepping-stone in the process of preventing and controlling NCDs. When obesity is addressed in relation to NCDs, an answer to Bacchi´s (2009) question *What´s the problem represented to be?* is that obesity is contributing to the NCD epidemic. Obesity is a part of the cause and therefore needs to be addressed.

Framing obesity mainly as a risk factor, somewhat took the focus away from obesity as a problem in itself. The pandemic proportion of obesity almost became silenced. The close linking of obesity to the major behavioral risk factors for NCDs, limited the policy options presented. Promoting healthy diet and physical activity became the main policy options (WHO, 2008: 19-21) and other possible determinants of obesity were left unaddressed – not considered. I find this highly interesting because WHO recognizes the epidemic proportions and the seriousness of obesity. I asked myself whether this was an informed choice of framing, and I think that would be an interesting thing to study. As *The Lancet* mentioned political problems of implementation (see p. 37), I asked myself whether it could

be, that the underlying reasons for this particular framing were based on the fact that addressing chronic diseases, such as heart diseases and stroke, might sound more urgent than addressing peoples body shape. Could it be that addressing body shape and food consumption is politically difficult, and thus the emphasis has been put on the NCD epidemic, knowing that obesity would also indirectly be addressed?

4.3 Iceland – A parliamentary representation of obesity

When studying the state level I chose to focus on the parliament instead of ready-made public policies, mostly coming from the Ministries. The main reason was my interest in including proposals that address obesity but may not have been implemented. I believed it was equally interesting for my study to include such proposals as they may have some common features or problem representations.

In order, for the reader, to better understand my analysis, a brief and simple introduction to the Icelandic parliamentary practices will precede the analysis. Understanding how issues may become laws or public policies and how the parliament contributes to that process is, in my opinion, necessary.

In the Icelandic parliament, Althingi, proposed legislation usually takes the form of government bills – introduced and supported by the government, at the instigation of the Minister concerned – or as private members' Bills – introduced by one or more members of Althingi. Occasionally, bills are introduced by a parliamentary committee (Althingi, 2010 D, p. 16). In reality, members of parliament (MPs) are rarely the authors or writers of legislature. They are entitled to submit a bill, but the initiative of legislature usually comes from the government. Government bills are written by committees appointed by a Minister (usually entailing stakeholders and specialists) or by the ministerial staff. Althingi´s approval is needed for bill to become law, but Althingi also influences the legislature process by making amendments to the bill during parlimentary readings (Kristinsson, 1994, p. 83; Althingi, 2010 D, p. 19).

Despite the above, MPs have other ways to raise awareness about issues and influence the government agenda and the legislation process. They may introduce a parliamentary resolution that, for example, urges the government to carry out a certain project, prepare legislation in some area or investigate some matter. MPs can also submit written questions (query) to a Minister, regarding official matters, receiving answers either orally at Question Time or in writing. Question Times, where MPs are able to question Ministers without prior notice, are also regularly scheduled, and are a good way to raise awareness about current issues and get immediate responds (Althingi, 2012 D, p. 16).

Stakeholders and specialist are often a part of committees, writing government bills, and are thus able to influence legislation during that phase. They also have the opportunity to influence it while being discussed in Althingi because, according to the constitution, no bill may be passed until it has received three readings in Althingi. Bills are referred to parliamentary committee between first and second reading and while committees discuss them, they contact major stakeholders and specialists, seek their opinions and offer them a chance to comment on bills or issues being discussed (Althingi, 2010 D, p. 20). Hence, democratic procedures and the parliamentary processes offer many opportunities for conflicting views to be heard.

4.3.1 Selecting documents from Althingi

As was mentioned earlier (section 3.4.3), documents from Althingi were selected after a keyword search in Althingi´s on-line database. After eliminating documents where the words obesity or overweight were only mentioned on one or two occasions in the entire text and only had secondary meaning in the whole context, I had eight different documents to analyze. Some of these documents had been submitted more than once and in that case I chose to analyze the most recent version. In order to get a clearer picture, I also studied the introduction speech

associated with each document. Six of these documents were parliamentary resolution proposals and two documents were queries. I chose to analyze the Ministers answers to these queries as well, so at the end I had 10 documents to analyze. After analyzing the documents I decided to present the findings in three groups, according to styles of framing, in order to make the presentation clearer.

4.3.2 Individualizing framing

According to Lawrence´s discussion about contesting framing of obesity (2004, p. 61-63), the *behavioral frame,* emphasizes individual consumption as the main cause of obesity, and individual solutions to address it – in other words it individualizes the causes and the responsibility. In no document did I find a clear individualization of the problem, but on two occasions, I found an individualization of responsibility. First, in a parliamentary resolution proposal on exercise prescriptions in the healthcare system (Althingi, 2008 A) and secondly, in an answer to an inquiry addressed to the Minister of Health about overweight children (Althingi, 2010 C).

In 2008, a parliamentary resolution proposal on exercise prescriptions in the healthcare system was introduced (Althingi, 2008 A), it stated:

> Althingi resolves to entrust the Minister of Health to appoint a committee that will manage the preparation of making physical exercise an option in health care, as a treatment and as a preventive action, so that doctors can prescribe exercise as a treatment of diseases in the same manner as prescribing medicine or medical treatment. The Committee shall examine the costs and benefits of this procedure. It will assess whether changing the laws will be needed in order to achieve this goal, and whether it will become necessary to establish a training- or retraining program for those responsible for the exercise-, lifestyle- or training programs.
>
> (Althingi, 2008 A; my translation)

The proposal´s report, in fact, framed obesity in two conflicting ways. The proposal stated that in times of ever rising health expenditure, where the use of prescribed medicines is constantly increasing and medical treatment in hospitals increasing every year, it becomes important to recognize that the cure of illnesses are not only medicines and medical treatments. Patients themselves can improve their own health through changed lifestyle, diet and physical exercise. The combination of lifestyle arguments and the encouragement to take more responsibility for one´s own health is an example of behavioural framing. This argument was strengthened when the proposal mentioned that many common diseases are caused by unhealthy lifestyles. But, then the focus shifted when it is stated that as these diseases place great cost on society, they are not only individual problems, but also a problem of the society (Althingi, 2008 A).

Of these common diseases, obesity was specially addressed – stated to be a *real* health problem in Iceland. The causes of increased prevalence of overweight and obesity were said to be social changes in the last decades, technological innovations and physically easier jobs – leading to a reduction in physical activity and reduced energy need. Here the *environmental frame* became apparent with the emphasis on unhealthy activity environment (Althingi, 2008 A).

Obesity, according to the proposal´s report, poses a great cost-burden threat to the welfare system if nothing is done. Addressing obesity was said to be necessary and physical activity said to be both a part of resisting this development and helping the patient to address his/her lack of health with his/her own ability or power. I could argue that the *environmental frame* is dominant as the document proposes to change the environment so that it encourages physical activity. But, in the end the aim is to activate individuals, encourage them to help heal themselves through lifestyle changes, so I think the overall context is more in line with the *behavioural frame*.

In 2010, a MP submitted an inquiry, asking the Minister of Health six questions about: the development in weight of children under the age of 18 in the last 20 years; reasons for that development; comparison to other OECD countries; effects overweight has on the well-being of children; what WHO´s recommendations for combating overweight among children are; and what measures health authorities have taken in the matter (Althingi, 2010 B). From these set of questions it is quite clear that the MP assumed three things: that children´s overweight either was, or was becoming, a problem in Iceland; that overweight affects children´s well-being; and that the government/health authorities should take measures in the matter.

Analyzing the answer, I only focused on the parts related to causes and actions. The Minister stated that overweight and obesity rates, among children, had been rising and that there was no singular reason for this development. He, however, identified three impact factors: changed lifestyles, diet and physical activity, and especially mentioned increased use of computers, television watching, car transportation and the marketing of unhealthy food, directed at children (Althingi, 2010 C). The causes were thus framed in a combination of the *behavioral*- and *environmental* way.

Listing measures government had taken, the Minister mentioned: the governmental health policy – setting goals in physical activity, dieting and weight in accordance to WHO guidelines; laws and regulation on food and business marketing aiming to improve public health (does not specify these laws); proposals for coordinated policies and measures in preventing and treating overweight and obese children; health promotion project at all school levels; systematic height and weight monitoring in elementary schools; information brochures regarding dieting, physical activities and healthy lifestyles; and facilities to treat severe cases of obese children and adolescents (Althingi, 2010 C). After listing these measures, the Minister referred to the *European Charter on Counteracting Obesity*, and stated that the responsibility of these matters was

governmental, social and individual. But then he stated that despite all preventions and available resources to combat obesity, it is the individual himself/herself that must be responsible for his/her own health and weight or body shape. And, when it comes to children, he placed the main responsibility with parents. Individuals were thus stated to be the main and most important preventions against overweight and obesity (Althingi, 2010 C). The *behavioral frame* was the dominant one in this document and in the overall context, the main problem was children´s unhealthy lifestyles.

4.3.3 Envrionmental framing

An environmental framing of obesity addresses obesity as a symptom of an unhealthy food and activity environment, created by corporate and public policy. A possible solution would be to change these actors´ policies (Lawrence, 2004, p. 62-63). Three documents fell under this classification: a parliamentary resolution proposal on restricting advertisements of unhealthy foods directed at children (Althingi, 2007 A); a parliamentary resolution proposal on physical education in schools (Althingi, 2007 B); and a parliamentary resolution proposal on regulating the maximum amount of trans fats in food (Althingi, 2010 A). All these documents focused on changing the environment – making it less obesogenic.

Starting with the parliamentary resolution proposal on restricting advertisements of unhealthy foods directed at children, it stated:

> Althingi resolves to entrust the Minister of Health to explore the basis for a regulation, limiting food advertising directed at children, if the product contains high fat, sugar or salt, in order to combat obesity, especially among children and adolescents. The Minister will seek to reach a consensus with manufacturers, importers and advertisers of these products so that these products will not be advertised during children television programs and not until after nine o'clock at nights.

(Althingi, 2007 A; my translation)

The proposal´s report and supporting documents presented obesity as a serious health problem and an epidemic in Iceland. The causes of obesity were, in the main supporting document, stated to be a combination of changes in the food system and the nutritional composition of foods, and sedentary lifestyles. The root of the problem was however stated to be persistent marketing, promoting consumption, and increased supply (Althingi, 2007 A). Obesity was presented as a risk factor for NCDs and Icelandic governments were criticized for the lack of direct actions aimed at combating obesity. The need for systematic actions, directed at the root of the problem was emphasizes and this proposal presented to be a part of such actions (*ibid*). Hence, the main problem representation was the marketing of unhealthy food, directed at children and the causes of obesity were clearly framed in an *environmental* way.

Children were targeted as an especially "vulnerable" group highly influenced by advertisement and marketing. It was clearly stated in the report that the MP places the main responsibility on parents but also stated: "However, that does not exclude others from bearing responsibility in these matters. To continuously direct unhealthy food at children and adolescents and not care for the consequences is irresponsible." (Althingi, 2007 A; my translation). The government plays an important role in encouraging them to act responsibly and should consider regulating them if they are uncooperative. Thus, responsibility was if fact socialized.

Also focusing on children, a parliamentary resolution proposal on physical education in schools, was introduced at Althingi in 2007 (Althingi, 2007 B). The proposal stated:

> Althingi resolves to encourage the Minister of Education, during the review of the elementary schools curriculum, to increase physical education so that students are guaranteed at least one exercise lesson a day.
>
> (Althingi, 2007 B; my translation)

The proposal itself did not directly address obesity, but in a speech, introducing the proposal, the MP frequently discussed obesity in this context. The proposal itself, along with its report, represented physical inactivity as a health risk, jeopardizing the life and well-being of people (Althingi, 2007 B).

According to the proposal, government, through the (compulsory) primary education, shares the responsibility of children upbringing with parents and was thus represented to be responsible for addressing this issue by increasing physical activity through education. In his speech the MP stated that obesity was not only a burden for individuals involved, but also a burden on society. Government need to act, and since they cannot enforce people to diet or exercise by law, at least they can agitate for healthy lifestyles and more importantly prevent obesity by teaching children to live healthy lives and exercise regularly (Schram, 2008). In other words, by changing the school environment, through public policies, and increase physical activity, obesity will be combatted. The main problem representation in the proposal was a lack of physical activity manifested in the sedentary life but instead of focusing on the responsibility of the individuals, the proposal focused on changing the activity environment.

In 2010, a parliamentary resolution proposal on the regulation of maximum trans fats in food was introduced in Althingi (Althingi, 2010 A). The proposal stated:

> Althingi resolves to assign to the Minister of Fisheries and Agriculture the initiative to prepare regulations, stating that the maximum trans fats in food will be no more than two grams for each hundred grams of the product´s fat quantity.
>
> (Althingi, 2010 A; my translation)

The focus of the proposal´s report was not obesity *per se.* However, the discussion was in line with WHO´s discussion on risk factors, as it discussed how consumption of trans fats increases the risk of developing heart- and cardiovascular diseases as well as obesity and diabetes type 2. Although the proposal aimed at improving the environment and promoting the optimal environment for individuals to make better and healthier choices, thus indicating the problem was unhealthy food environment, the *information deficiency frame* was also clearly present. The report mentioned that labeling food with nutrition labeling is not required in Iceland, and that there were no regulations on neither the maximum amount of hydrogenated fats in food nor labeling requirements to inform of such fats. As a result, consumers do not have the opportunity to avoid trans fats. The proposal followed WHO´s recommendations for maximum consumption of trans fats and urged the government to follow the example of Denmark, the first country to introduce trans fat regulations (Althingi, 2010 A).

4.3.4 Information deficiency framing

An *information deficiency frame* addresses obesity as an information deficiency problem meaning obesity results from individuals not fully understanding the consequences of their consumption (see p. 29). Food-relevant information, under this framing, is defined as a merit good. Four document were placed in this group: a parliamentary resolution proposal on the Nordic Health Mark *The Keyhole* (Althingi, 2011 A); a parliamentary resolution proposal on calorie labeling on fast food (Althingi, 2011 B); an inquiry to the Minister of Health about sugar consumption and prevention (Althingi, 2008 B); and the Minister´s answer to that inquiry (Althingi, 2008 C).

The parliamentary resolution proposal on the Nordic Health Mark *The Keyhole* (Althingi, 2011 A) stated:

> Althingi resolves to encourage the Minister of Fisheries and Agriculture to

> promote the use of the Nordic joint nutritional label, the Keyhole, on Icelandic food products.
>
> (Althingi, 2011 A; my translation)

According to the proposal´s report, the aim of *the Keyhole* is to make healthy choices easier for consumers. For a product to become labeled with *the Keyhole*, it has to fulfill specific requirements regarding the amount of salt, sugar, fat, saturated fat and fiber. Only the healthiest product in each category gets labeled. (Althingi, 2011 A).

The report stressed the urge to address rising obesity and lifestyle related diseases and mentioned that Nordic governments have emphasized the need to improve people´s dietary, for example, by making it easier for them to choose healthy foods. *The Keyhole* is a part of that plan, and since Iceland had not been participating in *the Keyhole*, it was encouraged to do so. It was stated that the Consumers Association in Iceland also urged participation in *the Keyhole* and so did numbers of private actors (Althingi, 2011 A).

Striking a similar tone, aiming to make healthy choices easier for consumers, the parliamentary resolution proposal on calorie labeling on fast food was introduced (Althingi, 2011 B). It stated:

> Althingi resolves to entrust the Minister of Welfare to ensure that fast food restaurants clearly display information about the amount of calories their courses entail.
>
> (Althingi, 2011 B; my translation)

In the proposal´s report, eating fast food was considered a part of modern lifestyle. In the West, fast food consumption has increased, in comparison with home cooked meals. As the Nordic Countries face some challenges due to changes in dietary and lifestyles, they deemed it necessary to combat obesity and lifestyle related diseases. These countries have emphasized improving the diet, for

example, by making it easier for people to choose healthy food. Making informed choices when people consume fast foods was a key issue in this relation. As obesity was becoming a serious health problem in Iceland, this proposal was introduced (Althingi, 2011 B).

The report pointed out that it is considered a "natural thing" to inform consumers about the ingredients in food sold in retail, but little or no information are provided at restaurants. This kind of labeling was, according to the report, believed to have positive effects on public health – given accurate information consumers will change their consuming patterns towards fast foods containing fewer calories. The report stated that it was time for government to start cooperating with fast food restaurants, urging them to provide this information. If they, after two year, were not cooperating with government, regulating them should be considered (Althingi, 2011 B).

These two documents were good examples of information deficiency framing as the main problem was presented to be lack of food-related information. The next document was not as clear in its representation, but it was my conclusion that the underlying assumption was that children consume too much sugar without realizing it – in other words because of information deficiency. This document is an inquiry addressed to the Minister of Health about sugar consumption and prevention (Althingi, 2008 B). The inquire was twofold, first asking whether the Minister intended to promote increased prevention and education due to the fact that sugar consumption among Icelandic youngsters was the highest in all the Nordic countries, and because obesity is becoming one of the biggest health problems of the West. Second, the MP asked whether the Minister intended to react on the facts that excessive consumption of sugar, among children and adolescents, was mainly related to soft drinks and candy consumption, and that other foods that are fed to young children, such as drinks, dairy products and cereal, contain significant amount of added sugar.

The Minister, in fact, did not answer the first question – not with a "yes" or a "no" and he did not mention any specific actions. Answering the second question the Minister did not specify any direct actions aimed at reducing sugar consumption but instead mentioned the importance of providing children with a healthy environment, at home and in schools. He discussed the importance of projects intended to raise people´s, especially the youth´s and their parents, awareness and increase their knowledge about healthy lifestyles, risk factors and effects of excessive consumption of soft drinks and candy. The Minister stated that he would keep on encouraging the food industry to cooperate, with the aim of increasing the supply of healthy foods and mentioned the importance of improving food labeling – helping consumers to make healthy choices. He however stated that Iceland could not set unilateral regulation on nutritional labeling – it needed to follow EU protocols (Althingi, 2008 C).

4.3.5 Summary of the Icelandic documents

Based on the analysis above, frame pluralism was clearly present in the parliamentary documents and in some cases within one and the same document. This was no surprise as these documents came from different individuals with different backgrounds and different political views – factors that are likely to influence their beliefs and interpretations of obesity. In no document were individuals blamed for their condition but individuals were in some cases stated to be responsible for their health and weight, and for their children. Discussions about life-styles and imbalance in energy consumption were usually put in context with the environment and in all documents the government was presented to bear some responsibility of addressing obesity, usually by changing the environment. Even when the responsibility was individualized, that did not exclude government actions, which was interesting as framing theories suggest that individualization of the problem limits the responsibility of governments.

I found it especially interesting to see how information deficiency framing was

prominent in these documents, usually accompanied with environmental changes. My impression was that this combination somewhat reframed the issue into, what could be called, consumers protection. Reframing like that is likely to reach a larger audience by targeting a large and usually powerful interest group, consumers, and might thus increase the possibility of implementation.

Overall, the *environmental frame* was dominant in the parliamentary documents. Obesity was clearly framed as a *real health risk* and children framed as especially *vulnerable* and in that sense obesity was partly framed as *involuntarily acquired*. The *information deficiency framing* also framed obesity as an *involuntary acquired* health risk, as the consumers are unable to make informed food choices.

I decided to investigate whether any of the parliamentary proposals, that were analyzed, had been implemented and three of them had been. First, the content of the proposal of restricting advertisements of unhealthy foods directed at children is today a part of Laws on media. The initiative of that was however not based on the proposal, but on directives from the European Parliament and the Council of Europe (Althingi, 2011 C). Second, in December 2010 a regulation on maximum levels of trans fats in food, was issued by the Minister of Fisheries and Agriculture (The Ministry of Fisheries and Agriculture, 2011). This regulation was implemented without the MP´s proposal being fully discussed at Althingi and I found it interesting that the Minister did not participate in parliamentary discussions on the proposal and indicate that this regulation would be issued. As the MP was introducing this proposal at Althingi for the fourth time, I am inclined to think it had some influence, but as two other European states were issuing such regulation at that time, that might also have influenced the decision. The third proposal was the proposal on the adoption of *the Keyhole*. In that case it is obviously related to the MPs proposal, because after the proposal was referred to parliamentary committee, its members decided to take it further and introduced a Bill on the matter, which was approved by the parliament.

The fact that two of these proposals are documents that may also be defined as consumers protection, and that the third one is implemented based on EU directives, is very interesting. Studying these proposals from John Kingdon´s (2011) Multiple Streams Model would be interesting, as that might reveal what factor were crucial in order for the proposals to get implemented and what changed from the first time they were introduced until they were implemented.

5. Discussions and conclusions

Carol Bacchi (2009) states that public policies imply a certain understanding of what needs to change, or what is the problem. Bacchi argues that problem representations, or problem framings, play a central role in how we are governed, by focusing the policy maker´s attention and at the same time limiting policy options. The representation, or the framing, expresses the policy maker´s interpretation of the situation, or the problem, and implies a course of action. It is my view that the word "limiting" does not have to have a negative meaning. Considering that issues or situations are often quite complicated, framing is a way of simplifying the situation, a way to focus on what the policy maker perceives as the most important part to address in order to improve the situation. Framing is in that sense a governmental tool, a tool to influence people´s understanding of a situation, how that situation should be addressed and who should be responsible for doing that. Framing is in fact a tool to justify governmental actions. But, "limiting" also has a negative aspect because by focusing the attention on a part of a situation, policy makers leave other parts of the situation unaddressed. Selecting the focus might also result in the roots of the problem never being addressed as well as only benefiting a small part of those affected by the problem.

The representation of a problem is crucial when it comes to the question who should be responsible for addressing a problem. Regina G. Lawrence (2004) suggests that public health problems become amenable to public policy when they can be framed in systemic terms. She sets up two kinds of opposite frames. First, an individualizing frame that limits the causes of a problem to particular individuals – often those afflicted with the problem – and thus limits governmental responsibility. And second, a systemic frame that broadens the focus and takes into account how the environment influences people´s choices, and assigns responsibility to government, business and large social forces. I think obesity is an excellent example of the importance of how problems are framed and represented. If obesity is represented as a lifestyle related condition, or as a

result of overconsumption of food, individual responsibility for the problem seems rational. But, if one sees obesity as a condition affected by, or resulting from environmental- or socio-demographic factors, social responsibility becomes relevant and so do public actions that address the problem. How policy makers understand or interpret the causes of obesity influences their choices of action – their policy preferences. The document analysis conducted for this study clearly supports that statement.

The analysis of documents from the medical journal The Lancet, the World Health Organization and the Icelandic parliament, revealed that a *systemic framing* of obesity, or the *environmental frame*, was dominant. *Biological framing*, emphasizing biological disorder as a cause of obesity, was never detected and neither was a pure *behavioral framing* of obesity. When life-style related causes were mentioned, they were usually put in an environmental context and obesity presented to be a symptom of social changes and unhealthy food and activity environments. Addressing obesity was in all cases presented to be mainly a governmental responsibility. Governments were seen as responsible for improving the environment and for promoting healthy food choices and physical activity through public policies. It was, however, emphasizes in documents from all actors, that combating obesity and reversing the pandemic is both a governmental and a social (meaning private actors) responsibility, because without multisectoral actions it would be almost impossible to change the obesogenic environment. These actions will, however, need to be policy led and thus governments were presented to be the key actors in addressing obesity.

Having stated that the environmental frame was dominant in these actors´ documents that does not mean their representations were identical. I have mentioned certain tangency points in their discussions but the environmental frame seemed to allow many different focal points as the actors´ different emphasis bear witness to. The WHO´s representation of obesity distinguished itself from the other actors´ representations with their strong emphasis on obesity

being a risk factor for NCDs, and with their lack of policy proposals directly addressing obesity. In Iceland an emphasis, not highlighted by the other two actors, was *information deficiency* and the need for better information to help people make healthier food choices. Obesity, from this angle was seen as resulting from a lack of information leading to uninformed food choices, and thus people underestimated the negative consequences of their consumption. Providing and improving food-related information through various food labeling, was in this case a policy preference. The Lancet deviated from the others by clearly identifying the global food system as the main global driver of obesity, but also by stating that the obesogenic environment individuals find themselves in, was a result of the market-based economy promoting consumption based growth and political culture that supports general overconsumption. They saw government not only as responsible for addressing obesity they identified them as part of the cause. They called for systematic changes, in the political- and economic environment – changes on the supply side of the market.

Despite different focal points, a general conclusion is that among the three actors studied in this thesis, the responsibility of addressing obesity was presented to be governmental. Systematic, multisectoral actions are needed to reverse the obesity pandemic and governments were represented to be the key actors in that battle.

Executive summary

Obesity, defined as abnormal or excessive fat accumulation that poses a risk to health, is rising in prevalence in almost all parts of the world, affecting children as well as adults. Obesity is a major risk factor for number of chronic diseases and is the fifth leading risk for global deaths. It is closely related to premature mortality and other negative affects on health-related quality of life. Obesity creates great economic burden, borne by obese individuals themselves, governments and private actors, and it is related to loss of productivity, increased medical treatment- and health care cost, increased disability, early retirement and work absenteeism. Obesity is a worldwide epidemic – a pandemic. It is a serious problem, but who´s problem is it? Who should be responsible for addressing this pandemic and why? That is the main topic of this thesis.

Discussing obesity from a public policy perspective and taking a constructionist and interpretivist epistemological stance, the aim of this thesis was to study how the problem representation, or the framing of obesity, affects the interpretation of the problem and our understanding of responsibility and policy options. The aim was also to study how three actors – the medical journal *The Lancet*, the World Health Organization and the Icelandic parliament – interpret and represent obesity and how that affects their policy preferences. These actors were selected based on their potential to influence the framing of obesity, at different levels.

As people´s body shape is generally not a public matter, a theoretical framework was created in order to explain how issues, in this case obesity, become social problems. The theoretical framework started by discussing economic theories about the role of the state, followed by a discussion about how the welfare state has widened the idea of government responsibility and debates on how far collective responsibility should go. As social problems and collective responsibility are usually manifested in public policies, a short discussion about the public policy making process and the relationship between problems and

policies was presented. The theoretical framework ended with a discussion of theories about problem representation and problem framing. Special attention was paid to Carol Bacchi´s (2009) theory about problem representations. Bacchi states that instead of being a response to an outside problem, public policies imply a certain understanding of what is the problem. Public policies are in that sense problem representations, or problem framings, and they play a central role in how we are governed, by focusing the policy maker´s attention and limiting policy options. The representation expresses the policy maker´s interpretation of the situation, or the problem, and implies a course of action. Because of that, the problem representations are crucial when we ask who should be responsible for addressing a problem. Focusing on public health problems, Regina G. Lawrence (2004) sets up two kinds of opposite frames: an individualizing frame that limits governmental responsibility by placing the cause of a problem with particular individuals, often those afflicted with the problem; and a systemic frame that broadens the focus and takes into account how the environment influences people´s choices, and assigns responsibility to government, business and large social forces. Based on these theories, it matters greatly how policy makers understand or interpret the causes of obesity as that influences their choices of action – their policy preferences.

The methodological part of this thesis explained how the interpretation and representation of obesity among the three selected actors was studied. Using a combination of Carol Bacchi´s (2009) *"What´s the problem represented to be"* approach to public policy analysis and Regina Lawrence´s (2004) approach to problem framing, 15 documents from the selected actors, addressing obesity, were analyzed. Bacchi´s approach was used to study the problem representation within each document, what assumptions were underlying the representation and how that affects our perceptions of who is to blame for the problem. Lawrence´s approach was, on the other hand, used as guidelines in framing identification and classification. In her study of US news discourse, Lawrence identified three competing frames of obesity: a *biological frame* seeing obesity as a result of

biological disorder that may be understood and possibly cured by science; a *behavioral frame* that sees obesity as a result of individuals consuming more calories than they burn and emphasizes individual solutions to the problem; and an *environmental frame* that sees obesity as a symptom of unhealthy food and activity environment, created by corporate- and public policy, and sees changed policies from these actors as a possible solution to the problem. In addition to these three frames, an *information deficiency frame*, based on economic theories, was added. It sees obesity as a result of individuals not fully understanding the consequences of their consumption and thus underestimating the risk of becoming obese. Food-related information are under this framing seen as merit-goods and thus governments should either provide them or make sure they are made available, to prevent obesity. A special attention was also paid to whether obesity was framed in terms of being: *involuntary acquired*; a *universal* health problem; arising from the *environment*; a *real* health risk; and whether it was *knowingly created* by others, as theories state that the more a public health issue is framed in these terms, the more it points to public responsibility or the responsibility of powerful groups.

The document analysis revealed that among the three actors, obesity was represented to be a *real health risk* and a *universal health problem*. Obesity was mainly framed in *environmental terms* putting people´s lifestyles in an environmental context and mainly representing obesity as a symptom of social changes and unhealthy food and activity environment. Children were presented to be an especially *vulnerable* group and in great need of social protection, but they were also seen as the greatest hope in reversing this pandemic and were thus frequently targeted in policies aiming to combat obesity.

Despite the fact that the environmental frame was dominant and that all cases presented governments as the key actors in addressing obesity, the actors did not represent obesity in an identical way. *The Lancet,* for instance, identified the global food system as the main driver of this pandemic. It framed obesity in very

strong environmental terms, stating that individuals were reacting normally to an obesogenic environment, created by the modern market-based economy, promoting consumption-based growth and political culture that supports overconsumption. *The Lancet* placed the responsibility for addressing obesity mainly with governments, but also identified them as a part of the cause and stated that this pandemic will not be reversed within the existing economic and political framework. The World Health Organization did not identify governments as the cause, but it did put great emphasis on environmental and social changes. The main problem was represented to be the lack of supportive environments and communities that are fundamental in shaping people´s choices – helping them to make healthier food choices and making physical activity easier. Different from the other two actors, the World Health Organization mainly treated obesity as a major risk factor for noncommunicable diseases and did not offer any clear policy choices, directly aimed at combatting obesity. The Icelandic documents revealed frame pluralism, although the environmental framing was dominant. This was not a surprise as the documents came from a number of MPs that have different backgrounds and different political views that are likely to influence their beliefs and interpretation of obesity. Governments were in all cases presented to bear responsibility for addressing obesity and even when the responsibility was individualized, that did not exclude government actions. This contradicted the framing theories that suggest that an individualization of the problem limits the responsibility of governments. Iceland also deviated from the other two actors, as the information deficiency frame was prominent in the parliamentary documents (usually combined with environmental framing) emphasizing the need for better information in order to make healthy food choices easier for people.

The document analysis, conducted for this thesis, revealed different policy preferences among selected actors, based on different understanding or interpretation of obesity. Obesity is thus an excellent example of the importance of how problems are framed and represented.

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