Commercial Fitness and Challenges for Health

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Abstract
The article explores the ambivalent relationship between the commercial fitness industry and question of health. While commercial fitness has drawn support and legitimacy from the health field, it is poorly equipped to address population health issues. The article draws from research on the US, where the commercialization and individualization of physical culture and leisure are most marked; however, these are global issues, just as obesity and inactivity are global problems. Using the example of commercial exercise manuals, the article outlines the problematic construction of fitness as an individualized consumer leisure activity, which obscures the social roots of health problems and further entrenches class-based stratification of health and health risks.

Introduction
Over recent decades, many Western countries have experienced a strange paradox, with sport, exercise and leisure industries expanding alongside problems with inactivity and obesity. It thus bears asking how commercial fitness relates to questions, definitions and problems of health. This discussion draws from a larger body of research (Maguire, 2001, 2002, 2006, 2007) on the commercial fitness field in the United States, where the pace and scope of the individualization and commercialization of fitness have been most dramatic. However, the commercial provision of fitness services is a global phenomenon. Bearing in mind that the commercialization of fitness (and associated declines in compulsory physical education and public provision of recreation programmes and facilities) is mediated by local conditions—including sporting traditions, patterns of state provision of leisure services, socio-economic stratification, climate, and patterns of urbanization and commuting—it can be particularly illuminating to study the US as an extreme example of the commercialization and individualization of physical culture and leisure in consumer societies around the world. It is important to set aside the commonplace assumption that fitness is ‘good for us,’ in order to ask how commercial fitness makes health more or less available for participants and non-participants. As such, the article proceeds with an overview of the health context of the commercial fitness field before using the example of exercise manuals to illustrate how the construction of fitness poses challenges for health outcomes.

Commercial Fitness and the Context of Health
In the US, commercial exercise facilities and equipment have a history that reaches back into the 19th century (Green, 1986); however, we can locate the take-off of this most recent boom in the commercialization of fitness in the late 1970s. A
complex matrix of historical and contemporary social, economic and political factors contributed to this ‘fitness boom,’ including a long-standing physical culture tradition that wed physical fitness to notions of social and self-improvement and individual responsibility; a well-developed consumer culture that emphasized the display and improvement of the body; a service economy and occupational market that required and rewarded particular forms of physical capital; and—most broadly—an increasingly sedentary mode of life that meant that physical activity was no longer an inadvertent part of everyday activity for most people. Alongside these factors, the health field has played a fundamental role in the development of contemporary commercial fitness.

Since the 1970s, health promoters, insurers and policy makers have focused on individual responsibility for taking up healthy, active lifestyles, prompted in part by rising costs of chronic diseases such as heart disease and cancer, and medical research on the health benefits of exercise. Corporations also took a fiscal management view of exercise, installing company fitness centres as a way to reduce health claims and absenteeism (Crawford, 1979). At the same time, proponents of demedicalization emphasized how taking care of one’s own health through a balanced diet, regular exercise, nutritional supplements and self-education were ways to increase ‘medical self-competence’ (Crawford, 1980, p. 374), thus reclaiming some control over health from medical experts. The commercial fitness field thus benefited from calls for healthy living from both ends of the political spectrum—top-down attempts to manage population health, and grass-roots attempts to reclaim control over health care.

The development of commercial fitness is linked as much to health as it is to disease. Advances in medical science, water provision and sanitation have meant that communicable diseases—the major causes of death in the 19th century—have been replaced by noncommunicable diseases, which accounted for 60 per cent of global deaths in 2001 (WHO, 2004). According to the World Health Organization (2004), five of the major risk factors for noncommunicable diseases are closely linked to diet and exercise—poor patterns of which give us global patterns of rising obesity and inactivity. These are intertwined problems, giving rise to interconnected agendas, including the WHO Global Strategy on Diet, Physical Activity and Health (2004), the Move for Health programme (WHO, 2002), and the UN’s 2005: Year of Sport and Physical Education campaign.

Thus, to understand the growth, success and limitations of commercial fitness, it is important to understand the problems of obesity and inactivity. Obesity and inactivity are global problems. Though linked in the media and popular imagination with the developed world, obesity and inactivity rates are rising across the globe, resulting in the coexistence of problems of obesity and under-nutrition in some countries (WHO, 2000). Global statistics on obesity are difficult to compare because of irregular definitions of the surveyed population, the definition of obesity, and the survey periods. The most comprehensive study is the WHO MONICA (MONItoring of trends and determinants in Cardiovascular diseases) Study that compares specific cities from 48 different, but mostly European countries, and shows that in all but one case, between 50 and 75 per cent of adults were overweight or obese between 1983-1986 (WHO, 2003b), and that these rates are increasing over time. In the past 10 years, European countries have seen an increase of between 10 and 40 per cent (WHO, 2000); more markedly, obesity rates in the US increased by two-thirds between 1960 and 1990, and increased another two-thirds over the 1990s alone (Farley & Cohen, 2001). Despite similar problems with global measures of inactivity,
statistics are largely consistent: around the world, 60 to 85 per cent of adults are not physically active enough to achieve any health benefits (WHO, 2002).

Significantly, obesity and inactivity are stratified by gender and class (National Center for Health Statistics, 2005; WHO, 2000, 2002; YWCA, 2001). Women have higher rates of obesity than men, men have higher rates of overweight, and in both instances, rates of obesity increase as socioeconomic class decreases. Similarly for inactivity: physical inactivity is higher for women and girls, and worse in poor urban areas (WHO, 2003a). Among other things, poverty means a lack of access to safe recreation areas and high-quality, low-cost foods—contributing factors in inactivity and obesity (Crister, 2000; WHO, 2000, 2002). But socioeconomic class is not only about economic capital. Food and activity choices reflect cultural and social capital as well (Bourdieu, 1984): for example, having the knowledge of and preferences for certain activities and foods such that the ‘healthy’ option takes on the appearance of being the ‘natural’ preference rather than the difficult choice. Rising socioeconomic levels on a population scale create the conditions for obesity and inactivity—eating too much becomes a possibility, rather than under-nourishment, while technology and urban development make physical inactivity a likelihood for increasing portions of the population. However, obesity and inactivity are then stratified individually by class—choosing to be fit then becomes a sign of status.

Exercise Manuals and the Construction of Fitness

Despite the support drawn from the broader health field, commercial fitness has an ambivalent relationship with health. Using the example of commercial exercise manuals (see Maguire, 2002), let us consider four ways in which the construction of fitness is problematic in terms of health.

First, and most directly relevant to the issue of health, exercise manuals use the health benefits of regular exercise as a tool for motivating people to take up fitness. In an attempt to motivate readers to discipline their leisure time appropriately and make time for fitness, manuals construct fitness as a panacea for the ills—individual and collective—of contemporary life: exercise is the means to reduce health risks, improve energy levels, cope with stress, lose weight, improve appearance, feel younger, and so forth. Fitness is constructed as a way to gain control over one’s body and one’s impression on others, and in service economies in which appearances count and physique is a form of capital, fitness offers (potential) rewards with real economic consequences. What is problematic about the construction of fitness as a cure-all is that collective sources of risk (geopolitical instability, pollution) and other risks beyond individual control (inherited predisposition for diseases, accidents) are obscured by the focus on individual responsibility. Although a sense of control over one’s life contributes to health (Epstein, 1998), the form of control on offer in the fitness discourse is inherently unstable and tenuous. Control over one’s life is reduced to a command of the body, which is often disrupted by impositions from a disorderly social world—highlighting the limits of the individual’s control.

Second, exercise manuals naturalize the association of fitness with one’s discretionary leisure time, and thus expenditure on fitness with discretionary income. This is important in terms of the status rewards possible through field participation, as leisure and lifestyle choices are the primary stakes in competition for distinction and prestige in consumer culture (Bourdieu, 1984). However, the cultural imaginary of leisure poses two problems—one for the field, the other for health. On the one hand, leisure is imagined as a time of relaxation, making working out (a sweaty, strenuous activity even for those who intrinsically enjoy it) a difficult ‘sell’ as a leisure pursuit,
especially in competition against other activities more in keeping with the consumer culture ethos of instantaneous gratification. Thus, exercise manuals attempt to educate readers to discipline their leisure time, applying a work ethic of time schedules, appointments and efficiency to their discretionary time in order to ‘fit in’ fitness. On the other hand, leisure is imagined as a time of freedom, creativity and control: a time to do with as one sees fit. The exercise manuals treat as unquestioned common sense that time for exercise is to be found individually during one’s leisure time, rather than through collective strategies that challenge the nature of the working day or patterns of urban development that discourage working in proximity to one’s residence (giving rise to patterns of sedentary commuting).

Third, exercise manuals construct fitness as a leisure activity in keeping with the broader cultural imaginary of fitness as a time of fun and pleasure. However, there is a particularly narrow vision of pleasure on offer in exercise manuals: exercise itself is not pleasurable; the pleasure comes from the effect one’s fitter body has upon others, or the satisfaction in having made ‘good’ use of one’s leisure time. Fitness activities are rarely constructed as enjoyable and as ends in themselves, but are instrumentally rationalized as means to other ends: reduced health risks, improved social status, and so forth. Non-instrumental pleasure, however, is often present in the narratives of fitness field participants, who may refer to feelings of freedom, competence and strength in doing the activity itself (see Maguire, 2007). With increasingly sedentary patterns of work and everyday life, it is little wonder that fitness activities can offer intense experiences of embodiment; what is striking is the relative absence of emphasis on such benefits in the exercise manuals’ discourse. In conjunction with the preceding themes, the fitness discourse tends to prioritize control over the body over pleasure in the body, and instrumental pleasure over spontaneous, non-directed play (Huizinga, 1955).

Fourth, exercise manuals construct fitness as a consuming activity. Commercial exercise manuals—including those published from a public health perspective—reproduce the message that participation in fitness requires consumption: a pair of shoes; a membership in a health club; the services of a personal trainer; a new piece of equipment. Furthermore, exercise manuals often prescribe consumption-oriented goals as motivational techniques, suggesting for example that the reader buy him/herself something new (for their fitter body) once a certain benchmark is reached. This highlights how the commercial fitness field functions as a web of consumption, linking consumers to ever more consumption opportunities and requirements, thereby aiding in the broader reproduction of consumer culture. The fitness field’s discourse resolves the tension between the hedonism of consumer culture and the inherent asceticism of exercise by linking them as cause and effect: be disciplined and work out now, in order to then engage in guilt-free shopping. This message, in addition to serving as an engine for consumption, perpetuates the double bind of indulgence and restraint characteristic of the contemporary era (Featherstone, 1982).

Commercial fitness has benefited from the health field: media attention on the dire predictions and exercise prescriptions from health leaders, direct referrals through physician-prescribed exercise, and scientific findings on the benefits of exercise have all helped to reinforce the fitness discourse’s construction of exercise as a panacea and a morally good use of leisure time. However, commercial fitness is poorly equipped to address the health problems that furnish it with legitimacy and, indeed, a market. In constructing fitness as a cure-all to be located strictly within leisure time and thus considered as a matter of individual choice, control and consumption,
exercise manuals present a vision of fitness that obscures the deeply social roots of population health issues such as inactivity and obesity.

Is Fitness Good for Us?

When we take for granted that fitness is ‘good’ we fail to question the vested interests and unintended consequences of the particular way in which fitness is constructed and sold to us. Is fitness good for us? For the majority—and in particular for those lower down the socioeconomic ladder who are more likely to be inactive and overweight—the answer is no, both because a lack of capital and suitable consumption preferences make participation unlikely, and because the private provision of fitness services facilitates the ongoing withdrawal of their public provision. For a narrow band of people who have the means and taste for participation, the answer is yes and no: commercial fitness provides goods and services that may facilitate the accomplishment of regular physical exercise, but in such a way that is deeply restrictive and possibly self-defeating. The ‘lessons’ of the exercise manuals include the promotion of an individualized notion of exercise, an instrumental view of pleasure through exercise, and the narrowing of the parameters of participation to those provided by the consumer market.

Medical research continues to substantiate the role of regular exercise in decreasing the risks of various diseases and ailments, including arthritis pain, breast cancer, colon cancer, osteoporosis, stroke, Type 2 diabetes and congestive heart failure (Krupa, 2001; Hardman & Stensel, 2003). To improve the health of the population, physical activity has to be ingrained as part of everyday behaviour—it must become a habit. Population inactivity and obesity stem in part from the decline—in the US and the West more generally—of compulsory childhood physical education, a central element of institutional socialization into physical activity and the production of exercise as a habit. Into this void has stepped the market, with a complex web of motivational goods and services aimed at producing new, fit habits for adults. But such motivation—flashy health club décor, inspiring stories in magazines, an enthusiastic personal trainer—comes at a cost, and is marketed to a middle-class market, reinforcing the economic and cultural capital boundaries to participating in the fitness lifestyle. And although commercial fitness has by and large addressed itself to adult consumers, this is changing as declining PE and anxieties about childhood obesity create a market for children-centred commercial fitness.

Childhood PE requires reinvestment and reinvention: PE’s focus on competitive, performance-oriented sports has excluded many from participation because of cultural backgrounds, body culture interests and physical capacities. Hence, we not only see declining provision of PE, but also declining participation of students, and especially young women (YWCA, 2001). At a more general level, schools need to be remade as healthy environments, by, for example, removing the reliance on income from vending machines, and redesigning schools’ interiors, exteriors and access routes to encourage physical exercise. At the most general—and most fundamental—level, PE needs to counter the market’s instrumental rationalization of physical activity. The need for and enjoyment of movement—of the body as a whole—is deeply embedded within us, but this play element of culture is increasingly subsumed within the rationalization of movement (Huizinga, 1955). Government policy makers, health workers and promoters, leisure and recreation professionals and physical educationalists need to find ways to facilitate the play ethos—on collective and individual bases.
The fat/fit paradox of the past three decades—in which fitness industries have boomed alongside increasing rates of population inactivity and obesity—can thus be understood as the rational outcome of addressing a social problem with an individualized and commercialized solution. The result is a further entrenchment of the existing class-based stratification of health and health risks, and the rationalization of health and exercise as matters of appearance management and status consumption. Individual sovereignty, so prized in consumer culture, is ‘healthy’ only insofar as it is accompanied by collective responsibility to tackle social problems through collective solutions: for example, more funding for public provision of recreation services accessible across class divides; a commitment to the sort of urban planning that makes active living the easy, not difficult choice; and compulsory childhood PE that produces an appreciation of the joy of movement and the habit of physical activity.

References


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