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Obesity prevention policy:
from harm regulation towards a neo-prohibitionist regime?

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Obesity prevention policy: from harm regulation towards a neo-prohibitionist regime?

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Abstract:

There has been increasing attention paid to non-communicable disease risk factors including tobacco, diet, alcohol and a lack of physical activity. The tobacco control model has moved from largely supply side, 'harm regulation' measures of the 1950s and 1960s (e.g. 'safe' cigarettes, education, self-regulation) to demand side, neo-prohibitionism in the 1980s (e.g. mandatory restrictions) with the increased attention paid to second hand smoke issues. Obesity as well as alcohol remain in the 'harm regulation' model although there have been attempts to move toward a more demand side model. Despite the attractiveness of the tobacco control model for obesity policy change, progress has been slow. We analyse the prospects for moving obesity policy towards a neo-prohibitionist model.

I Regulatory regimes for non-communicable diseases

While much of the improvement in life expectancy has been achieved through better prevention of infectious diseases, it is increasingly recognised that major advances now are required for dealing with non-communicable diseases (NCDs). The 2011 UN High-level Meeting on the Prevention and Control of NCDs refers to four risk factors - tobacco use, poor diet, lack of physical activity,[1] and harmful use of alcohol – for the four major NCDs: cancer, cardiovascular diseases, diabetes, and chronic respiratory illnesses. Recent reports on cancer warn of the increasingly strong relationship between obesity and cancer, now rivalling that of smoking.

Obesity has become a recognised policy problem globally over the past few decades. Similar to other food-related issues, it is subject to complex and fragmented regulatory arrangements intertwining public and private organisations at various levels of government. Questions about the relationship between nutrition and health, especially the role of calorie-dense and nutrient-poor foods, have reached the political agenda at all levels of government ranging from the local to the international. Hence the devolved government of Scotland has to make these choices as do international bodies such as the European Union, the United Nations – especially through the World Health Organisation (WHO) and the Food and Agriculture Organisation (FAO) – the

Organisation for Economic Cooperation and Development (OECD) and the World Bank. Indeed, since foods are large-scale consumer products, it is an issue that is also intimately connected to international trade and hence potentially to the World Trade Organisation (WTO) and global agreements on trade (e.g. the WTO's current Doha Round).

As a relatively new issue, obesity lacks successful 'exemplar programmes' for prevention (Swinburn *et al.* 2011). Several comparisons have been made about how obesity policies could follow the well-established path of public health tobacco policies in Western democracies, principally drawing lessons from individual countries, the EU and the WHO-stimulated Framework Convention on Tobacco Control (FCTC) of 2003 (Brownell and Warner 2009; Alemanno and Garde 2013; Klein and Dietz 2010; Lien and Deland 2011). From inauspicious beginnings where the political economy of tobacco growing, manufacture, consumption and taxation trumped public health interests, tobacco policy has haltingly emerged over the past half century to be considered a public health success story. The tobacco experience highlights a decades-long struggle by tobacco control groups to form alliances, challenge vested interests, engage in a 'battle of ideas' with tobacco companies, encourage major social change, shift policymaking responsibility to more sympathetic government departments and persuade governments to completely rethink the ways in which they understand the tobacco issue. Major changes in policy, including increasingly restrictive regulations on consumption, taxation, sales and advertising culminated in the first international health treaty. Collectively these measures have led to less smoking and measurable benefits in the reduction of morbidity and mortality (Cairney *et al*. 2012).

Alcohol regulation presents an alternative model of regulation, one that is more diverse across Western democracies. These policies range from relatively restrictive ones, especially on sales, in Scandinavian countries such as Iceland, Norway and Sweden to lighter regulation in more southern European countries such as Italy and France. But all of them could be called versions of a 'harm regulation' policy, modelled to fit local conditions, as also now obtains in the US and Canada on a state / provincial basis. Typically, analyses of the problem of alcohol consumption (as above) refer to 'excessive', 'harmful', 'addictive', or 'problem' drinking. The aim of these various policies is thus to minimise dangerous *effects* rather than to eliminate alcohol consumption *per se*. Over the past decade, the UK government under both Labour and the Conservative-Liberal coalition has resisted demands from public health advocates and officials, including medical officers, for tighter regulation (Baggott 2011; Cairney and Studlar 2014). Thus, in terms of policy, political economy considerations (i.e. the economic benefits of encouraging consumption) have continued to dominate over those of public health.

Despite a quarter century of growing international concern about obesity, it remains the case that it follows a 'harm regulation' regime everywhere and one that is even weaker than that for alcohol. A recent systematic study of obesity-related laws in Europe and the United States found that most

nutrition policies were targeted at: schools or other setting-specific sites; general consumer information through labelling; and government-encouraged collective 'voluntary' schemes by food producers (Sisnowski *et al*. 2015). Taxation, prohibition and direct regulation of food marketing were rare. 'Responsibility agreements' have become the norm for nutrition/obesity, despite criticism from public health advocates (Alemanno and Garde 2013; Gilmore *et al*. 2011; Sharma *et al*. 2010).[2] Perhaps surprisingly, the US federal government, following some state and municipal government action, has passed some of the strongest anti-obesity provisions through broad-ranging executive orders on posting calorie counts for prepared food as well as changes in agricultural price supports to encourage production and consumption of more nutritious food (Tavernise and Strom 2014; Sheingate 2014). What are the prospects for further change in obesity policy that might move toward the 'tobacco model' of increasing restrictiveness?

II Policy Approaches and Instruments

Governments are reluctant to take on the regulation of economically beneficial products if they require new agencies, reorganisation, new procedures, and/or additional financing. Thus, the first response usually is to try to institute a harm regulation (harm reduction, harm minimisation) regime, involving voluntary self-regulation, education, and perhaps a few targeted restrictions such as limits on televised advertising, plus sponsorship of research into how to make consumption of the product safer.

These policy instruments are related to a focus on supply versus demand side policy approaches. Demand-side policies emphasise 'informed consent' by buyers, with minimal government regulation. Voluntary 'codes of conduct' traditionally have been a major tool for public policy in the UK as part of what Vogel (1983) labels 'cooperative regulation'.

Supply-side solutions involve government interventions to limit the choices of consumers. Critics of supply side policies, including tobacco and food interests, typically argue that such measures constitute paternalism from 'the nanny state'. Proposals for wider supply-based policies to reduce obesity, such as considered in recent years by the UK Labour party, have been subjected to vigorous attack when proposed (Shaw 2008; Walters and Owens 2014).

In addition to these general approaches, recently there has emerged 'co-regulation' (also called semi-mandatory or even semi-regulatory instruments; see Sisnowski *et al*. 2015) in which private sector actors negotiate an acceptable regulatory regime with government. Mostly, enforcement is left to the private sector although a public authority can step in if necessary.

The problem with relying on the demand side, perhaps in combination with light regulation, is that, despite widespread availability of information, the public may not be able to apply it to purchases of harmful consumer products. Nutrition information is complicated and confusing. Voluntary interventions generally have been found to be ineffective (Sharma *et al*. 2010; Jacobsen 2014).

Harm regulation was the original policy adopted in tobacco control in the post-War period after the initial 'tobacco scare' of the early 1950s. Governments and tobacco companies attempted to deal with consumption hazards through the development of 'safer cigarettes' (Berridge 2004; Cairney et al. 2012). Since the 1980s, neo-prohibitionism became the goal of tobacco control policies (Cariney *et al*. 2012). Prohibition as policy option, including bans on the production, sale, and sometimes consumption of an already-established addictive product, has been in disfavour worldwide since the failed experiments of 'national prohibition' of alcohol in the US and other countries in the early twentieth century (Schrad 2010). In contrast, neo-prohibitionism involves government attempts to reduce consumption of a product to progressively lower levels through a variety of ever-more restrictive policy tools rather than banning sales entirely. The underlying philosophy, however, is well summed up by the Australian-originated slogan: 'Every cigarette is doing you damage'.[4]

There have been increasingly restrictive policy instruments on tobacco over the past half century, moving from education, self-regulation, and limited advertising restrictions toward fines, legal sanctions, and more restrictive calibrations (settings) of instruments (Studlar and Cairney 2014). The use of graphic warning labels in a growing number of countries, and plain packaging in a few (including the UK), shows the extent to which restrictions have been adopted. Advocates such as Marion Nestle (2013) have suggested that a similar repertoire of tools should be used to combat obesity.

Nevertheless, as indicated previously, harm regulation remains the dominant approach to obesity in the world, including by the WHO and the EU. Because of the complexities of food, it would be difficult to implement a policy of neo-prohibitionism. Limiting sales and consumption of some types of energy-dense foods along the lines now common for tobacco products may be possible, and several regulatory proposals have been made. Nevertheless, the standard so far has been to meet minimum labelling standards on contents. With only a few exceptions across the globe: unhealthy foods are taxed at the same rate as healthy foods; advertising restrictions, even for children's programming, are usually voluntary; and, there are few government-imposed warning labels. But there has begun to be discussion and some action on warning labels on nutritional value, mandated advertising limits for children's television programming, differential taxation and limits on sugary drinks (Alemanno and Garde 2013).

Some observers have questioned whether regulations on food to prevent obesity can follow a similar path as on tobacco because there is no equivalent to 'second hand smoke', which was a

critical issue in stricter regulation of smoking; no established single addictive element, such as nicotine (although sugar is a prime suspect); and no indications that a public health framing of food issues is likely to displace the political economy frame. Obesity policy also lacks equivalent measures to address damaging behaviour directly, such as the 'smoking ban'.

However, for obesity, arguments for stronger regulation have begun to focus on eating habits acquired in childhood, a vulnerable population group. As in smoking, any self-regulation conflicts with the industrial need to acquire lifetime customers of the product at an early age. More generally, harm regulation as a goal is not likely to be abandoned anytime soon in obesity prevention. Establishing the scientific evidence base for regulation is a slow process, proceeding country by country, and likely to encounter ferocious resistance by powerful food producing interests. But it took almost a half century for such a transition to occur in tobacco policy, a task that seemed unimaginable from the perspective of the 1950s.

III Conclusion

Nevertheless, overall tobacco policy still stands *sui generis* in its outputs among risk factors for NCDs. This is largely due to the development and spread of ideas that de-normalised not only the product (cigarettes) and behaviour (smoking), but also the industry itself ('Big Tobacco') as a source of trusted research and advice (Studlar 2002), a process that Smith (2013) calls 'tobacco exceptionalism'.

In principle, the regulation of other NCD risk factors provides comparable opportunities and constraints. Tobacco control has proceeded further along the path towards stronger regulation. Both alcohol and food have long regulatory histories, but only recently has food regulation focused on the obesity problem. Some advocates contend that obesity prevention has made considerable progress, considering its relatively short length of time on the political agenda (Emanuel and Steinmetz 2014).

Despite 'tobacco control envy', nutrition / obesity policy will find it difficult to follow the path of global tobacco policy towards neo-prohibitionism. It is difficult to demonise an industry that produces essential commodities and other products for which there is not yet an addictive 'smoking gun', and in a policy realm in which political economy considerations such as more food production still dominate. Nevertheless, the outcome of the contemporary policy struggle, at multiple levels, has enormous implications for the future of obesity policy across the globe.

Endnotes

[1] Lack of physical activity is often paired with diet / nutrition as part of the obesity problem although it is sometimes considered as a fourth dimension (Alemanno and Garde 2013). While activity is undoubtedly important, we focus specifically on diet / nutrition.

[2] For instance, the EU Pledge is a voluntary initiative by leading food and beverage companies to change food and beverage advertising to children under the age of twelve in the European Union. It consists of two main commitments: (1) No advertising for food and beverage products to children under the age of twelve on TV, print and internet, except for products which fulfil specific nutritional criteria based on accepted scientific evidence and/or applicable national and international dietary guidelines; and (2) No communication related to products in primary schools, except where specifically requested by, or agreed with, the school administration for educational purposes. These are minimum common standards that enable joint monitoring and accountability. Individual companies can apply corporate standards that go above and beyond these common rules. The EU Pledge was launched in December 2007 as part of the European Union Platform for Action on Diet, Physical Activity and Health, the multi-stakeholder forum. In the context of the EU Platform, the EU Pledge commitment is endorsed by the World Federation of Advertisers (WFA). EU Pledge member companies represent over 80% of food and beverage advertising expenditure in the EU. The initiative is open to any food and beverage company active in Europe and willing to subscribe to the EU Pledge commitments. (www.eu-pledge.eu).

[3] These are also called 'personal responsibility' versus 'envirornmental' (Kersh 2009) and 'soft' versus 'hard' policies (Engelhard *et al*.2009).

[4] Ironically, harm regulation has now returned to tobacco control policy debates in the controversy over how to regulate electronic cigarettes and other instruments designed to allow addicted smokers to satisfy their nicotine cravings without inhaling tobacco smoke. These sources of nicotine are demonstrably less harmful than cigarettes. On the other hand, neo-prohibitionists argue that they do not represent zero harm, may have unknown dangers, and also may be 'gateways' to regular smoking. Furthermore, the producers of e-cigarettes are increasingly major tobacco companies. The debate over an appropriate regulatory regime for e-cigarettes, especially how closely it should resemble those for cigarettes, has been joined in many jurisdictions in recent years (Gilmore and Hartwell 2014; Jopson 2014).

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