



Educating the American Obese: Reviewing a Questionable Theoretical Framework

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**Educating the American Obese:
Reviewing a Questionable Theoretical Framework**

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Paper Submitted April 2010

ABSTRACT

This paper will examine the history and recent development of anti-obesity programs adopted in the United States and abroad. The paper will pay particular attention to the theoretical premises on which each initiative relies, identifying two general ideological categories: (1) information campaigns that assume obesity rates are high at least partially because people do not know how or why it is important to live a healthy lifestyle, and (2) programs that rely on direct government intervention in order to make unhealthy lifestyle choices more difficult or more costly. After discussing the impact of the United States' campaigns, which have largely relied on educational programs to reverse historic obesity rates, the paper will suggest that direct intervention programs like those implemented by some foreign countries may be the more appropriate course. The paper will conclude with a specific proposal to enlarge the role of the FDA in order to facilitate experimentation with anti-obesity programs among state and local governments.

TABLE OF CONTENTS

I. INTRODUCTION 1

II. THE CURRENT ROLE OF THE FDA..... 4

A. The FDA and Dietary Guidance 4

B. The FDA’s Targeted Response to Obesity 6

III. REDUCING OBESITY BY CORRECTING MARKET FAILURES..... 7

A. Menu Labeling: Municipal-level Regulation 10

B. Menu Labeling: State-level Regulation 11

C. Menu Labeling: Federal-level Regulation 13

IV. REDUCING OBESITY BY CREATING MARKET DISTORTIONS 14

A. Controlling Advertising of Unhealthy Foods 16

1. Advertising Ban in the United Kingdom 18

2. Proposed American Legislation 20

B. Establishing Economic Incentives for Healthy Behavior 22

1. Japan’s “Metabo” Legislation 23

2. Obesity Penalties in State Insurance Programs 25

C. Removing Unhealthy Food Choices 27

V. UPDATING THE UNITED STATES’ ANTI-OBESITY MODEL 30

A. Education Campaigns Have Not Reduced Obesity Rates 30

B. Barriers to Direct Intervention 32

C. Proposed Role of the FDA 35

VI. CONCLUSION 37

I. INTRODUCTION

Historic obesity rates, both in the United States and around the world, have become a well-documented and salient political issue.¹ In 2003, the International Obesity Task Force estimated that 1.1 billion people were overweight or obese world-wide.² The Center for Disease Control (“CDC”) estimated that fifteen percent of the American population was obese in 1980, a figure that doubled to thirty-one percent in 2002.³ A 2008 study estimated over thirty-three percent of American adults to be obese.⁴ Today, obese and unhealthily overweight American adults significantly outnumber healthy adults sixty-eight to thirty-two percent.⁵ Although American children suffer from obesity at a percentage significantly lower than American adults, that percentage is rising at an even

¹ See e.g. Wendy C. Perdue, *Obesity, Poverty, and the Built Environment: Challenges and Opportunities*, 15 GEO. J. ON POVERTY L. & POL'Y 821 (2008); The Obesity Society, <http://www.obesity.org> (last visited March 29, 2010); The President's Challenge, <http://www.presidentschallenge.org> (last visited March 30, 2010) (“The President's Challenge is a program that encourages all Americans to make being active part of their everyday lives.”); Richard A. Epstein, *What (Not) To Do About Obesity: A Moderate Aristotelian Answer*, 93 GEO. L.J. 1361, 1366-68 (2005) (challenging the designation of obesity as an “epidemic” and arguing that individual lifestyle choices are too varied, and the science too muddled, for government programs to significantly reduce American’s collective waistline).

² See Press Statement, International Obesity Task Force (August 25, 2003), available at <http://www.ionf.org/media/ionf25.htm>.

³ See Graham M. Catlin, *A More Palatable Solution? Comparing the Viability of Smart Growth Statutes to Other Legislative Methods of Controlling the Obesity Epidemic*, 2007 WIS. L. REV. 1091, 1091 (2007); see also National Center for Health Statistics, Department of Health and Human Services, 2000 CDC Growth Charts for the United States: Methods and Development, Vital and Health Statistics, May 2002, at 13 fig. 2 (2002).

⁴ See Katherine M. Flegal et al., *Prevalence and Trends in Obesity Among US Adults, 1999-2008*, 303(3) JAMA 235 (2010), available at <http://jama.ama-assn.org/cgi/content/full/2009.2014#BIBL>.

⁵ *Id.*

faster rate—the childhood obesity rate tripled in the years between 1980 and 2006.⁶ However, the impact of these figures is not clear. While some academics dispute the extent of obesity’s negative health consequences,⁷ medical associations have consistently published information linking obesity with an increased risk of heart, liver, and kidney disease, as well as cancer, depression, and premature death.⁸ In 2000, the CDC determined that the yearly cost of obesity in the United States was 117 billion dollars—61 billion in direct medical costs and 56 billion dollars for indirect costs.⁹

The United States, along with many other countries, has taken affirmative steps to stem and eventually reverse the growth of the obese and overweight population. However, while these countries share a common goal, they have elected to address the obesity epidemic with drastically different programs. For example, the vast majority of American anti-obesity programs merely disseminate nutritional or exercise information in order to educate its citizens on how to live a healthier life. In contrast, the United Kingdom has supplemented its educational programs by eliminating the advertisement of unhealthy food products to children, while Japan has enacted a complex regulatory scheme that literally measures the waistlines of its populace. In addition to demonstrating a lack of consensus concerning the best method to combat obesity, the

⁶ See U.S. Department of Health and Human Services, *Preventing Obesity and Chronic Diseases Through Good Nutrition and Physical Activity 1* (2005), available at <http://www.cdc.gov/nccdphp/publications/factsheets/Prevention/pdf/obesity.pdf>.

⁷ See e.g. Katerine Mayer, *An Unjust War: The Case Against the Government's War on Obesity*, 92 GEO. L.J. 999 (2004) (arguing that fitness, not weight, should be the relevant metric for health and that the focus on weight exaggerates the impact of obesity).

⁸ See e.g. National Heart Lung and Blood Institute Obesity Education Initiative, http://www.nhlbi.nih.gov/health/public/heart/obesity/lose_wt/risk.htm (last visited March 29, 2010).

⁹ See *Preventing Obesity and Chronic Diseases* (2005), *supra* n. 6.

underlying assumptions on which these programs rely indicate that there is no agreement on what is responsible for the epidemic.

Despite the lack of agreement, anti-obesity programs generally address obesity in one of two ways, they either (1) spread information that enables autonomous citizens to make healthier lifestyle choices, or (2) directly intervene in citizens' lives to make unhealthy lifestyle choices more difficult or more costly. To this date, the United States has embraced programs that inform the public, with only limited experimentation in the latter method. However, in addition to a variety of educational programs similar to those found in the United States, countries across the world have begun to implement programs premised on large-scale intervention into the lifestyle choices of their citizens.

This paper will examine the theoretical framework underlying each of these general categories of anti-obesity programs. The paper will begin with an outline of the relationship between obesity and the FDA, the federal agency most responsible for educating and counseling Americans about what to eat. Section III examines the free market ideology that has driven the education campaigns sponsored by the federal government, as well as the new wave of restaurant menu regulations which continues this tradition. Section IV will discuss the decidedly anti-free market programs adopted by some foreign nations, as well as the fledgling steps taken by American state and local governments to implement the approach. Finally, Section V will address whether the information-centric methods used by the United States should continue to be the dominant anti-obesity technique, and proposes that the FDA take a new role in order to facilitate state and local government experimentation with anti-obesity programs.

II. THE CURRENT ROLE OF THE FDA

The United States has provided some form of dietary guidance since the creation of the Department of Agriculture (“USDA”) in 1862.¹⁰ Initially, this function was conducted exclusively by the USDA. It was the first agency to formally investigate the relationship between nutrition and agriculture, and published the caloric, protein, carbohydrate, fat, and “mineral matters” of several common foods in the 1890’s.¹¹ In the 1950’s, the USDA created the “Basic Four” food groups, a predecessor to the more familiar Food Guide Pyramid developed in the early 1990’s.¹² Today, the USDA and FDA share responsibility for the federal government’s dietary guidelines¹³, while the FDA has been charged with implementing more specific directives to address the “obesity epidemic”¹⁴

A. The FDA and Dietary Guidance

The FDA’s first foray into nutrition labeling occurred in 1941, when the agency promulgated regulations for foods that purported a “special dietary use” on account of their vitamin or mineral content.¹⁵ Only five vitamins and four minerals were initially recognized as dietary supplements.¹⁶ Under the regulation, products claiming a special dietary use were required to bear a product label that listed the minimum daily value of

¹⁰ See Kelli K. Garcia, *The Fat Fight: The Risks And Consequences Of The Federal Government's Failing Public Health Campaign*, 112 PENN ST. L. REV. 529, 530 (2007) (citing Marion Nestle, *FOOD POLITICS* 33 (University of California Press 2003)).

¹¹ *Id.* at 558.

¹² *Id.*

¹³ See 21 U.S.C. 5341.

¹⁴ See Section II.B, *infra*.

¹⁵ 21 C.F.R. § 125 (1941).

¹⁶ *Id.* § 125.3 - .4.

the recognized supplement it contained, as well as a disclaimer stating that the need for any additional vitamin or mineral contained in the product had not been established.¹⁷ In 1973, the FDA expanded labeling requirements to include some foods intended for general consumption. The FDA promulgated a regulation interpreting Section 201(n) of the Food and Cosmetics Act to require a comprehensive nutrition label whenever a manufacturer added a nutrient to a food or made any representation regarding its nutrient content.¹⁸

Comprehensive nutrition labeling was not required until 1990, when Congress passed the Nutrition Labeling and Education Act of 1990 (the “NLEA”).¹⁹ However, these “comprehensive labels” do not include all nutrition information. The statute recognizes that consumers have limited time and inclination to read nutrition information, and that nutrition listing should be limited to the information necessary to assist consumers in choosing foods wisely.²⁰ In fact, “section 403(q)(2)(B) gives the agency authority to exclude any nutrient from the declaration requirement, despite its presumptive public health importance, when the agency finds that the information “is not necessary to assist consumers in maintaining healthy dietary practices”²¹ As the

¹⁷ See Michael Sachs, *Ephedra and the Failure of Dietary Supplement Regulation*, 54 CATH. U. L. REV. 661, 668 (Winter 2004) (citing 21 C.F.R. §§ 125.3(2), 125.4(2)).

¹⁸ 38 Fed. Reg. 2125 (Jan. 19, 1973).

¹⁹ Pub. L. No. 101-535, § 2, 104 Stat. 2353 (codified at 21 U.S.C. § 343(q)(1)).

²⁰ See Frederick H. Degnan, *The Food Label and the Right-to-Know*, 52 FOOD, DRUG L. J. 49, 54 (1997).

²¹ *Id.*

only information most consumers review before purchasing their food, these labels are intended to play an important role in facilitating healthy eating habits.²²

The FDA is now jointly responsible for the dietary guidelines historically promulgated by the USDA. Under the National Nutritional Monitoring and Related Research Act of 1990, the FDA and USDA are required to publish guidelines that reflect healthy eating habits.²³ In the past, these guidelines had been issued voluntarily by the USDA and the Department of Health and Human Services.²⁴ The familiar Food Guide Pyramid was released pursuant to this statute in 1992.²⁵ The current dietary guidelines, which include an individualized new pyramid called the “MyPyramid”, are significantly more complex than their original manifestation. In addition to recommended values of key nutrients, MyPyramid’s interactive website includes references to exercise and food safety.²⁶

B. The FDA’s Targeted Response to Obesity

In 2003, the Commissioner of the FDA established the Obesity Working Group (“OWG”). The OWG was charged with examining obesity issues, formulating recommendations, and proposing a plan of action.²⁷ The OWG invited members of the food industry, academics, and consumer group representatives for several public

²² *See id.*

²³ *See* 21 U.S.C. 5341.

²⁴ *See* Garcia, 112 PENN ST. L. REV. at 561.

²⁵ *Id.*

²⁶ *See* MyPyramid.gov, <http://www.MyPyramid.gov> (last visited Apr. 2, 2007).

²⁷ *See* Cynthia Newton, "The Role and Responsibility of the FDA in the Obesity Epidemic" Paper presented at the annual meeting of the MPSA Annual National Conference, Palmer House Hotel, Hilton, Chicago, IL (Apr 03, 2008), available at http://www.allacademic.com/meta/p268707_index.html.

meetings, which focused on the impact of calories consumed and other scientific topics, rather than the environmental factors or lifestyle choices that influence behavior.²⁸ The proposals generated by the OWG primarily involved emphasizing caloric information, encouraging comparative labeling statements, and increasing enforcement against misleading weight loss products.²⁹ In 2006, the FDA's Keystone Forum Report recommended that consumers should be provided with nutrition information when eating at restaurants or other "away-from-home" food establishments.³⁰

III. REDUCING OBESITY BY CORRECTING MARKET FAILURES

As discussed in Section II, the vast majority of federal obesity and dietary programs are intended to educate the public. For example, the information contained in MyPyramid outlines healthy lifestyle choices, including recommended levels of calories, fats, and carbohydrates, while nutrition labels provide consumers with the information necessary to select the foods that meet their dietary needs. These resources equip interested consumers to make healthy dietary choices on their own. In addition to basic nutrition information provided by the FDA, almost every agency even tangentially related to food or physical exercise has launched its own information campaign.³¹ Many

²⁸ *See id.*

²⁹ *See id.* For a detailed report of the OWG's proposals, see *Questions and Answers - The FDA's Obesity Working Group Report*, Food and Drug Administration (page last updated May 22, 2009), available at <http://www.fda.gov/Food/LabelingNutrition/ReportsResearch/UCM082094>.

³⁰ *See* Backgrounder - Keystone Forum on Away-From-Home Foods: Opportunities for Preventing Weight Gain and Obesity Report, Food and Drug Administration (June 2, 2006), available at <http://www.fda.gov/Food/LabelingNutrition/ReportsResearch/ucm082064.htm>.

³¹ The number of government sponsored educational programs related to eating habits or exercise is staggering. A small sample of government funded educational programs includes: Small Step, Healthier US, The President's Challenge, Fitness.gov, Physical

agencies devote significant resources to these “lifestyle” programs. In 2004, the Department of Education was scheduled to spend \$70 million on programs to encourage “lifetime fitness activities and healthy eating habits.”³² Politicians at every level of government seem to have addressed the issue in one way or another. On March 17, 2010, First Lady Michelle Obama visited the country’s fattest state (Mississippi) to discuss obesity’s impact on everything from the nation’s healthcare costs to school-children’s classroom learning.³³

Although these education campaigns may emphasize different health-related information, they are all premised on the belief that educating obese and overweight Americans will change their behavior. In other words, they all presume a particular kind of market failure³⁴— that the current rate of obesity is not the product of reasoned lifestyle choices made by informed actors, but the distorted result of a population without access to the information necessary to make the right choices.³⁵ “As public health law

Activity for Everyone, Weight Control Information Network, MyPyramid, MyPyramid Tracker, BAM: Body and Mind, Powerful Bones and Powerful Girls, VERB: It's what you Do, and Small Steps for Kids. See Garcia, 112 PENN ST. L. REV. at 536, *supra* n. 10.

³² See *id.* at 534.

³³ See Press Release, Office of the First Lady, *Remarks by the First Lady at Newsweek Q&A Event* (March 17, 2010), available at <http://www.whitehouse.gov/the-press-office/remarks-first-lady-newsweek-qa-event>.

³⁴ At a basic economic level, a market failure exists when a market inefficiently allocates goods or services. See Paul Krugman and Robin Wells, *ECONOMICS*, Worth Publishers, New York, (2006). In other words, market failures exist when actors make choices that do not maximize their self-interest. For example, when a seller is willing to sell his widget for five dollars and a buyer is willing to buy that widget for ten dollars, a transaction for a price in between five and ten dollars should always occur. A market is considered to have failed when, despite these conditions, no transaction takes place. Because both the seller and the buyer would have been better off had the transaction occurred, some factor must have intervened and caused the market to fail.

³⁵ See *e.g.* Physical Activity Topics, Center for Disease Control, <http://www.cdc.gov/physicalactivity> (last visited March 28, 2010) (promoting fitness

scholar, Lawrence O. Gostin, notes, by supporting these campaigns, the government is thought to promote individual autonomy and provide the basic support needed to enable people to lead healthy lives.”³⁶ The belief inherent in each educational program is that obesity may be combated simply by broadcasting the relevant information and waiting for individuals to change their behavior on their own.

Educational programs cannot succeed if the dietary “market” is not failing in this specific way. For example, climbing Mount Everest is extremely dangerous and has caused hundreds of deaths. However, the experienced climbers who brave the mountain are all prepared for their trek and well-aware of the risks and past casualties. In this situation, an education campaign on the dangers of climbing to the earth’s highest peak is unlikely to dissuade these skilled and knowledgeable climbers. This is because the “market” for climbing Mount Everest is not failing; generally, people who climb the mountain are making informed decisions based on the relevant information. Climbers engage in this risky activity because other interests outweigh the risks, not because they are not fully aware of the danger. In fact, the danger of climbing the mountain may be a *motivating* factor in some peoples’ interest. Similarly, if obese Americans choose to eat unhealthy foods because short-term monetary, temporal, or taste benefits outweigh the potential long-term health costs, spreading duplicative information should not change their behavior. If obese Americans forgo regular exercise because of work and family commitments, merely reinforcing that exercise is beneficial will not be effective.

program as “[d]esigned for kids 9–13 years old, BAM! Body and Mind gives them the information they need to make healthy lifestyle choices.”).

³⁶ Garcia, 112 PENN ST. L. REV. at 537, *supra* n. 10.

Nutrition labels on packaged foods and dietary pyramids are likely the most well-known programs that spread dietary information. However, many state and local governments have chosen to supplement this information with more stringent labeling requirements for food sold by chain restaurants in their jurisdictions. Like the myriad of federal information campaigns, these regulations hope to alter consumer behavior by providing information not available, and ostensibly not fully considered, by restaurant consumers. Just as FDA mandated nutrition labels equip consumers to make healthy choices in the supermarket, restaurant menu labeling laws are intended to facilitate the same informed decision-making by customers waiting in line at McDonalds.

A. Menu Labeling: Municipal-level Regulation

Several municipal governments have recently required restaurants with a minimum number of locations to post the calorie information on menus and menu boards.³⁷ New York City was the first American governmental body to enact menu labeling laws.³⁸ While New York City's first menu labeling regulation was struck down for only including restaurants that voluntarily disclosed nutritional information,³⁹ the second iteration withstood constitutional attack and was upheld by the Second Circuit Court of Appeals in 2009.⁴⁰ The new regulation, which applies to all food service establishments with fifteen or more locations, requires the total number of calories of each dish to be placed on the menu or menu board. In order to ensure the program's

³⁷ Wendy N. Davis, *Biting Back at Obesity: The Big Apple's Calorie-Counting Law Is Staying on the Menu*, 95-AUG A.B.A. J. 17, 18 (2009).

³⁸ Anthony J. Marks, *Menu Labeling Laws: A Survey*, 29 FRANCHISE L.J. 90, 91 (Fall 2009).

³⁹ *Id.*

⁴⁰ *See N.Y. State Rest. Ass'n v. N.Y. City Bd. of Health*, 556 F.3d 114, 118 (2nd Cir. 2009).

efficacy, the “[f]ont and format used for calorie information must be at least as prominent in size as is used for the name or price of the menu item.”⁴¹

Westchester County, New York adopted a practically identical labeling scheme in 2008.⁴² King County, Washington implemented a more comprehensive regulation on December 31, 2008.⁴³ In addition to disclosing the calorie information of menu items, restaurants with fifteen or more locations and one million dollars in annual sales must list the saturated fat, sodium, and carbohydrate information for foods and beverages on their menus.⁴⁴ Similarly, Multnomah County, Oregon requires restaurants with fifteen or more locations to affirmatively post calorie information on menus, but must disclose saturated fat, trans fat, carbohydrate, and sodium information only upon request.⁴⁵

B. Menu Labeling: State-level Regulation

On September 30, 2008, Governor Arnold Schwarzenegger amended the California Health and Safety Code by signing Senate Bill 1420 into law.⁴⁶ California now requires food facilities that are part of a chain of twenty or more locations to provide nutrition information to its customers.⁴⁷ The requirement will be implemented in two

⁴¹ Marks, 29 FRANCHISE L.J. at 91, *supra* n. 38 (quoting Ctr. for Sci. in the Pub. Interest, Nutrition Labeling in Chain Restaurants: State and Local Bills/Regulations—2007-2008, www.cspinet.org/nutritionpolicy/MenuLabelingBills2007-2008.pdf).

⁴² Laws of County of Westchester, New York, § 708.01 (Local Law No. 13) (2008).

⁴³ Marks, 29 FRANCHISE L.J. at 92, *supra* n. 38.

⁴⁴ *Id.*

⁴⁵ Multnomah County Health Dep't, Policy Order 08-114. For more information, visit *Chronic Disease Prevention Program*, Multnomah County Health Department, <http://mchealth.org/chronic/labeling.shtml> (last visited March 27, 2010).

⁴⁶ Marks, 29 FRANCHISE L.J. at 91, *supra* n. 38.

⁴⁷ As defined by the regulation, “[f]ood facility’ means a food facility in the state that operates under common ownership or control with at least 19 other food facilities with the same name in the state that offer for sale substantially the same menu items, or

stages. Beginning on July 1, 2009, covered food facilities were required to “provide a brochure placed at the point of sale that includes[,]’ at a minimum, information about calories, sodium, saturated fat, and carbohydrates for each standard menu item.”⁴⁸ By July 1, 2011, covered food facilities must list calorie information on menus, menu boards, and food display tags next to the standard item.⁴⁹ California’s menu labeling requirement explicitly preempts local law on the subject.⁵⁰

Several states have passed but not yet implemented their own menu labeling laws. Both Maine and Oregon passed their own regulations in June 2009.⁵¹ Additionally, menu labeling laws are currently being considered Delaware, Hawaii, Illinois, Indiana, Kentucky, Massachusetts, Missouri, New York, Oklahoma, Pennsylvania, Rhode Island, Tennessee, Texas, Vermont, and West Virginia.⁵² However, not all state governments support additional labeling requirements. Connecticut’s recently passed menu labeling bill was vetoed by the Governor, while both Utah and Georgia have affirmatively prohibited local governments from regulating the posting of nutrition information on menus and menu boards.⁵³

operates as a franchised outlet of a parent company with at least 19 other franchised outlets with the same name in the state that offer for sale substantially the same menu items . . .” CAL. HEALTH & SAFETY CODE § 114094(a) (West 2009). Farmers markets, grocery stores, vending machines and some other establishments are excluded from the requirement. *See id.*

⁴⁸ Marks, 29 FRANCHISE L.J. at 91, *supra* n. 38.

⁴⁹ *Id.*

⁵⁰ *Id.*

⁵¹ *Id.* at 93.

⁵² *Id.*

⁵³ *Id.*

C. Menu Labeling: Federal-level Regulation

Congress' recent passage of the Democratic-sponsored health care legislation may moot the recent flurry of state-level enactments. In addition to its core provisions dealing with health insurance, the bill President Obama signed on March 23, 2010 included a menu labeling requirement modeled after the existing policies in New York City, California, and Oregon.⁵⁴ Once implemented, the federal law will require chains with twenty or more locations to “disclose calorie counts on their food items and supply information on how many calories a healthy person should eat in a day.”⁵⁵ Surprisingly, after fighting similar measures in courthouses around the country,⁵⁶ the National Restaurant Association supported the bill.⁵⁷ However, as a spokeswoman from the National Restaurant Association essentially admitted, the organization's support of the federal measure was likely spurred by the possibility of a conflicting patchwork of state regulations rather than a sudden change of heart.⁵⁸

It should be unsurprising that, after investing decades and hundreds of millions (if not billions) of dollars in educational campaigns, the federal government has continued to battle obesity with information. While it is unlikely many Americans are virulently opposed to seeing calorie counts on their menus, the passage of this provision is

⁵⁴ Stephanie Rosenbloom, *Calorie Data to be Posted at Most Chains*, New York Times at B1 (March 23, 2010), available at <http://www.nytimes.com/2010/03/24/business/24menu.html>.

⁵⁵ *Id.*

⁵⁶ See e.g. *N.Y. State Rest. Ass'n*, 556 F.3d 114, *supra* n. 40.

⁵⁷ Rosenbloom, *supra* n. 54.

⁵⁸ *Id.* (According to the National Restaurant Association's Sue Hensley, “[t]he association and the industry were supportive because consumers will see the same types of information in more than 200,000 restaurant locations across the country.”).

worrisome for another reason. Overshadowed by the more controversial aspects of the health care bill, the menu labeling provision received little public discussion on the floors of the House and Senate.⁵⁹ Although individual politicians have floated vague proposals that do more than offer information,⁶⁰ Congress has not appeared to seriously consider whether merely informing its citizens is sufficient to control the escalating rate of American obesity.

IV. REDUCING OBESITY BY CREATING MARKET DISTORTIONS

Although an observer of the federal government may not realize it, not all anti-obesity programs are educational. Some programs attempt to reduce obesity by interfering with the factors that contribute to unhealthy lifestyle choices. Unlike educational programs, direct intervention programs do not rely on the assumption that obesity rates are high because people do not have access to the relevant information.⁶¹ As the American obesity epidemic continues and worsens, some states have adopted, and the federal government has flirted, with direct government intervention to influence the public's lifestyle choices.

Direct government intervention operates under a theoretical framework very different than the market failure theory discussed, *supra* Section III. Education programs are premised on the assumption that people would make healthier lifestyle choices when

⁵⁹ *Id.*

⁶⁰ See e.g. David Saltonstall, *President Obama says 'Sin Tax' on Sodas is Food For Thought, Despite Gov. Paterson's Failed Proposal*, N.Y. Daily News (September 9, 2009), available at http://www.nydailynews.com/news/politics/2009/09/08/2009-09-08_president_obama_says_sin_tax_on_sodas_is_food_for_thought.html.

⁶¹ Although these programs do not rely on this assumption, they can still be effective even if the assumption is true. Direct intervention programs can operate effectively regardless of whether ignorance contributes to obesity levels as long as there are other causal factors that can be suppressed or eliminated.

exposed to the right information. In stark contrast, the goal of direct government intervention is to intentionally distort the market—essentially to create a market failure—in a way that induces individuals to reach the government-preferred outcome. These programs are paternalistic. In essence, the government has observed the choices made by individuals in the free market, disagreed with the outcomes which result, and intervened in order to push individuals toward “better” choices. Harkening back to the Mount Everest example in Section III, *supra*, a government interested in reducing deaths on Mount Everest could prohibit all advertising relating to the climb, tax all climbers who make the trip, or simply ban travel to Nepal altogether. Each would likely be far more effective at reducing deaths than an elaborate and potentially costly education campaign, but would entail significant government intervention into each climber’s decision-making.

For obvious reasons, government programs that directly distort the market in order to influence individual choices are much more controversial than educational programs that merely provide information to autonomous citizens. Due to a political climate is particularly resistant to some types of government intervention in the “free market,” the most invasive programs are located outside of the United States. This Section will address three ways that governments have attempted to directly intervene in response to the obesity epidemic: (A) eliminating advertising of unhealthy foods; (B) creating economic disincentives for taking part in unhealthy behavior; and (C) eliminating access to unhealthy foods.

A. Controlling Advertising of Unhealthy Foods

It is well-established that advertising has a profound effect on what consumers choose to purchase.⁶² Every year 400 billion dollars is spent on advertising worldwide, 200 billion in the United States alone.⁶³ Unfortunately for American waistlines, the food advertised on television is decidedly unhealthy. While all Americans frequently see candy and junk food commercials, children are targeted by these advertisements at a disproportionately high rate. According to a Kaiser Family Foundation study released in 2007, more than forty percent of all television advertisements viewed by children are for candy, snacks, or fast food.⁶⁴ Children eight to twelve view an average of fifty hours of advertisements for unhealthy foods each year.⁶⁵ Vicky Rideout, quoted on behalf of the Kaiser Family Foundation when the study was released, stated that the study demonstrated that “[t]he vast majority of the foods that kids see advertised on television today are for products that nutritionists would tell us they need to be eating less of, not more of, if we're going to get a handle on childhood obesity.”⁶⁶ Non-television

⁶² See e.g. Daniel A. Akerberg, *Advertising, Learning, and Consumer Choice in Experience Good Markets: A Structural Empirical Examination*, INTERNATIONAL ECONOMIC REVIEW, Vol. 44, No. 3, August 2003, pp. 1007-1040.

⁶³ See Note, *The Elephant in the Room: Evolution, Behavioralism, and Counter Advertising in the Coming War Against Obesity*, 116 HARV. L. REV. 1161, 1165 (2003).

⁶⁴ See Bootie Cosgrove-Mather, “Kids Get Diet Of Junk Food Commercials,” CBS News: Health (March 28, 2007), available at <http://www.cbsnews.com/stories/2007/03/28/health/main2620036.shtml>.

⁶⁵ See *id.*

⁶⁶ *Id.*

advertisements may be even more skewed, as children are estimated to see approximately 40,000 advertisements per year, 72% of which are for fast food, candy, or cereal.⁶⁷

Recent research has attempted to establish a causal link between food advertisements and the high rates of obesity in the United States. In 2008, a group of economists affiliated with the National Bureau of Economic Research released the findings of a longitudinal study that analyzed the relationship between a children's exposure to fast food advertising and their weight.⁶⁸ According to the study, the data showed a "strong positive effect of exposure to fast-food restaurant advertising on the probability that children and adolescents are overweight."⁶⁹ Although the authors noted that citing their study as a partial explanation for obesity was "premature", they went on to discuss how an outright ban on fast-food advertising would affect childhood obesity rates.⁷⁰ "A complete advertising ban on television would reduce the number of overweight children ages 3-11 in a fixed population by 18 percent. [citation omitted]. The impact of this policy for adolescents ages 12-18 amounts to a smaller decline of 14 percent."⁷¹ Other studies have reached similar conclusions.⁷²

⁶⁷ See Michelle M. Mello et al., *Obesity: The New Frontier of Public Health Law*, 354 NEW ENG. J. MED. 2601, 2606-07 (2006).

⁶⁸ See Chou, Rashad, & Grossman, *Fast-Food Restaurant Advertising on Television and its Influence on Childhood Obesity*, 51 J.L. & ECON. 599 (2008).

⁶⁹ *Id.* at 616.

⁷⁰ *Id.*

⁷¹ *Id.* The authors note that these figures could potentially both under and over represent the impact of a fast-food advertising ban. The figures may under represent a ban's impact because the study accounted for only "local or spot television advertising and ignore advertising associated with network, syndicated, and cable television." On the other hand, the figures may over represent the prospective decline in obesity because the study ignored the impact of non-television advertising. See *id.*

Several countries have acted to control the information disseminated through advertisements. By controlling what information reaches the public, advertising bans hope to artificially reduce the demand for the unhealthy products thought to be at least partly responsible for historic obesity rates. A few countries have opted for an outright ban on all advertising targeting children. For example, Sweden prohibits all advertisements, regardless of medium, designed to attract the attention of children under twelve years old.⁷³ Norway prohibits all television advertising in connection with children's programming or when directed at children.⁷⁴ However, this Section will focus on the advertising ban in the United Kingdom, which is specifically tailored to limit the exposure of children to advertisements of unhealthy food products.

1. Advertising Ban in the United Kingdom

The British Office of Communications (“Ofcom”), the United Kingdom’s regulatory agency with authority over television and radio broadcasts, instituted a limited ban on certain food advertisements in 2007.⁷⁵ The ban prohibits certain foods from being advertised “in or adjacent to children's programmes or programmes commissioned for, principally directed at or likely to appeal particularly to audiences below the age of 16.”⁷⁶

⁷² See Susan Linn & Courtney Novosat, *Obesity Rates Mirror Rise in Marketing; History of Television Deregulation Complicit*, 615 ANNALS 133, 134-35 (2008) (“the heavy marketing of high-calorie and low-nutrient foods and fast food outlets represents a probable increased risk for childhood obesity”).

⁷³ See Effects of Advertising Restrictions in Other Jurisdictions, Obesity Policy Coalition (April 2007), available at www.opc.org.au/download.asp?RelatedLinkID=86.

⁷⁴ See *id.*

⁷⁵ Press Release, Office of Commc'ns, Ofcom Publishes Final Statement on the Television Advertising of Food and Drink Products to Children (Feb. 22, 2007), available at http://www.ofcom.org.uk/media/news/2007/02/nr_20070222.

⁷⁶ *Id.*

Even advertisements not slotted in or adjacent to children’s programming must avoid broadcasting unhealthy messages. “Advertisements must avoid anything likely to encourage poor nutritional habits or an unhealthy lifestyle in children.”⁷⁷ Ofcom’s final report provides several examples of the kind of commercials that would be prohibited. Advertisements that condoned attitudes consistent with poor diets, like a dislike of vegetables, may not be aired.⁷⁸ While an advertisement featuring a child eating a candy bar passes muster, the ban “would, however, preclude someone being shown eating whole boxes of chocolates in one sitting.”⁷⁹

Although Ofcom promulgated the policy’s framework, it left the Food Standards Agency (“FSA”) to determine exactly which foods would be affected by the ban. The FSA developed a food categorization model “which recognises the contribution made by beneficial nutrients that are important in a child’s diet (protein, fibre, fruit and vegetables, and nuts) and penalises foods with ingredients that children should eat less of (saturated fats, salt and sugars).”⁸⁰ The FSA model produces two food groups: (1) foods high in fat, salt, and sugar, which may not be advertised in or adjacent to children’s programming; and (2) all other foods, which may be aired in any time slot. All food advertisements must not promote unhealthy eating habits regardless of their FSA categorization.

⁷⁷ *Id.*

⁷⁸ See David Darwin, *Advertising Obesity: Can the U.S. Follow The Lead of the UK in Limiting Television Marketing of Unhealthy Foods to Children?*, 42 VAND. J. TRANSNAT’L L. 317, 327(2009).

⁷⁹ *See id.*

⁸⁰ *Id.* at 327 (quoting Food Standards Agency, Nutrient Profiling, <http://www.food.gov.uk/healthiereating/advertisingtochildren/nutlab/> (last visited March 21, 2010)).

2. Proposed American Legislation

Organized groups of American citizens have petitioned for greater government control over “junk food” advertisements for decades. In 1970, several public interest groups petitioned the Federal Trade Commission (“FTC”) to promulgate rules to address “a generation of fat children with decaying teeth who are intellectually passive, prone to violence, and profoundly materialistic.”⁸¹ FTC staff responded by recommending a highly restrictive set of regulations that would have severely limited advertisements targeted at children. The proposed rules would have banned all commercials targeting children under eight and all commercials for “high sugar” products targeting children eight to twelve.⁸² “High sugar” advertisers targeting consumers above the age of twelve would be forced to create “counter ads” that promoted healthy foods and oral hygiene.⁸³ Despite initial support from the FTC administrators, the proposals engendered significant political backlash and were never implemented.⁸⁴

Despite the negative political reaction inspired by the proposed bans, Congress arguably gave the Federal Communications Commission (“FCC”) the opportunity to craft significant advertising regulations in the Children’s Television Act of 1990 (“CTA”). While the CTA did not ban any particular content in advertisements, it limited advertising during children’s programming to ten and a half minutes per hour during the weekend and twelve minutes per hour during the week.⁸⁵ The CTA left the implementation and

⁸¹ Susan Bartlett Foote & Robert H. Mnookin, *The “Kid Vid” Crusade*, 61 PUB. INT. 90, 92 (1980).

⁸² *See The Elephant in the Room*, 116 HARV. L. REV. at 1172, *supra* n. 63.

⁸³ *See id.*

⁸⁴ For an extended discussion of the reaction to these proposed rules, see *id.*

⁸⁵ *See Darwin*, 42 VAND. J. TRANSNAT’L L. at 323, *supra* n. 78.

oversight of these requirements to the FCC, and permitted the FCC to modify the advertising time limits “in accordance with the public interest.”⁸⁶ Despite some public pressure, the FCC has never modified these time limits.⁸⁷

Regulating the advertisement of unhealthy foods to children again became a prominent political topic in the mid 2000’s. In 2004, the Institute of Medicine asked the food and beverage industries to voluntarily cease advertising unhealthy products to children and recommended establishing nutrition standards that would differentiate healthy foods from unhealthy foods.⁸⁸ In 2006, the FCC commissioned a Task Force on Media and Childhood Obesity: Today and Tomorrow (“Task Force”) constituted of sitting Senators, FCC personnel, television networks, children’s advocacy groups and representatives from the food and beverage industries.⁸⁹ However, unlike Ofcom’s directive, the Task Force was created to explore how a reduction in unhealthy advertisements could be accomplished through industry self-regulation, rather than strict government policy.⁹⁰ Although some American politicians have called for a targeted advertising ban similar to the United Kingdom’s,⁹¹ no additional advertising restrictions have been enacted. Whether a victory for autonomous citizens or a defeat in the “battle” against obesity, the United States has not successfully limited advertisements that fuel the consumption of unhealthy food products.

⁸⁶ *Id.*

⁸⁷ *See id* at 324.

⁸⁸ *See id.*

⁸⁹ *See id.*

⁹⁰ *See id.*

⁹¹ Congressman Ed Markey, Chairman of the House Subcommittee on Telecommunications and the Internet, has been one of the most vocal proponents of regulating unhealthy food advertisements targeted at children. *See id.*

B. Establishing Economic Incentives for Healthy Behavior

While restrictions on advertising attempt to surreptitiously influence consumer choices by withholding information otherwise available, programs that rely on economic incentives are a far blunter tool. In most cases, consumers are painfully aware that their behavior is being influenced by government fiat. For example, a government interested in lower obesity rates could simply require consumers pay an addition 50% “junk food tax” on all unhealthy food purchases. In addition to raising revenue that could be used to fund other anti-obesity programs, the tax would create a market distortion by artificially lowering the demand for unhealthy food choices.⁹² Several states have employed this kind of tax on cigarettes for years,⁹³ while seventeen states and two major cities have some sort of “junk food tax” on the books.⁹⁴

⁹² For example, a team of researchers published in the Archives of International Medicine estimated that, based on an analysis of the diets of a group of over 5,000 young adults and contemporaneous food prices, an eighteen percent tax on pizza and soda would reduce calorie intake by an average of fifty six per person, resulting in a weight loss of approximately five pounds. See Reuters, *Tax Soda, Pizza to Cut Obesity, Researchers Say*, MSNBC.COM (March 8, 2010), available at <http://www.msnbc.msn.com/id/35770181/>.

⁹³ For a summary of California’s cigarette taxes, see California State Board of Equalization, *Cigarette and Tobacco Products Taxes, Excise Tax Facts, Pub. 93* (July 2009), available at <http://www.boe.ca.gov/pdf/pub93.pdf>. Despite the success of “sin taxes” in many state legislatures, there is still significant debate over their efficacy. See e.g. Echu Liue, Patrick A. Rivers, and Paul D. Sarvela, *Does Increasing Cigarette Excise Tax Improve People's Health? The Cases Of Heart Attacks And Stroke*, 34 No. 3 J. HEALTH CARE FIN. (ASPEN) 91 (2008) (finding no clear empirical evidence that raising cigarette excise taxes would lower morbidity rates associated with heart attack and stroke).

⁹⁴ Jeff Strnad, *Conceptualizing The “Fat Tax”: The Role of Food Taxes in Developed Economies*, 78 S. CAL. L. REV. 1221, 1226 (2005) (“Many of the existing junk food taxes pre-dated the obesity epidemic and were enacted when there was much less concern about the health impact of such foods. . . . It appears that most of these provisions were viewed simply as good sources of tax revenue.”).

However, economic incentives may be more complex and comprehensive than a simple sales tax. While a junk food tax may dissuade consumers from purchasing the taxed product, comprehensive programs are designed to induce citizens to take positive steps, such as exercising, in order to avoid economic sanction. This Section will explore how Japan's comprehensive health screening system arguably promotes healthy eating and exercise habits through the threat of monetary sanctions, as well as the fledgling steps taken in the United States to duplicate this model.

1. Japan's "Metabo" Legislation

Japan spends approximately twenty trillion yen on social welfare and medical services annually, a number that rises about one trillion yen each year.⁹⁵ One-third of these health care costs are expended to address lifestyle-related diseases, including metabolic syndrome.⁹⁶ Controlling the financial cost of an overweight population is particularly critical in Japan, where a quickly expanding elderly population already strains the budgets of social programs. Approximately ninety percent of the annual one trillion yen increase may be attributed to the elderly.⁹⁷

In early 2008, Japan implemented an aggressive anti-obesity program intended to control expanding health-related expenditures. Instead of merely controlling access to

⁹⁵ Christin Lawler, *An International Perspective on Battling the Bulge: Japan's Anti-Obesity Legislation And its Potential Impact on Waistlines Around the World*, 11 SAN DIEGO INT'L L.J. 287, 290 (2009). Japan has provided universal healthcare to its citizens for decades. *See id.*

⁹⁶ *See id.* Metabolic syndrome is the name for a cluster of conditions, including high blood pressure, high blood sugar levels, excess body fat, and abnormal cholesterol levels. *See* Metabolic syndrome. National Heart, Lung, and Blood Institute, http://www.nhlbi.nih.gov/health/dci/Diseases/ms/ms_all.html (last visited March 23, 2010).

⁹⁷ Lawler, 11 SAN DIEGO INT'L L.J. at 290, *supra* n. 95.

information, Japan's "Metabo" legislation took the extraordinary step of directly policing its citizens' waistlines. Each of Japan's three primary health insurance plans⁹⁸ is charged with implementing the program and will ultimately be responsible for the monetary consequences of non-compliance. The Ministry of Health, Labor and Welfare anticipates reducing the overweight and obese population of Japan by ten percent by 2012, and by twenty-five percent in 2015.⁹⁹

The program has two primary steps.¹⁰⁰ First, fifty-six million adults between the ages of eighteen and seventy-four will receive annual screenings for metabolic syndrome.¹⁰¹ Men with measured waistlines above eighty-five centimeters and women with waistlines above ninety centimeters will receive individualized support by specially trained nurses.¹⁰² In addition to designing a customized diet and exercise plan, these nurses are obligated to contact their patients every three to six months to monitor their progress and refer particularly severe cases to hospitals for more intensive treatment.¹⁰³

⁹⁸ Each plan is responsible for a unique segment of the population. The Employee Health Insurance program provides insurance for working adults and their dependents based on the size of their employer, while the National Health Insurance program is responsible for those employed by small business and the unemployed. The Health and Medical Services System provides care for citizens age seventy and above. *See id.* at 292. For a comprehensive discussion of Japan's health care system, see Naohiro Yashiro et al., *EVALUATING JAPAN'S HEALTH CARE REFORM OF THE 1990S AND ITS EFFORTS TO COPE WITH POPULATION AGING*, IN *HEALTH CARE ISSUES IN THE UNITED STATES AND JAPAN* (David A. Wise & Naohiro Yashiro eds., 2006).

⁹⁹ Lawler, 11 *SAN DIEGO INT'L L.J.* at 291, *supra* n. 95.

¹⁰⁰ *Id.* (citing Norimitsu Onishi, *Japan, Seeking Trim Waists, Measures Millions*, *N.Y. Times*, June 13, 2008, at A1, available at <http://www.nytimes.com/2008/06/13/world/asia/13fat.html>).

¹⁰¹ *Id.* at 293.

¹⁰² *Id.*

¹⁰³ *Id.*

The program's second component requires an audit of the results of this screening process to be conducted in 2012.¹⁰⁴ Instead of directly fining citizens unable to trim a sufficient number of centimeters off their waistline, the government allocates the burgeoning cost of geriatric care based on the compliance and success rate of each health insurance plan's Metabo Program.¹⁰⁵ For example, plans that do not meet the threshold sixty-five percent participation rate will be fined, while plans that do not effectuate a twenty-five percent reduction in the number of its insured suffering from metabolic syndrome will face a ten percent increase in its required contribution to the pooled healthcare fund for the elderly.¹⁰⁶

2. Obesity Penalties in State Insurance Programs

Escalating insurance and medical costs have led some states to adopt insurance schemes that require obese Americans to improve their health or pay a surcharge. Although the small steps taken by these states pale in comparison to Japan's intrusive national program, they go far beyond the traditional education programs implemented by the federal government.

Alabama will be the first state to charge overweight state employees an additional twenty-five dollar surcharge for failing to improve their health.¹⁰⁷ In 2008, the State

¹⁰⁴ *Id.* at 294.

¹⁰⁵ *Id.*

¹⁰⁶ *Id.*

¹⁰⁷ In defending the program from attacks of state paternalism, the CEO of Alabama's Insurance Board has attempted to describe the system as a premium discount for healthy employees and employees improving their health, rather than a surcharge for the obese. *See Alabama Fights Fat, Media with New Screening Program*, Employee Benefit Advisor (August 27, 2008), available at <http://www.alseib.org/PDF/SEHIP/EmployeeBenefitsNews.pdf>. However, despite his

Employees' Insurance Board passed a plan that would apply the surcharge to all employees unless they participate in a free health screening. If the screening discovers a serious problem with blood pressure, cholesterol, glucose, or obesity, the state employee will be given one year of free access to a doctor or wellness program to facilitate a healthier lifestyle.¹⁰⁸ Employees that show progress at the conclusion of that year will not be charged the additional surcharge. The first surcharge for employees that do not improve their health will be assessed in January of 2011.¹⁰⁹

However, despite the program's similarity to Japan's Metabo legislation, state officials are extremely careful to promote the plan's educational component, rather than its economic penalty. According to William Ashmore, the CEO of Alabama's Insurance Board, the plan is not a fax tax. Instead, "[w]hat we want to do is, number one, make the employee aware of any risk factors they may have . . . and then knock down the barriers so that they can go get the services they need."¹¹⁰ Rather than punishing people for their fat, Mr. Ashmore contends that, "[t]he state has been screening workers for 15 years and finds that 10% to 15% of at-risk employees are completely unaware of their health threat. The goal, he says, is to make sure everyone gets screened."¹¹¹ North Carolina is currently

efforts, the vast majority of news reports and media coverage have described the twenty-five dollar payment as a surcharge or tax.

¹⁰⁸ *Id.*

¹⁰⁹ *Id.*

¹¹⁰ Matt Sloane, *Alabama to Link Premium Costs to Workers' Health*, CNN.COM: Health (December 9, 2008) available at <http://www.cnn.com/2008/HEALTH/diet.fitness/09/19/alabama.obesity.insurance/index.html>.

¹¹¹ *See Alabama Fights Fat*, *supra* n. 107.

contemplating a similar program, which would provide a monetary incentive to overweight state workers beginning in 2011.¹¹²

C. Removing Unhealthy Food Choices

At the time of writing, no government appears to have seriously considered a broad prohibition of high-calorie or generally unhealthy foods. However, particularly progressive city governments, such as New York, San Francisco, and Boston, have successfully restricted the use of trans fat, a hydrogenated oil linked to high rates of “bad” cholesterol and heart disease, in foods sold by restaurants within their jurisdiction. In the last five years, each of these cities first voluntarily asked restaurants to cease using trans fats, and then eventually banned its use altogether.¹¹³ In 2009, California became the first state to completely ban the use of trans fats in food facilities.¹¹⁴ While the success of the “trans fat movement” has indicated that some political bodies are open to proscribing the worst ingredients in restaurant meals, there is no indication that maximum fat or calorie content will be instituted anytime soon.

However, there is at least one exception to the American public’s general reticence to restrict food options on the basis of health. Many state and municipal bodies have acted to remove unhealthy options from elementary and secondary schools. For

¹¹² See Mark Johnson, *N.C. to Penalize Obese Workers, Those Who Smoke*, The Charlotte Observer (October 7, 2009), available at <http://www.charlotteobserver.com/2009/10/07/988655/nc-to-penalize-obese-workers-those.html>.

¹¹³ See generally *Trans Fat News*, BanTransFats.com Inc., <http://www.bantransfats.com/transfatnews.html> (last visited March 28, 2010).

¹¹⁴ See Cal. Health & Safety Code § 114377(b)(1) (2009). A food facility is defined as “an operation that stores, prepares, packages, serves, vends, or otherwise provides food for human consumption at the retail level” *Id.* at § 113789(a). The ban will not affect the preparation of “deep frying of yeast dough or cake batter” until January 1, 2011. See *id.* at § 114377 (b)(2).

example, California strictly regulates the snacks available to children on public school property. In 2005, California passed Senate Bill 12, which set standards for foods sold in public K-12 schools, and Senate Bill 965, which set standards for beverages sold in the same facilities.¹¹⁵ West Virginia does not permit soda to be sold in schools during breakfast or lunch periods.¹¹⁶ At least twenty-one other states have considered legislation to restrict snacks or beverages available through vending machines.¹¹⁷

The State's paternalism in this context is likely tolerated, and perhaps broadly supported, both because it occurs on school grounds, where the government enjoys broad authority under the doctrine of *parens patriae*,¹¹⁸ and because the restrictions merely limit the food choices of children, who are not yet viewed as completely autonomous decision-makers. These factors are likely also at least partly responsible for why Congress has only seriously discussed addressing unhealthy advertising aimed at children.¹¹⁹ In contrast, State action that restricts the choices of adults has not been so openly received.

¹¹⁵ See Cal.Educ.Code § 49430-49431.7. While non-fried fruits/vegetables, nuts, nut butters, seeds, eggs, and string cheese are always permitted, other snacks offered for sale in elementary schools must meet the following standards: (1) no more than thirty-five percent of calories from fat, (2) no more than ten percent of calories from saturated fat, (3) no more than thirty-five percent of total weight from sugar, and (4) no more than 175 calories per food item. See *id.* at § 49431.1. Snacks offered for sale in middle or high schools must meet the same requirements, except that snacks may contain up to 250 calories per food item. See *id.* at § 49431.2.

¹¹⁶ W. Va. Code, § 18-2-6a (2009).

¹¹⁷ See *Garcia*, 112 PENN ST. L. REV. at 570, *supra* n. 10.

¹¹⁸ The traditional *parens patriae* (i.e. “parent of his or her country”) authority of the state permits compulsory education laws and a variety of other infringements on the autonomy of children. See *e.g. Prince v. Massachusetts*, 321 U.S. 158 (1944).

¹¹⁹ See Section IV.A.2, *supra*.

In July of 2008, the Los Angeles City Council unanimously passed an ordinance establishing a moratorium on all new fast-food restaurants in selected areas of Los Angeles.¹²⁰ In the areas of the city affected by the ordinance, 45% of the restaurants could be categorized as fast-food, compared to only 16% on the west side of the city.¹²¹ Clearly aware of potential attacks on the ground of government paternalism, city officials were careful to frame the ordinance as expanding alternatives, rather than prohibiting unhealthy food choices: “[t]his ordinance is in no way attempting to tell people what to eat but rather responding to the need to attract sit-down restaurants, full service grocery stores, and healthy food alternatives. Ultimately, this ordinance is about providing choices--something that is currently lacking in our community.”¹²² Despite city officials’ careful wording, the City Ordinance received heated negative publicity in the national press.¹²³

Thus, while advocates of removing unhealthy foods have had some success at the state and local level, their efforts have been limited to liberal communities or circumscribed areas of heightened state authority. Even where unhealthy foods are

¹²⁰ Los Angeles City Council Ordinance 180103, available at http://clkrep.lacity.org/onlinedocs/2007/07-1658_ord_180103.pdf (last visiting March 28, 2010).

¹²¹ *Id.* at 1.

¹²² Robert Creighton, *Cheeseburgers, Race, and Paternalism: Los Angeles’ Ban on Fast Food Restaurants*, 30 J. LEGAL MED. 249, 257 (2009) (quoting Press Release, Jan C. Perry, Councilwoman Ninth District, S. Los Angeles Fast Food Interim Control Ordinance Unanimously Approved by Los Angeles City Council (July 29, 2008)).

¹²³ See e.g. William Saleton, *Food Apartheid*, SLATE, July 31, 2008, available at <http://www.slate.com/id/2196397/> (last visited Feb. 2, 2009) (“This is the argument normally made for restricting children's food options at school--that they're more dependent and vulnerable than the rest of us. How do you feel about treating poor people like children?”).

restricted, the officials implementing the policies generally disclaim the significance of their restrictive effects.

V. UPDATING THE UNITED STATES' ANTI-OBESITY MODEL

Despite impassioned pleas from some corners, the United States has generally resisted deviating from its education-driven anti-obesity effort. The menu labeling requirement passed with the 2010 health care legislation indicates that the United States is likely to continue down this path. This Section evaluates whether the United States' emphasis on education campaigns is likely to be effective given its history, and proposes that the United States experiment with some methods of direct intervention in order to combat the historic rates of obesity.

A. Education Campaigns Have Not Reduced Obesity Rates

Despite state and federal efforts over the last several decades, the number of overweight and obese Americans continues to grow.¹²⁴ There is no evidence that governmental anti-obesity efforts have affected either obesity rates or, more importantly, the morbidity and disease rates attributable to obesity.¹²⁵ Research has indicated that large-scale information campaigns like those sponsored by the federal government are ineffective at altering the dietary or exercise behavior of individuals.¹²⁶ In fact, it is not even clear that the nutrition information mandated by the FDA or menu disclosures required by the 2010 health care legislation are addressing the relevant issue. “Contrary to popular belief, there is no consistent evidence that the current epidemic of obesity is

¹²⁴ See Section I, *supra*.

¹²⁵ See Mayer, 92 GEO. L.J. at 1019, *supra* n. 7.

¹²⁶ See Garcia, 112 PENN ST. L. REV. at 538, *supra* n. 10 (citing David R. Buchanan, DISQUIETUDES, IN PUBLIC HEALTH LAW AND ETHICS: A READER 339, 339-40 (Lawrence O. Gostin ed., 2002)).

due to an increase in caloric intake”¹²⁷ Whatever the reason, educational campaigns have had little success combating rising rates of obesity, and definitely not enough success to warrant their status as the primary method of obesity reduction sponsored by the federal government.

Although it is not entirely clear why these initiatives have failed to make a substantial impact, many scholars and researchers have proposed explanations for why obesity rates have increased despite the billions of dollars spent to educate the public. For example, Urban sprawl, an amorphous term used to describe “uncontrolled, poorly planned, low-density, and single-use development, which often expands noncontiguously from a metropolitan area”,¹²⁸ has been argued to contribute to the sedentary lifestyle choices made by overweight and obese Americans.¹²⁹ Urban Sprawl tends to create communities with no sidewalks, no parks, long commute-times, and has been directly correlated “to reduced leisure-time physical activity.”¹³⁰ In essence, obesity may be a byproduct of our city planning. Academics have proposed numerous other theories to explain the obesity phenomenon.¹³¹

Theories like Urban Sprawl, effective “junk food” advertising, and the fact that the health consequences of obesity generally impose only long-term costs, may all

¹²⁷ *Id.* (quoting Claude Bouchard, *Obesity in Adulthood--The Importance of Childhood and Parental Obesity*, 337 NEW ENG. J. MED. 926, 926 (1997)).

¹²⁸ *See* Catlin, 2007 WIS. L. REV. at 1110, *supra* n. 7.

¹²⁹ *See* Reid Ewing et al., *Relationship Between Urban Sprawl and Physical Activity, Obesity, and Morbidity*, 18 AM. J. HEALTH PROMOTION 47, 48 (2003)).

¹³⁰ *See* Catlin, 2007 WIS. L. REV. at 1110 *supra* n. 7.

¹³¹ *See e.g.* David M. Cutler, Edward L. Glaeser and Jesse M. Shapiro, *Why Have Americans Become More Obese?*, JOURNAL OF ECONOMIC PERSPECTIVES 17(3): 93-118, (Summer 2003).

contribute to obesity rates in ways that education campaigns cannot remedy. Reinforcing that exercise is important to a healthy lifestyle does not address the reality that many Americans do not have realistic access to recreation facilities. Government nutrition information may be drowned-out by the barrage of fast-food advertising. And even full-informed Americans may believe that the increased risk of some diseases decades down the line just isn't worth the new exercise regimen or the inability to eat at their favorite "value meal" at lunch. Further complicating the matter, recent animal research suggests that "overconsumption of high-calorie food can trigger addiction-like responses in the brain and that high-calorie food can turn rats into compulsive eaters in a laboratory setting."¹³² This emerging research suggests that obese and overweight Americans may be drawn to food in a way that healthy lifestyle education does not combat. Whatever the reason, the failure of information campaigns—when viewed in light of studies and academic literature that plausibly demonstrate ignorance may not be the problem—counsels against investing significant resources in education programs at the expense of direct intervention.

B. Barriers to Direct Intervention

American policymakers must walk a fine line between creating effective anti-obesity programs and infringing the autonomy of a public wary of new paternalistic intervention. Advocates of fat and junk food taxes, as well as other forms of government intervention, must bear the condemnation of commentators vehemently opposed to a

¹³² JoAnne Allen, *High-Calorie Bingeing as Addictive as Cocaine*, REUTERS (March 29, 2010), available at http://www.msnbc.msn.com/id/36081881/ns/health-diet_and_nutrition.

national nanny.¹³³ Even assuming the worst about obesity—that it is directly responsible for premature deaths and billions of dollars in increased medical costs—many believe that the choice of what to eat should be left to the autonomous individual. As one commenter has argued:

When the critics of fat begin to tell us why we must all be thin, even if this includes the use of the coercive powers of the state, they must tell us — and this they have never done — why a life of, say, 70 years packed full of the self-chosen pleasures of fast food and chocolate, for instance, is in some sense inferior to a life of 73 years without those pleasures.¹³⁴

The intensity of anti-paternalistic sentiment in the United States will be a significant bound on any new anti-obesity program. Its importance has led some commentators to speculate that “the range of federal policies that may be acceptable to the general public may be the most limiting factor of all in implementing a food policy that is based on health outcomes.”¹³⁵ Given this sentiment, it is unlikely that the federal government would be able to implement the invasive regulatory schemes developed by the United Kingdom and Japan.

However, attacks of government paternalism only reach so far. We do not live in a country or a world which tolerates all “personal” choices made by its citizens. Government frequently intervenes to influence the choices of individuals in order to lessen the burden of negative externalities. The quintessential example of this

¹³³ See, e.g. Jacob Sullum, *The War on Fat: Is the Size of Your Butt the Government's Business?*. REASON, Aug.-Sept. 2004, at 20, available at <http://reason.com/archives/2004/08/01/the-war-on-fat>.

¹³⁴ John C. Luik, *Losing More than Weight: Unscientific “War” on Obesity Will Trim Personal Freedoms*, WASH. LEGAL FOUND. LEGAL BACKGROUNDER, May 14, 2004, available at <http://www.wlf.org/upload/051404Luik.pdf>.

¹³⁵ Laura S. Sims, *THE POLITICS OF FAT: FOOD AND NUTRITION POLICY IN AMERICA*, 268 (1998).

intervention is mandatory seatbelt and motorcycle helmet laws, which endure despite vehement opposition by libertarians and scholars alike.¹³⁶ Although the decision to wear a seatbelt or helmet can be framed as a purely personal choice, the health consequences and costs borne by the community are thought sufficient to justify government interference.

Most Americans favor or tolerate paternalistic seatbelt and helmet laws because the relatively minor imposition is justified by a known value to society. Approximately eighty-one percent of Americans favor motorcycle helmet laws.¹³⁷ However, only thirty-three percent are in favor of a tax on unhealthy food products.¹³⁸ Some of this difference can be explained by the fact that the vast majority of people buy unhealthy products from time to time while only a small population drive motorcycles. It is also possible that support for helmet and seatbelt laws are high because it is proven to be effective. For example, we know that wearing a seatbelt greatly reduces the risk of death or injury, while there is no proof that interventionist anti-obesity programs will lower obesity rates. The National Highway Traffic Safety Administration has established that wearing a seatbelt reduces the risk of death by forty-five percent and the risk of serious injury by fifty percent.¹³⁹ There is no similar figure for a fat tax, junk food tax, advertising ban or

¹³⁶ See e.g. Leonard C. Schwartz, *The Seat Belt Defense and Mandatory Seat Belt Usage: Law, Ethics, and Economics*, 24 IDAHO L. REV. 275, 289 (1988) (arguing that “mandatory seat belt usage is meddlesome and unnecessary paternalism: Although it may be proper for the government to protect persons from harmful conduct of others, the government should not protect persons from their own improvidence.”).

¹³⁷ See *The Elephant in the Room*, 116 HARV. L. REV. at 1175, *supra* n. 63.

¹³⁸ *Id.*

¹³⁹ Motor Vehicle Traffic Crash Fatality and Injury Estimates for 2000, National Highway Traffic Safety Administration, November 2001.

double-bacon cheeseburger ban. Restrictions on liberty may be particularly difficult to swallow when there is no evidence that the restriction will be effective.

C. Proposed Role of the FDA

To date, the FDA has been primarily concerned with disseminating nutritional information and identifying unsafe or mislabeled food products.¹⁴⁰ For example, while some cities and the state of California have banned the use of trans fat in restaurants within their jurisdictions, the FDA is content to merely require trans fat disclosure on its nutrition label.¹⁴¹ The increasing obesity rate over the last three decades is evidence that mere dissemination of nutrition information is not an effective strategy. However, implementing a directly interventionist policy through the FDA will likely be difficult given anti-paternalistic sentiment across the country. Instead, the FDA should mimic the role of the United Kingdom's FSA and begin to categorize foods based on each product's health benefits.¹⁴² Categorizing foods instead of merely relating nutrition information would have two primary benefits.

First, labeling one product unhealthy and another healthy may motivate more consumers to choose the healthy product because it would no longer be necessary to spend minutes wading through nutrition information to determine its health

¹⁴⁰ See Peter B. Hutt, et al., *FOOD AND DRUG LAW: CASES AND MATERIALS*, 24 and 98 (3d ed. 2007).

¹⁴¹ See 21 CFR §101.9(c)(2)(ii) (2010).

¹⁴² It is not clear what the best categorization system would look like. As discussed in Section IV.A.1, *supra*, the FSA merely separates foods into two groups: healthy and unhealthy. This need not be the system adopted by the FSA. Designing the most effective system would likely require tailored field studies and a significant amount of research and comment by members of the public and relevant industries.

characteristics.¹⁴³ Second, and more importantly, this system would allow state governments and other federal agencies to target unhealthy foods with their own programs. In essence, an FDA categorization system would facilitate the kind of direct intervention programs that state and city governments have been toying with for years. By bearing the cost and controversy that inevitably accompanies such an undertaking, the FDA would pave the way for other governmental actors to experiment with programs similar to those enacted overseas. For example, San Francisco, in addition to banning trans fats, could enact a twenty percent “junk food tax” on all foods classified in the FDA’s most unhealthy category. Seattle may choose to imitate the scheme devised by the Classification and Rating Administration for movies rated “R”, and require parents to accompany their children when buying snacks in the unhealthiest category. By absorbing the costs of categorization, the FDA would lower the barrier to entry and support a variety of state and local anti-obesity programs.

In addition to potentially lowering the incidence of obesity in some communities, the programs enacted in response to the FDA’s categorization will build a record of the successes and failures of a variety of anti-obesity techniques. In essence, each program adopted by San Francisco, Seattle, or Boston, will serve as a trial run for the federal government. For example, the federal government may avoid Seattle’s prohibition on selling junk food to children without a parent if it proves too difficult to administer.

However, if San Francisco’s junk food tax lowers the obesity rate by three percent over a

¹⁴³ The United Kingdom current uses a “traffic light” system, which attempts to give consumers an immediate context for the nutrition information borne by product packaging. For example, instead of seeing five grams and a daily percentage, UK consumers see a green, yellow, or red signal, indicating that the product is low, medium, or high in the designated nutrient. *See* Traffic Light Labeling, Food Standards Agency, <http://www.eatwell.gov.uk/foodlabels/trafficlighs> (last visited March 30, 2010).

three year period, advocates of direct intervention will be armed with hard data when making their case before Congress. Encouraging state and local-level programs to implement anti-obesity approaches will also minimize government paternalism in unsupportive communities, at least until the benefits of a program are sufficient to warrant adoption by the federal government. By letting receptive communities experiment with interventionist programs, the federal government will avoid contentious debate about the proper role of government until a time where tangible evidence can inform the discussion.

VI. CONCLUSION

Obesity is a complex issue that defies simple solutions. Despite intense political will and academic interest, there is no consensus about why obesity rates have skyrocketed or how they can be reduced. The proposal advanced here is relatively modest. Instead of depending solely on information campaigns that rely on the dubious assumption of consumer ignorance, the federal government should transition towards programs that incentivize healthy lifestyle choices. However, the federal government should not blindly wade into this controversial and complex arena. By categorizing foods in a way similar to the United Kingdom's FSA, the federal government can begin by removing a significant barrier to the proliferation of a variety of state and local anti-obesity programs. By encouraging these programs, the federal government can benefit from their collective experience when crafting its own response.