World Cancer Research Fund International

# LAW AND OBESITY PREVENTION:

## Addressing some key questions for the public health community

**WCRF International Policy and Public Affairs** Working Paper No.1

This is the first in a series of WCRF International Policy and Public Affairs Working Papers. These Working Papers will explore some of the key topical issues around the use of evidence to inform and support the wider implementation of more effective policies for the prevention of cancer and other non-communicable diseases.

This Working Paper is based on a report prepared for the workshop *Using The Law Effectively For Cancer Control In Europe*, hosted by the McCabe Centre for Law and Cancer and the Norwegian Cancer Society, Oslo 6 – 7 March 2013. The goal of the workshop was to strengthen collaboration and information sharing on legal issues relevant to cancer control and care in Europe. It brought together organisations working on the prevention and control of cancer, researchers, lawyers and advocates.

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# KEY FINDINGS

- Most food policy actions to address obesity are in some way amenable to the use of law, whether this is through direct regulation or mandating a specific action in framework regulation.
- Governments have the necessary powers to legislate through their authority to regulate speech (restrict or compel) and to regulate conduct.
- Specific legal powers vary between international, regional (e.g. EU), national and sub-national jurisdictions, and there may be important limits to legal authority. Questions of constitutionality and the legal competence of different entities are key considerations.
- International trade and investment treaties are complex and highly nuanced, but generally give states significant regulatory autonomy and space to design and implement policies through law.
- There are many political and philosophical barriers to using the law for obesity prevention. Opponents of using legal approaches often simultaneously overplay gaps in the evidence, the limits of legal authority, and technical barriers, with a view to delaying or stalling the use of law.
- Evidence plays a critical role in building the case for the use of law, informing the process of defining clear objectives, and resisting legal challenges. In order to be robust, the objectives of legislation and regulations should directly reflect the nature of the available evidence.
- The public health and legal communities should therefore collaborate in order to:
  - Establish the legal basis for the action at the outset.
  - Use the available evidence to help frame the objectives of the law and ensure it is defensible if challenged.
  - Overcome barriers to the use of law, at all levels, including through a better understanding of relevant legal bases for action.

# INTRODUCTION

## Obesity and law

WCRF International considers that the wider implementation of more effective policy is necessary to prevent cancer and other non-communicable diseases (NCDs). Given the link between body fatness and the incidence of some cancers and other NCDs (WCRF/AICR, 2007), one of our concerns is the rising and/or high levels of overweight and obesity around the world.

In this context, this paper examines legislation as a potential tool to advance more effective policy. The paper was prepared for the workshop "*Using the law effectively for cancer control in Europe*" co-hosted by the McCabe Centre for Law and Cancer and the Norwegian Cancer Society in Oslo, Norway, 6–7 March 2013. The role of legislation to promote healthier diets was discussed in the session on obesity, with a focus on Europe.

Obesity has been described as the 'new frontier of public health law' (Mello, 2006). Interest in the use of the law to address obesity follows from its successful use in addressing other health challenges, notably tobacco use. Numerous civil society organisations and academics have called on governments to introduce policies backed by legislation, particularly on healthy diets, as part of a wider call to scale up action (Consumers International/International Association for the Study of Obesity, 2008). Yet the potential for the use of public health law remains largely unrealised (Magnusson, 2008a). Legislation has not proved the favoured approach in the current policy and political context where 'alleviating the regulatory burden' on the private sector is seen as a greater priority (European Commission, 2005).

## Working Paper objectives and structure

The law uses different terminologies to public health as well as different approaches to the construction of arguments and the collection and interpretation of evidence. This Working Paper aims to promote greater understanding among the public health community of key legal concepts and enhance opportunities for collaboration across the two disciplines when considering the use of law for obesity prevention.

Following a brief description of the obesity burden, with a focus on the potential food policy response, the Working Paper addresses some key questions about the role of law in the context of food policy and obesity prevention, namely:

- What is law?
- Why use law?
- What are the policy options amenable to law?
- How can the evidence on policy options support the development of law?
- What are the sources of authority to make law?
- At what level of government can law be implemented?
- What are the barriers to using law?

# THE BURDEN OF OBESITY

The increasing burden of overweight and obesity in Europe poses a serious threat to population health. Prevalence of obesity has more than tripled in many European countries since the 1980s, and the number of people affected continues to rise, particularly among children (European Commission, 2010). According to country estimates for 2008, over 50% of both men and women in the WHO European Region were overweight, and roughly 23% of women and 20% of men were obese (WHO, 2010).

In addition to causing physical disabilities and various psychological problems, excess weight dramatically increases the risk of developing a number of NCDs, including some cancers, cardiovascular diseases and diabetes. High body-mass index (BMI >25) is the fourth ranked risk factor in Europe both in terms of mortality and disability-adjusted life years (Lim, 2012) and 65% of the world's population now lives in countries where overweight and obesity kills more people than underweight (WHO, 2013a). With regards to cancer, there is strong evidence that excess body fatness is linked to an increased risk of cancer in seven different sites: oesophagus; pancreas; gallbladder; colorectum; breast (post-menopause); endometrium; and, kidney (WCRF/AICR, 2007). Breast and colorectal cancer are two of the most common cancers in the European region (Globocan, 2008).

Preventability estimates suggest that keeping body weight within a healthy range (BMI 21–23) would prevent between 16–20% of those cancers for which the risk is increased by excess body fatness in high-income countries, about 13% in middle-income countries, and 11–12% in low-income countries (WCRF/AICR 2009). Evidence also indicates that maintaining a healthy bodyweight reduces the risk of death from all NCDs collectively by around 22 per cent (Vergnaud, 2013).

The immediate health costs associated with obesity are high. In the UK, for example, they are estimated to increase to £2 billion/year by 2030 (Wang et al, 2011) and there is evidence to suggest that there are major productivity losses to the economy.

Thus there are significant potential gains from obesity prevention in terms of improved health and longevity, and the reduction of health inequities (OECD, 2010a). According to the WHO: *"investing in prevention…will reduce premature death and preventable morbidity and disability, improve the quality of life and well-being of people and societies, and help to reduce the growing health inequalities they cause"* (WHO Europe, 2012).

The rise in obesity has been in part caused by changes to the environment in which we live (Egger, 1997). There has been a major upsurge in energy-dense foods and beverages, which are now readily available and highly promoted in most parts of the world (Stuckler, 2012). There has also been a trend towards built environments that discourage physical activity/active transport and the widespread use of labour-saving devices such as cars, computers, and passive entertainment technology such as televisions, video and electronic games (Swinburn, 2008).

Most public health experts therefore argue for prevention through change to the 'obesogenic environment', both for physical activity and diet. For the purpose of this paper, we concentrate on the diet dimension.

Governments have begun to pay increasing attention to obesity prevention. In 2004, the WHO's Global Strategy on Diet, Physical Activity and Health (WHO, 2004) became both a global framework and stimulant for regional and national action. In 2011, the Political Declaration adopted at the United Nations General Assembly High Level Meeting on NCDs emphasised the need to accelerate implementation of effective policy, stating that Member States should *"advance the implementation of multisectoral, cost-effective, population-wide interventions in order to reduce the impact of…unhealthy diets"* (United Nations General Assembly, 2011). In 2013, the WHO Global Action Plan for the Prevention and Control of NCDs (2013–2020) included a package of policy options to promote healthy diets (WHO, 2013b). The World Bank (2011), the Organisation for Economic Cooperation and Development (Cecchini et al, 2010) as well as

NGOs (Consumers International 2011; NCD Alliance, 2011) have also recommended policies to promote healthy diet.

In Europe, the WHO Europe Second Action Plan on Food and Nutrition provides guidance to support countries in implementing policies in the areas of infant and early childhood nutrition, information and education to consumers, and healthy school environments, among others (WHO Europe, 2007). This will be renewed in 2014, following the adoption of the Vienna Declaration in July 2013, in which countries emphasised the challenge of obesity and diet-related NCDs in Europe, committed to scale up action, and mandated WHO Europe to develop an updated action plan (WHO Europe, 2013). The European Union has also adopted a Strategy on Nutrition, Overweight and Obesity-related Health Issues (European Commission, 2007).

# THE ROLE OF LAW IN FOOD POLICIES FOR OBESITY PREVENTION: SOME KEY QUESTIONS

## What is law?

Public health law comprises the legal duties of states to ensure the necessary conditions for people to be healthy (Gostin, 2000). Within this bigger picture, public regulation, where governments implement legal instruments to produce policy outcomes, is an important mechanism for achieving the goals of public health law. **Legislation** is law that has been adopted by the legislature (e.g. Parliament, Congress or state legislature). Some legislation allows for statutory **regulations** to be adopted to provide more details and achieve the regulatory objectives set out in the legislation. Both legislation and regulation have the force of law.

## Why use law?

Law is just one of a range of possible policy tools available. Other possible tools include official guidelines, 'self-regulation'[1] by industry, voluntary schemes, or co-regulation (i.e. self-regulation underpinned by an enabling statutory instrument). From a public heath perspective, the underlying rationale in calling for public regulation through the use of law rather than other mechanisms for implementing policy is the conviction that it will be more effective in achieving public health objectives (i.e. preventing obesity). Researchers and NGOs (e.g. Galbraith-Emami and Lobstein, 2014; Moodie et al, 2013; Persson, 2012) have argued the case for using the law for many years, based on an informed assumption that policies implemented through law will:

(i) be of general application to all relevant market actors, unlike many self-regulatory models where there is a lack of complete coverage;

(ii) be more likely to have stringent criteria, clear objectives and outcome measures if set independently by government, unlike many self-regulatory models where company definitions can favour their own products;

(iii) be binding, so more likely to be enforced and accompanied by appropriate scrutiny, control and sanctions;

(iv) have clear political accountability; and

(v) be permanent and less easily scaled back or reversed when adopted as part of democratic processes.

In contrast, industry and many policy-makers favour self-regulation. By 2010, for example, in over 20 countries with published policies on marketing to children industry-led self-regulation, codes and government-approved forms of self-regulation were dominant (Hawkes and Lobstein, 2011). Supporters of self-regulatory approaches point out that there is little evidence that legal tools will achieve the stated objectives more effectively than other policy approaches and point to the perceived advantages of self-regulatory models (European Advertising Standards Alliance, 2003). Yet, in addition to an evident difference in perception, supporters of public regulation highlight the inherent conflict of interest between the goals of industry to increase sales and profits from unhealthy food and the protection of public health (Moodie et al, 2013). In other words, industry's ability to act in the public interest is impaired by the existence of competing obligations and interests (e.g. to shareholders), which create a bias in favour of those interests over public health interests. In many cases, industry can only pursue other goals – such as public health – that may affect profit, under requirement of law (Alderman, 2007). Supporters of the use of law also point to evidence that suggests engagement with the food and beverage industry has failed to achieve effective public health outcomes

[1] Self-regulation is a regulatory process whereby an industry- or sector-level organisation specifies, administers and enforces the rules and standards relating to the conduct of companies in that industry/sector. By contrast to legislation, self-regulation is voluntary and is typically framed as good corporate responsibility, although it operates within the context of broader industry regulation by government (i.e. other basic government standards they must comply to).

(Mello, 2008; Wilde 2009; Rice, 2002; Moodie, 2013; Garde, 2011; Galbraith-Emami and Lobstein, 2013). For example, Hawkes and Harris (2011) and Galbraith-Emami and Lobstein (2013) report that self-regulatory pledges on marketing of food to children are insufficiently comprehensive, cover a narrow range of media, and have weak nutritional criteria. These concerns contribute to the increasing interest among public health experts to improve the effectiveness of policy through the use of carefully designed law. The evidence on this issue is not, as of yet, conclusive.

## What are the policy options amenable to law?

Over the past decade, governments around the world have been implementing food policies to address obesity, albeit with relatively slow progress. A 2013 WHO Global Nutrition Policy Review found that, globally, the most common approach to date has been the provision of consumer information (e.g. the development and communication of food-based dietary guidelines, food labelling, or promotion of healthy dietary practices through the media) (WHO, 2013c). Other policies implemented in a more piecemeal fashion include the reformulation of food products, food and nutrition standards in schools, nutrition labelling, restrictions on marketing to children and the promotion of fruit and vegetables (Hawkes, 2012). More recently there has been an increased interest in the use of fiscal measures (e.g. taxes) applied to food (OECD, 2012).

**Table 1** brings together the leading policy approaches into a single food policy framework – the WCRF International NOURISHING Framework.

The framework comprises:

- three broad domains of policy action – the three pillars of the response to obesity;
- ten key policy areas within these domains – which between them make up a comprehensive approach; and
- specific policy options – the actual actions put into place within the ten areas.

The domains of policy action ((i) changing the food environment (ii) conducting behaviour change communication, including food education and skills; and (iii) supporting these policies by action further upstream in the food system) are widely seen as central to any response (Capacci, 2012; Gostin, 2007; Hawkes, 2012; Mackay, 2012; Magnusson, 2008a; Pomeranz, 2011, 2012; Swinburn et al, 2008). Collectively implementing this package of policies would achieve the objective of influencing the availability, acceptability and affordability of foods and diets in a positive direction.

Most of the policy options identified in the framework are amenable to some aspect of legislation, whether it be a 'legal requirement' to label food products, laws requiring foods described in a given way to meet specific nutritional criteria, the legal mandating of school food standards, planning regulations for food retailers, the inclusion of dietary counselling in legally-embedded primary care guidelines, or the mandating of behaviour change communication campaigns in framework legislation.

Policies that address the **food environment** include comprehensive nutrition labelling on food products (e.g. front of pack and back of pack nutrition declarations), nutrition labelling/information in food outlets (e.g. calorie information at point of sale), and restrictions on the use of nutrition and health claims. The aim of these policies is to ensure the food information environment is supportive of healthy choices without being misleading and provides full disclosure. Traffic light labelling and other interpretative elements (such as the 'keyhole' or 'healthy choice' logos) on front of pack are emerging as potential policy options. Policies can also be applied in specific settings, such as food and nutrition standards for food provided/available in schools (e.g. school meals; vending machine restriction) in addition to school-based interventions/schemes to increase fruit and vegetable consumption. Policies that address food prices also fall under this domain, including food taxes (on specific nutrients or energy-dense products) and targeted subsidies. One of the most widely cited policies to influence the food environment is the restriction of marketing of unhealthy foods and drinks

**Table 1: A food policy package for healthy diets and the prevention of obesity: the NOURISHING Framework**

| DOMAIN | | POLICY AREA | POLICY OPTIONS/ACTIONS |
|---|---|---|---|
| FOOD ENVIRONMENT | N | Nutrition label standards and regulations on the use of claims and implied claims on foods | e.g. Nutrient lists on food packages; clearly visible 'interpretive' and calorie labels; menu, shelf labels; rules on nutrient & health claims |
| | O | Offer healthy foods and set standards in public institutions and other specific settings | e.g. Fruit and vegetable programmes; standards in education, work, health facilities; award schemes; choice architecture |
| | U | Use economic tools to address food affordability and purchase incentives | e.g. Targeted subsidies; price promotions at point of sale; unit pricing; health-related food taxes |
| | R | Restrict food advertising and other forms of commercial promotion | e.g. Restrict advertising to children that promotes unhealthy diets in all forms of media; sales promotions; packaging; sponsorship |
| | I | Improve the quality of the food supply | e.g. Reformulation; elimination of transfats; reduce energy density of processed foods; portion size limits |
| | S | Set incentives and rules to create a healthy retail environment | e.g. Incentives for shops to locate in underserved areas; planning restrictions on food outlets; in-store promotions |
| FOOD SYSTEM | H | Harness supply chain and actions across sectors to ensure coherence with health | e.g. Supply-chain incentives for production; public procurement through 'short' chains; health-in-all policies; governance structures for multi-sectoral engagement |
| BEHAVIOUR CHANGE COMMUNICATION | I | Inform people about food and nutrition through public awareness | e.g. Education about food-based dietary guidelines, mass media, social marketing; community and public information campaigns |
| | N | Nutrition advice and counselling in health care settings | e.g. Nutrition advice for at-risk individuals; telephone advice and support; clinical guide-lines for health professionals on effective interventions for nutrition |
| | G | Give nutrition education and skills | e.g. Nutrition, cooking/food production skills on education curricula; workplace health schemes; health literacy programmes |

Source: Hawkes et al (2013)

to children. Policies that address marketing[2] include statutory or voluntary rules that restrict the amount of unhealthy food advertising to children on television.

Other recommended policies to address the food environment include improvements to the food product composition, including calorie reduction. More recently, there has been increased attention on strategies to influence portion sizes (of soft drinks, for example). Finally creating a healthy retail environment is another policy area for action, policy options include those that aim at improving accessibility to food retailers in underserved areas (e.g. by incentivising businesses to operate in a certain area and/or provide healthy foods), and 'choice architecture' in retail settings to favour healthy choices (e.g. positioning healthy foods by checkouts rather than unhealthy options).

In the area of **behaviour change communication** potential policies include public information

[2] According to the WHO Set of Recommendations on the Marketing of Food and Non-Alcoholic Beverages to Children, "Marketing" refers to any commercial communication or message that is designed to, or has the effect of, increasing the recognition, appeal and/or consumption of particular products and services. It comprises anything that acts to advertise or otherwise promote a product or service.

campaigns, dietary advice in specific settings (e.g. primary health care and/or schools) and cooking skills taught in school. The aim is to raise awareness, increase knowledge, encourage the consumption of 'eat more' foods and discourage the consumption of 'eat less' foods and nutrients. Specific examples include the communication of food-based dietary guidelines, and public awareness campaigns around specific foods or nutrients (e.g. fruit and vegetable campaigns – '5 a day').

Finally, in the **food system**, policies and governance structures can leverage change in the food supply chain to reinforce and facilitate changes in the food environment closer to the point of consumption. Food system policies (which in practice have rarely been applied) can create incentives and reduce disincentives for the production, distribution and sale of healthier products, such as reducing supply chain bottle necks (which lead to waste) for fruit and vegetables. Such policies are likely to be specific to the supply chain, but require a coherent, multi-sectoral, 'whole of government' response.

As shown later in the paper in **Table 3**, governments can regulate speech and conduct, which would provide a legitimate mechanism to help achieve the public health objectives of the policies set out in the policy framework.

# HOW CAN THE EVIDENCE ON POLICY OPTIONS SUPPORT THE DEVELOPMENT OF LAW?

The interpretation and communication of evidence plays an important role in the development of policy. With any type of policy the evidence can help to identify priorities and feed into the process of framing the objectives of policy. More specifically in the context of legal measures, evidence is particularly important to:

- Build the case for legislation/public regulation (rather than other non-binding approaches/policy alternatives) and define clear regulatory objectives at the outset (Ex-ante).
- Support governments defend their decision to adopt legislation and other regulations when challenged before courts of law (Ex-post).

In the past both governments and industry have claimed that there was insufficient evidence demonstrating the effectiveness of policies to address obesity (Department of Health, 2011; Health Select Committee, 2004; Advertising Association). It is a regrettable reality that few (or, arguably, no) countries have made significant progress in reducing the burden of obesity (OECD, 2010b; Swinburn, 2008), and as such there has been limited 'practice based' evidence for effectiveness of interventions at reducing levels of obesity at the population level. Nevertheless, the evidence-base for action on unhealthy diet, has increased significantly in recent years and continues to grow.

**Table 2: Overview of convincing and probable evidence**

| POLICY | FOOD INFORMATION AND MARKET ENVIRONMENT | DIETARY PRECURSORS | DIETARY PATTERNS |
|---|---|---|---|
| **LABELLING** | | Convincing evidence that consumers use nutrient lists, but far lower among low SES.<br>Convincing evidence that consumers prefer interpretative labels.<br>Probable evidence that most liked format is 'traffic lights' in combination.<br>Probable evidence that health claims influence perceptions about product. | Probable evidence on impact of nutrient lists on dietary intake but small evidence base. |
| **MARKETING** | Restrictions on TV advertising of unhealthy food (statutory or voluntary restrictions) reduce the amount of advertising on the regulated channel, but marketing activity 'migrates' onto non-regulated channels that are not subject to the restrictions. | Convincing evidence that TV advertising influences food preferences and purchase requests.<br>Convincing evidence that sales promotions influence short-term purchasing. | Convincing evidence that TV advertising influences dietary intake. |
| **SCHOOL SETTINGS** | Probable evidence that policy interventions to restrict consumption of high calorie foods influence availability within schools. | Probable evidence that school garden improve attitudes. | Convincing evidence that multi-component school-based interventions modestly increase fruit and vegetable intake while at school (stronger for fruit).<br>Probable evidence that policy interventions to restrict consumption of high-calorie foods influence dietary intake within schools. |

| | | | |
|---|---|---|---|
| **RETAIL ENVIRONMENT** | | Probable evidence that farmers markets and community food access can have positive outcomes on attitudes (from United States).<br>In-store promotion and placement influence short-term purchasing. | |
| **PRICING STRATEGIES** | | Convincing evidence that food prices and taxes (modelling) influence the amount of food purchases (especially for soft drinks in the US).<br>Convincing evidence that targeted price reductions/ subsidies influence short-term purchasing of target item.<br>Convincing evidence that price reductions and subsidies targeted at select consumer groups influence short-term purchasing. | Convincing evidence that taxes and subsidies have the potential to lead to beneficial dietary changes. |
| **FOOD PRODUCT COMPOSITION** | Probable evidence salt reduction initiatives and restrictions, and labelling of trans fats reduce total availability to consumers (e.g. amount in foods). | | Probable evidence that salt reduction initiatives (e.g. reformulation programmes) reduce dietary intake of sodium. |

The evidence to build the case for regulatory intervention and defend it if challenged consists of evidence on what influences diets (rationale for intervention) and evidence that policy action will influence diets (effectiveness of intervention).

**Table 2** provides an overview of the currently available strong evidence for the most frequently proposed policies, based on systematic reviews (an in-depth discussion of the evidence base for each specific policy option is beyond the scope of this Working Paper). The table categorises the evidence according to what it demonstrates (e.g. impact on dietary patterns, precursors or the food information/market environment). It is also graded according to the current level of confidence in the evidence when considered collectively – convincing or probable. Systematically categorising the evidence helps to articulate what the currently available evidence shows.

Despite the growing evidence base, there are challenges to building the case for legal approaches. Three particularly relevant challenges are as follows:

- Predicting the effect of any single public health measure is difficult, if not impossible, when the problem to be addressed has multiple and complex determinants (Higgins, 2013). It is difficult to demonstrate that one measure in isolation is having significant material impact, when several factors may be working together synergistically to have negative or positive impact.
- Where policies are innovative, as is often the case in food policies to address obesity, there will inevitably be little practice-based evidence.
- Obesity (and related NCDs) often develops – and ameliorates – in individuals and populations over the long-term. Measuring outcomes on BMI in shorter-term studies thus may be misleading.

These science-based challenges have provided a fertile environment for the selective use of evidence to support special interests. The argument that policies are ineffective has, for example, been used by industry to stall policy proposals (Coca-Cola, 2012). The challenges have also led to a disregard for the

evidence that is available, and as an overall excuse for inaction.

While these responses to the challenges are not justified, the uncertainties highlight the need to pay particular attention to the nature of the evidence when developing policy objectives.

From a legal perspective it is particularly important that policy objectives reflect the evidence. For example, the objective of the regulation in the UK on food marketing to children is to improve public health by reducing children's exposure to food advertising, as a means of reducing attempts to persuade children to demand and consume unhealthy food and drink products (OFCOM, 2007). This is a direct reflection of the evidence base – which is built on research showing that it is exposure to advertising which influences children's food behaviours (Hastings, 2003). In an example from tobacco, the objectives of the Australian Tobacco Plain Packaging Act 2011 is to improve public health by discouraging people from taking up smoking or relapsing, encouraging people to give up smoking, and reducing people's exposure to smoke from tobacco products. The law states that these objectives are, in turn, to be achieved by regulating the packaging and appearance of tobacco products in order to reduce the appeal of tobacco products to consumers; increase the effectiveness of health warnings; and, reduce the ability of packaging to mislead consumers about the harmful effect of smoking or using tobacco products. Thus, the Act ultimately aims to improve public health by influencing behaviour and clearly sets out the mechanisms through which behaviour is to be influenced (and which can be monitored and evaluated). Both of these policies seek to regulate speech by restricting opportunities for marketing and promotion.

If the policy is subject to a legal challenge, questions about the necessary 'standard of proof' may come into play. That is, the degree of evidence that must be reached in order to decide an issue. The standard of proof required is likely to differ highly across jurisdictions and vary from case to case. Evidence from the tobacco field shows that there has been a degree of flexibility in how courts approach the scientific evidence, with an understanding that single measures may make a material contribution to the goal of reducing tobacco use over time as part of a comprehensive strategy (Higgins, 2013).

This analysis indicates that a key role of evidence is to inform the process of identifying the objectives of a law, help build the case for regulatory intervention, and be used to defend against challenges. It shows it is crucial to directly link what the measure is designed to do with the evidence, as well as how it is designed to do it (Higgins, 2013). In the case of food policy, the objectives must be linked to evidence on the factors that may be strengthened to discourage the consumption of unhealthy foods. The development of objectives as they relate to the evidence is thus an area in which public health and legal experts should work together.

# WHAT ARE THE LEGAL BASES FOR THE DEVELOPMENT AND IMPLEMENTATION OF LAW?

Once the public health objectives have been clearly identified, the next step is to establish what legal authority exists to develop and implement law. Public health law academics have identified several sources of legal authority commonly held by governments that hold particular relevance in regulating to achieve public health outcomes: the ability to regulate speech (both restricting and compelling) and to regulate conduct (Pomeranz, 2009). These are powers that most governments hold. **Table 3** illustrates how some of the policies included in the NOURISHING framework can be categorised according to these legal strategies.

**Table 3: Regulating speech and conduct**

| LEGISLATIVE APPROACH | POLICY OPTIONS |
|---|---|
| REGULATING SPEECH | **Restricting speech:**<br>Restrictions on marketing to children and other forms of commercial promotion.<br>Regulations on use of nutrition and health claims. |
| | **Compelling speech:**<br>Standards for nutrition labelling.<br>Calorie labelling in restaurants.<br>Public awareness campaigns.<br>Nutrition counselling in primary care. |
| REGULATING CONDUCT | Nutrient- and food-based standards in specific settings.<br>Use of measures to address affordability of foods.<br>Measures to improve quality of food supply (reformulation, calorie reduction, portion size limits, agriculture and food chain incentives).<br>Rules for a healthy retail environment (planning restrictions, in-store promotions). |

## Regulating speech

Restricting speech implies the placing of limits on the freedom of commercial operators to advertise their goods and services to protect the public interest – in this case, public health. There may be two different but overlapping objectives to restricting speech – firstly to regulate misleading speech (e.g. unfounded health claims, or misleading advertising), and secondly to regulate speech more generally because of its impacts.

Calls to restrict marketing (including advertising and nutrition and health claims) for consumer protection are in response to robust evidence that marketing, particularly of nutrient-poor, energy-dense foods and drinks, has negative health impacts. It has also been argued that heavy marketing targeting children is unethical because they are less able to differentiate between information and marketing messages (Cairns, 2009; Garde, 2010). In a few jurisdictions (notably the United States), there are particular issues around marketing restrictions, where courts have interpreted and applied 'commercial speech' or 'commercial expression' rights in ways that constrain legislative power. However, such challenges should not be overstated in the global context.

Compelling speech on the other hand allows for the use of powers to make actors (including commercial operators, government bodies or employees) provide accurate information to consumers/the public (e.g. through nutrition labelling; declaration of accurate portion sizes; calorie menu labelling) (Garde, 2009). In many ways this approach can be linked to freedoms around commercial expression, which has been made conditional on the disclosure of sufficient and reliable information (Garde, 2009). This has been easier to argue, as key stakeholders see this as a tool to enhance market efficiency and improve consumers' decision-making ability (Pomeranz, 2009; Magnusson, 2008a). Government can also mandate national public announcements/information campaigns, such as legislation in Texas that established "Obesity Awareness Week" and "Fruit and Vegetable Month" (Texas Statutes). It can also enact legislation that requires the inclusion of health education around diet within the school curriculum.

## Regulating conduct

Governments may regulate conduct to address both supply and demand side drivers of unhealthy diet (Pomeranz, 2009). For example, governments could require retail establishments to place fresh produce at the front of stores and processed products towards the back, regulate the availability of foods in school settings, or ban certain foods from vending machines (Gostin, 2007; Magnusson, 2008a). They could also legislate to maintain higher prices, either through direct regulation (establishing a minimum price) or by increased taxation. Governments could also remove fiscal inconsistencies, such as tax exemptions for highly sugared cereals in Australia (Magnusson, 2008a).

Within its powers to regulate conduct, government could also impose limits on the amount of a nutrient in a product, for example a maximum amount of added sugar in processed foods or beverages, or a maximum portion size (e.g. the New York proposal for a limit on soda portion sizes). They could also regulate where certain retail establishments (e.g. fast-food outlets) can locate within a community, known as 'zoning' (Pomeranz, 2009). The strongest form of regulation would be an outright ban on a type of food or a specific nutrient. Denmark introduced a law banning trans fats (given the convincing evidence that there is no safe level of consumption and the links to cardiovascular disease) but such legislation is likely to be extremely controversial if proposed for other foods or nutrients.

# AT WHAT LEVEL OF GOVERNMENT CAN LAW BE IMPLEMENTED?

Legal policy tools can be developed and applied at different levels of government:

- International and global
- Regional
- National
- Sub-national and local

## International and global

The WHO's highest decision-making body, the World Health Assembly (WHA), has constitutional authority to develop and adopt legally binding conventions or agreements on any matter within the competence of the WHO. These instruments come into force for individual Member States when formally ratified (or through an equivalent process). Civil society, lawyers and public health academics have all suggested that this mechanism be used to address global drivers of obesity (Lancet, 2011). The WHA has rarely used its law-making authority, but there are important exceptions, including the International Health Regulations, which relate to coordination and management of public health emergencies of international concern e.g. pandemic influenza outbreaks. In response to the globalisation of the tobacco epidemic, the WHA also adopted the Framework Convention on Tobacco Control (FCTC) in 2003 (see **Box 1** for details on this and other mechanisms). Under the treaty, State Parties commit to a range of measures dealing with demand reduction, supply reduction and international cooperation (including reporting). Since entering into force in 2005, the FCTC has become one of the most rapidly and widely embraced treaties in United Nations history, and now has 177 signatories.

Despite this constitutional mandate, when it comes to food policy, the WHA has mainly followed a course of developing non-binding recommendations and guidance for action by national governments (Member States). Significant developments include the Global Strategy on Diet, Physical Activity and Health (Global Strategy) in 2004, and a 2010 Set of Recommendations on the Marketing of Food and non-Alcoholic Beverages to Children. Although non-binding, these instruments can play an important role in setting international norms and documenting best practice/evidence-informed policy, thus providing a framework for action. Most recently, the WHA endorsed a Global Action Plan for the Prevention and Control of Non-Communicable Diseases 2013-2020, which reiterated the importance of accelerating national implementation of policy measures, including a set of actions to address unhealthy diet and the wider implementation of the Set of Recommendations on Marketing to Children.

Other international instruments with relevance to obesity include guidelines issued by the Codex Alimentarius Commission on food safety and some areas relevant to diet, notably labelling and product composition (L'Abbé et al, 2010). Although the Codex guidelines are voluntary in nature, they are recognised as the reference point for food standards applied in international trade agreements including the Sanitary and Phytosanitary (SPS) and Technical Barriers to Trade (TBT). As such, countries that implement policies that comply with relevant Codex standards may obtain the benefit of a presumption that such measures are in compliance with World Trade Organization (WTO) law.

[3] A full examination of the application of the legislation in each context is beyond the scope of this paper, so we provide an introduction to some of the different mechansims. We primarily consider the possibilities of legal action at different levels with the European situation in mind, so consider the sub-national, national, regional (EU) and international as it relates to European countries. But we include references to the United States since a significant part of the literature on the use of the law to address obesity comes from the United States. While this system is highly specific, it enriches our understanding of the interface between public health policy and the law and offers opportunities for comparison, given that there have been interesting and innovative legislative developments in recent years in the United States.

### Box 1: Key legal mechanisms, principles and terminology

| FRAMEWORK CONVENTION |
| --- |
| A framework convention is a form of international treaty that establishes general guidelines, principles and basic obligations for international and national governance on a particular issue. Separate, more specific protocols may be subsequently attached to a framework convention, building on the parent agreement by elaborating additional more specific commitments. Like other forms of international treaty, a framework convention is legally binding upon ratification (or equivalent process). |
| **LEGISLATION** |
| Legislation is law, which has been adopted by the legislature (e.g. Parliament, Congress or state legislature). Some legislation allows for statutory regulations to be adopted to provide more details and achieve the regulatory objectives set out in the legislation. Both instruments have the force of law. |
| **PROPORTIONALITY** |
| In law, the principle of proportionality aims to ensure that the severity of the restrictions imposed by a regulatory measure do not go beyond what is necessary to achieve the stated aims (i.e. the policy proposed should be the least restrictive in order to achieve the aims). Proportionality is a general principle of EU law. |
| **SUBSIDIARITY** |
| Subsidiarity is a general principle of EU law. According to this principle, in policy areas where both the EU and Member States are authorised to adopt binding acts, the EU may only do so if it can be demonstrated that the collective action at EU level will better achieve the aims of the policy than action by national governments. |
| **EU INTERNAL MARKET** |
| The European Union's Internal Market (sometimes referred to as the Single Market) seeks to guarantee the free movement of goods, capital, services and people between the 28 EU Member States. It intends to aid competition and economic efficiency by facilitating economic integration and the reduction on barriers to trade. National policies that are perceived to create a barrier to the functioning of the internal market may be challenged. |
| **PREEMPTION** |
| In the United States context, preemption refers to the invalidation of State law when it conflicts with Federal law and the invalidation of local and municipal law if it perceived to conflicts with State or Federal law. |

## European Union (Regional)

The key consideration when exploring the potential for action on obesity at the EU level relates to the regulatory powers of the EU relative to those of the 28 Member States. The scope for regulatory action by the EU is determined (and limited) by the powers that the Member States have conferred on the EU institutions, and the principles of subsidiarity and proportionality. As Garde (2010) notes, this results in a two-step test, which first determines whether the EU can take action (i.e. the EU must have powers to act), and, if so, the extent to which it should act, in line with both principles of subsidiarity and proportionality (see Box 1 for further details).

The powers of the EU in the field of public health are clearly defined in the EU Treaties (Treaty on the European Union and the Treaty on the Functioning of the European Union). The powers are relatively limited and exclude legislative harmonisation at the EU level, except in narrowly defined areas, which are

not directly relevant to obesity prevention (Garde, 2010). Thus the focus on 'soft' policy measures[4] for obesity prevention at the EU level, including the exchange of best practice. However, although legislation is explicitly excluded, the EU does have a duty to mainstream public health in all policies. Therefore, health protection should be considered and taken into account when pursuing EU action in other areas with potentially competing goals (Garde, 2010).

EU internal market policy is an important area of competence where there is potential for significant public health impact. The internal market is a geographic area within which the free movement of goods, services, people and capital is ensured, with the aim of enabling choice for citizens and consumers and opportunities for businesses (Garde, 2010). This has implications for the movement of food products and services related to their sale, including marketing. In practice this means that Member States should aim for deregulation and the abolition of any existing barriers to free movement. This might limit the ability of governments to introduce specific regulations around food products.

Free movement is not unlimited and specific provisions have been made that ensure that public interest concerns, including public health, can be protected. Member States are therefore able to derogate[5] from the protection of free movement to protect public health (i.e. enact a law that is contrary to the internal market), if they can demonstrate the action is necessary and the least restrictive of trade (Garde, 2010).

If competence to act (i.e. presence of EU powers) has been identified, then it will be necessary to engage with the principles of subsidiarity and proportionality. The principle of subsidiarity means that all proposals for EU action are scrutinised to assess whether the aims of the action would be better achieved at the national or EU levels. This means that the EU can only act when it is deemed that the EU will better achieve the proposed action than Member States (Garde, 2010). The principle of proportionality relates to the question of whether the proposed mechanism (or 'means') is appropriate to achieve the aims. Again proposals will be scrutinised to assess if the aims could similarly be achieved through another less restrictive means. In other words, EU action (in terms of content and form) should not go beyond what is necessary to achieve the stated aims (Garde, 2010). In essence these two principles ensure that two key questions are considered before each EU action – should the EU exercise its powers, and, if so, how?

To date, two significant pieces of legislation of relevance to food policy have been adopted at the EU level, both with the aim of improving the functioning of the internal market: the Nutrition and Health Claims Regulation in 2006, and the Food Information to Consumers Regulation in 2011 (European Parliament and Council, 2006; 2011). Both of these policies govern the provision and disclosure of information on food packaging in all 28 Member States. The decision to act was likely motivated by the fact that there is significant cross-border movement of food products, and there was potential for Member States to take divergent approaches to the regulation of food labelling and the use of claims, which would create increasing barriers to the internal market. However, despite the legal basis being internal market rather than public health, both pieces of legislation arguably have significant implications for obesity prevention and consumer protection. The Nutrition and Health Claims regulation is notable in that it restricts the use of claims to those that can be substantiated (to avoid misleading claims) and products that meet certain nutritional standards (though these nutritional standards have not yet been defined).

The EU also has some legal authority to regulate media broadcasting and advertising, with rules imposed on Member States through the Audiovisual Media Services Directive (European Parliament and Council, 2010). Given the transmission of media and

[4] Soft measures are distinguished from 'hard measures' and typically include measures such as promotion and provision of information, and awareness raising, but can also involve planning and coordination.

[5] Derogation implies that a government has opted out or gained permission not to enforce a specific provision due to internal circumstance or needs.

broadcasting services across Member State borders, the legal basis and primary regulatory objective is improved functioning of the internal market. Given the weak competence on health, the EU's approach to the marketing of unhealthy foods and drinks has been limited to date, with the European Commission favouring approaches to encourage industry self-regulation, such as through the EU platform for action on diet, physical activity and health.

Notably, however, EU legislation on media advertising provides minimum harmonisation (i.e. minimum standards to be met by all Member States), meaning that countries do have the authority to impose more detailed and stringent regulations and exceed the minimum level of protection that the Audiovisual Media Services Directive provides. The UK government, for example, introduced tighter statutory regulation on food advertising to children based on nutrition standards in 2007 (OFCOM). Nevertheless, Member States can only impose the enhanced standards on broadcasters established in their jurisdiction and are not allowed to restrict retransmission on their territory of media services from other Member States (Bartlett and Garde, 2013). In practice this 'country of origin' principle means that more stringent regulation does not apply to advertising beamed in from other jurisdictions; it is intended to strike a balance between moves to protect public interest and the free movement imperative of the internal market. As Bartlett and Garde (2013) note, this can become problematic when material is retransmitted from one Member State to another Member State with a higher level of protection. For example, food adverts originating from outside of the UK but broadcast within the UK would not in fact need to be in compliance with the UK's statutory regulation but with the laws (or legal practice) in the country of origin. This could be a significant concern in regions where there is strong cultural exchange across countries due to shared/similar languages (e.g. Austria and Germany; France and Belgium; Scandinavia), and thus lends support to the WHO's call for cross-border standards (Bartlett and Garde, 2013; WHO, 2010).

## National

National governments have significant autonomy to introduce legislation. In many cases they maintain control over the major policy levers such as taxation and budget, and hold powers to regulate industry and the communications sector. They also tend to have primary responsibility for disease surveillance. Within the European region it is important to note the interplay between the powers of the EU and the powers of Member States (as described above), particularly when national policy is developed that may have implications in areas where the EU has competence. National policies often need to carefully designed within this framework.

## Sub-national and local

Many countries delegate some legal powers to devolved administrations, regions or more local areas, or have established division of powers across different levels – this includes countries with federal systems such as Germany and those such as Spain that have autonomous provinces. However, almost all of the literature with examples of sub-national entities that have taken legislative action in the area of food policy and obesity comes from the United States, where state governments and their political subdivisions have powers to enact laws to protect public health and well-being and regulate the sale of products (Pomeranz, 2012). A growing number of states, cities and local authorities in the United States have introduced regulatory strategies to promote healthy food options and restrict unhealthy food options (Diller, 2011). Municipal authorities have been particularly active; states delegate powers to these authorities, but retain the right to usurp or 'preempt' as they see fit (Diller, 2011). Taxation, for example, is often highly circumscribed by state law.

While the United States legal system is unique, it provides an interesting case study of the interplay between state and local authorities in implementing policy measures in a particular area. Calorie labelling on menus has been striking as an example of the dynamics at play between municipal authorities

and state legislature and the role of preemption in influencing direction of policy. In some states, municipal authorities took action, which then encouraged the state to introduce state-wide labelling; others did the opposite by expressly forbidding local authorities from adopting local legislation and not adopting state-wide standards (Diller, 2011). Recently, New York City has received widespread attention for attempts to introduce portion-size restrictions for soda (Pomeranz, 2011). The form and legal authority for the proposal, led publicly by New York Mayor Michael Bloomberg, is as of September 2013 being challenged in the New York State courts.

In the UK, local planning laws allow for restrictions on hot food takeaways (e.g. fast-food outlets) on health grounds, with the authority to place limits on the concentration of takeaways or completely restrict any new outlet within a defined area (e.g. near schools), but legislative powers remain largely concentrated with central government (Healthy Places). The devolved powers of the Welsh and Scottish governments provide them with some legal authority, with both, for example, introducing policies on healthy vending machines in hospitals (NHS Wales, 2008).

# WHAT ARE THE BARRIERS TO USING LAW?

Despite the considerable scope for using law to regulate unhealthy diets at different levels of governance, there are also significant potential obstacles and barriers. These barriers include both limits to legal authority and political and philosophical objections. In practice, the two types of barriers are related: although there are genuine limits to legal authority, these limits are subject to interpretation, and opponents with philosophical objections often employ legal arguments to delay and stall legislative proposals and challenge them in courts once adopted.

## Limits to legal authority

**Legislation can be held to be unconstitutional where it infringes upon protected rights of people or commercial actors.** To be upheld, legislation must be shown to conform to constitutional agreements (Garde, 2010). Examples of constitutional agreements include the European Union treaties provisions on the free movement of goods (as defined in the Treaty on the European Union and the Treaty on the Functioning of the European Union) and the United States constitutional protections given to commercial speech under the First Amendment of the United States Constitution. In jurisdictions where constitutions protect commercial expression, restrictions on advertising may be interpreted as being contrary to such freedoms (Garde, 2009). In the United States, constitutional courts have generally rejected proposals for legislation that purposefully or inadvertently bans or restricts the 'accurate advertisement' of products to adults. The case for restricting advertising to children has been challenged on that basis, although legal experts have argued that limits are justified in light of children's known inability to differentiate between truthful and exaggerated messages or distinguish between marketing and information (Pomeranz, 2009; Gostin, 2007). Reconciling the legal arguments in favour of protecting children and counter-arguments around the "unnecessarily broad suppression of speech addressed to adults" has proved difficult (Harris, 2009). Much of the discussion about constitutional freedoms comes from the United States, but similar principles can be invoked in the EU, where the European Court of Justice has upheld the principle of freedom of expression as a general principle in its rulings (Garde, 2009). Commercial freedoms in the EU must be balanced against competing interests, including public health, and action for the protection of public health may be taken provided the measure is deemed proportionate to the aim pursued. The European Court of Justice has rarely exercised its review powers or required authorities to demonstrate proportionality in the field of freedom of expression as it relates to public health (Garde, 2009).

**Legislation is viewed as unfairly targeting one category of food or drink or having specific distorting effects on one type of business that sell these products in an arbitrary manner.** Legislation may be challenged or struck down in cases where the courts rule that the legislation has been poorly framed. In cases where legislation applies to specific foods or categories of food, the responsible body may be called upon to demonstrate that distinctions are sound (i.e. supported by evidence of a clear public health rationale) and not arbitrary in nature (i.e. based on economic or political considerations). For example, the New York State Supreme Court ruling against the New York City 'supersize soda ban' in 2013 held that the scope of the legislation was 'arbitrary and capricious', with numerous exemptions and loopholes relating to the types of products and settings to which the rules would apply, and the evidence linking targeted products to health outcomes was scrutinised (Supreme Court of the State of New York, 2013). The decision is currently being appealed. Legislative proposals could be upheld in such cases if it is ruled that there is a rational justification for a distinction to be made between the products (i.e. if there is solid evidence to support the distinction) (Pomeranz, 2011).

**Legislation is blocked by pre-emption by a higher level of government.** The scope for legislation at the national level maybe pre-empted by international and/or EU laws governing competition and the free

movement of people, goods, capital and services. In the EU, there are examples of limits to authority in specific policy areas. The EU Food Information to Consumers regulation expressly prohibits Member States from introducing national food labelling legislation that goes beyond the EU agreements. National labelling schemes extending beyond the Regulation – such as the traffic light labelling scheme in the UK and the Keyhole scheme in the Scandinavian countries – must therefore be voluntary (Department of Health, 2013; Swedish National Food Agency, 2007). Due to the Country of Origin Principle, EU law also prevents countries from imposing restrictions on advertising that originates from another EU country.

In practice, there has been a certain amount of flexibility demonstrated by the EU towards legislative measures taken by national governments. For example, Denmark's ban on trans-fatty acids in 2003 tested internal market legislation. Industry and some countries argued it was an obstacle to the free movement of goods, leading to a lengthy negotiation process with the EU authorities. Nevertheless it was deemed permissible within EU law on grounds of protecting public health. Countries must generally be able to show that measures are consistent with the functioning of the internal market, have clear public health objectives, are clearly designed to achieve those objectives, and cannot be achieved through less trade restrictive means (Garde, 2010). Opponents of legislation have argued against measures taken by European governments on the basis that they are inconsistent with the objectives of the internal market, even in the case for voluntary measures. In 2013, for example the European food industry argued that the voluntary traffic light system in the UK, while theoretically permissible, "runs counter to the EU's objective of the creation of one single European market" (Scott-Thomas, 2013). These issues of pre-emption also apply in other federal systems where there is a division of powers between the federal governments and the state governments and municipalities. In the United States, for example, when New York City first introduced menu labelling the restaurant industry argued that it could not be enacted because federal food labelling law pre-empted laws by cities and states. In this case, however, the courts ruled in favour of New York City (Pomeranz, 2011).

**Governments develop policy in the context of international trade and investment treaties.**
As with other areas of public policy, countries that use law to address obesity do so in the context of various obligations that they have accepted or commitments they have made under international trade and investment treaties, whether multilateral (most prominently World Trade Organization [WTO] rules), regional or bilateral. Under such agreements, countries make a range of commitments that impose constraints on the way they regulate goods, services and investments. These include commitments not to discriminate between locally produced goods and 'like' products imported from other states, not to adopt regulatory measures that are more restrictive than necessary to promote public interests such as public health, and not to expropriate the property of foreign investors (among others). In the food area, critical international agreements include the WTO Technical Barriers to Trade Agreement (TBT), the Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS), and the Uruguay Round Agreement on Agriculture.

International trade and investment law are complex, highly nuanced – and insufficiently understood – areas of law. While, generally speaking, they give states significant regulatory autonomy and policy space – that is, the ability of governments to choose, design and implement public policies that fulfil their regulatory aims – there can often be significant uncertainties. The combination of uncertainty, lack of technical legal capacity, and the possibility of (expensive) legal challenge in international fora can create what is referred to as 'regulatory chill' – where legal uncertainty and/or threat of legal challenge dissuade governments from acting.

Analysis of the effect of international treaties to date on the policy space for addressing unhealthy eating is relatively limited. According to Fidler (2010), international (WTO) rules do not limit the scope of governments to implement most policies to promote healthy eating, such as taxes and marketing restrictions. Analysis by Atkins (2010) and Thow et al (2011) also indicates that the Agreement of Agriculture

provides sufficient flexibilities for countries to develop policies to support increases availability of healthy foods. But there are clear limits on governments to impose import bans and increase import tariffs on imported goods beyond the agreed rate. This is because they are seen as unfairly restricting trade since they may be seen to discriminate between 'like' products and not be the 'least trade-restricting option'. For example, international rules have been invoked in the Pacific Islands against ban on the import of "mutton flaps" (a meat product comprising almost 100% fat) in Fiji and "turkey tails" Samoa (a meat comprising almost 40% fat); Fiji has managed to maintain its ban on "mutton flaps" while the Samoan ban on "turkey tails", which had been in place since 2007, was lifted in 2012 when the country acceded to the WTO (WPRO, 2013).

For food policy, as in other areas, the lack of understanding among the public health community about the implications of international trade and investment law on efforts to address obesity has allowed the promulgation of arguments by opponents of legislation that specific policy proposals are "trade barriers" (Telegraph, 2013; WTO, 2011). There is further concern among analysts of trade and public health that future negotiation of additional trade and investment treaties will adopt more onerous international obligations and thus have potential to impose greater restrictions on domestic policy space. This is an area that clearly requires close engagement between the public health community and experts on trade law.

## Political and philosophical barriers

**Perceived conflict between individual autonomy and the free market, versus public health and collective benefit.** The political, media and industry framing of obesity as an issue of individuals failing to exercise personal and/or parental responsibility can influence the policy framework by shaping the discourse on what is an acceptable and feasible government intervention. Those who view (or choose to portray) obesity as the result of individual lifestyle choices often exhort people to take greater responsibility in their food choices and exercise habits and push back against regulatory interventions (MacKay, 2011). This may be motivated in part by a philosophical commitment to 'small government' and socially libertarian values, but can also be motivated by economic liberalism and a commitment to limited government intervention in the economy (including services and goods). Legislative proposals that limit the availability of certain products, or target certain products for fiscal interventions may be particularly unpopular as they are seen to remove the freedom to choose.

**Perception that voluntary approaches are "more cost effective, more flexible, and easier to introduce rapidly than primary legislation".** Analysts of public policy point out that there are opportunity costs to consider, including significant time and resource costs associated with drafting and preparing legislation (Baggot, 1986). Legislation only applies within the specific jurisdictions where it is applied, and it has been argued that patchy adoption and implementation of legislation could lead to fragmentation, in contrast to voluntary initiatives adopted by industry operating in a globally integrated way (Garde, 2010). These perceptions remain despite a body of evidence, as already discussed, that suggests there are significant gaps and shortcomings with self-regulatory schemes (Persson, 2012).

**Influence of the food and drink industry.** While it is not a homogeneous entity, a limited number of transnational corporations and retailers (predominantly US and European firms) make up a significant share of regional and global markets and are expanding their presence in other countries (US Department of Agriculture, 2012). These companies are often organised into trade associations and lobby governments on issues relating to food policy. There is public and political debate over the appropriateness of legislative action, which industry seeks to influence. A central argument is that there is no such thing as 'bad' foods so long as individuals exercise dietary moderation (MacKay, 2011). In response to growing rates of obesity and growing pressure on governments to act, many food companies have announced policies of corporate social responsibility, which aim to "empower individuals to make informed choices",

and helping "children and their families to make healthy food choices while encouraging physical activity" (Ludwig, 2008). Industry is seen to be well-positioned to adopt voluntary measures to forestall public regulation and actors have strongly resisted policies that will restrict their activities (i.e. marketing restrictions, vending machine bans in schools, portion size bans, zoning restrictions) or create disincentives to consume their products (fiscal measures); have strongly resisted government legislation in favour of self-regulation; and, have been vocally critical of, or selectively represented, public health evidence (MacKay, 2011; Simon, 2006; Reuters, 2012). The ability of public health authorities to counter these challenges/claims is often undermined by their weak position relative to other portfolios (e.g. treasury) and policy objectives (e.g. economic growth).

**Lack of consensus on appropriate level of intervention.** As noted in relation to the doctrine of pre-emption (p.22), there may be disagreement over which level of government is most appropriate to implement a given law. Beyond legislation at local, state and national levels, there is also disagreement as to what extent global and regional-level legal action should play a part in addressing obesity and food policy, despite evidence pointing to cross-border determinants of obesity (Harris, 2009; Persson, 2012). Some have voiced concerns around global action if it leads to duplicative governance structures that prioritise process over outcomes, generality over specificity, state over non-state actors, and legal expertise over public health expertise (Chopra, 2011; Hoffman, 2011).

# WHAT SHOULD THE PUBLIC HEALTH COMMUNITY DO?

This Working Paper provides the opportunity for reflection on the role of law in obesity prevention. Focusing on food policy action, it explores the body of evidence available to inform policy and discusses the policy options that are amenable to the use of law. It also touches upon some of the advantages of using the law as opposed to other policy approaches to enhance the effectiveness of policy. Importantly it discusses ways in which the currently available public health evidence can be used to inform the development of clear policy objectives which will feed into the development and framing of objectives for legislation and regulation. It also reveals the importance of identifying a clear legal basis for legislative proposals and examines the different levels of government at which the law can be used. Finally it explores and addresses some of the barriers to the use of law, including limits to legal authority and political and philosophical barriers.

There is much scope for further work in this area. WCRF International believes there is a key role for law in addressing obesity and preventing cancer and other NCDs. We call upon the public health community to engage with the legal community to enable the wider implementation of more effective policy action to address unhealthy diets. We need to consolidate and expand engagement with the legal community in order to capitalise on their expertise and experience working on other public health challenges. In particular we need to collaborate in order to:

- Establish the legal basis for the action at the outset.
- Use the available evidence to help frame the objectives of the law and ensure it is defensible if challenged.
- Overcome barriers to the use of law, at all levels, including through a better understanding of relevant legal bases for action.

WCRF International looks forward to further engagement with the legal community, including continued collaboration with the McCabe Centre for Law and Cancer and their regional partners.

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