RESEARCH PAPER

Montreal Economic Institute

Ideas for a More Prosperous Nation

MAY 2013

NO MAGIC PILL

Positive Solutions to the Obesity Issue

DR. DAVID GRATZER
with the collaboration of Jasmin Guénette

Montreal Economic Institute
Ideas for a More Prosperous Nation

910, Peel Street, Suite 600
Montreal (Quebec)
H3C 2H8, Canada

Phone: 514-273-0969
Fax: 514-273-2581
Website: www.iedm.org

The Montreal Economic Institute is an independent, non-partisan, not-for-profit research and educational organization. Through its publications, media appearances and conferences, the MEI stimulates debate on public policies in Quebec and across Canada by proposing wealth-creating reforms based on market mechanisms. It does not accept any government funding.

The opinions expressed in this study do not necessarily represent those of the Montreal Economic Institute or of the members of its board of directors.

The publication of this study in no way implies that the Montreal Economic Institute or the members of its board of directors are in favour of or oppose the passage of any bill.

Graphic Design: Mireille Dufour

ISBN 978-2-922687-39-2

Legal deposit: 2nd quarter 2013

Bibliothèque et Archives nationales du Québec

Library and Archives Canada

Printed in Canada

Dr. David Gratzer

with the collaboration of

Jasmin Guénette

No Magic Pill

Positive Solutions to the Obesity Issue

Montreal Economic Institute Research Paper

•

May 2013

Montreal Economic Institute

Ideas for a More Prosperous Nation

Table of Contents

FOREWORD

There is no question that the growing proportion of overweight and obese people in our society has become an important health problem, with non-negligible financial consequences. But agreeing on the seriousness of a problem doesn't mean that the solutions to be applied are obvious and uncontroversial.

Unfortunately, the solutions we most often hear about are those that rely on taxation, coercion, regulation, and in general on more government involvement in people's lives. There are interest groups that have been set up in recent years specifically to lobby for the implementation of new taxes on certain food products. They propose that the funds raised from these taxes be used to educate the public on healthy habits and good nutrition. And such programs could be managed by… groups like themselves. How convenient!

Whenever a public debate involves public funds and more government intervention, we can be sure that groups that stand to benefit from such interventions will emerge and come to dominate that debate, even though there is no evidence that the solutions they propose will work.

What we eat and what we do with our own bodies are very personal issues. Taxes and regulations are crude instruments that very rarely bring about the kinds of changes in behaviour that are sought after on the part of individuals and corporations. No program will achieve results in the long term unless the targeted individuals are convinced of its usefulness and are willing participants.

There are other types of solutions that are respectful of personal choices and that rely on individual freedom and responsibility. This is the approach taken by Dr. David Gratzer in this *Research Paper*, on which I had the pleasure of collaborating.

Dr. Gratzer is one of Canada's leading experts in health care policy. He proposes various positive incentives that can be put in place by government, businesses, families and the health care community to help the overweight and obese eat better and exercise more. As he shows, there is no magic pill to cure such a complicated and multifaceted problem. But if all those involved do their part to promote better habits, we stand a much better chance of getting this problem under control.

Jasmin Guénette
Vice President of the
Montreal Economic Institute

Mr. Guénette also collaborated on the *Economic Note* "Are Soda Taxes A Cure For Obesity?" authored by Dr. Gratzer and published by MEI in November 2012.

Executive Summary

Medical researchers and journals have repeatedly ~~and~~ rightly—sounded the alarm about the risks of widespread obesity. Those risks are real. The demand for early ankle and knee replacements is rising, hypertension is more common, and Type II diabetes rates are soaring. Medical facilities have been forced to retool with new equipment designed to handle heavier patients.

While obesity rates are growing internationally, there are important differences between regional and individual factors. Unlike tobacco, food is sold and consumed in an unpredictable variety of public, private or semi-private environments, in millions of non-standard units, with supply chains that can vary radically from product to product.

This is why, for policy purposes, the only sensible way to address this reality is to attack obesity as the mass outbreak of millions of similar yet unique examples of an *individual* condition.

Solutions to this problem should focus on the incentives that individuals face. Negative incentives aim at discouraging (or prohibiting) certain behaviours on the part of consumers. They have a poor track record of success. Positive incentives, for their part, aim at reinforcing desirable behaviours on the part of consumers. Less often tried with regards to obesity, such incentives aim at increasing the returns for healthy behaviour.

The first step in crafting an effective anti-obesity policy is to accept that there are practical and political limits to the state's ability to micromanage dietary behaviour in a free society. Policymakers must abandon the search for one magic policy pill that can melt a nation's pounds away. There is no one law, no single tax, and no single food product scapegoat that can serve as the foundation for a successful anti-obesity strategy.

The puritan, coercive approach to the obesity problem favoured by many in the public health community is not the only possible one. Given the unique features of the crisis, it is time to give more weight to a more positive alternative approach. We have built social and economic systems that subsidize and accentuate bad choices. To replace them, we need systems, policies and attitudes that facilitate better choices.

Thanks to various government and private initiatives in schools, children are now the vanguard in the fight against obesity, with several studies showing positive results. Government can do more, not only in schools, but also by facilitating higher exercise rates in everyday adult life, and by developing a health insurance model based on positive incentives.

The medical profession has a critical role to play in the implementation of a successful anti-obesity policy. Patients often respond more earnestly to medical advice about clearly defined risks. Given the culture of our profession, physicians also tend to be more comfortable offering advice on specific risks and ailments.

With this in mind, it may be time to aggressively "medicalize" the medical world's response to obesity.

Key industries and employers can also foster a healthier adult society by building in support for positive changes, such as redesigning their routine environments to normalize healthy foods and regular physical activity.

While individual responsibility is a crucial tool in the obesity fight, food and beverage firms must be responsible as well. They must do their part to reduce the unhealthy impact of existing products, especially where added sugar, fat or salt can be reduced in the existing supply chain. They should seek to diversify their product portfolio to include a range of healthy products. And they should make clear and complete nutritional information about their products easily available to consumers.

Without responsible individual action to prevent obesity, there is little hope of reducing obesity rates, even if environmental factors are mitigated. Our policy choices must be designed to positively reinforce millions of individual choices for the long term. There is no shortage of positive approaches available. What has been missing is open-mindedness on the part of the public health community, which persists in its mistaken belief that only heavy-handed policy interventions are worthwhile.

INTRODUCTION

Understanding the obesity challenge

In medical school, my supervisor and I interviewed a patient. This patient was visibly overweight. "Why don't you list for him all the consequences of obesity?" the older doctor asked. From osteoarthritis to depression, I ticked off items on a long list of diseases before chatting with my supervisor about other health consequences. The patient listened in silence, humiliated. By the end, he was reduced to tears.

I have often thought of that encounter—and not just because of my own personal regrets. That gentleman and his condition, and also my own indifferent attitude, were a microcosm of what is wrong with modern health policy on the obesity issue.

Medical researchers and journals have repeatedly—and rightly—sounded the alarm about the risks of widespread obesity. Those risks are real. The demand for early ankle and knee replacements is rising, hypertension is more common, and Type II diabetes rates are soaring.[1] Medical facilities have been forced to retool with new equipment designed to handle heavier patients.[2]

Even optimistic observations on the crisis can be a cause for concern. When a recent study argued that moderately overweight people may live longer lives, *The Economist* wryly noted the downside: "corpulence may extend life, meaning [additional] treatment may be needed for many extra years. Expanding waistlines could be making people live longer, but sicker."[3]

While the costs and consequences can be tracked, the causes—and cures—are less certain, since any particular individual's excess weight can be rooted in a range of dietary, habitual, physical or social inputs.

There are, of course, common trends that transcend individual circumstances, countries or cultures. Rapid economic growth, especially in formerly poor non-Western countries, is one of those trends.

For example, as average incomes in coastal, industrial China grew higher over the last two decades, obesity rates rose quickly in tandem.[4] Higher disposable income, lower relative food costs and ready access to fast food and prepared foods has made it economically easy for hundreds of millions to satisfy their desires for calorie-rich, fatty, sugary and salty foods on a regular basis.

This has even become a challenge in markets that traditionally had no cultural propensity to eat this way.[5] Food industry firms often maintain market share by selling unhealthy foods that satisfy cravings rather than nutritional needs. Many of their customers can now afford to eat to excess accordingly, and too many of them do.

The situation is somewhat different in prosperous Western countries such as the United States and Canada, where people may have consumed more calories on average in the 19th century than they do now.[6] In fact, economists generally agree that the quantity of food consumed is not the only, nor perhaps even the main factor explaining the rise in obesity since the 1950s.[7]

1. The most up-to-date national level data on the impact of obesity can be found on the website of the Public Health Agency of Canada at http://www.phac-aspc.gc.ca/hp-ps/hl-mvs/oic-oac/index-eng.php, and the website of the Center for Disease Control at http://www.cdc.gov/obesity/data/adult.html for the United States.
2. For one example—in this case, larger MRI scanners—see "The Plus Size MRI Machine," *Wall Street Journal*, September 18, 2012.
3. "Fat Years," *The Economist*, January 4, 2013.
4. Paul French and Matthew Crabbe, *Fat China: How Expanding Waistlines Are Changing a Nation*, Anthem Press, 2010.
5. Japan is one notable example; see Rowan Hooper, "Obesity on the rise as Japanese eat more western style food," *Japan Times*, March 11, 2012.
6. In 2000, the USDA estimated that food consumption stood at 2,700 calories per person per day; see United States Department of Agriculture, *Agriculture Fact Book 2001-2002,* p. 14. In comparison, daily consumption of calories in the United States between 1839 and 1879 stood between 2,696 and 3,130 calories per day; see Robert Gallman, "Dietary Change in Antebellum America," *Journal of Economic History*, Vol. 56 (1996), No. 1, p. 195.
7. Tomas Philipson and Richard Posner, *Is The Obesity Epidemic a Public Health Problem? A Decade of Research on the Economics of Obesity*, National Bureau of Economic Research, 2007, p. 2.

The rise of new technologies and the changing nature of work, transportation and leisure is probably a better candidate. Work-saving technologies in many sectors of the economy, such as agriculture, allowed workers to migrate to less physically demanding jobs that accordingly burn fewer calories. As a consequence, physical activity has become more of a luxury and less of a routine necessity. Additionally, the rise in wages and in the overall standard of living meant that there was a higher demand for free time. Easy-to-prepare meals and time-saving techniques were adopted by consumers and as a result, their waistlines expanded.[8]

For most of human history, cooking a meal required an important quantity of time and human energy.[9] The arrival of cheap, already cooked meals in the 1950s (from TV dinners to fast-food meals) meant more free time.[10] While there is ample evidence that families that eat at home achieve better nutritional and calorific outcomes—so much so that nutritional scientists insists that cooking is a "healthy behaviour"[11]—wealthier societies are more likely to prioritize convenience and leisure. Hence the paradoxical success of television programs devoted to cooking in an age when the average person is less likely to cook at home than ever before.[12]

We cannot outlaw economic growth or technological development, nor can we force people to cook at home and exercise. And unless we ban popular food industries outright or ration net calories as we might in wartime, the end-consumer will always have the final say on their own balance—or imbalance—of calories.

Dr. David Katz is the founding Director of Yale's Prevention Research Centre. In his words, "we gain weight when calories in exceed calories out; period."[13] Too many people are taking in far more calories than they are burning, yet the exact combination of foods, habits, exercise opportunities and other environmental factors inevitably varies from person to person.

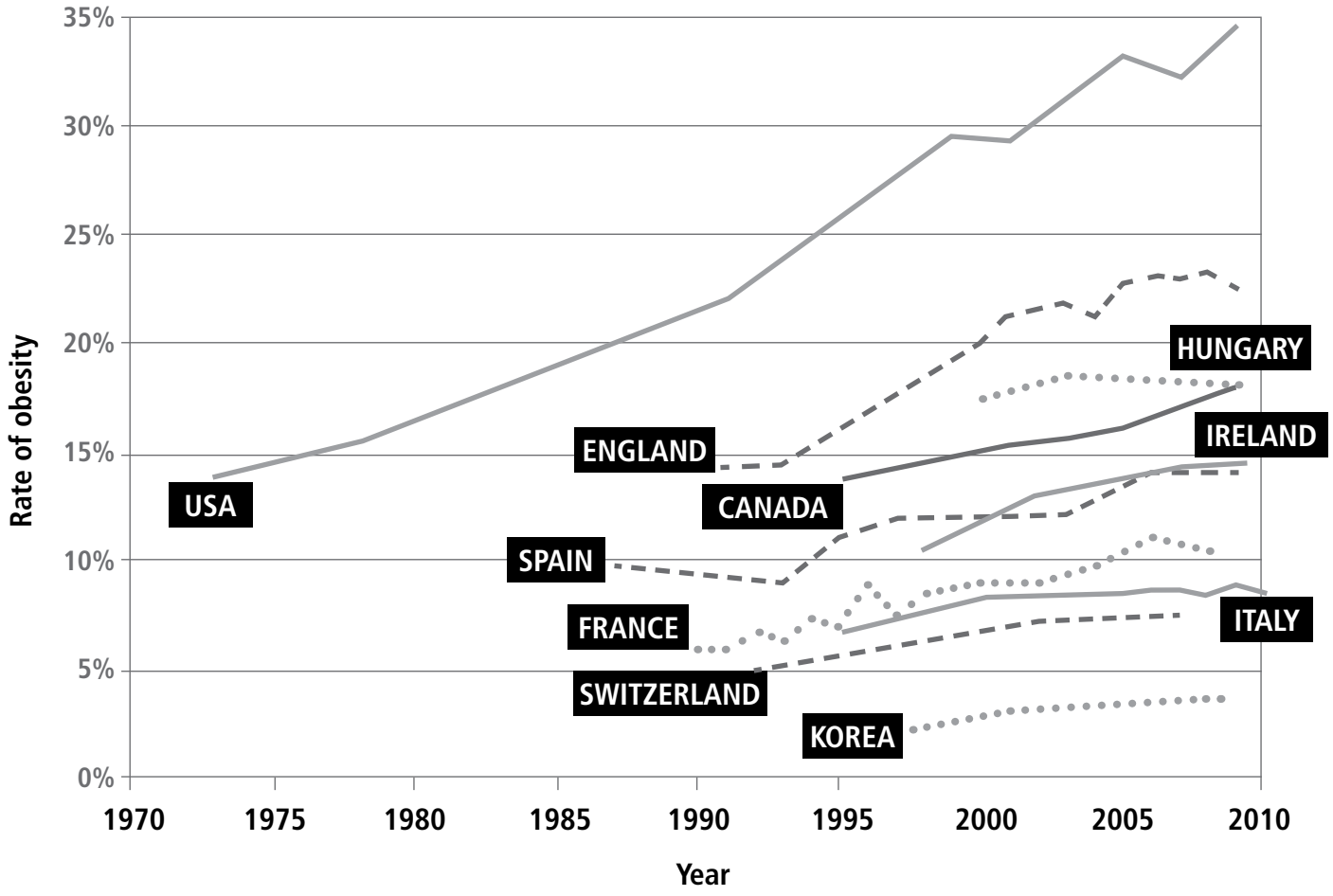
The simplicity of Katz's "calories in" mantra belies its complexity. Public health advocates had an easy target with anti-smoking policies, since interventions could be targeted at a visible public activity that is easily classified, regulated, and policed. Most tobacco is consumed in cigarette form, so taxes and regulations could be targeted at a standardized product, affecting only a few supply chains and a small group of companies. Nicotine is physiologically addictive, so legislators could use that fact to build public support for government intervention.

In contrast, any individual can gain excess weight by consuming any one of literally hundreds of combinations of different products and ingredients. And while obesity rates are growing internationally (see Figure 1), there are important differences between regional and individual factors. Even a cultural preference for a particular condiment (e.g., Nutella in France) can be a factor. Unlike tobacco, food is sold and consumed in an unpredictable variety of public, private or semi-private environments, in millions of non-standard units, with supply chains that can vary radically from product to product.

This is why, for policy purposes, the only sensible way to address this reality is to attack obesity as the mass outbreak of millions of similar yet unique examples of an *individual* condition.

8. Eric A. Finklestein and Kiersten Strombotne, "The Economics of Obesity," *The American Journal of Clinical Nutrition,* Vol. 91 (2010), No. 5, pp. 1520S-1524S.
9. Ruth S. Cowan, "The 'Industrial Revolution' in the Home: Household Technology and Social Change in the 20th century," *Technology and Culture,* Vol. 17 (1976), No. 1, pp. 1-23.
10. Hank Cardello, *Stuffed: An Insider's Look at Who's (Really) Making America Fat and How the Food Industry Can Fix It*, Ecco. 2009.
11. Editorial, "Cooking as a healthy behaviour," *Public Health Nutrition,* Vol. 15 (2012), No.7, pp. 1139-1140.
12. Michael Pollan, "Out of the Kitchen, Onto the Couch," *The New York Times*, July 29, 2010.
13. See his website at http://www.davidkatzmd.com/opose_summary.asp.

Figure 1
Obesity rates in some OECD countries



Source: Organisation for Economic Cooperation and Development, *Obesity Update 2012, p. 2.*

Solutions to this problem should focus on the incentives that individuals face. Negative incentives aim at discouraging (or prohibiting) certain behaviours on the part of consumers. As we shall see in the next section, they also have a poor track record of success.

Positive incentives, for their part, aim at reinforcing desirable behaviours on the part of consumers. Less often tried with regards to obesity, such incentives aim at increasing the returns for healthy behaviour. They will be discussed in later sections.

CHAPTER 1

What governments shouldn't do

The first step in crafting an effective anti-obesity policy is to accept that there are practical and political limits to the state's ability to micromanage dietary behaviour in a free society. Policymakers must abandon the search for one magic policy pill that can melt a nation's pounds away. There is no one law, no single tax, and no single food product scapegoat that can serve as the foundation for a successful anti-obesity strategy.

Unfortunately, the public health community remains fixated on studies that predict optimistic and dramatic results for anti-obesity taxes at rates as low as 10% *ad valorem*. Yet in empirical studies[1] and in real-world cases, these proposals rarely deliver on projected outcomes.

For example, a Cornell research team led by Dr. Brian Wansink recently ran a controlled experiment with a test group for six months, levying a simulated 10% sugar-sweetened beverage tax on the participants, with no tax payable for a control group. The tax reduced soda consumption modestly in the first month, but the shift was not sustained through the duration of the test. Consumer habits won over higher prices in the long run and the experiment also led to some cases of substitution for other—more problematic—products.[2]

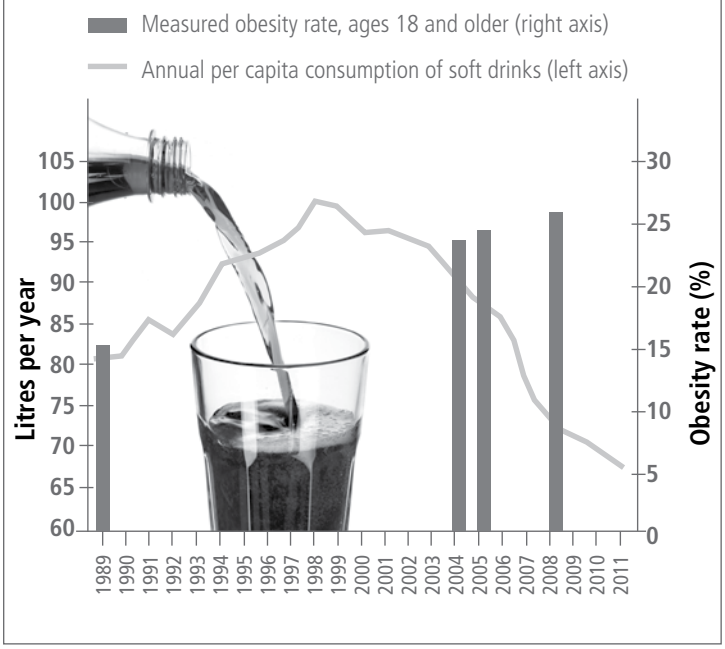
Many public health advocates blame soda as the primary cause of obesity and advocate a "soda tax," that is, a tax on soft drinks and other sweetened beverages. Although *per capita* consumption of soft drinks in Canada has already fallen by 32% between 1999 and 2011 (see Figure 2), they believe that this will reduce obesity by driving consumers away from these products in even greater numbers. Yet they fail to reconcile this view with different international consumption patterns. For example, while the Canadian obesity rate is closer to America's than that of almost any other country, in most age and gender categories, Canadian adults consume more coffee or beer than soft drinks.[3] Soda taxes in the U.S. have also had no measurable impact on obesity.[4]

While many public health lobbyists argue that broad-based, punitive excise taxes would be more effective than sales taxes, there is still no guarantee that any kind of tax will cut habitual consumption. Nor is there any guarantee that higher taxes will

1. I emphasize empirical studies here because much of the published literature in favor of anti-obesity taxation *projects* positive outcomes from soda or fat taxes, *presumes* uniformity of price impacts from those taxes, and *generalizes* assumptions about consumer response to public policy "nudges." For an influential example that projects reduced obesity solely on the basis of projected estimates, see Kelly Brownell *et al,* "The Public Health and Economic Benefits of Taxing Sugar-Sweetened Beverages," *New England Journal of Medicine*, October 15, 2009. But diet is not so simple. For a critique of optimistic projections in obesity policy interventions, see Kevin Hall *et al.*, "Quantification of the Effect of Energy Imbalance on Bodyweight," *The Lancet*, August 2011. For an empirical study on the challenge of consumer confusion or indifference to anti-obesity taxes, see Yuqing Zheng *et al.*, "Taxing Food and Beverages: Theory, Evidence, and Policy," November 2012 (accepted for publication in the *American Journal of Agricultural Economics*, 2013). For a field study of consumer confusion in response to calorie count menus, see Elizabeth Gross Cohn, *et al.*, "Calorie Postings in Chain Restaurants in a Low-Income Urban Neighborhood: Measuring Practical Utility and Policy Compliance," *Journal of Public Health,* August 2012.

2. Brian Wansink, *et al.*, "From Coke to Coors: A Field Study of a Sugar-Sweetened Beverage Tax and its Unintended Consequences," Cornell University (working paper), May 26, 2012.
3. David Gratzer and Jasmin Guénette, "Are Soda Taxes a Cure for Obesity?" Montreal Economic Institute, November 15, 2012; Didier Garriguet, "Beverage consumption of Canadian adults," Statistics Canada, November 2008.
4. Jason M. Fletcher, *et al.*, "The effects of soft drink taxes on child and adolescent consumption and weight outcomes," *Journal of Public Economics*, September 2010.

Figure 2
Consumption of soft drinks and obesity rate in Canada (1989 to 2011)



Sources: Statistics Canada, CANSIM Table 002-0011, "Food available in Canada," 2012. Public Health Agency of Canada, "Obesity in Canada," 2011, available at http://www.phac-aspc.gc.ca/hp-ps/hl-mvs/oic-oac/adult-eng.php.
Note: We have used the measured obesity rate rather than the self-reported obesity rate because the latter understates the problem of obesity. Data for measured obesity rates only exist for these four years.
The numbers for obesity in Canada in this figure differs from that given in Figure 1. The reason for this discrepancy is that the OECD standardizes the data so as to make them comparable across countries.

deliver uniform increases in product pricing for sugary or fatty products, since producers in these sectors can use a variety of pricing and packaging strategies to counter the impacts of taxation.

Heavy-handed tax and regulatory measures are also likely to fail due to the complexity of their application. Inevitably, taxes and regulations must be imposed on something in particular, not just on "unhealthiness." Tax targets have included sugar added at manufacture, single-serving foods, retailers who sell unhealthy foods (through business license fees), different levels of saturated fats, and even selected fatty ingredients (like palm oil). In each of these cases, the complexity of applying the tax leads to unintended consequences, as some undesirable foods are taxed, others are not, and still others are inevitably exempted.

The most common example of an unintended consequence is also the most important from an anti-obesity standpoint: the substitution problem. Habitual high-calorie consumers who are nudged away from one food category can simply replace the lost calories from another source. And they often do.

In 2010, a team led by Jason Fletcher of the Yale School of Public Health published a study in the *Journal of Public Economics*. Their review of historic nutrition and consumer data found that U.S. soft drink taxes "do not appear to have countered the rise in obesity prevalence *because any reduction in soft drink consumption has been offset by the consumption of other calories* [my emphasis]," specifically calories from whole milk and other calorie-rich beverages.[5]

5. *Ibid.*, p. 973.

Even if "fat taxes" or similar measures could be simply applied to produce predictable outcomes, public hostility to their use is a compelling reason to limit expectations for their success. Several anti-obesity tax measures proposed internationally in the last five years fostered a backlash in their respective jurisdictions, resulting in the ultimate demise of the measures themselves. Consider the outcomes in five recent campaigns:

- In April 2010, Washington State legislators introduced a sales tax on candy and an excise tax on soda. Opponents collected nearly 400,000 signatures supporting a voter-initiated referendum in just three months. In November 2010, voters defeated both taxes with over 60% support.[6]

- In the small California cities of Richmond and El Monte in November 2012, city councils asked for voter approval of proposed soda taxes in similar ballot measures. Despite a high profile campaign, high local obesity statistics, favorable national media coverage and celebrity endorsements for the pro-tax side, voters rejected both plans by decisive margins. Richmond voters defeated their measure by 66% to 33%, while El Monte voters rejected their own proposed tax by 76% to 23%.[7]

- In October 2011, Denmark levied a 16 kroner per-kilo[8] tax on foods with saturated fat levels higher than 2.3%. Many Danes responded by driving across the border to Germany to buy the same goods at lower prices, while the business sector complained about the complexity of applying the tax. Just thirteen months later, the Danish government announced plans to repeal the measure.[9]

- In France, senators named a popular hazelnut spread—Nutella—as a culprit in rising national obesity rates, and successfully amended a budget resolution to increase palm oil tariffs by 300% as an anti-obesity measure (palm oil is a key ingredient in the spread). Amid widespread criticism, the French Senate defeated this "Nutella Tax" and several related measures, including a proposed tax on aspartame.[10]

- A proposal by Mayor Michael Bloomberg of New York to impose soft drink serving size regulations, which was opposed by margins of 60% or more by voters in New York and across the United States,[11] was struck down as "arbitrary and capricious" by a state judge.[12]

Obesity tax advocates often blame corporate-funded campaigns for the defeat of these proposals. However, there is mounting evidence that opposition to "fat tax" policies transcends traditional left-right politics, given lower- and middle-class perceptions of self-interest on the issue. Minority leaders in the US often regard policies to tax or regulate soda as unfair,[13] especially in the (usual) absence of action to attack high-calorie luxuries that are more popular in high-income markets.

The push to make unhealthy food more expensive through taxation is also politically counterintuitive since at the same time, most industrial markets are reducing the relative cost of unhealthy food choices through various national food supply policies.

6. Rachel La Corte, "Opponents of soda, candy taxes turn in their signatures," *Seattle Times*, July 2, 2010; "Voters approve candy tax rollback," *MyNorthwest.com*, November 2, 2010.
7. County of Los Angeles Registrar-Recorder, *Local Contests: Election Statistics*, available at http://rrccmain.co.la.ca.us/0012_LocalContest_Frame.htm; Robert Rogers, "Voters resoundingly reject Richmond 'soda' tax," *Mercury News*, November 7, 2012.
8. At January 2013 exchange rates, this tax rate is equal to roughly C$1.30 per lb.
9. Kristina Chew, "Denmark Ends Fat Tax (But Not Because It Didn't Work," *Care2*, November 14, 2012; Sarah Kliff, "Denmark scraps world's first fat tax," *Washington Post*, November 13, 2012.
10. Kelly Phillips Erb, "New taxes boost cost of Nutella as French take measures to avoid getting fat," *Forbes*, November 15, 2012; Laurent Belsie, "Nutella tax: Is France taking austerity too far?" *Christian Science Monitor*, November 15, 2012.
11. Michael M. Grynbaum and Marjorie Connelly, "60% of New Yorkers oppose Bloomberg soda ban," *The New York Times*, August 2, 2012; for national results, Reuters, *Reuters/Ipsos Poll: sugary drinks*, available at http://reuters.tumblr.com/post/24681024695/sixty-four-percent-of-people-surveyed-in-a-new.
12. Michael N. Grynbaum, "Judge Blocks New York City's Limits on Big Sugary Drinks," *The New York Times*, March 11, 2013.
13. Michael N. Grynbaum, "In NAACP, Industry gets ally against soda ban," *The New York Times*, January 23, 2013.

In Canada, a complex network of food marketing boards regulates the supply and distribution of a broad range of foods, including poultry, eggs, dairy and vegetable produce. These systems artificially inflate the price of many local, natural foods at consumer expense. They limit market access by creating high entry costs through the requirement to "buy quota" in order to sell. Finally, many marketing boards have also fought to limit the introduction of new (and often healthier) food products to protect existing producers.[14]

In the United States, an even larger food subsidy system still spends billions of dollars annually to support industrial food producers, artificially lowering the price of corn-based sweeteners and marketing unhealthy food choices at taxpayer expense.[15] These subsidies have lowered the price of the unhealthy options relative to that of the healthier options that receive fewer subsidies. This means that these subsidies have increased the consumption of calories from "inexpensive, nutrient-poor snacks, sweets and sweetened beverages made with fats and sugars derived from these policy supported crops."[16]

If public health organizations truly believe that higher prices for industrial foods and lower prices for healthy foods are needed to break a generational preference for unhealthy options, then reducing subsidies to unhealthy foods and barriers to producing healthier foods is a much more logical first step than raising product taxes.

14. Examples of alleged preferential treatment for large producers, entry barriers and product restrictions are common. For the impacts of the now defunct Canadian Wheat Board, see Shon Ferguson, Simon Weseen and Gary Storey, *Organic Grains and the Canadian Wheat Board*, Working Paper, Department of Agricultural Economics, University of Saskatchewan, 2005; see also Paul Waldie, "Canadians don't know the price of milk," *The Globe and Mail*, November 23, 2010. Michael Pollan also offers several US examples in which regulators have limited local food movements and producer-led efforts to enter broader markets; Michael Pollan, *In Defence of Food: An Eater's Manifesto*, Penguin Press, 2008.
15. For one recent view, see "For a Healthier Country, Overhaul Farm Subsidies," *Scientific American*, April 19, 2012.
16. David Wallinga, "Agricultural Policy and Childhood Obesity: A Food Systems and Public Health Commentary," *Health Affairs,* Vol. 29 (2010), No. 3, p. 405.

CHAPTER 2

What governments should do

The puritan, coercive approach to the obesity problem favoured by many in the public health community is not the only possible one. Given the unique features of the crisis, it is time to give more weight to a more positive alternative approach.

We have built social and economic systems that subsidize and accentuate bad choices. To replace them, we need systems, policies and attitudes that facilitate better choices. A good place to start is to learn from one of the few areas where there are signs of early success in the obesity fight: the young.

Compared with adults, children do not have much autonomy in terms of choosing how they eat and what kind of lifestyle they have. The causes of childhood obesity are largely environmental in the sense that the context in which children evolve—in short, their environment at school and at home—explains obesity best.[1] If unhealthy food choices are combined with low levels of physical activity, children are more likely to exhibit a tendency to become overweight or obese. Changing this environment by reducing the supply of unhealthy foods in schools and allotting more time to physical exercise are obvious solutions to the problem of childhood obesity.

For over a generation in Canada and the United States, school boards saw their students as a captive market. School divisions and other levels of government sold soft drink companies preferential access to this market to generate revenue. Procurement policies favored low-cost food vendors, even if they relied on unhealthy, industrial approaches to food preparation. In an effort to balance competing demands on students' time, curriculum planners cut physical education courses as if they were a luxury. All of these steps were taken without regard for the impact they might have on a young person's health, discipline or level of focus.

In the last decade, anti-obesity campaigners have invested considerable time and energy in an effort to reverse these mistakes. The outcomes have been positive.

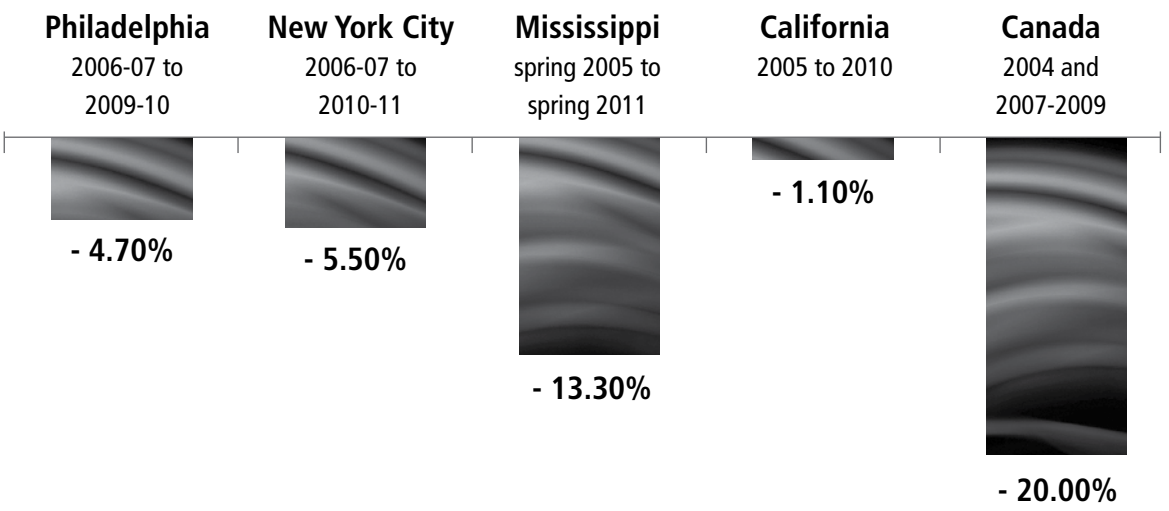
Federal, provincial, state and school board policymakers have worked aggressively to direct schools to provide healthier meal options. For example, in Ontario in 2010, a new provincial policy regulated the provision of food and beverages from any public or commercial source to students on school property.[2] Critically, the new policy does not attempt to control diets or manage off-property dietary choices. It merely seeks to improve healthy choices in an environment where these can be reasonably controlled.

Various jurisdictions have also reintroduced higher levels of physical education, even slipping 15-minute "physical activity breaks" into class schedules if better alternatives are impractical. Finally, schools and social agencies have helped educate parents on healthier food options, especially in low-income families.

1. Cara Ebbeling, Dorota Pawlak and David Ludwig, "Childhood obesity: public-health crisis, common sense cure," *The Lancet,* Vol. 360 (2002), pp. 473-482.

2. Ontario Ministry of Education, *Policy/Program Memorandum No. 150: School Food and Beverage Policy*, 2010, available at http://www.edu.gov.on.ca/extra/eng/ppm/150.html.

Figure 3
Evolution of childhood overweight and obesity rates in key American areas and in Canada



Source: Public Health Agency of Canada, *Obesity in Canada: A Joint Report From the Public Health Agency of Canada and the Institute for Health Information*, 2012, p. 10; Robert Wood Johnson Foundation, *Declining childhood obesity rates – where are we seeing the most progress?*, 2012, p. 2.

Note: For Canada, the number applies to the age group from 6 to 11 for obesity only; for Philadelphia, to children from kindergarten to grade 12; for New York City, to children from kindergarten to grade 8; for Mississippi, to children from kindergarten to grade 5; and for California, to children in grades 5, 7 and 9.

In Quebec, the Lucie and André Chagnon Foundation—one of the province's largest charity organizations—has devoted considerable resources to promoting healthy habits among children, in collaboration with the provincial government. For example, from 2003 to 2009, the foundation supported an initiative called "Five Spices Workshops" where families were taught the basics of healthy nutrition and cooking while developing their knowledge about possible food choices.[3] At present, the foundation is part of the *Québec en Forme* project—a $480 million initiative spearheaded by the Quebec government to promote physical activity among young Quebecers.[4]

In its action plan against obesity among children, *Pour un virage santé à l'école,* the government of Quebec announced its intention to push schools to reduce fat content in meat products, avoid trans fats, favour cooking techniques that require little fat, increase the presence of whole grain items and increase the variety of fruits and vegetables available to students. At the same time, the plan proposes to increase the amount of time allocated for physical activity.[5]

Thanks to these initiatives, children are now the the vanguard in the fight against obesity, with several studies showing positive results (see Figure 3).[6]

3. Fondation Lucie et André Chagnon, *Les ateliers cinq épices*, available at http://www.fondationchagnon.org/en/what-we-do/projects/completed-projects/les-ateliers-cinq-epices.aspx.
4. Fondation Lucie et André Chagnon, *Projet Québec en Forme*, available at http://www.fondationchagnon.org/en/what-we-do/partnerships/quebec-en-forme.aspx.
5. Ministère de l'Éducation, du Loisir et des Sports du Québec, *Pour un virage santé à l'école*, 2007, pp. 18, 22-24.
6. Ontario Ministry of Education, *Policy/Program Memorandum No. 150: School Food and Beverage Policy*, 2010, available at http://www.edu.gov.on.ca/extra/eng/ppm/150.html; Jonny Dymond, "Obesity rates fall in Philadelphia," *BBC News*, December 12, 2012; Centers for Disease Control and Prevention, *Obesity Prevalence Among Low-Income, Preschool-Aged Children – New York City and Los Angeles County, 2003-2011*, available at http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6202a1.htm.

For example, Mississippi has seen one of the largest drops in childhood overweight rates in recent years as a result of efforts to create healthier schools. The case of Mississippi is quite illustrative since students from kindergarten to grade 5 exhibited an obesity rate of 43% in 2005 against 37.3% in 2011. Even among poorer groups—like African-Americans—childhood obesity rates have stalled in recent years after long periods of sustained increases.[7]

An exhaustive study produced by the Centers for Disease Control and Prevention has also confirmed that in recent years—and likely as a result of these efforts—the childhood obesity rate has declined among low-income preschool children. Let us remember that the attraction of fast food and "cheap calories" are greatest for those whose incomes are lowest. Hence, if we see a decline in the rate of childhood obesity in that particular group from 2003 to 2010 (from 15.21% to 14.94%—it stood at 13.05% in 1998), there are reasons to cheer on this front.[8]

In Canada, in spite of data limitations stemming from different survey types, we can see a significant drop in childhood obesity as well. Using measured obesity rates, there is a drop of 20% in the obesity rate between the 2004 survey and the 2007-2009 survey.

Governments can do more. For example, students have organized campaigns attacking the quality of healthier food options now offered in schools.[9] Educational policymakers can counter this by treating school food choices as an educational opportunity. Parents and students can (and should) be integrated directly into the process of healthy menu development to help them make the same food trade-offs that they must learn to make in their own daily routines. U.S. researchers have also launched a "Smarter Lunchrooms" initiative, which has succeeded in raising voluntary student take-up of healthy choices by improving marketing, placement and student awareness of healthier options in school cafeterias.[10]

Meanwhile, where governments now devote millions in tax credits to subsidize middle class sports,[11] a better approach would be to target resources at improved access to coaching support and sports facilities across all income groups. Canadian schools were once available to families after hours for recreational activity, but insurance issues, management concerns and petty school board fee policies have dramatically reduced access.

In Canada, some governments have taken modest steps to reverse this trend. For example, the Ontario government's After School Program provides grants to non-profit organizations to promote wellness objectives.[12] The Toronto District School Board offers preferential permit rates for non-profits, many of which prioritize physical education and wellness goals.[13]

However, these programs still meekly accept the notion that school boards are morally in the right in creating barriers for community after-school use to begin with. Our society spent tax dollars to build schoolyards and school gyms for public use, not for the institutional needs of particular school board bureaucracies. It is time to liberate these facilities for those who are eager to use them, since we have already paid once for the privilege. Governments should consider radical action to return after-hours control of public property to the community at large, even if this means bypassing school board authority.

7. Robert Wood Johnson Foundation, *Declining childhood obesity rates – where are we seeing the most progress?*, 2012, p. 2.
8. Centers for Disease Control and Prevention, "Trends in the Prevalence of Extreme Obesity among US Preschool-Aged Children Living in Low-Income Families, 1998-2010," *Journal of the American Medical Association,* Vol. 308 (2012), No. 24, pp. 2563-2565.
9. I described one such campaign—and the flaws in its reasoning—in "Why conservatives treat access to junk food as a freedom," *National Post*, June 4, 2012.
10. "Some U.S. lunchrooms to get cheap makeover," UPI.com, September 29, 2011.
11. For example, the cost of Canada's federal "children's fitness tax credit" has grown from $90 million in 2007 to $120 million in 2012. Department of Finance Canada. 2013. *Tax Expenditure and Evaluations 2012*, p. 17.
12. Ontario Ministry of Education, *Ontario's After-School Program*, available at http://www.mtc.gov.on.ca/en/sport/afterschool/after_school.shtml.
13. Toronto District School Board, *Toronto District School Board, Facility Permit Fees, Effective September 1, 2012 to December 31, 2012*, available at http://www.tdsb.on.ca/wwwdocuments/about_us/permits/docs/G02%20CUS%20fee%20schedule%202012-2013.pdf.

Federal and provincial funds spent on fitness tax credits could be better spent reducing the costs of before- and after-school programs directly. Targets for funding can include direct investment in public facilities (thereby reducing fees for all), programs to offer free criminal checks or other supports for volunteer coaching organizations, and even the accumulation of public insurance funds for recognized leagues to help non-profits sidestep liability barriers.

When it comes to facilitating higher exercise rates in everyday adult life, we can take the same approach. Governments can adopt design standards for new public buildings to increase stair use and promote workplace activity. Urban and regional governments should embrace "complete streets" doctrines to open streetscapes for both vehicular and physical transportation modes.

Where existing infrastructure in urban or suburban neighborhoods is not safe or accessible for walking or bicycling, governments can deliver significant health benefits by targeting these neighborhoods for visible point-to-point routes to connect them to true active transportation grids.

For example, Vancouver's controversial decision to open dedicated bike lanes at two choke points into downtown—on the Burrard Bridge to the southwest, and on the Dunsmuir Viaduct to the southeast—made cycling a safe, practical commuting option for several residential neighbourhoods on either side.[14]

Montreal has been at the forefront in developing cycling routes. Between 2004 and 2012, the combined length of its cycling routes increased from 374 to 595 kilometres. Since 2009, the City has installed meters on key cycling routes in order to compile statistics on daily circulation. The most reliable data sets provided show that there was a 24% increase in daily circulation between 2010 and 2012.[15]

In small towns or exurban communities where physical activity is often below average, a single safe highway crossing or a single bus route can dramatically increase the odds that hundreds or even thousands of residents can safely cycle or walk on a regular basis.

Finally, governments should change our society's whole approach to health insurance. Car insurance rewards better driving. Life insurance also rewards healthy behaviour to some extent. We should do the same with health insurance.

While there are ethical issues with penalizing the unhealthy in our insurance systems, health insurance plans can and should offer modest rewards for healthier behaviour. Canada's provincial Medicare plans, U.S. Medicare and Medicaid programs and private US health insurance plans are almost all designed for a 1950s health care model that prioritizes "sick care" and emergency care over preventive health, wellness and chronic care management, with predictable results.

The effects of financial incentives in positively stimulating the adoption of healthy behaviour is well-documented in the medical literature. In a survey of this literature, it is found that financial incentives increase the likelihood that patients will comply with the recommendations of their physicians.[16] There are no logical reasons for these results not to extend to weight loss.

In a pilot study on the impact of such incentives, it was noticed that rewards ranging from $7 to $14 for each percentage point of weight loss (i.e., if I weigh 240 pounds, 2.4 pounds represent one percentage point) lead to appreciable weight reduction.[17] More comprehensive incentives not only confirm the results mentioned above, but they also generate substantially more weight loss.[18] A

14. David Dodge, "How one kilometer of bike lane sparked a revolution in Vancouver," *Troy Media*, February 8, 2013.
15. Ville de Montréal, Direction des Transports, *Bilan 2011: Mise en œuvre du Plan de transport*, 2012, p. 34; Ville de Montréal, *Vélos – comptage sur les pistes cyclables*, 2013, available at http://donnees.ville.montreal.qc.ca/fiche/velos-comptage/.
16. Antonio Giuffrida and David Torgerson, "Should we pay the patient? Review of financial incentives to enhance patient compliance," *British Medical Journal,* Vol. 315 (1997), pp. 703-707.
17. Eric Finkelstein, Laura Linnan, Deborah Tate and Ben Birken, "A pilot study testing the effect of different levels of financial incentives on weight loss among overweight employees," *Journal of Occupational and Environmental Medicine,* Vol. 49 (2007), No. 9, pp. 981-989.
18. Volpp Kevin, Leslie John, Andrea Troxel, Laurie Norton, Jennifer Fassbender and George Loewenstein, "Financial Incentive-Based Approaches for Weight Loss," *Journal of the American Medical Association,* Vol. 300 (2008), No. 22, pp. 2631-2637.

large experiment comprising more than 700 obese adults confirmed these results regardless of age group, and also show that the effects were lasting.[19]

Incentive programs tend to fail when they only offer a one-time benefit, such as a gift certificate or cash, to achieve a specific objective. People tend to return to their habits afterwards. In a yearlong study recently done with Mayo Clinic employees in Minnesota, the chance to win or lose $20 a month enticed dieters to drop an average of 9 pounds—four times more weight than others who were not offered incentives to change their eating habits. It was the longest lasting test yet of financial incentives for weight loss. It had a mix of carrots and sticks—penalties for not losing weight, multiple ways to earn cash for succeeding, and a chance to recoup lost money if you gave up your efforts but later repented.[20] This shows that incentive programs have a better chance of succeeding if they are self-sustaining and designed to have an effect over the long term.

Two real-life experiments stand out, offering hope that incentive-based models can change obesity outcomes.

In the United States, employers often provide health care insurance to their workers. This means that they pay for the risks associated with the overweight condition of their employees and have an interest in reducing the costs of these risks.

The case of Safeway (a grocery chain) provides a good illustration of how this could work in practice. In 2005, to manage rising health insurance costs, Safeway developed a "Healthy Measures" plan to offer cash to non-union employees who met basic healthy behavioural goals. If their condition improves or if they pass the test, the premiums and deductibles they have to pay are reduced. The incentive program was effectively designed to pay for itself by sharing out some of the projected savings that could be expected from reduced pressure on the company's health plan.[21]

In Britain, in cooperation with the National Health Service, insurers and researchers tested a "Pounds for Pounds" program (later known as "Weight Wins") in 2009-2010. The program offered cash rewards to participants in exchange for success in meeting sustained weight loss goals. While the program recorded a high dropout rate, overall weight reduction outcomes for both the dropouts and those who stayed with the program were better than outcomes for comparable programs without incentives.[22]

These and other incentivized insurance experiments have achieved positive results. Yet the public health community is so focused on punitive action that little has been done to export these models into the broader health economy. In fact, had it not been for aggressive action by a few legislators from both major parties, the *Affordable Care Act* in the United States would have effectively banned similar programs in 2010.

Meanwhile, Canada remains far behind the US and the UK in the development of incentive models—in part because the government's near-monopoly on health insurance leaves little room for product innovation in this area.

Canadians should correct this. Provincial governments should prioritize pilot projects in the field of incentivized insurance. Think tanks and health care professionals can work with governments to develop an appropriate incentive model that works with Canada's health care system, testing the efficacy of employer-based incentives, incentives built in to supplementary insurance

19. Monika Reuss-Borst, Alfredo Paloyo, Arndt Reichert and Harald Tauchmann, *Heterogeneous Causal Effects of Financial Incentives on Weight Loss: Results of a Large Prospective Randomized Trial,* Dortmund, Germany: Ruhr Economic Papers, 2012.
20. Marilynn Marchione, "Buying willpower: A chance to win or lose $20 a month led dieters to drop weight, study finds," The Associated Press, March 7, 2013.
21. Stephen A. Burd, "How Safeway is cutting health care costs," *Wall Street Journal*, June 12, 2009; and for a review of outcomes as of 2011, see Laree Renda, *Focusing on What Matters Most – Healthy Behaviour and Accountability*, available at http://www.theihcc.com/en/communities/employee_communication_education/focusing-on-what-matters-most-%E2%80%93-healthy-behavior-a_gqk6ur59.html.
22. Claire Relton, Mark Strong and Jessica Li, "The 'Pounds for Pounds' weight loss financial incentive scheme: an evaluation of a pilot in NHS Eastern and Coastal Kent," *Journal of Public Health*, December 2011; and "'Pounds for pounds' scheme helps obese people shed stones," *The Independent*, June 7, 2010.

plans, or even direct benefits administered through the primary care system.

In Canada and the United States, there is also a growing movement to penalize recipients of social assistance for unhealthy behaviour. For example, the Bloomberg Administration in New York City fought unsuccessfully to ban food stamp recipients from using their benefits to buy sweetened drinks.[23] Here, as elsewhere, a punitive, judgmental policy approach only produced a backlash.

Experimental research is needed to test the opposite approach. If debit card technologies and "electronic food stamps" can be used to ban or limit the purchase of certain unhealthy foods, then it should be equally possible to use these same systems to reward low-income families for making better food choices instead.

23. "US rejects Mayor's plan to ban use of food stamps to buy soda," *The New York Times*, August 19, 2011.

CHAPTER 3

What the medical profession should do

The medical profession has a critical role to play in the implementation of a successful anti-obesity policy. However, countless studies suggest that doctors would rather avoid the subject.[1] For example, a recent survey published in the Canadian Medical Association Journal found that close to half of Canadian physicians felt uncomfortable addressing obesity issues, and almost three quarters of primary care physicians believed no one in their particular practice was trained to deal with obesity.[2]

Arguably, this trend has already contributed to the failure to contain high obesity rates.

More training is obviously needed. But beyond that, given the sensitivity of the issue for patients and physicians alike, medical professionals should consider an entirely different approach to delivering advice to patients with the minimum of offence, awkwardness or issue avoidance.

Patients rarely act on generic advice to "eat better" or "get more exercise" for its own sake. Medical professionals may feel equally uncomfortable delivering these bromides. Our overall social culture remains obsessed with discussing obesity as an aesthetic issue rather than as a medical problem, so the consequent social taboos can even distort discussions about obesity at the primary care level.

However, patients often respond more earnestly to medical advice about clearly defined risks (for example, reducing high cholesterol below specific levels). Given the culture of our profession, physicians also tend to be more comfortable offering advice on specific risks and ailments.

With this in mind, it may be time to aggressively "medicalize" the medical world's response to obesity. The concept of medicalizing healthy behaviour was introduced recently by Mayo Clinic Dr. Michael Joyner.[3] Joyner argued that given the measurable health risks that come from the lack physical activity for patients with specific ailments, it is time for doctors to consider literally prescribing specific exercise regimes as a treatment, in the same way that they might prescribe a medication.

Meanwhile, in the same vein, New York City's experimental "War on Fat" includes an unusual reform. Since 2005, Section 13.04 of the New York City Health Code requires that any blood work sent to public labs be tested for Hemoglobin A1C levels to identify patients who face a high risk of developing Type II diabetes. If a patient is found to be at risk, the Department of Mental Health and Wellness then forwards a letter to both the patient and his or her physician, recommending behavioural changes on

1. For some discussions of the phenomenon from three vantage points (overweight doctors, pediatric challenges and the "blame/shame" challenge), see: http://www.npr.org/blogs/health/2012/01/27/145990665/heavy-doctors-avoid-heavy-discussions-about-weight; http://theweek.com/article/index/219905/should-doctors-avoid-calling-children-fat and http://www.huffingtonpost.com/david-katz-md/obesity-of-blame-and-sham_b_834937.html.
2. Patrick Luciani, "Are doctors making us fat?" *The Toronto Star*, November 8, 2012. See also Sara N. Bleich, Kimberly A. Gudzune, Wendy L. Bennett and Lisa A. Cooper, "Do physician beliefs about causes of obesity translate into actionable issues on which physicians counsel their patients?" *Preventive Medicine*, forthcoming 2013, for a recent study where US researchers found that primary care physicians' beliefs on the causes of obesity significantly influenced their advice on possible remedies (including dietary change).
3. Mayo Clinic, *Should Doctors Treat Lack of Exercise as a Medical Condition? Mayo Expert Says 'Yes'*, 2012, available at http://www.mayoclinic.org/news2012-rst/7031.html; Michael J. Joyner, "Standing up for exercise: should deconditioning be medicalized?" *The Journal of Physiology*, August 1, 2012.

the patient's part. At-risk patients are also tracked in a registry to help the City identify overall progress. The program has been introduced slowly to New York's various boroughs.[4]

Philosophically, the proposal was controversial. Section 13.04 is effectively a mandatory registry of diabetics and at-risk patients without their consent, as if these individuals were carrying a communicable disease. However, if the medical profession can adapt the doctrine to remove the overbearing aspects of the policy and focus on voluntary professional implementation of the same approach, the New York experiment may offer a useful lesson.

The program has many positive features: automatic testing, formalized risk assessments, evidence-based recommendations to patients and pre-written, standardized letters to explain the outcome. This model offers a process for both doctors and patients to define and discuss obesity dispassionately and strictly on medical terms. Primary care practitioners who choose to act on the notice in future appointments can also use the letter as a bridge to prescribe specific behavioural remedies in line with Joyner's thinking—even if this means issuing prescriptions for specific exercises, dietary changes or other behavioural remedies.

Canadian primary care practitioners should take the lead in testing and developing this approach. Public health officials, physicians and nutritionists should also develop a standard battery of positive metrics to match to common behavioural changes so patients can see these prescriptions as potential health remedies rather than as personal judgments.

4. City of New York, *Patient Letter Service: Quick Reference Guide for Health Care Providers*, 2012, available at http://www.nyc.gov/html/doh/downloads/pdf/diabetes/diabetes-patient-ltr-service-qk-ref.pdf.

CHAPTER 4

What the private sector should do

Just as schools can improve outcomes by focusing on choices within their daily routines, key industries and employers can also foster a healthier adult society by building in support for positive changes. In these cases, it is especially critical that policymakers in industry promote behavioural changes for workers and consumers who have the unhealthiest habits, rather than focusing on policies that will merely reinforce the healthy habits of those who are already motivated.[1]

For example, present-day wellness programs in the workplace often cater to those who are already striving on their own initiative to be healthy. Providing gym space for employees is a positive step. But in the absence of other incentives, gyms are most likely to be used by those already predisposed to do so, rather than by workers who face serious health risks from obesity or other preventable behaviours.

In line with school reforms, families and community organizations can redesign their own routine environments to normalize healthy foods and regular physical activity. Employers can do the same. By engaging those who might not normally be engaged, a firm (or, for that matter, a non-profit, or a family) that builds a thirty-minute "walk break" for everyone into its daily schedule can over time do far more to deliver positive changes than a firm that concentrates resources on helping a fraction of its workers in a company gym.

One such practice that recently caught on is that of holding "walk and talk" meetings. It is being promoted by a California business writer and corporate director, Nilofer Merchant, who was worried that workers are sitting around too much at the office and particularly in meetings, a sedentary lifestyle that entails adverse health effects, including obesity. She says walking 20-30 miles per week while holding meetings has changed her life. The idea has gained new currency amid recent reports that Facebook CEO Mark Zuckerberg is fond of the practice, as was Apple CEO Steve Jobs and Twitter co-creator Jack Dorsey.[2]

In the workplace, managers and leaders should also consider:

- Designing office, factory or retail routine workflows to build in a variety of physical activities. Just as schools were foolish to cut physical activity and expect better performance from unfit students, managers must develop holistic measures of productivity that factor in a worker's health and stamina alongside process efficiency.

- Offering incentivized insurance or other rewards for healthy behaviour across the organization, regardless of an employee's current health status.

1. This problem was apparent in a New York City program, the "Green Cart," designed to increase consumption of fresh produce through on-street sales. The outcome? New Yorkers who already consumed a healthy diet of fruits and vegetables consumed more, with little impact on the target audience.

2. Ryan Tate, "In Silicon Valley, Sitting Is the New Smoking," *Wired*, February 27, 2013; Fabien Deglise, "Le « marche et parle », nouveau remède à la sédentarité," *Le Devoir*, March 28, 2013.

- Providing private consultation time with a nutritionist or primary care advisor as a workplace benefit—again, universally to all staff.

- Offering workplace information on healthy choices at nearby restaurants to employees, especially new employees. Managers should be encouraged to seek information on ingredients, calories and nutritional value from caterers and food vendors before setting up an account to order in, and procurement policies can target healthier local providers for regular meetings, deliveries or accounts.

Beyond the workplace, the food and beverage industry also has a crucial role to play. While individual responsibility is a crucial tool in the obesity fight, food and beverage firms must be responsible as well. They must do their part to reduce the unhealthy impact of existing products, especially where added sugar, fat or salt can be reduced in the existing supply chain. They should seek to diversify their product portfolio to include a range of healthy products. And they should make clear and complete nutritional information about their products easily available to consumers. There are many reasons to believe that this is in the long-term business interests of these firms.

At a minimum, this will ensure that larger companies have less to lose and more to gain as consumers demand healthier choices or government regulation shifts the public away from unhealthy dietary habits.

As pointed out earlier with regards to the causes of the rise in obesity, the advantages of cheaper food (both money-wise and time-wise) will always remain important. Many consumers desire a quick and cheap meal. However, they will easily substitute high-calorie items for low-calorie items if they can do so without sacrificing the low prices and the quickness and easy availability of the service.

A recent study of the food service industry shows that from 2006 to 2011, the companies that increased the range of lower-calorie servings experienced greater growth than those that did not.[3] In fact, the restaurant chains that increased the number of lower-calorie food servings saw increases in their commercial volume while the other chains actually *lost* ground.

It has been shown that the amount of calories bought at Starbucks declined by 6% following the posting of calories in the items consumed. Furthermore, this decline in the intake of calories had no impact on average profits. In fact, where Starbucks was found to be in competition with other outlets, there was an increase in revenues.[4] Similar growth in commercial volume has been observed for firms in the consumer packaged goods sector that adopted lower-calorie products (firms like Kellogs or Campbell's).[5]

Ideally, these changes should be part of a larger strategy, rather than one-off changes that are easily reversed or forgotten. Firms that are concerned about the prospect of "taste shock" among habitual consumers can still reduce the per-unit calorie impact of their products gradually, reducing the risk that customers might simply seek higher-calorie substitutes elsewhere.[6]

At present, in several countries, major food sector firms are already voluntarily pledging to improve products and promote better health. These important changes must be measured, studied and transparently reported if they are to be believed and if they are to have an impact on public perceptions and consumer behaviour.

For example, in January 2013, Coca-Cola released an ad challenging consumers to watch their calories.[7] Critics described this as a matter of Coke "blinking,"[8] as if several prior years of shifting customers from high-calorie to zero-

3. Hank Cardello, *Lower-Calorie Foods: It's Just Good Business*, Hudson Institute, 2012.
4. Bryan Bollinger, Phillip Leslie and Alan Sorenson, *Calorie Posting in Chain Restaurants*, National Bureau of Economic Research, 2010.
5. Hank Cardello, Jeffrey Wolfson, Margaret Yufera-Leitch, Lauren Warren and Michael Spitz, *Better-For-You Foods: An Opportunity to Improve Public Health and Increase Food Industry Profits*, Hudson Institute, 2012.
6. For an interesting example of the challenge of product adaptation, see Jeff Gelski, "Keep desserts sweet with less sugar," *Food Business News*, July 29, 2011.
7. Coca-Cola, "Coming Together," available at http://www.youtube.com/watch?v=zybnaPqzJ6s.
8. For a sample of the tone of the backlash, see Mark Bittman, "Coke blinks," *The New York Times,* January 22, 2013 and Cristina Goyanes, "Are Coca-Cola's Anti-Obesity Ads Enough?" *Shape*, January 25, 2013.

calorie beverages were simply irrelevant to the discussion. In contrast, Mayor Michael Bloomberg's administration recently heaped praise on twenty-one food companies that reduced the salt content of their products. Tellingly, as these companies were part of an organized national program (the National Sodium Reduction Initiative) for reductions, no one attacked the companies for "blinking" or other perceived hypocrisies.[9]

Industry organizations should take the initiative to address this weakness, and create organized initiatives to track the success of voluntary reductions wherever possible. This is especially true in Canada. Here, the lack of a high-profile national obesity prevention strategy, interprovincial market differences and the balkanization of food industry firms means that there is no one source for reliable information. Academics and medical professionals, industry groups and individual firms should collaborate to collate data on voluntary industry product reforms in one place, where any change—and if need be, the lack of change—can be analyzed, and where credit for voluntary steps can be accountably recorded and assigned.

9. See MikeBloomberg.com, *Mayor Bloomberg Announces Results of National Effort to Reduce Sodium in Pre-Packaged Foods, 2013*, available at http://www.mikebloomberg.com/index.cfm?objectid=C9FE7C21-C29C-7CA2-F0852DFF23BFE058.

CONCLUSION

Opening our minds to new approaches

For too long, the larger policy debate about obesity has been self-defeating. The focus has always been on the costs and consequences of poor choices. We need to change that conversation, to shift our focus to policies that are both positive and plausible.

Jillian Michaels is the author of *Slim for Life* and a co-host of the popular reality show, "America's Greatest Loser." In reply to a question on the socioeconomic causes of obesity in February 2013, she had this message for CBC viewers:

> I could sit here and tell you all the reasons why people are overweight, federally, locally, all the socioeconomic reasons, the whole conspiracy theory about Big Food, and this and that. But it doesn't serve any purpose. Because all people do is feel defeated, and they sit there and they wait for some hero, whether it's the government or big business, to come in and save them. And here's the reality: even if you don't have a lot of money, you can move your body. It isn't that hard. It's free. You can get a six-dollar exercise DVD and do it in your living room in a 6' x 6' space. If you eat bad food, do me a favor: eat less of it… instead of having four pieces of pizza, eat two. I don't care how broke you are, you can still eat healthy.[1]

However tempting it may be to blame any one of dozens of scapegoats for the rise in obesity, the ultimate control over an adult's calorific intake and output will almost always rest with the individual. Without responsible individual action to prevent obesity, there is little hope of reducing obesity rates, even if environmental factors are mitigated.

Our policy choices must be designed to positively reinforce millions of individual choices for the long term. As noted above, there is no shortage of positive approaches available. What has been missing is open-mindedness on the part of the public health community, which persists in its mistaken belief that only heavy-handed policy interventions are worthwhile.

1. Author's transcript of a February 11, 2013 interview at http://www.cbc.ca/player/News/Business/ID/2334191680/. See also my article with a similar message: "The McVictim Syndrome could kill us," *Los Angeles Times*, December 8, 2010.

About the author

Dr. David Gratzer

DR. DAVID GRATZER is a physician and writer. His book *Code Blue: Reviving Canada's Health Care System* (1999), a national bestseller, won the Donner Prize for best Canadian public-policy book. He is the editor of *Better Medicine: Reforming Canadian Health Care* (2002) and the author of *The Cure: How Capitalism Can Save American Health Care* (2006), with a Foreword by Milton Friedman. He has served as a senior fellow at the Manhattan Institute of Public Policy in New York for nine years. Dr. Gratzer has been interviewed by CTV, CBC, TVO, and FOX. He is a blogger with *Huffington Post Canada*, and his articles have appeared in the *Toronto Star*, the *Ottawa Citizen* and *The Wall Street Journal*.

Ideas for a More Prosperous Nation

ISBN 978-2-922687-39-2

iedm.org