ESSAYS IN REGULATION

Obesity issues and public regulation

Tim Keyworth and George Yarrow
assisted by Karin Cheetham

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Regulatory Policy Institute

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31-33 Westgate, Oxford OX1 1NZ, UK
www.rpieurope.org

1. Introduction

The prevalence of obesity has featured prominently in the news of late, alongside a range of other 'diet and lifestyle' issues; and it has, almost inevitably, attracted a good deal of attention from various parts of government and from other public authorities. The relevant issues arise in a number of actual and potential public policy contexts, including for example: the provision of food to children at school; food labelling; TV advertising of snack foods and soft drinks; health education in general; and the promotion of exercise and sport.

One stimulus for the heightened public interest in body weight is evidence showing that, in the UK and across much of the world, the proportion of the population that is deemed to be substantially over-weight – at least in terms of widely adopted measures based on the Body Mass Index – has risen substantially over recent decades. Whether there continue to be strong upward trends in BMI measurements in the UK today is, on the available evidence, less than clear cut[1], but what appears indisputable is that the proportion of the population classified as obese is substantially higher now than it was a generation ago.

Unsurprisingly for anyone familiar with the ways of public policymaking, regulatory reactions to the observed tendencies appear to exhibit familiar pathologies. There is a repeating pattern in which (a) one of more aspects of human conduct comes to be defined as a *problem* ('problematisation'), (b) there are calls for government or a public authority to 'do something' about 'the problem', and (c) the authorities oblige with simplistic actions whose wider, more diffuse consequences are frequently ignored.

The tendencies toward simplistic, over-hasty regulation are particularly acute when either 'the public' or some particular, influential group has very strong opinions about the 'problem', as was recognised long ago by no less an authority than Adam Smith, when he observed that[2]:

"The laws concerning corn may every where be compared to the laws concerning religion. The people feel themselves so much interested in what relates either to their subsistence in this life, or to their happiness in a life to come, that government must yield to their prejudices, and, in order to preserve the publick tranquillity, establish that system which they approve of. It is upon this account, perhaps, that we so seldom find a reasonable system established with regard to either of those two capital objects."

In the realm of regulation, strong opinions are also often correlated with interests in the exercise of influence, power or social control. Thus, writers such as Michel Foucault have been concerned with issues such as the way in which societies have, over the centuries, defined a 'problem' such as madness, and have gone on to develop

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[1] There are also economic reasons for believing that growth in obesity may be self-limiting – see, for example, T.J. Philipson and R.A. Posner, *The long-run growth in obesity as a function of technological change,* Working Paper 7423, National Bureau of Economic Research, Cambridge, MA, November 1999.

[2] Adam Smith, *An Inquiry into the Nature and Causes of the Wealth of Nations.*

mechanisms of social control over those judged to suffer from the problem.[3] The point of relevance here is that the process of 'problematisation' and the definition of the associated 'abnormality' may have much less to do with (nominal) concerns about the welfare of the 'abnormal' than with the power agendas of those involved in the development and enforcement of regulation. Viewed from another perspective, it could be an excessive interest in the BMIs and lifestyles of fellow citizens that is considered problematic and abnormal, not the BMIs themselves.

It is only relatively recently that governments have begun to wrestle, systematically with the various pathologies of regulatory activity which tend to lead to ineffective or over-controlling public interventions, and to date the fruits of this labour have been relatively meagre. Across wide swathes of the public sector there continues to be strong resistance to the more reflective approaches to policy making that have been promoted by the Cabinet Office, and that are now championed by the Better Regulation Executive (BRE) and the Better Regulation Commission (BRC). Nevertheless, a reasonably coherent analytical framework has been slowly developed, which is potentially of considerable value when thinking about and analysing regulatory policy issues – a process generally referred to as regulatory impact assessment (RIA).

This way of doing things asks public officials to step back and consider, carefully, questions such as:

- Whether there really is a problem that might warrant regulatory intervention.
- If so, what *precisely* is the nature of the problem?
- What are the relevant public policy objectives in the particular context?
- What different options or ways forward might be available, including 'do nothing' and, where feasible, self-regulation?
- What might be expected to be the likely effects of pursuing each option, including any unintended or unwanted effects of intervention?
- How significant are the costs and administrative burdens of monitoring, enforcement and compliance with any regulation?
- Whether the costs and restrictions arising from any proposed intervention are proportionate when considered alongside the magnitude of the problem.
- Whether regulation would serve to prevent, restrict or distort competition in the market.
- Whether regulation would have a disproportionate impact on certain sections of the public.

In a sense, the principles of RIA, as set out in Better Regulation Executive guidelines, comprise a kind of manifesto for intelligent and responsible public policy making,

[3] Michel Foucault, *Madness and Civilization.*

albeit a manifesto that, at the current time, sets out aspirations that are running well ahead of actual achievements. One of the reasons for this gap is that, whilst bodies such as the National Audit Office have emphasised, very strongly, the over-arching importance of thinking clearly about the relevant issues and questions right at the outset of any policy making process, this 'applied intelligence' is often missing. Thus, whilst RIA exercises may now be relatively routine, they are *"only occasionally used to challenge the need for regulation and influence policy decisions…"* (NAO, 2006).[4]

In our experience, failure to 'frame' the issues to be considered in an appropriate way, right at the outset of a policy development process, is a major risk factor for the emergence of costly, ineffective regulation at a later stage. In other contexts, we have used the term 'QuickScan' for the desired, initial *tour d' horizon* at the start of any policy assessment process, and what follows can be understood as a form of QuickScan for obesity issues. It comprises a number of thoughts, preliminary lines of argument, and questions (including, crucially, questions about the evidence base) that might serve to guide and inform more detailed and specific assessment of possible policy stances. The organisation of the material is influenced by the structured guidance developed by the Cabinet Office, assisted by the NAO, and now supervised by the BRE, and hence the purposes of that guidance are summarised in the next section below.

The first steps in the relevant assessment process are to develop an understanding of the contexts in which policy evaluations are to be made (the 'background'), and to identify the relevant problems that might, depending upon the conclusions of fuller analysis, give rise to a case for public regulation. This is then followed by a consideration of the relevant public policy objectives and of alternative policy options or approaches considered worthy of more detailed assessment and development. The impacts of the candidate policy options then stand to be assessed, on the basis of questions such as: who will be affected, how, and by how much? – taking account of any associated costs of the option and of unintended or unwanted consequences.

Our intention is therefore not to set out a comprehensive analysis of the relevant regulatory issues associated with the prevalence of obesity, but rather to provide an indication of how best-practice policy development might begin to approach those issues. We do, however, focus part of the discussion on a particular, specific issue, namely food labelling, so as to provide more concrete illustrations of some of the relevant points.

2. Regulatory Impact Assessment and the Government's Better Regulation Agenda

Regulation is a necessary feature of a market economy, and it is a myth that market economies can function effectively without it. Indeed, decentralised 'free market' economies tend to require rather extensive rule-books. As one study of comparative deregulation in the Japan and the UK is cleverly titled[5] "*Freer Markets, More Rules"*; and although this view may seem to go against the grain of arguments in favour of de-

[4] National Audit Office (2006) *Evaluation of Regulatory Impact Assessments 2005-06*

[5] Steven Vogel, *Freer Markets, More Rules: Regulatory Reform in Advanced Industrial Countries*, Cornell University Press, 1998.

regulation, it is, once stated, really a rather obvious empirical point. To take just one indicator of the weight of the rule-books, lawyers are to be found in much greater relative abundance in the USA than they are, say, in North Korea.

That said, good rule-making is extremely difficult, and the study of economic policy making reveals a variety of factors that consistently lead to "regulatory failure", whether that failure relates to ineffectiveness in achieving objectives or to the imposition of excessive costs on those affected by government intervention, or to some other dysfunction. The Government's Better Regulation Agenda is aimed at seeking to mitigate some of these failures. As explained by the Better Regulation Executive, in its website[6] message to rule-makers, regulatory impact assessment is:

"... a framework for analysis of the likely impacts of a policy change and the range of options for implementing it. It is a comprehensive and flexible tool which considers:

- *any form of regulation - formal legislation, Codes of Practice, information campaigns, etc.*
- *the full range of potential impacts - economic, social and environmental.*
- *where the impact may fall - business, the public sector, the voluntary sector or other groups.*

The RIA is a key tool in delivering better regulation. This supports the government's aim of only regulating when necessary and, when it is, to do so in a way that is proportionate to the risk being addressed, and to deregulate and simplify wherever possible. All government policy proposals should meet the five Principles of Good Regulation, devised by the Better Regulation Task Force (an independent body set up by government to advise on regulatory issues). These are:

- *proportionate - to the risk*
- *accountable - to ministers and Parliament, to users and the public*
- *consistent - predictable, so that people know where they stand*
- *transparent - open, simple and user-friendly*
- *targeted - focused on the problem, with minimal side effects*

...

An RIA must set out the issue you want the policy to address and the options available to do this. The options you consider must include a 'do nothing' option and non-legislative options such as Codes of Practice, industry standards or accreditation schemes. A good RIA will address the question 'What is the best way of achieving the objective?'"

The underlying causes of regulatory failure are many and varied, but the pathology most likely to be relevant to current obesity issues has been very clearly set out in a

[6] http://www.cabinetoffice.gov.uk/regulation/ria/

recent (October 2006) BRC report *Risk, Responsibility and Regulation – Whose risk is it anyway?* We can do no better than quote from that Report:

"The plethora of rules, regulations and guidelines that has become familiar to all of us doesn't happen by accident.

The public response, often encouraged by the media, to a perceived risk (be that a risk emerging over time or a specific incident) is usually to call for regulation. We can characterise this process, whether precipitous or gradual, as a 'regulatory spiral', summarised as follows:

1. *The perception of a risk emerges. This can be progressive over time, such as the risks of obesity, or following a specific incident, such as the kayaking accident at Lyme Regis in 1993.*

2. *A public debate follows, often based around headlines and incomplete or biased information, resulting in a call for 'something to be done', which is amplified by the media.*

3. *Instinctively, the public looks to the Government to manage the risk.*

4. *Responding to this public pressure, the government makes ambitious claims that it can solve the problem and steps in with a regulatory response, rarely considering the tradeoffs involved.*

5. *As a result, the role of the Government as risk manager is reinforced.*

6. *When the regulations are implemented, they inevitably fail to solve all the problems and also bring with them unintended consequences.*

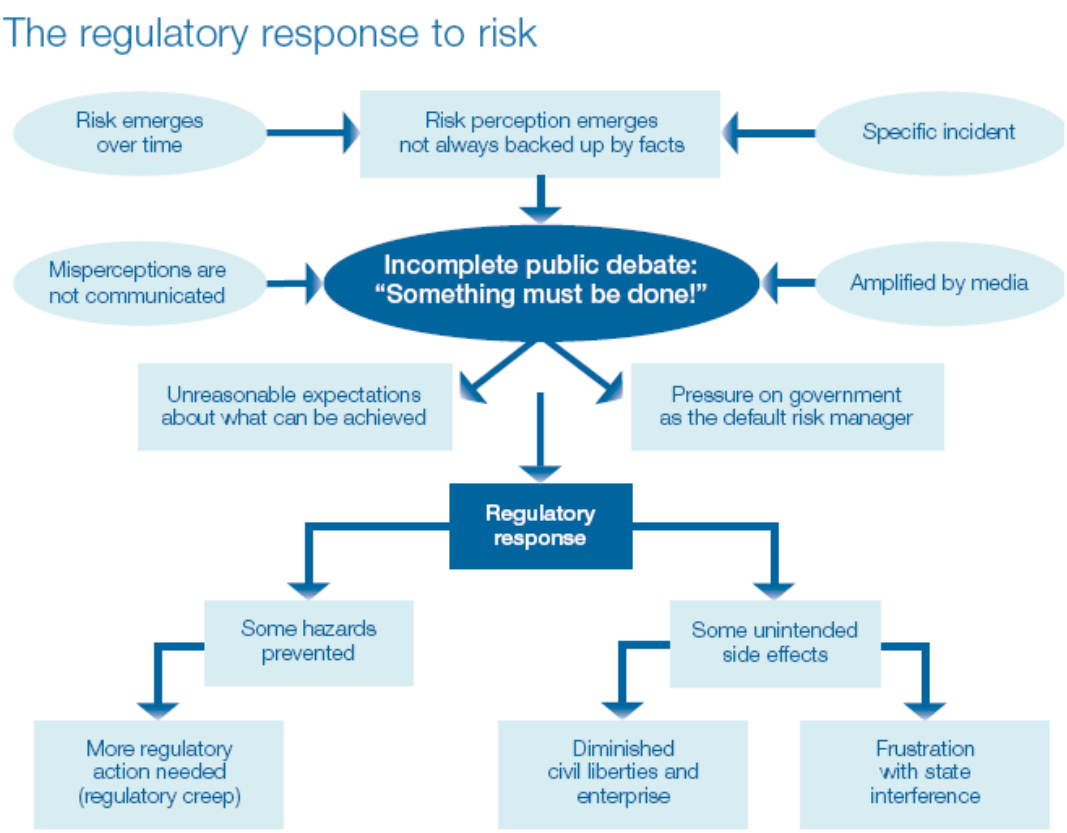
7. *With good implementation, some hazards are prevented, but this does not make news. Other hazards are not prevented and problems persist, leading to calls for more government action.*

8. *As a result of more regulation, people complain that liberties and enterprise are diminished and criticise the 'nanny state'.*

9. *Governments are blamed for interfering and acting unreasonably and, as a result, the national level of frustration shifts up a notch.*

10. *(If we are not careful), governments may seek to address issues of frustration and disengagement through more regulation."*

Risk, Responsibility and Regulation illustrates what it calls the 'regulatory spiral' as follows:



Particularly given that *Risk, Responsibility and Regulation* specifically makes reference to current debates concerning the prevalence and effects of obesity, the principles in the course of development by the BRC – which in many cases are reformulations and renewals of older wisdom – provide a natural jumping off point for detailed consideration of the relevant issues and evidence.

3. Obesity issues: background

Obesity can be defined as an excess of body fat. When a person gains weight, fat cells in the body increase first in size and then in number. The weight gain itself is caused by the intake of more calories than the body uses in its various activities. One pound of body fat is equivalent to about 3,500 stored calories.

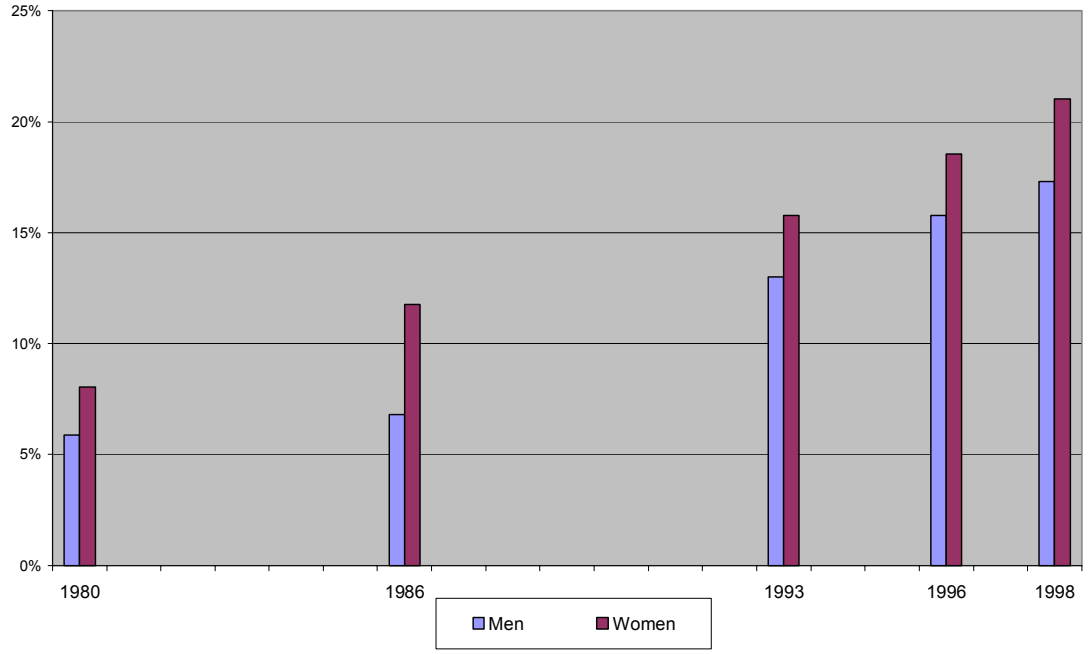
3.1 Assessing the prevalence of obesity

Current public interest in obesity is driven largely by the potential health consequences of being over-weight, combined with an observed upward trend in the proportion of the population classified as being over-weight. In assessing possible consequences of excess weight for health, the most widely used measure adopted in medical studies is the Body Mass Index (BMI).[7] Largely as a matter of convention, a BMI of above 25 has come to be used to describe a person as "overweight", whilst a BMI of over 30 is interpreted as designating "obesity".

[7] Defined as weight (in kgs) divided by the square of height (in metres).

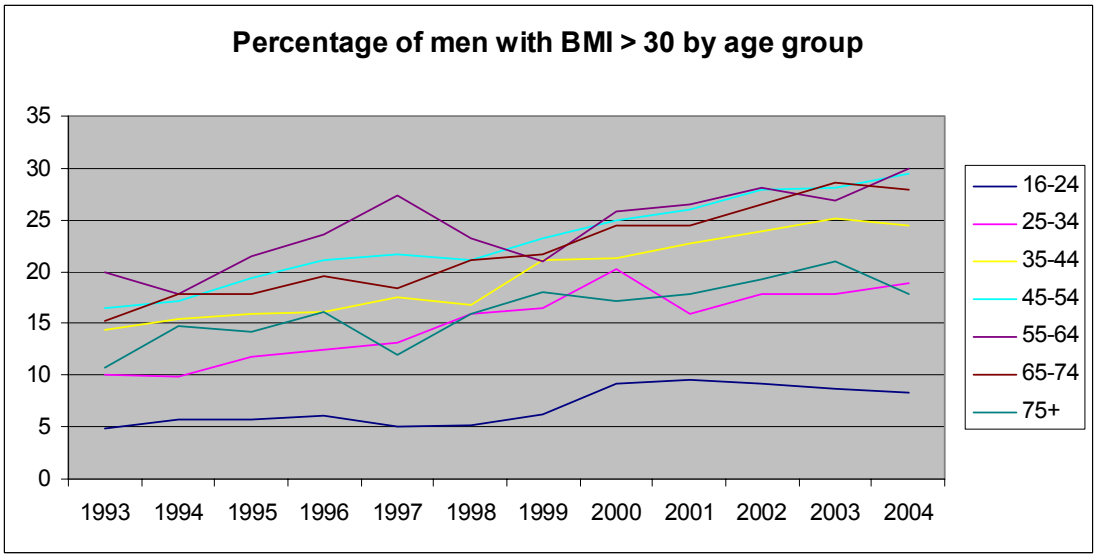
The prevalence of obesity in England, 1980-1998 (%)

Source: National Audit Office (2001) *Tackling Obesity in England*[8]



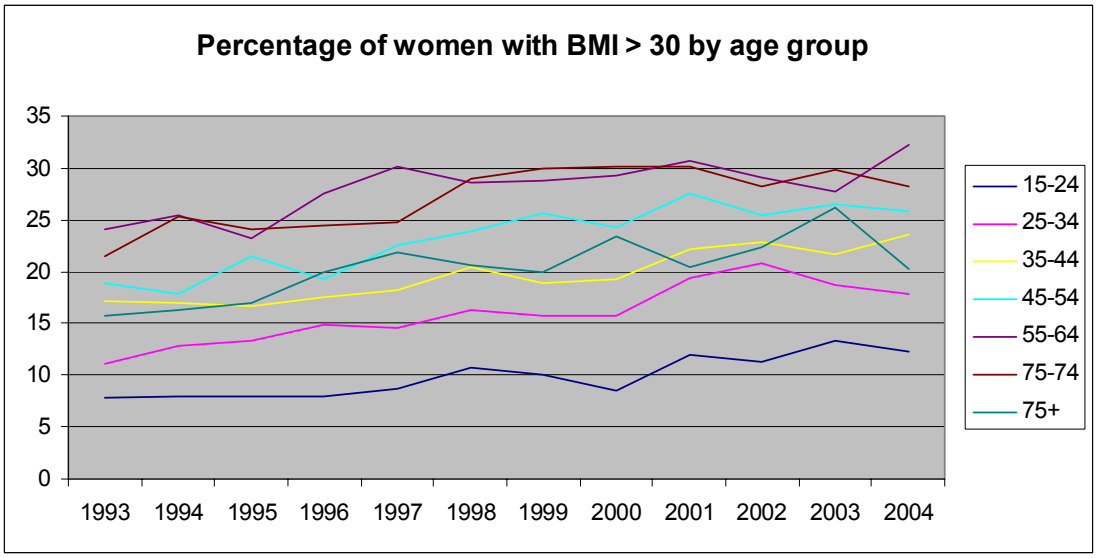
The graph above highlights the extent of the growth during the 1980s and 1990s in the percentages of men and women in England who were – on the above definition (i.e. BMI > 30) – obese. As can be seen, the prevalence of obesity among both men and women increased substantially over the period, with the 1998 percentages approaching levels three times those of 1980.

More recent trends in the proportion of various adult age groups who are classified (on the same basis as above) as obese are shown in the following charts, which are constructed from data provided in the *Health Survey for England 2004*, published by the Health and Social Care Information Centre.



[8] Data taken from the graph on page 12 of the NAO (2001) report.

These charts raise an immediate question: is it the case that the upward trends in the prevalence of obesity (on the BMI definition), which are clearly identifiable in data for the 1980s and the 1990s, still persist? There is some indication in the charts of a levelling off in the increase in the prevalence of obesity, particularly among women, and in the most recent year for which data were available from the *Health Survey for England* there was actually a fall in incidence in nine out of the fourteen age/sex categories.



Whilst it would be rash to conclude from this evidence that the prevalence of obesity has reached a turning point, it would be equally unsafe to presume that trends from the 1980s and 1990s continue to operate today. The most obvious implication of the data is that more up to date evidence could be particularly informative as to the likely development of prevalence in the future; and neglect of contemporary evidence on prevalence would increase the chance of proceeding on the basis of risk assessments that, in the BRC's words, were not "backed up by the facts."

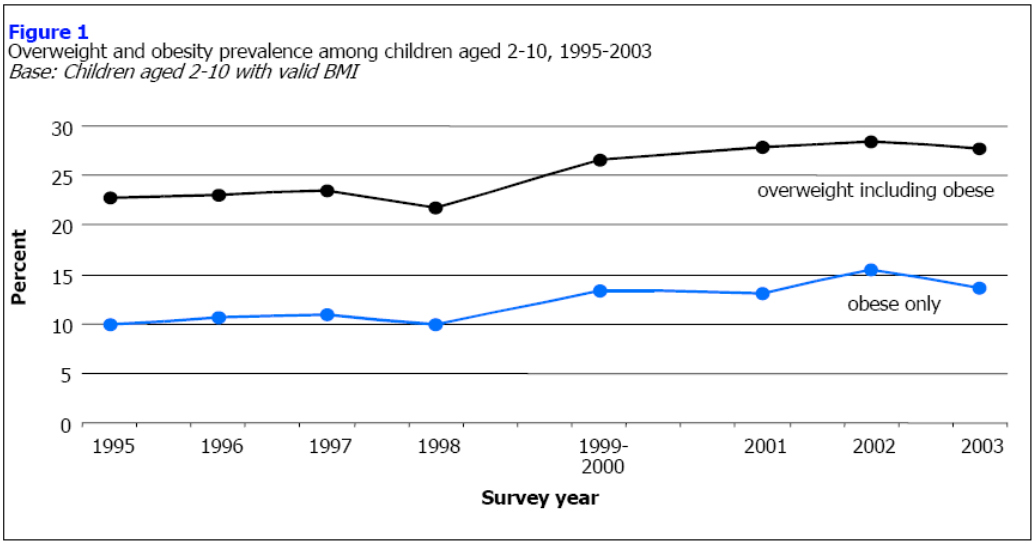
The conventional definition of obesity for adults (BMI > 30) is considered unsuitable for children, as a result of different growth patterns among boys and girls at each age. There are a number of possible approaches to measurement, but one method that has been used in the UK is to define obesity, for given age and sex, as a BMI in excess of the 95th percentile for the distribution of the BMI in the 1990 population (and to define 'overweight' as a BMI in excess of the 85th percentile). On this basis, therefore, 5% of children in 1990 were (by definition) obese and 15% were overweight.

The chart below shows the incidence of childhood obesity between 1995 and 2003, drawn from a Report prepared for the Department of Health, in collaboration with the Health and Social Care Information Centre.[9] Given the benchmark values of 5% for 1990, the increase in incidence of obesity in the 1990s is manifest. As in relation to the data for adults, however, the picture for the later period is less clear. Noting the decline in prevalence from 2002 to 2003, the authors of the Report say that:

[9] Dhriti Jotangia, Alison Moody, Emmanuel Stamatakis and Heather Wardle, *Obesity among children under 11*, April 2005.

"Obesity and overweight estimates in 2003 showed a slight decline compared with estimates for 2002. However, the difference between the two years was not significant. This means it is not possible to say whether this was a real decline in obesity prevalence, or whether simply by chance, fewer obese children were sampled in 2003."

Again, therefore, there is uncertainty as to current developments in prevalence, which reinforces the earlier suggestion that more recent data might be particularly informative as to the likely evolution of the numbers in future years.



3.2 Implications of high BMIs

Since the BMI depends on weight and height, it is clearly not itself a very direct measure of body fat. A relatively high BMI can, for example, reflect high muscle mass, rather than excess fat. There is, therefore, some lack of precision in the use of BMI as an indicator of obesity,[10] although it remains a useful measure for relatively broad brush assessments of trends and consequences.

According to best available medical evidence excess body fat is a risk factor for, among other things, diabetes, cardio-vascular disease, osteoarthritis, and some cancers. The quantification of the risks is a matter of continuing research, but the following tables, drawn from the website of the National Obesity Forum, give indicative numbers for the USA.

As for other medical research of this type (i.e. based upon observed correlations), care must be exercised in interpreting the available data. BMI measures may, for example, serve as a proxy measure for (i.e. be correlated with) a number of different characteristics of an individual's lifestyle. Research in the area therefore continues to

[10] At least if obesity is taken to refer to excess body fat. It is, of course, possible to define obesity by BMI measurements. An alternative indicator of potential health problems is the waist-to-hip ratio.

seek to disentangle the various causalities that may be at work, and the very scale and vigour of current research is indicative that there is still much to be learned.

Predominance of Medical Conditions by Body Mass Index (BMI) for Men

	BMI (%) 18.5-24.9	BMI (%) 25-29.9	BMI(%) 30-34.9	BMI(%) >40
Medical Condition		Prevalence Ratio (%)		
Diabetes	2.03	4.93	10.10	10.65
Coronary Heart Disease	8.84	9.60	16.01	13.95
High Blood Pressure	23.47	34.16	48.95	64.53
Osteoarthritis	2.59	4.55	4.66	10.04

Predominance of Medical Conditions by Body Mass Index (BMI) for Women

	BMI (%) 18.5-24.9	BMI (%) 25-29.9	BMI(%) 30-34.9	BMI(%) >40
Medical Condition		Prevalence Ratio (%)		
Diabetes	2.38	7.12	7.24	19.89
Coronary Heart Disease	6.87	11.13	12.56	19.22
High Blood Pressure	23.26	38.77	47.95	63.16
Osteoarthritis	5.22	8.51	9.94	17.19

Source : National Health and Nutrition Examination Survey (US).

By way of a concrete example, it can be noted that someone with a below average intake of calories may be overweight nonetheless, because of lack of physical exercise (i.e. a couch potato lifestyle). Quite apart from any health risks that are consequential on high levels of body fat, lack of exercise may be a risk factor for certain health problems in its own right. That is, inactive people may be subject to greater health risks than others *with the same BMI*, whether that BMI be high or low.

For example, one study that indicates the significance of lack of physical activity, as a risk factor in its own right, was conducted by researchers at the Harvard School of Public Health. From data collected from a sample of 116,000 nurses, it was concluded, among many other things, that obese women who worked out for more than 3.5 hours per week reduced their increased risk of premature death from 142% to 91% as compared with those who were less active, and that lean women who were inactive had a significantly greater risk of premature death than those who were more active.

4. Identification of the 'problem' and key issues arising

It is abundantly clear why obesity might be considered a problem for individual members of the public: it is their own health that is put at greater risk by high levels of body fat. It is much less obvious why obesity should be considered a problem that, at least potentially, might call for government/state action.

There is no immediate analogy with smoking in public places, for example. In the case of smoking an individual's conduct has negative consequences for others – whether in terms of immediate irritation from the smoke or of longer term health risks arising from passive inhalation of smoke. Sitting next to an overweight person on public transport may, other things equal, be less comfortable than sitting next to someone who is not overweight, but the most relevant factor at work here is body size not BMI (a technically obese woman may take up rather less space than a non-obese man). In any event, such minor irritants are not the stuff of public policy making: a decent level of toleration on these matters is indispensable to a well-functioning society.

In fact, given the social and political traditions of the UK, it can be argued that the public 'problematisation' of obesity is itself a problem. Why should the state take an interest in so personal a matter? Is this not a matter of personal responsibility?

The questions here are far from trivial, and are similar in nature to those raised by the Better Regulation Commission in *Risk, Responsibility and Regulation*. One of the strong themes of the Better Regulation Agenda is that government departments and agencies are to be discouraged from 'nationalising' all problems that are perceived to occur, and from being inordinately keen, using taxpayers' resources, to 'do something'. What then might the basis of a case to the effect that the growing incidence of obesity gives rise to problems of a public nature?

One line of argument is that being over-weight increases health risks which increases expected claims on the National Health System. Since the NHS is predominantly taxpayer funded, the implication is that obesity imposes (financial) costs on others. Hence, on this argument, taxpayers can have a legitimate interest in the body fat of users of the NHS, which can serve as an indicator of NHS liabilities.

Similarly, it is often argued that, because of poorer health associated with obesity, working days are lost, which leads to lower GDP than otherwise. Since governments are much concerned about GDP movements, and about the various positive and negative factors that contribute to such movements, this again may appear to establish a rationale for a governmental interest in obesity.

On reflection, however – and it can again be stressed that one of the purposes of regulatory impact assessment is to require policy makers to stop, reflect, listen and think – neither of the above lines of argument turns out to be at all convincing. One substantive underlying issue concerns incentives.

If obesity increases health risks, those people with excess body fat will themselves suffer the consequences – including, for example, loss of income through days of work lost – and will therefore have incentives to mitigate the risks. If it is concluded

that a taxpayer-funded health system provides insufficient incentives for mitigation, then it is unlikely that the 'problem' has anything specifically to do with obesity as such. Rather, the problem is likely to be more generic – lack of incentives for individuals to take mitigating steps across a range of controllable health risks – as are the appropriate policy responses (e.g. introducing a greater degree of co-insurance).[11]

Further, when considering whether or not individuals have sufficient incentives to mitigate risks, there are classic trade-offs between incentives and insurance to consider. The fact that lack of risk mitigation may impose costs on others – whether through higher NHS costs or lower income from work – is nowhere close to being sufficient to warrant a conclusion that some form of public intervention would be beneficial.

Considering the issues in terms of incentives serves to better focus analysis on potential sources of obesity-specific problems. In broadly similar economic contexts, incentive failures are generally viewed as being associated with one of two factors:

- The relevant individual can not reasonably be held to be responsible for his or her own conduct.

- The information available to the individual concerning the relevant choices is manifestly sub-optimal.

The first of these two possibilities should be handled with great care by policy makers in liberal democracies, since so much of the ethical framework of social life rests on the notion of individual responsibility. Nevertheless, there are sections of the population for whom the attribution of responsibility is generally weakened including the insane, those in relatively advanced states of dementia, (more arguably) those suffering from an addiction of one sort or another, and, most important of all in the current context, children.

The second possibility is also best approached with caution. The issue is not that members of the public will be imperfectly informed when making choices relating to diet and exercise: imperfect information is a simple fact of economic life. Rather, the question is whether relevant information flows are manifestly sub-optimal, either by dint of paucity of information or by manifest biases (i.e. misleading information).

5. Specification of public policy objectives

The relevant public policy objectives in relation to obesity are, of course, a matter for determination by government in the first instance and, ultimately, by the public via the democratic process. It is open, for example, for government to take the view that it wishes to see a reduction in some measure of the prevalence of obesity, or some reduction in the rate of growth of such a measure. In doing so, however, any government would be wise to recognise that large sections of the public might well take the view that body weight is not a legitimate interest of the state.

[11] The health funding issue is noted briefly in *Trends and drivers of obesity: A literature review for the Foresight project on obesity* (Office of Science and Technology), and it is discussed more fully in Philipson and Posner, *op cit*, who show why the common sense argument – to the effect that reducing the prevalence of obesity can be expected to reduce the tax burden – can be misguided.

This type of 'target' is nowadays a common feature of public administration, but one of its limitations in the current context is that, assuming the concern with obesity is a *derived concern*, stemming ultimately from the fact that it is a risk factor for a range of harmful medical conditions, then, as a matter of fairly general principle, it will tend to be better to specify policy objectives in terms of health outcomes. This then focuses attention on how best to get desirable outcomes, rather than a more prescriptive approach that specifies means as well as ends.

Another, more generic problem with specifying targets is that, in focusing upon a single number (e.g. the proportion of the population with BMI > 30), it is possible to create all sorts of unwanted side effects or unintended consequences, which may be costly and can actually detract from the achievement of wider goals. In the case of body weight issues for example, there will be a distribution for the BMI measure in the population as a whole. This distribution may be characterised by a whole set of measures: the mean, median, mode, variance, skewness, kurtosis, deciles, etc, etc. If one is picked and targeted, the effect may be to influence the whole distribution, possibly in ways that are unwanted. Thus, if all the focus goes on to reducing one parameter – the proportion of people with BMI > 30 – the nominal 'objective' may be achieved whilst mean BMI in the population increases, or whilst the proportion with BMI > 35 rises.

Since there is no indication in the medical evidence that there is anything particularly special about a BMI threshold of 30, there is a potential disconnect between a policy goal specified in terms of this threshold and wider policy goals that are related to health outcomes. There are difficult issues to be settled here, which is one of the reasons why good regulatory impact assessment requires explicit analysis and specification of relevant objectives. Good intentions are not enough, and, unsupported by clear thinking and analysis, can be positively dangerous, as folk wisdom concerning the Road to Hell has long recognised.

6. Policy approaches

RIA guidelines insist that a 'do nothing' option be considered, and they also encourage the assessment of alternatives to public regulation such as voluntary or self-regulatory initiatives.

Two common misconceptions of the 'do nothing' option, which plays a central role in best practice RIA, are that it implies (a) that government is washing its hands of the relevant issues, and (b) nothing will be done. With respect to the first, a decision not to initiate regulatory intervention today clearly does not preclude the option to do so in some future period, and it does not necessarily imply across-the-board inactivity. For example, emerging evidence can be kept under review; and, indeed, the value of wait-and-see policies can be expected to be higher the greater the expected information content of new evidence, other things equal.

Similarly, it would be quite wrong to think, because the government chooses to do nothing about a particular issue, that nothing at all will be done about that issue. Individuals and organisations will respond to 'problems' on their own account, including via their conduct in relevant markets. Although there tends to be ever-

abundant supply of willing leaders, controllers, and regulators, the public is not always in need of their services. One of the principal matters for consideration in any policy analysis therefore concerns whether or not public action will substitute for, and 'crowd out', private responses that would otherwise have occurred.

A further important point here is that the 'do nothing' option is intended to refer to the situation where there is no *change* in the extent and/or form of government intervention. The 'opening' regulatory position will not be a blank sheet. Rather, there will typically be a whole range of existing regulatory provisions/activities that have at least some bearing on the issues under consideration. A clear understanding of the regulatory landscape into which new provisions are potentially to be introduced is clearly essential for the proper assessment of likely impacts, since these impacts will tend to be heavily influenced by ways in which new and existing regulatory provisions interact. A thorough review of the existing regulatory background should thus form part of the 'do nothing' assessment.

6.1 The do nothing option

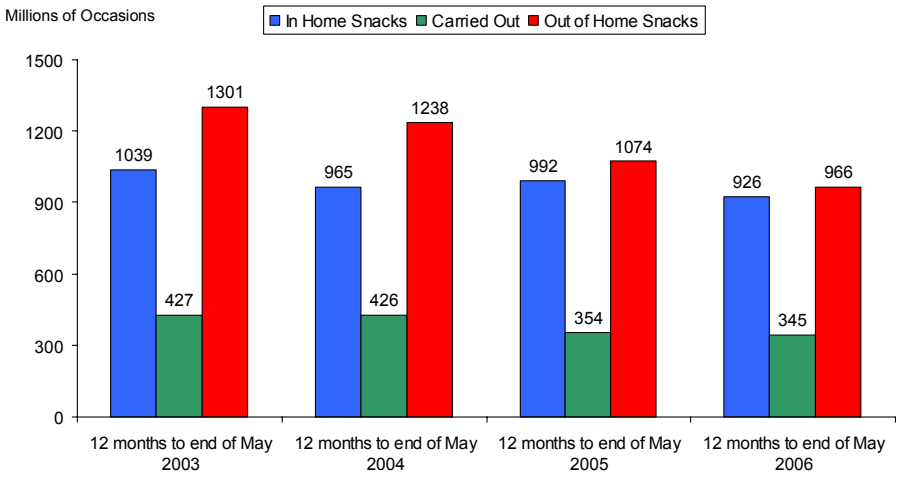
Given that obesity can be expected to give rise to health problems for the individuals concerned, those individuals will have incentives to mitigate the risks. They may for example seek to exercise more, or they may seek to reduce their calorie intake. To the extent that they go the latter route, food suppliers, including suppliers of snack foods, will have incentives to reformulate products in response to changing consumer preferences – for example, by introducing lower calorie, lower fat, or smaller sized variants of their products.

Assessment of the do nothing option therefore involves evaluation of these normal, individualistic, 'market' responses to a perceived problem. It is not, of course, to be expected that such feedback mechanisms operate instantaneously. It takes time for information (e.g. about the health risks of obesity) to be discovered, interpreted and absorbed, and for behavioural adjustments to be made in the light of the new information and experiences; and failure to appreciate the inevitable lags is one of the persisting failures of public regulators. Thus, public officials or experts sometimes come to identify an emerging problem – not infrequently somewhat later than at least some significant section of the public – and move into 'something must be done' mode, before properly examining whether or not a 'solution' is already emerging, unaided by the state.

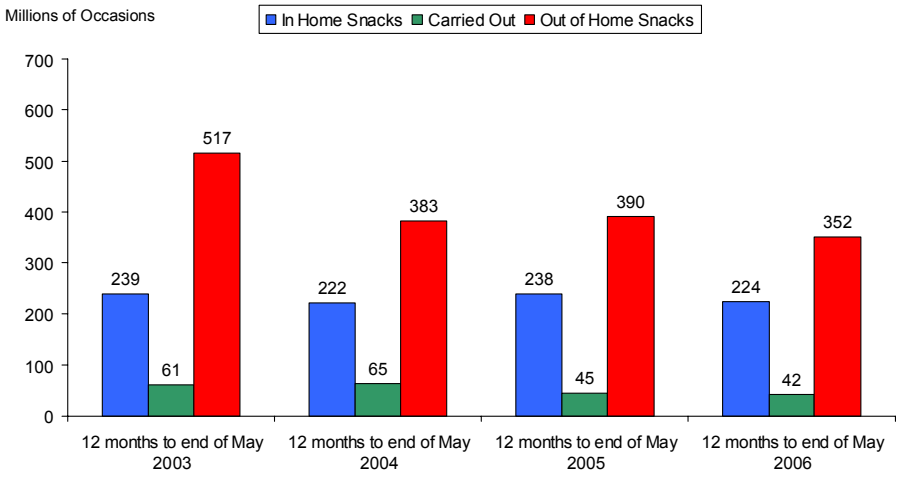
In the current context, a quick perusal of the evidence indicates that there is, in fact, a considerable amount of behavioural adjustment going on. For example, the following two charts, drawn from a TNS study, suggest that the number of occasions on which there is consumption of chocolate confectionery and of sugar confectionery has been falling over the last three years.

In response to the changes in the consumer preferences/behaviour that these charts appear to indicate, suppliers have responded in the way that might be expected from companies operating in competitive markets who find that demand is moving away from their existing products. They have increasingly sought to reformulate their products to meet the changing requirements of consumers, so as to be able to sustain sales volumes and profits.

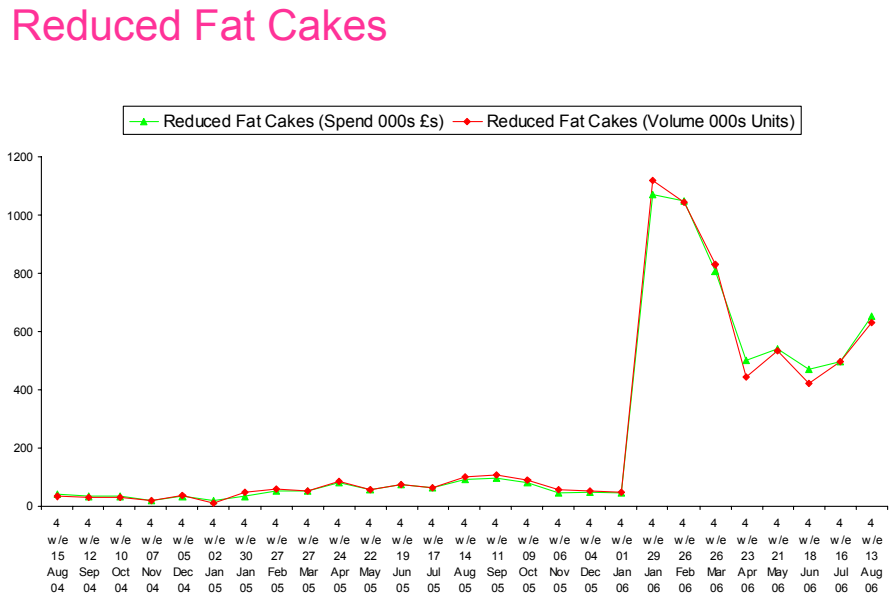
Chocolate Confectionery



Sugar Confectionery



The chart below shows one such adaptation, the introduction of reduced fat cakes. The sharp upward jump in consumption reflects the introduction of new products into the market, and it is notable that the product launches were in January, immediately after the indulgence of the Christmas and New Year holiday period. Thus, not only do commercial incentives induce the development of new products, but they also encourage innovation at the time of year when it is likely to have the greatest impact on consumer behaviour (i.e. when consumers are likely to be most conscious of the benefits of reducing fat and calorie intake).



In a short paper such as this, it is impossible to do justice to the market developments that are currently taking place. As is often the case, changes in the relevant markets are occurring in myriad ways, reflecting both the changing dietary preferences and requirements of a diverse population and attempts by suppliers to meet those changing preferences and requirements. It suffices to note that more careful assessment of such developments is a necessary first-step in best-practice RIA, not least because one of the effects of regulatory intervention is often to impose a 'standardised solution' to a perceived 'problem', which 'solution' is later discovered to have the unintended consequence of suppressing experimentation and innovation.

6.2 Self-regulation options

RIA guidance has emphasised that, as a matter of good practice, when public regulation is in contemplation, self-regulatory options should, where possible, also be considered. It is not always clear what is meant by 'self-regulation' in this context since, in one sense, a large variety of types of social and market processes could be described as 'self-regulation'; or, put another way, leaving matters to be determined by such processes, at least for the time being (i.e. the 'do nothing' option), could be regarded as a form of self-regulation. For current purposes, however, and to mark it out as a distinct type of policy approach, self-regulation will be interpreted to mean a legitimate coming together of market participants to agree, voluntarily, on establishing certain common constraints on their conduct.

Thus, in the context of obesity issues, one 'self-regulatory' option is to encourage food suppliers to agree among themselves to provide *similar* information on packs, and/or to provide information in *standardised formats*. We will examine food labelling options in greater detail below, since compulsory/regulatory alternatives are also possible, but, for now, simply note that encouragement of such measures is by no means cost-free. As noted, standardisation across suppliers in relation to almost any type of activity is liable to run a risk of reducing competition, since it tends to dampen inter-company rivalry in the search for new and better ways to satisfy customers'

requirements – which encompass not only the product itself but also the way it is packaged and presented, and the information that is provided about it.

Potential harm to competition should therefore be considered when assessing measures to standardise economic activities across competing companies, including via voluntary agreements and self-regulation as well as via statutory intervention. Further, in making these assessments, it is not just a matter of establishing that the benefits of standardisation can be expected to be greater than the costs arising from restrictions of competition. The more relevant question is whether the restrictions of competition are *indispensable* for achieving the given public policy objectives that standardisation is intended to achieve. Thus, if there are potential restrictions of competition involved, it should be asked, as a matter of course: are there other ways to achieve the given objectives which do not give rise to a risk of anti-competitive effects? In the limit, failure to address such issues will give rise to questions of whether a proposed option is a breach of competition law.

6.3 Public regulation options

One example of a possible public regulation response to perceived obesity problems is a proposal to introduce restrictions on the advertising of certain types of foods, snacks and soft drinks. Another is to promote certain types of food labelling which, even if intended to be voluntary in nature, properly fall under the heading of public regulation when they are instigated by a public body (action that is almost invariably backed by implicit or explicit threats of legislative action, albeit of varying degrees of credibility). Thus, as indicated in section 2 above, when it is the government or one of its agencies that is in the driving seat, the BRE guidelines call for Regulatory Impact Assessment for codes of practice, information campaigns, etc., as well as for measures that require legislation.

It is difficult to over-emphasise the importance of careful assessment of the likely impacts of the relevant, potential policy options. As *Risk, Responsibility and Regulation* implies, public officials can have strong incentives to be seen to be 'doing something' in response to a perceived 'problem', but the incentives to think through all the consequences of action – both intended and unintended, long-term as well as short-term – tend to be much weaker.

Take, for example, restrictions on marketing that lead to reduced advertising spends on certain foods and snacks. It may seem self-evident that, whatever the side-effects, one impact of such a policy would be to reduce consumption of the products in question. However, at one point in its history the Monopolies and Mergers Commission (now the Competition Commission), in an investigation of soap powders[12], recommended agreed reductions in advertising spend on certain products. The rationale for the reduction in advertising was to promote lower prices and to *increase* the consumption of the products concerned.

The Monopolies and Mergers Commission may, of course, have been wrong in its analysis of the market, and the soap powder context is no doubt rather different from that of snack foods. The only point here is that the impact of advertising restrictions is not obvious. It is an issue – and possibly a quite difficult issue – that stands to be assessed in the relevant factual context.

[12] *A Report on the supply of household detergents*, 1966.

7. An overview of the development of a regulatory option: signpost labelling

Signpost labelling provides an example of an area of activity where a number of policy options have been considered, and a particular policy approach – the Food Standards Agency's voluntary signposting scheme - has recently been recommended (by the Agency) as the most appropriate way forward. We begin by describing the recommended FSA scheme, before providing a brief review of the specific policy problems that have been identified as motivating its introduction, and of the various alternative options that were considered.

7.1 The FSA Traffic Light Scheme

In March 2006, the Board of the Food Standards Agency (FSA) recommended a scheme for 'front of pack' labelling, and, in particular, recommended that businesses adopt the scheme for the following set of 'composite processed foods':

- Ready meals;
- Breakfast cereals;
- Pizzas;
- Sandwiches;
- Meal components such as:
  - Burgers;
  - Sausages;
  - Pies;
  - Breaded, coated or formed meat, meat alternative, poultry and fish products.

Adoption of the scheme for any given product involves following the following four 'core principles':

- Separate information on: fat, saturated fat, sugar and salt;

- Use of red, amber or green colour coding to provide 'at a glance' information on the level (i.e. whether high, medium or low) of individual nutrients in the product (that is, use of what has come to be referred to as a 'traffic light' approach);

- Provision of information on the levels of nutrients present in a portion of the product; and,

- Use of nutritional criteria developed by an authoritative, trusted and independent body such as the Food Standards Agency *(sic)*.

The scheme is voluntary, and - as the wording above suggests - allows for some flexibility in terms of compliance. Whilst the FSA website[13] currently provides some *suggestions* about the presentation of nutrient information, no particular formats are specified as a necessary feature of the scheme in the March 2006 recommendation

[13] http://www.food.gov.uk

(compliant formats can thus simply be understood as those that are consistent with the 'core principles' above).

7.2 Background

The development of the FSA recommendations on signposting referred to above followed from a government commitment made in the 2004 Department of Health White Paper *"Choosing Health"*. Thus, the overarching Partial RIA document[14] for *Choosing Health* noted that:

"The White Paper announces that the Government will work with the food, catering and hospitality industries to establish a clear coding system for food. The intention is the system will be in common use and will tell people at a glance which foods make a positive contribution to a healthy diet, which can be eaten freely and which are recommended to be eaten in moderation. The Department of Health is working with the Food Standards Agency to develop simple "at a glance" criteria using levels of fat, sugar and salt to indicate the contribution a food makes to a healthy balanced diet. This work will enable the development of a coding system. This will provide information that might be necessary to support action on food promotion to children" (p9).

A major difficulty here is that there is no evidence – in the White Paper or its accompanying documents – to suggest that relevant issues were adequately assessed ahead of this White Paper commitment being made. A number of RIA documents were published alongside the White Paper, but there was no RIA of this particular line of policy development, which was considered to have "*...some impact, but not a significant impact on the public sector, businesses, charities and voluntary organisations...*" (p8). However, the extremely general manner in which the DH set out its views in the White Paper (for example, were the criteria intended to apply to all foods?) meant that there was necessarily significant latitude for subsequent interpretation.

7.3 Signposting and identified policy problems

When the rationale for government intervention with respect to 'signposting' has been presented in Department of Health or Food Standards Agency documents, much of the attention has typically been devoted to descriptions of health concerns. Thus, for example, much of the relevant section of the November 2005 Partial RIA document[15] for the FSA's proposed signposting scheme was concerned with a range of health issues that can be associated with consuming high levels of salt, fat, saturated fat and sugars.

Some analysis of the relevant health issues upon which consumption levels of the identified nutrients have bearing is clearly important for a proper understanding of the relevant factual context, within which the rationale for intervention – whether via a 'signposting' scheme or some alternative – stands to be examined. Such analysis will,

[14] Department of Health (2004) *Overarching Partial Regulatory Impact Assessment – Choosing Health: Making Healthy Choices Easier White Paper*

[15] Food Standards Agency (2005) *Partial Regulatory Impact Assessment: Voluntary front of pack signposting scheme for certain pre-packed foods sold through retail outlets in the UK*

for example, have implications for questions concerning appreciability/materiality of identified problems and of regulatory impacts.

However, the principal issues to be addressed when identifying relevant policy problems in the context of potential intervention related to signposting are much narrower than this, and concern the identification of problems with existing (and expected) product labelling practices. The main specific issue that has been highlighted is the potential for consumer confusion. Thus, the FSA November 2005 Partial RIA document states that:

"Without Government intervention the current proliferation of retailer and manufacturer designed schemes, based on different rationales and nutritional criteria will continue. This will lead to increased consumer confusion about the nutritional content of individual foods and make it increasingly difficult to make informed choices about the nutritional quality of the food they eat" (p5).

The Partial RIA thus indicates that it is the potential for consumer confusion that intervention is seeking to address.

7.4 Policy options with respect to signposting

7.3.1 Do Nothing

A significant feature of the description of the 'problem' to be addressed, arising from the potential proliferation of signposting schemes, is that it focuses attention on the formatting of nutrient level information, rather than on the provision of information *per se*. Thus, it is not obvious that there are material public concerns about the volume of information provided, and the issue appears rather to arise from the confusion that information flows can give rise to.

It is relevant here that front of pack schemes have been introduced over a relatively short time period. It is perhaps not surprising that a substantial growth in the level of 'front of pack' nutrient information has given rise to some confusion and to some difficulties in interpretation. Innovation generally poses learning challenges.

In the normal course of events, however, innovations tend to be followed by adaptations on both the demand and supply sides of markets: some consumers get more sophisticated, suppliers respond to the requirements of those consumers who want to keep it simple, and so on. The development of front of pack signposts to date has involved experimentation. Different designs have been adopted, and given the sophistication of supermarket data collection processes, it should be possible for the impacts of different approaches to be examined in some detail.

As has already been emphasised, the 'do nothing' option does not imply the abandonment of options to act in the future, when and if there is evidence that normal market processes do not appear to be working.

7.3.2 Facilitation of a voluntary scheme

One general point of note is that the option of facilitating the development of a voluntary scheme can be understood as encompassing a whole range of policy sub-

options – one for each specific form of implementation. One of the major tasks for best practice RIA is therefore the identification and assessment of potentially superior sub-options or variants.

As noted above, the March 2006 FSA recommendations were presented in the form of a set of 'core principles' that allowed for some flexibility with respect to how they were interpreted whilst remaining 'compliant'. The recommendation is thus clearly less restrictive than some potential sub-options (including some options that had been previously considered by the FSA). It is nevertheless also clearly more restrictive than some other potential sub-options – one obvious variant for consideration being a sub-option that excluded the requirement to use traffic light colours.

7.3.3 The legislative option

Whilst the option of legislation is presented in the FSA's Partial RIA document, there is no evidence to suggest that it was being progressed as a realistic way forward. A particular difficulty in this case concerns the relationship between UK and EU law. Thus, for example, the FSA noted that:

"Generally, in circumstances where the Community has acted to harmonise an area of law, it is no longer open to Member States of have their own rules in that area… There is a risk that national legislation would be viewed as illegal by the Commission and the European Court of Justice when set against the background of existing EC legislation in this area". (p8)

What is left unstated, however, is the fact that food labelling legislation is addressed at the EU level in large part because of its potential impact on trade between Member States. That is, there has been explicit recognition that food labelling legislation has the potential to distort trade flows and competitive activity within the single market. Whilst the FSA noted that the UK could press for revised EU rules, that option is not developed further: in this case, the threat of statutory intervention is kept low key.

7.4 Concluding comments on the evolution of the traffic lights scheme

We end this section by highlighting two points of note regarding evolution of the traffic light scheme to date. Firstly, the 2004 DH White Paper commitment with respect to signposting, and some of the FSA work that followed it, appeared – at least implicitly – to focus attention on the question of how to identify/develop 'the best way' of signposting. More recently - as indicated, in particular, by the form of the FSA March 2005 recommendations - attention appears to have become more closely focused on questions concerning the extent to which specific restrictions should be considered necessary. As indicated above, best practice RIA should include the identification and assessment of potential sub-options, and this should involve – importantly in the current context - the standard necessity/indispensability and proportionately assessments being undertaken on the basis of best available evidence.

Second, careful evaluation of the impacts of alternative courses of regulatory action on market competition has been notable largely by its absence from the assessment process. Any forced or induced standardisation can potentially have some restrictive effects on competition, since it precludes competition in respect of that which is standardised. Whether or not it has wider restrictive effects on competition in the

round, and, if it does, whether or not the restrictions are necessary/indispensable for the achievement of a legitimate public policy objective, are questions that should not be begged. Further, to the extent that MTLs draw the consumers' attention *toward* some of the factors relevant to making informed choices about dietary balance but draw attention *away* from others (such as typical portion size, water content, and energy content) – if only by comparative neglect – they are potentially capable of distorting competition by artificially penalising some suppliers (e.g. of dry foodstuffs consumed in small portions).

8. Conclusions on the assessment of alternative policy approaches

There is an underlying irony in the assessment of regulatory approaches to issues surrounding obesity. For very many of those now classified as obese by virtue of having a BMI in excess of the relatively arbitrary cut-off number of thirty, the high BMI is a consequence of lifestyle choices. We suspect that a poll would indicate that a large majority would like to reduce their weight, but that other things work against that outcome. The temptations to a little more indulgence, to a little smackerel of something tasty between times, to the couch rather than the road or gym, are strong for the many, if not for the few.

There is, however, another temptation in play. It is the temptation, so clearly identified by the BRC, for parts of government and for public agencies to 'do something' in response to 'problems' brought to their attention by some or other interest calling for action to be taken. Government, at least in the parts where the greatest intelligence with respect to regulatory issues resides, now recognises the temptations to excess, and would like to increase its own resistance (that is what large parts of the Better Regulation Agenda are about). Such resistance is, of course, likely to be highly partial: there will generally still be something to be gained by providing a smackerel of something helpful to groups whose political support is valued.

The fundamental difference between the two temptations is that, in the case of the citizen and his/her diet, the consequences of the choices made fall heavily, though not necessarily exclusively, upon the person making the choices: the individual will suffer the health consequences of over indulgence. In contrast, that incentive mechanism is absent in the case of over-regulation: it is others who suffer the consequences, particularly when the effects are to distort competition and/or otherwise impede the effective functioning of markets. The welfare of public officials will typically not be materially affected by their decisions, one way or another.

The temptation to develop public 'solutions' to perceived obesity 'problems' appears not to have been curtailed by the evidence. What struck us most in this regard when we came to look at the issues was that (a) in much of the public discourse, arguments depended upon assumed rates of increase in the prevalence of obesity that are there to be seen in the 1980s and 1990s, but that are less obviously visible today, (b) the latest, available figures, suggested the possibility that a turning point in prevalence had been reached, or is near, and they are themselves already two years out of date, and (c) would-be regulators appear not to be giving sufficient weight to evidence on changes in consumption patterns and changes in the portfolio of products being offered on the market.

What is not in doubt is that (a) there has, over a period of twenty years or so, been a marked increase in the proportion of the population with a BMI of over thirty, (b) the development, and its potential implications, has, at least in broad terms, been widely recognised and has received extensive coverage in the media and in public discourse, (c) there is considerable change and innovation taking place within the relevant markets as consumers and suppliers adapt their behaviour in response to changing circumstances.

However, what is missing from the much of discourse surrounding obesity, is any sense of the likely relative effectiveness of governments and markets in this area. Markets are at their best, in relative terms, in circumstances of change and innovation. That is because of the incentives that they establish for the discovery, processing, use, and transmission of new information – incentives that are much weaker in monopolised, public sector decision making. In relation to obesity, the discovery, learning and adaptation that are currently taking place in relevant markets is obvious. Whilst there may be a supporting role for public intervention, policy makers have a responsibility to ensure that they can demonstrate that any proposed actions can reasonably be expected to help, and not to hinder, that discovery, learning and adaptation.