Assessing Information on Public Health Law Best Practices for Obesity Prevention and Control

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In 2008, Representative John Read of Mississippi recently co-sponsored state legislation that would ban restaurants from serving obese customers. He later admitted that the bill was a publicity stunt, meant to “shed a little light on the number one problem in Mississippi.” Although controversial, Read’s bill exemplifies both the current perception of obesity as a national public health problem and the general sentiment underlying the types of interventions that are being considered to address this issue. The proposed legislation also demonstrates how policymakers can use or, in this case misuse, information about obesity to generate significant discussion on an issue along with ill-conceived legal interventions.

Information sharing and the methods used to share best practices are components of the fourth core element of public health legal preparedness. The way public health practitioners, health care providers, attorneys, and legislators share information or have access to information is critical for ensuring that laws and legal authority support best practices that address the complex public health issue of obesity.

Few people, especially health care and public health professionals, will disagree about the negative health consequences and substantial health care costs associated with obesity. Nonetheless, because obesity is often perceived as a failure of individual-control overeating and exercise habits, existing health policy tends to focus on individual behavior modification rather than a population health issue. As the companion public health framework paper demonstrates, body weight results from complex, multifaceted causal factors that involve far more than individual genes and behavior. The built environment (i.e., sidewalks, parks, and transportation), social determinants of health, a family’s economic status, and home environment also affect body weight. For example, the Surgeon General has found that behavior and environment contribute to obesity and emphasizes that policy should address both of these areas.

Various laws and legal authorities directly and indirectly regulate many (if not most) of the factors influencing obesity rates, such as food production, distribution, eating, and exercise. Therefore, it is important for public health and health care practitioners to share information with elected officials and other policymakers to develop sound public policy to reduce the incidence and prevalence of obesity. Legislators and practitioners seeking to improve policies and programs related to obesity prevention and control must have ready access to evidence-based information to support laws and implement programs that can have a long-term impact in reducing obesity as a chronic disease.

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This paper examines existing legal strategies designed to curtail the obesity epidemic. Three questions frame our analysis: What do we want law to achieve in this area? Where can law make the greatest difference? And what information do policymakers and practitioners need to shape and implement programs that reflect best practices? Without reciprocal information sharing strategies between policymakers and public health practitioners, it is difficult to enact effective legal innovations and best practices to curtail the obesity epidemic. To frame the discussion, the paper describes laws and legal authorities that influence obesity prevention and control, and then discusses the information strategies from various sectors needed to ensure dissemination of best practices for legal interventions designed to reduce obesity.

**Information Resources: An Assessment**

The public health initiative to prevent tobacco use has rich information resources, decades of research, and a strong scientific foundation for the development of laws and legal authorities. By contrast, the resources to address obesity from a population-based, public health perspective are not nearly as developed. While numerous sources of obesity-related information exist and more are developing, there is no coordinated approach to information management or dissemination, nor is there a centralized repository for use by lawmakers, practitioners, and policymakers. One problem is that obesity is such a growing and complex problem that it is not clear who represents the total “base” of stakeholders. A table in the appendix of this supplement presents a list of information resources currently available that begins to describe laws and legal authorities as well as policy resources available for information sharing about legal practices related to obesity prevention and control.

Despite the limited information base and information sharing, states and localities have already enacted laws and ordinances to address obesity. Currently, as reported in the laws and legal authorities assessment paper, sectors at all jurisdictional levels are implementing laws that make healthy food choices more available and encourage exercise. At the present time, these laws, regulations, and policies generally do not encourage the kinds of surveillance, monitoring, and evaluation needed to assess the impact of various program strategies and laws that attempt to address the obesity epidemic. As these laws and policies continue to evolve, they will generate the information base needed to assess best legal practices.

**Setting-Specific Information Dissemination**

*a. Schools*

In theory, laws and legal authorities supporting prevention strategies are most effective because, if successful, they can eliminate a given problem (e.g., the availability of sugar-sweetened beverages on school property and during school events, or the lack of fruits and vegetables in entire communities). To prevent obesity, most strategies have been directed at children through school-based interventions. Children represent an attractive target population to policymakers because laws and legal authorities to improve children’s health enjoy widespread public and bipartisan support, and thus are often easier to enact.

Lawmakers and policymakers believe that early intervention programs have superior outcomes than those directed at adults. The eating and physical activity habits of children are not yet ingrained, making them more susceptible to behavior modification and population-based strategies. School-based programs are especially popular because schools are an efficient medium to reach large numbers of children and legislators can easily mandate school-based programs, such as those that regulate nutrition and physical exercise.

Surveys and information sharing in the school setting are contributing to our knowledge base and influencing laws that authorize programs, especially at the federal level. These surveys demonstrate the potential for effective use of information sharing to identify where laws are making an impact and where improvement is still needed.

For example, surveys suggest that only 28% of high school students participate in daily physical education programs and that some schools have foregone physical education requirements altogether. As noted in the laws and legal authorities assessment paper, surveys have noted that schools are relying too heavily on inexpensive commodity foods high in salt, fat, and calories. As a result, the federal government in 2004 mandated that every local educational agency participating in the National School Lunch Program and the School Breakfast Program “shall establish a local school wellness policy by School Year 2006.” Local wellness policies must establish goals for nutrition education, physical activity, campus food provision, and other school-based activities designed to promote student wellness. A 2007 survey of how these policies were implemented found that many school districts continued to struggle with both the availability and pricing of products that meet nutrition standards.

For many years, schools have offered foods of minimal nutritional value. Because of these policies, schools have been highly criticized as contributing to the “toxic environment” associated with obesity. School-based
policies rarely consider the home environment of their students or take into account their students’ cultural diversity. Parents may want their children to be at a healthy weight, but may themselves lack the appropriate tools to achieve this outcome. Parental perception of what constitutes healthy weight may deviate from that of health care providers. Lower-income parents often believe that their overweight or obese child is either normal weight or even underweight. An overweight child is seen as a sign of good parenting in some social and cultural contexts. Thus, methods for information sharing and determining best practices must be diverse and consider stakeholders who represent a wide variety of cultures, interests, sectors, and populations.

Most of the legislation addressing obesity is developed at the state and local levels. For example, some school districts in the country are using newly implemented laws and or their existing legal authorities to improve nutrition, increase physical education programs, and monitor childhood obesity through BMI screening. A watershed year for such legislation, 2005, saw the passage of 17 state statutes relating to school-based nutrition and 21 related to physical education programs. Other legislation includes restricting access to vending machines, and introducing fresh, locally grown produce into school nutrition programs. To date, states have not imposed advertising and marketing limits on products that contribute to obesity rates, though we can anticipate such attempts in the future. In part because the laws have not yet been evaluated, they have not been widely adopted throughout the country.

In 2003, Arkansas was the first state to legislate statewide BMI measurements with school health report cards. These report cards provide parents with their child’s BMI percentage by age, and the results of vision and hearing screening. If the child is considered at risk for being overweight or is overweight or underweight, parents are provided local resources and contact information for potential health care providers. The Arkansas program has had a mixed reception from parents, health practitioners, and the media. Critics of program have raised self-esteem, stigmatization, and disordered eating concerns. In 2005 and 2007, bills were proposed to repeal the controversial law, but neither was enacted. Instead, in 2007, a law was enacted which changes the frequency of BMI screening (from every year to every other year), and allows parents to opt their children out from screening.

b. Community Setting
State and local jurisdictions may represent the cutting edge for demonstrating potentially innovative legal strategies to prevent and control obesity. Throughout the nation, state and local jurisdictions are enacting prevention-focused initiatives, including the creation of local obesity task forces, along with community and workplace fitness campaigns. Unfortunately, the successes and failures associated with these programs at the local level are neither adequately evaluated to identify model programs nor are the lessons learned communicated widely.

Some of the initiatives are contentious. For example, taxes on non-nutritious foods or “snack taxes” have been levied in seventeen states. Some public health officials use the parallel of the positive impact of tobacco taxes in reducing smoking as a model for taxing snack foods and sodas to promote healthier behavior. But these taxes are quite controversial and untested as to whether they make a significant impact on obesity prevention and control. Any evaluation of the potential positive effects on reducing the prevalence of obesity must be balanced against what opponents argue is the regressive nature of junk food, i.e., taxes are unlikely to encourage the substitution of healthier foods. The level of disagreement about the issue demonstrates the need for further study and a significant gap in our understanding of this legal strategy as a best practice.

Federal law also affects the range of actions that states and localities may take. For instance, the Nutrition Labeling and Education Act (NLEA) of 1990 requires a nutrition facts label on most food products and stipulates that 15 items appear on labels at all times. These items include serving size, servings per container, calories and calories from fat, cholesterol, sodium, carbohydrates, and fats. In 2006, the FDA required the fat category to include the explicit breakdown between saturated fat and trans fat. Empirical evidence suggests that access to this information has made consumers, as a whole, more discriminating about their food choices. Individuals who use food labels typically have better eating habits, with lower consumption of fat, and higher consumption of fruit and vegetables, compared to those who do not use food labels. Yet labels remain difficult to understand for many and their complexity remains a barrier to making good food choices.

In any event, not all food manufacturers and distributors are subject to NLEA’s requirements. For example, restaurants have historically been exempted from regulation. This exception has been called into question because of the dramatic increase of meals purchased in food establishments. The average American consumes approximately one-third of their calories from food purchased outside the home, and many food products available in restaurants have excessive...
amounts of sodium, cholesterol, and total fat (saturated and trans fatty acids).

To address the limited nutritional information available to consumers at the point of purchase, states and localities have proposed labeling and calorie-count requirements in restaurants. But only one state (California) and a handful of localities (King County, Washington; San Francisco and Santa Clara County, California; and New York City) have succeeded in passing such legislation. After overcoming the state restaurant association’s challenge in court in May 2008, the New York City Health Department started issuing citations to chain restaurants that were not posting calorie counts on their menus. New York and other cities, including Boston, have approved local trans fat bans. Studies have shown that high intake of trans fat is associated with the risk of weight gain and gain in abdominal fatness. While evaluation studies of these programs are under way, they have not yet resulted in widespread knowledge of the impact these legal strategies may have on obesity prevention and control.

State and local jurisdictions are also pursuing non-traditional partnerships that may emanate from the planning department instead of the public health department or the transportation department instead of the health care setting. A handful of state policies address the built environment. Critics of contemporary urban planning decry residential sprawl, which discourages physical activity and instead increases dependency on automobiles for mobility. Some commentators have posited creative zoning solutions, such as mixed-use solutions, which encourage the melding of commercial and residential communities to provide individuals with the opportunity to walk or bike to retail centers and their places of employment.

Perhaps the most aggressive use of law and legal authority to reduce obesity has emanated from New York City. Aside from the calorie posting requirement described above, in 2006, New York City promulgated a regulation requiring testing labs in the city to report the test results of all hemoglobin A1c diabetes test subjects to the New York City Department of Health and Mental Hygiene (NYDOH). The City intends to use these test results to address the growing diabetes outbreak among its residents. But the registry raises potential concerns for protecting privacy and confidentiality. At present, there are no indications that NYDOH plans to add obesity to the registry, and the code imposes strict privacy/confidentiality protections. Still, the relationship between diabetes and obesity presents an opportunity for a state or municipality to track the risk of diabetes with obesity. As a result, individuals with both diseases risk disclosure of their private data.

Another non-traditional approach is Pennsylvania’s “Fresh Food Financing Initiative” (FFFI), a public-private partnership to encourage supermarket development in low-income areas. Low-income residents often lack easy access to grocery stores to buy nutritious foods. This lack of access to healthy food is directly linked to higher rates of obesity. FFFI supplements the financing needs of supermarket operators that plan to operate in underserved communities where infrastructure costs and credit needs cannot be met through conventional financial institutions. As of 2007, FFFI had committed resources to 50 supermarket projects across the state. The program has received considerable positive attention, but has not yet been evaluated. Other states have also increased space and funding opportunities for local farmers’ markets. However, until systems are in place to promote widespread discussion of these legal strategies, they remain no more than case studies of promising programs that are destined to remain localized, independent, and unreplicated.

c. Health Care Setting

Currently, third-party reimbursement for obesity prevention and control is limited. Although prior research demonstrates that doctors and other health care providers can have a significant influence on their patients, state law provides few incentives to the medical care system for obesity prevention. It is only when the condition requires extensive and expensive treatment options that coverage is available.

In addition to prevention strategies, policymakers have considered and implemented legal strategies related to treatment interventions. As of July 2004, the Centers for Medicare and Medicaid Services (CMS) officially recognized obesity as a legitimate medical condition, which led to increased coverage for scientifically effective obesity treatments. Several states have implemented treatment programs through their Medicaid programs. For example, West Virginia and Tennessee offer full and partial reimbursement for weight loss surgery programs, and 42 states offer gastric bypass surgery for the morbidly obese (i.e., BMI of greater than 40). As of 2006, 17 states offered coverage of weight-loss drugs if a patient met the criteria for being diagnosed with a health condition such as Type 2 diabetes, hyperlipidemia, or morbid obesity.

Federal and state policymakers have also proposed legislation to encourage or mandate private health insurers to provide coverage for obesity treatment, such as medical nutritional therapy and bariatric surgery for the morbidly obese. Maryland requires insurers to cover morbid obesity treatment, including surgery, while Georgia, Indiana, and Virginia require
private insurers to offer general coverage for morbid obesity as an option.\textsuperscript{45}

\textbf{Gap Analysis}

Unfortunately, very few of the existing legal strategies have been rigorously evaluated, making it difficult to identify the best legal practices to curtail obesity. At this point, we are unable to say whether legal interventions have facilitated obesity prevention. The resulting gaps in our knowledge base need to be addressed.

Lawmakers and policymakers have not invested in research and rigorous program evaluations of existing legal strategies to establish which ones are effective and cost-effective at a population level. When such empirical research is conducted, best practices will begin to emerge. Until then, substantial gaps in identifying best legal practices will remain.

To be sure, lawmakers cannot easily wait for full evaluation results before taking action. But just doing something is not necessarily a better alternative. It is not likely that legislators will continue to enact new laws if obesity rates continue to escalate and doing so may come at the expense of implementing superior alternatives.

Thus, stakeholders at all jurisdictional levels and among interested sectors should evaluate their current status for sharing information and identifying best and promising practices. Advocates need to make choices about which laws to pursue. To move forward, we need to identify the following: criteria for deciding which laws are most beneficial and cost-effective; information about the types and scope of laws and regulations that could be considered; methodologies to evaluate existing laws; interventions that other state agencies can implement; benchmarks for legal preparedness for obesity prevention; and how to disseminate information to practitioners about the most effective legal practices.

In the interim, local health departments (LHDs) can use their broad authority to issue regulations with clear plans to assess their progress. That way, successful experiments can be replicated across departments, and unsuccessful ones can be abandoned. While there is evidence about what works at the individual level — education, better nutrition, and increased physical activity — these are hard to implement effectively at the population level, but at least provide a starting point.\textsuperscript{46} Indeed, maintaining individual behavior change is difficult. Even with intense scrutiny from physicians, many people fail to achieve their weight-loss goals or eventually regress back to their former, unhealthy behaviors. This demonstrates the complexity of the issue and the role environments play.

Obesity is rooted in more than individual behavior; the built environment plays an equally large causal role. Current policies in this area are admirable, but increasing access to bicycle paths and neighborhood farmer’s markets are tangential solutions that do not address the ingrained problems of the built environment. The 15 states with the highest levels of obesity are concentrated in the South and include the poorest states in the country.\textsuperscript{47} The greatest increases of obesity have occurred among low-income black and non-white Hispanic women.\textsuperscript{48} Census data indicate that low-income, minority populations are concentrated in densely populated, high-crime, inner cities or extremely rural areas.\textsuperscript{49} Our research about efforts in these settings and communication efforts to share best practices is severely lacking.

Poverty, racism, crime, inefficient urban planning, lack of public transportation, discriminatory zoning and housing policies all contribute to the deficiencies of the built environment. Lawmakers who seek tangible change will implement legal strategies that confront and rectify these structural and social failures.

The absence of benchmarks for best legal practices suggests that an immediate need is to develop and disseminate the information base that will enable states and localities to develop appropriate interventions. Indeed, one might argue that a multitude of state and local experiments that are subsequently evaluated and disseminated will provide the needed information base to use law effectively to reduce obesity rates.\textsuperscript{50} Until the benchmarks are identified, lawmakers will need to use the best available information to make decisions.

As noted above, we believe that a focus on the built environment is likely to achieve substantial gains in reducing obesity. Legal strategies should include incentives to facilitate individual behavioral change and simultaneously stimulate cultural change in behaviors that individuals can control. Steady changes in cultural attitudes played a significant role in reducing adult smoking, youth tobacco initiation rates, and smoking in public places. Legal intervention played an important role in facilitating those cultural changes, which needs to be replicated in reducing obesity rates.

In sum, we suggest the following strategies for determining best legal practices:

- Develop criteria and methodologies to determine laws’ benefits/cost-effectiveness and consistency with important legal principles;
- Catalog types/scope of laws/regulations to pursue;
- Determine whether the law is enforceable;
• Design benchmarks for legal preparedness;
• Disseminate effective practices (through manuals, fact-sheets, etc., for ready reference); and
• Encourage local health departments to issue regulations and assess programs.

Taken together, these efforts will result in a more effective information base for adopting best legal practices to reduce obesity rates.

Conclusion
Undoubtedly, law (especially public health law) has the inherent power to influence obesity in profound ways. But enacting laws may not solve the underlying factors driving the obesity epidemic. Beyond issues of personal responsibility, genetics, culture, the built environment, education, and income are contributing factors to the obesity epidemic. Law can certainly address some of these factors and lead to reduced obesity rates. Indeed, law can be integral to developing solutions once we identify the optimal legal strategies to pursue and disseminate that information widely. Yet expecting the legal system to resolve the complex interaction of these factors is unrealistic.

Lawmakers and other people interested in obesity prevention and control have a compelling need for improved information about best practices. Lawmakers should be afforded the opportunity to have comprehensive and scientifically sound information readily available. At present, there is no efficient strategy based in the law to ensure the effective use of this information or a central repository for access. Benchmarks, systematic baseline assessment of current laws and legal authorities, and a sustained program of applied research on strategies are currently unavailable, but should be a high priority if laws are to have a significant impact on reducing the obesity epidemic.

References
6. Id., at 118.
11. Id., at 30.
12. Id.
19. Id.
23. Id.
27. Id.
28. Id., at 333.
29. Id.

30. Id.


35. Id.


40. Id.

41. Id. See also Trust for America’s Health, supra note 22, at 37-38.

42. Id. (Trust for America’s Health), at 37-38.

43. Id., at 38.

44. Id., at 39.


46. See NIH Guidelines, supra note 4.

47. See Trust for America’s Health, supra note 22, at 15.

48. See NIH Guidelines, supra note 4, at 9.
