

The Increasing Weight of Regulation: Countries Combat the Global Obesity Epidemic

ALLYN L. TAYLOR,^{*} EMILY WHELAN PARENTO^{**} & LAURA A. SCHMIDT^{***}

Obesity is a global epidemic, exacting an enormous human and economic toll. In the absence of a comprehensive global governance strategy, states have increasingly employed a wide array of legal strategies targeting the drivers of obesity. This Article identifies recent global trends in obesity-related legislation and makes the normative case for an updated global governance strategy.

National governments have responded to the epidemic both by strengthening traditional interventions and by developing novel legislative strategies. This response consists of nine important trends: (1) strengthened and tailored tax measures; (2) broadened use of counter-advertising and health campaigns; (3) expanded food labeling; (4) increased attention to the built environment; (5) expanded use of bundled school-based strategies; (6) imposed greater restrictions on advertising and marketing to children; (7) strengthened restrictions, standards, and bans on specific foods and food additives; (8) created more targeted screening and brief interventions; and (9) ensured creative use of integrated programs to promote sustainable agriculture, environment, and healthy food.

Despite this response, there remains a need to create a centralized, publicly accessible database of interventions. In addition, the scale of the obesity epidemic combined with the global trend toward more comprehensive regulation may for the first time create political space and will for an international obesity strategy.

INTRODUCTION.....	258
I. THE GLOBAL OBESITY EPIDEMIC.....	260
II. PRIOR OBESITY REGULATION: CHARACTERIZED BY INEFFECTIVE, VOLUNTARY MEASURES	263
III. GLOBAL MOVEMENT TOWARD MORE EFFECTIVE REGULATION: STRENGTHENING EXISTING INITIATIVES AND USING NOVEL APPROACHES.....	267
A. THE TRADITIONAL REGULATORY APPROACH: TAXATION AND	

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* Affiliate Professor of Law, University of Washington School of Law; Adjunct Professor of International Relations at Johns Hopkins University School of Advanced International Studies. I wish to thank the University of California Hastings College of the Law, where I was a visiting professor for the spring term 2012, for its generous support of this research and, in particular, Dean Shauna Marshall and Dean David Faigman. I am also indebted to my coauthors and my research assistants at Hastings and Georgetown, Megan DeLan and Dan Hougendobler, for their devoted work on this project.

** Executive Director, Office of Health Policy, Commonwealth of Kentucky Cabinet for Health & Family Services; Georgetown Law Scholar. Immediately prior to her current position, Ms. Parento was a Law Fellow at the O'Neill Institute for National & Global Health Law, Georgetown University Law Center.

*** Professor of Health Policy, University of California at San Francisco School of Medicine, Philip R. Lee Institute for Health Policy Studies, Department of Anthropology, History and Social Medicine; Co-Director, Community Engagement and Health Policy Program, UCSF Clinical and Translational Sciences Institute.

EDUCATION	267
B. THE NEXT STAGE OF EVOLUTION: COMBATING OBESITY THROUGH THE INCREASED USE OF STRONGER AND NOVEL TYPES OF LAW	269
IV. THE PATH FORWARD: TOWARD AN INTERNATIONAL LEGAL STRATEGY	286
CONCLUSION	290

INTRODUCTION

It is widely recognized that the world is now in the midst of a globalized obesity epidemic. Though once considered a public health concern confined to high-income countries, obesity has spread rapidly to low- and middle-income countries over the past quarter century.¹ With the exception of those in sub-Saharan Africa, every country in the world faces worrying obesity rates.² Over the past two decades, global obesity has risen 82%, and certain regions, such as the Middle East and North Africa, have seen even higher rates.³ The massive growth in obesity is having an enormously significant impact on global health trends, placing people around the world at greater risk of a range of health problems, especially noncommunicable diseases (NCDs).⁴

In the past, global health resources and attention have been largely directed toward controlling the spread of infectious disease, particularly in developing societies. However, this paradigm is beginning to shift with the awareness that NCDs, including heart disease, diabetes, cancer, and other chronic ailments, now account for a greater health burden in developing countries than infectious diseases.⁵ This epidemiological transition has highlighted risk factors such as unhealthy diet, tobacco consumption, and alcohol consumption as significant contributors to the global burden of disease and has led policymakers to understand unhealthy diet as a causal agent in the global burden of disease.⁶ In response to this paradigm shift, in 2011, Member States of the United Nations convened a high-level meeting of the General Assembly to consider strategies for the prevention and control of NCDs worldwide and adopted a high-level political declaration calling for strengthened national and international action.

The obesity epidemic has risen to such significance that prominent journals in a multitude of fields are devoting entire issues to concerns surrounding the

1. Marie Ng, et al., *Global, Regional, and National Prevalence of Overweight and Obesity in Children and Adults During 1980–2013: A Systematic Analysis for the Global Burden of Disease Study 2013*, 384 LANCET 766 (2014).

2. *Id.*

3. *Id.*

4. See Rafael Lozano et al., *Global and Regional Mortality from 235 Causes of Death for 20 Age Groups in 1990 and 2010: A Systematic Analysis for the Global Burden of Disease Study 2010*, 380 LANCET 2095 (2012).

5. See, e.g., *Id.* at 2110; Majid Ezzati, Stephen Vander Hoorn, Carlene M. M. Lawes, Rachel Leach, W. Philip T. James, Alan D. Lopez, Anthony Rodgers & Christopher J. L. Murray, *Rethinking the “Diseases of Affluence” Paradigm: Global Patterns of Nutritional Risks in Relation to Economic Development*, 2 PLOS MED. 404 (2005).

6. See, e.g., WORLD HEALTH ORG., GLOBAL STRATEGY ON DIET, PHYSICAL ACTIVITY & HEALTH 2–3 (2004).

interrelatedness of global health concerns and large-scale food production (i.e., “Big Food”).⁷ However, while there has been much discussion of the tension between obesity drivers (including the prevalence of Big Food) and global health, there is a yawning gap in comprehensive research and analysis of existing national responses directed toward the drivers of obesity. Consequently, as this Article discusses, there is a need for greater harmonization and collaboration among countries on existing national and global strategies, best practices, and data sharing, including the changes in these strategies both over time and in dimension.

This Article takes a first step to fill the existing research void by surveying recent trends in obesity-related legislation that have been adopted and implemented in countries worldwide. As this Article describes, the last decade has seen a significant evolution in the policy environment, with more countries, including both high- and low-income states, implementing legal strategies to address the drivers of obesity. These legal strategies include the deepening of existing legislation and widening of the scope of regulatory interventions. For example, in the United States from 2000 to 2010, there was an increase across states in the introduction of bills and the passage of laws addressing childhood obesity.⁸ From 2003 to 2005, there was an increase in the annual number of childhood obesity bills introduced (from 199 to 339) and adopted (from forty to fifty-five) (the proportion of childhood obesity bills adopted, however, decreased 4% over the same time period).⁹ From 2009 to 2010 alone, forty-one states enacted forms of legislation addressing childhood obesity including school nutrition policies improving access to healthy foods and beverages and preserving time for physical activity, and states also created or improved new farm-to-school and farmers’ markets programs.¹⁰ Latin America has also seen a recent spike in anti-obesity legislation, becoming what Amy Guthrie of the *Wall Street Journal* termed “a laboratory for public policies meant to steer consumers away from processed food.”¹¹ Since 2012, Peru, Chile, Uruguay, Costa Rica, Ecuador, and Mexico have enacted a variety of policies, including imposing taxes on sugary beverages, banning Happy Meal toys and junk food in public schools, and enacting a nutritional traffic light system warning consumers of foods high in salt, sugar, and fat content.¹²

7. See *Table of Contents: PLoS Medicine Series on Big Food*, PLoS MED., <http://www.ploscollections.org/article/browse/issue/info%3Adoi%2F10.1371%2Fissue.pcol.v07.i17>

8. See, e.g., AMY WINTERFELD, DOUGLAS SHINKLE & LARRY MORANDI, STATE ACTIONS TO PROMOTE HEALTHY COMMUNITIES AND PREVENT CHILDHOOD OBESITY: SUMMARY AND ANALYSIS OF TRENDS IN LEGISLATION (2012); Tegan K. Boehmer, Ross C. Brownson, Debra Haire-Joshu & Mariah L. Dreisinger, *Patterns of Childhood Obesity Prevention Legislation in the United States*, 4 PREVENTING CHRONIC DISEASE: PUB. HEALTH RES., PRAC., AND POL’Y 1, 1 (2007).

9. Boehmer et al., *supra* note 8, at 3; see also John Cawley & Feng Liu, *Correlates of State Legislative Action to Prevent Childhood Obesity*, 16 OBESITY J. 162, 164 (2008).

10. AMY WINTERFELD, DOUGLAS SHINKLE & LARRY MORANDI, REVERSING THE TREND IN CHILDHOOD OBESITY: POLICIES TO PROMOTE HEALTHY KIDS AND COMMUNITIES 3 (2011).

11. Amy Guthrie, *Junk Food Feels the Heat in Latin America: Governments Enact Taxes, Restrict Sales as Obesity Rates Rise*, WALL ST. J., Dec. 27, 2013, at B3.

12. *Id.*

Overall, the emerging tide of new and varied legal interventions to combat the obesity epidemic from countries at all income levels, across the globe, is both unprecedented and also cause for optimism that countries are beginning to move toward stronger and more comprehensive responses to drivers of obesity. The development of an international legal framework could make an important contribution to protecting public health. However, consideration of an international regulatory strategy raises a host of new and, perhaps, more complex political and scientific issues than exist within individual states.

Part I of this Article provides an overview of the global obesity epidemic, including existing scientific research documenting the contributing factors of obesity. Part II describes traditional regulatory approaches to address the drivers of obesity, with a particular focus on voluntary mechanisms. Part III observes emerging trends in national obesity-related legislation worldwide, including strengthened traditional initiatives and novel regulatory strategies. Further, Part III describes nine core regulatory focal areas, including taxation; public education; labeling; school-based interventions; the built environment and access; marketing and advertising restrictions; controls and bans on products; screening and other individual interventions; and integrated programs to support environment, sustainable agriculture, and healthy food. Finally, Part IV discusses how for the first time, in view of the observed emerging global trend for strengthened and deepened obesity legislation in countries around the world, there may be political space for a much-needed global legal strategy to address some of the drivers of obesity, including collection of data regarding obesity-related legislation and policies in order to support efforts by countries to keep abreast of global developments and work toward sharing of best practices.

I. THE GLOBAL OBESITY EPIDEMIC

Overweight and obesity has rapidly emerged as a global epidemic and poses a serious global health challenge. Over 155 million children—one out of every ten—are overweight.¹³ In the United States, for example, childhood obesity has tripled over the last three decades.¹⁴ Recent data suggests that nearly one-third of adults in the United States eat fast food at least once per week, and approximately 16% do so several times per week.¹⁵ Fast food is quickly becoming ubiquitous on a global scale. As Igumbor et al. recently profiled,

13. INT'L ASS'N FOR THE STUDY OF OBESITY, THE POLMARK PROJECT: POLICIES ON MARKETING FOOD AND BEVERAGES TO CHILDREN 3 (2010).

14. *Childhood Obesity Facts*, CENTERS FOR DISEASE CONTROL & PREVENTION (Aug. 13, 2014), <http://www.cdc.gov/healthyyouth/obesity/facts.htm>.

15. Andrew Dugan, *Fast Food Still a Major Part of U.S. Diet*, GALLUP (Aug. 6, 2013), <http://www.gallup.com/poll/163868/fast-food-major-part-diet.aspx>; see also Sahasporn Paeratakul, Daphne P. Ferdinand, Catherine M. Champagne, Donna H. Ryan & George A. Bray, *Fast-Food Consumption Among U.S. Adults and Children: Dietary and Nutrient Intake Profile*, 103 J. AM. DIETETIC ASS'N 1332 (2003) (finding that 37% of individuals reported eating fast food on at least one of two randomly selected days in the span of a week).

McDonald's only entered the South African market in 1995 but by 2001, it had 103 outlets. It now has 161. According to the company 'South Africa is one of the most successful markets in McDonald's international history. A record was set when South Africa opened 30 restaurants in just 23 months, at one stage opening 10 restaurants in 78 days.'¹⁶

Given the considerable body of research linking fast-food intake and risk of obesity and diabetes,¹⁷ the levels of fast-food consumption are cause for alarm. Similarly, consumption of sugar-sweetened beverages (SSBs) is a known risk factor for obesity, diabetes, and heart disease,¹⁸ which creates a need for policies to discourage excessive consumption of these products given that half of Americans consume some type of SSB daily and 25% consume at least 200 calories daily from SSBs.¹⁹ Beverage companies have in recent years focused heavily on increasing their global presence. As Igumbor et al. observed, "Coca-Cola developed a strategy in the 1990s to 'double soft drinks sales' by 'building up per capita consumption.' . . . By 2005, around 95% of spazas [in South Africa] were selling Coca-Cola products, with the drinks forming a large proportion of the turnover of these small outlets."²⁰

While the United States and other industrialized countries have the highest obesity rates, the epidemic is rapidly spreading to low- and middle-income countries. Hyperpalatable foods—that is, processed, sugar- and salt-laden foods characteristic of the "American diet"—are now exported throughout low- and middle-income societies worldwide, and obesity rates have risen rapidly in countries in all regions.²¹ For example, in 2013 Mexico's obesity rate reached 32.8%, exceeding the U.S. rate of 31.8%.²²

16. Ehimario U. Igumbor, David Sanders, Thandi R. Puoane, Lungiswa Tsolekile, Cassandra Schwarz, Christopher Purdy, Rina Swart, Solange Durão & Corinna Hawkes, "Big Food," *the Consumer Food Environment, Health, and the Policy Response in South Africa*, 9 PLoS MED. e1001253 at 4 (2012), available at <http://www.plosmedicine.org/article/fetchObject.action?uri=info%3Adoi%2F10.1371%2Fjournal.pmed.1001253&representation=PDF> (citations omitted).

17. See, e.g., Artemis P. Simopoulos, Peter G. Bourne & Ole Faergeman, *Bellagio Report on Healthy Agriculture, Healthy Nutrition, Healthy People*, 5 NUTRIENTS 411 (2013).

18. Frank B. Hu & Vasanti S. Malik, *Sugar-Sweetened Beverages and Risk of Obesity and Type 2 Diabetes: Epidemiologic Evidence*, 100 PHYSIOLOGY & BEHAV. 47 (2010); Vasanti S. Malik, Walter C. Willett & Frank B. Hu, Letter to the Editor, *Sugar-sweetened Beverages and BMI in Children and Adolescents: Reanalysis of a Meta-analysis*, 89 AM. J. OF CLINICAL NUTRITION 438 (2009) (author reply at 439–40); Lenny R. Vartanian, Marlene B. Schwartz & Kelly D. Brownell, *Effects of Soft Drink Consumption on Nutrition and Health: A Systematic Review and Meta-Analysis*, 97 AM. J. OF PUB. HEALTH 667 (2007).

19. Cynthia L. Ogden, Brian K. Kit, Margaret D. Carroll & Soyhun Park, U.S. DEP'T OF HEALTH & HUMAN SERVS., NCHS DATA BRIEF NO. 71, CONSUMPTION OF SUGAR DRINKS IN THE UNITED STATES, 2005–2008 1, 5 (2011).

20. Igumbor et al., *supra* note 16, at 4 (citations omitted).

21. See, e.g., Ashley N. Gearhardt, Caroline Davis, Rachel Kuschner & Kelly D. Brownell, *The Addiction Potential of Hyperpalatable Foods*, 4 CURRENT DRUG ABUSE REV. 140 (2011).

22. FOOD & AGRIC. ORG. OF THE UNITED NATIONS, THE STATE OF FOOD AND AGRICULTURE 77, 79 (2013).

The scientific link between obesity and consumption of unhealthy foods is well established. Unhealthy foods, sometimes referred to as “hyperpalatable” and “obeseogenic” foods, include packaged foods and beverages typical of the modern “Western diet”—foods that have high sugar, sodium, and fat, leading to high energy and low nutritional density.²³ Particularly when consumed in the absence of regular physical activity and a diet rich in high-fiber fruits and vegetables, these foods lead to obesity and a cluster of interrelated risk factors—called “metabolic syndrome”—that increase risk for heart disease, stroke, diabetes, and many cancers.²⁴ Worryingly, these unhealthy foods may even have addictive qualities; biological studies on animals and humans demonstrate that, like alcohol and tobacco, hyperpalatable foods have similar effects on neurological reward pathways in the brain that reinforce increased consumption.²⁵ Neuroimaging studies of humans suggest that similar brain circuitry is activated during alcohol, tobacco, and sugar craving, providing evidence of both tolerance and withdrawal as well.²⁶

Although obesity at any stage of life is a risk factor for a host of health problems, childhood overweight and obesity is particularly detrimental to lifetime health, as it is linked not only to a number of physical and psychological illnesses during childhood but also to obesity in adulthood—with excess adiposity identified as a major risk factor for diabetes, hypertension, cardiovascular disease, and certain forms of cancer.²⁷ The problem is not confined to wealthy countries; of the forty-two million children under the age of five currently estimated by the World Health Organization (WHO) to be overweight, approximately thirty-five million reside in developing countries.²⁸ High rates of childhood obesity are prevalent in communities in Latin America, China, and the South Pacific.²⁹ Even in India, long the poster child for undernutrition, obesity rates among school-going children in urban areas have reached as high as 20%.³⁰ The combination of the unhealthfulness

23. See Gearhardt et al., *supra* note 21.

24. Pamela L. Lutsey, Lyn M. Steffen & June Stevens, *Dietary Intake and the Development of the Metabolic Syndrome: The Atherosclerosis Risk in Communities Study*, 117 CIRCULATION 754, 754 (2008).

25. Ashley N. Gearhardt, Carlos M. Grilo, Ralph J. DiLeone, Kelly D. Brownell & Marc N. Potenza, *Can Food Be Addictive? Public Health and Policy Implications*, 106 ADDICTION 1208, 1208 (2011).

26. E.g., Tanja C. Adam & Elissa S. Epel, *Stress, Eating, and the Reward System*, 91 PHYSIOLOGY & BEHAV. 449 (2007); Nora D. Volkow, Gene-Jack Wang & Ruben D. Baler, *Reward, Dopamine and the Control of Food Intake: Implications for Obesity*, 15 TRENDS IN COGNITIVE SCI. 37 (2011); Gene-Jack Wang, Nora D. Volkow, Jean Logan, Naomi R. Pappas, Christopher T. Wong, Wei Zhu, Noelwah Netusil & Joanna S. Fowler, *Brain Dopamine and Obesity*, 357 LANCET 354 (2001).

27. Benjamin Carabarello, *Global Epidemic of Obesity: An Overview*, 29 EPIDEMIOLOGIC REV. 1, 1 (2007).

28. WORLD HEALTH ORG., POPULATION-BASED PREVENTION STRATEGIES FOR CHILDHOOD OBESITY 8 (2009).

29. Terrence H. Witkowski, *Food Marketing and Obesity in Developing Countries: Analysis, Ethics, and Public Policy*, 27 J. MACROMARKETING 126, 126 (2007).

30. V. V. Khadilkar, A. V. Khadilkar, T. J. Cole, S. A. Chiplonkar & Deepa Pandit, *Overweight and Obesity Prevalence and Body Mass Index Trends in Indian Children*, 6 INT’L J. PEDIATRIC OBESITY e216, e219 (2011).

of these hyperpalatable foods and growing awareness of obesity's role in chronic disease has galvanized domestic and international support for the expansion of obesity prevention efforts, particularly those targeting childhood obesity.³¹

II. PRIOR OBESITY REGULATION: CHARACTERIZED BY INEFFECTIVE, VOLUNTARY MEASURES

Both comprehensive and targeted regulatory interventions for obesity are a fairly new global phenomenon. Historically, efforts to combat obesity have been characterized by industry-led measures designed within a “personal responsibility” framework, which considered the primary drivers of obesity to be poor diet and lifestyle choices by individuals. In this paradigm, interventions were primarily directed either at educating consumers on the relative healthfulness of diet and lifestyle choices or, in some instances, protecting children from excessive advertising of unhealthy foods under the theory that they were too young to take personal responsibility for their diet and lifestyle choices.³²

In most countries with strategies to restrict marketing of unhealthy food and beverages, voluntary industry self-regulation remains the dominant response to date. In recognition of the obesity epidemic, some food and beverage corporations launched voluntary pledges to reduce the extent and impact of commercially produced, energy-dense food and beverages marketed to children. These pledges may be specific to certain regions or countries, and they do not seem dependent on the urgency of public health need for obesity prevention measures. For example, food manufacturers have adopted voluntary pledges in some countries (primarily in Europe) while doing nothing in other countries with similarly alarming obesity statistics.³³

The most widely publicized of these pledges is the initiative launched by the International Food and Beverage Alliance (IFBA). The IFBA was “established in May 2008 to explicitly answer the WHO call to action [in its *Global Strategy on Diet, Physical Activity and Health*] by formulating a set of five global public commitments.”³⁴ These nonbinding commitments set goals in five categories:

- (1) Continue to reformulate products and develop new products that support the goals of improving diets;
- (2) Provide clear and fact-based nutrition information to all consumers;
- (3) Extend our initiatives on responsible advertising and marketing to

31. See INST. OF MED. OF THE NAT'L ACADS., *MEASURING PROGRESS IN OBESITY PREVENTION* (2012); WHITE HOUSE TASK FORCE ON CHILDHOOD OBESITY, *SOLVING THE PROBLEM OF CHILDHOOD OBESITY WITHIN A GENERATION* (2010).

32. See, e.g., ROBERT WOOD JOHNSON FOUND., *FOOD AND BEVERAGE MARKETING TO CHILDREN AND ADOLESCENTS: WHAT CHANGES ARE NEEDED TO PROMOTE HEALTHY EATING HABITS?* (2008).

33. See *Responsible Marketing and Advertising to Children*, INT'L FOOD & BEVERAGE ALLIANCE, <https://ifballiance.org/our-commitments/responsible-marketing-advertising-to-children/> (demonstrating differing levels of commitment by industry in different countries).

34. Derek Yach, Mehmood Khan, Dondeena Bradley, Rob Hargrove, Stephen Kehoe & George Mensah, *The Role and Challenges of the Food Industry in Addressing Chronic Disease*, 6 *GLOBALIZATION & HEALTH* 1, 1 (2010).

- children globally;
- (4) Raise awareness on balanced diets and increased levels of physical activity; and
 - (5) Seek and promote public-private partnerships that support the WHO *Global Strategy [on Diet, Physical Activity and Health]*.³⁵

The IFBA claims these commitments are a demonstration of industry willingness to partner with public-health advocates to improve the dietary profile of consumers.³⁶ However, the commitments are nonbinding and generally vague, making external monitoring of progress difficult to impossible.³⁷ For example, the IFBA recently announced its *Global Policy on Advertising and Marketing Communications to Children*, which was billed as a “strengthened” version of the IFBA’s 2008 commitment on the subject. However, the new commitment is demonstrably weak. Under the new policy, IFBA members commit either to

- (1) [O]nly advertise certain products that meet specific nutrition criteria based on accepted scientific evidence and/or applicable national and international dietary guidelines (since food company portfolios vary widely, each company determines its own nutritional criteria and makes these public) to children under 12 years; or
- (2) [N]ot to advertise their products at all to children under the age of 12 years.³⁸

These and other voluntary standards are, in large part, industry developed, implemented, and monitored. Among the regulatory options, self-regulation is unquestionably the food industry’s preferred approach, as there are very few documented instances in which industry has urged adoption of regulatory measures that limit its ability to market and sell food products.³⁹ Voluntary self-regulation eliminates pressure and the potential for negative publicity that could result from violations documented via external monitoring, as well as threats of financial penalties for failure to adhere to the standards.⁴⁰ At the same time, self-regulation gives industry a plausible basis upon which to claim that it is engaging in action to

35. *Our Commitments*, INT’L FOOD & BEVERAGE ALLIANCE (2012), <https://www.ifballiance.org/our-commitments/>.

36. *See id.*

37. *See id.*

38. INT’L FOOD & BEVERAGE ALLIANCE, *GLOBAL POLICY ON ADVERTISING AND MARKETING COMMUNICATIONS TO CHILDREN* (2011) (emphasis in original).

39. One notable exception to this is strong industry support for the new U.S. law mandating menu labeling for chain restaurants (*see infra* Part III.B.3 for more detail). However, industry support for this law was predicated on the requirement that the federal legislation preempt all state and local regulation on the same subject, disallowing states and cities the abilities to adopt stricter regulations. *See* AMALIA K. CORBY-EDWARDS, CONG. RESEARCH SERV., R42825, *NUTRITION LABELING OF RESTAURANT MENUS* (2012).

40. *See* Laura A. Schmidt, Pia Mäkelä, Jürgen Rehm & Robin Room, *Alcohol: Equity and Social Determinants*, in *EQUITY, SOCIAL DETERMINANTS, AND PUBLIC HEALTH PROGRAMMES 11* (Erik Blas & Anand Sivasankara Kurup eds., 2010).

protect public health.⁴¹ In addition, industry can use the existence of voluntary self-regulation schemes to forestall the imposition of stricter regulatory measures.⁴²

Given the factors described above, it is unsurprising that self-regulatory initiatives have proven insufficient to stem the childhood obesity epidemic, even in high-income countries where resources and political will exist to monitor industry actions. The limited success of self-regulatory initiatives is attributable to the fact that industry pledges are often restricted to young children (under the age of twelve or fourteen), as is the case in the European Union, the United States, Canada, and Australia.⁴³ Moreover, the pledges typically are far from comprehensive in scope; rather, they are usually confined to traditional advertising mediums such as print, Internet, and television media, leaving others untouched, including sporting event endorsements and product placements in film.⁴⁴ Where nutritional standards for products have been subject to voluntary bans, the standards are typically industry defined and arguably watered down from those promulgated by government and expert panels. Finally, at the end of the day, because industry members may opt in to the pledges, they are far from comprehensive in scope.⁴⁵

Thus, even under the best circumstances in high-income societies, there are many challenges inherent in creating an effective public health instrument whose design and implementation is industry led. All the more burdensome are the challenges of incentivizing industry to apply and abide by voluntary pledges in low-income countries. Industry-led pledges in place in European and other high-income countries are seldom applied to those in Africa, Southeast Asia, and other less developed regions of the world.⁴⁶ Moreover, monitoring and enforcement challenges abound for such pledges, particularly in low- and middle-income countries; without resources or political will to supervise industry conduct, there is little incentive for industry to adhere even to the modest standards it creates. However, industry advocates respond to this criticism by saying that “[t]he value of self-regulation is especially great in countries with weak to absent government regulatory capacity”⁴⁷—essentially, self-regulation is better than no regulation.

Still, even with their documented shortcomings, it is important to note that voluntary pledges are not necessarily inherently ineffective. If they are well designed and undertaken in good faith and genuine partnership with public health stakeholders, nonbinding agreements could potentially be valuable tools in support of public health. At the global level, scholars have, for example, supported the development of a voluntary intergovernmental code of practice that could be

41. *See id.*

42. *See id.*

43. *See* INT’L FOOD & BEVERAGE ALLIANCE, *supra* note 38.

44. *See* Allyn L. Taylor, Ibadat S. Dhillon & Lenias Hwenda, *A WHO/UNICEF Global Code of Practice on the Marketing of Unhealthy Food and Beverages to Children*, 5 GLOBAL HEALTH GOVERNANCE, Spring 2012, at 1, 2 (2012) (citing TIM LOBSTEIN, TRIIN PARN & ANGE AIKENHREAD, INT’L ASS’N FOR THE STUDY OF OBESITY, *A JUNK-FREE CHILDHOOD: RESPONSIBLE STANDARDS FOR MARKETING FOODS AND BEVERAGES TO CHILDREN* (2011)).

45. *Id.*

46. *Id.* at 3.

47. Yach et al., *supra* note 34, at 6.

implemented into national law and policy.⁴⁸ In contrast to industry-sponsored local voluntary measures, a nonbinding global legal instrument adopted by states at the international level, such as a code, could speak directly to industry and include it in the implementation process. However, similar to the historical practice of the tobacco industry, the food industry has often resisted efforts to work in partnership with public health officials and stakeholders to develop strong voluntary codes or pledges at the international, national, and local levels, preferring to work entirely without outside scrutiny, and the resulting pledges have been predictably weak.⁴⁹ In recognition of this problem, some scholars have analogized the food industry to the tobacco industry, observing that “[t]here are striking similarities” between food and tobacco industry responses to calls for regulatory responses to the tobacco and obesity epidemics.⁵⁰ Brownell and Warner identified key tactics the industry uses to resist any perceived infringement on its ability to sell its products:

- Focus on personal responsibility as the cause of the nation’s unhealthy diet.
- Raise fears that government action usurps personal freedom.
- Vilify critics with totalitarian language, characterizing them as the food police, leaders of a nanny state, and even “food fascists,” and accuse them of desiring to strip people of their civil liberties.
- Criticize studies that hurt industry as “junk science.”
- Emphasize physical activity over diet.
- State there are no good or bad foods; hence no food or food type (soft drinks, fast foods, etc.) should be targeted for change.
- Plant doubt when concerns are raised about the industry.⁵¹

These tactics are employed on a regular basis, even in response to proposed nonbinding codes developed by public health stakeholders. For example, in 2011 the Obama administration issued a proposal for food manufacturers to voluntarily adopt restrictions on the marketing of certain of their products (sugary cereals, salty snacks, and other unhealthy products) to children.⁵² In response, food industry representatives adamantly insisted to regulators that the proposed voluntary guidelines would have no impact on obesity and would constitute an unjustified infringement on the free speech rights of the industry.⁵³ Industry resistance proved effective, as Congress delayed finalization of the voluntary guidelines in December

48. See, e.g., Taylor et al., *supra* note 44, at 5; see also Allyn L. Taylor & Ibadat S. Dhillon, *The WHO Global Code of Practice on the International Recruitment of Health Personnel: The Evolution of Global Health Diplomacy*, 5 GLOBAL HEALTH GOVERNANCE, Fall 2011, at 1, 20–22.

49. See Taylor et al., *supra* note 44, at 2.

50. See, e.g., Kelly D. Brownell & Kenneth E. Warner, *The Perils of Ignoring History: Big Tobacco Played Dirty and Millions Died. How Similar Is Big Food?*, 87 THE MILBANK Q. 259, 262 (2009).

51. *Id.* at 265.

52. See WHITE HOUSE TASK FORCE ON CHILDHOOD OBESITY, *supra* note 31.

53. Lyndsey Layton & Dan Eggen, *Food, Ad Industries Lobby Against Nutrition Guidelines*, WASH. POST, July 10, 2011, at A03.

2011 by requesting a cost-benefit analysis of the proposal.⁵⁴ Other scholars have also found the “Big Tobacco-Big Food” analogy apt. Dorfman et al. (in the PLoS One Series on “Big Food”) compared corporate social responsibility (CSR) campaigns between tobacco and soda companies, finding marked similarities: “[t]hese [CSR] campaigns echo the tobacco industry’s use of CSR as a means to focus responsibility on consumers rather than on the corporation, bolster the companies’ and their products’ popularity, and to prevent regulation.”⁵⁵ Worryingly, the authors observed that “soda companies appear to have launched comprehensive CSR initiatives sooner than did tobacco companies,” and that “[u]nlike tobacco CSR campaigns, soda company CSR campaigns *explicitly aim to increase sales*, including among young people.”⁵⁶

These types of findings are emblematic of the problems with voluntary self-regulation. Although standards made in cooperation with industry are not inherently weak, particularly if monitoring and enforcement safeguards are employed, the fundamental economics of the food industry’s business model create strong incentives for industry to weaken and/or not comply with voluntary self-regulation initiatives. Obesity is caused in large part by excessive food consumption, but the industry’s profits depend on selling consumers ever more food, including those food products with the highest profit margins—highly processed foods with little nutritional value.⁵⁷ As Brownell observed, “[t]he arresting reality is that companies must sell less food if the population is to lose weight, and this pits the fundamental purpose of the food industry against public health goals.”⁵⁸ With such conflicting incentives (the good public relations that come from a voluntary code vs. the profits that come from selling unhealthy foods), it is a predictable result that voluntary self-regulation by the food and beverage industry has failed to meaningfully impact the obesity epidemic.

III. GLOBAL MOVEMENT TOWARD MORE EFFECTIVE REGULATION: STRENGTHENING EXISTING INITIATIVES AND USING NOVEL APPROACHES

A. The Traditional Regulatory Approach: Taxation and Education

After 1970, most developed societies began to observe trends toward obesity in their populations. Recognizing the inherent limitations of industry self-regulation, many countries have taken steps to address rising obesity rates through public health interventions, including through regulation of the food and beverage

54. Dina ElBoghdady, *New Hurdle for Rules on Marketing of Food to Kids*, WASH. POST, Dec. 16, 2011, at A27.

55. Lori Dorfman, Andrew Cheyne, Lissy C. Friedman, Asiya Wadud & Mark Gottlieb, *Soda and Tobacco Industry Corporate Social Responsibility Campaigns: How Do They Compare?*, 9 PLOS MED. e1001241 at 1 (2012), available at <http://www.plosmedicine.org/article/info%3Adoi%2F10.1371%2Fjournal.pmed.1001241>.

56. *Id.*

57. *See, e.g.*, MARION NESTLE, FOOD POLITICS 29–50 (2007).

58. Kelly D. Brownell, *Thinking Forward: The Quicksand of Appeasing the Food Industry*, 9 PLOS MED., e1001254 at 1–2 (2012), available at <http://www.plosmedicine.org/article/info%3Adoi%2F10.1371%2Fjournal.pmed.1001254>.

industry. In the first incursions, starting in the early 1980s, policymakers naturally veered toward control policies that fit neatly within the reigning “personal responsibility” framework, particularly taxation of unhealthy foods and beverages and educational campaigns urging individuals to make healthier lifestyle choices. Both of these strategies view obesity narrowly, as a personal problem driven primarily by individual behavioral choices, rather than as a societal epidemic that has exponentially worsened in the last quarter century.

“Sin taxes” on unhealthy foods and beverages have long been employed by many governments, particularly in developed countries. For example, twenty-three states in the United States have taxes on sugar-sweetened beverages, ranging from 1–8% (most toward the lower end of the scale), and Norway has taxed sugar, chocolate, and sugary drinks since 1981.⁵⁹ However, industry opposition to meaningful taxation of unhealthy foods ensured that initial taxation policies were weak and narrowly applied. And among lawmakers, the taxes were largely viewed as revenue-raising measures, not serious attempts to deter the consumption of unhealthful products. For example, Fiji taxes imported soft drinks (which are the exclusive source of soft drinks in Fiji) at only 5%, and Australia taxes soft drinks, confectionary, biscuits, and bakery products at only 10%.⁶⁰

Public health research supports the notion that taxes must meet a minimum threshold to have a deterrent effect on consumer behavior. A recent study cautions that the use of taxes to improve public health must be undertaken at a level of approximately 20% across a broad array of foods before the tax would meaningfully impact obesity.⁶¹ The authors also urge recognition of the possible unintended consequences of applying more significant taxes (e.g., substitution of the taxed unhealthy product with an untaxed unhealthy product, necessitating taxation on a broad range of unhealthy foods).⁶² Moreover, there are concerns about the need for further measures to offset the regressive nature of food taxes.⁶³

Similarly, educational campaigns urging a healthy lifestyle are a staple of many governments’ obesity prevention regimes. In the United States, the well-known food pyramid (now reconceived as “choosemyplate.gov”),⁶⁴ intended to educate consumers about a healthy diet, has been in existence since the early 1990s (and different versions of dietary guidelines preceded the pyramid itself).⁶⁵ Such campaigns are politically uncontroversial and have become commonplace among developed countries, nearly all of which have them in place to some degree as part of their national health programs.⁶⁶

59. Oliver Mytton, Dushy Clarke & Mike Rayner, *Taxing Unhealthy Food and Drinks to Improve Health*, 344 BRIT. MED. J. e2931, 1, 5 tbl. 1 (2012).

60. *Id.*

61. *Id.* at 3.

62. *Id.*

63. *Id.*

64. *Choose My Plate*, U.S. DEP’T OF AGRIC., <http://www.choosemyplate.gov/>.

65. For an excellent discussion of the history of USDA dietary guidelines, see U.S. DEP’T OF AGRIC., AGRIC. INFO. BULLETIN NO. 750, *AMERICA’S EATING HABITS: CHANGES AND CONSEQUENCES* (1999).

66. See, e.g., WORLD HEALTH ORG., *INTERVENTIONS ON DIET AND PHYSICAL ACTIVITY: WHAT WORKS* (2009).

B. The Next Stage of Evolution: Combating Obesity Through the Increased Use of Stronger and Novel Types of Law

Although educational campaigns and low-level taxation have been the traditional approaches to addressing obesity, recent interventions undertaken by countries around the world point to both a strengthening of existing legal measures and a widening of the range of legal tools employed to combat obesity. Moreover, whereas legal measures to combat obesity had traditionally been used primarily by high-income countries, the last decade has seen an increased willingness by countries around the globe—high, middle, and low income—to adopt and strengthen laws to combat obesity.

1. Strengthened Tax Measures: More Use, Higher Amounts, with a Public Health Purpose

As discussed above, the use of taxation to shape dietary choices is not novel—many countries have employed such taxes for many years, but primarily at low levels that did not deter consumption in a meaningful way. However, the trend over the course of the last decade has been a marked strengthening of tax measures, as well as an expansion of taxation to new types of food products. One of the most well-known examples is Denmark’s widely publicized “fat tax,” the first tax on saturated fat in certain foods, applying to foods with more than 2.3% saturated fat, with the stated intent of combating obesity and heart disease.⁶⁷ Similarly, Hungary enacted a so-called “hamburger tax” in late 2011 on foods with a high sugar or salt level, with plans to use the money to finance healthcare.⁶⁸ Further still, France enacted a “soda tax” effective in January 2012, though a small one (approximately one euro cent per container).⁶⁹

The French tax was framed primarily as an austerity measure, not a public health intervention, and involved a modest-sized tax. Even so, the food industry adamantly opposed the tax, warning that it could lead to a price increase of 35% on soda.⁷⁰ And although the tax was framed as a deficit reduction measure, press commentary indicated that the legislation was “part of a growing trend in Europe to impose sin taxes on food and drinks associated with poor health and obesity.”⁷¹ Indeed, in recent years, Finland, Romania and the United Kingdom have considered

67. Denmark Law No. 247 (Mar. 30, 2011), available at <https://www.retsinformation.dk/Forms/R0710.aspx?id=136314>.

68. Catherine Cheney, *Battling the Couch Potatoes: Hungary Introduces ‘Fat Tax’*, ABC NEWS (Sept. 3, 2011), <http://abcnews.go.com/International/battling-couch-potatoes-hungaryintroduces-fat-tax/story?id=14429418#.UBbnPDFrPxU>.

69. France Tax Code, Article 1613 ter (Dec. 2011), available at <http://www.legifrance.gouv.fr/affichCodeArticle.do?cidTexte=LEGITEXT000006069577&idArticle=LEGIARTI000025051323&dateTexte=&categorieLien=cid>.

70. See French “Cola Tax” Approved: Paris Vows to Fight Deficit and Obesity, ABC NEWS (Dec. 31, 2011), <http://abcnews.go.com/International/french-cola-tax-approved-paris-vows-fight-deficit/story?id=15254687#.UBbjjTFrPxU>.

71. *Id.*

adding taxes of varying amounts on certain types of unhealthy foods.⁷² However, the future path toward increased taxation is likely to be one marked with controversy, as evidenced by the recent repeal of the Danish “fat tax” on the grounds that the tax was harming consumers and businesses by raising food prices.⁷³

Still, even with uneven progress on taxation measures (as evidenced by the Danish fat tax repeal), an encouraging sign is the global spread of taxation of unhealthy foods and beverages beyond developed countries. Today it is increasingly the case that the taxation of unhealthy foods and beverages is no longer limited to high-income countries. In 2014, in the United States, the Navajo Nation’s tribal council imposed higher taxes on soda and fatty snacks (raising the current tax from 5% to 7%) and eliminated taxes on fresh fruits, vegetables, and nuts.⁷⁴ In late 2013, Mexico’s congress passed legislation placing an 8% tax on foods with high-caloric contents like potato chips and sweets and a tax of one peso per liter on soft drinks. The legislation awaits President Enrique Peña Nieto’s signature to pass into law.⁷⁵ In 2007, Nauru imposed a 30% tax on imported sugar, candies, soda, and flavored milk,⁷⁶ and in 2009, Fiji imposed a 15% tax on cookies and candies⁷⁷—a natural successor of its soft drink tax imposed in 2006 and later reduced in 2007.⁷⁸

Samoa acts as a prime example of the strengthening of tax measures: in 2008 the country increased its tax on soft drinks from \$.10 per liter to \$.15 per liter.⁷⁹ Other developing countries with recently enacted “fat taxes” include Papua New Guinea, Kiribati, Niue, and Tuvalu,⁸⁰ as well as French Polynesia.⁸¹ Importantly, international trade law mandates national treatment for “like” products. Consequently, if a state imposes taxes only upon imported goods, and not their similar domestic goods, aggrieved trading partners can claim violations of the World

72. Tiago Villanueva, *European Nations Launch Tax Attack on Unhealthy Foods*, 183 CMAJ E1229 (2011).

73. Stephanie Strom, *Fat Foods Tax is Repealed in Denmark*, N.Y. TIMES, Nov. 13, 2012, at B4.

74. Ana Campoy, *Navajos Vote to Try Junk-Food Tax*, WALL ST. J., Feb. 1, 2014, at A5.

75. Elwyn Lopez, *Mexican Senate: Tax on High-calorie Food Could Bite into Obesity Problem*, CNN (Nov. 2, 2013, 8:03 AM), <http://www.cnn.com/2013/11/01/world/americas/junk-food-tax-mexico/>; Paulina Villegas, *Mexico: Junk Food Tax is Approved*, N.Y. TIMES (Oct. 31, 2013), <http://www.nytimes.com/2013/11/01/world/americas/mexico-junk-food-tax-is-approved.html>.

76. A.M. Thow, W. Snowdon, J.T. Schultz, S. Leeder, P. Vivili & B.A. Swinburn, *The Role of Policy in Improving Diets: Experiences from the Pacific Obesity Prevention in Communities Food Policy Project*, 12 OBESITY REVS. 68, 70 (Supp. 2 2011).

77. Jason Gale, *Choosing Between Free Trade and Public Health*, BUSINESSWEEK (November 22, 2011), <http://www.businessweek.com/magazine/choosing-between-free-trade-and-public-health-11232011.html#p1>.

78. Thow et al., *supra* note 76.

79. Anne Marie Thow, Christine Quested, Lisa Juventin, Russ Kun, A. Nisha Khan & Boyd Swinburn, *Taxing Soft Drinks in the Pacific: Implementation Lessons for Improving Health*, 26 HEALTH PROMOTION INT’L 55, 58 (2010).

80. See DAVID CLARKE & TIM MCKENZIE, LEGISLATIVE INTERVENTIONS TO PREVENT AND DECREASE OBESITY IN PACIFIC ISLAND COUNTRIES 29 (2007).

81. See Thow et al., *supra* note 76, at 70.

Trade Organization's General Agreement on Tariffs and Trade.⁸² Thus, countries face not only industry resistance to increased taxes but also the complexity of international trade law when structuring their public health taxation initiatives.

2. Public Education, Counter-Advertising, and Health Campaigns: More Initiatives and Stronger, Broader Messages

In the past decade, more countries have initiated concrete efforts to educate their populations about the importance of healthy eating and physical activity as risk factors for obesity. Educational initiatives have long been in place in many countries; however, there is now a strong body of evidence to suggest that, in the absence of regulatory controls on the availability of unhealthful foods, education alone cannot substantially mitigate rising rates of obesity worldwide.⁸³ Recent measures focused on educating the public have, however, been more hardhitting than previous ones, and there is some evidence from tobacco research that powerfully-imaged advertising featuring health warnings can impact public opinion.⁸⁴ Hard-driving counter-advertising campaigns have begun to spring up at the national and subnational levels.

For example, in 2009, New York City undertook its "Man Drinking Fat" campaign, which graphically depicts "globes of human fat gushing from a soda bottle."⁸⁵ The city took the campaign even further in 2012, running ads linking soda consumption to amputations caused by diabetes.⁸⁶ Beyond New York City, which is well known as an early adopter of progressive public health measures,⁸⁷ other progressive jurisdictions have demonstrated greater willingness to make strong public claims concerning obesity and its risk factors. In June 2012, the Western Australian Health Department launched its "LiveLighter" campaign, featuring graphic images of obese persons with messages such as "Grabbable Gut Outside

82. See *infra* Part III.B.7.

83. See Robert H. Lustig, Laura A. Schmidt & Claire D. Brindis, *Public Health: The Toxic Truth About Sugar*, 482 NATURE 27 (2012). Public health officials express continued frustration with these trends—at the World Nutrition Rio 2012 meeting, Philip James of the London School of Hygiene and Tropical Medicine and President of the International Association for the Study of Obesity said: "Want to end obesity? Then talk to the ministries of finance, not health. . . . The impact of health education is zero." Christopher Wanjek, *Fight Obesity With Economics, Not Health Campaigns, Experts Say*, LIVESCIENCE (May 8, 2012, 7:49 AM), <http://www.livescience.com/20143-obesity-health-campaigns-economics.html>.

84. ROBERT WOOD JOHNSON FOUND., TOBACCO CONTROL POLICY 25 (Stephen L. Isaacs, James R. Knickman & Kenneth E. Warner eds., 2006).

85. Sewell Chan, *New Targets in the Fat Fight: Soda and Juice*, N.Y. TIMES, Sep. 1, 2009, at A22.

86. Jonathan Allen, *New York Anti-Obesity Ads Pair Soda, Leg Amputations*, REUTERS, Jan. 9, 2012, available at <http://www.reuters.com/article/2012/01/10/us-obesity-ads-newyork-idUSTRE80902Y20120110>.

87. For example, New York was among the first cities to ban the use of artificial trans fats in restaurant-prepared foods and to require menu labeling of restaurant food, and the city also initiated a controversial program to monitor blood-glucose test results of diabetics. David Gratzer, *The Bloomberg Diet*, NAT'L AFFAIRS, Fall 2012, at 129.

Means Toxic Fat Inside.”⁸⁸ The campaign was billed as a “world first,” with the intent to “graphically portray the effects of being an unhealthy weight.”⁸⁹ The government intends that LiveLighter “will encourage and support Western Australians to make positive lifestyle changes and maintain healthy behaviours.”⁹⁰

The past decade has also brought along a broader swath of countries to engage in educational initiatives, and many on a broader scale. For example, in 2009 Colombia began a campaign promoting physical activity, healthy eating, and nutritional awareness in schools;⁹¹ Caribbean Wellness Day (a day of promoting healthy lifestyles choices) was initiated in 2008;⁹² Mexico has implemented programs to raise awareness of hypertension and improve detection and treatment of the condition;⁹³ and a Central America Diabetes Intervention (CAMDI) program is now in place in Guatemala, El Salvador, Nicaragua, and Honduras.⁹⁴ Additionally, Cameroon has begun a ten-year plan on health promotion, involving the creation of public health departments and health promotion activities.⁹⁵

As the obesity epidemic has spread, Brazil has updated its “Agita Sao Paulo” campaign (begun in 1996) to encourage healthy lifestyles,⁹⁶ and Thailand’s ministry of health has engaged in multiple campaigns to promote exercise in the first decade of the twenty-first century.⁹⁷ Finally, India has seen the emergence of community-based interventions involving advocacy, mediation, and training campaigns for NCD prevention and control in low-income urban settings,⁹⁸ and since 2008 India has begun a national program on diabetes, cardiovascular disease, and stroke (obesity being a risk factor for all three).⁹⁹ The spread of these educational

88. *LiveLighter Ads*, LIVELIGHTER.COM, <http://livelighter.com.au/tools-and-resources/advertisements>.

89. Press Release, LiveLighter, A World First Campaign to Tackle Obesity (June 24, 2012), available at <http://livelighter.com.au/news/a-world-first-campaign-to-tackle-obesity>.

90. *Id.*

91. L. 1355, Octubre 14, 2009, Diario Oficial [D.O.] (Colom.), available at <http://web.presidencia.gov.co/leyes/2009/octubre/ley135514102009.pdf>.

92. *From the Americas: Success Stories in the Fight Against Noncommunicable Diseases*, PAN-AMERICAN HEALTH ORG. & WORLD HEALTH ORG. (Sept. 21, 2011), http://new.paho.org/hq/index.php?option=com_content&view=article&id=6017&Itemid=25.

93. *Id.*

94. *Id.*

95. Justin B Echouffo-Tcheugui & Andre P Kengne, *Chronic Non-Communicable Diseases in Cameroon – Burden, Determinants and Current Policies*, 7 GLOBALIZATION & HEALTH 1, 6 (2011).

96. Victor Matsudo, Sandra Matsudo, Douglas Andrade, Timoteo Araujo, Erinaldo Andrade, Luis Carlos de Oliveira & Glauca Braggion, *Promotion of Physical Activity in a Developing Country: The Agita São Paulo Experience*, 5 PUB. HEALTH NUTRITION 253, 254 (2002).

97. Lisa R. Pawloski, Manyat Ruchiwit & Samantha M. Markham, *The Growing Burden of Obesity in Thailand: A Review of Current Trends and Policies*, 37 PEDIATRIC NURSING 256, 260 (2011).

98. See A. Krishnan, R. Ekowati, N. Baridalyne, N. Kusumawardani, Suhardi, S.K. Kapoor & J. Leowski, *Evaluation of Community-Based Interventions for Non-Communicable Diseases: Experiences from India and Indonesia*, 26 HEALTH PROMOTION INT’L 276, 278 (2010).

99. K. Siegel, K.M. Venkat Narayan & Sanjay Kinra, *Finding a Solution to India’s Diabetes Epidemic*, 27 HEALTH AFFAIRS 1077, 1079 (2008).

campaigns to a wide range of countries and the increasingly hard-hitting nature of the campaign messages evidence a trend toward a higher level of government focus on combating obesity and a willingness to make stronger statements about the obesity risk factors of poor diet and insufficient physical activity.

3. Labeling: More Information on More Food Products

As with education and taxation, food labeling is not new in and of itself. In the United States, for example, the Nutritional Labeling and Education Act has required some level of affirmative information disclosure on packaged foods since 1990,¹⁰⁰ and many other countries have similar requirements.¹⁰¹ However, over the course of the last decade there have been a number of new initiatives, all with the objective of enabling consumers to make healthier and more informed decisions about which foods to consume. These measures have been aimed not only at expanding the range of products for which information must be provided to consumers (e.g., restaurant and prepared foods) but also at increasing the required disclosures (e.g., requiring trans fat levels to be specified), as well as requiring that the information be provided in a way that consumers can understand it.

As a first step, some countries that have not historically required significant nutritional labeling of food have adopted new regulations. In 2011, Cameroon adopted the Law Framework on Consumer Protection, mandating that information on the nutritional value of foods, microbial content, and additives be clearly displayed on packaging.¹⁰² Similarly, in 2012, South Africa promulgated “draft regulations relating to foodstuffs for infants and young children,” which will set standards for foods and restrict inappropriate marketing practices.¹⁰³ The Chilean Senate approved the Law of Food Labeling and Advertising in 2012, requiring improved point-of-purchase food health information for consumers through simple front-of-package labeling; the law also restricted the marketing, advertising, and sale of unhealthy foods to children.¹⁰⁴ Yet, even with the law’s passage, Chilean advocates are worried that it will never be implemented due to industry pressure. The deadline passed for health authorities to publish implementation regulations on July 6, 2012. Before the law’s passage, industry groups successfully lobbied the Chilean Congress to remove traffic light health symbols on packages before the law’s approval.¹⁰⁵

100. See FOOD AND DRUG ADMIN., NUTRITIONAL LABELING AND EDUCATION ACT (NLEA) REQUIREMENTS (8/94–2/95) (1994), available at <http://www.fda.gov/ICECI/Inspections/InspectionGuides/ucm074948.htm>.

101. See Barry M. Popkin, Linda S. Adair & Shu Wen Ng, *The Global Nutrition Transition: The Pandemic of Obesity in Developing Countries*, 70 NUTRITIONAL REV. 3 (2012).

102. See Framework on Consumer Protection in Cameroon, L. No. 2011/012 (May 6, 2011) (on file with the Indiana Law Journal).

103. See *Draft Regulations on Baby Formula, Foods Published*, SA NEWS (July 3, 2012), <http://www.sanews.gov.za/south-africa/draft-regulations-baby-formula-foods-published>.

104. C. Corvalan, M. Reyes, M.L. Garmendia & R. Uauy, *Structural Responses to the Obesity and Non-Communicable Diseases Epidemic: The Chilean Law of Food Labeling and Advertising*, 14 OBESITY REVIEWS 79, 79 (Supp. II 2013).

105. Barbara Fraser, *Latin American Countries Crack Down on Junk Food*, 382 LANCET 385, 386 (2013).

Unlike Chile, both Ecuador and the United Kingdom have instituted traffic light labeling schemes. The Ecuadorian Ministry of Public Health issued a regulation in 2013 that required packaged foods to carry traffic light nutrition labeling based on the total fats, sugars, and salts contained within the food, a regulation that will come into force in May 2014.¹⁰⁶ The regulation also barred industrial food makers in Ecuador from “using images of animal characters, cartoon personalities or celebrities to promote products high in salt, sugar or fat.”¹⁰⁷ In the United Kingdom, the government introduced a voluntary new front-of-pack labeling system in 2013: through a combination of color-coding and more prominent and clear nutritional information, consumers have better at-a-glance access to information about how much fat, sugar, and calories are in food products using a traffic light color scheme.¹⁰⁸ While the labeling is voluntary, nearly 60% of foods will be covered and big food retailers like Tesco and Sainsbury’s, and manufacturers like Mars, Nestle, and PepsiCo have agreed to the new labels. The United Kingdom could not introduce a mandatory system because such regulations would require European-level agreement.¹⁰⁹

In addition to general nutrition labeling requirements, one major obesity-fighting initiative has been the requirement that packaged foods add an additional line-item disclosure specifying trans fat content. The public health justification for requiring this regulation is the uniquely harmful nature of trans fat to cardiovascular health.¹¹⁰ Canada was the first country to require trans fat labeling in December 2005, while the United States implemented a similar regulation that became effective in January 2008.¹¹¹ Since then, additional countries including Argentina, Brazil, Paraguay, Chile, Uruguay, South Korea, Hong Kong, and Taiwan have required trans fat labeling.¹¹² From a public health perspective, some researchers consider the labeling requirements to have had a significantly positive impact. For example, a recent study documented sharp decreases in trans-fatty acid levels in Americans since the United States began requiring trans fat labeling.¹¹³ Public health advocates have pointed to this study as evidence of the effectiveness

106. See Amy Guthrie, *Junk Food Feels the Heat in Latin America: Governments Enact Taxes, Restrict Sales as Obesity Rates Rise*, WALL ST. J., Dec. 27, 2013, <http://online.wsj.com/news/articles/SB10001424052702304773104579270523572200790>.

107. *Id.*

108. See Nick Triggle, *Food Labelling: Consistent System to Be Rolled Out*, BBC (June 18, 2013, 7:10 PM), <http://www.bbc.co.uk/news/health-22959239>.

109. *See id.*

110. See, e.g., Dariush Mozaffarian, Martijn B. Katan, Alberto Ascherio, Meir J. Stampfer & Walter C. Willett, *Trans Fatty Acids and Cardiovascular Disease*, 354 N. ENG. J. MED. 1601 (2006).

111. See Regulations Amending the Food and Drug Regulations (1416—Nutritional Labelling, Nutrient Content Claims and Health Claims), 139 C. Gaz. 1570 (2005) (Can.); *Trans Fat Regulation*, NEWSMEDICAL.NET (Feb. 1, 2011), <http://www.news-medical.net/health/Trans-Fat-Regulation.aspx>.

112. EUROPEAN FOOD INFORMATION COUNCIL, GLOBAL UPDATE ON NUTRITION LABELLING: EXECUTIVE SUMMARY 4 (2011).

113. Press Release, Ctrs. for Disease Control and Prevention, CDC Study Finds Levels of Trans-Fatty Acids in Blood of U.S. White Adults Has Decreased (Feb. 8, 2012), *available at* http://www.cdc.gov/media/releases/2012/p0208_trans-fatty_acids.html.

of labeling on two theories: that consumers will choose foods with less trans fat when presented with information, but also that food manufacturers were incentivized to sharply reduce the amount of trans fat in packaged foods once labeling regulations became effective.¹¹⁴

Similar dynamics are evident in the recent regulatory trend toward mandatory menu labeling in chain restaurants in the United States. Spearheaded by a small number of states and cities (New York City was the first jurisdiction to require menu labeling, followed by California¹¹⁵), menu labeling will now be mandatory across the United States for all restaurants with twenty or more outlets, as well as for vending machines where the operator has twenty or more machines.¹¹⁶ The national menu labeling law preempts stricter state and local regulations of chain restaurants, and allows restaurants with fewer than twenty outlets to “opt in” to the federal scheme if they choose (which is primarily relevant if a state or locality has a stricter regulation in place that applies to small restaurants).¹¹⁷ The New South Wales government in Australia also passed laws in 2012 requiring larger fast food and snack food chains to display point-of-sale kilojoule information.¹¹⁸ The government combined this labeling system (enacted with relevant food industry support) with an education campaign and also an advertising campaign that graphically displayed the kilojoules contained within popular fast food and snack food items.¹¹⁹ Though other countries have not immediately followed suit in enacting menu labeling laws, public health officials and advocates in varied jurisdictions, including the United Kingdom and Canada, have begun to strongly urge the passage of legislation similar to the U.S. law.¹²⁰

4. Built Environment: Promoting Easier Access to Healthy Foods

One of the more controversial issues surrounding the obesity epidemic is the role of the built environment on an individual’s ability to make healthy food choices. If there are many environmental and structural obstacles to obtaining

114. See Debra Van Camp, Neal H Hooker & Chung-Tung Jordan Lin, *Changes in Fat Contents of US Snack Foods in Response to Mandatory Trans Fat Labelling*, 15 PUB. HEALTH NUTRITION 1130 (2012). However, the perceived effectiveness of labeling has also been used against public health advocates seeking to impose stronger regulations (i.e., content restrictions or bans or both) on trans fat in packaged foods. See David Resnik, *Trans Fat Bans and Human Freedom*, 10 AM. J. BIOETHICS no. 3, 2010, at 27.

115. N.Y.C. HEALTH CODE §§ 81.50, 81.08; S.B. 1420, 2011–12 Leg. (Cal. 2011), CAL. HEALTH & SAFETY CODE § 114094.

116. See 21 U.S.C. § 343(q)(5) (2012).

117. *Id.* § 343(q)(5)(H)(ix)(I).

118. See ELENA ANEAR, REGULATORY IMPACT STATEMENT: FOOD VARIATIONS REGULATIONS 2012 at 6 (2011), available at http://www.dpc.sa.gov.au/sites/default/files/pubimages/documents/RIS_FoodVariationRegs2012.pdf.

119. AUSTRALIAN NAT’L PREVENTIVE HEALTH AGENCY, STATE OF PREVENTATIVE HEALTH 2013, at 100 (2013).

120. See ISRA LEVY, REPORT TO OTTAWA BOARD OF HEALTH: HEALTHY EATING, ACTIVE LIVING STRATEGY (2012); U.K. Food Standards Agency, *Restaurants and Catering Companies Bring in Calories on Menus*, NAT’L ARCHIVES (Apr. 6, 2009), <http://tna.europarchive.org/20111116080332/http://www.food.gov.uk/news/pressreleases/2009/apr/companiescaloriesmenus>.

healthy foods—lack of supermarkets, lack of public transportation, unsafe neighborhoods—individuals are incentivized to opt for the less healthy food options that are easier to obtain. There are two components to accessing healthy foods: physical accessibility and economic accessibility.

The main strategy to increase economic accessibility involves decreasing the cost of fresh fruits and vegetables to consumers. While the United States has long had programs to support low-income persons' ability to purchase food (such as the Supplemental Nutritional Assistance Program (SNAP), formerly known as "Food Stamps"), in recent years there have been initiatives designed to steer the use of those dollars toward healthier foods. The USDA recently announced grant awards of \$4 million for state agencies to allow farmers' markets to purchase "SNAP machines" to process the SNAP debit card payments.¹²¹ This program will open farmers' markets to at least some of the forty-six million SNAP recipients in the United States.¹²² Even more directly, some cities have begun to subsidize the purchase of fresh fruits and vegetables at farmers' markets. In Philadelphia, SNAP recipients who spend \$5 on fresh fruits and vegetables receive a \$2 coupon for additional food, and similar programs are in place in a number of jurisdictions nationwide.¹²³ Though direct subsidization of consumer purchases of fruits and vegetables appears to be unique to the United States presently, farm subsidies for fruit and vegetable growers have long been in effect in many countries in the EU, and have served to moderate the prices of fruits and vegetables relative to other foods.¹²⁴ It remains to be seen whether other countries will adopt similar economic accessibility measures to those in the United States.

Making healthy food more physically available has been a topic of much commentary and analysis in recent years, primarily around the concept of "food deserts"—areas without access to healthy foods, which are often also saturated with junk food outlets and corner stores specializing in less healthy alternatives.¹²⁵

121. Press Release, U.S. Dep't of Agric., News Release No. 0149.12: USDA Grants to Increase Farmers Market Participation in SNAP (May 9, 2012), *available at* <http://www.usda.gov/wps/portal/usda/usdahome?contentid=2012/05/0149.xml&contentidonly=true>.

122. *See id.*

123. *What We Do: Philly Food Bucks*, THE FOOD TRUST, <http://thefoodtrust.org/what-we-do/farmers-markets/philly-food-bucks>. Other jurisdictions have begun smaller-scale programs of the same sort. *See, e.g.*, Press Release, Larimer Cnty. Bd. of Cnty. Comm'rs (Aug. 23, 2012) (press release on file with the Indiana Law Journal), (Larimer County: matches up to \$10 spent); Press Release, N.Y.C. Office of the Mayor, Mayor Bloomberg and Speaker Quinn Announce That, for First Time Ever, All of City's Farmers Markets Will Make Fresh Fruits and Vegetables More Affordable for Low-Income New Yorkers (July 2, 2012), *available at* <http://www.nyc.gov/html/om/html/2012b/pr252-12.html> (New York City: \$2 coupon for \$5 spent).

124. *See, e.g., Consultation Begins on Reforming Subsidies for Fruit, Vegetables*, FOOD PRODUCTION DAILY (May 23, 2006), <http://www.foodproductiondaily.com/Supply-Chain/Consultation-begins-on-reforming-subsidies-for-fruit-vegetables> (subsidies in Europe more broadly); *France: New Subsidies for the Fruits and Vegetables Sector*, GLOBAL TRADE ALERT (Aug. 16, 2009), <http://www.globaltradealert.org/measure/france-new-subsidies-fruits-and-vegetables-sector> (subsidies in France).

125. *See, e.g., U.S. DEP'T OF AGRIC., ACCESS TO AFFORDABLE AND NUTRITIOUS FOOD: MEASURING AND UNDERSTANDING FOOD DESERTS AND THEIR CONSEQUENCES: REPORT TO*

Physical accessibility encompasses more than the mere availability of healthy food—it depends on transportation options, public safety, community redlining and the density of fast food outlets that are legally zoned. Appropriately, in practice, most initiatives have centered on increasing the physical availability of healthy foods in underserved, low-income areas.¹²⁶ Canada has been a leader in increasing physical accessibility, primarily through its Nutrition North Canada Program (formerly known as the Food Mail Program), which provides nutritious perishable food to isolated northern communities at reduced postal rates.¹²⁷ The program served more than 70,000 people¹²⁸ in 18 communities, shipping over 18 million kg annually.¹²⁹ India has attempted to create additional transportation options as part of its obesity control program, giving government priority to construct bike lanes and pedestrian paths.¹³⁰

To a lesser extent, policymakers have enacted legislation seeking to *reduce* the number of purveyors of fast food, which is considered by many public health advocates to be presumptively unhealthy.¹³¹ In 2008, the Los Angeles City Council enacted a temporary moratorium (made effectively permanent in 2010) on the building of new fast food establishments.¹³² Although certain other jurisdictions have adopted similar regulations for aesthetic reasons, the Los Angeles ordinance is the first of its kind to be enacted on public health grounds.¹³³ The Irish government is currently considering a ban on fast food restaurants on the theory that school interventions will be of limited success if students can access fast food immediately outside the schoolyard, but only around schools.¹³⁴ It remains to be seen whether additional countries will adopt similar zoning restrictions, but the emergence of such restrictions on public health grounds without an aesthetic justification represents an

CONGRESS (2009); Steven Cummins & Sally Macintyre, “*Food Deserts*”—*Evidence and Assumption in Health Policy Making*, 325 BRIT. MED. J. 436 (2002); Renee E. Walker, Christopher R. Keane & Jessica G. Burke, *Disparities and Access to Healthy Food in the United States: A Review of Food Deserts Literature*, 16 HEALTH & PLACE 876 (2010).

126. Walker et al., *supra* note 125.

127. *Fact Sheet: The Nutrition North Canada Program*, ABORIGINAL AFF. AND N. DEV. CAN. (May 7, 2013), <http://www.nutritionnorthcanada.gc.ca/eng/1367932314461/1367932387670>.

128. Dylan Robertson, *How Privatization will Make Food Less Affordable in the North*, THIS MAG. (Feb. 16, 2011), <http://this.org/blog/2011/02/16/food-subsidy-northern-canada/>.

129. *Id.*

130. See Karen Siegel, K.M. Venkat Narayan & Sanjay Kinra, *Finding A Policy Solution to India's Diabetes Epidemic*, 27 HEALTH AFFAIRS 1077 (2008).

131. See e.g., Lukar E. Thornton & AM Kavanagh, *Association Between Fast Food Purchasing and the Local Food Environment*, 2 NUTRITION & DIABETES e53 (2012).

132. L.A., Cal., Ordinance 180,103 (July 29, 2008), available at http://cityplanning.lacity.org/Code_Studies/Misc/FastFoodInterim.pdf. The ordinance was made permanent in 2010. See Los Angeles City Council, Journal/Council Proceedings: Special Council Meeting (Dec. 8, 2010), available at http://ens.lacity.org/clk/oldactions/clkcouncilactions269735_12082010.pdf; see also Allyson C. Spacht, *The Zoning Diet: Using Restrictive Zoning to Shrink American Waistlines*, 85 NOTRE DAME L. REV. 391, 392–93 (2009) (providing a detailed explanation of the ordinance and its passage).

133. *Zoning in on Healthy Fast Food*, CMTY. HEALTH COUNCILS, INC., <http://www.chc-inc.org/downloads/NFW%20Fast%20Food%20Fact%20Sheet.pdf>.

134. *Fast Food Outlets Face Schools Ban*, BELFAST TEL. (Nov. 9, 2011), <http://www.belfasttelegraph.co.uk/news/local-national/republic-of-ireland/fast-food-outlets-face-schools-ban-16075162.html>.

important shift in countries' willingness to think creatively about ways to combat the obesity epidemic.

5. School-Based Interventions: Moving Beyond Health Education Through Bundled Strategies

As with many of the initiatives discussed herein, school programs to promote access to healthy food are not new. Rather, the novelty lies in the scale and breadth of these programs in recent decades. New measures have included restrictions on the types of food products that can be sold in schools as well as required body mass index (BMI) screening of children. In some cases, traditional health education has been expanded to include cooking education, sometimes in local cultural traditions using indigenous foods, along with gardening programs, increased access to water in lieu of sugar-sweetened beverages, and healthy school lunch programs. These measures combined produce what can be termed "bundled interventions" that tend towards a more integrated approach to feeding and educating children about dietary health.

Since 1995, Brazil has had a National School Meal Program, under which healthy meals are considered a basic right of every student.¹³⁵ The program has been accompanied by generous income supplements for rural families threatened by undernutrition, along with careful regulatory controls of food components to protect urban children currently experiencing growing rates of overweight and obesity.¹³⁶ As of 2009, Brazil's program requires that 30% of school meal funds be used to purchase locally produced foods, and a majority must be fresh fruits and vegetables.¹³⁷ When schools balked at the time and effort required to manage fresh produce, the government intervened by negotiating a compromise whereby local food producers would deliver pre-chopped and prepared produce to the schools.

In 2009, Colombia passed an "obesity law" designed to "reverse inactivity and obesity trends by promoting physical activity, healthy eating and nutrition education in schools."¹³⁸ Under the law, schools must provide healthy food (including fruits and vegetables), as well as educational programs emphasizing healthy eating.¹³⁹ Since 2003, Norway has expanded both the subscription and free versions of its School Fruit Programme nationwide, with the result that participating schools have seen an increase in the fruit intake of their students.¹⁴⁰ Spain has moved beyond subsidizing or mandating healthy food offerings by enacting legislation banning the sale of food and drinks that have high amounts of saturated fat, trans fats, salt, or sugar.¹⁴¹ Similarly, in 2010 the Mexican Senate approved an anti-obesity law that bans the "sale and advertising of food and drinks

135. See PAN-AM. HEALTH ORG., NON-COMMUNICABLE DISEASES IN THE AMERICAS: BUILDING A HEALTHIER FUTURE 35 (2011).

136. *Id.*

137. *Id.*

138. *Id.*

139. *Id.*

140. Elling Bere, Marit Hilsen & Knut-Inge Klepp, *Effect of the Nationwide Free School Fruit Scheme in Norway*, 104 BRIT. J. NUTRITION 589, 589 (2010).

141. Maria de Lago, *Spain Bans Sale of Unhealthy Food in Schools in Bid to Tackle Obesity*, 342 BRIT. MED. J. 4073 (2011).

with high caloric content and low nutritional value” in elementary and middle schools.¹⁴² However, contemporaneous commentary observed that a number of senators were “reluctant about the decision, worried about clashing with the interests of the food industry . . . [Thus] although the law has been passed, parts of it will go back to being reworked and edited.”¹⁴³ In 2012, the Ministries of Public Education and Health in Costa Rica set restrictions on products sold to students in school cafeterias, including “[f]ood products with high concentrations of sugar, oil, or salt such as chips, cookies, candy and carbonated sodas.”¹⁴⁴ The Ministry based their calculations on energy density as opposed to setting maximum sugar and fat levels, which industry representatives heavily lobbied for to simply sell the same products in smaller packages.¹⁴⁵ The Costa Rican Constitutional Court has since upheld the constitutionality of the restrictions based on health rights.¹⁴⁶ In Uruguay, legislation banning unhealthy food and beverage sales on public school premises passed Congress in 2013 and was accompanied by a healthy lifestyle curricular program launched by the education ministry.¹⁴⁷

Japan has taken an arguably more holistic approach, revising the school lunch program objective in 2008 from promoting healthy development of the minds and bodies of schoolchildren to “promoting Shokuiku” (“food education”).¹⁴⁸ Under the revised approach, students are responsible for serving lunch and clearing the dishes.¹⁴⁹ In addition, the Japanese Ministry of Education, Culture, Sports, Science, and Technology has supported the placement of “Diet and Nutrition Teachers” in schools since 2007, with the reported result that teachers and parents demonstrate an increased awareness and interest in diet.¹⁵⁰ Taken together, these school interventions demonstrate an increased willingness of countries in most regions of the world to adopt increasingly strong legislation directed at fighting obesity in children through healthier school food programs.

In the United States, a variety of initiatives have been adopted at the state and federal level. For example, Arkansas passed legislation in 2003 requiring that parents be provided with the BMI of their children, along with an explanation of what BMI means and the health effects associated with obesity.¹⁵¹ As of 2013, at least nineteen U.S. states have followed suit in requiring that schools conduct BMI

142. *Mexico Fights Obesity*, C3 COLLABORATING FOR HEALTH (Nov. 8, 2010), <http://www.c3health.org/alerts/alerts-governmentaction/mexico-fights-obesity/>.

143. *Id.*

144. Marcel Evans, *Ban on Selling of “Junk Food” in Costa Rica School Cafeterias Upheld*, COSTA RICA STAR, (June 21, 2012), <http://news.co.cr/ban-on-selling-of-junk-food-in-costa-rica-school-cafeterias-upheld/8785/>.

145. Fraser, *supra* note 105, at 386.

146. Evans, *supra* note 144.

147. *Uruguay’s Battle Against Childhood Obesity Focuses on School Meals*, EU FOOD LAW (May 3, 2013), <http://www.eurofoodlaw.com/food-safety-and-standards/health/uruguays-battle-against-childhood-obesity-focuses-on-school-meals-64282.htm>; Guthrie, *supra* note 11.

148. Nobuko Tanaka & Miki Miyoshi, *School Lunch Program for Health Promotion Among Children in Japan*, 21 ASIA PAC. J. CLINICAL NUTRITION 155, 155–56 (2012).

149. *Id.* at 155.

150. *Id.* at 156.

151. ARK. CODE ANN. § 20-7-135 (2014).

assessments of students.¹⁵² In addition, in 2012 the U.S. Department of Agriculture updated its standards regarding school nutrition programs for the first time in fifteen years, as part of the Healthy, Hunger-Free Kids Act (HHFKA), adding a number of requirements that will improve the nutritional content of school lunches.¹⁵³ As a follow-on measure to increasing access to healthy foods during school lunches, HHFKA includes a “Smart Snacks in School” component that is even more far-reaching, covering all food and beverages sold to students during the entire school day, imposing significantly more rigorous nutritional standards.¹⁵⁴ In addition, there is a trend toward facilitating access to local foods, and as of the end of 2013, forty-six states, including the District of Columbia, have proposed legislation establishing farm-to-school programs, and a total of twenty-two states have passed such laws.¹⁵⁵

6. Advertising and Marketing Restrictions: Moving Beyond Bans on Marketing to Children

Regulatory controls on the industry advertising and marketing of unhealthy foods have long been a source of significant controversy. Such initiatives tend to be roundly supported by public health advocates, but are usually adamantly opposed by food industry trade groups, making the passage of such legislation a contentious, lengthy process. Even so, recent years have seen increased willingness of countries to enact stronger and broader advertising restrictions that may help combat the obesity epidemic—some going so far as to include restrictions on advertising to the general population. The historical trend has been to limit such restrictions to children first, on the theory that children lack the ability to distinguish fact from opinion, and are thus unable to accurately assess marketing directed towards them. In a normative shift, some countries have shown a willingness to restrict advertising of certain products to the whole population as well, with some restrictions focused on product claims made by certain individuals (i.e., doctors,

152. Julia Deardorff, *BMI Measuring in School Proves to be a Weighty Issue*, CHI. TRIB., May 17, 2013, http://articles.chicagotribune.com/2013-05-17/health/ct-met-bmi-backlash-20130517_1_bmi-childhood-obesity-rates-muscular-people.

153. Press Release, U.S. Dept. of Agric., News Release No. 0023.12: USDA Unveils Historic Improvements to Meals Served in America’s Schools (Jan. 25, 2012) (on file with the Indiana Law Journal). Under the updated standards, students will be offered both fruits and vegetables every day of the week, schools will “substantially” increase offerings of whole grain-rich foods while offering only fat-free or low-fat milk varieties. However, under the new standards pizza sauce will still be considered a vegetable, and skim chocolate milk will still be permitted. *Id.*

154. See National School Lunch Program and School Breakfast Program: Nutrition Standards for All Foods Sold in School as Required by the Healthy, Hunger-Free Kids Act of 2010, 78 Fed. Reg. 39,068 (June 28, 2013).

155. VT. LAW SCH. CTR. FOR AGRIC. & FOOD SYS. & NAT’L FARM TO SCH. NETWORK, STATE FARM TO SCHOOL LEGISLATIVE SURVEY: 2002-2013 (2014); *Policy*, NAT’L FARM TO SCH. NETWORK, <http://www.farmtoschool.org/policy>. States that have passed laws establishing farm-to-school programs: AL; AK; CT; DC; DE; FL; GA; IA; IL; MD; MI; MT; OK; OR; PA; SC; TN; TX; VT; WA; WI; and WV. VT. LAW SCH. CTR. FOR AGRIC. & FOOD SYS. & NAT’L FARM TO SCH. NETWORK, *supra*.

health professionals), on the theory that such advertisements are also misleading to adults, and contrary to the country's interest in promoting public health.

Quebec has long been a leader in restricting marketing to children, as its Consumer Protection Act has banned *all* marketing to children under age thirteen since 1980, unless advertisements meet stringent requirements.¹⁵⁶ Similarly, Norway passed legislation in 1992 banning television advertising to children.¹⁵⁷ A number of other European countries, including Belgium, Denmark, Finland, France, Germany, Greece, Iceland, Ireland, Luxembourg, Liechtenstein, the Netherlands, Portugal, Sweden, and the United Kingdom have some level of restriction on television advertising directed at children.¹⁵⁸ Beyond Europe, Australia and Canada also have strong regulations regarding advertising to children,¹⁵⁹ and in 2010 the South Korean government endorsed a bill prohibiting television advertising of high-calorie, low-nutrition foods from 5:00 p.m. to 7:00 p.m.¹⁶⁰ However, these restrictions are generally applicable to all products, not merely food and beverages, and, as Hawkes observed, there has been a trend in recent years among countries to propose—if not always pass—strong legislation directed specifically at food and beverage marketing to children.¹⁶¹

Moreover, countries have shown a willingness to restrict advertising in other mediums beyond television advertising, such as store displays and billboards. In Chile, a food labeling and advertising law prohibits advertising food that the Health Ministry identifies as high in calories or salt to children younger than fourteen years of age; this includes advertisements using toys, stickers, or other forms of enticement.¹⁶² However, subsequent rules issued by the Chilean Ministry of Health permitted companies to give toys and stickers as long as they carried a registered trademark.¹⁶³ In 2013, Peruvian President Ollanta Humala signed into law legislation that, in addition to requiring school education campaigns, a monitoring system for obese children and adolescents, and healthy foods in school cafeterias or kiosks, prohibits “advertising that encourages ‘immoderate consumption’ of food and non-alcoholic beverages that contain trans fats or high levels of sugar, salt, and saturated fat; shows ‘inappropriate portions’; appeals to children’s naiveté or emotions; . . . or

156. Consumer Protection Act §§ 248–49, R.S.Q. 2014, c. P-40.1 (Can.); *see also Ad Regulations: Quebec Regulations on Advertising to Children*, PUBZONE, <http://www.pubzone.com/fc/child-que/index.cfm>.

157. Norway Broadcasting Act No. 127 of 1992 § 3.1 (1992) (Norway); *see also Regulation and Self-Regulation on Advertising Directed at Minors, Audiovisual and Media Policies*, EUROPEAN COMMISSION, <http://ec.europa.eu/avpolicy/docs/library/studies/finalised/studpdf/oview.pdf> [hereinafter EC Audiovisual and Media Policy].

158. EC Audiovisual and Media Policy, *supra* note 157.

159. CORINNA HAWKES, *MARKETING FOOD TO CHILDREN: THE GLOBAL REGULATORY ENVIRONMENT* 14 tbl. 3 (2004).

160. *See Restrict Food Marketing*, WORLD CANCER RESEARCH FUND INT’L (June 11, 2014), <http://www.wcrf.org/int/policy/nourishing-framework/restrict-food-marketing>.

161. HAWKES, *supra* note 159, at iii.

162. Fraser, *supra* note 105, at 386.

163. Guthrie, *supra* note 11.

uses testimony from real people or fictitious characters whom the children might admire.”¹⁶⁴ The law applies to children and youth under the age of sixteen.¹⁶⁵

As noted above, certain countries have enacted legislation directed at the broader public in addition to strengthened restrictions on marketing to children. For example, France adopted legislation in 2007 requiring advertisements for processed, sweetened, or salted foods on television, radio, billboards, and the Internet to include a health message created by the government.¹⁶⁶ The legislation included relatively significant fines for noncompliance (1.5% of the cost of the advertisement).¹⁶⁷ In 2006, Spain adopted legislation giving the Spanish Food Safety and Nutrition Agency expanded regulatory powers, including the ability to bring causes of action to enjoin false or misleading advertisements.¹⁶⁸ In addition, since 2011, Spain has forbidden doctors, scientists, and patients from recommending food products in advertisements, in addition to banning the promotion of food products through pharmacies.¹⁶⁹ Finally, the United Kingdom adopted legislation in 2008 creating stronger protection against advertisements that claim, “without any identifiable scientific evidence, to provide physical and mental health benefits such as tackling obesity or depression.”¹⁷⁰ Though the legislation was primarily directed at products such as pills, drinks, or creams—in recognition of the severity of the obesity epidemic (and the implied susceptibility of consumers to ads promising to help people lose weight)—its passage demonstrates the seriousness with which the UK government views the issue. If the trend among these few countries is a harbinger of future regulatory actions, public health advocates should expect an increased willingness among countries to consider broader and stronger advertising restrictions, including those directed at the general public.

7. Restrictions, Standards, and Bans on Specific Ingredients: Strengthened Regulations in More Jurisdictions

Some of the most contentious public health laws are those that severely restrict, or even ban, the use of specific ingredients or the sale of certain products deemed harmful to public health. One of the most high profile cases has been a ban on the use of artificial trans fats in restaurant and prepared foods. Most recently, the U.S. Food & Drug Administration has made a preliminary determination to deny “Generally Recognized as Safe” (GRAS) status to artificial trans fat, which would

164. Fraser, *supra* note 105, at 386.

165. *President Humala Signs Law to Curb Advertising of Junk Food*, ANDEAN AIR MAIL & PERUVIAN TIMES (May 17, 2013), <http://www.peruviantimes.com/17/president-humala-signs-law-to-curb-advertising-of-junk-food/19183/>.

166. *French Food Ads Carry Health Warnings*, CTV NEWS (Mar. 2, 2007), <http://www.ctvnews.ca/french-food-ads-carry-health-warnings-1.231591>.

167. *Id.*

168. Ley 44/2006, de 29 de Diciembre, de Mejora de la Protección de los Consumidores y Usuarios (B.O.E. 2006, 46601) (Spain).

169. de Lago, *supra* note 141.

170. Rory Watson, *New Law Bans Selling of Products with False Health Claims*, 336 BRIT. MED. J. 1150, 1150 (2008).

effectively prohibit its use in food.¹⁷¹ Denmark has taken a different approach to eliminating unhealthy ingredients in foods by adopting legislation that sets limits on the percentage (no more than 2%) of trans fat in oils and fats destined for human consumption; this appears to have sharply reduced artificial trans fat intake in Denmark.¹⁷² Austria, Iceland, and Switzerland have also adopted legislation, in recent years, restricting trans fat content in foods.¹⁷³ In December 2013, the federal cabinet of the United Arab Emirates, the fifth highest consumer of soft drinks globally, banned “supersized” fizzy drinks as part of a collection of health measures addressing rising obesity rates.¹⁷⁴

While progressive from a public health standpoint, restrictions on the use of artificial trans fat have perhaps been more politically palatable because artificial trans fats are man-made and unnecessary in nearly all food production. More controversially, some countries have enacted bans on the sale of particular natural foods, primarily fatty meats, on the grounds that such products are harmful to public health. It has been argued that such laws are a restriction on international trade, in violation of legal commitments such as the World Trade Organization’s Sanitary and Phytosanitary Agreement.¹⁷⁵

For example, Ghana has enacted legislation, for human health reasons, prohibiting the sale of meats that exceed maximum fat content limits (25% for beef and poultry, 35% for mutton, and 42% for pork), and prohibiting turkeys from being imported unless their oil glands are removed.¹⁷⁶ Though this legislation was framed as an import restriction rather than a general ban (applying only to imported meats), the consensus appears to be that the measure “controls imports in a manner designed to protect public health and to be acceptable internationally from a trade perspective.”¹⁷⁷ Similarly, Samoa has adopted a ban on the sale of turkey tails, though it later lifted the ban in the face of pressure from international trade groups, imposing import tariffs instead.¹⁷⁸ Fiji adopted a ban on imported mutton flaps in 2000, and Tonga

171. Tentative Determination Regarding Partially Hydrogenated Oils; Request for Comments and for Scientific Data and Information, 78 Fed. Reg. 67169 (proposed Nov. 8, 2013).

172. STEEN STENDER & JØRN DYERBERG, DANISH NUTRITION COUNCIL, *THE INFLUENCE OF TRANS FATTY ACIDS ON HEALTH* 50 (4th ed. 2003).

173. See Steen Stender, Arne Astrup & Jørn Dyerberg, *A Trans European Union Difference in the Decline in Trans Fatty Acids in Popular Foods: A Market Basket Investigation*, 2 BRIT. MED. J. OPEN e000859 (2012).

174. Ola Salem, *New York-style Supersize Soda Ban for UAE as Nation Battles Obesity*, NATIONAL (U.A.E.), Dec. 9, 2013, <http://www.thenational.ae/uae/health/new-york-style-supersize-soda-ban-for-uae-as-nation-battles-obesity>; Daniel Shane, *UAE Bans Supersize Fizzy Drinks in Obesity Battle*, ARABIAN BUS. (U.A.E.), Dec. 10, 2013, <http://www.arabianbusiness.com/uae-bans-supersize-fizzy-drinks-in-obesity-battle-530131.html>.

175. Jason Gale, *Choosing Between Free Trade and Public Health*, BLOOMBERG BUSINESSWEEK (Nov. 22, 2011), <http://www.businessweek.com/magazine/choosing-between-free-trade-and-public-health-11232011.html>.

176. OFFICE OF THE U.S. TRADE REPRESENTATIVE, 2009 NATIONAL TRADE ESTIMATE REPORT ON FOREIGN TRADE BARRIERS 212 (2009).

177. CLARKE & MCKENZIE, *supra* note 80, at 12.

178. Michael Field, *Samoa Rewarded for Turkey Tail Turnaround*, STUFF.CO.NZ (Nov. 30, 2011, 2:12 PM), <http://www.stuff.co.nz/business/world/6062457/Samoa-rewarded-for-turkey-tail-turnaround>.

considered a similar ban in 2007.¹⁷⁹ New Zealand, a prime exporter of the flaps to the Pacific Island nations, heavily lobbied against the bans, arguing that individuals would simply substitute a similarly fatty protein in lieu of the flaps, undermining the government's goal of improving public health.¹⁸⁰ The emergence of these measures suggests that governments in varied parts of the world are beginning to closely examine the dietary drivers of obesity and consider ways to improve diet through affirmative restrictions on the types of food products that may be sold.

8. Screening and Brief Intervention: Targeting High-Risk Individuals

Some governments have become even more aggressive in targeting the obesity epidemic by enacting legislation that requires the dietary-based health screening of individuals. In 2008, Japan passed its so-called "metabo law," requiring screening for metabolic syndrome for all adults, treatment for those diagnosed, and fines on providers who have low participation or who fail to reduce rates of metabolic syndrome in their caseloads.¹⁸¹ Under the law, men are required to maintain a waist circumference of 33.5 inches, and women a waist size of 35.4 inches.¹⁸² Though individuals do not face penalties for exceeding the waist size maximums or for failing to comply with the monitoring requirements (for those who fail the waist measurement test), employers and local governments are subject to financial penalties for failure to meet population health goals.¹⁸³ These providers must ensure at least 65% participation, and the program's objective is to reduce the Japanese obesity rate by 25% by 2015.¹⁸⁴

In the United States, New York City enacted a regulation in 2005 requiring medical laboratories to report results of all hemoglobin A1C tests, thereby creating the country's first population-based registry to track blood sugar levels in diabetics, with the stated goal of "better understand[ing] the epidemiology of diabetes" in New York City, and providing a basis on which to design future interventions.¹⁸⁵ The program has led to concerns about infringement on individual privacy, as the test results must be reported together with a patient's name, address, and date of

179. A.M. Thow, W. Snowdon, J.T. Schultz, S. Leeder, P. Vivili & B.A. Swinburn, *The Role of Policy in Improving Diets: Experiences from the Pacific Obesity Prevention in Communities Food Policy Project*, 12 OBESITY REV. (Supp. 2) 68, 71 (2011).

180. Jason Gale, *Stopping Turkey Tails at the Border Pits Trade Against Health*, BLOOMBERG BUSINESSWEEK, Nov. 28–Dec. 4, 2011, at 16, 18.

181. See Nandini Jayarajan, *The Fat's on Fire: Curbing Obesity in Japan*, BOSTON U. SCH. PUB. HEALTH (May 29, 2011, 9:50 PM), <http://www.bu.edu/themovement/2011/05/29/the-fats-on-fire/>.

182. *Id.*

183. *Id.*

184. *Id.*

185. Letter from Thomas R. Frieden, Comm'r, N.Y.C. Dep't Health & Mental Hygiene, to N.Y.C. Health Care Professionals (Jan. 15, 2006), available at <http://www.nyc.gov/html/doh/downloads/pdf/chi/chi-letter-diab-0106.pdf>; see also Notice of Adoption to Amend Article 13 of the New York City Health Code, N.Y.C. Dep't Health and Mental Hygiene (Dec. 14, 2005), available at <http://www.nyc.gov/html/doh/downloads/pdf/public/notice-adoption-a1c.pdf> [hereinafter NYC—Notice of Adoption].

birth, and are therefore personally identifiable.¹⁸⁶ In addition, the program is also intended to allow the government to “report a roster of patients to clinicians, stratified by patient A1C levels, highlighting patients under poor control (e.g., A1C > 9.0%) who may need intensified follow-up and therapy.”¹⁸⁷ To date, no other jurisdictions appear to have adopted laws similar to those in Japan and New York, which may be evidence that public health advocates and legislators remain unconvinced that the benefits of such programs outweigh the cost and infringement on individual privacy.

9. Integrated Programs to Promote Sustainable Agriculture, Environment, and Healthy Food: The New Frontier

Arguably, the most progressive policy regimes for combating obesity today are multisectoral, integrated programs that link systems of food production and transport with food distribution and trade in ways that promote the health of the environment and the health of people by making healthy food choices maximally available. Such approaches require regional and national authorities to support and promote the decentralization of food production and consumption to the local or community levels. A central tenet of these programs is that, by and large, local production and consumption of food tends to promote sustainable agricultural practices, as well as possible advantages in nutritional health, more than large-scale industrialized agribusiness operations that dominate the global food system. These integrated programs seek to create conditions in which all people have access to not just adequate caloric intake, but also nutritionally sound dietary options. An intersectoral approach includes productive, active engagement of government with the private sector and across stakeholders, including the agriculture, food production, consumption, education, and nutrition industries.

A key example is Thailand’s Strategic Framework for Food Management, which represents one of the most comprehensive efforts of this kind.¹⁸⁸ This effort was stimulated by the government’s awareness of rising rates of NCDs, and the willingness of local academics to form multisectoral teams that became very active in governmental planning around agriculture, nutrition, and health. At the center of the effort is Thailand’s National Food Committee, which coordinates and manages all laws and over thirty government units dealing with food, and which elevates food policy by placing the Food and Drug Administration director, the Ministry of Agriculture director, and the prime minister in committee leadership roles. Multisector teams manage all aspects of safety, transport, education, cultural messaging, food supply and access, environmental concerns, and agricultural resources. At its base is a food production and consumption approach focused at the village, or community, level. Community-based health providers and community leaders are the key interface with higher levels of the system, functioning in a

186. NYC—Notice of Adoption, *supra* note 185, at 4; Wendy K. Mariner, *Medicine and Public Health: Crossing Legal Boundaries*, 10 J. HEALTH CARE L. & POL’Y 121, 121 (2007).

187. NYC—Notice of Adoption, *supra* note 185, at 2.

188. Thailand Food Committee, *Strategic Framework for Food Management in Thailand*, GOV’T PUB. RELATIONS DEP’T (Feb. 12, 2010), http://thailand.prd.go.th/view_news.php?id=5392&a=2.

supportive role. It remains to be seen whether the political and policy climates in other countries will allow for the adoption of such coordinated, holistic efforts.

IV. THE PATH FORWARD: TOWARD AN INTERNATIONAL LEGAL STRATEGY

The confluence of factors leading countries to engage in new and varied legal interventions to combat the obesity epidemic is unprecedented. In view of this emerging trend, there may, for the first time, be political space for a much-needed global strategy to address some of the primary obesity contributors, such as food composition, international trade in unhealthy food, and food and beverage marketing to children.

In response to rising public concern about global obesity trends, there have been a number of proposals in the last several years calling for new frameworks to address the obesity epidemic. These proposals can roughly be divided into three categories. First, some scholars, as well as industry representatives, have continued to urge for traditional voluntary approaches and strengthened partnerships between industry and governments.¹⁸⁹ However, given that industry-driven voluntary “pledges” have proven to be insufficient to stem the growing obesity epidemic even in high-income countries, such proposals for strengthened voluntary action have encountered considerable skepticism in the public health community. In addition, voluntary industry initiatives do not provide the much-needed framework for global coordination or capacity building in low-income countries. Second, inspired by the perceived success of WHO’s first treaty, the Framework Convention on Tobacco Control, a number of commentators have specifically called for a framework convention on obesity¹⁹⁰ and, most recently, the *Lancet* has joined the chorus in support for the codification of such a treaty.¹⁹¹ Finally, a number of commentators,¹⁹² including civil society organizations, have proposed the elaboration of an International Code of Practice on the Marketing of Unhealthy Food and Non-Alcoholic Beverages to Children.¹⁹³ This idea has recently received renewed attention and legal refinement in a proposal, by Taylor and colleagues, to develop a WHO/UNICEF Global Code of Practice on the Marketing of Unhealthy Food and Beverages to Children, as a first step leading to the eventual codification of a treaty in this realm.¹⁹⁴

189. See, e.g., Devi Sridhar, Lawrence O. Gostin & Derek Yach, *Healthy Governance: How the WHO Can Regain Its Relevance*, FOREIGN AFFAIRS (May 24, 2012), <http://www.foreignaffairs.com/articles/137662/by-devi-sridhar-lawrence-o-gostin-and-derek-yach/healthy-governance>.

190. See Roger Magnusson & David Patterson, *Role of Law in Global Response to Non-Communicable Diseases*, 378 LANCET 859, 860 (2010).

191. *Urgently Needed: A Framework Convention for Obesity Control*, 387 LANCET 741 (2011).

192. See WORLD HEALTH ORG., *MARKETING OF FOODS AND NON-ALCOHOLIC BEVERAGES TO CHILDREN* 23 (2006).

193. INT’L ASSOC. FOR THE STUDY OF OBESITY, CONSUMERS INT’L & INT’L OBESITY TASKFORCE, *RECOMMENDATIONS FOR AN INTERNATIONAL CODE ON MARKETING OF FOODS AND NON-ALCOHOLIC BEVERAGES TO CHILDREN* 5 (2008).

194. Taylor et al., *supra* note 44, at 5; see also Allyn L. Taylor & Ibadat S. Dhillon, *An*

As a consequence of mounting public concern about global obesity trends, the drumbeat is intensifying for the elaboration of some type of legal instrument, binding or nonbinding. A concrete international framework could potentially make an important contribution to curbing the rising epidemic. Obesity is now a globalized phenomenon, whose drivers are beyond the reach of national governments alone. Thus, a global framework with comprehensive and cogent global standards may be the only way to meaningfully address this epidemic. The challenge of implementing voluntary self-regulation and national regulations surrounding healthy diet and lifestyle choices, particularly in resource-poor countries, highlights the need for a global framework incorporating meaningful international standards and effective legal and institutional mechanisms, including information sharing, reporting, and monitoring. In that regard, a global framework could strengthen the capacity of countries to act in support of public health legislation.

Although a cogent international legal framework could potentially make a contribution to stemming the growth of global obesity, it should be recognized that obesity is a highly difficult international regulatory topic. This is due in part to the underlying political resistance to global standard setting in this realm. But, apart from the question of political will, obesity is also a challenging international legal topic because of the sheer complexity of the global obesity epidemic and the large remaining areas of scientific uncertainty. As discussed above, the global growth of obesity is being driven by many different trends, and these trends differ between and within countries. For example, obesity is driven in part by social dynamics—including the impact of globalization demographics and cultural norms—but the changes that societies are experiencing do not happen uniformly across all countries or all sectors of society at the same time. The significant variations between and within countries deepen the challenge of drafting cogent international standards that can be applied effectively between and within states. This regulatory hurdle is augmented by the major gaps in obesity literature, particularly in low-income countries. The absence of a strong evidence base to support international legislative intervention will also serve as a significant challenge in reaching political, as well as technical, consensus on concrete, international standards.

Furthermore, the ongoing scientific debate about the very basics of obesity compounds the challenge of drafting and reaching political consensus on meaningful international standards to protect public health. In particular, there is continuing debate about whether obesity is a disease or merely symptomatic of disease. Many take the position that obesity is a disease, including the American Medical Association, which labeled obesity a disease in June 2013.¹⁹⁵ If obesity is a disease, it needs measures for prevention and control. However, some strongly suspect that obesity is a mere symptom of underlying disease. Consequently, those who view it as a symptom argue that the entire focus on obesity, including an international legal framework, is misplaced and that the focus should be shifted to chronic diseases.¹⁹⁶

International Legal Strategy for Alcohol Control: Not a Framework Convention—at Least Not Yet, 108 ADDICTION 450 (2013).

195. Press Release, Am. Med. Assoc., AMA Adopts New Policies on the Second Day of Voting (June 18, 2013), available at <http://www.ama-assn.org/ama/pub/news/news/2013/2013-06-18-new-ama-policies-annual-meeting.page>.

196. Gina Kolata, *Asking if Obesity is a Disease or Just a Symptom*, N.Y. TIMES, Apr. 16,

The sheer complexity of obesity, along with observed variations among and within countries and continuing scientific uncertainty, make obesity a uniquely challenging regulatory topic on which to draft cogent international standards. Ultimately, the complexity and uncertainty surrounding obesity makes tackling it at the global level a much thornier political problem. Global policymakers will have room to interpret data in a way that suits political interests. What is “true” regarding the science of obesity may well matter less than how the topic is politically framed in global negotiation.

A challenge of any future international legal strategy, whether binding or nonbinding, is that a legal instrument in this realm should, and will likely have to, address the tensions between the protection of global public health on one hand and international trade and investment law on the other. It is widely recognized that trade liberalization and market integration have been factors in the rise of NCDs, generally,¹⁹⁷ and in particular, have facilitated the trend towards higher consumption of sugars, fats, meats, and processed foods at the global level and in low-and-middle-income countries.¹⁹⁸ Just recently, South Korea announced that, per a new trade agreement with Australia, it would eliminate its 3% tariff on raw sugar, putting “Australian producers on an equal footing with their competitors in Thailand.”¹⁹⁹ There is no shortage of policy statements that support public health protections against obesity. In 2003, WHO argued for a paradigm shift in global food policy, focusing on diet, tobacco, and alcohol together as causes of NCDs worldwide.²⁰⁰ In 2006, the World Health Assembly published a resolution stressing the need for greater coordination in the development of trade and health policies,²⁰¹ which was later reaffirmed by foreign ministers in the Oslo Ministerial Declaration.²⁰² And that same year, the World Bank recognized the increasing burden of chronic disease on the poor.²⁰³ More recently, in 2011 the United Nations General Assembly convened a high-level meeting on NCDs, which resulted in the unanimous adoption of a political declaration on the prevention and control of NCDs.²⁰⁴ However, as briefly described in the Part on food bans above, there exist international trade obligations that may substantially impede action on these goals.

For obesity prevention, the two most important treaties are the General Agreement on Tariffs and Trade (GATT) and the Agreement on Technical Barriers

2002, at F5.

197. David Stuckler, *Population Causes and Consequences of Leading Chronic Diseases: A Comparative Analysis of Prevailing Explanations*, 86 MILBANK Q. 273, 320 (2008).

198. CORINNA HAWKES, CHANTAL BLOUIN, SPENCER HENSON, NICK DRAGER & LAURETTE DUBE, *TRADE, FOOD, DIET AND HEALTH: PERSPECTIVES AND POLICY OPTIONS* 35–36 (2010).

199. Craig Zonca, *Sugar Industry Applauds Korea FTA Deal*, ABC RURAL (Feb. 18, 2014), <http://www.abc.net.au/news/2014-02-18/sugar-industry-applauds-korea-fta-deal/5267840>.

200. WORLD HEALTH ORG. & FOOD AND AGRIC. ORG. OF THE UNITED NATIONS, WHO TECHNICAL REPORT SERIES NO. 916, *DIET, NUTRITION AND THE PREVENTION OF CHRONIC DISEASES*, 30–36 (2003).

201. WORLD HEALTH ORG., *FIFTY-NINTH WORLD HEALTH ASSEMBLY: RESOLUTIONS AND DECISIONS* 37–38 (2006).

202. *The Oslo Ministerial Declaration—Global Health: A Pressing Foreign Policy Issue of Our Time*, 369 LANCET 1373 (2007).

203. See Sania Nishtar, *Time for a Global Partnership on Non-Communicable Diseases*, 370 LANCET 1887, 1887 (2007).

204. G.A. Res. 66/2, U.N. Doc. A/RES/66/2 (Jan. 24, 2012).

to Trade Agreement (TBT Agreement).²⁰⁵ Several formal complaints have asserted that state public health measures have violated these international trade commitments. Under GATT, there have been complaints that national public health measures have discriminated against foreign producers. For example, the WTO required that Samoa lift bans on fatty poultry scraps prior to earning approval to join, which helped reopen the market to U.S. turkey farmers.²⁰⁶ Additionally, Tonga shelved measures to restrict the importation of mutton flaps through quotas, under threat of a complaint by New Zealand because it feared losing New Zealand's and Australia's (two large exporters of mutton flaps) sponsorship for joining the WTO.²⁰⁷ Under the TBT Agreement, there is currently an ongoing discussion within the TBT Committee as to whether a new Chilean junk food labeling law constitutes a technical barrier to trade.²⁰⁸

Perhaps more importantly, the impact of international trade law on the drivers of obesity may not be as significant as advocates assume. Stuckler and Nestle point out that the vast majority of the growth of "Big Food" sales is occurring in low-income countries.²⁰⁹ However, trade accounts for virtually none of this growth. Trade accounts for only about 6% of current processed food consumption, and most of the growth of "Big Food" in low-income states is a direct consequence of foreign investment.²¹⁰ The power of "Big Food" is also more diffuse at the global level. In the United States, the ten largest food companies control over half of all food sales. However, worldwide this proportion is only about 15%, though rising.²¹¹ Hence, any cogent future legal instrument would need to address both international trade and foreign investment, both highly troublesome political issues.

Supporters of a framework convention on obesity have argued that a treaty is necessary to essentially trump international trade law and protect public health.²¹² However, it is doubtful whether there is sufficient political will to override international trade law in such a new public health treaty. Notably, the negative impact of trade on health was a major discussion during FCTC negotiations. There

205. Agreement on Technical Barriers to Trade, April 15, 1994, 1868 U.N.T.S. 120; General Agreement on Tariffs and Trade, April 10, 1947, 55 U.N.T.S. 194.

206. Jason Gale, *Choosing Between Free Trade and Public Health*, BLOOMBERG BUSINESSWEEK (Nov. 22, 2001), <http://www.businessweek.com/magazine/choosing-between-free-trade-and-public-health-11232011.html>.

207. See Mike Evans, Robert C. Sinclair, Caroline Fusimalohi & Viliami Liava'a, *Globalization, Diet, and Health: An Example from Tonga*, 79 BULL. WORLD HEALTH ORG. 856, 860 (2001); Geoff Cumming, *Fat to the Health Fire*, NEW ZEALAND HERALD (Jan. 30, 2010), http://www.nzherald.co.nz/nz/news/article.cfm?c_id=1&objectid=10623091.

208. See *Members Discuss Guidelines for Trade-Friendly Regulation and STOP Sign for 'Junk Food'*, WORLD TRADE ORG. (Mar. 13, 2013), http://www.wto.org/english/news_e/news13_e/tbt_13mar13_e.htm.

209. David Stuckler & Marion Nestle, *Big Food, Food Systems, and Global Health*, 9 PLOS MED. e1001242 at 1 (2012), available at <http://www.plosmedicine.org/article/info%3Adoi%2F10.1371%2Fjournal.pmed.1001242>.

210. *Id.*

211. *Id.*

212. See, e.g., *Urgently Needed: A Framework Convention for Obesity Control*, *supra* note 191.

was no agreement among states to trump trade law for tobacco control at the time of the adoption of the treaty and such agreement is still lacking today, ten years later.

While scholarly work is underway on the consideration of alternative international legal strategies that can be developed to address the globalization of obesity, more can, and must, be done at the global level to assist states in their efforts to counter the epidemic through domestic legal tools. As a first step, there is a need for more and comprehensive research regarding existing legislation targeting obesity. The absence of a central source of information about country-level activities impedes the ability of scholars and policymakers to draw on expertise and assess emerging trends and developments. This Article has made an important start in identifying overarching trends in recent legislation; however, research in this area is limited by the lack of a comprehensive database. A global database of obesity-related legislation would provide a valuable resource for all countries, reflecting and reinforcing what countries are already doing while at the same time facilitating sharing of best practices and possibly assisting public health advocates in marshaling political will in support of legislation. This Article aims to be the initial step in the direction of such a global database.

CONCLUSION

The epidemiological evidence clearly demonstrates that the obesity epidemic is a problem of potentially catastrophic dimensions, from both a public health and economic perspective, that demands urgent action, given the correlation between obesity and a host of chronic diseases. National and international policymakers facing choices regarding public health interventions to address obesity will argue for action at different thresholds of evidence. Part of what should define this threshold is the cost of not taking action while waiting for an even more robust evidence base. In the case of rising NCD rates, the costs of inaction have already been quantified in the pages of *Lancet*—an estimated 35 million people will continue to die from NCDs annually, with 80% of these deaths occurring in low- and middle-income countries.²¹³ Projections like this should point policymakers towards a cluster of risk factors that can be effectively controlled through policies placing reasonable limits on the marketing and availability of a few commodities. We submit that the emerging evidence on the health detriments of unhealthy food and beverages and their role as a proximate cause of NCDs should help inform national public health policy and a new global strategy to address the shifting worldwide burden of disease.

The traditional tools of relatively mild taxation and educational campaigns have done little to nothing to stem the global rise of obesity. In recognition of the critical nature of the epidemic, countries have been increasingly willing to impose stronger educational and tax initiatives and to build on those measures by employing different and novel techniques to combat obesity, moving beyond a “personal responsibility framework” to a framework in which interventions seek to address broader social determinants of health. This evolving global trend towards

213. Rafael Lozano et al., *Global Burden of Disease Study 2010*, 380 *LANCET* 2095, 2095–127 (2012).

strengthened national action should inform and inspire public health regulatory initiatives in countries worldwide. Moreover, the emergence of this global trend may create political and policy space for a much-needed global legal framework for addressing obesity. As this Article has discussed, however, cogent international standing in this realm will face some new and unique political and practical challenges. Importantly, in order to submit unilateral national efforts and promote best practices and coordinated global action, there is a strong need for a global database of legislation addressing the drivers of obesity and NCDs, as a first step. Regardless of the means selected, in view of the obesity and NCD epidemics and the global trend toward broader and stronger obesity legislation, it is an appropriate time for the public health community to move toward a global framework to address the primary drivers of obesity.

