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SURGERY FOR OBESITY AND RELATED DISEASES

Keynote address

Legal and policy approaches to the obesity epidemic

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Abstract Although 85% of the American public believes that obesity is an "epidemic," great controversy exists what role the government, public policy, and law should play in addressing the problem. This keynote address discusses the philosophical and economic justifications for treating obesity as a public health problem meriting government intervention and explores the possible legal and policy solutions. (Surg Obes Relat Dis 2012;8:507–513.) © 2012 American Society for Metabolic and Bariatric Surgery. All rights reserved.

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Until recently, the terms "obesity" and "law" were not used together very often. One did not find lawyers and legal advocates and legal scholars who specialized in obesity. That is not true today. It has become a niche area of legal practice and scholarship, because a great number of people have begun to consider the contributions that the law can and should make as a tool in our arsenal against obesity.

That recognition has both inspired and responded to developments in the political realm. We have increasingly seen state and federal governments using the law in their own fight against obesity. One such measure that has been in the news recently is the State of Arizona's effort to tax its Medicaid beneficiaries if they are smokers or are obese and fail to adhere to a physician-supervised weight loss program. This is one of the more creative state efforts to generate revenue to continue to provide Medicaid services in an era of budget deficits, and it is one that has provoked a great amount of controversy for targeting a patient population that is doubly vulnerable because of both their obesity and their poverty.

Similarly, initiatives across the United States have attempted to use laws more or less coercively—sometimes supportive, sometimes punitive—in an effort to prevent obesity. These laws have been roundly criticized, particularly by those on the political right, as evidence that we are cultivating a "nanny state" in the era of "Obamacare." They are an additional example, it has been said, of the government impermissibly and unjustifiably intruding into people's personal lifestyle decisions.

Although it is clear that obesity is a public health problem of enormous proportions, I believe it is not clear to many Americans that this should be a public policy problem—that it is a legitimate target for legal and governmental intervention.

What I wish to discuss are some of the arguments around that question, and I will put forth the proposition that a legitimate basis exists for the law to take action, even using methods that are relatively coercive (or at least that might be perceived as coercive by certain segments of the population). However, I believe we need to consider carefully the case for the legitimacy of action for several reasons.

One reason is that the government is expending resources that are shared and that are provided by the taxpayers. Expending resources in one area means fewer resources available to expend in other areas. Another reason is that the institutional legitimacy of government should be maintained. If people do not believe in the legitimacy of official action, they are less likely to comply with it, and that is particularly important in the realm of health interventions. Thus, "public buy-in" is important because that affects our ability to achieve the health goals of public health programs. Finally, I believe legitimacy is important because many of these laws do burden individual liberty and autonomy. They bring the coercive power of the state to bear on individuals in shaping their choices and behaviors, and that requires moral justification.

Therefore, in the first part of the session, I will discuss the case for government action and legal action in this

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realm. In the second part of the presentation, I will discuss some of the actions occurring at the local, state, and federal levels that can be described as legal approaches to obesity.

First, what makes obesity a legitimate public policy problem? Essentially this is a question about whether obesity is an "other-regarding" health status—a status that affects other people—which makes it the government's business, or by extension, our business as taxpayers and members of society. How can this question of when one person's weight becomes another person's business be answered? A philosopher might give several distinct answers to this question.

One is that we must move away from the concept that obesity is a manifestation of free will. We live in a society whose ideological roots are very firmly rooted in the notions of individualism, free will, and autonomous choice and the belief that the free market can solve a number of our social problems. In contrast, the public health model of ecologic determinants of health states that we need to recognize that people's choices, and ultimately their health outcomes, are intimately shaped by their environment, the social options available to them, and the social construction of those options—how people describe, think about, and evaluate different options. Once it has been recognized that people's health status is, to a large extent, socially or environmentally determined, it becomes much easier to argue that the government ought to intervene to change people's health status and health-related choices. That is because it has already been acknowledged that we do not operate in a realm of perfect free will, and it becomes easy to argue that once we have set up social options and environments that lead to particular health outcomes, it is legitimate to become involved in changing those social options and environments to change the outcomes.

I believe a philosopher might offer a second argument to justify government intervention, and that is the argument for paternalism—the notion that in certain cases it is legitimate to argue, "I know what is better for you than you do" or "I know methods that can help effectuate better choices for you that you cannot yet recognize or cannot take advantage of." Paternalism tends to have a very bad connotation in the United States. In particular, in clinical practice, it is a notion that physicians have tried very hard to move away from in the modern era. However, there are forms of paternalism that are relatively benign and that recognize that, particularly for vulnerable populations, it might well be that the individuals are not in a great position to evaluate their choices and to make health-promoting decisions or are in a position to make the right choices but not to continue in these decisions. (We know this is a particular problem in the realm of nutrition and physical activity.) Thus, one school of thought states that when these conditions exist and when someone in a position of power and in control of resources can help individuals make better choices or can help good choices become habitual, it is more than legitimate- it is perhaps morally obligatory- for them to intervene.

Finally, an argument can be made from solidarity. This is the somewhat radical idea that we ought to work together to help each other bear very significant burdens. It is a philosophy very common in Europe but it does not have as much support in the United States. Few physicians, though, would dispute the notion that individuals should be helped when they are facing terrible health burdens. Some of the emerging research around childhood obesity, I think, places severe obesity firmly in this category. Severely obese children who completed quality-of-life assessments rated their quality of life about the same as did children who were undergoing chemotherapy. Obesity is clearly a health burden that has very significant psychosocial consequences, as well as, of course, medical consequences. Thus, I believe a strong argument exists that individuals should not be left to bear that burden alone, that they should be given support and assistance, and that government has a role in doing that.

These are some of the philosophical or moral arguments in favor of action. An economist, however, might give a different answer to this question, one no less worthy of consideration. An economist would point to the problem of externalities. An externality occurs when I generate social costs that I do not fully bear. For example, the healthcare-related expenses associated with obesity and the indirect economic costs of obesity in terms of reduced productivity and economic output are costs for which the obese individual is not fully held accountable. An economist would contend that when externalities are present, it is reasonable to address them with some form of regulation.

An economist might also address the market model. Those who believe that the "invisible hand" of the market can provide solutions to the obesity epidemic need to consider whether informational asymmetries or other failures in the market could lead us to state: "Well, perhaps this is not going to be an ideal solution here. We might need government." Finally, an efficiency argument could be made for the law or government to provide some type of solution to obesity which might achieve more at lower cost than what individuals or firms in the market might be able to achieve on their own.

By far, the strongest argument among these is the argument concerning externalities. That raises the question: how much are we paying for obesity-related costs as a polity in the United States? The latest data suggest that when we consider the increase in per capita medical expenditures from 1987 to 2001, an incredible one quarter of those expenditures can be attributed to obesity and overweight [1]. In a more recent, cross-sectional analysis from 2008, obesity accounted for direct healthcare expenditures of about $266 per capita for overweight individuals and >$1700 for obese individuals [2]. When that is aggregated at the national level for 2008, the healthcare expenditure is nearly $114 billion. Depending on the measure of total

national healthcare spending used, this constitutes 5–10% of the national healthcare cost, a staggering amount of money. Even more staggering is the projection for the future. By most models, these costs have been projected to double every decade between 2012 and 2030 [3]. Thus, in 2030, we can expect 16–18% of the national healthcare expenditures—almost $900 billion—to be for obesity-related care. These are very significant externalities that "give us all skin in this game"; that is, we all have a stake in preventing obesity.

The costs redound not just to public payers, but also to employers and employer-sponsored health plans. Data from a 2010 study showed that the costs of obesity to employers totaled $73 billion annually [4]. About 40% of that cost was related to healthcare expenditures, but 40% was related to "presenteeism," the lost productivity that employees experience working, with the remainder due to absenteeism related to obesity-related health conditions. One final measure that is interesting is workers' compensation claims. Employers finance the workers' compensation system through their insurance premiums. The more workers' compensation claims an employer experiences, the more that employer pays, and we would expect lower wages and higher prices as a result. Research data have revealed that obese employees are more likely to make claims for workplace injuries [5]. Those claims are more likely to be paid at a very high level, both in terms of medical claims costs and overall indemnity costs, or overall payments, and many more lost workdays are associated with those claims. All these data highlight the very significant externalities associated with obesity and present a compelling argument that taxpayers have a right to insist that the government take action.

So far, we have been discussing the moral and economic justifications for the law intervening; however, policymakers will ask, not only what is justified in theory, or what is a meritorious idea, but "what can I get away with?" "What actual political support exists? What is politically feasible?" Thus, when politicians answer a question of when it is legitimate to intervene with the law, the first question they will consider is the interest group politics around that issue. Certainly, a number of medical and public health organizations have engaged in very vigorous advocacy concerning obesity. The Clinton Foundation, American Heart Association, and many others have been very effective advocates for various policy approaches to obesity.

However, equally effective and better funded advocacy against public policy approaches to obesity has been pursued by several other interest groups. The food industry, beverage industry and, to some extent, the agricultural industry (because agricultural subsidies are 1 of the policies being considered) have spent billions fighting obesity prevention laws. At present, they are a formidable set of adversaries for those who want to go forward with these types of policies.

A second concern for policy makers is, "can I create these various legal interventions legally? What is the scope of legal authority?" One of the key issues is determining the scope of legal authority to restrict food advertising and marketing, a potentially very efficacious strategy, but one that raises a number of constitutional red flags.

Finally, the policy makers are interested in the degree of public support for these policies in general. Interestingly, scholars who have tracked public support for related types of legal interventions have identified a series of "cultural triggers" that suggest that the public is truly ready for various types of legal regulations. Research by Kersh and Morone [6] focused on a variety of forms of regulation of so-called "vice" products, with alcohol and cigarettes the most common examples. However, they have also begun to apply this thinking to the obesity model and food products [6].

They have identified some "triggers" that signal that it is time for an aggressive regulatory response to a "vice." First is the science base around the use of the product suggesting it is harmful. Certainly, with respect to obesity, we have an increasing body of evidence, beginning with the landmark Surgeon General's report in 2001 and continuing with mounting evidence about the national cost of obesity and, most recently, supplemented by reports suggesting the effect of advertising on childhood obesity and the potential effect we could have by restricting food advertising.

The second major trigger has been to "medicalize" the problem. We have moved from, for example, seeing alcohol use as a vice to viewing it as a disease, alcoholism. The same is true for tobacco use (nicotine addiction). We have begun to see this transition for obesity as well, with Medicare's decision to create a diagnostic code for obesity. The key political factor is that when we medicalize a condition, we shift from thinking about individual and personal responsibility for the condition, from thinking about it as purely a product of a vice, to thinking of it as a disease entity that is worthy of medical treatment and preventive services.

A third trigger that these researchers have identified is what they term "demonization" of both the user of the vice products and the supplier of those products. We have certainly seen this with tobacco, with the increasing belief that the tobacco companies were culpable in the tobacco epidemic leading to significant legal restrictions. We are just beginning, I believe, to see this in the realm of food, with increasing calls for major food companies to "clean up their act" with respect to advertising and marketing, to design better, more healthful products, and to stop "supersizing." To some extent, we have also seen the demonization of the users of these products, which is an interesting tension. Although we have begun to medicalize obesity, a political current also exists that continues to stigmatize and blame those who have the condition of obesity and to connect it very strongly to particular behaviors. These 2 cultural trig-

gers might support different types of regulation or lawmaking—with one, the medical model, tending to support preventive and supportive services being provided to this population and, the other, the demonization model, leading to support for more punitive forms of lawmaking.

Finally, Kersh and Morone [6] stated that when social disapproval of the product and the behavior in play are present, public support for regulation is more likely. Again, alcohol use is a classic example. Obesity remains a curious paradox. It is the only health condition that affects most of the U.S. population, yet remains heavily stigmatized and, in a sense, "othered." Thus, at the same time that we have a highly prevalent condition, there is a high prevalence of social disapproval of it and people tending to think of it as a problem that affects other people more than themselves. This creates a challenge for regulation, because at the same time that we have support, in principle, for a variety of forms of action to address the disapproval of condition and behavior, we also have to acknowledge that a variety of people will be negatively affected by that regulation. When a regulation will negatively touch the lives of more people, it can be more difficult to pass.

Where are we in terms of public support for particular types of obesity-related laws? The trend from public opinion data has been steadily toward greater levels of support overall. Survey data have shown there is a very high level of support for even quite restrictive measures, as long as they are confined to the school environment [7]. When interventions are focused on children in schools, it is very difficult to find people who really oppose them, even if they significantly shape the day-to-day environments in which the students interact.

When we consider adults in the community, the levels of support tend to be a little bit lower; however, there are still, certainly, high levels of support for interventions that are primarily informational and choice enhancing, such as providing calorie information at the point of food purchase. What has been more surprising is the increasing support for information-restricting mechanisms, primarily the restriction of food advertising. In 2004, fewer than one half of American adults were willing to state they somewhat or strongly supported measures to restrict food advertising [8]. In 2010, two thirds expressed somewhat higher levels of support for these measures [7]. I would expect these trends to continue, and this concerns food advertising that is not just child oriented.

Thus, I believe it is fair to state that a strong majority of the U.S. public is supportive, certainly, of child-oriented legal interventions and, to a large extent, toward information and choice-enhancing laws that would affect adults. The support is more mixed for restrictive measures that affect adults, and the political waves in this area will certainly be affected by the growth of the Tea Party Movement and its libertarian ideology. There is not much support at present for government measures that are perceived as coercive or restricting individual liberty. However, if the policies and choice sets can be reframed so they are perceived as choice-enhancing or "nudging" mechanisms, rather than outright restrictions, I would expect greater levels of support to emerge.

Having reviewed some of the arguments for the legitimacy of this type of action—moral arguments, economic arguments, and arguments about political feasibility—I will discuss the local, state, and federal approaches to obesity prevention.

There is a huge tool kit that governments can draw on to prevent and treat obesity. Educational campaigns are an uncontroversial and potentially effective method of providing information to the public. What has received increasing attention is the potential use of incentives in health plans, employment and workplace environments, and public benefits programs. These benefits might be conditioned on participation in weight loss or wellness programs or on meeting other conditions. Great interest exists in using money as a lever for changing individual behavior. The political appeal is that one is not forcing, in a literal sense, anyone to do anything. Another selling point for these types of measures is that they tend to be revenue generating. We get a double win: addressing obesity by tweaking the influences on individual behavior and generating income at the same time.

Another area with huge amounts of legislative activity at the state and local levels is standards for school and daycare environments. This policy making reflects the high level of public support for action in this area. There is the obvious appeal of helping children, the opportunities for lifelong prevention that come from education at an early stage, and the ability to effectively control the environment in a school setting and have a large effect.

Zoning law is an area also receiving increasing attention but that has not been used very often. It has been discussed, in particular, in research studying the health disparities involved in obesity, which has noted that neighborhoods in which obesity is very high often have high levels of minority representation. In these locations, the research has also shown the overrepresentation of fast food outlets and the underrepresentation of businesses selling healthful foods, creating so-called "food deserts". The idea behind zoning policies is that one can actually use land use restrictions to affect what kinds of businesses locate in a neighborhood. Also, legal and financial incentives can be provided for businesses to locate or not locate in particular locations. Using these methods, one can, potentially, profoundly affect the food environment in a neighborhood.

The regulation of food products—what is made, what is in it, and what the label on the food product includes—has also been an area that has received a lot of attention lately. We saw this, for example, in the effort across the states to eliminate trans fat. To some extent, this was related to an interest in reducing obesity. It was more strongly driven by

concerns about cardiovascular disease but certainly redounds to the benefit of the obesity prevention effort.

Food labels are another very promising area. It is difficult to generate much political opposition to the idea that people should have more and better information regarding the foods they purchase. To date, policymakers have done a lousy job with food labeling. No one would consider that the nutrition facts label is a particularly helpful or comprehensible tool for making responsible food choices. A good bit of interest exists in developing better mechanisms. For example, a working group in the United Kingdom proposed, for its food regulatory agency, a stoplight system; a label on all foods that would have a green, red, or yellow light, indicating some overall judgment of the healthfulness of the food product, something to enable consumers to make quick decisions about food purchases.

Returning to the issue of the regulation of food marketing, there is the idea that we need to begin to curb advertising of "obesogenic" products, particularly when advertising to children. The regulation of agricultural production has also been discussed. There is a hypothesis that agricultural subsidies for corn have contributed to the overproduction of corn, and this, in turn, has led to the creation of high-fructose corn syrup products, which, in turn, has led to increased obesity. This is a disputed hypothesis, but a large number of questions have been asked about whether the government should be supporting the production of products that seem to be contributing to obesity.

Personal behavior mandates and prohibitions are at the far coercive end of the types of legal approaches possible. They have not been used too often, but they have certainly been debated. Should we be telling individuals directly what they can and cannot or must do in terms of nutrition and physical activity? Another type of mandate receiving increasing consideration and support is laws that promote and facilitate breastfeeding. For example, requiring employers to give breaks and provide space for breastfeeding in the workplace has been supported by research that strongly connects having been breastfed with a lower probability of obesity in childhood.

Litigation has received a great amount of attention as a mechanism for combating obesity. There have been a small number of actual cases, but they are very newsworthy. In 2003, when a group of overweight and obese adolescents in New York City sued McDonald's for selling defective and dangerous products, it seemed that every newspaper in the United States followed the case. Nothing ultimately resulted, except that McDonald's began to change what was offered on its menu, perhaps in an attempt to recoup some of the public relations "hits" it took as a result of this litigation. There have been other attempts to use litigation as a strategy, not so much with the expectation that the plaintiffs will prevail regarding arguments that certain products are unreasonably dangerous or defective, as the law has traditionally understood those terms, but as an effort to embarrass companies and induce them to offer more healthful products, market products in more reasonable sizes, or curb how they market to children. Finally, there have been insurance coverage mandates in an effort to increase access to care.

The last area I will discuss briefly is 4 measures that have received much attention during the past few years. The first is taxes on soda. This is, again, 1 of those interventions that has great appeal because, not only does it have the potential to reduce the consumption of an obesogenic product, but it also generates revenue. How many public health interventions can not just solve health problems, but actually result in revenue? Not very many. Most states already tax soda, either as a sales tax, which is based on the price of the product, or as an excise tax, which is based on the amount of the product sold. However, these taxes tend to be low. On average, they are about 4% of the price of 1 unit of soda. Thus, when scientists studied the effects of these taxes, they have found them to be quite weak. The tax is just too low a cost to really affect consumption. However, we know from other research regarding cigarette purchases that when excise taxes were increased significantly, demand for the product decreased greatly. Thus, during the past couple of years, many states have begun to propose much greater taxes on soft drinks. In the last round of federal health reform, it was proposed that a 3-cent tax be added to a 12-oz. unit of soda. That would not be expected to do much to curb consumption, but it was a method of paying for some of rest the healthcare bill.

Some research has suggested larger taxes could have a very significant effect on soda consumption. However, to date, states have had difficulty pursuing the larger taxes, and the federal proposal faltered in the last round of the health reform. The reason is simple: the beverage industry has spent millions to defeat these proposals. In the federal effort, it was estimated that the industry spent $24 million to defeat a 3-cent-per-can tax [7]. One can imagine that these efforts have been even greater in those states contemplating larger taxes on soda. Proponents face a formidable challenge in attempting to overcome this opposition and the tactics used in this advocacy campaign, which have framed these taxes as an assault on personal liberty and choice.

A second major thrust of legal advocacy efforts in the past few years has been the regulation of advertising. Some very significant legal, and political, barriers exist in this arena. However, people have continued to persist, because evidence has shown that advertising restrictions could potentially have a very great effect. One formidable barrier is posed by U.S. Constitution. The First Amendment guarantees a right of free speech that the Supreme Court has interpreted to include commercial speech. Thus, to have a regulation upheld, the government must to show that it directly and materially advances an important government interest, such as obesity prevention, and that it does this by being very carefully and narrowly tailored so that it does not

restrict more speech than is absolutely necessary. In practice, these showings have been difficult for government to make, because the courts have been very protective of businesses' right to advertise.

Thus, frontal assaults on advertising will be very difficult to sustain and will certainly be subject to constitutional challenges. Nonetheless, some latitude exists for government to achieve inroads in this area and begin to build the case that certain forms of advertising restrictions can be effective and are not broader than necessary. A political difficulty, however, is that the primary agency that would be tasked with doing this is extremely "gun shy." The Federal Trade Commission (FTC), which has responsibility for regulating food advertising, actually attempted, in the 1970s, to substantially restrict the advertising of highly sugared foods to children—not because of a concern about obesity, but because of a concern about dental caries. This "kid-vid" effort attracted about 60,000 negative public comments in the rulemaking process and led Congress to threaten to defund the agency unless it ceased its efforts, which it did. Congress also significantly restricted the FTC's authority in this area from then on. Thus, starting in the 1980s, the FTC could not regulate food advertising on the basis that it was an unfair business practice but only if the individual advertisements were deceptive.

Unless Congress acts to change this restriction of authority, it will be difficult to achieve much through regulation. Legislative action is needed, not agency action. The past couple of presidential administrations have not moved in this direction, despite strong calls for it, but rather made attempts to engage the food and beverage industries in regulating themselves. An organization of child-oriented advertisers set standards in this area, but the government, under the Obama Administration, has gone further. It convened an Interagency Working Group of officials from the Centers for Disease Control and Prevention, Food and Drug Administration, FTC, and the U.S. Department of Agriculture to consider what standards to suggest to industry concerning marketing to children. In 2009, that Interagency Working Group issued its report, and the standards were extremely strict. They were widely lauded in the public health community as being unprecedented in their stringency, and they produced an outcry on the part of the food and beverage industries, who stated, "Look, basically none of our products, under this standard, would qualify to be advertised to children"—which was kind of the point.

The difficulty, of course, is that these are voluntary guidelines, and industry compliance with voluntary guidelines has historically been relatively low. There are obvious collective action problems when an action is voluntary, with 1 food company being very good about following the no advertising rule and then a competitor comes in and simply steals that market, penalizing the compliant company for following the guideline. Thus, without regulation, it will be difficult to achieve change. The barriers are very substantial, legally and politically, to moving forward in this important area.

The third area with a great amount of action recently is menu labeling, beginning a few years ago in New York City with an effort to require chain restaurants in the city to post information about the calorie content and other nutrients on menu boards. That was the subject of a very vigorous constitutional challenge. The legislation survived that challenge. It was subsequently replicated by a number of other states and localities, and, then during the federal health reform, this measure was nationalized. We are beginning to see the implementation of the federal menu labeling requirement, which, similar to New York City's requirement, applies to chain restaurants only. It also applies to certain vending machine companies and should provide a significant mechanism for providing additional information to consumers about the calorie content. It preempts conflicting state and local laws; thus, national standards will begin to emerge for what can be done in this area as regulations are issued.

The great question is, what effect will it have? Some evidence is beginning to emerge about the effects of the state and local menu labeling laws, and the evidence is actually somewhat dispiriting. Studies have tended to find that labeling laws have a statistically significant effect—people purchase fewer calories and consume fewer calories in areas that have menu labeling than in areas without—but the effects are fairly small and probably not enough to reduce the prevalence of obesity and overweight. A subset of consumers exists, however, who are high users of this information and more responsive. Overall, however, there seems to have been more interest in this area than the evidence perhaps would support.

The fourth area is insurance coverage mandates. Access to obesity-related services is a critical issue in preventing and treating obesity, and the legal landscape has varied tremendously in terms of what is covered. The rates of coverage among public insurance programs have generally been high. However, within the Medicaid program, the variation from state to state in terms of whether programs will cover weight loss drugs and whether and under what conditions different forms of bariatric surgery are covered has been great. In the private plan marketplace, the heterogeneity has been even greater. One of the issues for private plans has been the return on the investment: because working-aged people tend to change insurance companies very often with employment changes, an investment in obesity prevention does not necessarily have a return for any particular insurer. Furthermore, because much of the large costs associated with obesity occur at an older age and are borne by the Medicare program, the incentives for investment in this area could be unclear to many insurers.

Increasing evidence has shown that covering obesity-related services, whether nutritional counseling or surgery, does have a return on the investment; however, it has been

a difficult case to prove. One of the issues is, again, the collective-action problem. If 1 insurer begins to cover these types of services, how will the market respond? Will that insurer begin to draw all the high-risk obese patients into its plans, resulting in higher costs, such that other insurers who have not been covering these services will actually benefit from receiving a disproportionately lower risk enrollment? Again, such a collective-action problem is a classic economic case for regulation. To "level the playing field," a simple mechanism is to require all insurers to cover it. Few states have yet taken that approach. An opportunity has been presented by the federal health reform to begin to standardize the "playing field," if, as a part of the essential benefits package that health insurance exchanges will be creating, some of these obesity services are included.

In conclusion, in the legal landscape, the focus to date has been on legal interventions that are child oriented. This is relatively politically uncontroversial and the potential effect is great. The focus has also been on mechanisms that primarily provide more information in the information marketplace, and, at best, "nudging" people toward particular choices. It should not be unnoticed that President Obama appointed, as the head of the Office of Information and Regulatory Affairs, a University of Chicago law professor, Cass Sunstein, who is best known for his book, *Nudge*, and is a strong advocate of a model of regulation that does not mandate particular behaviors or particular choices but sets up environments around choices to lead individuals to make good choices. Consistent with these ideas, the primary obesity prevention strategies achieving support have been tactics such as menu labeling that better inform people and might shape their choices by the manner in which the choices are presented to them but that do not mandate a particular behavior.

Another major component of the current regulatory stream is the continued hope that we can achieve our aims through partnerships with industry and a reliance on companies to behave appropriately. I believe the skepticism in the advocacy and medical communities that this will happen has not yet permeated the upper realms of policy making. Thus, efforts in that area will continue in the years to come, although in the long term, as obesity-related costs begin to increase and some of these voluntary strategies have been proved failures, an increasing acceptance of farther-reaching approaches will occur.

To summarize, several very good arguments exist that obesity is not just a public health problem, but is also a public policy problem—a legitimate target for legal intervention. Some arguments are moral arguments regarding our obligations to one another and the presupposition that obesity is the product of free will and free choice in the marketplace, rather than a product that is highly socially determined. Some of the strongest arguments, however, are economic and suggest that we have the right as taxpayers and as members of the polity to insist that action is taken to stem obesity-related costs. The difficulty is that many of the potentially most efficacious legal strategies are difficult to pursue because of legal barriers or political feasibility concerns, and those we are pursuing are largely untested. We know very, very little about how these various legal approaches will work, despite the wide prevalence of lawmaking and widespread dissemination of particular policy ideas. The emphasis on evaluating what works has been less.

To move forward, it will important to cultivate the demand for additional government action by reiterating some of these arguments more strongly and more persuasively. We must also demand an evaluation of the legal approaches to obesity. We need to know whether we are receiving good value for the money we are spending; whether, when we ask individuals to give up liberties, we are receiving public health gains; and, ultimately, whether the strategies we are pursuing in this area are morally justified and legitimate.

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