Entrenched deterrents to obesity prevention necessitate radical measures

Abstract

Despite multiple individual-based strategies to reverse the obesity epidemic in America for some 30 years, obesity rates continue to climb: 39.8 percent of U.S. adults were obese in 2016 with another 27 percent classified as prediabetic and 18 percent of American children diagnosed as obese – a figure that has tripled in three decades [3-4]. Missing from this battle of the bulge is a population-based approach that would model those deployed during the anti-smoking campaign of the 1980s and beyond. Societal/legislative actions, while perceived by many as draconian and/or “un-American”, must be implemented if we are truly serious about addressing this national health epidemic.

Keywords: Obesity; Obesity prevention; Population-based approaches; Food environment regulation

Introduction

Obesity evokes many reactions in America today. Tragically, the overwhelming majority of those responses has been counter-productive in resolving this national health problem: Denial, misplaced anger directed toward those who broach the subject, resignation, and outright acceptance/celebration of the condition itself [5-6,11,15]. Given the woeful track record of obesity prevention interventions over some three decades, these jaded reactions should not be that surprising albeit they perpetuate and exacerbate the epidemic. Continuing the same failed strategies is folly. Clearly, a different (or at the very least, another) approach is needed – a population-based approach that models the one deployed during the anti-smoking campaign of the 1980s and beyond.

Deterrents of obesity prevention

When obesity becomes the norm, its acceptance is readily accommodated. When some 67 percent of the adult population is obese or well on their way toward that designation, acceptance of this hypokinetic condition is virtually guaranteed [3]. Eighteen and one-half percent of American children (ages 2-17) were classified as obese in 2015-16 – a figure that has tripled in 30 years [4]; sadly, this rate also continues to climb. Complicating this obesity acceptance mindset has been its devolution to obesity celebration – an end-result of obesity advocates mistakenly morphing the condition obesity with the person with obesity [6]. Such co-mingling has miscast well-meaning healthcare providers as “fat shammers”. Another powerful force that under-
mines obesity prevention is that cherished American ideal of individual rights whereby the individual citizen enjoys the God-given right to choose poorly. A related argument posits that the American emphasis on the value of individual responsibility creates a deep-rooted reluctance for societal intervention in what are viewed as personal behavioral choices [16]. Additionally, today’s political climate (articulated from both sides of the legislative aisle) has been vehemently opposed to government meddling in citizens’ private lives—a doctrine that poses a huge roadblock to population-based interventions, i.e., legislative actions. A corresponding factor that has obviated obesity prevention efforts is an increasing distrust of government and science research/data documenting the prevalence, incidence, distribution, and detrimental effects of obesity. When the general public does not perceive/acknowledge that a problem exists, then no corrective action is warranted nor sought. Paradoxically, there also appears to be a public perception that modern medical science will ameliorate obesity concerns with a new drug here and a new surgical procedure there. Such wishful thinking eliminates the need for individual effort and/or change by placing the onus of cure solely upon the medical/pharmaceutical professions—professions which many obesity nay-sayers are conflicted.

**Failed past practices**

A person’s health status is influenced by multiple, interdependent forces: Genetics (biology); social circumstances (e.g., income); environmental exposures, including access to healthcare services; policy-making; and individual behavior/lifestyle choices [21]. Historically, the focus of obesity prevention has rested virtually exclusively upon the individual whereby healthcare providers have concentrated on changing individual behaviors: Decrease caloric intake; increase caloric expenditure; take medications; and, undergo surgeries. Unfortunately, the individual-based approach has yielded minimal gains in combating the national obesity epidemic. To be fair there have been dramatic success stories for select individuals utilizing sheer willpower and/or medical intervention but these victories are more anecdotal than universal as evidenced by the nation’s escalating obesity rates each successive year. Thus, one can reasonably conclude that additional, or alternative, approaches are required. One such approach appears to be promising: Population-based policies whereby taxation, legislation, regulation and dietary reformulation have achieved greater public health gains than the previously-mentioned individual interventions [7-8].

**Nutritional shift**

The dramatic increase in obesity across the population is not attributable to a sudden mass failure of peoples’ self-discipline but rather a reflection of significant changes in living environments [13]. Specifically, the food supply and the infrastructure that affects physical activity are the central determinants of American (and other nations’) obesity today: Pronounced increase in caloric availability and affordability of convenient, enticing, tasty foods and beverages coupled with technological and scientific innovations (e.g., smart phones, tablets, computer games, Netflix) that tend to diminish opportunities for physical activity and its concomitant expenditure of calories. America’s nutrition transition (toward high fat, sugar, and salt) is not only unhealthy, it can be characterized as incredibly diverse and gratifying—fat and sugar are two of the most pleasurable elements of diet in terms of taste preferences [12]. Given the price reductions of unhealthy foods (calorie-rich, nutrition-poor) and the higher prices attached to healthier foods, the poor are particularly disadvantaged with fewer opportunities to “choose” the healthy, more expensive diet [18]. As stated previously, lack of will power is not the primary reason for today’s obesity epidemic; “Big Food” plays a key role in perpetuating and exacerbating obesity and its concomitant co-morbidities of diabetes 2, heart disease, stroke, sleep apnea, specific cancers, and joint dysfunction [19]. It is this author’s contention that dramatic changes must occur in the food supply system if reduction of obesity is to be realized—a conclusion shared by others [10]. Such changes will require a population-based approach whereby the food industry is regulated by local, state, and federal governments providing fiscal interventions. Without question, a “hard approach” that focuses on governmental interventions will be vigorously opposed by the obesogenic processed-food industry that favors the “soft approach” of educational and industry voluntary codes [17]. In short, dramatic actions in producing, marketing, distributing, and selling foods are required to improve the quality and quantity of American life—actions that will force most Americans out of their comfort zone.

**Societal, legislative interventions**

1. Health warning labels on selected foods or beverages high in sugar, calories, fat, salt
2. Ban sale of selected foods and beverages to children under age 16
3. Ban sale of selected foods and beverages at federal, state, municipal locales (schools, museums, historical sites, parks, swimming pools)
4. Ban sale of selected foods and beverages at youth-oriented locales (schools, sport/dance/karate venues, Scouts)
5. Eliminate vending machine sales of selected foods and beverages
6. Ban advertising of selected foods and beverages on TV, radio, billboards, internet
7. Ban display of selected foods and beverages at point-of-sale
8. Restrict companies to “plain packaging” of selected foods and beverages
9. Eliminate drive-in for selected “fast food” restaurants whose menu offerings include items more than 30 percent of selected foods and beverages
10. Provide monetary incentives for persons with healthy BMIs (annual bonus from employers, income tax credits)
11. Provide “Food Addiction Counseling” services in health coverage plans
12. Subsidize producers of healthy foods and beverages
13. Levy “distributor tax” on companies that produce or sell selected foods and beverages
14. Levy “sin tax” on buyer of selected foods and beverages

**Radical measures**

**Regulation Justification**

Most assuredly, the aforementioned governmental interventions will elicit a fusillade of outrage accompanied by acrimonious defenses of multiple U.S. Constitutional Amendments—a
The determinants of health.