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Childhood obesity policies – mighty concerns, meek reactions

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Summary

Background: The increasing number of children defined as overweight or obese is causing concern among politicians and health advocates; several countries have launched policies addressing the issue.

Method: The paper presents an analysis of how the childhood obesity is defined, explained and suggested policies to address the problem from the WHO, the EU, Canada, England and New Zealand.

Results: Considering the dramatic language used when describing childhood obesity, the proposed interventions are modest. Either the politicians do not consider the problem that great after all, or other concerns, such as the freedom of the food and drink industry and local authorities, are seen as more important. The causes identified are multiple and varied, including the physical and commercial environment, whereas the interventions primarily address the information level of the population, placing responsibility on the shoulders of the parents. Only the World Health Organization argues that statutory measures are required, and the English Government suggests one: a levy on sugary drinks. Otherwise, local authorities, schools and the industry are expected to act on a voluntary basis. Very little is explicitly substantiated by evidence, and the evidence cited is sometimes misinterpreted or disregarded.

Conclusion: There is a discrepancy between how the problem of childhood obesity is presented as alarming and the modest measures suggested.

Keywords: Childhood obesity, evidence, policies, responsibility.

Introduction

The increasing number of children defined as overweight or obese is causing concern among politicians and health advocates. The problem is presented with a strong rhetoric. Who states: ‘Childhood obesity is reaching alarming proportions in many countries and poses an urgent and serious challenge’ (1). In Canada, it has been named a ‘national crisis’, and the government states that ‘Canada is in the midst of a childhood obesity epidemic’ (2). The European Union (EU) is less dramatic in talking about ‘a worrying trend’ (3). Some countries, the World Health Organization (WHO) and the EU have issued plans to deal with childhood obesity. The increased political focus on the subject calls for analyses of the ways in which the issue is framed. Through a reading of policy plans from the WHO, the EU, Canada, England and New Zealand, I address questions such as: how is childhood obesity defined? Why is childhood obesity considered a political issue? What causes are identified? What measures are suggested to reduce childhood obesity? Who is considered responsible for acting? Is there an evidence base for the policies?

Research on childhood obesity policies

Several researchers have studied obesity from a policy perspective during the last decade; fewer have studied...
Childhood obesity. Many of the studies on childhood obesity policies are written from an explicit normative or political stance where the authors see it their task to identify measures to reduce the prevalence of obesity (4,5) and to discuss how childhood obesity should be addressed (6). Others criticize the policies presented, namely, the English plan from 2016 (7–10). Some scholars maintain that too much emphasis is placed on information and too little on interventions to reduce exposure and access to food and drinks that can increase obesity. Others mention that the plans are too industry friendly and that they rely almost entirely on voluntary measures at the cost of children’s health and well-being. Simone Fullager describes the interventions as focused on individuals who are ‘urged to exercise freedom via “technologies of the self” organized around the prevention of “risk”’ (11, p. 108). She writes that policies neglect both the social relations people act within and the pleasure people may derive from certain behaviours, such as eating. While some researchers present childhood obesity as a huge problem, labelling it an epidemic (5), others criticize the idea of there being a problem of childhood obesity (12).

Studies have pointed out that the policies build on two different frameworks (13). One framework stresses the personal responsibility: ‘holding that food consumption is an individual matter’, reducing the task of politicians to provide information and improve ‘access to volitional physical activity and healthy diets’. The other focuses on ‘an obesogenic environment’ where food choices are influenced by ‘availability, price and marketing of high-fat, low-nutrient processed foods’. According to this framework, policymakers must intervene in order to regulate the food environment (13).

Theory

Childhood obesity can be understood and framed in different ways. In this paper, I draw on theories about problematization (14) and problem definition (15). These are processes through which a phenomenon is constructed in ways that make it accessible to political action and define how it should be addressed. They imply presenting something as a problem, defining what the problem is, what causes it and how and by whom it shall be solved. The problem definitions, also the scientific ones, are important to consider because ‘the production of scientific knowledge is simultaneously the production of social order—that scientific practices have social effects’ (16), p. 266). The definition of a given phenomenon forms part of a policy process and serves to convince the reader of the appropriateness of the policy suggested as well as serving to demonstrate that the issuing bodies take the problem seriously. Political statements, such as obesity plans, play a decisive role ‘in promoting (or not) public acceptance’ (17), p. 12). To identify the problem definitions, one can analyse ‘the language, arguments and discourse through which policy is constructed and enacted’ (18), p. 40). The solutions suggested could be seen as governing technologies (19), where the aim is to change the behaviours of citizens and institutional actors, such as schools, local communities and the food and drink industry.

The identification of problem definitions and governing technologies in the policies is the analytical purpose of this paper.

Methods and material

The aim of comparing plans from different countries and organizations is to provide material for reflection on childhood policies. It also serves to qualify the description of each policy as the comparison reveals traits that may otherwise have been taken for granted or overlooked. I have chosen to study programmes from three industrialized countries with welfare states and two international organizations. The fact that the programmes stem from relatively similar countries facilitates the identification of nuances.

The plans differ in size and scope. The country plans are published by the respective governments and are shorter and less elaborate than those of the EU and the WHO. The audiences addressed in the country plans are healthcare professionals and others working in the public health field, politicians and civil servants at different levels. The general public is most likely, directly or indirectly, also targeted in order to persuade it to endorse the policy or at least endorse the governments for presenting a policy. The EU and the WHO most likely mainly address the governments, civil servants and public health officials of their member states.

Whereas the country plans express a commitment from the governments and contain few suggestions for specific measures, the international organizations recommend policies to be carried out by governments and other actors and list a number of possible interventions. Interestingly, the plan farthest away from executive power, the one from the WHO, was seemingly the one that was best prepared. It built on a commission report (1) and an evidence report (20). At the 17th World Health Assembly on 22–31 May 2017, the WHO draft implementation plan (21) was ‘welcomed’ (22). In 2015, the British House of Commons Health Committee issued a report (23) suggesting a number of interventions, as did Public Health England; the English Government followed only few of them.

Measures of childhood obesity are arbitrary

Defining what constitutes a problem is a crucial step when it comes to identifying the size and seriousness of the phenomenon. Whereas the cut-off points for overweight and obesity among adults are based on health issues or mortality rates, the cut-off points for childhood overweight and obesity are arbitrarily defined as a centile in relation to a weight
scale (11,24). The English plan, for example, states: ‘Children with a BMI above the 98th centile are considered clinically obese. For population monitoring, those above the 95th centile are classed as obese’ (25), p. 3). The plan does not define overweight, and it is not indicated which growth scale is used. The WHO uses the WHO growth reference and defines obesity in a similar way as 2 or 3 SD above the median (depending on age) and overweight as 2 to 5 SD above the median (26). Nevertheless, the WHO plan also expresses unease about the BMI measure: ‘Although BMI is the simplest means to identify children who are overweight and obese, it does not necessarily identify children with abdominal fat deposits that put them at greater risk of health complications’ (1.), p. 7). However, this does not prevent the WHO from using it, nor does the organization suggest an alternative measure. The EU simply employs the WHO definition, while neither Canada nor New Zealand presents any definition of obesity or overweight.

Using Guthman’s terminology, there might be different ‘social effects’ of definitions in this arena. Firstly, those defined as overweight or obese may become the subject of intervention. This is certainly the case when a population measure, such as BMI, is used in the clinic (6). Secondly, the cut-off points also decide the size of the problem. Thus, the statements about prevalence of childhood obesity rely on apparently arbitrarily set measures. The increase in childhood obesity can, of course, be identified with this measure.

All plans discuss problems of overweight and obesity in conjunction; consequently, they do not distinguish between the two. The plans (except the one from New Zealand (27)) use statistics on the prevalence of childhood overweight and obesity to indicate the size of the problem, without distinguishing between children who are overweight and those who are obese. When overweight is implicitly seen as being just as problematic as obesity, the size of the problem appears much bigger than if obesity alone had been measured (11).

The idea of a direct connection between health and weight, which is assumed with the BMI limits, is expressed in the concept ‘a healthy weight’. Apart from the WHO plan, all the plans mention a healthy weight, indicating that weight in and by itself is a measure of health status (16).

When childhood obesity is defined by an arbitrary measure, one may, as critiques have pointed out, both understate and overstate the problem. If it is overstated, it might also incline us to become less critical about evidence and about respecting important constraints when it comes to interference with lifestyle’ (28), p. 32).

**Childhood obesity is unhealthy, unequal and expensive**

All countries and organizations studied here present similar reasons for dealing with childhood obesity politically, focusing in particular on three different concerns. These concerns concentrate on the effects of obesity on the individual, on specific social groups and on society as a whole. The overriding reason in all the plans is concern about the health consequences for the children, either in childhood or in later life. Childhood obesity sparks a risk of adult obesity, possibly leading to serious health problems. The consequences also include psychological and social issues such as bullying, stigmatization and low self-esteem; these potential consequences are mentioned a few times by the EU and the WHO. The English plan identifies depression and social stigmatization as potential consequences of obesity. However, the physical health risks receive more attention, especially those that may occur in adulthood. The WHO writes ‘(o)besity can affect a child’s immediate health, educational attainment and quality of life. Children with obesity are very likely to remain obese as adults and are at risk of developing serious non-communicable diseases’ (21), p. 3). And more alarming: obesity has the ‘potential to negate many of the health benefits that have contributed to increased life expectancy’ (21), p. 3).

The second concern dealt with in the plans is the way in which obesity prevalence renews social inequalities. The EU states in its plan: ‘Problems related to overweight, obesity and physical inactivity tend to start in childhood, and often disproportionately affect disadvantaged socioeconomic groups’ (3), p. 6). And the English plan: ‘The burden is falling hardest on those children from low-income backgrounds’ (25), p. 3) Similarly, the Canadian plan declares that obesity ‘increases disparities in health status and behaviours’ (2), p. 1).

A third concern focuses on the financial costs to the healthcare sector associated with adulthood obesity and the impact on the general economy stemming from lowered productivity. For example, the English plan states: ‘The economic costs are great. We spend more each year on the treatment of obesity and diabetes than on the police, fire services and judicial system combined’ (25), p. 3). The EU writes that it is ‘estimated that around 7% of national budgets across Europe are spent on diseases linked to obesity each year. Substantial indirect costs are also incurred from lost productivity arising from work absences due to health problems and premature death’ (3), p. 2) The WHO does not mention costs of obesity as an issue.

Thus, according to the plans, there are considerable reasons to act. See also Table 1.

**Poor choices and poor environments**

When it comes to causes of childhood obesity, the plans predominantly point to poor choices and poor environments. Those responsible for acting are individuals who are said to make bad choices; they are mainly parents and pregnant
women, while the children are seen as blameless. It is not as obvious who is responsible for the poor environments.

It is, however, also characteristic that the plans point to a host of factors. In the English plan, it is said: ‘Obesity is a complex problem with many drivers, including our behaviour, environment, genetics and culture’ (23), p. 3. The WHO mentions ‘peer pressure and social norms’ (27), p. 4. And the EU writes that ‘young people in the EU now consume more fast-food and substantial amounts of sugar-sweetened beverages, eat outside the home more frequently and spend less time eating family meals’ (3), p. 3. The Canadian government lists a ‘complex and interacting system of factors … biological, behavioural, social, psychological, technological, environmental, economic and cultural – operating at all levels from the individual to the family to society as a whole … the marketing of foods and beverages high in fat, sugar and/or sodium to children, and increased food availability’ (2), p. 1. Furthermore, it writes: ‘Canada’s response to childhood obesity requires a broad social determinants of health perspective’ (2), p. 4.

In the WHO evidence report, the authors point to reasons why people’s eating habits go against the advice (21), p. 44) instead of merely giving even more advice. The report’s authors write at great length about the importance food’s taste has for people’s eating behaviours; these ideas did not find their way to the WHO policy papers. Among the plans, only those from the EU and NZ mention that taste may influence food choices.

Although the plans differ in the causes mentioned, they are alike in pointing to a number of different factors, factors that may be influenced by several different actors. This could lead one to expect that these factors are also addressed.

Information and voluntary actions

Interventions are suggested both to increase information to customers, the parents, and to change the food and physical environment. Apart from the WHO’s plans, the plans expect retailers, industry and local governments to act voluntarily to prevent childhood obesity.

The most frequently suggested measure in the plans concerns information: education of children and parents; labeling of food products; development of nutrition guidelines and recommendations; and suggestions concerning portion sizes, guidance, support and health and nutrition literacy. The information aims at making parents and children consciously change their behaviour. The idea is that a well-informed parent or caregiver will take responsibility and change his or her practices. In other words, parents and caregivers are supposed to learn how to govern themselves and the children.

The healthcare sector receives a role when it comes to informing and guiding individual citizens. The WHO, the EU and Canada suggest interventions towards pregnant women to prevent their offspring becoming overweight. Another measure, which all programmes suggest, is that children should be measured to provide early detection of those who are overweight or obese. This should be done for monitoring purposes to follow the development on a population level. However, several plans also suggest early measuring as a means of detection and intervention regarding individual children who are already obese or are at risk of becoming obese. The EU suggests ‘treatment programmes for prevention and therapy of overweight and obese children’ (3), p. 28). New Zealand proposes targeted initiatives, where children diagnosed with obesity at pre-school checks will be offered a referral to a health professional for clinical assessment and family-based nutrition, activity and lifestyle interventions. Thus, all children with obesity shall be approached even though one does not know whether they will continue being obese in their adulthood.

The EU addresses the risk of stigma in relation to interventions: ‘It is important that the health promoting work in schools not only focuses on overweight and that overweight children are not stigmatized. Promoting healthy eating and physical activity should be stimulated regardless of body size and appearance’. And by the WHO: ‘issues of stigmatization and bullying need to be given special attention’ (21), p. 18). None of the individual country plans addresses the issue of stigma in relation to interventions.

As mentioned, the WHO tends to intervene in the industry, and states that one must ‘ensure that conflicts of interest, such as those that can arise when the food and beverage industry is involved in such programmes, do not undermine progress’ (21), p. 17). The WHO suggests ‘legislation or regulation, to restrict marketing of foods and non-alcoholic beverages to children’ (21), p. 11) and expresses the belief that ‘voluntary actions or self-regulation commonly have limited value’ and that they can also ‘impede progress if they are used to defer effective regulation’ (21), p. 11). However, among the interventions listed
by the WHO, only few are about interventions towards industry or about legislation and regulation. The WHO cannot mandate any country to follow its suggestions.

The other plans reject statutory measures, limiting themselves to encouraging industry and retailers to contribute to the efforts to reducing childhood obesity. The EU suggests ‘the food industry ... [takes] voluntary initiatives to restrict the marketing of less healthy food options to children’ (3), p. 15). These stakeholders shall, according to the plans, be encouraged or challenged to change behaviours when it comes to marketing, product formulas, urban planning, school surroundings, including access to clean water and healthy foods. Interventions that may limit the freedom of retailers and industry or even mandate authorities to provide an environment that may prevent obesity are practically non-existent. The EU ‘encourages the creation of environments in which health and well-being are promoted and healthy options become the easy option’ (3), p. 10). The English plan mentions respecting ‘economic realities’ (25), p. 3). However, as the only country, England, does suggest one statutory measure, namely, a levy on sugar-sweetened beverages.

Notably, the interventions suggested deal with only some of the causes of childhood obesity identified by the plans. See Table 2. The EU and the WHO suggest many more measures than do the individual countries. They are freer to make suggestions because they are not committed to implementing the proposals. The suggestion of national plans brings with it the expectation that the politicians are prepared to commit themselves to carrying them out.

The evidence base

Whereas few of the country plans cite references to evidence supporting the proposed measures, this is not the case for the WHO and the EU. Nevertheless, to what extent does the evidence back up the suggested measures? There is a discrepancy between the suggestions presented in the WHO plan and the statements in the organization’s evidence report. According to the WHO’s own evidence report, several of the suggested measures are poorly supported by evidence. For example, for enhancing the citizens’ knowledge, the WHO evidence report states: ‘(a) number of studies (...) suggest that increasing nutrition knowledge alone may be ineffective in improving dietary behaviour’ (20), p. 65). Moreover, it states: ‘To date, the effectiveness of food labeling to support and promote healthier dietary behaviours is not clearly established’ (20), p. 66).

The EU plan sometimes shows a relatively relaxed attitude to the documentation. It states: ‘There is increasing evidence to show that preventive interventions targeting children and young people pay off with a return of investment of 6–10% expected from interventions implemented in early life’ (3), p. 5). The so-called increasing evidence stems from the 1960s from one intervention with early education targeting disadvantaged children in the US. No health data were included in the follow-up of this study. The other references rely solely on this study and add no new evidence (29).

Breastfeeding is mentioned as a means of reducing the risk of obesity in the offspring despite a lack of evidence, at least according to the WHO evidence report: ‘Despite this widely held hypothesis, research, albeit limited, suggests that bottle-feeding does not uniformly place infants at risk of overfeeding and excess weight gain’ (20), p. 53). The EU states that: ‘Research also shows that children who are breastfed appear to have reduced risk of obesity later in life’ (3), p. 11). In the cited report about the benefits of breastfeeding, the only mention of breast was in relation to breastfeeding, the only mention of breast was in relation to breast cancer (30). In the EU plan, it is also stated that: ‘A mother’s pre-conception weight and her weight gain during pregnancy are two of the most important pre-natal determinants of childhood obesity’ (3), p. 11). Again, with a reference to the same report that mentions nothing about it (30).

The apparent lack of evidence for the effectiveness of several of the suggested interventions could be seen as an ethical problem. Bothering children and others with interventions not proven beneficial to their health and well-being cannot be justified ethically. Moreover, the possible benefits of an intervention should be evaluated in relation to possible harms, including stigmatization. The most well-documented intervention according to WHO reports,
Discussion

Much ado about nothing? The policies are launched with a rhetoric emphasizing the seriousness of the problem, while the interventions suggested are minimal. The causes identified are many; the causes addressed are few.

Childhood obesity is obviously a phenomenon causing concern among politicians and public health officials. However, considering the language used when describing the problem, the interventions suggested are relatively modest. Either the politicians do not consider the problem that great after all, or other concerns, such as the freedom of the food and drink industry and local authorities, are seen as more important.

The causes identified are multiple and varied, including the physical and commercial environment, whereas the interventions primarily address the information level of the population and place the responsibility on the shoulders of the parents. More knowledge is expected to make people change behaviours. Local authorities, schools and the industry are expected to act on a voluntary basis. Only the WHO and the EU suggest several statutory measures, and the English Government suggests one: a levy on sugary drinks.

Perhaps the greatest problem is the apparent lack of documentation of the effects of the suggested interventions. As mentioned, it is an ethical problem in relation to the interventions’ recipients, who may be bothered in vain. It is also unethical from a resource perspective inasmuch as funding might be used on ineffective interventions at the expense of other, more beneficial moves.

Conflict of interest statement

No conflict of interest was declared.

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