

## Chapter 2

# Ethics and Public Policy

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### Introduction

Ethical reflections help us decide what are the best actions to pursue in difficult and controversial situations. Reflections on public policy consider how to alter patterns of individual activity and institutional policies or frameworks for the better. The rising prevalence of childhood and adolescent obesity may pose serious health issues. As such, it is related to ethical and public policy questions including responsibility for health, food production and consumption, patterns of physical activity, the role of the state, and the rights and duties of parenthood.

The problem of rising prevalence of obesity is mainly an issue in the Western world. Many developing countries going through rapid economic growth now face or might soon face similar problems. However, in this chapter we will offer only a Western perspective on the current problem of rising childhood and adolescent obesity, drawing many of our examples from the British context.

### What are Childhood and Adolescence?

Every society constantly receives an influx of strangers into its midst – children. The concept of childhood has been long discussed by ethicists and philosophers. However, only recently has the philosophy of childhood been recognized as a specific area of philosophy concerned with what childhood is, what are children's rights and interests, societies' attitudes toward children, and the role of children in society (Matthews 2005). While philosophers don't often agree on how to best describe childhood and what is the role of children in society, they do agree that children have limited responsibility for their actions and that adults owe them a strong duty of care. Together with cognitive development and increasing experience, a child's moral development is a gradual progress towards adulthood. This means that crucial decisions in children's interests have to be made by parents, responsible guardians, schools, other public institutions and state bodies until the individual reaches a level of moral development, or attains an age that his/her society accepts as indicating adulthood. This may be general, or situation-specific.

How should we decide the ages when a child becomes an adolescent and an adolescent an adult? Both transitions relate to social and legal norms that have altered considerably in the recent history of Western societies. Since childhood, adolescence and adulthood represent a gradual and continuous

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personal and social development, it is impossible to exactly mark the age of transition into a fully responsible member of a society. Moreover, this development clearly varies considerably between individuals. David Archard writes: “Adulthood is to be thought of as a state of mind rather than a question of age” (Archard 1995, p. 6). However, adulthood is also a status, involving increased rights and responsibilities. As such, it depends on others recognizing a person as an adult. The law necessarily draws some clear lines marking such a status, for instance, ages for criminal and civil responsibility. At the same time, parents and institutions that deal with children are under a clear duty to recognize – and foster – the child’s increasing independence and responsibility for self and others as it enters adolescence and adulthood.

Just as the concept of childhood varies culturally, so do the rights accorded to parents. This can be seen in the thought of Aristotle, the Greek philosopher from the fourth century B.C. He claimed that what happens inside families are private matters that are regulated by the head of the family, and not regulated by laws as are public relations between citizens: “What is just for a master and for a father are not the same as [political justice], though they are similar. For there is no unqualified injustice in relation to what is one’s own, and a man’s property, as well as his child until it reaches a certain age, are, as it were, a part of him; and no one rationally chooses to harm himself, which is why there is no injustice in relation to oneself. So nothing politically just or unjust is possible here” (Aristotle 2000, p. 1134b). Aristotle’s idea is that a father’s children are, just like slaves, “part of him,” and as no one chooses to hurt himself, there can be no injustice done to children by parents. This is similar to the concept of childhood that appeared in Roman law where parents had absolute power over their children (Archard 1995, p. 9). There is no doubt that the idea that children fully “belong” to their father was long accepted and practiced in European history. However, in recent centuries, we have moved far from the idea of parent’s absolute power over the child. Cases of domestic abuse especially have changed public attitudes, and societies – in particular state-sponsored institutions – intervene far more in the name of children’s interests. Nowadays, while parents or legal guardians have direct responsibility for their children, it is essentially the state that has the last word in protecting child’s interests. This doctrine involves an immense extension of state power into what Aristotle saw as the “private sphere” – although, at the societal level, it may also be related to adults taking a lower degree of responsibility for children who are not their own (Furedi 2001).

## Obesity and Individual Choice

Without entering into the debate as to whether it is a disease or not, obesity is defined by the World Health Organization as a body mass index (BMI) over 30. It is widely held that obesity carries significant health risks to individuals; it therefore has implications for national health systems, and as such imposes costs on others. It is more controversial – and in any case a distinct claim – to maintain that increased body weight below this high threshold also poses health risks. (The frequently used term “overweight” seems to assume that it does; we will generally avoid this term because this assumption is dubious. Further, although it might be argued that overweight is a stage “on the way” to obesity, most “overweight” children and adults never become obese.) The majority of authors accept that it is in each individual’s best interest not to be obese, and that having non-obese citizens is also a good for the whole society. Questions for ethics and public policy arise when we ask what these interests imply for people’s individual responsibilities and the responsibilities of a whole series of institutions – from schools to companies to local councils to state bodies.

Many of the questions that arise around obesity in adults can be set aside when we consider the situation of children. For instance, some argue that adults who engage in unhealthy behaviors impose costs upon other members of society, and that it is unfair to allow people to impose this responsibility on others. (A parallel argument could be offered that parents who “allow” their children to become

obese should be judged responsible for imposing costs on society. We consider arguments concerning the responsibilities of parents in the next section.) Whether or not people who become obese should be considered responsible or as imposing costs on others, it is clear that children should not be. An opposing argument – usually based on a liberal notion of autonomy – contends that neither state nor society have a right to impose “paternalistic” policies on adults. For example, governmental policies advising us to eat “five [fruit and vegetables] a day” are often derided as the voice of a “nanny state.” Paternalism, however, is precisely the course of action that parents, or those helping to fulfill duties of care to children, ought to adopt. Children need nannies, so to speak – although they also need to be equipped with the education and skills that will enable them to act independently, and to be granted an increasing freedom (especially in adolescence) so that they can meaningfully practise those skills.

However, it is worth observing some important difficulties in the common line of thought that adults make their own choices – whether it is held that they are responsible for those choices, or ought to be allowed to make those choices free of state interference. These difficulties have important implications for how we think about children’s upbringing and parental duties.

In the first place, the choices we make depend very much on the range of opportunities open to us and the costs of those choices, not to mention a whole range of social pressures, many magnified through the mass media or by the advertising of commercial bodies. All sorts of organizations are continually acting to alter and structure the opportunities open to us. Market forces promise to promote choice but also channel and stimulate it in particular ways. State and other bodies continually influence our field of opportunities – sometimes in obvious ways, but sometimes in important ways that we may not notice.

In other words, although most authors reject the use of state coercion against, for example, adults who are acting to damage their own health, there are many social, economic and state activities that affect the opportunities available to people and the choices that they make. While some of these measures make unhealthy behaviors more costly or less attractive, others may create pressures toward unhealthy behaviors. Simple examples of the first sort would be the taxation of tobacco and the ban on smoking in public areas. But it is easy to cite examples where collective actions undermine healthier choices. For instance, European Union subsidies of meat, animal fats, grains and sugar contribute toward an “obesogenic” environment – one that makes energy-dense and processed foods cheaper as compared to, say, fresh fruits and vegetables. Or again: many media representations simplistically equate health and thinness, as well as promoting unrealistic and unhealthy ideals of body shape. They therefore play a role in encouraging widespread, harmful “yo-yo” dieting, as well as more extreme eating disorders.

Moreover, people’s ability to navigate such opportunities, constraints, and pressures in their own interests is related to their socio-economic status (SES, in which we may include social advantages or disadvantages linked to race and ethnicity). Complex and contested as the connections involved are, it is clear that both subjective factors (such as education or locus of control) and objective factors (actual opportunities and costs) will tend to vary with SES. More simply, “choice” is generally more real and meaningful for higher social classes. One implication of this is that discourses emphasizing individual responsibility may have invidious effects from the point of view of social justice.

While many adults have only a partial awareness of the complex forces that structure and constrain their choices, young children have none, while adolescents obviously vary greatly in this regard. Likewise, children have very restricted choices. This suggests two different routes for interventions at a public policy level. On the one hand, we might try to limit the sorts of opportunities and choices that we extend to children, or the sorts of pressures we expose them to. (For instance, we might try to limit the power of companies to promote their products to children.) But as they grow up, those children will eventually be expected to make their own choices in a very complex environment. This suggests a second priority. We need to foster children’s abilities to handle the freedom of choice they will eventually be granted – which means that we must also equip them with

some ability to recognize the ways in which others may be affecting their choices, or making choices on their behalf. In this regard, it may even be counter-productive to shelter children from the sorts of choices, risks and pressures that they will later encounter. As most parents find out, at some point our natural desire to protect children actually becomes risky for them. For example keeping children in a “safe” home environment where they spend much of their leisure time watching television and playing video games increases their risk of becoming obese (Hancox and Poulton 2006). Letting children play outside or cycle on the road involves risks, to be sure. One might argue, however, that the long-term risks of bringing up “cotton-wool kids” are far greater. In general, allowing children to be active in their own right, and to socialize with their peers, is essential to their development into adults capable of dealing with a wider world. To some extent, this point must also extend to their food choices.

Finally, there is an obvious difficulty with the common liberal idea that adults may do as they please, as long as they do not harm others (and so long as they respect the contractual undertakings they have made – for instance, in employment). Adults who become parents have responsibilities to care for children. Although the points at which state intervention may be legitimate are difficult to judge, no one any longer holds – as Aristotle seemed to claim – that it is enough for parents to avoid harming their children. Many authors and some laws pronounce that parents are obliged to act in a child’s “best interests” – a very demanding standard. Certainly, parents must show active care and concern for their children, as must some institutions, schools and health services for instance. States, as noted already, are charged with ensuring that parents do this, and with taking that responsibility over where parents fail.

## Parental Responsibility

The previous section has suggested that many organizations, including the state, are constantly influencing the choices we make and altering the opportunities that are open to us. We may desire to protect children from the responsibilities of individual choice and the pressures to unhealthy behaviors of our “obesogenic” environment. However, we have pointed out that protecting children may come at a price, insofar as children also need to learn how they can handle the choices, pressures and responsibilities that they will soon be exposed to.

In the first instance, children learn from their parents what are acceptable and desirable behaviors. It is in the family that children pick up elementary dietary and lifestyle habits and receive the first guidance that influences their health, fitness and wellbeing. Parents (or legal guardians) decide what a child eats, drinks, what sorts of activity are open to them, and what environment they live in. Parental influence plays a strong role in children’s future health from the day a child is born. For example, research on breastfeeding suggests that it has not only positive effects on child’s health but also on reducing the risk of childhood obesity (Armstrong et al. 2002).

Indeed, parents affect the health of their children even before they are born. The effect that a pregnant mother’s alcoholism and drug addiction has on health of the fetus has been long recognized. Latest research results suggest that the food mothers eat during pregnancy may be important; research conducted on animals has showed that BMI of their young increases significantly after the mothers were fed on junk food during pregnancy and lactation (Bayol et al. 2007). Mothers’ dietary and lifestyle habits during pregnancy may even affect future food and taste choices of their children. In one study a group of pregnant mothers was given carrot juice to drink during pregnancy. As a result, their children later showed less distasteful faces when they first tasted carrots compared to children whose mothers didn’t drink carrot juice during pregnancy (Mennella et al. 2001).

However, the responsibility of parents for their children becoming overweight or obese is often overestimated (Food Ethics Council 2005, pp. 21–29). Much media coverage and a good deal of

political discussion assume that the parents of obese children and adolescents should shoulder most of the responsibility – or blame – for the weight of their children. We see this in extreme form in many television “reality shows.” Obese children and their parents receive not only public, and often insensitive, criticisms of their lifestyle habits, but are also inducted into radical lifestyle changes by supposed “experts.” We now consider four reasons why parents should not be expected to shoulder such a heavy responsibility.

1. Firstly, parents may not be responsible for their child’s obesity as they often don’t know what to do. Today’s parents may not have received much dietary education in school (if any at all) – nor, perhaps, much guidance from their parents in planning and preparing meals. Even if parents are resolved to make the best health choices for their children, they may be discouraged by the fact that it is difficult to find clear and helpful advice.

Parents get conflicting messages on what is best for children from their GPs, available literature, media, scientists and government. This is often because scientific results with regard to nutrition and obesity are uncertain, and the way this research is reported in the media and translated into medical advice is confusing or contradictory. (We should not forget that there are many commercial interests that sponsor and influence research in nutrition and related areas.) For example, a woman seeking advice on whether it is harmful to have an occasional glass of wine during pregnancy might end up utterly confused. If she looked at the scientific evidence, she would realize that there is no clear evidence whether a small amount of alcohol (1–2 units once or twice a week) causes any harm to the fetus. As a result, in some countries one or two glasses of wine or beer a week during pregnancy is allowed or even recommended, while in other countries mothers-to-be are strictly discouraged from any alcohol whatsoever. In Britain a small amount of alcohol wasn’t regarded as harmful until the British Medical Association recently changed their recommendations to zero tolerance. The reason the recommendations changed wasn’t due to new research; rather, the judgment that it is better to recommend zero tolerance as it is – somewhat patronizingly – deemed difficult for women to tell how many units they are consuming (British Medical Association 2008).

Of course, there are some clear, simple and useful messages such as the benefits of eating more fruit and vegetables, currently promoted by the “five-a-day” campaign. Although regarded as an overall success across Europe, even this campaign has been criticized. A recent survey showed that while most adults are aware of the “five-a-day” message, most of them eat only two or three portions daily. Moreover, there is a wide-spread confusion about what counts as a portion, with 25% believing that a glass of squash counts and 3% that potato chips (fries) count too. Also, some 60% of people believed five pieces of fruit alone ticked the “five-a-day” box, while there should be a mix of portions (Hickman 2008).

These confusions point to a broad issue with any general formula such as improving diet, increasing physical activity, or decreasing the amount of time children watch TV. While easy to understand in the abstract, they are not always easy to translate into action in particular circumstances. One reason is that in many cases individual factors may be at work and might affect possible courses of action. The primary causes of a child’s becoming obese may not be dietary and lifestyle habits themselves. For example, a child being bullied at school or abused at home might find overeating as a solution (comfort food) or even a way of calling for help (attention seeking). Trying to change the child’s diet or exercise regime might work in the short term, but will not address the root problem.

2. This leads us to a second difficulty with the argument that parents bear primary responsibility for their child’s obesity, which is that so many other social factors make it difficult to put advice about healthy living into practice. The “obesogenic” society can be described as an environment where there is an abundance of cheap and easily accessible high-calorie food, cars are used even for small distances instead of walking and cycling, and sedentary activities predominate over

manual labor and physical exercise. For children, opportunities for play and activity depend especially heavily upon the environment and social structures. Similarly, many organizations – especially companies selling confectionary, other processed foods, fast food and games – seek to influence children’s choices and opportunities.

3. Although all parents act in an environment that can make it difficult to institute healthier behaviors and eating in their children’s lives, these factors do not impact equally on all families. A third factor that undermines parental responsibility concerns the effects of low socio-economic status (SES). Most studies show that low SES is related to higher prevalence of obesity in both children and adults. For example a study done across the US, Canada and Norway on 6–10 year olds proved that children from poor families are more likely to be obese (Phipps et al. 2006). While it remains controversial just what causal factors underlie such associations, it is surely true that parents from lower SES groups have relatively less power to alter their lifestyles and those of their children. That is, after all, part of what it means to be socially disadvantaged. And it would surely be wrong to blame parents for being poor!

It should be added that correlations between low SES and exposure to factors conducive to obesity are no simple matter. For example, one study of levels of overweight and obesity in various socio-economically deprived areas of the city of Liverpool asked why it is that some areas have higher levels of childhood obesity, while other even more impoverished areas (among the most deprived areas of England) have almost the lowest prevalence of childhood obesity in Liverpool. In looking at the differences between these areas, what became apparent was that the areas with high prevalence of overweight and obesity are heavily built on with Victorian terraces, narrow streets and parks too dangerous to play in. On the other hand, the other areas are estates built in the 1970s with wide streets, many green areas around houses and plenty of other grass areas to play on. The team concluded that rather than socio-economic status as such, the prevalence of obesity depends on whether the built environment that children live in encourages or discourages physical activity (Dummer et al. 2005; see also Public Health Information for Scotland 2008, for some further complexities in the relation between SES and obesity rates). Naturally, however, it will often be the case that lower SES families live in environments that are less conducive to safe outdoor activities than wealthier families.

4. A last and major reason why parents cannot be expected to bear sole responsibility for their child’s diet and health is that every child’s development is also in the hands of public institutions (such as kindergartens and schools) as well as the state. Although there is no doubt that parents are in charge of everyday active care for their children, then, their efforts need to be supported by state and other institutions – and are sometimes undermined by those bodies. So it is also necessary to discuss the role that public policy measures may play with regard to the prevalence of childhood obesity. We turn, first, to the possibility of intervening via schools and kindergartens.

## Interventions Through Schools and Kindergartens

The range of possible anti-obesity interventions is very broad, from small initiatives on local levels (such as a community’s joint effort to build a new playground) to large-scale interventions and policy changes at national and international level. In this section we focus on interventions aimed at tackling childhood obesity happening in or through schools and kindergartens, with or without the involvement of parents. The next section will consider some proposals for changes at the public policy level.

Interventions in schools and kindergartens can be very influential as that is where children spend much of their time and receive much of their education. Introducing lessons on dietary



education as well as cooking classes have been one of the main initiatives in recent years. Schools can tackle childhood obesity by offering healthy lunches, snack options and low-sugar drinks. There has also been a call to increase weekly hours of physical education, to improve sports facilities and playgrounds. The role, amount and quality of physical education have been under threat in many countries (Marshall and Hardman 2000). School based interventions may also be attractive because they have the potential to be specifically targeted at areas of relative economic deprivation.

There are other intervention programs that contact children through schools but go beyond school settings. For example, the MEND program that started in Britain in 2002 offers free after-school courses that include teaching children how to play physically active games or showing them how to eat healthily by offering cooking lessons, food tasting and visits to supermarkets. MEND can be regarded as a success so far as it started as a small-scale trial; after continuous evaluation it currently operates in over 230 locations in Britain and is even expanding to other countries (MEND 2008).

Without denying the importance and advantages of school- and kindergarten-based interventions, however, we should note some significant problems and limitations that they face.

Firstly, many interventions don't get evaluated. We will only know what interventions are truly effective by checking their effects. This evaluation cannot be done on short-term basis, but needs to be monitored for many years since a truly effective intervention is meant to have long-lasting impacts. Therefore it is useful to have intervention studies such as IDEFICS that include school- and kindergarten-based interventions that will be evaluated over 2 years with an option for future follow-up (IDEFICS 2008). One might argue, of course, that even 2 years is rather short: we are hoping, after all, that the interventions will have lasting effect on *adult* health.

A related difficulty is that most interventions include many different actions and are done on many levels, so it is difficult later to identify which parts worked and which didn't. For example an evaluation of a school-based intervention including lunch meals, regular dietary lessons and increased physical activities can hardly identify which parts of the intervention had positive, negative or no effect on the health and weight of children. It cannot be doubted that there are very good reasons for intervening in this way, since a multiplicity of factors are undoubtedly at work here, but there is a price in terms of evaluation. Although it is possible to compare an intervention region with a control region, and hence to gain some sense as to whether an intervention program has significant effects, there are many difficulties in assessing which aspects of the intervention were most important, or whether any aspects were, perhaps, counter-productive.

A third difficulty with childhood-obesity interventions done in school or kindergarten settings is that it might be too late as some children enter these institutions already overweight or obese. Furthermore, by the time children enter a kindergarten or school, they have tasted thousands of foods and have very clear taste preferences as well as other habits (such as how much or when they eat, or how much they like to exercise). It is very difficult to change such behaviors without the involvement of their families.

This relates to a fourth problem. Many school- and kindergarten interventions are done without the involvement of parents and families. Even the best school taking the most comprehensive anti-obesity measures has a limited impact on what children do and eat outside of school hours, when children may well not do, or be unable to do, what their teachers tell them. Children spend most of their time outside of school, where they follow eating and lifestyle habits of parents (the more so, the more parents supervise their children's activity, perhaps fearing that it would be irresponsible to allow their children to play independently). So a truly effective intervention has to have impact on both children and their families. For example the MEND Program agrees to enroll only children who come with at least one parent. That way parents learn together with their children, and the courses have a chance to have long-lasting effects on the whole family's lifestyle. It should be added, however, that a well-known problem in addressing lower socio-economic status groups is

the greater difficulty of involving parents. While the MEND policy is well-founded from the point of view of effectiveness for individual children, it may have an unwanted effect in terms of reaching children from lower SES backgrounds.

A final problem that we need to be aware of is that most interventions aren't aimed at individual children, but are implemented on whole groups. As a result, children who are of a perfectly healthy weight – or even underweight – may come to think of themselves as “overweight.” Teenage girls especially have a tendency to overestimate their body weight, and this is also a group where acutely dangerous eating disorders such as bulimia and anorexia are real problems. On the other hand, many obese children, or children who may be deemed “overweight” by those conducting the intervention, think that they have a reasonable body weight. Weighing and measuring children and informing them and their parents that they are obese – or “overweight” – is therefore a sensitive activity. For example, schools in several U.S. states have sent parents report cards on their child's risk of becoming obese. While some parents thought the report card a great idea, many complained “the notices are stigmatizing and damaging to a child's self-esteem” (Wadas-Willingham 2008). For this and other reasons, we would strongly argue that interventions should be focused on promoting healthy lifestyles rather than weight loss per se. Nonetheless, there remains a clear danger that children and parents will still perceive thinness itself as a healthy goal, and treat it as a measure of their individual or family success.

## Possible Public Policy Measures

Policy changes on national and international level aim to affect whole groups of citizens. One problem with large-scale interventions is that they require significant political will, over an extended period of time. As a result, they are very difficult to administer, never mind to guarantee success. Apart from the difficulties of pursuing any policy or political reform, the biggest challenge is to decide which policies will bring the most benefit and involve a proper division of responsibilities between state, organizations and families. While we know that the prevalence of obesity is rising in the developed world, we don't know exactly what factors are causing and affecting it. The idea that changes in BMI correspond to imbalances between energy intake and energy expenditure may be strictly correct (for a person who is not growing), but it is not very informative, practically speaking.\* That is, it points to no obvious policy changes needed to halt the trend towards increasing obesity in our societies. In this section we briefly review three possible policy measures. The first is higher taxation of foods contributing to obesity, or the subsidy of healthier options such as fruit and vegetables. The second one is the proposal to ban or restrict advertising of “unhealthy” foods on one hand, and/or to promote healthier eating by advertising on the other. A third possible intervention concerns changes in transport infrastructures. These three types of interventions are amongst the most prominent measures suggested in the policy literature (Millstone et al. 2006).

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\*There is much scope for simplification on both sides of this equation. On the one hand, food eaten does not simply correspond to energy uptake by the body. (For example, the calorie value of foodstuffs corresponds to the energy uptake expected in a normal digestive tract. But this will clearly differ between individuals and in the same individual over time.) On the other, energy expenditure is not directly proportionate to the amount of “exercise” that a person undertakes. Even an intervention that is simply aimed at reducing BMI – as we argue above, not a goal that we think is helpful for policy purposes – might therefore intervene at numerous points that have no obvious relation to calorie intake or amount of physical activity. For some indication of the range of such factors, including the impact of ambient temperature control, pollution, smoking, medications and amount of sleep, see Keith et al. (2006).



One intervention that has often been aired to tackle obesity is the idea of altering food prices in line with their supposed effects on health or body weight. This might include higher taxation of high-fat, high-sugar and high-salt food products, or the subsidy of healthy foods such as fruit and vegetables, or both (Garson and Engelhard 2007). Some people argue that prices of food should be higher in general as people are overeating as a result of cheap food (Pollan 2008, p. 187). (A complementary suggestion might be that people are eating too much of the wrong sorts of food – meats from animals fed and reared in damaging ways, for instance.) In Britain the proportion of family income that is spent on buying food has been dropping for the last half of century. Statistics show that both in Britain as well as in the US the percentage of the average family budget spent on food and non-alcoholic drinks has decreased by approximately half in last 50 years (National Statistics 2008). This trend may be slightly changing with recent worldwide rises in food prices (Department of Agriculture and Economic Research Service 2008). In general, however, it can be said that the percentage of average income spent on food decreases with a country's economic development. This can be clearly seen in Europe, where the average citizen of the European Union spent 17.4% of their income on food in 2004, while people spent almost half of their income on food in the EU accession countries (FAO 2004).

Most commentators, however, oppose such direct state interventions. One objection is that any such system would inevitably create somewhat arbitrary food groups; another that it would be difficult to implement. The EU-funded PorGrow project interviewed stakeholders on their opinions of anti-obesity interventions, and found many doubts over strategies based on taxation of certain types of food. Overall, stakeholders representing food industry, non-governmental public sector as well as policy makers rated the idea of taxing of high-fat and high-sugar foods very negatively. One of many concerns raised was that the taxation option would impact most on lower socio-economic groups (Millstone et al. 2006, pp. 120–123). It might be argued that this should not be of concern, since a similar effect arises with regard to the high taxation of tobacco, which affects lower socio-economic groups most since they smoke more than other groups. On the other hand, many have contended that healthier foods are less easily available in poorer neighborhoods; if true, that should surely count against the justice of such a policy (unless, perhaps, it were accompanied by additional interventions with regard to food availability).

In addition, we should not ignore the fact that governments already intervene extensively in the price of food. In the European Union this is principally via the Common Agricultural Policy. This policy may have made sense in a time of food shortages. Now, however, it is perverse in terms of food and health, as well as damaging to food production in developing countries (Oxfam 2002a, b, 2004a, b). The EU system of subsidizing and supporting agriculture artificially lowers the prices of foods (especially those high in sugar or fat, including meat and dairy products) and rewards large-scale industrial agriculture (often to the detriment of the (micro-)nutritional value of the resulting foodstuffs) (Pollan 2008, p. 108). From the point of view of obesity – or of healthy eating in general – there is little doubt that this policy is counter-productive (Schafer Elinder 2005).

A second example of a possible policy intervention is the proposal to ban or restrict advertising of “unhealthy” foods or to advertise healthier eating, or both. Some of these interventions are already taking place. For example, the United Kingdom has a ban on advertising “junk” foods before, during and after educational TV programs aimed at children. There is also a call to restrict advertising of high-fat and high-sugar food in all media in the same way as tobacco and alcohol advertising. In the last few years the British government has been regularly warning the food industry as well as the media that if they don't start acting “responsibly,” strict restrictions on food advertising will be introduced (BBC 2006). On the face of it, this seems like an eminently sensible policy measure, and there is certainly something deeply unattractive about large companies exercising finely-honed marketing skills on young children to the likely detriment of their health. Despite the gut-appeal of such a policy, however, it may still leave important questions unaddressed.

In the first place, there are some doubts as to whether restricted advertising would have a significant effect, given how pervasive is children's exposure to the full panoply of marketing techniques –

from supermarkets through bill-boards to the internet and disguised advertising in the form of “product placement” in many films and television shows. Whatever restrictions are imposed, children are bound to see or watch thousands of adverts and brand messages. Moreover, they often watch a great deal of adult television, or will soon do so. Second, observe that there is an important connection to socio-economic status here. It might, indeed, be argued that restrictions on advertising might benefit lower SES children more, because they are more susceptible to advertising messages (cf. respondent quoted in Millstone et al. 2006, p. 107). It seems to be true that subjective abilities to deal with consumer choices tend to vary with SES, and are to some extent independent from the restrictions on choice imposed by lower income. To the extent that advertising restrictions were effective, then, they might “protect” children in the short-term. However, those children will still be exposed to some advertising and will soon be adolescents who must develop sophisticated consumer skills to navigate the full gamut of marketing techniques. One may argue, therefore, that we should be more concerned with developing children’s ability to respond to advertising intelligently, than with the (probably vain) attempt to prevent their being exposed to it.

In this context it is also worth emphasizing how much is involved in educating future consumers. Children need to learn how to enter the market place and make choices that relate to their own interests, as opposed to the interests of those who are selling. They need to learn how to see past all manner of largely irrelevant or misleading factors, such as branding, advertising, one-sided health claims, not to mention the latest dietary fads and health-related panics being aired in the media. This sort of education is not only a matter of providing people with information. The skills involved are primarily practical, and are developed through actual experience of navigating consumer and lifestyle choices. This is not, of course, a reason to reject information-based measures, such as education about healthier lifestyles or better nutrition labeling of food. Nonetheless, the importance of these practical consumer skills does suggest a critical channel that interventions – not least school-based interventions – might also seek to address.

A third possible intervention concerns transport systems and infrastructure, given our societies’ over-reliance on the private car. (This is also a major issue for developing countries, as many are rapidly moving to car-based economies). There is no doubt that many measures to improve transport infrastructures and public transport, or to alter urban planning, would be very expensive and would take a lot of time (Millstone et al. 2006). However, states have easier and cheaper options such as building safe footpaths and cycle-paths to promote walking and cycling to school. That could reduce how often children are driven to school, and regular exercise before and after school would obviously increase the amount of time children are physically active. There are currently many new initiatives of local councils, governments and independent groups to promote healthy walking and cycling to school as a way of tackling childhood obesity (Surrey County Council 2008; Walk to School Campaign 2008).

However, many parents are reluctant to allow children to go far from the house due to perceived dangers from road traffic. According to a survey conducted by the government-backed “Cycling England” initiative, although the number of children involved in cycling accidents has been dropping in recent years, eight out of ten parents don’t allow their children to cycle to school for safety reasons. While most parents admit they used their bike as regular transport when they were school age, most of them ban their children from enjoying the same freedoms (Taylor 2008).. But as a separate survey for sustainable transport charity “Sustrans” found, nearly half of all pupils answered that they want to cycle to school, yet only 2% of British schoolchildren actually do (BBC 2008).

Street crime and violence – or rather, the fear of these – may also play a role in parents’ decisions whether to allow their children to walk and cycle to school, or to play independently. Although the statistics remain more or less static, perceptions of risk and danger seem to have increased considerably, which may have something to do with increasing media coverage of (for example) pedophilia or the place of crime on politicians’ agendas (Gill 2007). They also relate to parents’ increasing tendency not to expect other adults to take responsibility for their children (Furedi 2001).

Such concerns affect how many children are allowed to play outside, if they are allowed to use a bicycle, and account for the increasing tendency to drive children to school.

There are many stereotypes about children and childhood that are related to the current preoccupation with safety concerns. For example, media representations in the UK often see-saw between picturing children as either powerless victims or dangerous and potentially criminal. This schizophrenic attitude reflects a more realistic concern that our societies are overly protective of (most) children, and as a result are not bringing up a generation of responsible and independent adults. As discussed above with regard to children's walking and biking to school, many are concerned about the effect these overprotective attitudes have on children. Terms such as "cotton-wool kids," "cul-de-sac generation" and (on the other hand) "free-range" children have recently appeared in the media. American journalist Lenore Skenazy published an article about her 9-year old son traveling on his own on public transport across New York. She subsequently described how this sparked more negative responses than anything she had written in her 28-years career as a political and war journalist. Major TV channels labeled her as "America's Worst Mom"; yet in her words, "My son got home, ecstatic with independence" (McDermott 2008). Only a generation ago, it was common for children to play together unsupervised, and to make their own way to and from school. As many commentators have emphasized, letting children take risks is part of their development. As Penny Nicholls, strategy director at the Children's Society, recently pointed out: "Over-protecting children carries different risks to under-protecting them, but can still cause long-term damage to their well-being" (BBC 2007). A society that is overprotective of its children may soon find out that they are not learning how to become responsible adults.

## Concluding Reflections

We have discussed Western perspectives on childhood and adolescence, the responsibilities that their parents or guardians have for their development, interventions in schools, as well as the possible role of the state. We have presented many doubts as to why parents cannot be fully responsible for their children. It is not only that there is much confusion over what is best for children, but also developed societies constitute an "obesogenic" environment, so that our social structures and environments often contradict the clearest and most general aspects of the advice that is given. At the same time, it is difficult to say exactly what changes would render that environment healthier for children and adults, or how they might be brought about. What is certain is that parental efforts need to be supported by public institutions, and that commercial interests often run counter to the efforts of both. We have therefore discussed some ways in which states and local authorities can alter the opportunities available to children, and suggested that schools and health campaigns need to support the development of children's abilities to respond intelligently to widespread social pressures for all sort of unhealthy behaviors. We have also discussed three possible policy measures that could counter the rise of childhood obesity: altering food prices, banning or restricting food advertising to children, and altering children's use of different modes of transport. While all of these point to useful areas for change at community, social or policy levels, however, none of them promises a simple or direct remedy. This is because in each case we are pointed to more complex surrounding factors. Proposals to tax unhealthy foods really point us back to our system of food production, already subject to extensive state intervention and enormous commercial forces. Measures to do with advertising point us to children's – and adults' – abilities to act as intelligent, independent consumers in a complex market-place. Measures relating to transport point us to many factors, not least to children's freedom of movement and safety in societies of strangers – societies that increasingly see adult strangers as a threat to children, rather than a source of guidance and oversight.

Rather than offering particular prescriptions, then, we conclude by emphasizing how great are the challenges involved here, both culturally and institutionally. Culturally speaking, a number of popular stereotypes may get in the way of sensible responses to the issues. We have already noted that contemporary ideas about childhood often over-emphasize children's vulnerability and inability to act independently – increasing pressures upon parents while limiting children's freedom to socialize and be active. Furthermore, we have only touched on other stereotypes that affect how we think about food and health. While we clearly need to develop children's abilities to navigate an environment which favors low levels of physical activity, unhealthy food choices, and so on, we also need to avoid playing into the stigma and prejudices surrounding “fat.”

There can be little doubt that Western societies entertain many dubious stereotypes about body image, and there is emerging opposition to our recent obsession with “overweight” and obesity. Feminists have long argued that women are oppressed by developed societies' very slim, indeed boyish, body ideals, while pro-fat activists argue more broadly that our society has cultivated a “fat phobia” (NAAFA 2008). Anorectic supermodels are presented in the popular media as examples of desirable body shape, or even as images of health, while fatness is popularly associated with laziness, incompetence and stupidity. “Letting yourself” become obese is seen as a moral and social failure. Given this background, there is a real danger that anti-obesity interventions might contribute – in effect, though not of course in intention – to increased stigma upon “overweight” or obese children. There is also a danger that anti-obesity interventions may play into social tendencies to demonize (some) foods, to regard food merely in terms of its (supposed) health effects, and to ignore or even spoil the pleasures and sociability that most people and cultures have traditionally found in eating.

Institutionally, it is also worth bearing in mind how powerful are the commercial interests at stake here. Many argue that the food industry is irresponsibly contributing to obesity and indeed profiting from it, a point that we have only touched on in this chapter. Processed foods, which are certainly a major factor in the rise of obesity and dietary problems, generate much more profit than whole foods; they can be branded, and are easier to store and transport. The food industry has also played into confusion among the general public as to what constitutes a healthy diet. Consider the manifold ways in which packaging makes or implies health claims for all sorts of foods, or the ways in which images of forbidden indulgence are attached to all sorts of allegedly unhealthy foods. It might also be argued that we rely too much on – at any rate, are often confused by – what the latest research claims is beneficial to our health, forgetting that powerful food companies often fund research. Other industries profit from obesity too, such as the pharmaceutical and dieting industries. Think not only of the thousands of books available on the topic of dieting, but also the enormous number of “low fat,” “low carb” and “diet” foods available for sale, and the various commercial weight-loss programs. Insofar as institutional changes are unlikely, this again highlights the importance of equipping children – and adults – with the skills and independence to make consumer-choices that serve their own interests, rather than those of private companies.

The need to equip children with the personal and social resources to make such choices points us back to one of the most difficult questions for all health-oriented social policies. This is the undoubted link between social class and poorer health, which in developed countries is now manifesting itself in problems of overweight rather than underweight. Immensely complex as this link is, it certainly relates to the greater difficulty people with fewer opportunities and lower education will always face in negotiating social life to their lasting advantage. None of the measures we have discussed provides any straightforward answers to this problem, nor could it, for it relates to the most fundamental problems of social justice.

In sum, simple interventions to tackle the rise of childhood obesity are not available, and all the measures we have touched on face considerable challenges. They must tackle the opportunities we extend to children, the ways we have come to think and feel about food, powerful institutional and

commercial pressures, and deep social inequalities. At the same time, we might take heart from the thought that developing children's abilities to be active, independent and informed promises social benefits much beyond a reduced incidence of obesity and improved health.

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