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Title Guest Commentary: Fat and other taxes, lessons for the implementation of preventive policies

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The article by Bødker and colleagues in this edition of Preventive Medicine raises several issues for policy. These include the role and influence of evidence versus political will and powerful industry lobbying, the often

conflicting timescales required for evidence of effect acceptable to policy makers and public health advocates and the need to consider unintended consequences. Much previous research in this area has been based on modeling and has not been able to consider actual consumer behaviour and reaction to taxes on food items (Mytton, Clarke, Rayner, 2012; Mytton, Eyles and Ogilvie, 2014, Shemilt 2015). The article is important as it adds to our understanding of behaviour and outcomes in this area but also shows that policy implementation and repeal are not solely dependent on evidence of impact. The authors show small potential improvements in health and urge policy makers to be *'more ambitious in relation to food taxes, e.g. by implementing more comprehensive tax-subsidy schemes'*. The article also shows how single issue policy approaches run the risk of unintended consequences and demonstrates the complexity of issues which require consideration when trying to affect health-related purchasing. Unintended effects, in this instance, included the shift from sweet to salty foods, the rise in butter and oil sales and the reduction in the intake of unsaturated fat.

At its core, the fat tax was never intended as a health protection measure. When setting the tax, the Danish Government was aware that it was unlikely to be a huge revenue earner, that the health effects would be insignificant and that the administrative burden high. Income from the tax was devised to be set against a lower tax on labour income. The fat tax was set at a low level (Bødker and colleagues acknowledge in their article that this may have been set too low) and there appear to have been few public health voices arguing for a higher level of taxation (Vallgård, Holm and Jensen, 2014) despite existing evidence suggesting that taxes need to be set at a sufficiently high level to influence the consumer (generally an increase of 20%) and be part of package of policies which use a stick (taxes) and carrot (subsidies) approach [add ref here].

The article shows that evidence - or in this case the promise of evidence - is not sufficient to maintain policy. In this case, the tax was rescinded because of industry pressure, a failure of political will and the scarcity of policy actors to defend the tax rather than because evidence showed the tax to be

inefficient or unsuccessful in addressing heart disease (Vallgård, Holm and Jensen, 2014). These debates come at the same time as the release of a report from the World Health Organization (2015) on using pricing policies to support healthy eating. The problem seems to be one of turning evidence into policy and of how public health can address competing interests. What the Danish food tax and the social experiment it entailed shows is that public health advocates are weak in tackling the issues of corporate power and providing evidence to maintain a policy, lacking what Forest and colleagues (2015) called policy capacity.

In public health nutrition policy, we need to be aware that what is available are a range of interventions; some of which may achieve little on their own but in combination may act in tandem to support one another. One such example is front of pack nutrition labeling - which while directed towards consumers may result in manufacturers reformulating products to achieve a healthier nutrition profile [House of Commons Health Select Committee 2015]. Alcohol and tobacco-control studies suggest that a combination of interventions are needed to achieve public health outcomes (Scottish Health Action on Alcohol Problems, 2013; Gual and Anderson, 2011) and that key here is regulation. In alcohol prevention, combining training for primary care workers for short interventions with financial incentives resulted in a doubling of the effect over and above any of the interventions on their own (Angus, Parrot and Brennan, 2015); when combined with regulation - especially around price and availability - of alcohol consumption, there was a major impact on alcohol morbidity related incidents (Gual and Anderson, 2011). For nutrition and food policies the same is likely to hold true, although the evidence base requires further development. Regulation, however unpalatable to key players like the food industry, must be part of the policy process (Brownell and Warner, 2009).

Another problem for policy formation and maintenance is that academic research often reports long after the event. This highlights the need for on-going evaluative research which feeds back into processes as they happen (Quinn Patton, 2008; Panjwani and Caraher 2014). Evaluative research can provide the evidence for immediate changes in a programme or activity and

can be useful in maintaining political support.

Kingdon (2010) in his analysis of Clinton and Obama health care argues that three areas, what he calls *policy streams* of 'problem', 'politics' and 'context' need to overlap for policy to occur. The content and problem can, of course, be reformulated by business interests. A well-used approach for alcohol, tobacco and, more recently, food-related corporate interests is to shift the focus away from health. This involves reframing a fat or soft drinks tax as an issue of consumer rights and a debate over the role of the state in 'nannying' or restricting people's choices (Mindell, Reynolds, Cohen and McKee 2012). .

We said in 2005 that taxes need to be addressed paralleled by subsidies and other interventions to encourage healthy eating - the stick and the carrot (Caraher and Cowburn, 2005). We continue to encourage further empirical research on the impact of subsidies as a means to encourage the consumption of healthier foods. This approach seems to have received less attention than taxation as a route to influence food prices but may turn out to be less regressive than other forms of taxes and the extensive use of price promotions by retailers as a means to drive consumer spending (Dobson, 2014) suggests that subsidies are worthy of consideration.

Building support for policies is never just a matter of evidence. In public health and preventive medicine there is a long history of interventionist public health policy. The new and powerful influences are the corporate interests and the influence of neo-liberal economics above and beyond health (Moodie et al 2013; Mindell, Reynolds Cohen and McKee, 2012). The corporate capture of public health is epitomised by government's eagerness to enter into voluntary agreements, which place the views of industry above those evidence-based findings that prioritise public health (Panjwani and Caraher 2013). Public health advocates are still caught in old ways of working. We agree with Bødker and colleagues that policy makers should show more ambition and we think this should be informed by the real world of policy making. Policy capacity needs to be developed with public health advocates becoming more savvy around policy development combined with developing new skills and

ways of engaging with policy action (Forest et al, 2015). This requires understanding of how food policy is made and key among the influences on this are knowledge but also health actors and large corporate interests (Panjwani and Caraher 2013). A different skill set may be needed to counter these oppositional forces. This may need a move from the traditional position of advocacy and the role of evidence to include a fuller commitment to the development of policy, with all that this entails in terms of leadership and social responsibility. One step forward would be for public health advocates to work together across different behaviour domains, rather than jostling for supremacy for their particular area of interest (Malhotra, 2015) – a move which is likely to add to the confusion for both public and policy makers and allow an easy victory for corporate interests keen to demonstrate that there is insufficient evidence to act in the interest of public health.

Part of this new development might involve developing outcome measures to hold actors such as the food industry accountable for actions. This could be achieved by foot-printing food impacts on health, which might require the development of the food equivalent of greenhouse gas lifecycle analysis. This could form the basis for a tool to measure accountability with respect to the consequences of food related disease in society. Such models could be broad enough to address not just the nutritional aspects of food but the related marketing and advertising opportunities. It could even lead to a tax levy based on the – health and ill-health - outcomes. The econometric data on food products is available and could be used for such public health purposes (see a commercial application of this by Euromonitor at <http://www.nutraingredients.com/Markets-and-Trends/Euromonitor-debuts-nation-based-nutrition-data-cruncher>). But even if this is feasible, public health advocates still need to continue to develop the political will among politicians and the public for such an initiative and this still requires a new way of looking at policy formation, its influences and the role of professionals in shaping it.

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Editorial:

It is time to bust the myth of physical inactivity and obesity: you cannot outrun a bad diet

A Malhotra, T Noakes, S Phinney

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