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Paternalism, Obesity, and Tolerable Levels of Risk

Michael S. Merry

ABSTRACT

In this article the author examines the relationship between paternalism and childhood obesity. In particular he examines the risks of paternalistic intervention in order to prevent or curtail the occurrence of obesity among young children.

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The preventive function of government . . . is far more liable to be abused, to the prejudice of liberty, than the punitive [sic] function; for there is hardly any part of the legitimate exercise of freedom of action and a human being which would not admit of being represented, and fairly, too, as increasing the facilities for some form or other of delinquency. (Mill, 1978, p. 95)

OBESITY DESCRIBES AN abnormally high fat accumulation that impairs health. It is crudely measured by a body mass index (BMI) of greater than 30 kg/sq meters. That is to say, if a person's weight in kilograms divided by height in meters equals 30 or more, that person may be considered medically obese. The BMI for being overweight is 25kg/sq meters.

Obesity now ranks among the highest of concerns by the World Health Organization (WHO) and not only in countries of affluence; the figures of obesity worldwide have doubled since 1980 and the problem can now commonly be found in low- and middle-income countries, especially in urban centers. The figures that map the steady rise of obesity across continents are staggering: between 20-24% of adults in the United Kingdom, Australia, New Zealand, Iceland and Luxembourg are officially obese. In Mexico and the United States the figure now tops 30% (OECD 2010).¹

The correlation between poverty and obesity should not surprise us: Poorer people are generally less well educated than are those who have money to spend on quality private education or housing in a district that provides quality public education and have less access to reliable health information and to preventative health care. Further, unable to afford more expensive and healthy food, poorer people generally purchase processed foods with high concentrations of fat, salt, and sugars. Conversely, wealthier and better educated people are more likely to carefully monitor their caloric intake, to exercise regularly, and to belong to social networks that do the same. They are able to sustain healthy eating

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habits by having on average more leisure time that allows them to invest in healthy food selection and to teach their children about thoughtful meal preparation, including using cookbooks or recipe websites by those advocating low-calorie food and reading popular authors, such as Eric Schlosser and Michael Pollan, who investigate the food industry.

The widespread availability of cheap and unhealthy food is no accident; rather, policy decisions facilitate its mass distribution and availability. For example, the American government invests billions in subsidies so that farmers grow corn; processed food made from corn starch supplies the basis for all kinds of inexpensive and unhealthy foods. This includes food that routinely appears in American school lunch programs. Corporations, too, have a vested interest in targeting younger and younger consumers and invest billions both in advertising and product placement. The result is that millions are at greater risk of diabetes, cardiovascular diseases, and cancer. The health risks associated with obesity accrue not only for individuals but also for society, which must shoulder the exorbitant costs associated both with missed workdays because of obesity-related illnesses as well as with health care for those whose obesity is causally related to a range of poor health outcomes. For WHO as well as a number of governments throughout Europe and North America, the frontline of this battle against obesity is its occurrence in young children.

Taking all the research together, it is not difficult to understand why the spread of obesity for many signals a need for more intervention from governments, particularly to protect the welfare of children. Efforts to address the epidemic that is child obesity take many forms. Many of these aim simply to supply and distribute reliable health information; they seek to construct better choice sets in order to facilitate the conditions and opportunities necessary for sustaining well-being. These efforts aim to steer, direct, guide, and enable people to choose something better for themselves (see Thaler & Sustein, 2008). Often these efforts are labelled as paternalistic. The label is misleading, however. Paternalism does not merely entail attempts to guide or suggest. Rather, paternalism entails interference with the liberty of another for the purposes of promoting some good or preventing some harm, for the sake of the other person or for that of the person acting paternalistically. In this article I focus on paternalism so understood, and especially its relevance to the question of childhood obesity. I map out the basic contours of paternalism, followed by an analysis in which the purpose is to assess the appropriateness or inappropriateness of paternalistic intervention in order to prevent or curtail the occurrence of obesity among young children.

The moral aim of paternalism is to act on behalf of the interests of others who presumably lack sufficient information or the resolve to inform and guide their actions. Such interference can be justified when people are treated with respect or when compelling reasons for interference override basic liberty claims. Respect normally begins with the recognition that we must value another's capacity for self-determination to the extent that it exists, or could exist. For example, because many citizens cannot be relied upon to always exercise their liberty responsibly, states behave paternalistically by imposing traffic laws, subjecting restaurants to periodic

health inspections, forbidding the possession of certain weapons, and imposing building safety codes and environmental restrictions. And when parents fail to exercise their duties responsibly, they too are subject to state interference. In each of these cases, the justification seems fairly straightforward: Certain overriding factors—in particular public health and safety—trump the exercise of personal liberty, and these goods are therefore sufficient to justify the restriction of liberty.

Young children are therefore a special case. Given their limited emotional and cognitive development, as well as what Feinberg (1986) called their “right to an open future,” paternalism is typically necessary to secure a child's immediate and future interests. Young children cannot be assumed to take responsibility for their own choices or health, let alone to understand their impact. For instance, elementary-school children may receive information about a balanced diet from their physical education teachers, yet be bombarded every day with advertisements for junk food and, moreover, encounter pizza, hot dogs, and hamburgers as the main menu items in their school cafeteria. Accordingly, most liberals justify paternalism when a child's well-being appears to be at stake.

Nevertheless, paternalism remains objectionable to many not only because of the way in which it generally interferes with individual liberty but also because of how it seems to infantilize us. As de Marneffe wrote, “In limiting our liberty for our own good, it seems that the government treats us like children or that it impedes our development into fully mature adults” (2006, p. 68). Again, this is because at the heart of paternalism there is interference, interference of a coercive sort, even when it is justified on the basis on prevention from harm.

Now even strong libertarians hold that it is necessary to interfere with the liberty of another if the exercise thereof would have disastrous consequences, or when the exercise of liberty needlessly incurs harm on others. But while the interference with another's liberty is not morally objectionable *per se*, three things must be stressed: (a) Coercive interference with the liberty of others requires strong justification; (b) affixing blame without regard to context is a losing strategy; (c) interference with the purpose of preventing harm is particularly subject to abuse—as the earlier quote from Mill explains.

When we come to the question of childhood obesity, there is broad consensus that it is unequivocally harmful. Moreover, not a few believe that parents—many of whom themselves are obese—are largely responsible for this harm. Accordingly, in many countries governments are aggressively stepping up their efforts to stamp out childhood obesity. For example, in 2009 34 states in the United States passed legislation on a range of issues from physical exercise, to healthy eating, to access to healthy food (Winterfeld, Shinkle, & Morandi, 2010). The general motivations clearly are to improve the health of young people, while the specific policy initiatives are to advise parents and ensure that there is adequate knowledge about and better access to a nutritional diet and exercise.

It is not difficult to assess what the harms of obesity are; many of these have already been mentioned. Nor is it difficult to determine the conditions under which obesity is likely to occur. Be that as it may, knowing precisely how to balance the liberty interests of

ordinary citizens against what many feel is a public health concern is very complex, as is determining the seriousness of obesity compared to other forms of harm. For example, is the harm caused by being obese analogous to being denied a blood transfusion or a decent education? Can it even remotely be compared to harm involving physical or psychological violence? Even if we dismiss the false analogies, recognizing that these represent criminal activity against others, to what other risky behavior will we compare obesity and will similar interventions be justified? What will such interventions portend with respect to basic liberties, particularly those that involve risk? Who will determine whether—let alone when—there is a crisis? Should intervention to avert harm occur in the absence of consent? However we answer these questions, the burdens of proof of harm and neglect for preventative interference are not trivial.

As I hope these preliminary comments show, the issues before us are not, as most liberals generally argue, simply about safeguarding the interests of children. Nor are they, as most libertarians argue, merely about the liberty to do what one pleases without interference from others so long as the exercise of my freedom does not trespass against others. Contra the standard liberal argument, determining what the best interests of any child are is not a simple affair, even though it is rather easy to claim that a child's best interests are paramount. Even so, the well-being of any *particular* child will vary in the details from one to the next. This is because beyond a basic set of conditions such as shelter, adequate nourishment, relational intimacy, and physical safety, well-being is somewhat context-dependent. Contra the standard libertarian argument, the exercise of individual liberty is never absolute, and certainly not when the liberties of others are compromised. The exercise of any liberty must be checked against the interests of others. So I think it is a good idea if we push these two competing conceptions aside and explore the major dilemmas.

As I see it, the first dilemma is how to balance state paternalism against the special privileges and relationships parents have with and toward their own children. When these conflict, who is to decide how they should be prioritized? Most parents are positioned to their children in unique ways. Mothers conceive, give birth, and raise children, knowing their needs and interests like few others ever could. Notwithstanding personal shortcomings and errors of judgment, most parents also unconditionally love their own children, nourishing them with affection and concern (albeit in a variety of ways), a gift no child protection or welfare service ever could satisfactorily supply. Nor could any competency test measure a parent's love.

That said, parents do not possess *rights* to have or raise children, even if that is how most of us continue to think of it. Biology does not confer entitlement. Our relationship as parents to our own children is largely role-dependent, which means that we are charged with duties to care for our own children, and states have prerogatives to intervene when there is clear evidence of abuse or neglect. States, even liberal democratic ones, ascribe to themselves—legitimately or not—ultimate authority over the lives of citizens and when parents fail to meet their basic duties to their children, those adults effectively surrender their privileges. For

example, child protection services can place abused or neglected children in foster care. States already possess the trump card.

Yet liberals routinely describe the state as a benevolent political entity whose infinite wisdom with respect to human affairs can be trusted to adjudicate between competing interests. But why should we take this for granted? After all, the state is not a collection of philosopher rulers, tried and tested through rigorous selection processes in a utopian state in which the family has been abolished. Rather, the state invariably consists of individuals with their own disputable interests, and many of these conflict with other values citizens are entitled to have. Of course, state officials are believed to possess competences with respect to the charges they are asked to carry out. Health officials presumably know more about health, secretaries of finance more about balanced budgets, and so forth. But agents of the state cannot simply be presumed to have the best interests of the public at heart. Here I need not indulge the temptation to say something about corruption. It will suffice to say that incompetence by state officials often leads to misdiagnosis and often dramatically worsens, rather than helps, the plight of those whose well-being is in question. Finally, states do not remain static from one moment in time to the next. Public attitudes shift according to circumstance and perceived threat, politicians with different attitudes and orientations are elected and deposed, and policies can be quickly turned on their head. So we would be naive to take a singularly optimistic view of the state, even when the so-called best interests of the child are the principal concern.

Consider compulsory school attendance laws: These were instituted with the aim of providing all children equal access and opportunities. Even so, German parents have been jailed simply for homeschooling their children, even when there was no evidence of harm (Spiegler 2003). Liberal states are not immune from behaving illiberally, regardless of what their stated motives are. (I shall say more about this shortly.) The point is this: Like parents, liberal states are quite capable of viewing persons instrumentally, not to mention exercising indiscriminate power over the lives of vulnerable subjects. So in saying that children are entitled to equal protection and that states have moral requirements to supply that protection, we have not solved the challenge of determining what the nature of the entitlement is, nor what the scope of that requirement is.

This brings me to the second dilemma, namely the formulation of risk and the harms of stigma. This concerns not only who gets to define *risk* but whose lives are directly affected by these one-sided discussions. Labelling children and families as being at risk often carries moralizing baggage that contributes to the perceived risk. It is no accident, for instance, that so many children from poor backgrounds end up in unchallenging classrooms where their label of being *at risk* results in their being recipients of condescending treatment and lowered expectations. A label often becomes a self-fulfilling prophesy. Risk does not only go in one direction, i.e., the direction that the so-called liberal state says it does. Families also incur risks when subject to arbitrary state oversight. Minority families in particular are at risk of highly discriminatory interference by a state that claims to know—without including the views of others—what is best. Indeed,

whenever the state decides that it will define what acceptable behavior is, it exercises power over the lives of others.

Let's return for a moment to the parents of overweight or obese children, because the paternalist line of argument often assumes these children to be victims of bad parenting; this unarticulated assumption certainly is used to justify state interventions that aim to curtail childhood obesity. But why start with the parents? Why not begin with the context in which all of us think and act, namely the broader culture in which we live? For starters, we have not even begun to address the socially unacceptable prejudices against overweight people, and until we do, all talk of intervention by the state with a view to protecting the best interests of children will remain one-sided.

Are the risks associated with childhood obesity strong enough to justify state interference in the lives of families? Is our concern about that analogous to concerns over sexual abuse, for instance? If it is, it remains a curious fact in Western societies that it is socially acceptable to openly ridicule and humiliate overweight persons with impunity. Indeed, unlike most other kinds of health risks, obesity is a condition that is already subject to social stigma. (For an historical overview of stigma attached to fatness in American public life, see Farrell, 2011). Such stigmas merely compound the difficulty many people already experience. If those who are overweight don't first begin to loathe themselves, ridicule from others quickly turns to disgust and hatred, and these too often turn to violence. Children are especially vulnerable here. Overweight children are far more likely to be harassed, teased, bullied, and terrorized for no reason other than the shape of their bodies. And these effects of the prejudice are no different from those for people who suffer on account of their sexual orientation or the color of their skin.

Or consider the labor market, where overweight people are far more likely to be discriminated against than those who are considered average-sized or thin. The issue is serious enough that cities like Washington and San Francisco have passed legislation forbidding weight-based forms of discrimination that are every bit as serious as other forms of discrimination. It seems to me that these facts highlight another dimension to the problem that frequently goes unmentioned, namely that the attitudes and prejudices of the public—and here I do not hesitate to include higher educated people and the medical establishment—continue to countenance the public shaming and stigmatization of overweight people. In short, the prejudice against overweight people is widespread and troubling.

If I am right, then it is no thought experiment to imagine that interventions and competency tests (not unlike those wishing to adopt must meet; see LaFollette, 1980) for parents will proceed in much the same way that other kinds of paternalistic interventions do, targeting the poor generally and specific ethnic minorities in particular. Inasmuch as strong correlations between ethnic minority status, poverty, and obesity continue to persist, this outcome is not far-fetched. There is perhaps no easier way to quickly justify public alarm and subsequent state intervention than by stigmatizing some attribute of society's weaker members. The advent of the following prejudice requires little imagination: Having failed to satisfy some ideal—in this case, good health—that

more privileged members of society more easily maintain, poor parents cannot be relied upon to make responsible decisions for themselves or for their children.

Let's come back to paternalism. As we have seen, paternalism involves interference with the liberty of others with the aim of promoting some good, and this commonly occurs during moments of perceived harm. But before there is harm there is risk of harm. There is risk both to one's present and to one's future health states, as well as risks to one's general state of well-being. Accordingly, public health officials would like to see more done by the state to prevent harm from occurring in the first place. But attempts to prevent harm also entail risk, and those with medical degrees are not immune from criticism. Within my lifetime, and in the sincere belief that they were serving the public interest, so-called liberal states and their medical experts have sanctioned the infection of Black men with syphilis and the denial of treatment long after penicillin was discovered for the purposes of accurately recording their symptoms; they have smiled upon the eugenic sterilization of couples deemed unfit to bear children on the belief that the sterilization of the retarded or physically disabled would reduce suffering; they have diagnosed homosexuals as having a psychiatric illness on the belief that another's sexual orientation can be a condition in need of a cure; they have sanctioned the banning of children with disabilities from school on the belief that to do so would be a waste of public expenditure and a detriment to the learning opportunities of so-called normal children.

It is well-known that widespread abuses of power—in particular by the medical establishment—led to an entire restructuring of laws and procedures (including the requirement of informed consent) that were put in place precisely to protect the innocent from paternalism run amok. The point is this: The coercive use of power is always justified as a prevention of risk by those wielding said power, be those risks to the state, to others, or to oneself. Yet when risk is defined unilaterally by people with tremendous power, other risks are incurred: risks to privacy, risks to family intimacy, risks to free choices over an individual's own leisure time, etc. We might remember the words of Mill: "Wherever there is an ascendant class, a large portion of the morality of the country emanates from its class interests and its feelings of class superiority;" (1987, p. 6). We should be extremely wary of unilateral attempts by the state—even so-called liberal democratic states—to define the parameters of a child's best interest and through policy and interventionist schemes to impose these on an unsuspecting public. The narrower the definition of *best interest* is, the more wary the public should be.

Clearly, if the state is to take a more proactive role in interference with parental liberty, at a minimum some account is needed concerning what desirable preferences and behaviors are. Efforts to reduce risk entail drawing boundaries, and boundaries in ethics assume some conception of what is good or preferable. Yet when states draw boundaries and apply them to others in the form of laws, they restrict liberty by defining permissible risk. (I am not referring to the liberty of corporations or other political entities but to individual liberty.)

We might begin by offering an account of behaviors that should be forbidden, those that clearly violate basic freedoms and

welfare. Legal courts normally begin by addressing instances of abuse or neglect, but even with broad definitions in place and clear examples (e.g., sexual abuse) to illustrate what is impermissible, things quickly become very fuzzy. Interferences with parental liberty in cases involving obesity, even when it allegedly entails imminent harm, fall into this category. After all, cases of child obesity are not morally different from many other cases involving health risk. Therefore, to argue that the state must interfere with parental liberty in cases involving obesity begs a number of questions concerning why it is not also necessary to restrict other similarly risky behaviors.

But suppose that we were able to agree on some areas of risk (and this is easier said than done). What constitutes a risk? In its broadest sense, risk occurs the moment there is life: being born places us at risk; the air we breathe places us at risk; stepping onto trains or into automobiles places us at risk; eating food sprayed with pesticides places us at risk; climbing trees places us at risk; riding bicycles to work places us at risk; drinking water from a stream places us at risk; being in relationships places us at risk. In short, life is defined by risk, though we generally overestimate risk regarding things less familiar to us and underestimate risk where our own habits or behaviors are concerned.

So what does it mean to say that the state is entitled to safeguard the developmental interests of children, and what are the limits to preventative state intervention? How far should we go in the prevention-of-obesity risk? If there are genetic causes to weight analogous to genetic causes of height, should we begin with genetic screening? Should the state tell certain couples that they may not have children? Conversely, should couples be permitted to abort knowing there is a probability of inheriting a “fat gene”? Shall we dictate which snacks children are permitted to eat? However much we may lament less-than-optimal parenting habits or outcomes, assessing parental competence with respect to obesity without analogous supervision in hundreds of other less-than-optimal activities is question begging.

Free and plural societies must permit a wide range of lifestyle choices, even when some of these are probably not desirable in any objective sense given the known risk factors. Consider the vast number of parents who are divorced,² who smoke, whose children play outside without sunscreen, whose children watch several hours of television a day, whose children attend conservative religious schools, whose children play contact sports. In each of these examples, there are known risks: of emotional distress from divorce, of cancer from smoking or sunbathing, of attention deficit from chronic television watching, of indoctrination from dogmatic teaching, of serious injury and death from contact sports. And lest I devote too much attention to supposedly harmful activities, consider the risks involved with activities most consider beneficial, such as fitness and dieting, or the ambitious pursuit of a successful career! Perhaps there are those who would respond by saying, “Let’s regulate all of these activities, too!” OK. But then do we not see Orwell’s specter rising?

In urging caution and restraint, I have not argued for uncontrolled liberty, nor have I neglected the welfare of the child. I have argued that interventions that aim to prevent harm circumscribe *risk*

too narrowly without considering other risks that arise when paternalistic governments intervene. Because there are legitimate concerns about the integrity of the family, the use of coercive power, a respect for people, and the pluralism in free and democratic societies, interference with ordinary liberties, including those involving risk, must be strongly justified. Further, given the range of choices all of us make that have less-than-optimal outcomes, I have also suggested that censuring parents for obesity begs a number of questions concerning tolerable levels of risk. Let me close with two more concerns: The first is practical and the second is procedural.

First, we can all agree that paternalist state intervention in principle is guided by some version of the harm principle. But we should also remember that poorer families on average are more likely to purchase cheaper—hence often less healthy—food for themselves and their children. Little surprise, then, that obesity is most widespread among poorer groups. Efforts to improve parenting skills in themselves can do a lot of good, but proposals that aim to prevent obesity by calling parental competence into question put the responsibility on the wrong actors.

Rather than stigmatizing and penalizing parents—which is precisely the effect competency tests will have—why are there so few restrictions on what advertisers can do? Why are corporations that produce unhealthy food not restricted: from misleading the public with language like *pure* and *natural* on their factory-made products; from targeting young people with their advertising, particularly when the products have little if any nutritional value; from coaxing families with young children into frequenting their establishments by offering free toys, coupons, and playgrounds that make it more attractive to eat there; and finally, from allowing fast-food corporations inside of schools?

States also could do a lot more to structure and facilitate well-informed and affordable alternatives. For example, a more productive interventionist approach would be to heavily subsidize healthy food, making it much cheaper and available to all and, conversely, to heavily tax unhealthy food. Liberal states have a much longer history of doing precisely the opposite. Nutritional information on packaging is now standard practice in Western countries, and further efforts are underway to force restaurants to publicize the number of calories in servings of food. But states could also demand that products with questionable nutritional value be packaged with warning labels, much like tobacco products are, or put out of sight from the average consumer, like pornography is. And notice that taking this approach would avoid many of the pitfalls of paternalism by not directly interfering with the liberty of ordinary citizens.⁴

Second, decisions about public health should be deliberated upon democratically. Of course the state has reasons to promote safety, good health, education, etc., but for its interference to be perceived as legitimate by a majority of society’s members, it will need to make its decisions in as democratic a way as possible, procuring the consent of the governed—particularly when many of the so-called offenders are vulnerable to the stigmatization that both precedes and follows punitive actions imposed by the state.³ As I have already shown, interventions in liberal democratic societies are often decidedly harmful, even when the aim is to

prevent harm. Average-sized or thin people should not unilaterally make decisions on health in the absence of overweight people any more than the able-bodied should define *normal functioning* in the absence of people with disabilities, or men or heterosexuals should define *equal treatment* in the absence of women or gays and lesbians. When this happens, the conversation is one-sided and the outcomes are morally suspect. How decisions are made is every bit as important as which decisions are made. Failure to take these democratic procedures into account undermines the state's legitimacy and surely guarantees abiding resentment from those accused of parental incompetence. If that is the outcome, we should expect state interventions that aim to prevent obesity to fail.

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Notes

1. Different sources report slightly different figures but these represent reliable and conservative estimates.
2. Divorce per se may leave few scars on children's lives; much depends on how old the child is at the time of the divorce, how the couple handles the conflict, and the continuity of parental involvement after the separation. The point is not that the risk factors associated with divorce are as certain or as automatic as, say, smoking, but rather that an enormous literature substantiates my claim that divorce brings a variety of risks.
3. This is precisely the worry that one researcher found with respect to a Dutch policy that aims to improve parenting. See Atze H. M. Van den Bos. (2010). *De Overheid Achter de Voordeur: waar ligt de grens? Opvoedproblemen binnen de Amsterdamse Achter de Voordeur aanpak* [The government behind the front door: where does the boundary lie? Childrearing problems with the Amsterdam-based Behind the Frontdoor approach]. (Unpublished master's thesis). University of Amsterdam, Netherlands.
4. One recent European study found that there is widespread public support for three initiatives: (1) providing parents with more information, (2) requiring more activity in schools, and (3) restricting advertising. Notwithstanding isolated experiments that tax high-fat-content food (e.g., Denmark), public support remains very low. See Suggs & McIntyre (2011).