References to obesity in advertisements: CAP and BCAP's evaluation of responses

Introduction

After a period of public consultation the Committee of Advertising Practice (CAP) and the Broadcast Committee of Advertising Practice (BCAP) are amending rules in their Codes to allow advertisers of lifestyle weight loss programmes which meet particular criteria to make reference to obesity in their advertising, and therefore target people who are obese.

The policy context, full rationale for the decision, technical changes to the Codes and timetables are set out in the Regulatory Statement which should be read first.

This document provides CAP and BCAP's evaluation of summarised, relevant points made by respondents in response to specific proposals and questions set out in the original consultation document and should therefore be read alongside that document.

CAP and BCAP are also publishing the original consultation responses.

List of respondents

1	A natural health therapist
2	A private individual
3	Beachbody UK LLC
4	British Psychological Society (BPS)
5	Cambridge Weight Plan (Cambridge)
6	Diet Chef
7	Dietitians in Obesity Management UK (domUK)
8	Electronic Retailing Association UK (ERA)
9	Health at Every Size UK and four professional, individual co-signatories (HAESUK)
10	Lighterlife
11	National Institute for Healthcare and Clinical Excellence (NICE)
12	Public Health England (PHE)
13	Rosemary Conley
14	Royal College of Physicians (RCP)
15	Royal College of Psychiatrists (RCPsych)
16	Royal College of Surgeons in Edinburgh (RCSEd)
17	Saatchi & Saatchi
18	Slimming World
19	Very Low Calorie Diet Industry Group (VLCD)
20	Weight Watchers UK Ltd (Weight Watchers)

Question 1: Do you agree with CAP and BCAP's proposal to allow certain lifestyle weight loss programme providers who fulfil particular criteria to refer to obesity in their marketing, and in doing so to target obese individuals? If not, please provide your rationale and any relevant evidence.

	Respondent/s	Comments	CAP and BCAP's evaluation:
1.1	Saatchi & Saatchi, SW, WW, Rosemary Conley, ERA, Lighterlife, PHE, Beachbody, Cambridge, VLCD, RCP, NICE, RCPsych	**Notwithstanding other arguments summarised in this document the organisations listed on the left supported the proposal in principle. Many respondents variously made one or more of the following points:** • Approximately a quarter of the UK population is now obese and obesity is a risk factor for a range of diseases with ensuing social and health costs (particularly to the NHS). The proposed change would bring CAP and BCAP rules into line with government policy and clinical practice and contribute to the national ambition of tackling obesity. • Lifestyle weight management programmes are proven to be effective and safe means of losing weight. • Obesity is not in and of itself a medical condition and health care practitioners may not need to supervise the weight loss of someone who is otherwise healthy. Direct supervision by a healthcare practitioner is not required by NICE Guideline PH53. • The current rules prevent obese people being targeted despite the fact they have the most to gain from such programmes. Advertising therefore has to disproportionately depict those who need such programmes less which is misleading. • Surgical interventions (which can depict obese people because the service is medically supervised) are presently allowed to advertise which risks giving the impression that obesity always needs to be treated medically. • The vast majority of clients who are referred onto lifestyle weight management programmes do not have any obesity-related co-morbidities. • Change the rules promotes information for consumers and therefore patient choice.	CAP and BCAP agree. Looking across all responses, CAP and BCAP consider that there is broad support for regulatory change to allow certain lifestyle weight loss programme providers to make responsible references so long as they meet particular criteria.
1.2	RCP	Consider that NICE guidelines and good practice guidance make clear that lifestyle weight management programmes should constitute 'tier two' obesity services only. This means some obese people will need to access support from medically-qualified health professionals (as detailed in the NICE guidelines). It is therefore critical that any changes to regulations do not impede obese people from accessing suitable medical services for obesity if and when their health requires it (e.g. if complex co-morbidities are present).	The Committees do not consider that the proposed rule changes are likely to impede obese people from accessing other interventions.
1.3	Cambridge	Revising the prohibition on weight loss programme advertisements targeting obese individuals would resolve the current conflict between this rule and the EU Nutrition and Health Claims Regulation (1924/2006) which regulates the use of nutrition and health claims on commercial communications	The NHCR applies only to claims for specific foods. Neither it, nor the CAP or BCAP Codes, preclude

		across the EU, including advertising: only approved claims may be carried, including claims related to weight loss. Currently companies can go to the time and expense of securing an approved claim for weight loss on one of their products only to find themselves banned from making any reference to the fact that these products form part of a weight loss programme.	substantiated claims for weight loss plans as a whole.
1.4	A natural health therapist	Disagree with the proposal. A change in the rules would result in advertising which presents obesity and overweight as undesirable when they are just normal variations on the human form. People should not be shamed into starting weight loss programmes. Supervision by health professionals protects people from buying/trying out unsupervised, potentially harmful programmes. The premise that weight-loss equals health is questionable and the process of weight loss and most diets/exercise programmes ask subjects to refer to their GP/health provider before starting. Movement and activity levels seem to be much more important than bodyweight.	CAP and BCAP understand that it remains the view of NICE and other expert bodies that obesity remains a major risk factor in a number of serious conditions. Programmes will only be permitted to advertise under the new rules if they are multi-component, addressing lifestyle changes and activity levels as well as weight loss. Any advertisement which attempts to shame people who are obese is likely to be in breach of the CAP and BCAP rules on responsibility and offensiveness.
1.5	domUK	Not aware of evidence that obese individuals are deterred from using weight management services because of the current rules on advertising. If indeed there is no evidence there is no need for the rules to be changed. Also concerned that those with a BMI of ≥30 are likely to have one or more co-morbidities, which need to be identified and monitored by healthcare professionals. The greater the degree of obesity, the more likely this is. While good quality weight management interventions should already be including this, we would welcome a recommendation to this effect as part of any change to the guidance.	As communications regulators CAP and BCAP have had to consider whether a prohibition on effective and safe lifestyle weight management communicating directly with obese people remains proportionate. For the reasons given in the Regulatory Statement they consider that the current prevalence of obesity and broader public policy changes warrant changes in the rules.
1.6	RCSEd	RCSEd would caution against the decision to relax the current rules and allow permissible responsible references to obesity. The big lifestyle weight loss programme providers are already well known for their weight controlling strategies and do not need to include the term obesity in their marketing. There is a real risk that vulnerable obese patients may not seek the necessary medical help and common medical conditions could go untreated if they are lured into self-referral to these programmes by advertising. Consider that the minimum standards for the entitlement to use the term obesity in advertising have been clearly laid out in NICE guideline PH53 and that CAP & BCAP should not be allowed to accept any advertisement which falls below these minimum standards. The current proposal appears to	See 1.1 and 1.5 CAP and BCAP do not consider that requiring compliance with the entirety of Guideline PH53 is desirable. It is not

		suggest the standards are too rigorous and state a wish to lower the threshold by accepting lower standards, and as such RCSEd cannot support this position.	written as a regulatory tool and would put the industry at risk of being judged on the same criteria by multiple bodies.
1.7	HAESUK	A different approach is needed which supports people of all shapes and sizes in healthful behaviours and body respect.	See 1.1
1.8	Diet Chef	Strongly disagree with the approach taken by CAP and BCAP; it lacks proportionality and there is a strong risk that by adopting these criteria CAP and BCAP are acting ultra vires. The approach is at odds with the approach presently taken in other cases by CAP and BCAP, including in relation to medicines, under the proposals advertisements targeting obesity would be required to satisfy a higher threshold than those advertising medicines. The approach taken by CAP and BCAP would seem to foreclose competition within the UK (in particular by requiring services to show that they are effective at 12 months and beyond) and is at odds with the approach taken in some other European jurisdictions such as Germany. CAP and BCAP have not demonstrated that the advertising of weight loss offerings which do not satisfy the criteria set out in this consultation would be misleading, harmful or offensive if they were to refer to Category 1 of obesity and to encourage those to whom they were targeted to seek medical advice. As such therefore CAP and BCAP have not demonstrated why their proposal is the least onerous proposal necessary to achieve their aims. The proposals will singly fail to achieve the intended outcomes while foreclosing competition in this important area.	See 1.1 CAP and BCAP consider that the rule change reduces regulatory burdens in the sector by creating the opportunity for responsible and effective programmes to advertise when previously they could not. The advertising of medicines is subject to regulation through specific sections in both Codes which are directly informed by the relevant legislation and are therefore not a relevant comparator for this issue. See 1.4
1.9	BPS	Consider that there is no reason to change CAP and BCAP guidelines. The revised NICE guidance is insufficient, in and of itself, to legitimise direct marketing to people with obesity. Advertising will naturally emphasise the optimal outcome and give the false impression that someone with obesity entering a commercial programme would not be obese at its end. Unfortunately, the data as it is, demonstrates that this is not the case. Evidence shows that weight loss in these programmes, for those who complete (a limited number) is, at best, 4-5kg.	See 1.1 / 1.5 / 1.6

	Question 2: Do you agree CAP and BCAP have identified appropriate criteria to include in the rules? If you consider different criteria are required, or if a different approach to provide for a change in the rules is required altogether, please provide your comments, rationale and any relevant evidence.		
	Respondent/s	**Comments**	**CAP and BCAP's evaluation:**
2.1	domUK, Rosemary Conley, RCPsych	Agree with the criteria as proposed.	CAP and BCAP agree. In finalising the rules the Committees have chosen criteria which they consider describe the correct balance the need for marketers to meet particular standards without placing disproportionate burdens on industry and the need for those same criteria to be workable in the context of advertising regulation and enforceable by the ASA.
2.2	Weight Watchers, Saatchi & Saatchi, Slimming World, Beachbody	**Notwithstanding other comments made in answer to this question, the organisations listed on the left agreed with the proposal to select particular criteria for inclusion in the rule but considered that the criterion that lifestyle weight management programmes should be of at least three months duration, was unnecessary. In their responses those organisations made one or more of the following points:** • Losing weight at a rate that is compatible with good medical and nutritional practice naturally requires following a weight loss programme for a sufficiently long period. However it is not necessary to require programmes to be "of at least three months duration", as there are already CAP and BCAP rules in place that restrict advertisers from encouraging weight loss over periods of time that are not compatible with good medical and nutritional practice. • While many individuals will follow lifestyle weight management programmes for at least 3 months there are those who can, and do follow programmes for shorter periods of time and that doesn't make the programme any less relevant or beneficial as a tool for obese individuals to lose weight. Indeed any weight loss for an obese individual during that period will have a positive impact on that individual's physical and mental wellbeing. • That the wording should be changed to be clearer and say 'available for at least 3 months duration' as a programme should be available for someone to access for as long as they wish/need to and not necessarily 3 months in duration. • Like smokers, people who struggle with their weight may need to make several attempts	CAP and BCAP understand that when NICE conducted their review of the evidence that went on to underpin PH53, none of the effective programmes in the evidence base lasted less than three months. Requiring this as a minimum duration accurately reflects the evidence base and prohibits programmes of a shorter duration than three months targeting obese people. However the Committees understand that many lifestyle programmes are provided in perpetuity with individuals joining and leaving as they see fit. Programmes provided on an ongoing basis are likely be compliant with this criterion. CAP and BCAP have decided to implement this criterion but have re-worded it to bring it in line with that used in the NICE Guideline.

		to change their behaviour and develop new habits so the emphasis should be as much on the range of available support and accessibility as the length of time for which it is available. • It is not necessary that the same programme be responsible for success over the entire three months and in reality, many people using weight loss management programmes will maintain a healthy lifestyle shift over the course of three months using a mix of shorter programmes	
2.3	Saatchi & Saatchi, WW	Agree that only the following criteria should be included: multi-component and developed by a multi-disciplinary team; shown to be effective at 12 months and beyond, and provided by staff who are trained to deliver them.	CAP and BCAP agree that these criteria should be included.
2.4	NICE	Consider that an additional key criterion is needed: that advertisers should not present / suggest unrealistic weight loss. Recommendation 7 in NICE Guideline PH53 states that providers should discuss realistic weight-loss goals. On average, people attending a lifestyle weight management programme lose around 3% of their body weight, but this varies a lot. Preventing future weight gain and maintaining a lower weight trajectory leads to health benefits. Welcome the comment that 'CAP and BCAP consider that there may be occasions when the ASA needs to draw on the wider Guideline to inform its understanding of the key criteria and therefore propose to allow the ASA the discretion to have regard to Guideline PH53 to help judge whether a particular marketing communication for a lifestyle weight loss programme may permissibly refer to obesity.' This statement could be stronger to indicate that programmes should aim to meet the wider recommendations in the guideline. For example the rule could state "In assessing whether a particular marketing communication may permissibly refer to obesity the ASA may have regard to NICE Guideline PH53. Programmes should therefore aim to adhere to wider recommendations in PH53." An outstanding issue may be what 'effective' means in practice. PH53 recommendation 12 has particular recommendations in this regard, including the need for PHE and others to establish a national source of information on programmes suitable for commissioning.	Under the terms of the new rule advertisers need to hold robust evidence that their programmes are effective before advertising to people who are obese. Rules in the weight loss sections of both Codes already prohibit any claims that programme participants will lose precise amounts of weight. Any claims made about the weight loss experienced by existing programme participants need to be substantiated, not misleading and used with the permission of the individual concerned as already required by the strict rules on testimonials. So long as these rules are complied with CAP and BCAP do not consider that there is necessarily a problem with advertisers using accurate testimonials from those who have lost substantial amounts of weight but advertisers choosing to do so should take care not to state or imply that such depictions are normal where that is not the case. See also 1.6
2.5	RCSEd	Consider that all the following criteria must be achieved by the lifestyle weight loss providers:	See 2.1

		• The programmes must be delivered by multidisciplinary teams and be covered by indemnity insurance. • The trained dieticians must not only be fully qualified but must also ensure that specified dietary targets are given to each client. • The qualified psychologist must be able to offer a variety of behavioural change methodologies which can be adapted to support the individual client's needs and finally the physical exercise instructor must be on the register of Exercise Professionals at or above the level 3 Standard. • The lifestyle weight loss providers must provide audit data to demonstrate an average program weight loss of 3% and confirm that at least 30% of their clients loose 5% of their initial weight in order to substantiate their efficacy claims. • They must also be able to provide documentary evidence that their staff have undertaken regular professional development which includes training in tailoring the client interactions to individual needs; the provision of constructive feedback and most importantly a knowledge of common medical conditions.	
2.6	Slimming World	Consider that some areas which are covered in the NICE guideline have been omitted and should be included in the new rules. There should be specific criteria regarding the level of support given over the programme duration to support its effectiveness as specified in the NICE guidance. Within the NICE guidance it is specified that at least fortnightly sessions should be offered which include a weigh in. Regular support is a vital part of any effective weight management programme. Also recommend the criterion that a respectful and non-judgemental approach be taken. This is a fundamental principle in the NICE Guideline and should be included.	See 2.1 and 2.2 CAP and BCAP consider that criteria of the sort identified by the respondent are amongst those in the Guideline PH53 which are more relevant for commissioners of services and likely to be too granular for inclusion in the rule.
2.7	Lighterlife	Agree with the general thrust of the criteria that CAP and BCAP have identified to change the rules in terms of the holistic approach (behaviour, physical activity and diet) in dealing with the obesity crisis. In relation to the criterion that programmes should be at least three months duration: Agree that there is a need for a programme to have a minimum duration and we suggest that an initial 12 week intervention is a more appropriate objective as it is the industry standard. Agree also that programmes should be multi-component and address dietary intake, physical activity levels and behaviour change. However those that are physically disabled by their obesity will not be able to undertake physical activity until they have lost considerable amounts of weight. In relation to the criteria that programmes "have been developed by a multi-disciplinary team;	CAP and BCAP agree. See 2.2 CAP and BCAP understand that programmes will naturally need to have flexibility on a per-client basis. CAP and BCAP consider that the

		including input from a registered dietician registered practitioner psychologist and a qualified physical activity instructor": concerned at the need to include a practitioner psychologist. Many programmes that use CBT to help people identify and change unhelpful behaviours have been shown to be efficacious in changing behaviours and are not devised with input from psychologists. Agree that a programme should be shown as being effective at one year and beyond. Query how CAP and BCAP intend to assess how programmes are judged to be effective and whether the assessment process will be open and transparent. Agree that the criterion that programmes are provided by staff who are trained to deliver them is important. Query what CAP and BCAP's definition is of "training" and who will judge what level of training is appropriate.	involvement of a psychologist is an important aspect of programme development; hence its inclusion in Guideline PH53. The ASA will expect to see robust scientific evidence that programmes have caused people to lose significant amounts of weight at 12 months or beyond. In relation to training, CAP and BCAP understand that there is not a commonly accepted qualification for staff who deliver weight loss programmes. CAP and BCAP have modified the criterion since consultation to make clear that practitioners are trained in the delivery of the specific programme.
2.8	Beachbody	Do not agree that CAP and BCAP have identified entirely appropriate criteria to include in the rules. Consider that the wording and qualifications in the proposal have been chosen arbitrarily. Specifically concerned by the choice of only five rigid criteria from the NICE Guideline. The Code already ensures that advertisers must not mislead therefore, there is a strong argument for allowing the revised Code to be broader than that proposed. The criterion that programmes be "multi-component and developed by a multi-disciplinary team" is important but too subjective as it is unclear how 'a multi-disciplinary team' should be interpreted and what level of input from the various specialists is required. It is also unclear how products developed outside of the UK might meet the criterion. Consider that the criterion that programmes be "shown to be effective at 12 months and beyond" is drawn from a need in PH53 for programmes to show a return on investment over time. It is arbitrary to restrict advertisers to this time period as a criterion for a successful weight loss programme targeting consumers. The term "effective" will need significantly more clarification. In relation to the criterion that programmes are "provided by staff who are trained to deliver them" Beachbody understand the requirement in PH53 for health Care commissioners to refer patients to trained teams to deliver community activities. In order to transfer this criteria from a clinical	See 2.2 The Guideline and the consultation document set out clear explanations for these criteria. CAP and BCAP do not propose to exclude programmes developed outside the UK if they meet the criteria. CAP and BCAP understand that this criterion is included in the NICE Guideline because weight loss achieved over that longer period stands a better chance of being maintained. The change in the rule is intended to apply to ongoing multi-component

		environment to broadcast advertising code, Beachbody recommends that the criterion "make qualified staff available after purchase" is appropriate. Agree the criterion that programmes be multicomponent should remain but PH53's Recommendation 9 suggests several other criteria which may be a more appropriate qualification for a provider using broadcast advertising such as assisting in providing achievable goals for weight loss; reducing sedentary behaviour and including behaviour change methods. The criteria set out in PH53 are recommendations and it is not expected that every provider meet all 13 criteria. The most reasonable way forward would be to request that a provider of a weight loss management programme which is advertised through broadcast is expected to meet at least 3 of the 13 criteria in Guideline PH53.	weight loss programmes. It is unlikely that a standalone purchased product would meet that criterion. See 2.1
2.9	RCP	Lifestyle weight management programme providers should be permitted to refer to obesity in their advertisements only if they can demonstrate that they will refer their service users to support from medically-qualified health professionals if/when additional support is required. This could be necessary if, for example, an obese person has not been able to maintain a healthy weight through their participation in a lifestyle weight management programme alone, or if an obese person has complex co-morbidities that are not being managed appropriately under the supervision of a qualified health professional. Additionally the criteria need to make clear what is meant by 'trained staff' and specifically what type or level of training is considered sufficient to meet this criterion.	See 2.1 and 2.6. CAP and BCAP consider that a criterion of this sort is unlikely to be effective because there are few ways that an advertiser can meaningfully substantiate compliance with it. See 2.7
2.10	Diet Chef	Strongly disagree with setting criteria for who may refer to obesity in their marketing. Five criteria from Guideline PH53 have been chosen on a seemingly arbitrary basis without justification for choosing them and excluding others. The NICE Guidance is fundamentally addressed towards health services addressing obesity issues and aimed at assessing the suitability of programmes to be commissioned from the perspective of both commissioners and programmes themselves. The only effect of the proposed rules is to prevent advertisers from referencing obesity visually or verbally. It is difficult to envisage the harm in a weight loss programme that does not satisfy all of these criteria but which encourages participants to seek medical assistance in parallel, showing a picture of a person who might be seen by the public as being overweight but who is in fact Category I obese. There is no evidence to illustrate that the public are able to clearly delineate between a person who has a BMI of 29.9 (overweight) and someone who has a BMI of 30 (obese). The chosen criteria are inappropriate and disproportionate. Query the imposition of a minimum three month duration requirement. Individuals approach weight loss in different ways and this requirement will reduce the ability of consumers to make an informed choice as to the options available to them. Weight loss programmes which make reference to Category I obesity should indicate that customers should seek medical advice or supervision in parallel and the individual's medical practitioner in consultation with the individual is better placed to suggest an appropriate	See 2.2 As a result of obesity's links with other serious conditions CAP and BCAP consider that the rule should not be relaxed completely. The ASA will have to make judgements on individual ads on a case-by-case basis. See 2.2

		length of time for the weight loss programme. In relation to the multi-component requirement it is not clear what would be required to satisfy the requirement that programmes addressing dietary intake, physical activity levels and behaviour change. Individuals have different preferences as to how they approach weight loss and this approach is unnecessarily prescriptive. Also consider that it is not clear on what constitutes a multi-disciplinary team. Unclear on the meaning of "*developed by":* is it sufficient for them to merely approve a programme that has been developed by a third party. Is their continuous involvement required? Query the need for programmes to be shown to be effective at 12 months and beyond; the requirement is not drawn from Recommendation 9 of PH53, rather the section concerning national sources of information. Query how effectiveness will be measured and by whom. The 12 month time limit also poses questions as to whether the programme must be effective at that precise point in time or whether "and beyond" adds an on-going obligation to monitor and ensure continued effectiveness. The requirement that programmes be provided by staff that are trained to deliver them is also ambiguous. Training needs to be defined. It is also not evident how programmes must be delivered (e.g. face-to-face / online).	CAP and BCAP consider that these criteria are sufficiently clear when read alongside the entirety of the NICE Guideline. The requirements of this criterion are set-out in the consultation document. Advertisers should have evidence that the course in question has been developed by the professional listed. See 2.7 and 2.8 See 2.7
2.11	ERA	If the supplier of a programme can provide robust evidence supporting its claims for efficacy and safety then that should be sufficient to permit marketing of the product or service. Any changes to the rules should allow for this. As such, all advertisements targeting obese individuals should contain a recommendation that individuals seek professional medical advice before embarking on any weight-loss programme.	Providers meeting the new criteria may make reference to obesity. CAP and BCAP do not consider that it is proportionate to exhort consumers to consult a doctor before embarking on a safe and effective programme.
2.12	Cambridge	There must be a strict and well thought-through definition for 'multi-component' programmes which takes into account those instances where requirements on increasing physical activity or effecting behaviour change may be ineffective in the short term. Agree that programmes must have an established minimum duration and should be able to demonstrate that they are effective at one year and beyond. Question how programmes will be deemed to be effective, what standard and by whom. Criterion on effectiveness should be sufficiently broad and encompass instances where overweight individuals may only need to lose weight in the short term, like when needing to lose weight to qualify for surgery. In that instance, effectiveness would surely be measured in terms of whether the subject was able to qualify for surgery, not whether their weight loss was maintained at 12 months and beyond, when their	CAP and BCAP consider that this is well-defined both in the rule and in Guideline PH53. See 2.7 and 2.8

		increased activity after knee replacement would also be a major contributory factor.	
2.13	VLCD	Criteria should include complying with and following NICE guidance and all applicable legislation; ensuring there is oversight by in-house medical professionals; providing sufficient safety guarantees; and providing the evidence on effectiveness and safety of weight management programmes that is already required by the advertising codes. Agree that programmes should be of an approximately three month minimum duration, which is the industry standard. Agree in general terms with the criteria proposed, but request clarity on how evidence of effectiveness at 12 months and beyond will be assessed, who will be doing the assessment and how this process will be fair, public and transparent.	See 2.2 See 2.7
2.14	A natural health therapist	Disagree. NICE itself admits that most weight-loss programmes result in a total average loss of about 2 kg and cease to be effective after 18 months at the longest. Hence the 3-month to 12-month time-span that is in the re-worded rules is more about selling than providing any real health benefit. In fact such short-term programmes are likely to contribute to weight cycling which is emerging as disastrously harmful to health. Any lifestyle programme should be effective for 5 years or more, otherwise the description "lifestyle" is inappropriate. The dangers or side-effects of such programmes should be consulted for, and listed with each advert (for example those side effects associated with weight cycling, obsession, depression, dementia etc). The inclusion of side effects has not even been mentioned.	The emphasis on efficacy at 12 months or beyond is to ensure that weight loss is indeed achieved over the longer term. Information about the rationale behind NICE's recommendation and the corresponding evidence base is available on NICE's website. CAP and BCAP are not aware of evidence that the listed conditions occur as a result of attending safe and effective weight loss programmes.
2.15	HAESUK	It must be stated what criteria constitutes 'being effective at 12 months and beyond' and what standard of evidence is required. Currently, for medical interventions other than weight management the highest standard of evidence is considered to use data from systematic reviews of randomized controlled trials. This standard should be adopted for weight management. Adverse effects must be routinely monitored covering at minimum physical health, overall psychological wellbeing and eating disorder symptomology. We believe that a different approach to provide for a change in the rules is required altogether. Traditional scientific beliefs on BMI are outdated and it is unethical to use BMI categories as a basis for treatment for individuals. The current approach focusing on weight change is associated with adverse effect on eating disorder symptomology that is routinely ignored.	CAP and BCAP agree. See 2.7. CAP and BCAP do not have a regulatory role in relation to the content of programmes or how they are delivered. BMI remains the central measurement tool used by NICE. The change in the rules specifically requires programmes to be multi-component.
2.16	PHE	Agree that it should be specified that a 'multi-disciplinary team' should include input from a	CAP and BCAP agree.

		registered dietician, registered practitioner psychologist and a qualified physical activity instructor; also that 'multi-component' addresses dietary intake, physical activity levels and behaviour change. It is good to see that interventions need to be shown to be effective at 12 months and beyond.	
2.17	BPS	Consider that the criteria are inadequate to determine if a programme is comprehensive or effective which makes them unenforceable. The proposed duration of a minimum of three months is inadequate. The criteria also fail to specify the depth of content of the multi-components. A third issue is that the multi-disciplinary team should be delivering the programme but if that is not the case it needs to be specified how training will be delivered, to what standards, and how skills are maintained and how are programmes and sites are audited to maintain adequate standards.	See 1.1, 2.7 and 2.8

Question 3 Do you agree that the ASA may have regard to NICE Guideline PH53 to judge whether an advertisement for a lifestyle weight management programme may make permissible responsible references to obesity? If not, or if you consider that the ASA should use the Guideline in a different way please provide your comments.

	Respondent/s	Comments	CAP and BCAP's evaluation:
3.1	NICE, RCPysch, PHE, RCP, Slimming World, Weight Watchers, Saatchi & Saatchi, Rosemary Conley	The organisations on the left agreed with the proposed role of Guideline PH53 given its comprehensive nature. Some of these respondents also drew attention to the value of related NICE guidelines, including CG189 (Obesity: identification, assessment and management of overweight and obesity in children, young people and adults), PH47 (Managing overweight and obesity among children and young people: lifestyle weight management services) and PH29 (Weight management before, during and after pregnancy). To ensure quality of the overall lifestyle programme including the dietary advice, physical activity support and behaviour change techniques used we feel it is appropriate for the NICE Guideline PH53 to be used in this way as this provides a thorough outline of what a suitable lifestyle programme should entail.	CAP and BCAP agree that PH53 needs to be referenced in the rule, however they acknowledge the concern from many respondents that the rule as drafted suggests that it may routinely be used in ASA enforcement decisions. CAP and BCAP have reworded the rule to make clear that it is advertisers (rather than the ASA) that should have regard to it. The Committees do not consider it appropriate, proportionate or practical for the ASA to enforce compliance with the entirety of PH53. It may however be the case that the ASA will refer to PH53 and other relevant documents when needing to inform itself of the underlying reasons for the criteria and the wider context in which it is making enforcement decisions.
3.2	RCSEd	Consider that NICE guideline PH53 in its entirety must be the minimum standard.	See 2.2 and 3.1
3.3	LighterLife, VLCD	Agree the ASA should have regard to Guideline PH53 but NICE guidance should not become the sole reference point, rather it should form the basis for any decision particularly as it provides guidance for organisations operated by the NHS, not for private providers. If responsible private weight management providers can supply adequate scientific evidence that is not covered in NICE guidance then the ASA should take due account of this evidence, even if it conflicts with or supersedes NICE guidance.	See 3.1
3.4	Beachbody	Welcome the use of the NICE Guideline PH53 but have concerns that it is unclear what the ASA define as having "regard to". It must be understood that in the process of pre-clearance of advertising, there is a requirement that the Code is clear enough for Clearcast to make sense of what an ASA Executive may regard as permissible.	See 3.1

3.5	Diet Chef	Disagree with the approach of adopting criteria from PH53 and also disagrees with allowing the ASA to have regard to PH53 in its entirety to adjudicate on compliance with the Code. It is inconsistent as regards the ASA's ability to rely on PH53 stating both that the ASA should not have to adjudicate on another body's Guideline, but at the same time may have regard to it.	See 3.1
3.6	ERA	NICE Guideline PH53 was not intended to be used as a surrogate code or guideline for the regulation of weight-management advertising. Therefore not in favour of ASA referring to the NICE Guideline in the process of deciding whether an advertisement may or may not contain references to obesity. The focus should be on whether it complies with the codes and whether claims are responsible and appropriately substantiated.	See 3.1
3.7	Cambridge	Disagree with the proposal that the ASA have regard solely to NICE Guideline PH53. NICE guidance is designed for the NHS and is not intended to extend to private providers of weight management programmes.	See 3.1
3.8	A natural health therapist	Disagree. The guideline is necessarily one sided, because it tries to make a political decision from a mass of contradictory data. It has chosen data to take notice of, which means there are other data which have been ignored. The NICE guideline should be interpreted with caution, and not used as an irrefutable document.	See 3.1
3.9	HAESUK	Disagree. NICE Guideline PH53 relies on a common, convenient, but out-dated scientific stance on BMI and health. The recommendations in NICE PH53 do not appear to be informed by any literature from critical weight science. The use of BMI is widely critiqued as an unreliable indicator of health at the level of an individual. It is therefore misleading to rely on NICE and to use BMI categories to indicate health. Interventions should target promoting health behaviours and body respect for people of all shapes and sizes.	See 3.1
3.10	BPS	Welcomes the pragmatic approach that there is expertise in weight management in commercial sectors (some not for profit) outside the NHS. Unfortunately within the NHS, what constitutes a tier 2 service remains unclear and how commercial programme relate to wider patient care is confused. The guidance implies that tier 2 services should have significant NHS input. However, advertising creates a direct link with the consumer from which health practitioner is excluded.	See 3.1

Question 4: Do you have any comments or suggestions on the drafting of the proposed rules?			
	Respondent/s	**Comments**	**CAP and BCAP's evaluation:**
4.1	domUK	Agree that the proposed changes to the codes are appropriate, if the rules are altered.	CAP and BCAP agree.
4.2	NICE	The document should be clearer that it applies to programmes for adults only (age 18 and over).	The Codes already prohibit weight loss marketing targeted to those under 18.
4.3	RCSEd	To ensure that the ASA does not open the floodgates and become swamped by applications the rules need clearly state the minimum standard and documentary evidence required before an organisation can be considered for permission to use responsible references to ensure that only applications of an appropriate standard come forward for review.	CAP and the ASA do not pre-approve advertisements but they do carry out enforcement work both proactively and in response to complaints. CAP does provide free pre-publication advice to marketers. TV advertisements on all major channels are pre-cleared by Clearcast and radio broadcasters receive pre-clearance advice from Radiocentre
4.4	Beachbody	Guideline PH53 was designed for commissioners, health professionals and providers of lifestyle management programmes. The cost to the public purse is a guiding theme and skews the advice it gives. Care should be taken when trying to apply it to advertising regulations predominantly used by private organisations to communicate directly with consumers mostly through television As this is a new and complicated area Beachbody recommends that the ASA agree to period of working with advertisers informally in cases of viewer escalations, in the spirit of finding a workable and more durable mechanism for applying the NICE guidelines through retrospectively devised guidance notes.	See 2.2 CAP and BCAP advise advertisers to satisfy themselves that they meet the criteria set out in the rule and seek input from Clearcast, Radiocentre and CAP's Copy Advice team where relevant. The ASA will judge any complaints on a case-by-case basis and CAP and BCAP will conduct a 12 month review of the effect of the rule change.
4.5	ERA	As in many other potentially controversial areas, we believe that the interpretation of any new rules by regulators will be of almost as much significance as the rules themselves. The potential for different interpretations of the rules by different bodies and/or individuals will surely lead to confusion, controversy and contradiction among and between advertisers and the regulators. We would therefore urge that in writing new rules for this area, BCAP should aim for maximum simplicity, objectivity and clarity with a view to reducing the potential for different interpretations of the rules.	CAP and BCAP agree.

Question 5 For advertisers meeting the criteria, do you think they should be able to refer to (and therefore target):
• category I
• category I and II, or
• category I, II and III
of obese people? Please provide any evidence you consider supports your response.

	Respondent/s	Comments	CAP and BCAP's evaluation:
5.1	RCSEd, Weight Watchers, Saatchi & Saatchi, Slimming World, Beachbody, ERA, Rosemary Conley, RCPsych, Cambridge, VLCD	Notwithstanding other comments made, the organisations listed on the left considered that advertisers meeting agreed criteria should be able to makes references to all three categories of obese people. Respondents pointed out that: • Having additional information on the effective programmes that exist to help them lose weight is beneficial to all obese people. • It may be difficult for consumers, advertisers and the ASA to distinguish between adverts targeting individuals in each of these classifications as there is very little difference between those on either side of a BMI borderline. • A significant proportion of those already seeking out lifestyle weight loss programmes have a BMI in the higher bands and programmes are equally effective at those levels.	CAP and BCAP agree that responsible marketing is likely to be of use to people within any of the three categories of obesity.
5.2	NICE	NICE guideline PH53 covered overweight and obesity; some consideration needs to be given as to whether the proposal also covers overweight. PH53 did not have an upper BMI limit but the majority of evidence available was for BMI 30 to 40 and recommendations were aimed 'tier 2' services. The definition of obesity is given in Guideline PH53; please note that this definition should include a reference to NICE guideline PH46. The following text could be added: The use of lower BMI thresholds to trigger action to reduce the risk of conditions such as type 2 diabetes has been recommended for black African, African–Caribbean and Asian groups. The lower thresholds are 23 kg/m2 to indicate increased risk and 27.5 kg/m2 to indicate high risk.(See'BMI and waist circumference – black, Asian and minority ethnic groups', NICE public health guidance 46).	Marketing to those who are overweight was / is not subject to the same restriction being relaxed by these changes to the Codes. CAP and BCAP welcome this clarification. With the change in the rules marketers who meet the criteria will be able to advertise to advertise to the full spectrum of obesity categories, regardless of race or ethnic group.
5.3	PHE	Marketers should be able to refer to and therefore target categories I and II of obese people as there are increased morbidity and mortality risks with increasing BMI. Do not agree that advertisers meeting the criteria should be able to refer to or target category III obese people. Extreme images of morbid/severe obesity (category III) could be used to illustrate overweight and obesity in a voyeuristic fashion and it is important to prevent this (for example in 'before' and 'after' images). Also such images contribute to the normalisation of obesity within	See 5.1.

		society.	
5.4	Beachbody	There are a number of well-documented issues with the use of BMI as a measure of personal health. PH53 advocates the use of waistline circumference measurement and BMI and distinguishes between the BMI of different ethnic groups.	See 5.2
5.5	Diet Chef	A better approach is to allow weight loss programmes not conducted under medical supervision to refer to Category I obesity provided that advertisers encourage people to seek medical help. The ban on targeting Categories II and III could remain given the greater risk of co-morbidities at these higher classifications of obesity.	See 5.1.
5.6	ERA	Consider that advertising for such services should include a recommendation that the user seeks medical guidance before embarking on the programme. There has been a suggestion that weight-management programmes that produce too rapid weight loss (based on actual weight-loss over time) may be inappropriate for some people and potentially harmful. The NICE Guideline now refers to percentage of weight lost over time and if these criteria are met, then there should be no restriction as to whom a weight-management programme may be targeted.	See 2.14
5.7	A natural health therapist	Consider that there should not be any depictions of obese/overweight individuals in weight-loss advertisements at all. The psychological effect of size-perception in UK culture is usually harmful.	See 2.2
5.8	HAESUK	Consider that the issue becomes redundant with a scientific scrutiny of BMI categories.	See 5.1
5.9	BPS	There is no specific evidence to suggest lifestyle weight loss programmes are any less effective or contraindicated in people with a BMI of 40+. What is clear is these programmes require intensity and longevity of the intervention that far exceed the proposed criteria (see the reference and description of Look AHEAD above. A patient group with morbid obesity are more likely have specific health issues, medical requirements, and possible functional limitations that necessitate personalised approaches and individual motoring that cannot be delivered outside of a multi-disciplinary professional setting.	See 5.1. CAP and BCAP will carry out a review of the rule change after 12 months to look for any evidence of harm that may have arisen.

Question 6 Do you agree with CAP and BCAP's proposal to maintain the prohibition on the advertising of weight loss treatments and services to those under 18? You are welcome to provide any other comments you might wish to make on this issue.

	Respondent/s	Comments	CAP and BCAP's evaluation:
6.1	domUK Weight Watchers, Saatchi & Saatchi, Diet Chef, ERA, Lighterlife, Cambridge, VLCD, HAESUK, PHE, Rosemary Conley, BPS, NHT, RCSEd, NICE, RCPsych, Beachbody	The organisations listed on the left agree with the proposal to maintain the prohibition on the advertising of weight loss treatments and services to those under 18.	CAP and BCAP agree.
6.2	Slimming World	11-15 year olds who are overweight / obese require support to manage their weight (with the support of their parent/guardian and the support and advice of a health professional). The review should be mindful of the fact that, as child obesity is a growing problem, responsible organisations should be able to offer support to whole families which may include young people under the age of 18 while not necessarily wanting to advertise directly to this group.	See 6.1

Question 7 Are there any other comments you wish to make, or evidence you wish to submit, in relation to CAP BCAP's consideration of the issues set out in this document?			
	Respondent/s	**Comments**	**CAP and BCAP's (B/CAP's) evaluation:**
7.1	domUK, RCP	Concerned that if images of obese individuals only are used to promote lifestyle weight management services, then an unintended consequence may be that overweight individuals could perceive these services to be inappropriate for their needs. It is important that overweight people are still encouraged to seek support to manage their weight and thus prevent obesity.	Given that those who are normally overweight remain in need of lifestyle weight loss programmes CAP and BCAP currently consider it unlikely that marketers will stop targeting them also.
7.2	domUK, HAESUK, RCP	The organisations on the left expressed concerned about types of images of obesity that would be shown and requested guidance on what is, and is not, acceptable.	CAP and BCAP already provide rules that prohibit images that are likely to cause serious or widespread offence. Advertisements that depict obese people in a derogatory way would risk ASA action.
7.3	NICE	Consider that the Codes could include reference to PH53 recommendation 2 and the core components of programmes (recommendations 9 and 10) that providers and programmes should 'adopt a respectful, non-judgemental approach'. The Code could also encourage marketing communications to take a 'person first' approach in this instance for example 'people who are obese' rather than 'obese people'.	See 7.2. CAP and BCAP note the response but consider that such criteria are not sufficiently specific to make them useful to marketers preparing advertising, or to the ASA when enforcing the rule. However both Codes contain rules prohibiting advertisements from causing serious or widespread offence. Marketers should therefore be careful not to trigger those rules when exploring references to people who are obese.
7.4	Beachbody	The consultation makes no reference to overweight (as distinct from obesity) and this should be addressed. NICE have changed their guidelines from 2lb per week to a % of baseline weight over a time period appropriate to a programme: PH53 makes it clear that both the overweight and the obese	There are no particular restrictions on advertisements targeting the normally overweight and that issue is therefore not the subject of this consultation. CAP and BCAP are aware of this change in the wider NICE Guidelines.

		should target a 10% weight loss but that even a weight loss in the 3% to 5% range and 'maintaining a lower weight trajectory' has a significantly better outcome. This suggests a 'cut off' at BMI 30 is arbitrary and not relevant.	However the 2lb/week rate is well established in the Codes and is well understood by industry to whom it gives certainty when preparing advertisements. CAP and BCAP will however continue to monitor the appropriateness of this rule.
7.5	HAESUK	Currently the Codes state a recommended weight loss is 2lb per week. Consider that CAP and BCAP need to corroborate this statement in conjunction with the requirement for efficacy and no harm at 12 months and beyond. The best available evidence shows that the benefits of dieting are simply too small and the potential harms of dieting are too large for it to be recommended as a safe and effective treatment for obesity. It is unethical to recommend dieting unless the ASA has good quality evidence to refute this finding.	The Codes state 2lb a week as a maximum rate of weight loss unless the person in question is obese. CAP and BCAP do not see a tension between that position and the deregulation set out in their consultation. CAP and BCAP are not recommending dieting. Both the proposal and the final position make clear that the conditional relaxation in the rules is for programmes that are multi-component, in other words those that are not just focused on reducing calorie intake, but also increasing physical exercise and implementing long-term behavioural change.
7.6	Mr A.	The US Federal Trade Commission used an expert team to compile a list of "Red Flag" claims that should not be permitted in weight-loss advertising because they are impossible. They are now called "gut-check claims." Suggest these be included in guidelines.	The CAP and BCAP Codes do not seek to reflect United States law or guidance.
7.7	BPS	Regulators should be aware of how poor weight loss results are for the majority undergoing any programme. Individual testimonials and generally unrepresentative of this and should be controlled. The use of these cases is misleading as they are very much the exception to the rule. Most people will not pass from obesity to normal weight.	CAP and BCAP are aware of the limitations of lifestyle weight loss programmes, however they are proven to be effective. On average people lose 3% of their weight but this varies a lot. CAP and BCAP understand that even losing this small amount of weight is likely to lead to health benefits.