The Health Select Committee Inquiry into Obesity and Type Two Diabetes in New Zealand: An initial analysis of submissions

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Executive Summary

For almost a year the Health Select Committee of the House of Representatives has been holding an inquiry into obesity and type 2 diabetes in New Zealand. This report describes what the 312 submissions had to say on a number of issues relating to obesity prevention. It quotes extensively from submissions to reveal dramatic differences between what the health sector believed was required to prevent obesity and what Government is currently doing or apparently planning. A disturbing feature was that Government seemed more aligned with industry views than those from the health sector in terms of its response to the obesity epidemic.

For the purposes of this report, the submissions were grouped into "sectors": health, nutrition, breastfeeding, physical activity, industry and "other". Health was the largest sector, with 141 submissions. The industry sector (21 submissions) comprised organisations from both the food and advertising industries.

The numerical analysis in this report is based on coding whether each submission contained specific 'propositions', which are general statements that indicated the submitter's position (section 2.2). Analysis of many of the propositions revealed sharp differences between the views of submitters in the health and industry sectors, particularly in relation to advertising restrictions, food labelling, and the role of education in obesity prevention. Propositions on which there was major disagreement are the main focus of this report. Such disagreements were invariably between industry on one hand, and the health sector on the other.

The framework for obesity prevention

There was very little disagreement among submitters that for obesity, prevention was better than cure (section 3). Further, the overwhelming balance of opinion within the health sector was that obesity was at least a major risk factor for type 2 diabetes, with many describing it as the primary modifiable risk factor. These views generally led submitters to the position that essentially the same set of interventions would be required to prevent both obesity and type 2 diabetes.

No submission opposed the view that reducing obesity involved individuals making healthier choices about the food they ate or the activity they engaged in. However, submissions differed in how this goal might be realised. Industry submitters argued that obesity could be reduced if individuals were educated and provided with information that would improve their knowledge and thus lead them to make healthier choices. On the other hand a wide range of submitters, including several international experts, rejected this view and argued strongly for environmental changes that would make it easier for individuals to exercise healthy choices.

There was also disagreement between the health and industry sectors on the need for further evidence before further interventions were implemented. Public health experts submitted there would never be perfect evidence, but that enough was known, particularly from experience with other public health issues such as smoking, to implement measures now. Submissions from industry, on the one hand, argued that there was a lack of evidence for solutions favoured by the health sector such as restrictions on the advertising of less healthy foods.

Views on current Government obesity interventions

The Healthy Eating - Healthy Action (HEHA) strategy has been and remains the cornerstone of the government response to preventing obesity and type 2 diabetes. Industry sector submissions were supportive of HEHA, but elsewhere, and particularly in the health sector, there was a great deal of disquiet, both about the framework and its implementation (section 4). Concerns about the HEHA framework focussed on its failure to tackle the underlying environmental drivers of obesity. There was strong criticism of the failure, under HEHA, to address issues such as the promotion of less healthy food and measures to alter the price differential between more and less healthy food in favour of the former. Concerns about implementation centred around the haphazard and fragmented nature of responses to obesity across the country as a result of perceived leadership failure.

No submission suggested that were not many good initiatives in place and planned under the HEHA umbrella. There was strong support for the commitment of more resources to HEHA interventions. But this was accompanied by a widespread view that interventions needed to be evaluated at a national level, with those most likely to be effective then implemented nationally, and with interventions aimed at changing individual behaviour supported by moves to curb the obesogenic (obesity-inducing) environment.

The need both for stronger national leadership and a cross-sector, whole-of-government approach came together in calls for the establishment of an obesity taskforce.

Advertising of less healthy food

There was powerful support, particularly from the health sector, for regulation by Government of all forms of promotion of less healthy food (section 5). In terms of advertising specifically, 120 submissions proposed that *some form of regulation of the advertising of less healthy food is required.* Of the 120*,* 76 were from the health sector. This represented 54% of the 141 submissions from this sector. This is a massive figure, particularly considering that food advertising was not mentioned in the terms of reference, and that many submissions restricted themselves to their own area of expertise. With the exception of an industry-funded group, not a single submission outside the industry sector stated their opposition to advertising regulation.

Among the 76 health sector supporters of advertising restrictions were:

- nine of the 12 District Health Boards to make a submission;
- six health-related professional associations including the New Zealand Medical Association, the New Zealand Society for the Study of Diabetes, and the Paediatric Society;
- internationally recognised public health experts Dr Robert Beaglehole and Professors Boyd Swinburn and Jim Mann.

The specific proposal to restrict advertising that attracted the most support was that *the advertising of less healthy food to children on television should be banned or strongly regulated by Government.* This was called for in 106 submissions, 67 of which were from the health sector. Again, the only opposing submissions were from the industry sector and an industry-funded group. There was also strong support from the health sector to prohibit sponsorship that associated brands of less healthy food with schools or children's sport.

Many submissions made the point that what was at issue extended beyond specific proposals such as restrictions on advertising and sponsorship. In the words of Professor Boyd Swinburn, the issue was "all commercial food marketing targeting children". Thirty-nine submissions proposed that *the promotion of all less healthy food across all media types should be banned or strongly regulated by Government.*

Professor Swinburn summed up the health sector position by noting that the "interventions needed are government regulations and not industry codes of practice". This was reflected in health sector opposition to industry self-regulation using the Advertising Standards Authority's voluntary codes as the appropriate mechanism to control the promotion of less healthy foods.

Opponents of regulatory restrictions on advertising and other forms of promotion included leading groups from the food and advertising industries that supported the Food Industry Accord: the Food Industry Group, the Food and Grocery Council, and the Association of New Zealand Advertisers.

There was a huge difference in the quality of the evidence and arguments in health sector submissions (for regulation) compared to industry submissions (against regulation). Health sector submissions were able to back their case by referring to the relevant major international academic reviews. Industry submissions, on the other hand, tended to put too much faith in a review of poor academic quality that they had commissioned themselves via the Foundation for Advertising Research. Worse, five industry groups, including the Food Industry Group and the Association of New Zealand Advertisers, built their case against restrictions on advertising around "research" conducted by the World Federation of Advertisers which is completely discredited in this report.

Taxes and/or subsidies to encourage healthy eating

The health sector gave very strong support to at least consideration of tax changes and/or subsidies to encourage healthy eating (section 6). This was based on the potential for pricing mechanisms to affect food choices. Pricing mechanisms were seen as a particularly useful measure since they operated at a population level. Health sector submissions tended to concentrate more on the need for pricing mechanisms in general than on advocating implementation of particular measures. This was presumably because of a general recognition by submitters that they lacked expertise about taxes and subsidies. The submissions suggest that many would have agreed with the Ministry of Social Development that pricing mechanisms "should be approached with caution", but also with the Ministry's conclusion that because of their potential to influence food choices, "they should at least be considered".

Calls for GST to be removed, or at least considered for removal, were popular among those arguing for tax changes to reduce the cost of more healthy food. The motivation behind the majority of these calls was to increase the access to more healthy food for low income families. Subsidies to reduce the price of more healthy food for targeted groups were also supported, with reference made in one submission to the 'Healthy Start' programme being rolled out in the United Kingdom.

Tax changes to increase the cost of less healthy food had substantial support: 39 health sector submissions believed that these should at least be considered. A tax on sugary drinks, for example, was advocated by a university group based on evidence of effectiveness from the research literature.

No health sector submission opposed at least consideration of taxes on less healthy foods. There was, however, substantial food industry opposition. Arguments used included that population-level measures such taxation were inappropriate because they would adversely affect many consumers who were not obese, and that would have little impact on consumption while increasing the price of food for those who could least afford it.

The only submission from other than industry to oppose additional taxes was from the Child Poverty Action Group, which argued that people needed sufficient money to feed their families, and raising the price of cheap food would not achieve this.

Many submissions acknowledged the regressive nature of additional tax on less healthy food, and suggested that such tax increases would need to be accompanied by at least a compensating reduction in the price of more healthy food. Professor Boyd Swinburn pointed out that pricing mechanisms were in fact more equitable than the message-based approached favoured by the industry sector, as the latter was least effective for groups at higher risk of obesity.

It was concluded that the application of taxes and/or subsidies to move food consumption in a more healthy direction was recognised as complex in many submissions. Because of its potential, however, there was a very strong call from the health sector for serious consideration to begin on how to include pricing mechanisms as a leading component in the arsenal of weapons to prevent obesity. Many submitters were less cautious, and wanted measures such as the removal of GST from some foods to be implemented now.

Food labelling

Food labelling was not specifically mentioned in the Terms of Reference, and was addressed in only a minority of submissions (section 7). Nevertheless a clear pattern emerged. Fifty-four submissions, 31 of them from the health sector, wanted to see the introduction of a simple labelling system that distinguished more healthy from less healthy food. A number of submissions made the point that a simple labelling system was particularly important for those segments of the population among whom obesity and type 2 diabetes were more prevalent.

Eight submissions, all but one from industry, proposed that individual foods were not in themselves unhealthy, implying that there was no logical basis for distinguishing more healthy from less healthy foods on food labels. This view was strongly challenged in submissions from the health sector.

The National Heart Foundation's 'Pick the Tick' labelling scheme found support from industry submissions. It was, however, generally seen by health sector submissions that mentioned it as having a major drawback: foods that should at best be eaten only occasionally could still carry the Tick because they were less unhealthy than other foods in the same category, and this was confusing for consumers.

Around half of the submissions wanting simple labels that distinguished more healthy from less healthy foods referred favourably to a 'traffic light' system using a green, amber or red symbol. Twenty-seven submissions said that such a system was required, with a further six calling for it to at least be considered. The only specific opposition to a traffic light system in the written submissions came from two beverage companies unhappy about the colour category assigned one of their products in the Waitemata District Health Board's traffic light beverage guidelines for schools. This, however, illustrates why a proposal to implement a traffic light scheme in New Zealand would almost certainly meet strong industry opposition, as is currently occurring in the United Kingdom.

The industry submissions that addressed health claims wanted to be able to make such claims on food labels and to be able to advertise them. They believed that this would be beneficial in helping prevent obesity and type 2 diabetes. Some industry submitters believed that the current FSANZ proposal to allow health claims did not go far enough.

Submitters from outside industry, however, took a very different view. They believed that health claims only benefited industry, and were much more likely

to mislead consumers than inform them. No submissions outside the industry sector supported the FSANZ proposal, and many opposed it, including 15 submissions from the health sector.

Health sector recommendations and current Government policy

It was noted that current Government policy relating to regulation as a preventive measure for non-communicable diseases was contained in a recent Ministry of Health publication on proposals in the Public Health Bill. The Ministry expected this Bill to be introduced some time in 2007. The proposal indicated there would be provision in the Bill for the Director-General of Health to make non-binding codes and guidelines (but not regulations). This would probably be regarded by some submitters as a positive first step. On the other hand, many in the health sector submitted that the current voluntary regime for advertising was inadequate (section 5.4) and would probably see little reason as to why non-binding codes and guidelines will result in much improvement when they believed regulation by Government was required.

The Bill as currently proposed requires the Minister of Health to come back to the House within three years of enactment with further proposals that may include regulation. Parliament would then have to debate and act on the Minister's proposals, adding a further delay. Given the apparent reluctance of successive Ministers to regulate, current proposed provisions in the Bill make it around 2012 at best before any regulatory action might occur.

The public health view of this, as expressed in the calls for regulation of the promotion of less healthy food and the need for urgent action, would probably be that this represented unnecessary and damaging delay on Government's part.

Twenty submitters in the health sector proposed that *the Public Health Bill needs to be progressed so that it provides a framework for effective action to prevent obesity.* Most of these 20 would probably be disappointed that there is no move at this stage to include regulation-making powers.

Diabetes New Zealand (DNZ) made the only submission that ignored the Public Health Bill as the suitable vehicle to obtain changes to the obesogenic environment called for by the health sector. Instead they proposed a 'Healthy Environments Act'. Unless the proposed Public Health Bill is given regulatory teeth, many public health advocates may well move to support something like the DNZ proposal as a Private Member's Bill.

It appears that use of taxes and/or subsidies as a means of encouraging healthier food choices is scarcely on the radar for the present Government. The weight of argument from the submissions is clearly and firmly on the side of using pricing mechanisms of some sort as an important component of obesity prevention. One would expect that therefore many submitters will be hoping that the Select Committee adopts in principle the position that pricing mechanisms are required to help make healthy choices the easy choices, and

recommends to the House that prompt and serious consideration is given to the forms such mechanisms should take.

It was apparent when the Ministry of Health appeared before the Inquiry on 7 March 2007 that they did not favour the 'traffic light' proposal. It is assumed that this is the current Government position.

Conclusion

A compelling feature of the submissions, particularly from the health sector, was a call for public health measures (measures impacting at a population level) to be introduced as a key component of obesity prevention (section 3). A very strong message has come from those in the health sector dealing with the consequences of obesity and type 2 diabetes that a much stronger preventive response is required from Government. To date Government has generally ignored this call. Instead it has, largely through the Food Industry Accord, sought to achieve change through voluntary actions by the food and advertising industries. Those at the coalface rejected this approach in their submissions (section 4), and asked for a great deal more done on prevention than is currently occurring. And they wanted action urgently, not by perhaps 2012.

The health sector, through its submissions, has given a very clear message. To make effective progress in reducing obesity, action must be taken by changing the environment to make healthy choices easier. These actions include:

- restricting the advertising and other forms of promotion of less healthy foods, particularly to children;
- finding ways of using pricing mechanisms (taxes and subsidies) to encourage New Zealanders to adopt a more healthy diet;
- making it easier for consumers to make healthy food choices through changes to food labelling such as the proposed 'traffic light' system.

1 Introduction

1.1 The Inquiry

On 22 February 2006 the Health Select Committee of the House of Representatives announced that it was to hold an inquiry into obesity and type 2 diabetes in New Zealand, and invited submissions. The Terms of Reference were as follows:

1. To examine the causative factors likely to be driving increases in obesity and type 2 diabetes, including nutrition and physical activity.
2. To identify the effects of obesity and type 2 diabetes on the health of both children and adults and across ethnic and socio-economic groups and potential future costs.
3. To inquire into the effectiveness, particularly for children, of current obesity prevention approaches and interventions including primary prevention and screening, information provision, education, physical activity and voluntary steps taken by the food industry.
4. To inquire into whether additional interventions aimed at changing features of the environment that promote obesity are required.
5. To consider what policy or legislative mechanisms, if any, should be used to give effect to any findings of the inquiry.
6. To report the inquiry's findings and recommendations to the House of Representatives.

The Committee commenced public hearings on 10 May 2006 with the Ministry of Health presenting its background paper. Public hearings were held on about 20 days. The last such day was 8 November 2006, except for two further hearings on 7 March 2007 (the Ministry of Health) and 14 March 2007 (the New Zealand Food Safety Authority). Most hearings were in Wellington, but the Committee also travelled to Christchurch, Palmerston North, Auckland (twice) and Hamilton. The Committee heard oral presentations for a fraction over half of the submissions (158 of 312).

1.2 The rationale for an analysis of the submissions

It was clear to those who followed the Inquiry that a great deal of very valuable material had been made available to the Committee. Fight the Obesity Epidemic New Zealand Incorporated (FOE) was concerned that this material should form a resource that could inform debates on how best to reduce obesity and type 2 diabetes in New Zealand. It therefore commissioned the author to produce this report. In particular, FOE wanted information it could use to assess how well the Committee's report, when it becomes available, reflects the main themes in the submissions. Further, it wished to strengthen its position for the debate that is expected, both in and

outside Parliament, while the Committee's report lies on the table of the House.

The report contains extensive quoting from submissions. This is central to the approach adopted, with the intent being to give an accurate picture and something of the flavour of what the submissions are saying.

2 Method and scope

2.1 Selection and classification of submissions

The Committee's records show that it received 313 submissions, as well as a background paper from the Ministry of Health with is treated as a submission for the purpose of this report. Two "submissions" were excluded from the analysis. The first, submission 302, proved to be a duplicate of submission 151. The second, submission 295, was a set of papers forwarded by an overseas academic, but without any covering submission. This left 312 submissions for use in the analyses on which this report is based.

The 312 submissions were classified into 43 categories, as set out in Table 2.1.[1] Horticulture New Zealand (s140)[2] was classified as "industry group – food and beverages" as its submission referred to the activities of "The Chip Group".

Table 2.1 also shows how the categories were then grouped into "sectors": health, nutrition, breastfeeding, physical activity, industry and "other". The industry sector (21 submissions), for example, included two broadcasting companies, five companies in the food and beverages industry, six advertising or broadcasting groups, and eight food and beverages groups. The last two categories mainly comprised umbrella groups acting on behalf of individual companies.

The selection of sectors was partly dictated by the needs of the quantitative analysis, which considers differences across sectors in the clustering of support for particular propositions. It is acknowledged that many of those who wrote submissions classified as in the nutrition sector, for example, would regard themselves as part of the health sector. Similarly it could be said that breastfeeding is part of nutrition.

The 141 submissions received from health sector (see Table 2.1) comprised 45% of all submissions received.

[1] Where a submission could be classified as belonging to more than one category, the first descriptor mentioned was used to classify the submission. If, for example, a submitter described herself as a dietitian and parent she was classed as a dietitian. If she said she was a parent and a dietitian she was classed as a parent.

[2] Throughout this report 's140' means 'submission number 140', and so on.

Table 2.1 The 312 submissions by category and sector

Category	Health	Nutrition	Breast-feeding	Physical Activity	Industry	Other	Total
Academic group - health	6						6
Academic group - nutrition		2					2
Academic group - other						1	1
Academic group - physical activity				2			2
Academic individual - health	8						8
Academic individual - nutrition		2					2
Academic individual - other						1	1
Breastfeeding group			9				9
Broadcasting company					2		2
Central government agency - health	1						1
Central government agency - other						4	4
Central government agency - physical activity				2			2
Church group						3	3
Company - food and beverages industry					5		5
Dietitian		10					10
District Health Board	12						12
Group - other						15	15
Health group - diabetes	9						9
Health group - other	12						12
Health group - public health	7						7
Individual - other						30	30
Industry group - advertising/broadcasting					6		6
Industry group - food and beverages					8		8
Local Cancer Society	5						5
Local Diabetes Society	7						7
Maori health provider/service	8						8
Medically-qualified health professional	11						11
National group - specific health condition	5						5
Nutrition group		14					14
Obese or diabetic person, or formerly one						8	8
Other health worker	16						16
Other physical activity worker				6			6
Pacific peoples health group	3						3
Parent						12	12
Physical activity group				13			13
Physical activity professional/academic				3			3
Primary Health Organisation	6						6
Professional association - health related	14						14
Professional association - nutrition		2					2
Professional association - physical activity				1			1
Regional group - nutrition & physical activity	11						11
Regional Sports Trust				8			8
School						2	2
Total	141	30	9	35	21	76	312

2.2 Propositions

2.2.1 Definition of 'propositions'

The numerical analysis in this report is based on coding whether each submission contained specific 'propositions'. These are generalised statements that reflected common statements expressed in similar ways across a range of submissions. They are not quotations from particular submissions. Propositions are shown in italics in sections 3 to 8 below.

There were two ways in which a submission was coded as *proposing* a proposition:

1. The submission included a statement that had the same or a very similar meaning to the proposition.

2. The proposition was clearly implied by statements made in the submission. For example, the statement "GST should be removed from fruit and vegetables" implies the proposition that *some form of tax changes and/or subsidies to encourage healthy eating is required*, which in turn implies that *some form of tax changes … should at least be considered*.

Submissions were similarly coded as *opposing* a particular proposition when opposition was specifically stated, or clearly implied. An example is the proposition that *the advertising of less healthy food to children on television should be banned or strongly regulated by Government.* A number of industry submissions stated their opposition to this proposal in anticipation that it would be included in other submissions

Sometimes submitters indicated their support for the arguments advanced in other submissions. In two such cases, where statements implying full support for all aspects of another submission were made, the same coding for propositions was used as for the other submission. The two submissions were:

- The Dietetic Association (s121): "We are members of Agencies for Nutrition Action (ANA) and endorse the causes, effects and recommendations proposed in the submission made by this group."
- CAANZ (s250): "The submission of the Food Industry Group (FIG) should be regarded as the submission for the Communication Agencies' Association (CAANZ)."

2.2.2 Selection of propositions for analysis in this report

Submissions were coded using some 270 propositions. Only a fraction of these propositions are covered in this report.

Analysis of many of the propositions revealed sharp differences between the views of submitters in the health sector as compared to industry, particularly in

relation to advertising restrictions, food labelling, and the role of education in obesity prevention. Propositions on which there was major disagreement are the main focus of this report. The main reason for this is that, in terms of obesity prevention, it is only in relation to certain foods and drinks that a powerful group with a very different message from that of health advocates has the ear of Government. There were no submissions opposing, for example, the strongly supported expansion of active transport.

Analysis of less controversial propositions is generally missing from the present report because of limitations of time and space. These will be included in a more comprehensive report to be prepared in collaboration between the author and Associate Professor Grant Schofield from the Centre for Physical Activity and Nutrition Research at the Auckland University of Technology.

For each proposition selected for analysis, every effort has been made to provide a fair and objective description of the arguments advanced both for and against it.

2.3 Common sources of information used in submissions

A number of submitters used common information for part of their submissions. About 10% of submissions used material supplied by the Obesity Action Coalition (OAC).

Three of the 21 industry submissions drew heavily on a report prepared by Associate Professors Debra and Michael Harker from the University of the Sunshine Coast in Queensland (submission 161, hereafter referred to as the Harker Report). Five industry submissions used a table from the World Federation of Advertisers (WFA) as evidence that advertising restrictions do not work.

This report assumes that the views expressed in all submissions are those of the organisations that made them, irrespective of whether they draw to some extent on information provided by others.

2.4 A note on terminology

The terms ‘healthy’ and ‘unhealthy’ food were widely used in submissions, particularly among those from the health and nutrition sectors. On the other hand the general industry view was that individual foods could not be labelled as good or bad, since it was their role in a person’s total diet that mattered. In somewhat of a compromise the terms ‘more healthy’ and ‘less healthy’ food are used in this report.

References to more healthy or less healthy food should be read throughout the report as including drinks.

3 The framework for prevention

3.1 Introduction

3.1.1 The case for obesity prevention

The general view among submitters was that, for obesity and type 2 diabetes, prevention was much better than cure. Thirty-two submissions, for example, expressed the view that *because obesity and its consequences for health are difficult and/or expensive to treat, prevention is crucial*[3]*.*

The New Zealand Society of Anaesthetists demonstrated the huge costs that could be incurred just for one case resulting from obesity, their example being that of a man aged 39 years and weighing 276kg who had gastric bypass surgery (s215A).

The Kidney Foundation made a typical case as to why urgent preventive action was needed. The Foundation noted a prediction that numbers of people suffering from End Stage Renal Disease is expected to double in 10 years, mainly as a result of increases in type 2 diabetes. They continued:

> With this overwhelming number of potential end stage renal failure patients requiring renal replacement therapy we believe urgent and effective action must be undertaken before the already stretched renal services in New Zealand are totally overwhelmed in terms of capacity and financial resources …, [and that] prevention is the key (s16, p2)

The Foundation's view that urgent preventive action was required was widely shared. Forty-eight submissions explicitly stated that *urgent action is required to tackle obesity.*

3.1.2 Preventing type 2 diabetes

An assumption underlying the great majority of submissions that considered the prevention of type 2 diabetes was that this required essentially the same measures as obesity prevention. This was because type 2 diabetes was generally considered to be a consequence of obesity. Thirty-eight submissions, 30 of them from the health sector, stated that *obesity is a major risk factor for the development of type 2 diabetes.* Of the 38, 21 believed that *obesity is <u>the</u> primary modifiable risk factor for developing type 2 diabetes*. There were three dissenters to both these propositions, the only one from the health sector being bariatric surgeon Richard Stubbs (s191, p2).

[3] Throughout this report, statement in italics express "propositions" as defined in section 2.2.

3.1.3 Two approaches to prevention

Two propositions relating to the making of healthy choices had substantial support from submissions:

- *Educating, informing and encouraging individuals to make the right choices should be the central focus of efforts to reduce obesity;*
- *Changing the environment to make healthy choices the easy choices is central to reducing obesity.*

These two propositions cover the two main themes in the submissions relating to prevention. The first proposition summarises the industry position[4], and the second that of the health sector.

3.2 The industry position: changing individual behaviour

Table 3.1 shows that in nine (of 21) of the industry submissions it was proposed that *educating, informing and encouraging individuals to make the right choices should be the central focus of efforts to reduce obesity*. No submissions from other sectors proposed this, and 11 specifically opposed it.

Table 3.1 Educating, informing and encouraging individuals to make the right choices should be the central focus of efforts to reduce obesity

Sector	Proposed	Opposed
Health		6
Nutrition		3
Physical activity		1
Industry	9	
Other		1
Total	9	11

A crucial point must be understood in interpreting the numbers in Table 3.1 and later tables. The numbers in the "Proposed" column indicate the number of submissions in which this proposition was made (see section 2.2). The numbers in the "Opposed" column refer to those submissions that specifically stated their disagreement with the proposition. Many other submitters would doubtless have agreed or disagreed with the proposition if asked for their

[4] References to "industry" or the "industry sector" throughout the report refer to the food and advertising industries as represented in their 21 submissions (see section 2.1).

view. But a well-based view on this proposition requires knowledge of the relevant literature, something that the majority of submitters would not have.

The key point about Table 3.1 and others like it is therefore not the total numbers, but the distribution of the numbers. In Table 3.1 it is highly significant that ***all*** of the submissions that state the proposition are from just one sector (industry), and ***all*** the submissions stating their opposition to the proposition are from sectors other than industry. Such a strong dichotomy means the view that *educating, informing and encouraging individuals to make the right choices should be the central focus of efforts to reduce obesity* can properly be described as 'the industry position'.

The Food Industry Group (FIG) summed up the industry position as follows:

> At the centre of the solution is the individual… Given the range and availability of food items on offer, the key is in giving people the knowledge and ability to make healthy choices. It comes down to teaching people the basic principles of how much they consume vs. how much they move (s157, p15).

The McDonald's submission pursued the same theme:

> We believe that food choice is a matter for the individual, or in the case of children, for parents or caregivers who have a personal responsibility to exercise that choice wisely… We believe the strategic response must focus on education and information. Education is needed to help people appreciate the importance of a balanced diet and physical activity in their own health and the health of their children. Information about food choices and the role of exercise is needed to help people exercise their choices wisely (s192, pp7,21).

The New Zealand Food and Grocery Council reiterated this position:

> We live in a democracy, not a dictatorship, and thus we cannot tell people that they cannot eat some foods but eat lots of others. We can only exhort. It is how well we exhort the consumption of healthy diets and living healthy lifestyles that will achieve the objectives of reducing obesity and the incidence of type 2 diabetes (s163, p3).

The food industry thus saw its role as providing a wide range of food choices from among which individuals could select. Reducing obesity came down to informing, educating and exhorting individuals to choose wisely, a role mainly for Government, but with industry prepared to help.

3.3 A different view to the industry approach

The health, nutrition and physical activity sectors strongly supported the proposition that *education and information provision without environmental changes will be ineffective in reducing obesity* (Table 3.2) This point was made in 43 health sector submissions, as well as in a further 21 submissions from other sectors. The only opposition to this proposition expressed was from nine industry submissions that proposed that education and information provision should be central (Table 3.1).

Table 3.2 Education and information provision without environmental changes will be ineffective in reducing obesity

Sector	Proposed
Health	44
Nutrition	5
Physical activity	4
Other	11
Total	64

This proposition was fundamental to many of the submissions advancing it. Professor Boyd Swinburn's submission epitomised the argument with his statement that obesity "is NOT a knowledge-deficit problem". He noted:

> Most people, including children, know what is healthy food and what is junk food and that regular exercise is good for health. Education approaches alone (increasing knowledge) have proven to be weak in influencing most epidemics except where there is clearly a knowledge deficit… Education needs to be part of the mix of interventions but not amongst the top priorities (s189, p5).

The National Heart Foundation drew attention to the evidence that education alone was ineffective when used to reduce obesity among high at-risk groups:

> The government should consider obesity a normal response to an abnormal environment. Many of the determinants of obesity are structural and environmental and are outside the control of families/whanau and individuals. Therefore focussing interventions solely on educating people and trying to get them to 'pull themselves up by their bootstraps' ignores all that we know about what determines health and wellbeing. Worse, it is an ineffective, naïve and futile approach that delays effective actions and widens … disparities (s47, p4).

Dr Robert Beaglehole, Director of the Department of Chronic Diseases and Health Promotion at the World Health Organisation, made the same point:

> Simply asking people to change their behaviour is not sufficient and as a strategy for health promotion it has a long history of failure, especially for disadvantaged groups (s307, p6).

Beaglehole instead sought "sustained political commitment to shape healthy environments" (*ibid*.).

The Clinical Trials Unit at the University of Auckland gave a more academic tone to the same message:

> There is a large body of literature on educational and behavioural programmes that shows that such individual-orientated programmes have modest success but at high cost… In cardiovascular disease prevention, large community programmes focussing mainly on education have had

> little or no effect, whereas projects combining education with environmental or structural changes … have produced impressive results (s83, p6).

Otago University's Professor Jim Mann and his colleagues wrote:

> Our own experience in New Zealand confirms that education measures and programmes aimed at individuals or groups are unlikely to succeed at a national level unless complemented by additional measures which may have policy or legislative implications (s256, p7).

And finally, Janet Hoek, Professor of Marketing at Massey University, argued that, from an advertising and marketing perspective, a focus on changing individuals' knowledge was ineffective. She concluded:

> I do not accept the argument that consumers' behaviour should change through exertion of greater self-control or in response to education campaigns. Instead, I believe it is timely to consider how environmental changes can help increase the probability that consumers will develop healthier eating habits (s127, p11).

The author was unable to find, in any submission, any evidence-based argument that drew a different conclusion to that of Swinburn, the National Heart Foundation, Beaglehole, the University of Auckland Clinical Trials Unit, Mann, and Hoek.

In conclusion, those arguing that education and information provision will be ineffective in the absence of environmental change are internationally recognised experts on issues relating to obesity prevention.[5] Second, it is striking that so many submitters, working in quite different fields, advanced this proposition. The submissions reveal a widespread concern that Government may accept industry arguments and initiate a programme aimed only at changing individual behaviour. While submitters recognised that implementation of population-level measures opposed by the food and advertising industries may be unpopular with those groups, they nevertheless were unanimous in their view that no progress against obesity and type 2 diabetes could be made without major changes to the current obesogenic (obesity-inducing) environment.

3.4 The health approach: making healthy choices easier

3.4.1 The need for environmental changes

The health sector put a heavy emphasis on environmental change as the key to prevention. Of the 141 health sector submissions, 77 (55%) proposed that *to be effective, obesity prevention requires environmental changes that impact at a population level.*

[5] For example, Professors Swinburn and Mann and Dr Beaglehole were prominent at the 10th International Congress on Obesity held in Sydney in 2006.

Only one submitter from the health sector specifically disagreed with this proposition. Bariatric surgeon Richard Stubbs argued:

> While there are almost certainly environment factors contributing to obesity and diabetes, these are most unlikely to be of primary importance. Genetic factors, currently not well understood, are much more likely to be found to be of primary importance. For this reason environmental manipulations are unfortunately very unlikely to provide a major turnaround in the present trends (s191, p2).

Dr Robert Beaglehole was among the obesity prevention experts who disagreed with the Stubbs position. Beaglehole noted:

> Environmental factors are responsible for the emergence of childhood obesity in New Zealand and elsewhere… Genetic susceptibility to obesity, or other ill defined social or psychological factors, play an insignificant role (s307, p4).

Seventeen submissions made the point that *genetic explanations cannot account for recent increases in obesity at the population level*. As was pointed out by Regional Public Health South, while genetic influences undoubtedly have an influence on obesity in *individuals,* this does not explain increases in *populations* (s135, p4). Changes in the gene pool which could explain changes in population obesity rates could only take place over generations.

3.4.2 Making healthy choices the easy choices

The argument in favour of environmental change was sometimes expressed by the proposition that *changing the environment to make healthy choices the easy choices is central to reducing obesity.* This proposition, which sums up the public health approach, was specifically stated in 37 submissions.

A typical expression of this proposition was stated by the Ministry of Social Development. After outlining some of the actions required to reduce the long term effects of obesity, the Ministry concluded that:

> Sitting above all of these specific actions is the concept of changing the obesogenic environment to make healthy choices the easier choices (s301, p4).

As Professor Boyd Swinburn put it, “Healthy environments make the default choices the healthy ones” (s189, p5).

Making healthy choices the easy or default choices was seen by submitters as applying to both healthy eating and healthy action. The Canterbury District Health Board provided an example of the latter, “If walking and cycling are the easiest ways for people to get where they need to be their physical activity levels are likely to rise” (s83, p30).

3.5 Evidence and the need for action

There was widespread agreement across all sectors that the evidence base relating to specific interventions to prevent obesity was generally weak. This prompted calls in a number of submissions such as that from the Otago Obesity Research Consortium at Otago University (s279) for a strong focus on, and commitment of resources to, research and evaluation.

There were contrasting views as to what the state of the evidence base implied for preventive actions, as is shown in Table 3.3. Eight submissions, none from industry, expressed the view that *enough is known about effective prevention to implement measures now without waiting for further evidence.* A further four, all from the health sector, argued in similar vein that *lack of evidence should not be used as an excuse for failing to take action now.*

Table 3.3 Enough is known about effective prevention to implement measures now without waiting for further evidence

Sector	Proposed	Opposed
Health	5	
Physical activity	1	
Industry		4
Other	2	
Total	8	

The numbers Table 3.3 are small because few submissions referred to implications of the evidence base for obesity prevention. The distribution of the numbers (only industry submissions opposing the proposition and none supporting it) is highly significant, and shows a clear difference between health and industry perspectives.

Dr Robert Beaglehole put the case that preventive actions could not wait for more evidence.

> As is usual in public health, the scientific basis for action is incomplete. It is important to make the best inferences on the basis of existing information while continuing to build the evidence base. As in other public policy areas, waiting until the evidence base is complete is not a helpful option… Furthermore, there is sufficient evidence upon which to base a national strategy and plan of action for the prevention of obesity (s307, p12).

Professor Boyd Swinburn noted that ideally priorities for prevention should be evidence based. He continued:

> The problem is that specific evidence on the effectiveness of interventions is very thin, although we know in general which ones are likely to be effective. This is based on the experience of the control of

> other epidemics (eg cardiovascular diseases, smoking diseases, road injuries, HIV AIDS, cot death, cancer control) and modelled estimates for the impact of interventions (s189, pp4-5).

The Ministry of Social Development observed:

> Lack of clear evidence of effectiveness of interventions is not a reason not to act, but it is a very strong reason to evaluate new actions (s301, p6).

All four submissions opposing the view that *enough is known about effective prevention to implement measures now without waiting for further evidence* were from the industry sector. The submission from the Food Industry Group (FIG) is representative of the industry position. FIG referred to a number of what they believed were inconsistencies in obesity research findings to argue that there was insufficient understanding of the causes of obesity on which to base preventive action. They continued:

> Some people claim that even though we do not know enough about the causes of the problem, we must still act – as if panicking blindly will be more helpful than taking a moment to size up the situation. If we do not answer the questions above [about causes], then New Zealand runs the risk of attempting solutions which unnecessarily impact on all New Zealanders while being unlikely to make any significant impact on those who are obese (s157, p9).

The Radio Broadcasters Association took a similar approach to FIG:

> [We] … still suffer from an absence of definitive knowledge about causation of obesity and indicators as to the success or not of various interventions. We therefore reason that it would be unwise to initiate new interventions unless there is overwhelming "balance of probability" of success in their favour (s187, p6).

Professor Janet Hoek would not be surprised at the industry position. She drew a parallel with tobacco:

> Deferring action until a specific causal relationship between advertising and obesity levels has been established would overlook actions that could be taken using existing knowledge on how advertising supports and maintains behavior. Drawing on our experience with tobacco, I believe a requirement to identify a definitive causal relationship between environmental factors, such as advertising and marketing activities, and food consumption will prove problematic and contentious… The methodological debates that I anticipate occurring would inevitably delay the implementation of policies that might aim to curtail marketing activities. In the case of tobacco, the industry's well-documented determination to dispute the existence of any causal link between smoking and a range of illnesses effectively delayed the introduction of warning labels, restrictions on marketing activities, and limits on product supply arrangements. I believe the food industry, by which I mean manufacturers and suppliers of foods high in fat, salt and sugar and their advertising and marketing partners, has already adopted a similar line of reasoning in the obesity debate (s127, p2).

3.6 Summary and conclusions

There was very little disagreement among submitters that for obesity, prevention was better than cure. Within the health sector there was an overwhelming balance of opinion that obesity was at least a major risk factor for type 2 diabetes, with many describing it as the primary modifiable risk factor. These views generally led submitters to the position that essentially the same set of interventions would be required to prevent both obesity and type 2 diabetes. As well, 48 submissions explicitly stated that *urgent action is required to tackle obesity.*

No submission opposed the argument that reducing obesity involved individuals making healthier choices about the food they ate or the activity they engaged in. However, submissions differed in how this goal might be realised. Industry submitters argued that obesity could be reduced if individuals were educated and provided with information that would improve their knowledge and thus lead them to make healthier choices. On the other hand a wide range of submitters, including several international experts, rejected this view and argued strongly for environmental changes that would make it easier for individuals to exercise healthy choices.

There was also disagreement between the health and industry sectors on the need for further evidence before further interventions were implemented. Public health experts submitted there would never be complete and uncontested evidence, but that enough was known, particularly from experience with other public health issues such as smoking, to implement measures now. Submissions from industry, on the other hand, argued that there was a lack of evidence for solutions favoured by public health advocates such as restrictions on the advertising of less healthy foods.

It is ironic that industry submitters argued that there was insufficient evidence to implement measures that they did not like, while strongly supporting interventions based on information provision and education alone. Public health experts submitted evidence that this approach favoured by industry would not be effective, and that major changes to the environment were required.

Three of the environmental changes called for by submitters are discussed below in sections 5 to 7. But before that, we consider what the submissions had to say about the adequacy of current government actions, bearing in mind the general points made above by submitters about the direction in which they believed change was required.

4 Views on current prevention initiatives

The Healthy Eating – Healthy Action (Oranga Kai – Oranga Pumau) strategy (HEHA) provides the current strategic framework for the Government response to obesity. It is a high-level framework designed to improve nutrition, increase physical activity and reduce obesity among New Zealanders. It was launched in 2003, with an Implementation Plan for the years 2004 to 2010 released the following year.

This section outlines the differing views on HEHA among submitters, and describes features of a high level of dissatisfaction about HEHA, particularly in the health sector. The section ends with a description of how this dissatisfaction has led to widespread calls for an obesity taskforce to drive cross-sector action, in conjunction with changes to reduce the impact of environmental factors driving increases in obesity such as the promotion of less healthy food.

4.1 HEHA as a sufficient strategic framework

There were widely differing views on the proposition that *HEHA provides a sufficient framework for addressing the prevention of obesity in New Zealand.* Table 4.1 shows that this proposition had some support from within all sectors except nutrition, but predominantly from industry (7 submissions). The two health sector organisations supporting the proposition were the Ministry of Health in its background paper, and the Waitemata District Health Board. The 12 submissions opposing the proposition were all from the health sector.

Table 4.1 HEHA provides a sufficient framework for addressing the prevention of obesity in New Zealand

Sector	Proposed	Opposed
Health	2	12
Physical activity	3	
Industry	7	
Other	1	
Total	13	12

4.1.1 The arguments for: HEHA is all that is required

The 21 industry submissions comprised 7% of all submissions, but 54% of the submissions proposing that HEHA provided a sufficient framework for obesity

prevention. This is an interesting statistic, given that one might expect that expertise as to what constituted a suitable framework for addressing obesity was less likely to be found in the industry sector than in, for example, the health sector.

Among the strongest endorsements of HEHA was that from the New Zealand Television Broadcasters' Council (NZTBC):

> The NZTBC considers that the Government's Healthy Eating, Healthy Actions strategy (HEHA) represents a state of the art plan for action. The NZTBC fully supports the approach advocated by HEHA and urges the Government to place more resources behind this programme of action. No additional interventions are required (s293, p2).

McDonald's believed that HEHA was "a sensible and workable strategic framework for tackling obesity". They were impressed that HEHA was an "educational rather than prescriptive response", and included a "commitment to working with the food sector, encouraging a voluntary and shared response to an issue affecting all New Zealanders" (s192, p6).

There was very limited support for the proposition from outside the industry sector.

The Waitemata District Health Board, while critical of the implementation of HEHA, supported the strategic framework.

> The HEHA Strategic Framework and Implementation Plan were widely viewed by local and international public health experts in this area as ground breaking documents. The quality of the work done was high. Therefore one needs to review the barriers to its implementation (s110, p2).

The submission from "Active Hauraki" praised HEHA as "an evidence based and very comprehensive plan with the potential to reduce obesity if adequately resourced" (s204, p4), and as containing the strategies needed to achieve environmental change (p1).

4.1.2 The arguments against: HEHA does not go far enough

The National Heart Foundation did not believe that "there is an adequate framework in place for the prevention of overweight and obesity in New Zealand":

> Few of the really effective policy initiatives that would change the default options in society from unhealthy to healthy are specified in HEHA and all of the actions are voluntary (s47, p7).

The Heart Foundation believed that environmental changes needed such as "restricting advertising of low nutrient/energy dense foods, changing the ratio of healthy to unhealthy food in the food supply and changing social policy to reduce poverty" were unlikely to be achieved under HEHA.

The submission from Associate Professor Robert Scragg and others on behalf of the Obesity Prevention in Communities (OPIC) project took a similar view to the Heart Foundation:

> The current focus of obesity prevention by the Ministry of Health … is mainly on social marketing. Given the multiple drivers for the obesity epidemic operating in many settings, it is unrealistic to expect the current HEHA strategy to reverse current obesity trends. The Ministry of Health should use all the options it used to tackle the tobacco smoking epidemic. These include legislation and taxation (s190, p7).

None of the 12 submissions critical of HEHA as providing a sufficient framework for addressing obesity were dismissive of much that was happening or planned under HEHA. The complaint was that HEHA did not go far enough as it failed to address key environmental drivers of obesity. The views of health sector critics can be summed up by a statement from the Public Health Association: current interventions under HEHA will alone be inadequate, since the strategy "does not include significant changes to the obesogenic environment" (s156, p7).

4.2 Implementation of HEHA

4.2.1 Concerns about implementation to date

There was a widespread view among submissions from the health, nutrition and physical activity sectors that *HEHA has been poorly implemented to date.* This proposition was expressed in 51 submissions, 33 of which were from the health sector (Table 4.2). No submission expressed the opposite view.

Table 4.2 HEHA has been poorly implemented to date

Sector	Proposed
Health	33
Nutrition	6
Physical activity	6
Other	6
Total	51

The Heart Foundation described implementation of HEHA as a 'shotgun' approach.

> The Minister of Health has instructed District Health Boards (DHBs) to make HEHA a focus and DHBs are expected to show how they intend to meet the objectives of HEHA in their planning documents… However, while recognising that each community and DHB needs to tailor their actions to meet the needs of its own constituents there is no national

> coherent coordination and no national priorities established. The response … is therefore piecemeal and there is no universal progress on any of the actions in the strategy. For example, while progress may be being made on one thing in Greymouth the problem may not even be on the agenda in Blenheim (s47, p7).

National Maori health provider Te Hotu Manawa Maori held a similar view:

> Some initiatives are being developed in individual regions and local communities, but in the absence of government leadership and strategic process with the national HEHA obesity strategy, they are not as effective as they could be. National standards need to support a mix of local services to meet a diversity of local needs (s100, p4).

The Canterbury District Health Board wrote that a lack of resources, leadership and structure meant that implementation of HEHA "has been fragmented and haphazard at best" (s83, p17).

Professor Jim Mann and colleagues from the University of Otago made the same point, noting that implementation of HEHA "appears haphazard with different actions and varying degrees of intensity being undertaken by various District Health Boards" (s256, p8). Mann and his colleagues suspected that "considerable sums of money are being expended on potentially unhelpful strategies".

The effect in practice of the reported lack of coherent national planning and priority setting within the HEHA framework showed through in the submission from Northland residents Robin and Jenny Hoare. For some time the Hoares have been researching and promoting the establishment of 'Healthy Life Centres', funded by central government, and operated at first on an experimental basis . These centres would cater for a wide range activities, but with a focus on non-competitive and fun physical activity, and would provide advice on healthy lifestyles. The Hoares made a strong case for such centres in their submission (s29). As reported in their submission, the Minister of Health wrote to them on 17 February 2006 as follows:

> Your concept of having Healthy Living Centres fits in well with the HEHA strategy, in particular the HEHA objectives that mention creating supportive environments and strengthening community action… [Such facilities are] largely the responsibility of local bodies working with the various communities in their areas (s29, p11).

The Hoares reported having no success with local authorities, and believed that most are either unable or unwilling to provide such facilities. They went on to pose a crucial question: "Should health promotion really be their [local authorities'] responsibility?". The strong weight of opinion in the health sector, as evident from submissions, was that it was a central government responsibility to evaluate and implement nationally those interventions likely to have the greatest impact in reducing obesity.

4.2.2 A major concern: lack of national leadership

A common theme among submitters was that implementation of HEHA was haphazard, and that resources were likely to be wasted since local decisions about the best approaches would not always be optimal. This emerged in the substantial support for the proposition that *HEHA lacks effective national leadership.* Table 4.3 shows that this view was expressed in 34 submissions, including 21 from the health sector.

Table 4.3 HEHA lacks effective national leadership

Sector	Proposed
Health	21
Nutrition	4
Physical activity	3
Other	6
Total	34

4.2.3 Resourcing of HEHA

The proposition that *more resources should be allocated to assist implementation of HEHA* was expressed in 63 submissions from across all sectors (Table 4.4). No submissions suggested that resources available to implement HEHA should be reduced.

Table 4.4 More resources should be allocated to assist implementation of HEHA

Sector	Proposed
Health	36
Nutrition	6
Physical activity	8
Industry	5
Other	8
Total	63

It should be noted that Government has provided significantly more funding for interventions under HEHA since most submissions were written. Some submitters may have changed their view somewhat as a result.

Of the 63 submissions supporting greater resourcing of HEHA, 42 had expressed the view that HEHA had been poorly implemented to date. The most common view among submitters referring to HEHA in their submissions was therefore that HEHA initiatives should be expanded, but a change in the framework under which they were implemented was required. The solution most mentioned was the establishment of an obesity taskforce to oversee cross-sector action.

4.3 The call for stronger cross-sector leadership

4.3.1 The need for a cross-sector approach

Table 4.6 shows that there was strong support, particularly from the health sector, for the proposition that *a cross-sector, whole-of-government approach to preventing obesity and/or type 2 diabetes is needed.*

Table 4.6 A cross-sector, whole-of-government approach to preventing obesity and/or type 2 diabetes is needed

Sector	Proposed
Health	51
Nutrition	5
Physical activity	7
Industry	1
Other	12
Total	76

The New Zealand Medical Association gave an example of the difficulties faced in implementing a consistent and integrated strategy across sectors:

> While some positive steps have been taken in regard to halting this [obesity] epidemic, we have an overall concern about the fact that policies tend to be created in discreet silos and as a consequence run into obstacles when applied to situations where more than one organisation has control… Unfortunately, the Ministry of Transport's plan to include healthy outcomes in the transport equation has been hampered by local government District Plans that haven't provided for this, as well as Councils, and developers who may not be interested in this issue, and finally the Resource Management Act that doesn't reflect this interest. We can see this as an example of why in order to fight obesity, the campaign must be driven across all government departments and across all sectors (s128, p14).

4.3.2 Calls for an obesity taskforce

Many submitters believed that given the importance of a cross-sector approach, leadership should not be vested in an organisation located in a single sector (the Ministry of Health). This thinking lay behind much of the support for the proposition that *an obesity taskforce needs to be established.* This proposal was made in 42 submissions, the large majority (34) from the health sector (Table 4.5).

Table 4.5 An obesity taskforce needs to be established

Sector	Proposed
Health	34
Nutrition	2
Physical activity	1
Other	5
Total	42

Submissions varied substantially on the precise nature and responsibilities of an obesity task force. It is beyond the scope of this report to describe and discuss all the views presented. A sample of these views is outlined below.

The Australasian Faculty of Public Health Medicine (AFPHM) gave particular importance to the need for a taskforce:

> The AFPHM's central recommendation is that an Obesity Taskforce should be established across central and local government to drive responses to the obesity and type II diabetes epidemics. The Taskforce needs a clear mandate, accountability, resources and an evaluation programme, and must have a strong focus on reducing inequalities in health (s159, p17).

The Canterbury District Health Board recommended establishment of an obesity taskforce to research, develop, manage and monitor a comprehensive strategy that built on HEHA (s83, p6).

Dr Robert Beaglehole recommended that:

> A high level ministerial task force should be established as a matter of urgency and co-chaired by the Prime Minister and the Minister of Health to lead the "whole of government", and the nation's, overarching response to the obesity epidemic. The ministerial task force should bring together all relevant government departments, especially Education, Transport, Treasury and Sports and Recreation and appropriate independent expert advisers and be serviced by the Ministry of Health. The immediate goal of the ministerial task force would be to develop and then oversee the implementation of a coordinated and overarching national strategy and plan of action for the prevention of obesity. The

national plan should incorporate existing successful initiatives such as Healthy Eating and Healthy Action (s307, p9).

If the Medical Association is right about the difficulties of implementing an integrated strategy across sectors, Dr Beaglehole's emphasis on the need for obesity prevention to be driven from the highest levels of Government does not seem misplaced.

4.4 The Food Industry Accord

The Food Industry Accord (FIA) was established by advertising and food industry groups in 2004 with the stated objectives of reducing obesity, improving nutrition and increasing physical activity. HEHA relies on the FIA as the means to make progress against obesity in areas where it does not itself tread, such as regulation of the advertising of less healthy food.

Only six submissions, all from industry, supported the proposition that *the Food Industry Accord has an important role in reducing obesity and/or deserves support.*

The Food Industry Group (FIG) gave an extensive outline of what it viewed as the accomplishments of the FIA (s157, pp19-23). The list is too long to summarise here. Included were:

- product reformulation to reduce saturated fat, salt content etc of existing products e.g. McDonalds (p19);
- Coca-Cola Oceania Ltd has committed to not selling full sugar carbonated soft drinks to primary schools (p20);
- Increased communication relating to healthier food items in existing ranges e.g. Cadbury, Progressive Enterprises, Arnott's (p22).

In general, most submissions outside industry that referred to the FIA were not impressed by it. The proposition that *the Food Industry Accord to date has produced little or no effective progress in reducing obesity* was expressed in 17 submissions, 13 from the health sector (Table 4.6). All three submissions expressing the contrary view were from industry. There was thus a complete polarisation of views between the industry and other sectors on the achievements of the Accord.

Table 4.6 The Food Industry Accord to date has produced little or no effective progress in reducing obesity

Sector	Proposed	Opposed
Health	13	
Nutrition	1	
Industry		3
Other	3	
Total	17	3

Professor of Marketing Janet Hoek reviewed the FIA in her submission:

> I believe … the FIA carefully positions obesity as a "health challenge" that is not amenable to "simplistic measures" such as advertising restrictions. The challenge presented in the FIA is not one of restraint, where industry members are encouraged to reduce some of the more aggressive marketing activities they undertake, but one of innovation, where the emphasis is on developing "products and services that will make a positive contribution to the health of New Zealanders".
>
> While the development of better products and services is laudable, the FIA is silent on the need to delete those products that do not make a positive contribution to New Zealanders' health, and desist from marketing activities that support the increased sale and penetration of those products. The FIA objectives focus more on developing relationships with key stakeholders and ensuring that signatories' voices are heard in the wider debate than they do on specific measures that might reduce the attractiveness of products high in fat, salt and sugar.
>
> … Although the advertising and food industry representatives have stated that they recognise the need to change unhealthy eating behaviours, I believe the initiatives they have developed are unlikely to achieve this outcome (s127, p6).

The New Zealand Medical Association expressed a view shared in other submissions that any gains from the FIA were undermined by its failures:

> We … do not consider that the voluntary steps taken by the Food Industry have had any significant impact. For any steps taken are undermined by the fact that advertising of food products is still heavily targeted at children (s128, p14).

The National Heart Foundation agreed:

> There is a good deal of rhetoric from the Food Industry Accord (FIA), but to date they have produced little evidence of effective progress in making universal changes to reducing the energy density of processed foods, or in improving marketing methods. Token efforts, particularly by the fast-food sector, to produce and promote healthier options are typically undermined by more rigorous efforts to increase consumption of less nutritious items (s47, p5).

The Obesity Action Coalition (OAC) believed that the FIA had been counter-productive:

> OAC believes the relationship the Ministry of Health has with the Food Industry Accord (FIA) is delaying the public health response to the [obesity] epidemic. The activities of the FIA to date appear to be more about delaying effective action than taking effective steps such as improving the food supply by replacing energy dense, low nutrient foods with better alternatives and reducing the marketing of unhealthy foods (s129, p8).

4.5 Summary and conclusions

The Healthy Eating - Healthy Action (HEHA) strategy has been and remains the cornerstone of the government response to preventing obesity and type 2 diabetes. Industry sector submissions were supportive of HEHA, but elsewhere, and particularly in the health sector, there was a great deal of disquiet, both about the HEHA framework and its implementation.

One concern about the HEHA framework was its failure to tackle the underlying environmental drivers of obesity. There was strong criticism of the failure, under HEHA, to address issues such as the promotion of less healthy food and measures to alter the price differential between more and less healthy food in favour of the former. HEHA relies on the Food Industry Accord (FIA) as the means to make progress against obesity in such areas (see section 8). Submissions from outside the industry sector believed that the FIA was ineffective and that HEHA's reliance on it was badly misplaced.

Concerns about implementation centred around the haphazard and fragmented nature of responses to obesity across the country as a result of perceived leadership failure.

No submission suggested that were not many good initiatives in place and planned under the HEHA umbrella. There was strong support for the commitment of more resources to HEHA interventions. But this was accompanied by a widespread view that interventions needed to be evaluated and implemented at a national level. The need for stronger national leadership, together with the need for a cross-sector, whole-of-government approach, came together in calls for the establishment of an obesity taskforce.

The sections that follow discuss some of the environmental changes not at present being addressed as part of HEHA that many submitters believed were essential components of a national strategy to prevent obesity.

5 The promotion of less healthy food

Calls for regulatory action by Government to control the promotion of less healthy food, particularly to children, had powerful and virtually unanimous support across the health sector. This was expressed in many submissions through proposals that advertising required regulation. Regulation of sponsorship by companies or brands associated with less healthy food was also strongly supported, particularly when such sponsorship was associated with schools or children's sport. Many submissions went further, calling for regulatory controls on all aspects of the marketing of less healthy foods, particularly to children. Such calls were very unpopular within the industry sector, leading to a complete polarisation of views on the need for Government regulation.

5.1 Regulation of advertising

5.1.1 Calls for some form of regulation of advertising by Government

Concern about the advertising of less healthy food was one of the strong features of the submissions. As Table 5.1 shows, 120 submissions proposed that *some form of regulation of the advertising of less healthy food is required.* The only submissions stating opposition to this proposal were from the industry sector, together with one submission from an industry-sponsored university group.

Table 5.1 Some form of regulation by Government of the advertising of less healthy food is required

Sector	Proposed	Opposed
Health	76	
Nutrition	8	
Physical activity	3	
Industry		9
Other	33	1
Total	120	10

The 76 health sector submissions in Table 5.1 seeking some form of regulation on advertising of less healthy food constitute 54% of the 141 submissions from this sector. This is a massive figure given the context – almost all of the remaining 46% simply did not address the advertising issue in their submissions, presumably for many because this was well removed from

their expertise or direct concern. No submission from the health sector stated opposition to some form of advertising restriction. This leaves a very clear outcome: the health sector was strongly of the view that the advertising of less healthy food needed to be regulated.

Table 5.2 lists the names of 41 of the 76 health sector submissions from Table 5.1.[6] The list is impressive. Nine of the 12 submissions received from District Health Boards, for example, proposed that *some form of regulation by Government of the advertising of less healthy food is required.* As Table 5.2 shows, this view was very much the mainstream view across the health sector.

All ten submissions opposed to some form of regulation of advertising are listed in Table 5.3. The only non-industry submission in the list, that from the University of the Sunshine Coast, is discussed in section 5.1.6 below.

5.1.2 Arguments for regulation of advertising

Dr Robert Beaglehole submitted that options "for restricting food and beverage marketing to children should be widely discussed and agreed as a matter of urgency" (s307, p10).

The Australasian Faculty of Public Health Medicine believed that "regulation of marketing – particularly to children – is an obvious strategy as part of a comprehensive, coordinated approach" (s159, p19).

Consumers' Institute expressed a commonly-held view among submitters that restrictions needed to apply more widely than just to direct advertising:

> Children are bombarded with sophisticated marketing. Recently the Institute looked at over 200 breakfast cereals and of the 26 cereals marketed specifically to children we were not able to recommend any – in fact more than half contained a third or more sugar. These poor nutritional cereals … were found to be the ones that had been made the most appealing to children through a range of promotional techniques… Marketing not only promotes individual products, it also normalises unhealthy food. High fat and high sugar food and drinks are promoted as the obvious choice for all situations, are cheap and readily available (s64, p4).

[6] The 41 are all the submissions supporting regulation from nine of the 17 health sector "categories" listed in Table 2.1. The remaining 35 health sector submissions supporting regulation are not included in Table 2.1 for reasons of space.

Table 5.2 Some of the health sector submissions supporting some form of Government regulation of the advertising of less healthy food

District Health Board	
	Canterbury District Health Board
	Capital and Coast District Health Board
	Hawke's Bay District Health Board
	Hutt Valley District Health Board
	Nelson Marlborough District Health Board
	Southland District Health Board
	Tairawhiti District Health
	Taranaki District Health Board
	Waikato District Health Board
Professional association - health related	
	College of Nurses Aotearoa (NZ) Inc
	New Zealand Branch of the Australasian Faculty of Public Health Medicine
	New Zealand Medical Association
	New Zealand Nurses Organisation (NZNO)
	New Zealand Society for the Study of Diabetes
	Paediatric Society of New Zealand
National group - specific health condition	
	Cancer Society of New Zealand Inc
	Diabetes New Zealand Inc
Maori health provider/service	
	Te Hauroa O Turanganui-A-Kiwa
	Te Hotu Manawa Maori
Primary Health Organisation	
	Health Rotorua Primary Health Organisation
	Manaia Health PHO
	Pegasus Health and Partnership Health, Christchurch
	TaPasefika Trust PHO
	Wairarapa Community Public Health Organisation
	Whanganui Regional Public Health Organisation
Health group - public health	
	Public Health South
	Public Health Unit, MidCentral DHB
	Quigley and Watts Ltd
	Regional Public Health (Greater Wellington Region)
Academic group - health	
	Department of Public Health, Wellington School of Medicine and Health Sciences
	Obesity Prevention in Communities project
	Professor Jim Mann and staff from the Edgar National Centre for Diabetes Research
Academic individual - health	
	Elmslie, Dr Jane
	Goodhead, Anne
	Raizis, Dr Anthony
	Simmons, Professor David
	Swinburn, Professor Boyd
	Wilson, Dr Nick
Medically-qualified health professional	
	Abernethy, Dr Melanie
	Baird, Tony
	Beaglehole, Dr Robert

Table 5.3 All submissions opposing some form of Government regulation of the advertising of less healthy food

Industry sector	
	Advertising Standards Authority Inc
	Association of New Zealand Advertisers
	Communication Agencies Association of New Zealand
	Food Industry Group, The
	Foundation for Advertising Research
	McDonald's Restaurants (New Zealand) Ltd
	New Zealand Food & Grocery Council Inc
	New Zealand Television Broadcasters' Council
	Radio Broadcasters Association
"Other" sector	
	Social Marketing and Advertising Research Team, University of the Sunshine Coast

After citing international research[7] demonstrating that advertising adversely affected children's food choices, diets and health, Consumers' Institute went on to suggest:

> Restrictions on the marketing of energy-dense, high-fat high sugar foods across the board. Restrictions need to consider unhealthy marketing as a whole, including advertising, sales promotions, product development, sponsorship, pricing and availability (s64, p4).

The Canterbury District Health Board considered the balance between public health law and the maintenance of individual rights. The Board believed:

> With the current situation, the case for risk management and protection of children justifies legislation… The precautionary principle, which states "when an activity raises threats of harm to human health or the environment, precautionary measures should be taken even if some cause and effect relationships are not fully established scientifically" should prevail.

The Board continued:

> Many laws that curtail individual autonomy in order to protect society already exist. Examples of this are: fences around swimming pools, the compulsory wearing of seatbelts and restrictions on the sale and advertising of alcohol and cigarettes… It is also important to note that there is a difference between a fence around a pool (the danger) and a "fence" protecting children from marketing of unhealthy products. With the pool there is no industry actively spending millions of dollars trying to push people towards the danger (s83, p27).

[7] Consumers' Institute was well informed on the major relevant literature, citing recent reviews by the WHO and FAO Expert Consultation, the UK's Food Safety Agency, and the US Institute of Medicine.

The Board concluded:

> As correctly argued by the food industry, a single intervention will be ineffective in preventing the obesity epidemic. As part of a coordinated approach however, controls on advertising and marketing are obvious options for intervention (s83, p29).

A more "grass roots" perspective was provided by CAPS Hauraki, a non-profit agency working with families and children to improve health and well being.

> Total marketing controls across a wide range of media would help our clients. We are all saturated with advertising – its everywhere – like oil on chips. It's powerful and compelling… Children want what is advertised and their 'pester power' is harnessed to put pressure on parents. Our parents are low income but they want their kids to have what everyone else has. The don't have the money to provide their kids with expensive outings and treats – but junk food is relatively cheap so that's an affordable option for them. And the kids love it. Of course they do – it's designed to taste good and is well marketed to meet other needs – belonging, having… (s179, p1).

CAPS Hauraki continued:

> Our clients … watch a lot of TV which re-saturates them with adverts for mindless eating. As a group, they are the least able to critically evaluate advertisements but they … have the most exposure to them because of the time they spend in front of television… Marketing and advertising of high energy low nutrient foods is a big factor in the food choices made by our clients. Legislation is needed to eliminate this. Is this being a nanny state? It is looking after the most vulnerable and not allowing them to be used for corporate profit (s179, p2).

Linwood Avenue School, on behalf of ten Christchurch primary schools, wanted restrictions on the promotion of less healthy foods:

> We do our best to restrict the amount of junk food that is brought into school from home with bans on fizz and sweets etc. We take pride in providing an environment that supports health but it is hard when you consider the many factors that influence what families buy and eat at home. We ask the Health Select Committee to recommend to Parliament that restrictions on the promotion of high sugar and high fat foods be introduced. The constant barrage of advertising for low nutrient foods that appears on television, radio, in the print media, on billboards in the community, and on the internet leads children and their parents to believe that it is normal to eat "treat foods" everyday (s88).

The school perspective was reiterated by a mother whose 12-year-old son has had a long battle with obesity. She referred to the constant difficulties the two of them had faced in an environment where junk food was considered 'normal', and she wanted this to change.

> Large food corporations … bombard our poor children almost every minute of their life. Not only that, this insidious advertising machine has not only infiltrated their home life through television, radio and the internet, but they've also managed to creep into healthy activities such as sport in the name of 'sponsorship' and 'support' (s238, p3).

5.1.3 Industry arguments against regulation of advertising

Among industry submissions taking a broad approach to regulation, the New Zealand Television Broadcasters' Council (NZTBC) argued that Government regulation was not needed in the area of marketing and advertising.

> An effective, socially responsible fabric of rules and regulations exists across all advertising with television being at the forefront of offering a socially responsible approach in New Zealand [based around Broadcasting Standards Authority and Advertising Standards Authority codes]… This framework works well. The NZTBC has seen no information that the incidence of obesity would be reduced through greater regulation (s293, p4).

The Advertising Standards Authority (ASA) mounted a legal argument against regulation of food advertising:

> Critics of the system of advertising self-regulation often refer to banning advertising. The ASA notes that Section 14 of the New Zealand Bill of Rights Act protects freedom of expression. The ASA believes a ban on food advertising would contravene this section of the Act. While Section 5 provides that a ban could be imposed only if it was a "reasonable limit(s) prescribed by law as can be demonstrably justified in a free and democratic society". The ASA believes this to be a high threshold and the ASA does not believe that the arguments to ban food advertising have met this threshold (s31, p10).

The New Zealand Retailers Association did not support "a ban on the advertising of fast food given that it is primarily an individual's own personal responsibility to determine the nature of his or her particular daily dietary intake" (s7, p3). This is in effect an argument for a totally *laissez faire* state that has been rejected in New Zealand. It could be used, for example, to argue that cigarette advertising should be allowed.

Some of the cases made in industry submissions against the regulation of advertising focussed specifically on television advertising to children, and are discussed in section 5.1.6 below.

5.1.4 Industry arguments against restrictions and bans in general that applied to advertising

The Food and Grocery Council (FGC) stated that they did not support "frequently advocated" restrictions and bans.[8] The example they used to make their case was about restricting children's access to treat foods. This argument is discussed in some detail below because the FGC is an important industry player that stressed the need in its oral submission for obesity interventions to be evidence-based, yet was prepared to make a general statement in its submission against restrictions and bans on flimsy grounds.

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[8] Since the restrictions and bans most frequently advocated in the obesity debate relate to the advertising of less healthy food, the FGC submission was coded for the purpose of this report as being opposed to regulation of advertising.

The FGC sought to make the case that research does not support a "popular view that food restrictions and bans will halt over-consumption" (s163, p3). They cited research from an American academic, Professor Leanne Birch, who claimed that "children who have access to sweet treats restricted wind up eating even more of these things". The Birch study (not referenced by the FGC) involved offering children a range of toys and treat foods after they "had been given enough lunch to make them full". If their mothers "greatly restricted the foods offered" the children ate more than did the children with less restrictive mothers. The FGC took this to mean that children's food choices should not be restricted, quite a large jump to make from a very artificial experimental situation. This is also an odd position for the FGC to take, given the usual industry position that it is the responsibility of parents to control what is eaten by their children when their children are too young to take personal responsibility.

McDonald's also put forward a case against regulation in general (s192, pp15-20). They summarised their case as follows:

- It is likely to be inconsistent, illogical and unfair in its treatment of various product and food industry sectors.
- Definitions of what constitutes "healthy" and "healthy food" would present huge definitional challenges for law drafters…
- Legislation would be impossible to enforce without an army of enforcers paid from the public purse.
- Overseas experience suggests that a regulatory, quick fix solution is unlikely to achieve meaningful and measurable improvements (s192, p20).

The McDonald's argument against advertising restrictions in particular was that countries that have had these in place showed no sign of having lower obesity rates than countries that had not. Correlation-based arguments such as this are weak, as is demonstrated below in section 5.1.6.

5.1.5 Calls for regulation of television advertising to children

The main form of advertising regulation called for by submitters was that *the advertising of less healthy food to children on television should be banned or strongly regulated by Government* (Table 5.4). This was proposed in 106 submissions, 67 from the health sector.[9] The nine submissions opposing this proposition were all from industry (43% of the 21 industry submissions).

[9] A further two health sector submissions called for regulation if voluntary codes failed to stop the advertising of less healthy food to children on television.

Table 5.4 The advertising of less healthy food to children on television should be banned or strongly regulated by Government

Sector	Proposed	Opposed
Health	67	
Nutrition	8	
Physical activity	2	
Industry		9
Other	29	1
Total	106	10

The wider case for advertising restrictions made by the submissions considered in section 5.1.2 also apply to the more specific case of advertising less healthy food to children on television, and are not repeated here. The case against advertising restrictions made by the food industry merits its own section.

5.1.6 The industry case against restrictions on television advertising

The industry case against restrictions on food television advertising depended heavily on the Harker report[10] (s161) commissioned by the Foundation for Advertising Research (s133). The Harker report, which was part funded by the Food Industry Group and McDonald's, is of a poor academic standard. It is beyond the scope of this report to elaborate on this, other than to note the lack of scholarship exhibited below.

The Harker report made use of "research into responsible food advertising" conducted by the World Federation of Advertisers (WFA) in 2005.[11] Table 5.5 repeats the WFA data on "Ads per hour" and "Percentage obese" as reported by the Harkers (s161, p138), as well as adding alternative OECD data for "Percentage obese".

There was no significant correlation between "Ads per hour" and "Percentage obese" as reported by the WFA, a fact made a great deal of in industry submissions.

[10] Harker, D. and Harker M. (2006). Advertising's role in diet and exercise in New Zealand and Australia: Developing a research agenda. Available from www.ffar.org/PDFS/ADnEiOzNZ.pdf.

[11] The WFA report does not appear to be publicly available. The Harkers' reference to it is: "World Federation of Advertisers (2005), 'Responsible Food Advertising: The Key Arguments', *WFA,* September, PowerPoint Presentation.

Table 5.5 A reworking of World Federation of Advertisers Data

	Ads per hour (WFA)	Percentage obese (WFA)	Percentage obese (OECD)
Australia	12	19	21.7
USA	11	15	30.6
Poland	11	19	n.a.
UK	10	22	23.0
France	8	18	9.4
Greece	7	31	21.9
Germany	6	15	12.9
Finland	6	13	12.8
Denmark	5	18	9.5
Netherlands	4	14	10.0
Norway	2	21	8.3
Belgium	2	18	11.7
Sweden	0	18	9.7
		r = .08 (not significant)	r = .78 (p<.01)

It would be apparent to anyone reasonably familiar with the epidemiology of obesity that there is something very wrong with the WFA's obesity data. The most obvious is that the United States is shown as having the third equal lowest obesity rate among the 13 countries listed. So what happens if another set of data on obesity rates is used instead? Conveniently, the Harkers provided suitable data elsewhere in their report where obesity rates in 2003 obtained from the OECD are reported (s161, p56). The outcome is remarkable: a highly significant correlation ($r = .78$, $p<.01$) between Ads per hour and the incidence of obesity.

The following industry submissions used the WFA data reported in Table 5.5 as the centrepiece of their case that regulation of television advertising was shown to have no effect on obesity:

- The Food Industry Group (s157, pp16-17)
- The Association of New Zealand Advertisers (s158, pp6-7)
- The Radio Broadcasters Association (s187, pp6-7)
- The Foundation for Advertising Research (s133, p4)
- The Communications Agencies Association (s250 – as for the Food Industry Group (s157)).

The Food Industry Group made a statement typical of these submissions:

> The World Federation of Advertisers' (WFA) research into responsible food advertising (2005) is conclusive… It shows that there is no correlation between exposure to food advertising (numbers of advertisements per hour) and overweight/obesity… So the overall

> conclusion is unequivocal. Not only is advertising and weight levels among the general public not causally linked, there is not even a correlation (s157, pp16-17).

No claim is made in the present report that the Table 5.5 demonstrates a causal relationship between advertisements per hour and obesity, although the strength of the relationship certainly encourages speculation that some causal mechanism may be at work. The point of Table 5.5 is to totally demolish any pretence that the industry case against the regulation of television advertising made in submissions is evidence-based.

In any case, as Professor Boyd Swinburn noted, the industry argument that no causal link has been established between advertising and obesity is irrelevant:

> The question to be answered in relation to food marketing to children is NOT: 'Has food marketing to children been shown to cause childhood obesity? The question for governments is 'Are regulations to minimize food marketing to children likely to be an effective and cost-effective strategy as part of a multi-pronged approach to reduce childhood obesity? (s189, p6).

Professor Swinburn referred to evidence from modelling work commissioned by the Victorian state government that "reductions in exposure to junk food advertising to children are likely to be highly effective and cost effective, and indeed cost-saving" (s189, p6).

5.2 Regulation of sponsorship

5.2.1 School-related sponsorship

Table 5.6 shows a complete split between those supporting the proposition that *sponsorship that associates brands of less healthy food with schools should be prohibited* (none of the 46 were from the industry sector), and the three opposing submissions (all from industry).

Table 5.6 Sponsorship that associates brands of less healthy food with schools should be prohibited

Sector	Proposed	Opposed
Health	27	
Nutrition	5	
Physical activity	2	
Industry		3
Other	12	
Total	46	3

In addition to the 46 submissions asking that school-associated sponsorship be banned, a further 11 (making 57 in all) proposed that *sponsorship that associates brands of less healthy food with schools is inappropriate.* No submission outside the industry sector expressed support for sponsorship of any school-related activities with brands of less healthy foods.

Tairawhiti District Health, the DHB based in Gisborne, wanted schools sufficiently resourced so that they did not have to utilise sponsorship from fast food companies to support school activities. They suggested implementation of a similar scheme to 'Smokefree' which was used to end dependence of tobacco sponsorship (s80, p7). The Rotary Club of Wellington North took a similar approach in recommending that all costs for school road patrols, dental vans and the like where fast food company sponsorship is involved should be met out of increased Government funding (s149, p5).

A submission was received from a mother who has been involved with junior soccer for 12 years, and who was also a member of a school Board of Trustees. Her submission included reproductions of reward vouchers redeemable at McDonald's for things such "helping out at school" and being "player of the day". She concluded:

> The above is a small snippet of how some members of the Fast 'Food' industry market themselves to the young children of New Zealand. This is on top of the huge amount of advertising children are exposed to on a daily basis. In my opinion it is incongruous to have, as sponsors of activities associated with improved health and welfare, ever increasing relationships with 'food' industries whose purpose is to increase their profit margin and establish client loyalty (s91).

5.2.2 Sponsorship of children's sport

The same dichotomy of views between industry and other sectors emerged over the proposition that *sponsorship that associates brands of less healthy food with children's sport should be prohibited* (Table 5.7). All seven opponents of this proposition were from industry; all 18 supporters were from other sectors.

Table 5.7 Sponsorship that associates brands of less healthy food with children's sport should be prohibited

Sector	Proposed	Opposed
Health	13	
Nutrition	2	
Physical activity	1	
Industry		7
Other	2	
Total	18	7

A further nine submissions proposed that *sponsorship that associates brands of less healthy food with children's sport is inappropriate,* taking to 27 the number holding this view when added to those who wanted such sponsorship banned.

In her submission, Professor of Marketing Janet Hoek provided a detailed critique of Food Industry Group (FIG) initiatives outlined in their report on achievements under the Food Industry Accord. She wrote:

> I am … concerned that the FIG report appears to view sponsorship activities as an instance of responsible marketing. I believe sponsorship enables manufacturers of foods high in fat, salt and sugar to obtain widespread access to young children via sports sponsorship. Children are typically rewarded with vouchers that they (and their families) can redeem at a store outlet; this may increase brand penetration, thus enabling companies to reach families who may not previously have purchased from them. More subtly, I believe sponsorship assists brands to become paired with highly desirable attributes that enhance and facilitate consumption. Thus foods high in fat, salt or sugar become paired with sporting activities and, at times, with individuals who represent the epitome of sporting excellence. I am concerned that these pairings not only reinforce the notion that brands promoted in this way are "fun" but may also be interpreted as implying that regular consumption of these brands is not inconsistent with a healthy diet (s127, p8).

It was not only FIG that appeared to assume that sponsorship activities should be interpreted as providing a public good rather than as an aspect of marketing. McDonald's devoted two pages of their submission outlining good causes that they supported, either through Ronald McDonald House Charities or more directly. These included the Ronald McDonald Mobile Dental Care Programme, road safety for children, and assistance for Northland Maori students to pursue tertiary education (s192, pp26-7).

5.3 Regulation of all forms of promotion

5.3.1 Calls for regulation of all forms of promotion of less healthy food to children

Many submissions, particularly from the health sector, did not restrict themselves to calling for bans on the promotion or advertising of less healthy foods in particular areas such as sponsorship or television advertising. They wanted comprehensive regulation of all forms of promotion, either to children (this section) or to anyone (section 5.3.2).

In all, 56 submissions proposed that *the promotion of less healthy food to children across all media types should be banned or strongly regulated by Government* (Table 5.8), 37 of these from the health sector. All but one of the 11 submissions opposing this proposition were from industry, the exception being an industry-funded university group.

Table 5.8 The promotion of less healthy food to children across all media types should be banned or strongly regulated by Government

Sector	Proposed	Opposed
Health	36	
Nutrition	4	
Physical activity	1	
Industry		10
Other	15	1
Total	56	11

Professor Boyd Swinburn, one of the world's leading experts on obesity prevention, supported wide-ranging regulation:

> The issue of promoting junk food to children is more than TV advertising and much more than advertising in designated children's TV slots. The issue is all commercial food marketing targeting children. The interventions needed are government regulations and not industry codes of practice. The purpose of industry codes is to protect industry and remove the worst excesses of narrowly-defined advertising content. Their purpose never has and never will be to improve public health (s189, p4).

5.3.2 Calls for regulation of all forms of promotion of less health food to anyone

Table 5.9 shows that there was substantial support for more wide-ranging regulation of the promotion of less healthy foods, with 39 submissions proposing that *the promotion of all less healthy food across all media types should be banned or strongly regulated by Government.*

Table 5.9 The promotion of all less healthy food across all media types should be banned or strongly regulated by Government

Sector	Proposed	Opposed
Health	22	
Nutrition	3	
Physical activity	1	
Industry		12
Other	13	1
Total	39	13

5.4 Views on the advertising codes

In April 2006 the Advertising Standards Authority (ASA) released two revised codes, the "Code for Advertising to Children" and "Code for Advertising Food". These revisions replaced codes last revised in 2001. The release of the new codes created substantial interest, and submissions referring to the codes were generally familiar with the 2006 revisions.

The industry sector was supportive of the revised codes. All seven submissions proposing that *the Advertising Standards Authority's codes provide a sufficient basis for regulating advertising with respect to obesity* were from industry (Table 5.7). Thirteen submissions, mainly from the health sector, expressed a contrary view.

Table 5.7 The Advertising Standards Authority's codes provide a sufficient basis for regulating advertising with respect to obesity

Sector	Proposed	Opposed
Health		8
Nutrition		3
Industry	7	
Other		2
Total	7	13

ASA described the background, philosophy and detail of the codes and the complaints process in their submission (s31).

The Association of New Zealand Advertisers (ANZA) were very strong supporters of self-regulation and the ASA codes. They believed this had many advantages over other forms of regulation. These included speed of response to complaints, the burden of proof resting with advertisers rather than complainants, and flexibility to respond to changed circumstances quickly. Further:

> The codes include an obligation to "observe a high standard of social responsibility" when advertising to children. This is a provision that can be in a code but not enacted in law, which requires greater precision than codes. Such a provision allows spirit and intention to be considered even when an advertisement may technically comply (s158, p11).

ANZA submitted that, therefore, advertising in New Zealand was well regulated.

Critics of self-regulation, however, took a very different view. Professor Janet Hoek believed that "advertising self-regulation is an inappropriate mechanism to deal with issues that have public health implications" (s127, p9). She

argued that, “according to the ASA’s own definitions, a wide range of marketing activities are unregulated if they do not appear in some form of advertising”. She believed that the ASA drew selectively on the UN Convention on the Rights of the Child to argue that children have a right to receive advertising messages.

Quigley and Watts Ltd described what they called the “tortuous process” of complaining about food advertisements in two complaints about the same advertisement. They noted that the process took 6 months, during which the advertisement subject to the complaints continued to be aired (s106, pp4-7).

The dichotomy of views on the effectiveness of the ASA codes was entirely to be expected, and reflected the complete split between the health and industry sectors evident throughout this section on whether regulation by Government was required to restrict the promotion of less healthy foods.

5.5 Summary and conclusions

There was powerful support, particularly from the health sector, for regulation by Government of all forms of promotion of less healthy food.

In terms of advertising specifically, 120 submissions proposed that *some form of regulation of the advertising of less healthy food is required.* Of the 120, 76 (54%) were from the health sector. This is a massive figure, particularly considering that food advertising was not mentioned in the terms of reference, and that many submissions restricted themselves to their own area of expertise. With the exception of an industry-funded group, not a single submission outside the industry sector stated their opposition to advertising regulation.

Among the 76 health sector supporters of advertising restrictions were:

- nine of the 12 District Health Boards to make a submission;
- six health-related professional associations including the New Zealand Medical Association, the New Zealand Society for the Study of Diabetes, and the Paediatric Society;
- Internationally recognised public health experts Dr Robert Beaglehole and Professors Boyd Swinburn and Jim Mann.

The specific proposal to restrict advertising that attracted the most support was that *the advertising of less healthy food to children on television should be banned or strongly regulated by Government.* This was called for in 106 submissions, 67 of which were from the health sector. Again, the only opposing submissions were from the industry sector and an industry-funded group. There was also strong support from the health sector to prohibit sponsorship that associates brands of less healthy food with schools and with children’s sport.

Many submissions made the point that what was at issue extended beyond specific proposals such as restrictions on advertising and sponsorship. In the

words of Professor Boyd Swinburn, the issue was "all commercial food marketing targeting children". Thirty-nine submissions went beyond this by proposing that *the promotion of all less healthy food across all media types should be banned or strongly regulated by Government,* with this including promotions targeting the population in general.

Professor Swinburn summed up the health sector position by noting that the "interventions needed are government regulations and not industry codes of practice". This was reflected in health sector opposition to industry self-regulation using the Advertising Standards Authority's voluntary codes as the appropriate mechanism to control the promotion of less healthy foods.

Opponents of regulatory restrictions on advertising and other forms of promotion included leading groups from the food and advertising industries that supported the Food Industry Accord: the Food Industry Group, the Food and Grocery Council, and the Association of New Zealand Advertisers.

There was a large difference in the quality of the evidence and arguments in health sector submissions (for regulation) compared to industry submissions (against regulation). Health sector submissions were able to back their case by referring to the relevant major international academic reviews. Industry submissions, on the other hand, tended to put too much faith in a review of poor academic quality that they had commissioned themselves via the Foundation for Advertising Research. Worse, five industry groups, including the Food Industry Group and the Association of New Zealand Advertisers, built their case against restrictions on advertising around "research" conducted by the World Federation of Advertisers that was completely discredited in section 5.1.6.

6 Taxes and subsidies

> Fiscal mechanisms, such as a tax on energy-dense foods and subsidies on healthy foods, should be approached with caution. Prices can however influence choices of foods, and public policies can affect prices (either as an intended or unintended consequence) so they should at least be considered (Ministry of Social Development, s301, p7).

6.1 Tax changes or subsidies to encourage healthy eating

6.1.1 The potential for pricing mechanisms to influence behaviour

A common theme among many submissions was that changing the price to consumers of some foods had substantial potential to encourage more healthy eating. No submissions, however, were received from tax experts, and the majority of submitters were reluctant to make specific proposals that particular tax changes or subsidies should be instituted. Many submissions, while stating that using price to influence the purchase of more healthy food was required, did not commit to any particular interventions and preferred to say only that these (excise tax on less healthy foods, subsidies for more healthy foods, etc) should be considered.

Just over a third of all submissions supported the proposition that *tax changes and/or subsidies to encourage healthy eating should at least be considered.* This included 66 (47%) of submissions from the health sector (Table 6.1). This is a very high level of support when it is noted that there was no reference to price mechanisms as possible interventions in the Terms of Reference, and given that many submitters would have steered clear of expressing a view in this area because it was outside their expertise.

Table 6.1 Tax changes and/or subsidies to encourage healthy eating should at least be considered

Sector	Proposed
Health	66
Nutrition	9
Physical activity	2
Industry	1
Other	26
Total	104

While a number of submissions from the industry sector opposed imposition of additional taxes on foods high in fat, sugar or salt, no submission stated opposition to consideration being given to tax changes and/or subsidies to encourage healthy eating.

National Maori health provider Te Hotu Manawa Maori summed a very common view from across the health sector: "There is a need to make the healthy choice of foods the affordable choice especially for low socioeconomic groups" (s100, p4).

The Paediatric Society of New Zealand was entirely in agreement:

> As fatty foods cost less than healthy fruit and vegetables, we stress the importance of looking for mechanisms to enable low-income families to purchase nutritious food for their children (s259, p3).

The New Zealand Branch of the Australasian Faculty of Public Health Medicine concluded, after reviewing evidence from the literature, that:

> Taxation of high fat foods and tax relief on food such as fruit and vegetables have been widely proposed as a way of increasing consumption of healthy foods… Considering the impact that pricing has on determining food-purchasing choices, especially on low-income households, this strategy must be carefully considered as part of a whole approach to food policy for New Zealand (s159, p20).

The Faculty also quoted from the WHO Global Strategy on Diet, Physical Activity and Health:

> Prices influence consumption choices. Public policies can influence prices through taxation, subsidies or direct pricing in ways that encourage healthy eating and lifelong physical activity (s159, p20).

The Clinical Trials Unit at the University of Auckland School of Population Health argued for consideration of pricing mechanisms because of promising leads as to effectiveness from related public health issues. They gave as an example that high taxes on cigarettes have proved to be one of the most effective ways to reduce smoking.

A parent was concerned about the cost and availability of healthy foods compared with unhealthy foods, and was one of a number of submitters who believed that it "should not be more expensive to buy 2 litres of milk than it is to buy 2 litres of coke" (s25).

6.1.2 An advantage of pricing mechanisms: they operate at a population level

One of Professor Boyd Swinburn's basic principles for selecting priority interventions to prevent obesity related to taxes and subsidies.

> Economic environments … are powerful determinants of behaviour and are amenable to changes to promote healthy choices (eg taxes, subsidies). Policy and environmental changes are more equitable than 'message-based' approaches which will be less picked up and acted upon in higher risk groups (s189, pp5-6).

An illustration of Swinburn's point about the potential of pricing mechanisms to have impact at a population level came from the submission from a community health worker who was particularly concerned about the paucity of healthy food options at events. She attended the whole week of racing at the national Waka Ama Championships at Lake Karapiro in 2006.

> I found it very alarming that the general public was relying on hot dogs, chips, and latte as their breakfast at 7:30am. Competitors were also accessing this food in between races and sometimes for breakfast too. The people accessing the food were from all age groups (s175).

The community health worker pointed out that this was not an isolated example, and suggested tax changes to make healthy food the cheaper option was one means of addressing this issue. Swinburn would agree: as population-level measures, pricing mechanisms can flow through to affect behaviour at the local and individual level. In the case of events, if healthy food was cheaper then more demand would be created for healthy options, encouraging more stall holders to make healthy options available.

6.2 Tax changes to reduce the cost of more healthy food

Many submissions wanted to see a reduction in the price to consumers of more healthy foods, with 53 submissions proposing that *tax changes to reduce the cost of more healthy food should at least be considered* (Table 6.2). In most cases these submitters called for changes to, or consideration of changes to, GST.

Table 6.2 Tax changes to reduce the cost of more healthy food should at least be considered

Sector	Proposed
Health	34
Nutrition	7
Other	12
Total	53

Professor Jim Mann and his colleagues wanted urgent consideration given to adjustment of GST in order to promote consumption of appropriate foods. They argued that "Treasury's current commitment to an across the board tax level should not preclude consideration of an approach which might favourably influence one of the greatest health issues of our time" (s256, p7n).

The TaPasefika Health Trust recommended "improving access to healthy food choices for the poor by reducing the price of food through a "food card" to remove GST for example" (s150, p5).

Te Hauora O Turanganui-A-Kiwa (Turanga Health) were also concerned about the relative cost of food for low income families:

> We would recommend the removal of GST on the basic foods needed on a daily basis for a healthy diet. This would include fresh fruit and vegetables, low fat milk, and wholegrain bread. Unfortunately at present these foods are often more expensive than other foods, which is a huge barrier to the low-income families we work with on a day-to-day basis. A loaf of "budget" white bread is around 99c compared to wholegrain bread at around $2.50 a loaf. Fizzy drink is much cheaper than milk and in some lower income families milk is often watered down to make it last longer, which greatly diminishes the nutritional value (s79, p3).

The Taranaki-based Children's Healthy Eating Healthy Action group asked for "removal of GST on minimally processed foods such as meat, plain milk, fruit, vegetables, and wholemeal and wholegrain breads" (s93). This, they argued, would increase access to these foods by those from lower socio-economic groups.

6.3 Subsidies to reduce the cost of more healthy food

Fourteen submissions specifically referred to the need for subsidies to be considered to reduce the cost of more healthy food.

Fight the Obesity Epidemic (FOE) recommended consideration of the 'Healthy Start' programme in the United Kingdom for application in New Zealand. FOE described the scheme as follows:

> Food vouchers are another approach to making healthy foods more affordable for identified groups such as children and those on low incomes. Such a scheme, called Healthy Start, is currently being implemented in Great Britain. Under the scheme, pregnant women and parents/carers of children aged over one and under five will receive one voucher per week. Parents/carers of children aged less than one will receive two vouchers for each such child. Each voucher is worth £2.80 (between eight and nine New Zealand dollars). The vouchers can be exchanged for milk, fruit and vegetables. The scheme has started in Devon and Cornwall, and will be implemented throughout the rest of Great Britain later in 2006 (s136, p.53).

One industry submission supported consideration of subsidies to reduce the cost of more healthy food: Fonterra suggested that the Inquiry look at the

example set by the European Community by considering a Government subsidy for agricultural products (s138, p9).

6.4 Tax changes to increase the cost of less healthy food

The most controversial proposal among those relating to pricing mechanisms was that *additional tax should at least be considered for particular less healthy foods or their constituents such as fat or sugar.* This proposition was made in 62 submissions, including 39 from the health sector.

Table 6.4 Additional tax should at least be considered for particular less healthy foods or on their constituents such as fat or sugar

Sector	Proposed	Opposed
Health	38	
Nutrition	5	
Physical activity	1	
Industry		4
Other	18	1
Total	62	5

The most detailed argument in favour some form of tax on less healthy foods was made by the Ecologic Foundation. They gave four main reasons, which are quoted below:

- a tax would address financial costs to society of obesity and act as an insurance premium for the cost of prevention measures and future medical treatment linked to diets rich in fats and calories;
- while a junk food tax might have little deterrent effect on most consumers, a tax could deter children or at lest reduce their purchases of unhealthy products;
- a tax that imposes only a small burden on consumers could still create a strong incentive for food manufacturers to alter product composition to reduce the energy content and hence the amount of tax paid;
- a tax would generate revenue that could be used to fund complementary measures, e.g. a major advertising campaign [to encourage consumers to improve their diet] (s109, p2).

The University of Auckland's School of Population Health argued from the research literature for a tax on sugary drinks, citing evidence that this would decrease consumption, particularly among those with high levels of consumption (s190a, p1).

Four industry submissions opposed additional taxes. The New Zealand Sugar Company argued that population-level measures such as taxation were

inappropriate because they would adversely affect many members of the public for whom obesity was not an issue (s84, p3). The Retailers Association opposed any regulatory measures including taxation (s7, pp3-4). Both the Food and Grocery Council (s163, p3) and Foodstuffs (N.Z) Ltd (s283, p7) argued that additional taxes on certain foods would have little impact on consumption while imposing extra costs on those who could least afford it.

Additional taxes on less healthy foods were opposed in one submission from other than from industry. The Child Poverty Action Group argued that such taxes would be regressive. "The aim should be to ensure people have more money to feed their families adequately, and raising the price of cheap food will not achieve this" (s228, p7). This point was in fact recognised in many submissions that supported pricing mechanisms, with their response outlined in the next section.

6.5 A combined approach: increasing the price of less healthy food while reducing that of more healthy food

Many submissions calling for increased tax on less healthy food linked this with a reduction in the price of more healthy food. Regional Public Health (greater Wellington), for example, regarded economic interventions as "a vital part of any comprehensive strategy to deal with obesity", but that any interventions should include both taxes and subsidies so as not to further disadvantage those who were financially struggling (s135, p17).

Hawke's Bay cardiologist Miles Williams argued that "a very clear incentive to purchase healthy produce over unhealthy energy dense food and drink must be provided by way of a tax imposed on the latter with subsidisation of the former" (s288, p7).

The Department of Public Health at the Wellington School of Medicine recommended that pricing mechanisms should be considered "to help make healthy choices the cheaper choices", giving as examples both additional tax on unhealthy foods and the discounting of healthy choices such as fruit and vegetables (s255, p3).

The Rotary Club of Wellington North wanted both tax on less healthy food and GST removed from fruit and vegetables to encourage consumption among the 'less well off'. The latter "should be seen as a counter-balance to the higher taxing and cost of convenience food and drink" (s149).

6.6 Summary and conclusions

The health sector gave very strong support to at least consideration of tax changes and/or subsidies to encourage healthy eating. This was based on the potential for pricing mechanisms to affect food choices. Pricing mechanisms were seen as a particularly useful measure since they operated at a population level.

Health sector submissions tended to concentrate more on the need for pricing mechanisms in general rather than advocating implementation of particular measures. This was presumably in part because of a general recognition by submitters that they lacked expertise about taxes and subsidies. This makes it likely that many would have agreed with the Ministry of Social Development that pricing mechanisms "should be approached with caution" (s307, p7). There was overwhelming support for the Ministry's conclusion that because of their potential to influence food choices, pricing mechanisms "should at least be considered".

Calls for GST to be removed, or at least considered for removal, were popular among those arguing for tax changes to reduce the cost of more healthy food. The motivation behind the majority of these calls was to increase the access to more healthy food for low income families. Subsidies to reduce the price of more healthy food for targeted groups were also supported, with reference made in one submission to the 'Healthy Start' scheme that was being rolled out in the United Kingdom.

Tax changes to increase the cost of less healthy food had substantial support: 39 health sector submissions believed that these should at least be considered. A tax on sugary drinks, for example, was advocated by a university group based on evidence of effectiveness from the research literature.

No health sector submission opposed at least consideration of taxes on less healthy foods. There was, however, substantial food industry opposition. Arguments used included that population-level measures such taxation were inappropriate because they would adversely affect many consumers who were not obese, and that would have little impact on consumption while increasing the price of food for those who could least afford it.

The only submission from outside the industry sector to oppose additional taxes was from the Child Poverty Action Group, which argued that people needed sufficient money to feed their families, and raising the price of cheap food would not achieve this.

Many submissions acknowledged the regressive nature of additional tax on less healthy food, and suggested that such tax increases would need to be accompanied by at least a compensating reduction in the price of more healthy food. Professor Boyd Swinburn pointed out that pricing mechanisms were in fact more equitable than the message-based approached favoured by the industry sector, as the latter was least effective for groups at higher risk of obesity.

To conclude, the application of taxes and/or subsidise to move food consumption in a more healthy direction was recognised as complex in many submissions. Because of its potential, however, there was a very strong call from the health sector for serious consideration to begin on how to include pricing mechanisms as a leading component in the arsenal of weapons to prevent obesity. Many submitters were less cautious, and wanted measures such as the removal of GST from some foods to be implemented now.

7 Food labelling

The submission from the New Zealand Food Standards Authority (NZFSA) (s313) provided useful background information about food labelling in New Zealand. NZFSA explained that New Zealand and Australia have a joint food standards system, and joint regulations with respect to the composition and labelling of foods. The Australia New Zealand Food Standards Code provides standards for composition, labelling (including nutrition labelling and claims), and contaminants that apply to all foods produced or imported for sale in New Zealand and Australia.

Food Standards Australia New Zealand (FSANZ) develops and reviews joint food standards. NZFSA's role in this process includes input into work undertaken by FSANZ to ensure that standards reflect New Zealand conditions and concerns.

7.1 Distinguishing healthier and less healthy foods on food labels

The issue relating to food labelling that attracted most attention from submitters related to the provision of simple information on labels that enabled shoppers to readily distinguish more healthy and less healthy foods and drinks. This section outlines the case for doing this, the case against, and several proposals as to how it might be implemented.

7.1.1 The case for: consumers need help to distinguish more and less healthy foods

There was substantial support across all sectors except industry for the proposition that *a simple labelling system that distinguishes more healthy from less healthy food is required* (see Table 7.1). This was proposed in 54 submissions, 31 of them from the health sector.

Table 7.1 A simple labelling system that distinguishes more healthy from less healthy food is required

Sector	Proposed
Health	31
Nutrition	4
Physical activity	4
Other	15
Total	54

Dietitian Nicky McCarthy set out the situation faced by the New Zealand consumer:

> Currently consumers are expected to interpret Nutrition Information Panels, a variety of 'health' claims, Ministry of Health guidelines, diet books, magazine and media articles, as well as manufacturers' information and advertising when deciding whether a food product is healthy enough to include regularly in the diet or should only be eaten occasionally (s76, p8).

A number of submissions made the point that complex information is least effective for the segments of the population where obesity levels and related health problems are highest. As CAPS Hauraki (a non-profit community agency working with low income families) put it:

> Our clients would struggle to interpret and understand current labels and compare different products using that information. A simplified traffic light system as proposed by some of the health sector would help our clients (s179, p2).

7.1.2 The case against: there is no such thing as unhealthy food

Industry submissions did not directly state their opposition to introducing a labelling system that distinguished healthy from less healthy foods. There was, however, substantial indirect opposition based around the postulate that it was wrong to define individual foods or drinks as healthy or unhealthy. Eight submissions, seven of them from industry, proposed that *individual foods are not healthy or unhealthy, although overall diets may be unhealthy.* Four submissions from the health sector specifically opposed this proposition.

The Food and Grocery Council (FGC) opposed defining food as "good" or "bad":

> The important message to convey is to eat foods in the amounts that are good for health. There is no such thing as a food that is good or bad for health; it is the overall diet that affects health (s163, p4).

As a supporting argument the FGC suggested that:

> when food is deemed "bad" it unconsciously tells the consumer they are a bad person. If all food is however seen as "good" then it loses its power to make people feel ashamed or guilty and becomes a freedom from the emotional power of food (s163, p4).

The other submission that included supporting argument was from McDonald's.

> We consider attempts to define what constitutes healthy or unhealthy food will not result in lasting solutions. It is not a matter of unhealthy foods as a matter of unhealthy food choices within the context of a person's overall diet. One to two meat pies every month and some physical activity is not going to result in an obese child. Ten meat pies every week and little or no physical activity may well lead to obesity. It is about balance, the ability to exercise choice and, in the case of children,

> the exercise of that choice on their behalf by parents and care-givers (s190, p18).

The Beer Wine and Spirits Council wished to highlight the lack of evidence that light to moderate alcohol consumption contributed to obesity. They used essentially the same argument against blaming the product for over-consumption as did McDonald's, suggesting instead that over-consumption resulted from "personal and social attitudes" (139, p1).

The Confectionery Manufacturers of Australasia Ltd opposed "demonising any foods by presenting a good or bad food philosophy" (s252, p4).

The opposing case (that some foods can clearly be described as more healthy than others) was stated by FOE as follows:

> In its inquiry into obesity, the House of Commons Health Committee dismissed this [the no unhealthy foods] argument, stating that "it is patently apparent that certain foods are hugely calorific in relation to their weight and/or their nutritional value compared to others". The Committee gave, as an example, a Snickers Bar weighing 61 grams and with 280 calories against an apple weighing 112 grams and with 53 calories.
>
> Put in terms of smoking, the argument that there are no unhealthy foods would run like this. There is no evidence that people who exercise self-control and have the occasional cigarette, without making a habit of it, are harming themselves. Therefore cigarettes are not unhealthy, only smoking too many cigarettes is unhealthy, and we should not restrict the promotion or sale of cigarettes (s136, p41).

7.1.3 The existing option: 'Pick the Tick'

The National Heart Foundation's 'Pick the Tick' scheme goes some way towards providing a simple food labelling system that distinguishes more healthy from less healthy choices. However, as Table 7.3 shows, the proposition that *the 'Pick the Tick' scheme contributes to healthier eating and should be supported and/or expanded* had only limited support. The scheme was endorsed without major qualification in only eight submissions, with half of these being from industry. Only one submission (from the Heart Foundation itself) was from the health sector.

Table 7.2 The 'Pick the Tick' scheme contributes to healthier eating and should be supported and/or expanded

Sector	Proposed
Health	1
Industry	4
Other	3
Total	8

The most common view of 'Pick the Tick' among submitters from the health sector was that *while the 'Pick the Tick' scheme is of some help, it has major limitations and/or disadvantages* (Table 7.3).

Table 7.3 While the 'Pick the Tick' scheme is of some help, it has major limitations and/or disadvantages

Sector	Proposed
Health	7
Nutrition	1
Total	8

The New Zealand Branch of the Australasian Faculty of Public Health Medicine described 'Pick the Tick', then went on to outline why they believed the scheme was not ideal:

> *Pick the Tick* is a high profile and widely used programme designed to give immediate nutritional information to consumers. Food manufacturers, whose products meet defined nutritional criteria and pay fees, are able to display the *Pick the Tick* logo on food labels. Food companies are encouraged to reformulate product if they fail to meet criteria. However, *Pick the Tick* has criteria for each food product category rather than an overall set of criteria. This leads to some high fat food items gaining the Tick if the fat content is lower than comparable products. Consumers may not appreciate this distinction (s159, p21).

In similar vein, the Medical Association described 'Pick the Tick' as "problematic in that the approval is given within food categories" (s128, p22). Dietitian Nicky McCarthy gave an account of the effect of this "within category" approval feature:

> Many consumers incorrectly interpret the 'Tick' to mean that the food with the tick is a healthy product. For example, many schools defend their selling of meat pies or similar items on a daily basis by stating that the pie has the tick, therefore is a suitable daily lunch option for children. A chicken nugget manufacturer similarly defended a television advertisement of their product which depicted children eating chicken nuggets five times a week. However, the 'Tick' is included on products that the Heart Foundation recommends only for 'occasional' consumption. (The chicken nugget manufacturer was subsequently required to remove the tick from the advertisement – but not the product) (s76, p8).

A health worker wrote that the while the heart tick was helpful, many products with the Tick were "loaded with sugar" making them unsuitable for people with diabetes and those wanting to lose weight (s146, p1).

The susceptibility of the Tick to misinterpretation is borne out by the fact that two of the three "other" submitters endorsing the scheme (Table 7.3) appeared to not fully understand what the Tick meant (s5 and s245).

Of the eight submissions concerned about limitations and disadvantages of 'Pick the Tick', seven went on to suggest that, at the least, favourable consideration should be given to the introduction of a 'traffic light' food labelling system.

7.1.4 The 'traffic light' proposal

The background to proposals in a number of submissions calling for a 'traffic light' system of food labelling to be introduced was set out by the Obesity Action Coalition (s129, p51) and Fight the Obesity Epidemic New Zealand Incorporated (FOE). As FOE described it:

> What is needed is a simple scheme that enables shoppers to immediately identify more healthy and less healthy foods and drinks from the label. Such a scheme was strongly supported by the House of Commons Health Committee in its 2004 report on obesity. The Committee recommended that the Government legislate to introduce a 'traffic light' system – red, amber or green symbols – that would be compulsory for all foods. The criteria, based on energy density, would identify products that should be eaten less often (red), those that were low in energy density (green), and those in between (amber). The Committee noted that not only would such a scheme "make it far easier for consumers to make easy choices, but it will act as an incentive for the food industry to re-examine the content of their foods, to see if, for example, they could reduce fat or sugar to move their product from the 'high' category into the 'medium' category".
>
> In the United Kingdom, the Food Standards Agency (FSA) has been developing a traffic-light scheme that goes some way towards meeting the House of Commons Health Committee recommendation. The scheme uses red, amber or green colour coding to indicate levels of fat, saturated fat, sugar and salt according to nutritional criteria developed by the FSA, but allows supermarkets and manufacturers to develop their own labelling "with an individual look and feel that appeals to their shoppers". The FSA scheme has met with serious opposition from a number of major food manufacturers and retailers (s136, p50).

FOE concluded that, given the evidence from the United Kingdom, it was unlikely that such a traffic scheme would be universally supported by food manufacturers and retailers in New Zealand, and thus the scheme would need to be developed by a government agency and made compulsory (s136, p51).

The NZFSA has closely studied the UK traffic light system. They noted that the UKFSA had extensively researched a number of options before selecting traffic lights, and that consumer research in the UK "has shown that consumers understand and are able to correctly interpret and use this multiple traffic light signposting quickly and effectively" (s313, p4).

Table 7.4 shows support for the proposition that *a 'traffic light' food labelling system should be introduced in New Zealand.* This was proposed in 27 submissions, 16 from the health sector, and opposed in two industry submissions. A further six health sector submissions wanted at least consideration given to the introduction of a traffic light scheme.

Table 7.4 A 'traffic light' food labelling system should be introduced in New Zealand

Sector	Proposed	Opposed
Health	16	
Nutrition	4	
Physical activity	1	
Industry		2
Other	6	
Total	27	2

The NZFSA noted that the UK scheme was "voluntary because only the European Union can set mandatory food standards" (s313, p3). Most submissions favouring traffic lights either stated or implied that the system should be mandatory.

After discussing the complexity of current labelling and other information facing consumers and the limitations of 'Pick the Tick', Dietitian Nicky McCarthy gave her view as to what was needed:

> A mandatory food labeling system that divides foods into three categories similar to a traffic light system should be independently developed and implemented. This should take account not just of the energy and nutrient density and portion sizes of foods but also how frequently they should be included in a healthy diet (s76, p8).

Two beverage companies, Fonterra (s138b, p2) and Coca-Cola (s160, p23), did not like the way the school traffic light beverage guidelines developed by the Waitemata District Health Board classified their products. Fonterra believed that flavoured milk drinks should not be in the same (amber) category as soft drinks, while Coca-Cola believed that sugar-free (artificially sweetened) soft drinks should be green rather than amber.

Coca-Cola found it "alarming" that the Waitemata guide did not include sugar-free soft drinks as a green (drink most) beverage. They argued that if the purpose of the guidelines was to reduce sugar intake, it was illogical to exclude sugar-free drinks. This might be an argument against the Waitemata guidelines if indeed their purpose was only to reduce sugar intake. It is not an argument against what is generally proposed for a traffic light system, where it

is the total impact of a product on health that determines its colour category. In this case Diet Coke may rightly fail to be classified green (drink often).

Fonterra concluded that a traffic light system "offers a short-term, out of sight, out of mind solution which has been implemented across many countries with a range of problems" (s138b, p2). The claimed implementation of traffic lights across many countries is simply wrong.

7.1.5 Other proposals

Two other proposals for food labelling systems were proposed in written submissions.

A submission from an individual argued for:

> Consideration and wide discussion of the introduction of a policy to require the printing of health warnings on foods (particularly fast foods) that are clear contributors to obesity (similar to the health warnings on cigarette packets) (s22, p2).

The Nutrition Foundation provided the Inquiry with a lengthy description of the "e mark" symbol they were developing and planned to trademark (s30b). This has some features of traffic lights, but provides more information.

Finally, the Food Industry Group (FIG) introduced a proposal not included in their written submission when they made their oral presentation to the Committee in November 2006. They supported "percentage daily intake" labelling, which was claimed to provide better information to consumers than traffic lights in a very simple way. No details on the FIG proposal were given, but it appeared to the same or similar to a UK development referred to by the NZFSA. As reported by the NZFSA:

> Industry [in the UK] has not been unanimous in its support of the UKFSA traffic light system. Some manufacturers … have their own front of pack labelling based on percentage Guideline Daily Amounts (%GDA). These systems vary slightly by company, but the general features are a row of percentages for a number of nutrients … based on the contribution of a serve of the product to the daily requirements of an average adult (s313, p5).
>
> The UKFSA consumer research, undertaken prior to implementation of the voluntary [traffic light] system, tested a number of %GDA systems alongside a range of alternatives. That research showed that %GDA labelling was not well understood by consumers (s313, p.6).

7.1.6 Summary

Food labelling was not specifically mentioned in the Terms of Reference, and was addressed in only a minority of submissions. Nevertheless a clear pattern emerged. Fifty-four submissions, 31 of them from the health sector, wanted to see the introduction of a simple labelling system that distinguished more healthy from less healthy food. A number of submissions made the point that a simple labelling system was particularly important for those

segments of the population among whom obesity and type 2 diabetes were more prevalent.

Eight submissions, all but one from industry, proposed that individual foods were not in themselves unhealthy, implying that there was no logical basis for distinguishing more healthy from less healthy foods on food labels.

The National Heart Foundation's 'Pick the Tick' labelling scheme found support from industry submissions. It was, however, generally seen by health sector submissions that mentioned it as having a major drawback: foods that should at best be eaten only occasionally could still carry the Tick because they were less unhealthy than other foods in the same category, and this was confusing for consumers.

Around half of the submissions wanting simple labels favoured a 'traffic light' system using a green, amber or red symbol. Twenty-seven submissions said that such a system was required, with a further six calling for it to at least be considered. The only specific opposition to a traffic light system in the written submissions came from two beverage companies unhappy about the colour category assigned one of their products in the Waitemata District Health Board's traffic light beverage guidelines for schools.

As part of the Food and Grocery Council's oral presentation, executive director Brenda Cutress made a revealing comment pertinent to the central argument made by supporters of traffic lights. She cited an example she heard at a meeting in Europe where a manufacturer could provide two mayonnaise products, one with less fat than the other, but both still having a red sticker. Cutress used this as example of a weakness in the traffic light system. Traffic lights proponents, however, would regard this as a strength. From their perspective, this gives the message that if mayonnaise manufacturers are unable to make products that cannot at least make it to amber, then consumers should at best eat mayonnaise only occasionally as a treat.

7.2 Health claims on food labels

As described by the Obesity Action Coalition (s129, p51), health claims on food labels are illegal in New Zealand, although this has not been enforced. At present Food Standards Australia New Zealand (FSANZ) is developing a standard which would allow health claims on food labels by declaring health benefits for the food or a component of it (Proposal P293 – Nutrition, Health and Related Claims).

There are very different views among submissions from industry and those from other sectors on both the general issue of health claims and the acceptability of the FSANZ proposal, as is illustrated below.

7.2.1 The case for health claims: consumers would be better informed

The Food and Grocery Council (FGC) strongly supported increased provision for health claims:

> Nutrition and Health Claims can make a significant contribution to public health. In addition they can reach all consumers, even consumers that do not have access to other forms of nutritional information, many of whom carry the greatest burden of obesity and type 2 diabetes (s163, p6).

The Association of New Zealand Advertisers believed that if advertisers were able to describe foods as 'healthy' there would be an immediate increase in the number of advertisements for nutritious food (s158, p14).

7.2.2 The case against health claims: consumers would be misled

Within sectors other than industry, however, there was strong opposition to health claims on food (Table 7.5). Thirty-one submissions proposed that *health claims on food labels should either not be permitted, or if permitted then they should be strictly regulated.* All four submissions supporting health claims on food were from the industry sector.

KANOHI, a Marlborough HEHA implementation group, wanted legislation "to prevent misleading health claims such as 'low in fat' and 'lite' on products which are high in sugar, noting that this could give the misleading impression that the products were healthy (s145, p2). The Auckland Regional Public Health Service was similarly concerned that consumers "can be misinformed if a content claim does not consider the total nutrient profile and the food's impact on health" (s82, p33).

Table 7.5 Health claims on food labels should either not be permitted, or if permitted then they should be strictly regulated

Sector	Proposed	Opposed
Health	20	
Nutrition	4	
Industry		4
Other	7	
Total	31	4

A parent described the effect of currently-used nutritional claims, and wanted change.

> My 6 year old son is always commenting that a product must be good for you because it is promoted as having Vitamin C, or 99% fat free. What these advertisements aren't showing is the sugar content for example.

> Could there not be a restriction on these companies that they promote all the ingredients equally or not at all… [While] the food giants are free to advertise as they wish, it is no wonder that the majority of the public are confused about 'good' choices (s6).

The Heart Foundation suggested one solution to the concern expressed by this parent.

> The regulatory agencies need to provide a framework to minimise misleading food, health, and nutrition claims and require that reduced-fat and reduced sugar claims carry a reduction of at least 25% energy as compared with a standard reference food (s47, p6).

7.2.3 Views on the FSANZ proposal

There was substantial opposition, particularly from the health sector, to implementation of the FSANZ proposal to allow health claims as it stood in 2006. Table 7.6 shows that 24 submissions expressed the view that *the FSANZ proposal to allow health claims on food labels is more likely to promote than prevent obesity and should be opposed.* The four submissions that expressed disagreement with this were all from the industry sector.

The Heart Foundation's Pacific Islands Heartbeat Unit was strongly opposed to the FSANZ proposal:

> There is no evidence that health claims will lead to positive changes in behaviour that lead to better food choices. This initiative has been driven by the food industry … [so] that it can be used as a marketing tool to increase sales, including sales of inappropriate products. Health claims have the potential to cause an increase in consumption of processed products, since process products are most likely to use the claims, and are the types of foods most likely to need the marketing advantage that a health claim will provide… Core foods, such as fruit and vegetables, do not have the same advantage. The result has the potential to … increase the fat, sugar and sodium consumption of New Zealanders and the adverse consequences on their health (s274, pp8-9).

Table 7.6 The FSANZ proposal to allow health claims on food labels is more likely to promote than prevent obesity and should be opposed

Sector	Proposed	Opposed
Health	14	
Nutrition	4	
Industry		4
Other	6	
Total	24	4

The Nutrition and Human Health Cluster at Massey University's Institute of Food, Nutrition and Human Health was similarly concerned that "[unless] the foods permitted to carry health claims are carefully chosen there will be an unspoken message that more of these foods is good" (s199, p6).

The National Heart Foundation noted that from 2007 the food industry was likely to be able to make health claims on foods, and that regulations would need to establish robust disqualifying criteria for foods to carry health claims (s47, p6).

While disagreeing with the view that the FSANZ proposal was a backward step in terms of obesity prevention, there were differing views among industry submitters as to changes required to the draft standard as it stood in 2006. The Food and Grocery Council was highly supportive of the draft proposal (s163, p6). Both the Association of New Zealand Advertisers (ANZA) and Fonterra, however, wanted further liberalisation than FSANZ was proposing.

Fonterra's concern was:

> The Draft Assessment Proposal proposed that foods containing high saturated fat and sugar would fall into disqualifying criteria and would be unable to make claims. Fonterra does not agree with the disqualifying criteria. The disqualifying criteria restrict the ability of the food industry to raise consumer awareness of health food options. For example, health claims are unable to be made on yogurt as it falls into the disqualifying criteria. However, yoghurt should be permitted to have claims on it as consumers should be aware of its ability to be used as a low-fat substitute for cream, for example (s138, p8).

ANZA noted that:

> Food Standards Australia New Zealand is currently reviewing the law but there are no proposals that will make advertising to children of nutritious foods more attractive. The playing field is tilted against advertising nutritious food (s158, pp8-9).

7.2.4 Summary

The industry submissions that addressed health claims wanted to be able to make such claims on food labels and in advertising. They submitted that this would be beneficial in helping prevent obesity and type 2 diabetes. Some industry submitters believed that the current FSANZ proposal to allow health claims did not go far enough.

Submitters from outside industry, however, took a very different view. They believed that health claims only benefited industry, and were much more likely to mislead consumers than inform them. No submissions outside the industry sector supported the FSANZ proposal to allow health claims, and many opposed it, including 14 submissions from the health sector.

7.3 Conclusions

Section 7.1 outlined the call from the health and other sectors for a simple labelling system that allowed consumers to quickly distinguish more healthy and less healthy foods. By far the most popular choice for this role was a 'traffic light' system in which a green symbol indicated that a food should be consumed often, whereas a red symbol meant that a food should be consumed only occasionally as a treat, if at all. This approach was opposed in industry sector submissions, making it likely that a proposal to implement a traffic light scheme in New Zealand would almost certainly meet strong industry opposition, as is currently occurring in the United Kingdom.

The main theme in industry submissions with respect to food labelling was that food labels should be allowed to carry health claims (section 7.2). This was in turn strongly opposed from within the health and nutrition sectors.

As is suggested by Massey University's Nutrition and Human Health Cluster, there is a link between the traffic light system and concerns about health claims. The Massey group suggested that the traffic light proposal could mitigate the negative effects of health claims (s199, p6). As example of what they meant, a children's breakfast cereal advertising itself as "high on iron to build strong bodies", but with a high sugar content, would carry a symbol telling consumers that this was not a product for everyday consumption.

If a mandatory traffic light system was introduced, and a successful campaign was conducted to inform consumers about what the colour symbols meant, then food companies would have much less reason to make claims that particular products were healthy (a green symbol would be doing this for them). Public health advocates would know that any claims about the benefits of food constituents would be set in the context of a clear message (green, amber or red) about the total health-related status of the product.

8 Health sector recommendations and current Government policy

In sections 3 to 8, a clear health sector position was identified from submissions on a range of issues. In many cases this position was strongly opposed by submissions from the industry sector. In this final section, an attempt is made to assess the extent to which what the health sector wants is matched by Government actions and apparent intentions.

8.1 HEHA and addressing the obesogenic environment

The health sector and industry sector, as section 3 illustrated, took contradictory positions on what was required to prevent obesity. The widespread view in submissions from the food industry and advertisers was that *educating, informing and encouraging individuals to make the right choices should be the central focus of efforts to reduce obesity.* All nine submissions that proposed this were from the industry sector. The health sector view, on the other hand, was that *education and information provision without environmental changes will be ineffective in reducing obesity.* What the health sector wanted was a strong focus on changing the obesogenic environment, which included restricting the promotion of less healthy food, finding and implementing pricing mechanisms (tax changes and/or subsidies) to encourage healthy eating, and making some fundamental changes to food labelling.

Sections 5 to 7 showed very strong and at times overwhelming support from the health sector for changes to the obesogenic environment that are not currently receiving Government attention. This was one of the reasons for the very high level of dissatisfaction among submitters with HEHA (Healthy Eating - Healthy Action), the current vehicle for delivering Government obesity-related interventions (section 4).

The state of play regarding changes to the obesogenic environment discussed in sections 5 to 7 is outlined below.

8.2 Regulations and the promotion of less healthy food

8.2.1 What the health sector wants

Section 5 showed that there was powerful support, particularly from the health sector, for regulation by Government of all forms of promotion of less healthy food. As an example, 54% of all submissions from the health sector proposed that *some form of regulation of the advertising of less healthy food is*

required.[12] No health sector submission stated that they opposed this proposition. This represents massive support for regulation from the health sector, noting that not all submitters who may have had a view on the regulation of advertising would have expressed their view in their submission. Many submissions confined their recommendations to their own particular area of expertise.

Table 5.2 in section 5.1.2 lists some of the health sector submitters for whom some form of regulation by Government of the advertising of less healthy food was a sufficiently salient issue for them to express their view. Submitters favouring regulation included nine District Health Boards, leading international obesity prevention experts Professor Boyd Swinburn, Professor Jim Mann and Dr Robert Beaglehole, the Medical Association, Paediatric Society, Faculty of Public Health Medicine, Society for the Study of Diabetes, Cancer Society, Dietetic Association, College of Nurses Aotearoa, New Zealand Nurses Organisation, and Diabetes New Zealand. On the other side of the fence, the ten submissions that opposed some form of advertising regulation were the Food Industry Group, the Food and Grocery Council, McDonald's, six advertising-related organisations, and an industry-funded university group.

There was also a substantial difference between the quality of evidence and arguments relating to regulation of advertising between the health and industry sector submissions. A number of health sector submissions were well argued from available evidence. This could not be said at all for industry submissions, which generally relied on poor quality research. Five submissions from major industry players in fact built their case against restrictions on television advertising on "research" conducted by the World Federation of Advertisers that was completely discredited in this report (section 5.1.6).

The analysis in section 5 of what submitters had to say about advertising regulation and obesity demonstrates a total polarisation of views. On one side was a large and impressive group from the health sector which included a number of evidence-based submissions. On the other side was a group from the food and advertising industries who might fear their profits would be damaged if the health sector view was to prevail. Given this, one might expect that the position adopted by Government would be more closely aligned to the health sector than industry on such a major health issue as obesity prevention. But this is by no means clear.

8.2.2 The Public Health Bill and regulation-making powers

Current Government policy was set on 3 September 2004 with the launch of the Food Industry Accord. At the launch the then Minister of Health Annette King had the following to say regarding regulation:

[12] It should be noted that many submissions wanted to go further in restricting the promotion of less healthy food than just the regulation of advertising (see sections 5.2 and 5.3).

> As you know, the Ministry of Health is currently developing proposals for a new Public Health Bill… Quite clearly, there will be those who advocate that the Bill should … include prescriptive provisions, such as the use of regulations, to be considered if other strategies are ineffective in meeting public health objectives. I repeat, however, that in my view collaborative approaches are vastly preferable to legislative options.[13]

Current Minister of Health Pete Hodgson has been giving a similar, but perhaps slightly firmer, message. In an address to a Food Industry Group seminar in April 2006, for example, the Minister stated:

> I am not averse to considering regulation in the area of food marketing and supply. If you look at my work in previous portfolios you will see that I am not afraid to use legislation where necessary. But I also recognise the place of industry self-regulation. I would like to think that regulation is a last resort and so I ask you to rise to the challenge you have set yourselves in the Food Industry Accord and assist with making healthy food choices the easy choices for all New Zealanders.[14]

A detailed outline of what is proposed in the Public Health Bill is now available.[15] This is quoted at length because it sets out a number of relevant aspects of current Government policy, and shows that the King/Hodgson reliance on industry self-regulation, at least in the first instance, is to continue.

> The new Bill, when drafted, will allow for the management of a wide range of risks to public health including some provisions relating to non-communicable diseases such as cancer, diabetes and cardiovascular disease. However the focus will continue to be on communicable disease and environmental health.
>
> While the timing is not yet certain and remains subject to a number of factors, the Ministry hopes to have the new Bill drafted and introduced to Parliament in mid 2007.
>
> The major causes of population ill-health at present, and the major drivers of health care expenditure, are those broadly categorised as non-communicable diseases, such as cardiovascular disease, diabetes, cancers, mental ill health and addictions.
>
> Reducing the impact of non-communicable diseases in the population requires intervention at a number of levels, as well as co-ordinated efforts across key sectors and settings that can support outcomes, such as improved nutrition and physical activity. Legislation alone is not the answer but, as experience with tobacco control has shown, appropriate legislative provisions can support effective public health action in a way that also reduces inequalities.

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[13] Hon Annette King, Signing and launch of Food Industry Accord, 3 September 2004. Accessed from www.beehive.govt.nz on 21 March 2007.

[14] Hon Pete Hodgson, Address to food industry group seminar, 20 April 2006. Accessed from www.beehive.govt.nz on 23 March 2007.

[15] Ministry of Health. 2006. Public Health Bill Summary. Wellington: Ministry of Health.

It is proposed that the Bill include principles and provisions for making codes or guidelines to address non-communicable disease risk factors. The codes and guidelines would not bind affected parties, although compliance with at least the spirit of their provisions may be taken into account in some circumstances.

The Director-General will be able to make non-binding codes and guidelines to promote public health, for example, in relation to:

- exposure to, or access or use by, the public or specific groups to products and services relevant to non-communicable disease risk factors
- matters relevant to advertising, sponsorship or marketing (direct or indirect) of products and services with an impact on non-communicable disease risk factors
- the performance, composition, contents, additives, design and construction of goods, things or services or processes that impact on non-communicable disease risk factors.

There will be provision in the Bill for the Minister of Health to be required within a specified timeframe of three years from date of enactment (with an option to extend this period) to report to the House on options and proposals for addressing non-communicable disease issues; with recommendations as appropriate to amend the Act so as to better address such issues, for example, by strengthening any existing provisions or by inclusion of regulation-making powers.

A number of submitters would probably regard provision in the Bill for the Director-General of Health to make non-binding codes and guidelines (but not regulations) as a positive step. On the other hand, many in the health sector submitted that the current voluntary regime for advertising was inadequate (section 5.4), and would probably see little reason as to why non-binding codes and guidelines would result in much improvement when they believed regulation by Government was required.

The Bill as currently proposed requires the Minister of Health to come back to the House within three years of enactment with further proposals that may include regulation. Parliament would then have to debate and act on the Minister's proposals, adding a further delay. Given the apparent reluctance of successive Ministers to regulate, current proposed provisions in the Bill make it around 2012 at best before any regulatory action might occur, assuming the Bill became law in 2008.

The health sector view of this, as expressed in the calls for regulation of the promotion of less healthy food and the need for urgent action, would probably be that this represents unnecessary and damaging delay on Government's part. Public health expert Professor Boyd Swinburn was completely clear: what is required "are government regulations and not industry codes of practice" (s189, p4).

Twenty submitters from the health sector had proposed that *the Public Health Bill needs to be progressed so that it provides a framework for effective action to prevent obesity* (Table 8.1). Most of these 20 would probably be

disappointed that there is no move at this stage to include regulation-making powers.

Table 8.1 The Public Health Bill needs to be progressed so that it provides a framework for effective action to prevent obesity

Sector	Proposed
Health	20
Nutrition	2
Physical activity	1
Other	6
Total	29

Diabetes New Zealand (DNZ) made the only submission that ignored the Public Health Bill as the suitable vehicle to obtain changes to the obesogenic environment called for by the health sector. Instead they proposed a 'Healthy Environments Act'. Perhaps they had a crystal ball. Unless the proposed Public Health Bill is given regulatory teeth, many public health advocates may well move to support something like the DNZ proposal as a Private Member's Bill.

8.3 Taxes and subsidies

The health sector gave very strong support for at least consideration of pricing mechanisms such as tax changes or subsidies to encourage healthy eating (section 6). This was based on the potential for pricing mechanisms to influence food choices across the population, and particularly among those segments of the population less likely to respond to other measures such as education and information provision. A common view was that pricing mechanisms were potentially powerful and needed to be part of the solution to obesity, but that consideration was needed as to which particular mechanisms should be employed.

In its background paper to the Inquiry, the Ministry of Health was silent on taxes and subsidies until the penultimate page, where it was noted that:

> Professor Philip James, an expert on obesity prevention, … contends that price, availability and marketing of food are the key areas to consider for the prevention of obesity (MoH background paper, p28).

The Ministry went on to say that future work in implementing HEHA includes improving our understanding of the most effective actions, and that this "needs to particularly focus on their impact on the price [author's underlining], availability and marketing of food, as well as increasing physical activity as a normal part of life" (*ibid*.). This reads as though the Ministry wanted more

research before committing itself to the need for actions involving changes to food prices.

The Minister appears to be similarly reticent. To date, to the author's knowledge, he has challenged the food sector to "improve the pricing, availability and marketing of healthy food" (Hon Pete Hodgson, *ibid.*), but he has not indicated that any direct action by Government to use pricing mechanisms to encourage healthier food choices is under consideration.

Treasurer Dr Michael Cullen certainly did not favour additional tax on less healthy food when, in May 2005, he addressed the Diabetes New Zealand annual conference in Napier.[16]

It appears then, that use of taxes and/or subsidies as a means of encouraging healthier food choices is scarcely on the radar for the present Government. The weight of argument from the submissions is clearly and firmly on the side of using pricing mechanisms of some sort as an important component of obesity prevention. Presumably many submitters will therefore be hoping that the Select Committee adopts in principle the position that pricing mechanisms are required to help make healthy choices the easy choices, and recommends to the House that prompt and serious consideration is given to the forms such mechanisms should take.

8.4 Food labelling

Many submissions, particularly from the health sector, called for a simple labelling system that allowed consumers to quickly distinguish more healthy and less healthy foods (section 7). By far the most popular choice for this role was a 'traffic light' system in which the colour of a symbol (green, amber or red) indicated the extent to which a food should be part of a healthy diet.

It was apparent when the Ministry of Health appeared before the Inquiry on 7 March 2007 that they did not favour the 'traffic light' proposal. It was not clear whether this related just to school food, or more generally.

8.5 Conclusion

A compelling feature of the submissions, particularly from the health sector, and with the exception of industry, was a call for public health measures (measures impacting at a population level) to be introduced as a key component of obesity prevention (section 3). A very strong message was delivered from those in the health sector dealing with the consequences of obesity and type 2 diabetes: a much stronger preventive response is required from Government. The health sector, in other words, called for a much more effective fence at the top of the cliff. This section has shown that to date

[16] Hon Dr Michael Cullen, Address to Diabetes Conference, 7 May 2005. Accessed from www.beehive.govt.nz on 23 March 2007.

Government has generally ignored this call. Instead it has, largely through the Food Industry Accord, sought to achieve change through voluntary actions by the food and advertising industries. Those at the coalface rejected this approach in their submissions (section 4), and asked for a great deal more done on the prevention front than is currently occurring. And they wanted action urgently, not by perhaps 2012.

The health sector, through its submissions, has given a very clear message. To make effective progress in reducing obesity, action must be taken by changing the environment to make healthy choices easier. These actions include:

- restricting the advertising and other forms of promotion of less healthy foods, particularly to children;
- finding ways of using pricing mechanisms (taxes and subsidies) to encourage New Zealanders to adopt a more healthy diet;
- making it easier for consumers to make healthy food choices through changes to food labelling such as the proposed 'traffic light' system.