Individuals, the Environment or Inequalities: Industry and Public Health Framing of Obesity and its Presence in New Zealand Government Policy on Food and Nutrition

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Abstract

Background

Although research on major public health issues such as tobacco has revealed that the framing of an issue can constitute a form of political influence in the policy making process, little has been documented about the framing of obesity. In 2006, the New Zealand Parliamentary Health Select Committee conducted the Inquiry into Obesity and Type 2 Diabetes (the Inquiry). This thesis made use of this unique forum as an opportunity to investigate the framing of food and nutrition issues by two key players involved in the policy debates surrounding the issue of obesity – the food and marketing industries, and the public health sector.

Aims

The two aims underpinning this investigation were: to describe how the food and marketing industries and the public health sector framed the issue of obesity; and, to examine the extent to which these frames were evident in the official Government’s stance on food and nutrition policy.

Data and methods

This research used a case study methodology based on five sources of data related to the Inquiry. These sources were: key industry and public health written submissions; industry and public health oral submissions; direct observations of the Inquiry hearings and informal ‘corridor conversations’; documentary data on the submitters; and the subsequent official reports, the Health Select Committee Report of the Inquiry into Obesity and Type 2 Diabetes; and the Government Response to the Inquiry into Obesity and Type 2 Diabetes 2007.

A framing matrix, informed by previous framing research and data from the submissions, was developed to identify the signature features of the obesity frames presented to the Inquiry by industry and public health submitters. The framing matrix was then applied to the Government Response to determine the extent to which industry and public health obesity frames were evident in the Government’s stance on food and nutrition policies.
Results

The industry and public health sectors framed obesity in markedly different ways. The industry sector predominantly drew on an ‘individual behaviour’ frame, and the public health sector drew on arguments from the ‘obesogenic environment’ and ‘structural’ obesity frames. As a consequence of these divergent frames, public health submitters called for greater government regulation of key aspects of the obesogenic environment and policies to address social inequalities, while industry called for the provision of education and information to address supposed knowledge deficits amongst individuals and communities affected by obesity.

Aspects of both the industry and the public health frames were evident in the stance taken by the Government. However, in the most significant feature of framing, the solutions, the Government’s stance in the majority of the most contested policy areas (the overall national obesity strategy, the regulation of the food industry and the regulation of the marketing industry), was aligned with the industry framing of obesity. However in another contested policy area, food and nutrition policy in schools, the Government’s stance was aligned with the public health framing of obesity.

Conclusion

The framing of obesity by the key groups investigated in this case study appears to have been an important component of the political and rhetorical landscape on which food and nutrition policy in New Zealand was formed. Although, it was not clear whether the dominance of industry framing in the Government’s stance constituted evidence of effective framing by the industry – as other influences on the Government’s stance were not examined – this analysis of framing revealed whose interests were served by food and nutrition polices in New Zealand at the time of the Inquiry.

One strategy for making the policy environment more conducive to food and nutrition polices that promote rather than damage public health, may be for public health advocates to strategically reframe the obesity issue as a problem of unhealthy food, thus shifting the focus from one on obese people to one on unhealthy food. However, such reframing would need to be part of a strategy which would also need to address the greater economic and ideological power of the food and marketing industries.
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<tr>
<td>AFPHM</td>
<td>Australasian Faculty of Public Health Medicine</td>
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<tr>
<td>ANA</td>
<td>Agencies for Nutrition Action</td>
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<tr>
<td>ANZAD</td>
<td>Association of New Zealand Advertisers</td>
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<td>ASA</td>
<td>Advertising Standards Authority</td>
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<tr>
<td>BMI</td>
<td>Body Mass Index</td>
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<tr>
<td>BWSC</td>
<td>Beer Wine and Sprits Council</td>
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<tr>
<td>CAANZ</td>
<td>Communications Agencies’ Association of New Zealand</td>
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<tr>
<td>CCF</td>
<td>Centre for Consumer Freedom</td>
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<tr>
<td>CDC</td>
<td>Centers for Disease Control and Prevention</td>
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<tr>
<td>CMA</td>
<td>Confectionery Manufacturers of Australasia</td>
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<td>CMW</td>
<td>CanWest Media Works Television</td>
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<td>CSDs</td>
<td>Carbonated Soft Drinks</td>
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<td>DHBs</td>
<td>District Health Boards</td>
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<td>DVDs</td>
<td>Digital Video Disks</td>
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<td>EDNP</td>
<td>Energy-dense nutrient-poor</td>
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<td>FGC</td>
<td>Food and Grocery Council of New Zealand</td>
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<td>FIG</td>
<td>Food Industry Group</td>
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<td>FOE</td>
<td>Fight the Obesity Epidemic</td>
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<td>FOP</td>
<td>Front of Pack</td>
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<td>FSANZ</td>
<td>Food Standards Australia and New Zealand</td>
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<td>HEHA</td>
<td>Healthy Eating-Healthy Action</td>
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<td>HSC</td>
<td>Health Sponsorship Council of New Zealand</td>
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<td>MP</td>
<td>Member of Parliament</td>
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<td>MMP</td>
<td>Mixed Member Proportional Representation</td>
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<td>NAAFA</td>
<td>National Association to Advance Fat Acceptance</td>
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<td>NAGs</td>
<td>National Administration Guidelines</td>
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<td>NGO</td>
<td>Non-Government Organisation</td>
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<td>NHF</td>
<td>National Heart Foundation</td>
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<tr>
<td>NZFSA</td>
<td>New Zealand Food Safety Authority</td>
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<td>NZMA</td>
<td>New Zealand Medical Association</td>
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<td>NZNO</td>
<td>New Zealand Nurses’ Organisation</td>
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<td>NZRA</td>
<td>New Zealand Retailers’ Association</td>
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<td>NZTBC</td>
<td>New Zealand Television Broadcasters’ Council</td>
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<td>OAC</td>
<td>Obesity Action Coalition</td>
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<td>PHA</td>
<td>Public Health Association of New Zealand</td>
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<tr>
<td>RBA</td>
<td>Radio Broadcasters’ Association</td>
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<td>SSG</td>
<td>Sector Steering Group (of HEHA)</td>
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<td>TVNZ</td>
<td>Television New Zealand</td>
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<td>UNCROC</td>
<td>United Nations Convention of the Rights of the Child</td>
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<td>WCRF</td>
<td>World Cancer Research Fund</td>
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<td>WHO</td>
<td>World Health Organization</td>
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Chapter 1: Introduction

It is the political task of the social scientist – as of any liberal educator – continually to translate personal troubles into public issues, and public issues into the terms of their meaning for a variety of individuals (Mills 2000: 187).

This thesis investigates the political and rhetorical landscape on which food and nutrition policy in New Zealand is formed. It argues that an important component of this political and rhetorical policy landscape is how policy issues are framed by key interest groups. The thesis focuses particularly on the issue of obesity, and on key players in this arena of food and nutrition policy – the food and marketing industries and the public health sector – who appear to be engaged in a framing contest to dominate the policy discourse.

Recent rapid increases in obesity, internationally and in New Zealand, are a critical concern in the field of public health nutrition. The obesity ‘epidemic’ has warranted the attention of policymakers and governments alike. Following the UK House of Commons inquiry into obesity in 2003, the New Zealand Parliamentary Health Select Committee, in 2006, initiated its own Inquiry into Obesity and Type 2 Diabetes (hereafter referred to as the Inquiry). This thesis makes use of the unique forum of this Inquiry as an opportunity to investigate the food and nutrition policy debates surrounding the issue of obesity.

This chapter, in outlining the critical background information, provides the rationale behind the specific research questions posed in this thesis. It also details the research aim, briefly describes the data sources on which the investigation is based, and the methodological approach adopted. The introduction closes with a brief overview of the chapters in this thesis.
1.1 Background

This section provides the rationale for the investigation in this thesis. It begins by highlighting the public health significance of obesity, namely: its population level increase and its unequal distribution. This is followed by a discussion of the significance of framing as an influence in the policy making process. The final part of the background section outlines the core positions of two key players in the framing of obesity. The place of these two players – the food and marketing industries and public health sector – within the context of the relevant policy actors is described in Chapter 2.

1.1.1 Obesity as a significant public health issue

Recent increases in obesity, both globally and in New Zealand, pose a significant threat to the public’s health (World Health Organization 2000; Ministry of Health 2004). Obesity is linked to a number of major health risks and these are outlined in Chapter 2. Obesity is also distributed unevenly amongst population groups such that there are important gender, ethnic and socioeconomic patterns in obesity (Friel & Broom 2007).

While the basic cause of obesity is known to be an imbalance of calorie expenditure to calorie consumption, the factors contributing to this large scale population level energy imbalance are multidimensional. The complexity of causes has led to what Lang and Rayner (2007: 166) have termed a policy cacophony: “noise drowning out the symphony of effort”. Causal explanations of the obesity epidemic and their implicated solutions are not only varied but politically charged, being framed by the vested interests of competing stakeholder groups (Kwan 2009; Lang & Rayner 2005; Lawrence 2004; Saguy & Riley 2005).

1.1.2 Framing as a political influence on policy

Framing has been defined in a number of ways (Siegel & Lotenberg 2007). In simple terms, framing is a way of describing and defining a problem in a manner that implies particular solutions. Another way of thinking about framing, suggested by Bacchi (1999), is to think of it as a ‘problem representation’. Typically, critical characteristics of problem representations include: the overall description of the problem; the causes identified or emphasised (and their underpinning assumptions); and, the proposed solutions (Bacchi 1999; Kwan 2009). The solutions implied by a particular frame can have many effects. They can support policy change, reinforce the status quo, or even obscure alternative
questions or explanations that may suggest different solutions. Problem representation, or framing, often also involves identifying who is affected by a problem. This in turn, often suggests who is to blame for a particular problem and therefore who should be held accountable for its resolution (Lawrence 2004).

Framing is important because, if it is successful in dominating public or policy discourse on an issue, it can involve tangible benefits or losses to particular interest groups. As such, it can be argued that framing constitutes a form of political influence. The influence of framing on public opinion has been demonstrated across a range of public policy issues, including affirmative action and welfare policies (Siegel & Lotenberg 2007). Similarly, the influence of framing has been documented for a number of public health issues, namely, mandatory car seat belt wearing, and alcohol and tobacco policies (Siegel & Lotenberg 2007). Some observers of the policy process have suggested that debates over public policy issues largely “represent a battle for framing the issue in the eyes of the public” (Siegel & Lotenberg 2007: 137).

Thus, as there is evidence that framing influences public opinion on an issue, there is a high probability that framing has the potential to influence the policy making process, either directly by influencing the policy makers or politicians themselves, or indirectly by building public and therefore political support for particular policy options. Evidence noted by Lawrence (2004) does in fact suggest that the way in which public health issues are framed can alter the discourse surrounding the policy making environment. An obvious example of this framing is apparent in the competing explanations for the recent rapid increases in obesity offered by two key players in the food and nutrition policy arena: the food industry and the public health sector.

1.1.3 Framing of obesity by key players in the food and nutrition arena

The rhetoric from the food industry, in the US at least, holds that obesity is an issue of personal responsibility (Nestle 2002; Brownell & Horgen 2004; Seiders & Petty 2004; Brownell 2005; Simon 2006). According to the food industry, there is no such thing as unhealthy food, and health is achieved by moderation, balance and exercise (Nestle 2002; Tao & Glazer 2005). The food industry propose that the solution to the obesity epidemic lies in health promotion activities that seek to change health-related dietary and physical activity behaviours, through public information, consumer education and the support of increased participation in sport and exercise (Brownell & Horgen 2004; Food Industry Group 2005; Nestle 2002; Simon 2006; Tao & Glazer 2005).
In contrast, a broad public health perspective typically argues that obesity is a “normal response to an abnormal environment” (Egger & Swinburn 1997: 477). According to this perspective, we live in an obesogenic environment which has increasingly promoted sedentary behaviour and easier access to energy-dense/nutrient-poor (EDNP) foods (Hawkes 2006; House of Commons Health Select Committee 2004; World Health Organization 2003b). A major component of the obesogenic environment is the ever increasing array of perniciously marketed unhealthy food options, that are cheaper, more accessible and more convenient than their healthier alternatives (Seiders & Petty 2004). In an environment where unhealthy foods are cheap and ubiquitous, such foods become the ‘default’ option (Swinburn & Egger 2004). It has been suggested by public health advocates that the government needs to reverse this situation, and make healthy food options plentiful, affordable and accessible. In other words, healthy food needs to become the ‘default’ option. Policy mechanisms for achieving this may include: the introduction of healthy food policies in various settings; differential taxes on healthy versus unhealthy foods; incentives to industry to reformulate unhealthy products; subsidies on fruit and vegetables; and, the regulation of advertising and marketing (Seiders & Petty 2004; Swinburn et al. 1999; Wilson et al. 2006).

However, there are considerable political barriers to the abovementioned strategies to address obesity, most notably the opposition voiced by vested interests from the food industry. Lang and Rayner (2007: 166) argue that the issue of obesity has become “shrouded by ideological fears” where certain interventions are:

interpreted as ‘nanny-ish’ or restricting ‘personal’ choices in food and lifestyle. Obesity it appears, has a capacity to raise deep philosophical questions of liberty and the role and responsibility of the state, the citizen and companies (Lang & Rayner 2007: 307).

Although it is not universally accepted that obesity, and in particular mass obesity, is a public health problem (Campos 2004; Guard & Wright 2005), a number of governments around the world appear to be concerned. In 2003, the UK House of Commons conducted an inquiry into obesity (House of Commons Health Select Committee 2004). Shortly after, in February of 2006, New Zealand followed suit with the announcement by the Parliamentary Health Select Committee of their intention to conduct the Inquiry into Obesity and Type 2 Diabetes. This is the context which inspired the investigation in this thesis.
1.2 Research aim, data and methods

This section describes the aim of this thesis; the specific research question posed and briefly outlines the methodological approach adopted.

1.2.1 Aim and research questions

The overall aim of this thesis was to examine industry and public health framing of obesity in the context of food and nutrition policy in New Zealand at the time of the Inquiry. The specific research questions underpinning this investigation were:

1. How do industry and public health groups frame the issue of obesity?
2. To what extent are these frames evident in the New Zealand Government’s declared stance on food and nutrition policies?

In answering these two questions, it is important to note that the definition of ‘industry’ adopted in this thesis includes the food and marketing industries, while the definition of the public health sector includes the key public health oriented national Non-Government Organisations (NGOs), and, the three public health oriented independent advisors appointed by the 2006-2007 Health Select Committee. More detailed definitions and the criteria for selecting public health and industry submitters are provided in Chapter 4.

The rationale behind the first research question was simply to identify and document how two of the key players in the New Zealand food and nutrition policy arena – the industry and public health sectors – frame the issue of obesity within the context of the Inquiry. To date, published research on the framing of obesity by industry groups is limited to one specific analysis of a US food industry group (Kwan 2009), and more general and infrequent documentation of various food industry group or company positions on specific food and nutrition issues (Nestle 2001; Brownell & Horgen 2004; Simon 2006). Even less has been documented in relation to the framing of obesity by the marketing industry. Therefore, there is a paucity of New Zealand and non-US data on the industry framing of food and nutrition issues such as obesity. Internationally, there is also a paucity of data on the framing of such issues by the marketing sector.

The rationale for investigating the second research question was to see whether one frame is more evident in the Government stance, and if so, does this suggest evidence of effective framing or influence? As already noted, framing can have a number of possible effects on policy. It can reinforce the status quo, support proposed change, obscure
alternative options, or shift the responsibility for resolving the issue. Furthermore, it was noted that there is evidence that the framing of public policy issues can influence policy by affecting public opinion and support for or opposition to an issue, and by altering the policy discourse. By first identifying and describing the framing of food and nutrition issues by the public health and industry sectors, and then comparing these frames to those evident in the official reports resulting from the Inquiry, it may be possible to determine which frame was the most effective in influencing the Government’s stance on food and nutrition policy.

1.2.2 Data and methods

This research used a case study methodology. It examined the submissions from key submitters to the Inquiry and the surrounding parliamentary and government activity. Specifically, the key sources of data included: the relevant oral and written industry and public health submissions to the Inquiry and the two official reports: the Health Select Committee Report of Inquiry into Obesity and Type 2 Diabetes (Health Committee 2007); and, the Government Response to the Inquiry into Obesity and Type 2 Diabetes 2007 (New Zealand Government 2007). Other data sources were also included and these are described in Chapter 4.

A framing matrix, informed by Bacchi’s (1999) concept of ‘problem representation’ and useful elements of a framing matrix used by Kwan (2009), was developed and applied to the data. This matrix was further refined in an iterative process involving its repeated application to the key sources of data. This identified the signature features of the obesity frames used by public health and industry submitters. To assess their alignment with the Government’s stance on food and nutrition policies, these obesity frames were then compared with those found in the committee and Government reports. The analyses conducted in this thesis are not intended to suggest that particular framing caused the stance taken by the Government, but rather, that any evidence of similarity between the framing of obesity by the industry or public health sectors and that found in the Government Response, suggests some level of ‘influence’.

It is also important to note that the Government referred to throughout this thesis was the Labour-led Government of 2005-2008. This Government was superseded by the National-led Government in the election of 2008. Therefore, the findings and conclusions in this thesis are specific to the Government at the time of the Inquiry.
1.3 Thesis overview

This section provides a brief overview of the remaining chapters in this thesis. Chapters 2, 3 and 4 provide the background information, including the literature review on framing and obesity frames, and the methods and methodology adopted in this thesis. The results are presented in Chapters 5, 6 and 7. Chapter 8 provides a detailed discussion of these results and the conclusion. A brief overview of each of these chapters is provided below.

Chapter 2: Background and context

Chapter 2 describes the epidemiology of obesity. It outlines the definition and measurement of obesity, describes the relationship between obesity and health, and provides an overview of the demographic distribution of obesity internationally and in New Zealand. The latter part of the chapter outlines the food and nutrition policy landscape in New Zealand, including the main policy players. This includes a description of the national obesity strategy in New Zealand at the time of the Inquiry. The chapter also examines the select committee process in New Zealand, describes the Health Select Committee, and outlines the political context at the time of the Inquiry.

Chapter 3: Framing theory and framing obesity

Chapter 3 reviews relevant literature on framing theory and obesity frames. It begins by examining Bacchi’s (1999) ‘problem representation’ concept of framing. It draws upon Bacchi’s historical analysis of ‘family violence’ framing to illustrate the links between various problem framings, their underlying assumptions, and the plausible and possible policy consequences. It demonstrates how framing can have various effects, such as supporting the status quo or promoting policy change, or in some cases, obscuring policy options.

The second part of the chapter reviews recent research on obesity frames (Kwan 2009; Lang & Rayner 2005; Lawrence 2004; Saguy & Riley 2005). Some of the concepts identified by these authors relating to a frame’s influence, in policy terms, are noted. Four key obesity frames likely to be adopted by industry or public health submitters are described: the ‘epidemic as a myth’ frame; the ‘individual behaviour’ frame; the ‘obesogenic environment’ frame; and a ‘structural’ frame. Although three of these frames were readily identifiable from the obesity framing literature, the ‘structural’ frame had not yet been clearly articulated. This ‘structural’ frame was developed from the health inequalities and
public health literature in an attempt to account for the unequal distribution of obesity along lines of social inequality. The chapter concludes by hypothesising that the food and marketing industries will be most likely to draw on arguments from the ‘epidemic as a myth’ and ‘individual behaviour’ frames, and the public health sector will be most likely to draw on arguments from the ‘obesogenic environment’ and ‘structural’ frames.

Chapter 4: Methods and methodology

The methodology guiding the research is described in Chapter 4. This includes the definitions used in this thesis and a description of the data sources and their collection. The criteria for identifying the public health and industry submitters are described and the case study research methodology underpinning this investigation is outlined. The framing matrix for identifying the critical features of frame is detailed and accompanied by the proposed methods for analysing the results.

Chapters 5, 6 and 7: Results I,II and III

Chapters 5, 6 and 7 contain the results. Chapter 5 begins by providing some relevant contextual background about the seventeen industry submitters examined in this research. It then outlines the framing of obesity by these submitters, using the framing matrix developed and described in Chapter 4. Chapter 6 follows the same format as Chapter 5; this time examining the framing of obesity by fourteen key public health submitters. Chapter 7 examines the framing of obesity by the Government, evident in its response to the Health Select Committee recommendations from the Inquiry. By necessity, the framing of obesity by the committee is also explored in Chapter 7 to provide context to the Government Response.

Chapter 8: Discussion

The final chapter revisits the research questions and draws together the research findings presented in Chapters 5-7. The chapter summarises the key findings and explores some alternative explanations for these. After discussing the strengths and limitations of the research, the implications for public health and public health advocacy are considered and directions for future research are explored. This is followed by the conclusion.
Referencing of submissions and transcripts

The intext citations to the written and oral submissions throughout this thesis are presented in the following format. References to the written submissions provide the name of the organisation, or its acronym where there is one (see list of acronyms), followed by the submission number, and for direct quotations also the page number. A list of written submissions used in this thesis is provided in Appendix A, as these submission references do not appear in the reference list. Similarly, references to the transcripts from the oral submissions do not appear in the reference list, but are provided in Appendix B. The intext references to direct quotes from the transcripts, first list the surname of the speaker, followed by the name or acronym of the organisation they represented, followed by the word transcript. In some cases the name of the speaker in the oral submissions was unknown (as the background noise rendered their names inaudible) and in such cases the intext references refer to these speakers as ‘representative’.
Chapter 2: Background and context

This chapter provides background information as context for the research questions examined in this thesis. Section 2.1 describes the social epidemiology of obesity amongst adults, internationally and in New Zealand. The focus of this chapter reflects the overall focus of this thesis on the public health aspects of obesity. These are the population level increases in obesity and its unequal distribution in the population. Therefore, differences in obesity between individuals and changes amongst individuals over time are not examined as they are outside the public health focus of this thesis.

The chapter outlines the key population-based definition of obesity and overweight. It then describes the prevalence of obesity internationally, noting some important features of the way obesity is distributed within and between countries. It describes key features of the association between weight and health. This is followed by an overview of the growth of obesity in New Zealand in the past thirty years and a description of gender, ethnic and socioeconomic variations. It also notes some of the economic and social costs of obesity, and briefly outlines the scientific ‘consensus’ on the causes of obesity as documented in two key international reports. It is important to note that the focus of this section is on adult obesity. Childhood obesity is not explicitly examined as it is outside the scope of this thesis. Another aspect not examined is the myriad of policy options to address obesity. This is because policy options to address obesity are contested by various interests and, as later chapters will reveal, are dependent upon various perspectives on the underlying causes of obesity.

Section 2.2 describes the New Zealand food and nutrition policy context at the time of the Inquiry. This section outlines the national obesity strategy: Health Eating-Healthy Action (HEHA), and the rationale behind it. It also explores the key sectors and players involved in the food and nutrition policy community in which the key public health and industry sectors are located. Other pertinent contextual factors are also outlined.

Section 2.3 describes the select committee process in New Zealand and the political context at the time of the Inquiry. This provides a description of: the purpose and functions of select committees; the political context of the Mixed Member Proportional Representation system and its relationship to the select committee process at the time of the Inquiry; and, the Inquiry itself.
2.1 Epidemiology and context of obesity

This section draws on a contemporary health-related definition of obesity and examines how obesity and overweight are typically measured amongst adults. It also outlines the relationship between obesity and health and examines demographic patterns in obesity prevalence, internationally and in New Zealand. This is followed by a brief overview of the social and economic costs of obesity and an overview of the international ‘consensus’ on the causes of obesity identified in two key global reports.

2.1.1 Definition and measurement of obesity

Definition of obesity

A contemporary definition of obesity, and that used by the World Health Organization (WHO), states that obesity is “a condition of abnormal or excessive fat accumulation in adipose tissue to the extent that health may be impaired” (World Health Organization 2000: 6). By this definition, optimum weight in an individual or a population is therefore the weight associated with the most reduced prevalence and risk of illness. Because of this, the health concerns extend not just to those who can be classified as ‘obese’, but also to those who are considered as ‘overweight’. Since it is difficult to measure body fat directly, surrogate measures are typically used to estimate body fat for the purpose of determining health risks.

Measurement of adult obesity

While there are a number of measures to estimate obesity and overweight that differ in their accuracy, validity and sensitivity (Bjorntorp 2001), the measure most frequently used to determine population level prevalence of obesity and overweight is the Body Mass Index (BMI). The BMI is a height-adjusted measure of body weight, calculated by dividing weight in kilograms by the square of height in metres (kg/m$^2$). For example, if a person weighs 90kg and is 1.70m tall, their BMI will be:

$$\frac{90}{1.7 \times 1.7} = 31$$

The WHO classification of the four main weight classes by BMI is given in Table 1.
### Table 1: Classification of weight in adults using the BMI

<table>
<thead>
<tr>
<th>Weight classes</th>
<th>BMI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Underweight</td>
<td>&lt;18.5</td>
</tr>
<tr>
<td>Normal range</td>
<td>18.5 - 24.9</td>
</tr>
<tr>
<td>Overweight</td>
<td>25 - 29.9</td>
</tr>
<tr>
<td>Obese</td>
<td>30+</td>
</tr>
</tbody>
</table>


The WHO classify as ‘overweight’ those with a BMI of 25-29.9 kg/m\(^2\), while those with a BMI of 30 kg/m\(^2\) or more are classified as ‘obese’. A ‘normal’ weight is defined as within the BMI range of 18.5 and 24.9. Those whose weight is lower will be classified as ‘underweight’.

Critics of the BMI have noted that there are a number of limitations to the BMI related to level of muscularity (Frankenfield & Rowe et al. 2001; Prentice & Jebb 2001), age and sex (Stevens & Cai et al. 1998; Willett & Dietz et al. 1999) and ethnic variations in fat mass (Deurenberg 1998). These criticisms are acknowledged by the WHO. It states:

> BMI can be used to estimate, albeit crudely, the prevalence of overweight and obesity within a population and the risks associated with it. It does not, however, account for the wide variations in obesity between different individuals and populations (World Health Organization 2003: 68).

As a tool for measuring obesity and overweight, the BMI is therefore useful for determining population prevalence and is predictive of common health conditions such as hypertension and diabetes, however, its use as a diagnostic tool at the individual level is less than ideal (Kuczmarski & Flegal 2000). Clinical assessment of individual obesity in a number of national clinical guidelines recommend the use of the BMI in conjunction with a measure of waist circumference and an assessment of existing comorbidities (National Institutes of Health 2000; National Institute for Health and Clinical Excellence 2006).

### 2.1.2 Obesity and health

Obesity is a major risk factor for non-communicable diseases such as: cardiovascular disease; Type 2 diabetes; a number of cancers (particularly hormone dependent and gastrointestinal cancers); physical disabilities; and, psycho-social conditions (World Health Organization 2000). Obesity also increases the risk of: Coronary Heart Disease; gallbladder disease; osteoarthritis; hypertension; dislipidaemia; insulin resistance; and,
sleep apnoea (World Health Organization 2000). This section examines the health consequences of obesity and overweight in terms of mortality and morbidity.

Relationship between BMI and mortality

The association between obesity or overweight (as defined by the BMI) and mortality has been documented in numerous epidemiological studies (National Heart Lung and Blood Institute 1998; Troiano et al. 1996; World Health Organization 1995). This relationship between BMI and risk of all-cause mortality is depicted in Figure 1.

![Figure 1: Relationship between BMI and relative risk of mortality from all causes](image)

Source: (World Health Organization 2000: 41)

*Based on professional white US women who have never smoked

It is evident from Figure 1 that there is a graded increase in the relative risk of premature death (from all causes), with moderate increases in risk at BMI’s of 25-29.9, and substantial increases in risk at BMI’s of 30 and over. Compared with those of a normal weight (BMI’s between 20-25), obese individuals (BMI 30+) have a 50-100% greater risk of premature death from all causes (United States Department of Health and Human Services 2001).

Association between BMI and morbidity

The US Surgeon General’s report into obesity prevention suggests that morbidity from obesity may be as great as that from smoking, problem drinking or poverty (United States Department of Health and Human Services 2001). Like the association between BMI and
mortality, the association between BMI and morbidity is also graded – although the risks for some illnesses start at a BMI as low as 22 (World Health Organization 2000). Of particular concern is the increased risk of Type 2 diabetes – a major comorbidity of excess weight – with increasing BMI. One estimate suggested that about 64% of male and 77% of female Type 2 diabetes could potentially be prevented if no-one had a BMI of 25 or more (World Health Organization 2000: 10). A crude summary of the overall health risks associated with the various discrete BMI categories is depicted in Table 2.

Table 2: Association of BMI categories with obesity related comorbidities

<table>
<thead>
<tr>
<th>Classification</th>
<th>BMI (kg/m²)</th>
<th>Risk of comorbidities*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Underweight</td>
<td>&lt;18.50</td>
<td>Low (but risk of other clinical problems increased)</td>
</tr>
<tr>
<td>Normal range</td>
<td>18.50-24.99</td>
<td>Average</td>
</tr>
<tr>
<td>Overweight</td>
<td>≥25</td>
<td></td>
</tr>
<tr>
<td>Pre-obese</td>
<td>25.0-29.99</td>
<td>Increased</td>
</tr>
<tr>
<td>Obese class I</td>
<td>30.0-34.99</td>
<td>Moderate</td>
</tr>
<tr>
<td>Obese class II</td>
<td>35.0-39.99</td>
<td>Severe</td>
</tr>
<tr>
<td>Obese class III</td>
<td>≥40.00</td>
<td>Very severe</td>
</tr>
</tbody>
</table>


* The data in the above table needs to be interpreted with care, bearing in mind both the limitations of the BMI previously outlined, and the fact that in reality the graded risk between BMI and morbidity from various health conditions is much more complex than the table suggests. The risks for various health conditions for a given BMI range will also vary by health condition and be modified by a range of other factors such as diet, physical activity level, and ethnicity for instance (Visscher & Seidell 2001).

Clearly, the health consequences of obesity range from moderate to very severe. Those directly affected by obesity and its related comorbidities have a compromised quality of life and health, and a lower life expectancy. Increasingly, there is recognition in the medical and health sectors that while the treatment and management of obesity and its comorbidities remain important, a much greater reduction in the health consequences of overweight and obesity necessitates a population-based prevention strategy (Prentice 2006).

2.1.3 International context

The recent rapid growth of obesity over the past thirty years has prompted a number of national and international organisations to refer to the phenomenon as a global epidemic. There is some evidence to suggest that the obesity epidemic originated in the US as early as 1960 (Prentice 2006), then developed in Europe, and was later followed by other ‘wealthier’ nations (House of Commons Health Select Committee 2004: 15).
Current prevalence of obesity

In 1995, the WHO estimated that 200 million adults were obese (House of Commons Health Select Committee 2004: 15). By the year 2000, this estimate had increased to 300 million adults (Prentice 2006). The obesity epidemic, although more advanced in ‘developed’ nations, is also increasingly a characteristic of ‘developing’ countries particularly in their urban populations (House of Commons Health Select Committee 2004). Just over a third of obese adults are living in developing countries (Popkin 2006: 291). Figure 2 illustrates some recent international data on obesity prevalence amongst men and women for selected countries.

![Figure 2: Adult obesity prevalence in selected countries throughout the world](#)


US = United States; UK = United Kingdom; GDP = gross domestic product (per capita $US).

Of the eight countries depicted in Figure 2, the prevalence of obesity is the greatest in the US, at 26.3% for men and 32.7% for women. This is followed closely by the UK with the prevalence of obesity amongst men at 23% and 23.8% for women, while in Australia it was 21.6 and 24.1%, for men and women respectively. It is noteworthy that, with the exception of China, the prevalence of obesity is higher amongst women than men. However, in half
of the countries depicted in Figure 2, the prevalence of overweight is higher amongst men (and these are the lower GDP countries). Data for New Zealand is presented in section 2.1.4.

Obesity trends in ‘developed’ and ‘developing’ countries

The prevalence of obesity has increased in almost all countries in recent decades, although the rate of increase has varied considerably by country. In general, low income countries exhibit different patterns than high income countries. In low income countries, obesity is more prevalent amongst middle aged women, people of higher socioeconomic status and urban dwellers (World Health Organization 2003). By comparison, in high income countries, while obesity is also common amongst middle aged adults, it is increasing rapidly among younger people and children, is more prevalent amongst lower socioeconomic groups (particularly for women), and the rural and urban differences in obesity are generally non-existent or even reversed (World Health Organization 2002; World Health Organization 2003).

For developing countries, there is an additional burden. The epidemic of obesity is occurring alongside the problem of malnutrition – a situation that has been described as the ‘double burden of disease’ currently being experienced by poorer countries (House of Commons Health Select Committee 2004). In Ghana, for instance, the number of obese adults equals that of underweight adults (House of Commons Health Select Committee 2004).

One critical implication of the developed and developing country differences – with the apparent association between increasing obesity and ‘development’, ‘urbanisation’ or ‘westernisation’ – is that economic development or prosperity appears to produce obesity. However, there are some exceptions to this pattern. If we compare Japan and the US for instance – both countries with high Gross Domestic Product – we find that the US has one of the highest rates of obesity in the industrialised world, whereas Japan exhibits one of the lowest (House of Commons Health Select Committee 2004). This suggests that obesity is not an inevitable consequence of economic prosperity. Clearly, other factors are involved.

Another important feature of the developed and developing country differences is the opposite socioeconomic distributions in obesity prevalence, suggesting that obesity is associated with affluence in low income countries and with poverty in high income countries (Friel & Broom 2007). A number of explanations for this difference have been put
forward by various authors (Pickett et al. 2005; Prentice 2006; Song 2006), some of which are examined in Chapter 3.

2.1.4 New Zealand context

New Zealand, like other industrialised countries, has experienced an unprecedented increase in rates of obesity in the past few decades.

Current prevalence and growth of adult obesity in New Zealand

The prevalence of adult obesity in New Zealand in 2003 was 26.5% – equivalent to 826,100 adults – and the prevalence of overweight was 36.2% – equivalent to 1,128,500 adults (Ministry of Health 2004). Thus, in 2003, 62.7% of the New Zealand adult population were either overweight or obese.

In terms of the growth of the epidemic, the prevalence of adult obesity in New Zealand has more than doubled from 1977 to 2003 (Ministry of Health 2004). According to the New Zealand Ministry of Health, although data are incomplete, there is some evidence that the increase in obesity began earlier than 1977 (Ministry of Health 2004; Ministry of Health 2006). Figure 3 shows the population percentage increase in obesity and overweight from 1977 to 2003 for New Zealand adults by sex.

Source: (Ministry of Health 2004: 88-89).
Note: Overweight defined as a BMI of 25.0 to 29.9 for European and Asian adults and a BMI of 26.0 to 31.9 for Māori and Pacific adults. Obesity defined as a BMI ≥30 for European and Asian adults and a BMI of ≥32 for Māori and Pacific adults. Data for 1977 defined adults as those age 20+

Figure 3: Population prevalence estimates of adult (aged 15+) overweight and obesity in New Zealand 1977-2003, by sex
As can be seen from Figure 3, during the twenty-six-year period from 1977 to 2003, the prevalence of obesity increased from 9 to 20% amongst men, and from 11 to 22% amongst women. In comparison, the population percent prevalence of *overweight* changed marginally in the same period for women, from 26 to 28%, while for males, 42% were overweight in both 1977 and 2003 (with minor fluctuations in the years between). The slightly higher prevalence of obesity amongst women, and the overall higher prevalence of overweight amongst men, is also evident from the data in Figure 3. Correspondingly, with increases in obesity, the mean BMI of the total New Zealand population has increased, amongst males, from 25.5 in 1977 to 26.9 in 2003, and amongst females, from 24.5 in 1977 to 26.4 in 2003 (Ministry of Health 2004).

In summary, in the twenty-six year period, there has been a *doubling of the prevalence of obesity* amongst both men and women, and little change in the prevalence of overweight. For this reason, the subsequent sections examining ethnic and socioeconomic patterns focus on obesity only.

**Ethnic and socioeconomic patterns in obesity**

The burden of obesity is not shared equally amongst New Zealanders. Like many industrialised countries, obesity in New Zealand is more prevalent amongst lower socioeconomic groups and particular ethnic groups, specifically Māori and Pacific populations.

**Ethnicity**

Compared with the rest of the population, Māori and Pacific people are at greater risk of being obese. The most recent data on obesity prevalence by ethnicity are given in Table 3.

**Table 3: Adult obesity prevalence in 2006 by ethnic group**

<table>
<thead>
<tr>
<th>Ethnic group</th>
<th>Percent obese</th>
<th>Number of adults</th>
</tr>
</thead>
<tbody>
<tr>
<td>European/ Other</td>
<td>24.3</td>
<td>619,200</td>
</tr>
<tr>
<td>Māori</td>
<td>41.7</td>
<td>148,300</td>
</tr>
<tr>
<td>Pacific</td>
<td>63.7</td>
<td>104,900</td>
</tr>
<tr>
<td>Asian</td>
<td>11.0</td>
<td>30,800</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td><strong>903,200</strong></td>
</tr>
</tbody>
</table>

Source: (Ministry of Health 2008: 110).

Note: This data was collected two years after the data presented in section 2.1.4 so the numbers in this table are higher as rates of obesity have increased in New Zealand.
As shown in Table 3, the prevalence of obesity amongst Pacific populations was the highest of any ethnic group (at 63.7%), followed next by Māori (at 41.7%). In 2006, Māori were 1.7 times, and Pacific people 2.5 times more likely than the total population to be classified as obese. This suggests that targeted interventions may be necessary to address ethnic inequalities in obesity. Yet, in terms of actual numbers, the majority of obese adults (68.5% n= 619,200) were European/Other. This suggests that any substantial reduction in the overall scale of the obesity epidemic may require a population-based approach.

**Socioeconomic status**

Like other industrialised countries, obesity in New Zealand is also more prevalent amongst lower socioeconomic groups than higher socioeconomic groups (Ministry of Health 2006). This pattern has also been reported in Australia (Friel & Broom 2007). In New Zealand, this socioeconomic pattern exists whether socioeconomic position is measured by income, education, or by a measure of neighbourhood deprivation (Ministry of Health 2006). Figure 4 shows the percent prevalence of obesity amongst adults by the 2006 New Zealand Deprivation Index (NZ Dep 2006) – a measure of neighbourhood deprivation derived from selected socioeconomic variables from the New Zealand Population Census.

![Figure 4: Adult obesity by NZ Dep 2006 quintile and sex](image)
Figure 4 shows that for both men and women, the prevalence of obesity increases with increasing neighbourhood deprivation as measured by NZ Dep 2006 quintile. The prevalence of obesity amongst those living in the most deprived neighbourhoods (quintile 5) was 35.4% for men and 39.7% for women, compared to 21.5 and 20.4%, for men and women respectively, living in the least deprived neighbourhoods (quintile 1). The New Zealand data so far examined (on ethnicity and socioeconomic status) is however, a simplification of the social patterning of obesity. More complex patterns are revealed when examining the socioeconomic patterns in obesity by gender and ethnicity. Key findings from a recent report revealed, for instance, that:

- the association between socioeconomic status and obesity was strong for non-Māori females (lower socioeconomic position was clearly associated with a progressively heavier BMI)
- there was no socioeconomic gradient in obesity for Māori women (it was flat or irregular depending on the measure of socioeconomic status)
- for Māori men the socioeconomic gradient was reversed (Māori men of a higher socioeconomic status were more likely to be obese than their lower socioeconomic counterparts)
- non-Māori males showed a similar pattern to Māori females (Ministry of Health 2006).

It is also noteworthy that complex patterns in obesity when examined by gender and socioeconomic position have also been reported in the Australian data (Friel & Broom 2007).

One explanation for the abovementioned patterns suggested in the report was that the timing of the epidemic may be different in the two ethnic populations being compared. Another explanation suggested that cultural differences in the status or stigma attributed to obesity may explain these differences (Ministry of Health 2006). However, these and other potential explanations are yet to be empirically tested.

### 2.1.5 Economic and social costs

As well as the health consequences of obesity there are potentially enormous financial costs to the economy. The association between obesity and social inequality also has important social implications for society generally. These social and economic costs are considered below.
Economic costs

The economic costs of obesity are typically quantified in terms of either direct costs (to the community for the diagnoses and treatment of diseases directly related to obesity), or indirect costs (work-days lost, physician visits, disability costs and premature mortality). A recent estimate from the US suggested that in 1995, the direct costs of obesity were equivalent to 6.8% of the total healthcare costs for the country (Ministry of Health 2008: 2). For New Zealand, a recent estimate of the direct healthcare costs of obesity, for the year 2004, was NZ$460 million and an estimate for the indirect costs was NZ$370 million – “based on international estimates of productivity losses at around 0.25% of Gross Domestic Product” (New Zealand Government 2007: 24). It is important to bear in mind however, that estimates of the costs attributed to obesity in any given country are dependent on the availability and accessibility of various treatment options. Furthermore, health costs attributable to obesity are likely to rise with increases in childhood obesity as children who are obese are likely to suffer the health consequences (for instance Type 2 diabetes) earlier and for longer.

Social costs

There are also social costs for the individual and for the wellbeing of society as a whole. Obese individuals are not only at risk of adverse health consequences but also, because of the stigma attached to obesity (which varies for different populations), at risk of being discriminated against. There is evidence to suggest that weight-based discrimination occurs in a whole host of social and economic spheres, in education and employment (Carr & Friedman 2005), healthcare treatment (Rand & MacGregor 1990; Brownell & Puhl 2003), and participation in social and economic life generally (Carr & Friedman 2005; Andreyeva & Puhl et al. 2008). Recent evidence from the US suggests that such discrimination has increased from 1995 to 2006 and is unlikely to be explained by increases in obesity rates (Andreyeva & Puhl et al. 2008). This discrimination can have significant impacts on the social and economic wellbeing of individuals affected, as well as their families. For instance, weight-based discrimination in employment is likely to limit upward social mobility and thus impact on socioeconomic position. Fear of weight-based discrimination from providers of medical treatment has also been shown to prevent some obese individuals from seeking medical care (Brownell & Puhl 2003). The consequences of weight-based discrimination may be particularly salient for Māori and Pacific communities since not only do their higher rates of obesity place them at a greater risk of weight-based discrimination, but because they also face racial discrimination. This is likely to exacerbate existing health, social, economic and ethnic inequalities.
2.1.6 Causes of obesity

This section outlines what could be considered as the international ‘expert consensus’ on the causes of obesity. This includes the most recent WHO position on the matter, as outlined in the 2003 WHO Technical Report 916 (World Health Organization 2003), and the position taken in a recent international review of the evidence by the World Cancer Research Fund (WCRF) and the American Institute for Cancer Research (AICR), published in 2007 (World Cancer Research Fund & American Institute for Cancer Research 2007). The causes of weight gain listed in these documents were claimed to be reached after extensive expert consultation and comprehensive reviews of the evidence according to best-practise, evidence-based grading systems available at these times.

Table 4 is reproduced from the 2003 WHO Technical Report 916, listing a summary of the strength of evidence on factors that might promote or protect against weight gain and obesity. Table 5 is reproduced from the WCRF and the AICR 2007 report summarising the evidence on factors that increase or decrease the risk of weight gain.

<table>
<thead>
<tr>
<th>Evidence</th>
<th>Decreased risk</th>
<th>No relationship</th>
<th>Increased risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>Convincing</td>
<td>Regular physical activity</td>
<td></td>
<td>Sedentary lifestyles High intake of energy-dense micronutrient poor foods*</td>
</tr>
<tr>
<td></td>
<td>High dietary intake of NSP (dietary fibre)*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Probable</td>
<td>Home and school environments that support health food choices for children</td>
<td></td>
<td>Heavy marketing of energy-dense foods* and fast food outlets*</td>
</tr>
<tr>
<td></td>
<td>Breastfeeding</td>
<td></td>
<td>High intake of sugars-sweetened soft drinks and fruit juices</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Adverse socioeconomic conditions* (in developed countries especially for women)</td>
</tr>
<tr>
<td>Possible</td>
<td>Low glycaemic index foods</td>
<td>Protein content of the diet</td>
<td>Large portion sizes</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>High proportion of food prepared outside the home (developed countries)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>“Rigid restraint/periodic disinhibition” eating patterns</td>
</tr>
<tr>
<td>Insufficient</td>
<td>Increased eating frequency</td>
<td></td>
<td>Alcohol</td>
</tr>
</tbody>
</table>

*for an explanation of all the terms see original source.
Table 5: Causes of weight gain identified by the World Cancer Research Fund and American Institute for Cancer Research in 2007

<table>
<thead>
<tr>
<th>Evidence</th>
<th>Decreases risk</th>
<th>Increases risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>Convincing</td>
<td>Physical activity</td>
<td>Sedentary living*</td>
</tr>
<tr>
<td>Probable</td>
<td>Low energy-dense foods*</td>
<td>Energy-dense foods*</td>
</tr>
<tr>
<td></td>
<td>Being breastfed*</td>
<td>Sugary drinks*</td>
</tr>
<tr>
<td></td>
<td></td>
<td>‘Fast foods’*</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Television viewing*</td>
</tr>
<tr>
<td>Limited suggestive</td>
<td>None identified</td>
<td></td>
</tr>
<tr>
<td>Limited – no conclusion</td>
<td>Refined cereals (grains) and their products; starchy roots; tubers, &amp; plantains; fruits; meats; fish; milk and dairy products; fruit juices; coffee; alcoholic drinks; sweeteners</td>
<td>None identified</td>
</tr>
<tr>
<td>Substantial effect on risk unlikely</td>
<td>None identified</td>
<td></td>
</tr>
</tbody>
</table>

Source: (World Cancer Research Fund & American Institute for Cancer Research 2007:323). *for an explanation of all the terms see original source.

Focusing on the ‘convincing’ and ‘probable’ evidence from the two reports, both found that sedentary lifestyles and energy-dense foods increased the risk of weight gain. The WHO Technical Report 916 also found probable evidence that adverse socioeconomic conditions in developed countries and heavy marketing of energy-dense foods also contributed to weight gain. In contrast, the WCRF report found probable evidence that television viewing contributes to weight gain (rather than heavy marketing per se). A key difference between the two reports was the inclusion in the WHO report of adverse socioeconomic conditions as a probable cause of weight gain – a cause that was not recognised in the WCRF report.

However, the causes of weight gain identified in these reports are not the definitive word on the matter, as they are contested by scientists and vested interests as the analyses later in this thesis reveals. Furthermore, there is also some evidence to suggest that political lobbying by vested interests has at times influenced the content of WHO reports on obesity and nutrition (Cannon 2004).
2.2 New Zealand policy context

This section outlines the New Zealand policy context at the time of the Inquiry. The first part of this section describes the national obesity strategy: Healthy Eating Healthy Action (HEHA) and the rationale behind it (the Ottawa Charter for health promotion and the Treaty of Waitangi). The second part of this section provides an overview of the food and nutrition policy community in New Zealand. The final part of this section examines briefly some other contextual factors including the different ethos of industry and public health and two key proposed pieces of legislation that were under consultation at the time of the Inquiry: the proposed Public Health Bill; and, the proposed Nutrition, Health and Related Claims legislation.

2.2.1 National obesity strategy: HEHA

HEHA was launched in 2003. The scientific basis and strategic rationale for the HEHA strategy was outlined in *Healthy Eating – Healthy Action: Oranga Pumau: A background* (Ministry of Health 2004). The HEHA strategy was described by Ministry of Health as an ‘integrated framework’ to improve nutrition, increase physical activity and reduce obesity. It addressed three of the thirteen population health objectives outlined in the New Zealand Government’s Health Strategy (Ministry of Health 2003). These three objectives were also consistent with the *WHO Global Strategy on Diet, Physical Activity and Health* (World Health Organization 2004) recommendation to governments to take ‘strong actions’ to improve nutrition, increase physical activity and reduce obesity and other chronic diseases (Ministry of Health 2008).

In 2004, the HEHA implementation plan for 2004-2010 was developed after consultation with: government agencies; Non-Government Organisations (NGOs); nutrition and physical activity experts and providers; and, the food and physical activity industries (Ministry of Health 2004). The plan had eight objectives based on the eight key strategies to improve public health outlined in the Ottawa Charter for health promotion (Ministry of Health 2004: 8-9). These eight strategies were, in turn, linked to four pathways to progress whanau, hapu, and iwi wellbeing, identified under He Korowai Oranga – the Māori Health Strategy (Ministry of Health 2004: 7). These four pathways to progress Māori wellbeing were developed to assist funders and planners to ensure appropriate services can be purchased and delivered in a way that is meaningful and sustainable for Māori: “meaningful in that Māori communities are able to participate and contribute to the development of any service, and sustainable in that Māori communities are given opportunities to take ownership of the
issue – doing it ‘with’ rather than doing it ‘to’” (Ministry of Health 2004: 8). The four pathways to progress Māori wellbeing were:

Pathway 1 – development of whanau, hapu, iwi and Māori communities
Pathway 2 – Māori participation
Pathway 3 – effective health and disability services for Māori
Pathway 4 – working across sectors (Ministry of Health 2004: 9).

The link between the four pathways and the eight Ottawa Charter based objectives is illustrated in Table 6.

<table>
<thead>
<tr>
<th>Objectives</th>
<th>He Korowi Oranga Pathways</th>
</tr>
</thead>
<tbody>
<tr>
<td>build healthy public policy</td>
<td>X</td>
</tr>
<tr>
<td>create supportive environments</td>
<td>X</td>
</tr>
<tr>
<td>strengthening community action</td>
<td>X</td>
</tr>
<tr>
<td>develop personal skills</td>
<td>X</td>
</tr>
<tr>
<td>reorient the health sector</td>
<td>X</td>
</tr>
<tr>
<td>monitor, research and evaluate</td>
<td>X</td>
</tr>
<tr>
<td>communication</td>
<td>X</td>
</tr>
<tr>
<td>workforce (health and physical activity)</td>
<td>X</td>
</tr>
</tbody>
</table>

Source: (Ministry of Health 2003: viii).

In addition to these eight objectives, the HEHA implementation plan provided direction to the identified sectors (academia, government agencies, District Health Boards, NGOs, Māori communities and industry) by identifying twenty-six ‘outcomes’ with eighty-seven related ‘actions’ (some of which are specific while others are more general). Key food and nutrition policy related actions and the identified sectors ‘responsible’ are listed in Appendix C. In addition, separate actions and outcomes were identified by the Māori caucus of the External HEHA Implementation Advisory Group.

The HEHA plan was also underpinned by key population health messages for improving nutrition, increasing physical activity, and maintaining a healthy body weight. These were:

- eat a variety of nutritious food
- eat less fatty, salty, sugary foods
- eat more fruits and vegetables
• fully breastfeed infants for at least six months
• be active everyday for at least 30 minutes in as many ways as possible
• add some vigorous exercise for extra benefit and fitness
• aim to maintain a healthy weight throughout life
• promote and foster the development of environments that support healthy lifestyles (Ministry of Health 2004).

In recognition of ethnic and socioeconomic inequalities in obesity and nutrition, the HEHA strategy identified priority groups for action. These were: Māori and Pacific communities; children and families; and, lower socioeconomic groups (Ministry of Health 2003). It is also important to understand that under the Treaty of Waitangi, the Crown has an obligation to protect the health of Māori hence the incorporation of the He Korowi Oranga Pathways into the HEHA strategy to facilitate partnership and participation of Māori to improve Māori health and wellbeing.

### 2.2.2 Food and nutrition policy community in New Zealand

Within the food and nutrition policy sector, there are numerous organisations and individuals that have the potential to influence food and nutrition policy. These were outlined in the HEHA strategic framework and they included: the local government sector; employers; the weight-loss industry; the agricultural sector; schools and consumers (Ministry of Health 2003). However, the sectors and groups that appeared to be actively engaged in this policy arena, on the basis of more than 300 submissions to the Inquiry, are outlined in Table 7.
Table 7: Key sectors and groups actively engaged in the food and nutrition policy arena

<table>
<thead>
<tr>
<th>State sector</th>
<th>NGO* sector</th>
<th>Other groups</th>
<th>Business oriented NGOs</th>
<th>Industry</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ministry of Health</td>
<td>Public health oriented NGOs</td>
<td>Professional associations</td>
<td>Various NGOs &amp; professional associations (with funding from the food industry)</td>
<td>Food industry groups &amp; companies</td>
</tr>
<tr>
<td>Ministry of Education</td>
<td>Other health focused NGOs</td>
<td>Academics</td>
<td></td>
<td>Marketing industry groups &amp; broadcasters</td>
</tr>
<tr>
<td>District Health Boards &amp; Public Health Units</td>
<td>Māori Health NGOs or groups</td>
<td>Research groups</td>
<td></td>
<td></td>
</tr>
<tr>
<td>New Zealand Food Safety Authority</td>
<td>Other issue NGOs</td>
<td>Experts – medical &amp; nutrition</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Television New Zealand</td>
<td>Other health providers</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* NGO = Non-Government Organisation

Of the sectors and groups depicted in Table 7, only those that met the definition of public health NGOs (and public health oriented professional associations) and industry – as defined in Chapter 4 – and the three independent advisors chosen by the Health Select Committee, formed the final data set of submissions for analysis in this thesis. These groups were found under those sectors outlined in bold in Table 7. The purpose here is to locate the public health and industry sectors in the context of the wider food and nutrition policy community.

**State sector**

Key agencies involved in food and nutrition policy from the state sector included: the Ministries of Health, Education and Social Development; the District Health Boards (DHBs); and, the five regional Public Health Units. This sector also included one of the two agencies responsible for food regulation and food safety; the New Zealand Food Safety Authority (NZFSA). The other agency (not shown in Table 7 as they did not participate in the Inquiry), Food Standards Australia New Zealand (FSANZ) is responsible for the
Australia and New Zealand joint food standards system and joint regulations. This joint regulatory system (known as the Food Treaty) is governed by the Australia and New Zealand Food Standards Code on food composition and labelling (the Code).

The Code “provides standards for composition, labelling (including nutrition labelling and claims)” applicable to all foods sold in Australia and New Zealand” (NZFSA s313:1). The Code also regulates advertisements for food, which by law “must not contain anything that would not be permitted on a food label” (NZFSA s313:2). The responsibility for the implementation and enforcement of the Code in New Zealand lies with the NZFSA.

The stated role of the NZFSA was to “protect and promote public health and facilitate access to markets for New Zealand’s food and food related exports” (New Zealand Food Safety Authority 2008). While FSANZ was responsible for the development and review of joint standards, the NZFSA had an active role and provided input into the work undertaken by FSANZ “to ensure standards are reflective of New Zealand conditions and concerns” (NZFSA s313:2). Key policy issues for the NZFSA relevant at the time of the Inquiry included: food fortification; aspartame; and, Front of Pack (FOP) labelling. At the time of the Inquiry, the NZFSA was also consulting with stakeholders on the proposed Nutrition, Health and Related Claims legislation (outlined in section 2.2.3).

Television New Zealand (TVNZ) was another key agent from the state sector with an interest in aspects of food and nutrition policy (related to marketing). TVNZ was the state-owned broadcaster, although it was required by the state to operate as a commercial business. For this reason and for the purpose of this thesis, TVNZ was treated as an industry organisation. Further background information on TVNZ is provided in Chapter 5.

NGO sector

The NGO sector included: public health oriented NGOs; other health focused NGOs; Māori health groups and NGOs; and, some non-health focused NGOs. Many of these NGOs were focused on a specific health issue, such as kidney disease or blindness, while others were focused on non-health issues, such as child poverty or consumers rights. The criteria for selecting the public health oriented NGOs for the forthcoming analysis are outlined in Chapter 4.
Other groups

Other groups actively involved in the food and nutrition policy area included: academics; research groups; individual medical and nutrition experts (such as bariatric surgeons); health providers (such as Primary Health Organisations); and, various professional associations.

Business oriented NGOs

Business oriented NGOs and professional associations included groups that could not be clearly classified, either as health or business oriented, as they were a combination of both. These groups claimed to promote public health and nutrition but they were found to be funded, partly or wholly, by aspects of the food industry. For this reason they were excluded from the dataset for analysis in this thesis. This is discussed in more detail in Chapter 4.

Industry

The food and marketing industries in New Zealand appear to be particularly powerful interest groups, in part because they are major contributors to the economy – the food industry alone accounts for 50% of the national economy (Health Committee 2007) – and in part because their human capital, resources, and economic wealth enables them to actively pursue their interests via a number of industry associations. The key food industry associations included: the Food Industry Group; the New Zealand Food and Grocery Council; and, the Retailers’ Association of New Zealand. Key industry groups from the marketing sector included the Advertising Standards Authority – the body responsible for the self-regulation of advertising in New Zealand and the New Zealand Television Broadcasters’ Council – an industry group representing the interests of the major broadcasters. These groups, and others, as well as the commercial businesses that met the definition of industry (including food industry giants Coca-Cola, McDonalds, and Fonterra) are listed in Chapter 4 and further described in Chapter 5.

Self-regulatory nature of food and advertising in New Zealand

Apart from some basic government regulations of the food supply administered by the NZFSA (concerning food safety, composition and labelling requirements), and some basic regulations in the area of marketing (covered by the Advertising Standards Authority), the
food and marketing industries in New Zealand essentially operate under a self-regulatory model. This means, in general, the industry defines and sets the rules by which they comply. A similar self-regulatory system operates in Australia.

2.2.3 Other contextual factors

This section briefly outlines the different ethos underlying the public health and industry sectors and outlines two pieces of proposed legislation of relevance at the time of the Inquiry.

Public health and industry ethos

The ethos underpinning the public health and commercial business sectors are fundamentally different. The central aim of public health is to protect and promote the health of the public (Baum 2002). It has been suggested by Beauchamp (1976) that an ethos of social justice underpins public health. For Beauchamp (1976), this ethos is characterised by a focus on: controlling hazards rather than behavioural defects; prevention rather than treatment; collective action and responsibility for health (rather than individual); and, a fair sharing of the burdens and benefits of health and health risks. The definition of public health and other key features of the public health stance adopted in this thesis are outlined in Chapter 4.

In contrast, the core aim of the commercial business sector is to make profit (Hancock 1998). More precisely, businesses have an obligation to maximise shareholder-value: “a stock market’s valuation of a company’s shares” (McSweeney 2008: 55). Under the ethos of maximising shareholder value, it is held that social wealth is also maximised. In other words: “We all get a slice of the action . . . . ‘trickle-down’ and other processes improve the lot of everyone” (McSweeney 2008: 55). These two disparate ethos have been summarised by Hancock:

The motivation that underlies the private sector is very clear – profit. The motivation that underlies the health promotion sector is also very clear – better health for all and a narrowing of the health gap between rich and poor. These motivations are not necessarily incompatible, but nor are they necessarily compatible (Hancock 1998: 193).

The different views and aims of the public health and industry sectors need to be kept in mind when considering the differences in framing that emerge in the results chapters presented later in this thesis.
Proposed legislation

The proposed Nutrition, Health and Related Claims legislation

Under food labelling laws, only a limited range of nutrition claims are allowed on foods and the Nutrient Information Panel (NIP) must state the amount of the claimed substance (NZFSA s313:2). However, at the time of the Inquiry, FSANZ had been consulting on the proposed Nutrition, Health and Related Claims legislation which, if progressed, would “enable manufacturers to state the product’s health benefits [subject to some disqualifying criteria for less healthy products] on the label where these claims are substantiated” (NZFSA s313:2). This proposed legislation was generally opposed by the public health sector and supported by the industry sector.

The proposed Public Health Bill

The proposed Public Health Bill was a piece of legislation that has been though a series of drafts by the Ministry of Health since the 1990s to address non-communicable diseases (for instance, heart disease, cancers and diabetes) and their risk factors (Ministry of Health 2002). It proposed to replace the Health Act 1956 and related legislation which, according to the Ministry of Health has “major gaps, is based on outmoded organisational and technological assumptions, and does not accord well with the human rights values of today’s society” (Ministry of Health 2002: iii).

Clause 374(r) of the Bill covers regulation-making powers to allow “the prohibition or regulation of the importation, manufacture, packing or sale of any thing likely to introduce or increase a risk to public health” and makes provision for the Government to regulate to reduce risk factors for non-communicable diseases (2007). There was considerable support for this Bill by the public health sector and considerable opposition to it from the industry.

2.3 The select committee process and the political context

To provide some political context, this section provides a brief overview of the New Zealand select committee process (section 2.3.1). This overview examines the purpose, tasks and procedures of select committees. This is followed by a brief overview of the political context at the time of the Inquiry; in particular the Mixed Member Proportional
Representation (MMP) environment and its relationship to political representation on the
Health Select Committee (section 2.3.2).

The third part of this section provides information relevant to the Inquiry. This covers: the
Terms of Reference; provides a description of the selection by the Health Select
Committee of the independent advisors; describes the staff of the committee and their
roles; and, briefly outlines the process of the Inquiry (section 2.3.3).

2.3.1 Select committee process in New Zealand

For New Zealand governments (as in similar jurisdictions), the select committee system
performs a number of functions, one of which is to act as a mechanism for public
consultation. The committee process is significant for the public in that it provides an
opportunity for interested parties to ‘influence’ or participate in the decision making process
of government. The history of the select committee process has revealed that inquiries can,
and have had, significant policy consequences (Palmer & Palmer 2004). Furthermore,
since the introduction in New Zealand of the MMP electoral system in 1996, the select
committee process has become much more significant in the system of government, as
select committees have become a critical place for policies to be ‘brokered’ (Palmer &
Palmer 2004). For example, four select committee inquiries were conducted in 1997,
these inquiries are broad ranging and have included inquiries into student fees, loans and
allowances, public tertiary institutions, sustainable futures of indigenous forests, to an
inquiry into the powers and operations of the Inland Revenue Department (Palmer &
Palmer 2004: 171). It has been argued (Palmer & Palmer 2004: 172) that prior to MMP “in
the two party system with the government enjoying a majority, such inquiries would not
have been commenced let alone make findings and recommendations at variance with
government policy”.

Select committees have been described as the ‘workhorses’ of Parliament with the
potential to provide a ‘comprehensive scrutiny of government activity’ (Palmer & Palmer
2004: 175). As well as conducting inquiries in their subject area, select committees
undertake a number of functions. They examine bills (proposed laws); conduct financial
reviews of public organisations and of the Estimates of government spending plans; and,
examine petitions and international treaties (Mulgan 2004). Select committees have the
power to initiate their own inquiries with the decision to do so dependent on the political
significance of the issue to the committee members. A common theme in these activities is
the provision of evidence to the committees by concerned parties, and the questioning by committee members of relevant parties.

At the time of the Inquiry, there were thirteen subject select committees covering the areas of ministerial responsibility, for instance: commerce; law and order; Māori affairs; education and science; social services; and, health (New Zealand House of Representatives 2005). Ad hoc committees are set up from time to time for particular purposes. The number of Members of Parliament (MPs) on each committee has varied from five to thirteen, with political parties generally represented in proportion to their party membership in the House (Mulgan 2004). Select committee members are appointed at the beginning of each Parliament (following a general election) by an all-party Business Committee chaired by the Speaker of the House (New Zealand House of Representatives 2005). As Cabinet Ministers may be required to appear before select committees (and held accountable for their policy decisions) they are generally not members of subject select committees (Palmer & Palmer 2004).

When considering an inquiry, select committees can (and often do) call for public submissions. To this end, Terms of Reference are formulated and publically advertised. As set out under the Standing Orders (rules of parliamentary process) of the House of Representatives, the select committee chair person can request any evidence, papers or records from (New Zealand) public and private organisations and individuals where a summons for doing so has been obtained on application to the Speaker of the House (personal communication, G. Hill, November, 2009).

After evaluating the evidence, committees may report to the House with findings and recommendations. If there are contentious issues on which the committee cannot agree, a select committee can indicate in its report the differing views of its members, in effect, set out minority or dissenting views (New Zealand House of Representatives 2005). The Government must respond to the committee’s recommendations within 90 days (Palmer & Palmer 2004). Although the Government is required to make a formal response, the decision to take up the recommendations is entirely voluntary (New Zealand House of Representatives 2005).

The select committee hearings themselves are usually open to the public (unless the committee unanimously decides to conduct ‘secret’ hearings’), although some sessions may be held in private, and some sessions, where evidence is not being presented, are closed to the public to allow members to discuss and debate issues freely (New Zealand House of Representatives 2005). Unlike secret evidence, which remains secret after the
committee presents its report, private evidence only remains confidential until the release of the report, when it becomes publically available along with all other committee proceedings (Palmer & Palmer 2004). This information is stored and is publically available in the Parliamentary Library upon the release of the select committee’s report.

2.3.2 Political context

The political context at the time of the Inquiry is important because under the MMP system select committee membership generally reflects the multi-party composition of Parliament at the time (Shaw & Eichbaum 2008). Under MMP, there are four possible forms of Government; a single-party majority; a coalition majority; a coalition minority; and, a single party minority (Palmer & Palmer 2004). If the government of the day is a minority government (coalition or single-party) it will be unlikely to have the numbers on a select committee to control the proceedings (Mulgan 2004). In contrast, a majority government or a coalition majority can dominate the proceedings by virtue of their numbers. Whether they do so may depend on whether or not there is an agreed party position on the issue under investigation (Ganley 2001).

Labour-led coalition (minority) Government

At the time of the Inquiry (and as a result of a coalition agreement following the 2005 General Election), the government of the day was a Labour-led minority coalition (with the Progressive Party). Although the Progressive Party was the formal coalition partner of Labour, the Government also had a Confidence and Supply Agreement with a number of the minor parties (United Future, New Zealand First, the Māori Party, and the Green Party). Such agreements require support from those parties for major budget issues, but not for select committee reports (Decision Maker Guide to Parliament and Government). Sue Kedgley, of the Green Party, was appointed as the Chair of the Health Select Committee as a result of an agreement with the Government that the Greens would be allowed one Chair on a select committee (personal communication, A. McLeod, June, 2009). The composition of the 2005 Parliament and the Labour-led coalition Government, and the proportional representation of MPs on the Health Select Committee (at the time of the Inquiry) is presented in Table 8. The names of the MPs on the select committee are presented in Appendix D.
As can be seen from the final column in Table 8, there were eleven members on the Health Select Committee at the time of the Inquiry. There was equal representation on the committee from the governing Labour party and the major opposition National Party with four members each. Three members of the committee were from three of the minor ‘partners’ with the Government on issues of Confidence and Supply (the Green Party, New Zealand First and the Māori Party). One of these members was the chair of the committee (Sue Kedgely from the Green Party). The other minor parties (ACT, United Future, and Progressive) did not have any representation on the Health Select Committee. However, in proportion to their numbers in Parliament, the Greens, New Zealand First, and the Māori Party, had almost double the select committee seats compared to the main parties (they had three select committee seats and twenty parliamentary seats; while Labour had four select committee seats and fifty parliamentary seats). Thus, there was disproportionate representation on the committee of the small parties relative to their numbers in Parliament. This power imbalance needs to be kept in mind when considering the response of the Labour-led minority Government to the recommendations of the committee.

### 2.3.3 Health Select Committee Inquiry into Obesity and Type 2 Diabetes

This section outlines critical information about the 2006-2007 Health Select Committee Inquiry into Obesity and Type 2 Diabetes – the principal source of data for this thesis. It
The Terms of Reference

On 22 February 2006, the Health Select Committee announced their intention to hold the Inquiry into Obesity and Type 2 Diabetes. The committee called for submissions, with the closing date of 26 April that year, with the following Terms of Reference:

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 and 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 (Health Committee 2007: 39).

Independent advisors

From a list of potential advisors supplied to the committee by the Ministry of Health, the committee appointed three independent specialist advisers (personal communication, M.L. Hannah, June, 2006). These advisors also provided the committee with their own submissions. They were:

- Dr Robert Beaglehole – previously the Director of Chronic Diseases and Health Promotion at the World Health Organization
- Professor Jim Mann – Professor of Human Nutrition at the University of Otago
- Professor Boyd Swinburn – Chair in Population Health at the School of Exercise and Nutrition Sciences, Deakin University, Melbourne, Australia.
Staff of the Health Select Committee

There were three staff for the Health Select Committee. They were:

- Graham Hill – Clerk of the Committee
- Marian Horan – Parliamentary Officer (Report Writer)
- John Thomson – Parliamentary Officer (Committee Support).

The committee staff undertake a number of administrative functions including: organising the hearings and the attendance of submitters; recording the hearings; taking notes; providing the public with photocopies of written submissions; and, obtaining additional information requested by the committee members of submitters and government officials. The staff of the committee also drafts the issues papers for discussion by the committee. These issue papers are then circulated to the committee members for discussion and debate, and the issues papers are redrafted accordingly and recirculated back to the committee for further comment. The final drafts form the basis of the select committee report. On items of business that are reported to the House, such as an inquiry report, there is a formal process known as ‘deliberation’ where the chairperson puts questions to the committee (‘committee resolutions’), and where opinions are divided the votes can be counted and recorded (personal communication, G. Hill, December, 2009).

Officials from the Ministry of Health

One or more Ministry of Health officials were also present at most of the public hearings. These officials took notes and often stayed behind to speak in private with the committee members. The Ministry of Health was also provided with copies of the written submissions before the start of the Inquiry (personal communication, M.L Hannah, March, 2006).

The process of the Inquiry

The committee received 313 written submissions. The public sessions of the Inquiry began on 10 May 2006, opening with the hearing of evidence (not technically a submission) from the Ministry of Health. During the ten months of the Inquiry, the committee was based mostly in Wellington, but also travelled to Auckland, Christchurch, Hamilton and Palmerston North hearing from 142 submitters in total (Health Committee 2007: 38). Some of these submitters were heard via telephone or video conference. Not all those providing a written submission requested to attend the Inquiry in person. One committee session was
conducted in private (the hearing of evidence from Mr Yves Bur, Vice-President of the National Assembly of France on actions taken by the French Government to combat obesity). The committee also received sixteen written responses from the Ministry of Health (to the committee’s requests for information) and heard oral evidence from the Ministry (in private) on a number of occasions (Health Committee 2007: 38). The final evidence was heard in March 2007.


**Summary of Chapter 2**

This chapter has examined some of the fundamental issues surrounding recent increases in obesity, internationally and in New Zealand. It has outlined the WHO definition of obesity and the rationale behind its use. The association between weight and health in terms of morbidity and mortality has also been outlined.

International and national demographic patterns in obesity were also examined. It was noted that, at the international level, there were important developed and developing country differences in obesity. Rates of obesity were generally higher in developed than developing countries, and the direction of the socioeconomic gradient in obesity appeared to be associated with development (although there were some exceptions). Gender differences in obesity were also apparent, with women in almost all countries exhibiting a higher prevalence of obesity than men, while amongst men, overweight was more prevalent. At the national level, some complex gender, ethnic and socioeconomic patterns in obesity were also outlined. As well as the health implications of obesity, it was noted that there were important economic and social costs for those affected, their families, the wider community and the country.

The international consensus on the causes of weight gain was examined briefly, although it was noted that the causes themselves are contested by various interests. The policy recommendations in relation to the identified causes were not examined however, as they are outside the scope of this thesis.

Key features of the food and nutrition policy context at the time of the Inquiry have been outlined. The national obesity strategy and the rationale behind it was described. To place the industry and public health sectors in the context of the wider food and nutrition policy
community, the main players in the food and nutrition policy community and other relevant contextual factors were outlined. This was followed by a description of the select committee process in New Zealand, the MMP representation on the Health Select Committee at the time of the Inquiry, and a description of the Inquiry. It was noted that the Health Select Committee at the time of the Inquiry had a disproportionate number of minority party MPs compared to their representation in Parliament.
Chapter 3: Framing theory and framing obesity

This chapter begins by providing a brief overview of ‘framing’ as a mechanism for understanding policy problems and solutions (section 3.1). It examines a particular type of framing, conceptualised by Bacchi (1999), as a ‘problem representation’ approach to understanding policy problems.

This is followed, in section 3.2, by an overview of the recent literature focused on identifying, describing and analysing obesity frames (Kwan 2009; Lang & Rayner 2005; Lawrence 2004; Saguy & Riley 2005). Although each of these pieces of research examines obesity frames from a different perspective, together they provide a useful background to inform the identification of frames likely to be relevant to the research questions investigated in this thesis. This literature also provides further insights for understanding framing in general and its potential significance in the policy process. It needs to be noted that some of this literature (Kwan and Saguy and Riley) is particularly focused on the US experience.

Drawing together the above literature on framing theory and competing obesity frames, four key obesity frames are then identified and outlined (in section 3.3). These frames were selected because: 1) preliminary reading of the public health and industry submissions suggested that these four frames were most commonly articulated in the submissions’; and, 2) theoretical understanding of industry and public health perspectives indicated that a number of alternative frames would not appeal to these groups. The four frame are: the obesity ‘epidemic as a myth’ frame; the ‘individual behaviour’ frame; the ‘obesogenic environment’ frame; and, a ‘structural’ frame. The ‘structural’ framing of obesity is a new development which does not appear to have been explicitly documented in the obesity framing literature (although some of the structural ideas contained within it have been discussed by others and applied to other health issues). The policy implications and likely sponsors of each of the four key obesity frames are also discussed.

The chapter concludes by suggesting, on the basis of the solutions implicit from the key obesity frames, that the food and marketing industries will be most likely to draw on features of the ‘epidemic as a myth’ and the ‘individual behaviour’ frames, while the public
health sector will be more likely to draw on aspects of the ‘obesogenic environment’ and the ‘structural’ frames.

3.1 Framing theory

The influences on the policy making process are numerous. They include: the influence of interest groups and their strategies and tactics (Tenbensel & Gauld 2001); the influence of current and past policies (incrementalism); the evidence base; public opinion; fiscal constraints; ideology; institutional factors; the influence of policy elites; politics; the media and so on.

Nonetheless, one school of thought highlights the importance of ‘framing’ as a critical part of the overt or covert politics of the policy making process (Bacchi 1999; Kwan 2009; Nathan et al. 2005; Tesh 1988). Siegel and Lotenberg (2007: 137) argue that:

It is not necessarily the relative merits of various arguments for and against a proposal that most influence its legislative fate. Rather, it is the relative success of proponents and opponents in framing the overall terms of the debate.

Furthermore, it has been suggested that the assumptions and values underpinning the framing of an issue are a more influential driver of policy outcomes than scientific evidence (Lang & Heasman 2004).

The concept of framing has its historical origins in sociology (Goffman 1974), and the sociology of social problems and social constructivism (Colebatch 2002; Kwan 2009). Framing analysis has been used in a variety of disciplines for a variety of purposes. It has been used to: (i) understand the sociology of social problems; (ii) identify and document debate and discourse on a particular policy or social issue in the news or popular media (Iyengar 1991); (iii) understand social and political movements (Johnston & Noakes 2005); and more recently; (iv) to analyse the framing of public health issues such as: tobacco (Jacobson & Wasserman et al. 1993); alcohol use (Gusfield 1996); air pollution and asthma (Brown & Mayer et al. 2004); skin cancer (Garvina & Eylesb 2001); and, gambling (Korn & Gibbins et al. 2003).

Underpinning the idea of framing is the notion that we use frameworks, or frames of reference, to make sense of the world, and, these frameworks affect what we see. In other words:
For the most part we do not first see, and then define, we define first then see (Lipmann 1922: 44).

Framing has been defined in various ways, but in general it refers to a way of describing and defining an issue, which involves naming the problem, identifying the causes of the problem, identifying who is (or is not) affected by the problem (as well as who is to blame), proposing solutions to the problem and assigning responsibility for these solutions. Framing is important because first, if it is successful in dominating the discourse on an issue, it involves tangible benefits to particular groups, and second, because frames imply particular solutions, they have the potential to increase or decrease social and health inequalities (Kwan 2009).

While there are a number of useful framing concepts that have been identified by various scholars of framing research (and these are considered in section 3.2), this thesis draws particularly on one conceptualisation of framing, that articulated by Bacchi (1999) as the ‘problem representation’ approach to the analysis of policy problems.

### 3.1.1 Framing as problem representation

According to Bacchi (1999), a critical question to ask in any analysis of policy problems is not so much, *what is the problem?* But, *what is the problem represented to be?* For Bacchi (1999: 1), at the most basic level “how we perceive or think about something will affect what we think ought to be done about it”. Thus, any discussion of an issue or problem, is really an interpretation, involving judgements, assumptions and choices.

For Bacchi, interpretations are interventions, because they have ‘programmatic outcomes’. That is, interpretations are aligned to particular policy recommendations and proposals. These ‘programmatic outcomes’, are themselves, the result of “explicit or implicit diagnoses of the ‘problem’” contained within the interpretation (Bacchi 1999:1). Problem representation is therefore, an interpretation, that in identifying the cause, implies a particular policy response.

Drawing on retrospective analyses of a number of social polices – historically considered as most relevant to the problem of ‘women’s inequality’ (for instance, pay equity, sex discrimination, sexual harassment and so on), Bacchi illustrates how policy responses are a result of the assumptions and presuppositions underpinning various problem
representations. To illustrate this, it is useful here to examine some of Bacchi’s analysis of the problem of ‘family violence’.

The ‘problem’ of ‘family violence’

Historically, a number of terms have been used to describe “women’s experience of brutal physical and psychological treatment” by their male partners (Bacchi 1999: 165). In the nineteenth century, the ‘problem’ was called ‘wife battering’. By the twentieth century, the problem was labelled ‘domestic violence’. Now, a number of terms are used to describe the problem, such as: spousal abuse; women battering; family violence; violence against women; battered women; and, more recently, violent men (Bacchi 1999: 165). These various problem descriptions did, and do imply, very different problems and thus suggest quite different responses.

Within the ‘family violence’ problem representation for instance, a number of discourses were operating. The psychodynamic model for instance, attributed family violence to sick relationships and sick individuals. The solution arising from this problematisation was treatment through counselling – targeted to the affected individual. However, until recently, the general historical pattern has revealed this counselling treatment was focused on the psychopathology of the female recipient of violence and not the perpetrator (Bacchi 1999).

Another discourse, viewed the problem of ‘family violence’ as situated in a context of ‘family dynamics’ where particular norms and social values were held to condone various forms of violence. Under this perspective, causal explanations for family violence took three main forms: socioeconomic or personal stress factors; social learning theory (behaviour is socially learned); or, theories implicating the sexist organisation of society and its traditions as encouraging men’s abuse of women (Bacchi 1999). The solutions implied by such explanations aimed to address the ‘cause’ – in this case addressing the ‘culture of violence’. These solutions included: counselling; stress and anger management; structural interventions to eliminate norms that serve to legitimise or glorify violence (eg: physical discipline of children, the death penalty, corporal punishment, and media violence); reducing stress believed to provoke violence (for instance by addressing unemployment, poverty and social isolation); and, addressing the sexist character of society and gendered roles in the home and workplace (Bacchi 1999: 168). Bacchi argues that in these interpretations, violence against women is viewed as part of a larger subset of social violence, which will be reduced when wider societal violence is addressed.
There is also often a ‘discourse of exit’ operating in representations of the family violence problem which raises the question: why doesn’t she leave? (Bacchi 1999). This ‘discourse of exit’ (which is also apparent in sexual harassment discourses), presumes the possibility of choice, in that women victims of partner violence are assumed to have the necessary resources to act independently. Thus, if the woman chooses to stay, then this is translated as meaning that things can not have been so bad. Bacchi (1999: 171) argues that the major problem with the ‘choice’ discourse is that it avoids a “consideration of structural prerequisites for meaningful choice”. Furthermore, the ‘discourse of exit’ fails to address any questions about the “woman’s desire and right to stay in her home” (Bacchi 1999: 169). In this sense, alternative policy options have been rendered invisible.

A contemporary family violence discourse positions the problem as one of ‘violent men’ and ‘passive women requiring protection’ (Bacchi 1999: 175). There are a number of implications of this frame. It serves to justify a greater commitment of government resources to the police and justice system and programmes for battering men, possibly at the expense of resources committed to women’s refuges. Furthermore, if women are considered as passive victims, those who hit back in defence might not be considered as entitled to protection.

The problem of ‘family violence’ illustrates how policy responses vary according to different representations of the issue. These policy outcomes were essentially responses to the identified ‘causes’: sick relationships; a culture of violence; ‘choice’; or, violent men. The causes are, in turn, underpinned by various assumptions about the nature of family violence – who is affected by it and who is to blame, appropriate gender roles, and about the relative influences of human agency and social structure. Although the example of family violence seems far removed from the obesity issue, the analytical approach is nonetheless as applicable to examining the ‘problem’ of obesity as it is to an examination of any other policy issue.

**The ‘problem’ of obesity**

As with the issue of family violence, alternative framings of the obesity issue suggest different policy responses, and the causal explanations for obesity range from the individual level, to the social and environmental levels. At the individual level, some believe that the causes are biological and lie in one’s genetic predisposition to store body fat, while others argue that the causes are behavioural – too much food and not enough physical activity. At the social level, some have argued that changes in norms about what and where we eat, as well as increasing social acceptance of larger bodies, have led to the
normalisation of overeating and obesity. Arguments arising out of public health circles have recently emphasised environmental explanations of obesity. These tend to highlight the impacts of the built environment and technological changes on physical activity patterns, or they may focus on the obesity-promoting aspects of the modern food supply and its marketing – in particular the abundance and ubiquitous nature of unhealthy food. Others argue that obesity is a multi-causal problem requiring multiple solutions. As we will see, each of these causal explanations implies a different set of policy options and, as is the case in any problem representation, each of the explanations rests upon particular assumptions and interpretations of the issue.

**Summary**

Bacchi’s *problem representation* approach informs the understanding of framing in this thesis. This approach holds, that problem representations are interpretations of an issue that imply particular solutions. This was illustrated using Bacchi’s (1999) analysis of ‘family violence’ frames. This demonstrated how various problem representations are translated into the ‘available’ policy options. These available policy options can reinforce the status quo, support policy change, or obscure alternative questions or explanations that may suggest different solutions. Key features of problem representation according to Bacchi include: the overall description of the problem; the type of problem suggested; who is thought to be affected by the problem (including stereotypes); the causes; and, the solutions (explicit or implicit).

### 3.2 Framing obesity: Recent research

Several noteworthy research attempts to describe or analytically examine obesity frames or framing have been undertaken. These include: an analysis of obesity frames in the news media (Lawrence 2004); an analysis of ‘claims’ and ‘claimants’ in the obesity ‘controversy’ (Saguy & Riley 2005); various model explanations for the obesity epidemic identified by Lang and Rayner (2005); and, a recent analysis by Kwan (2009) of some prominent obesity frames. Together, this research provides an overview of our current understanding of various obesity frames, their main features, likely sponsors or claimants, and their implicated policy responses. The most useful components of this research and the relevant findings are considered below.
3.2.1 Obesity framing in the news media: Lawrence

Lawrence (2004) argues that a critical aspect of problem framing is where the blame is located, since this suggests who should be held accountable. Of particular relevance to identifying who is to be blamed for a given problem are the notions of individualising and systemic frames (Lawrence 2004). Individualising frames are defined as those that “limit the causes of a problem to particular individuals, often those who are afflicted with the problem”, while systemic frames “broaden the focus, assigning responsibility to government, business, and larger social forces” (Lawrence 2004: 57). Correspondingly, solutions to individualising frames suggest limited government responsibility and intervention, while systemic frames “invite governmental action” (Lawrence 2004: 57).

Arguing that in the US, public policy issues face “political resistance to claims of ‘systemic causation’ and governmental responsibility for solutions”, Lawrence suggests that moving the discourse from individualising to systemic framings, may be a strategy to make the policy environment more conducive to policies that hold powerful groups and political institutions accountable for addressing the problem (Lawrence 2004: 57). Four key dimensions of public health risk framings are suggested as having various levels of influence on public policy outcomes because of their attribution of blame (Stone 1997; Nathanson 1999; Lawrence 2004). Specifically, public health risks can be portrayed as:

- an involuntarily or deliberately acquired risk – with the person innocent or guilty
- a universal or particular risk – a risk to everyone or just oneself
- caused by the individual or the environment
- or, when the health risk is well known “whether that danger was knowingly or intentionally created by others” (Lawrence 2004: 59).

Drawing on the experience of framing by the anti-tobacco movement, for example, Lawrence suggests that:

The more an issue is framed in terms of involuntary risk, universal risk, environmental risk, and knowingly created risk, the more likely the opinion environment is to be conducive to public policy solutions that burden powerful groups (Lawrence 2004: 59).

Using the example of tobacco, Lawrence (2004) explains how involuntary risk was established with evidence of the adverse health effects on non-smokers of exposure to second-hand smoke (which also made it a universal and environmental risk), and evidence
of the addictive properties of tobacco transformed the portrayal of the smoker from one who *chooses to smoke* (despite knowledge of the adverse health effects), to one who is a *victim of addiction*. However, the major breakthrough for the anti-tobacco lobby, in terms of policy action, is believed by some to have been the emergence of evidence from internal industry documents. This was the evidence that the tobacco industry *knowingly* created an addictive product and marketed it to adults and children (Lawrence 2004).

In examining who is burdened and blamed for the obesity problem, Lawrence (2004) conducted a *content analysis* of news reporting of the obesity issue in the US media from 1985-2003. The key frames were identified from: an ‘extensive reading’ of news articles, scholarly articles and books; Websites; and, personal interviews with health experts and advocates (Lawrence 2004: 61). The prominence of these frames in the news media was then identified from the following sources of data: 136 items from the *New York Times*; news articles identified from a key word search of a database (Nexis) of ten major US newspapers; and, abstracts from eighty-nine prime time new items on television. Obesity frames evident from this data were classified into three groups (on the basis of identified causes). These were:

- **biological** – impersonal causes at the molecular level
- **behavioural** – individual behaviour of eating more than you expend
- **environmental/systemic** – due to unhealthy food and physical activity environment created by corporate and/or public policy (Lawrence 2004: 61-62).

This research revealed that overall, the *causes* of obesity had been reframed from the “individualized and medical realms of biology and personal behaviour toward the realm of environmental causation” (Lawrence 2004: 69).

Lawrence concluded that the ‘framing contest’ is far from over:

> As claims about an unhealthy food and activity environment have increased, the role of personal responsibility for one’s health has been strongly articulated in response (Lawrence 2004: 69).

In other words, the causes and solutions to the obesity epidemic remain a contested issue in news discourses in the US.
3.2.2 Claims and claimants in the obesity controversy: Saguy and Riley

Saguy and Riley (2005) examined claims and claimants in what they described as ‘framing contests’ over obesity. They argued that there were four main groups of people, or claimants, involved in this controversy: anti-obesity researchers and anti-obesity activists on the one side; and fat acceptance researchers and fat acceptance activists on the other. Anti-obesity researchers and activists were suggested as subscribing to the view that higher weight is risky for health and thus framed excess weight as a medical issue; while fat acceptance researchers and activists argued that weight variation was merely a harmless form of body diversity and therefore frame excess weight as a political issue. This particular categorisation of claimants into two opposing camps stems from the authors’ interest in understanding how ‘medical’ frames of obesity successfully stymie fat rights arguments, and how different groups frame weight in relation to health and morality.

Saguy and Riley (2005) conducted a thematic analysis of various published works. These included: technical studies identifying the health risks associated with obesity and technical studies questioning the health risks; six in-depth interviews with anti-obesity researchers and nine with leading fat acceptance activists; and, participant observation at the 2001 National Association to Advance Fat Acceptance annual convention and on a fat acceptance Listserv – showmethedata (Saguy & Riley 2005).

Their research identified four competing frames: ‘fatness as body diversity’; ‘obesity as a risky behaviour’; ‘obesity as disease’; and ‘obesity as an epidemic’ (Saguy & Riley 2005). These frames are not described here, as their main arguments are incorporated into the subsequent description of key frames likely to be drawn upon by industry and public health (section 3.3). However, it is important to note the key findings of this research. These were, that although the fat acceptance and anti-obesity camps were both found to draw on the ‘obesity as disease’ framing, the fat acceptance camp otherwise embraced the ‘fatness as body diversity’ frame, while the anti-obesity camp drew on the ‘obesity as a risky behaviour’ and ‘obesity as an epidemic’ frames.

 Aside from the issue of the types of obesity frames that exist and their likely supporters, a critical issue is whether one or other of these frames will become accepted by the policy makers as a more legitimate explanation of the problem. On this matter, Saguy and Riley (2005) argued that a frames’ effectiveness depends on the rhetorical skill and the credibility of claimants. Although they did not define rhetorical skill or explore it further in their article, Saguy and Riley did consider the issue of credibility struggles.
On the matter of credibility struggles, Saguy and Riley (2005) highlighted a number of strategies adopted by the fat acceptance and anti-obesity camps to discredit their opponents. These included, for the fat acceptance camp, invoking personal experience as a form of expertise and highlighting economic conflicts of interest between anti-obesity researchers and their funders. For anti-obesity researchers and activists, the strategies included, questioning the academic standing of those in the fat acceptance camp and pointing to the physical form of the bodies of fat acceptance researchers as evidence of a personal conflict of interest “in which denying the health risks of obesity is read as making excuses for personal fatness” (Saguy & Riley 2005: 902).

3.2.3 Kwan’s obesity frames

Kwan also suggested that rhetoric on obesity, in the US context, has been characterised by a framing competition (Kwan 2009). For Kwan, framing competitions are essentially “struggles over the production of ideas and meanings” where different frames compete to be accepted as the legitimate ‘truth’ or ‘authoritative version of reality’ (Kwan 2009: 26). Kwan notes that a critical implication of the successful framing of an issue is its translation into tangible benefits for some groups. For example:

framing obesity as a personal right or preference in a democratic capitalistic society helps maintain sales of certain foods that may be accused of causing the ‘epidemic’. Similarly, framing obesity as an individual and surmountable problem caused by moral shortcomings encourages weight loss, thus translating into profits for the diet and fitness industry . . . . There are even profits through legal and insurance benefits . . . . Simply put, when a frame resonates with audiences there are potentially large financial returns (Kwan 2007: 3-4).

Another important implication of the successful framing of an issue is its potential effect on social inequality:

framing of fat as an individual health problem suggests that its cause is partly genetic and/or due to a lack of restraint and discipline. This frame blames individuals for their bodies and suggests policy that encourages changes in individual lifestyle. It also endorses moral judgments of fat individuals, thus legitimizing social inequality and health disparities. In contrast, framing obesity as a result of structural influences, such as a lack of access to nutritional knowledge or high-quality foods, suggests that individuals are less blameworthy. Here, an appropriate line of action involves addressing these structural disparities, a strategy that redirects focus from the individual. The relationship between frames and social inequality is especially important because in modern Western societies fat is a visible status characteristic that often comes with stigma and bias. Research points to widespread size-based discrimination in all areas of
social life such as employment, medicine, education, and law (Kwan 2009: 27).

Thus, if the blame for obesity is set at the individual rather than the structural level, inequalities may be exacerbated both in health and other social and economic outcomes.

Kwan (2009) examined a number of prominent obesity frames from different organisations in the US to see how they framed fat, their key messages and how these were promulgated (Kwan 2009). This research involved an analysis of organisational materials disseminated by:

- government officials at the US Centers for Disease Control and Prevention (CDC) – a branch of the US Department of Health and Human Services
- activists from the National Association to Advance Fat Acceptance (NAAFA)
- food industry representatives from the Center for Consumer Freedom (CCF) – an interest group formed in 1995 (formally called the ‘Guest Choice Network’) by the Phillip Morris tobacco company. The CCF represents more than 30,000 restaurants in the US as well as the tobacco and alcohol industries (Kwan 2009).

The data sources for Kwan’s research included forty-two documents (mostly available from the organisation websites) selected as representative of each group’s position on obesity. Seven of these documents were from the CDC website and included: The Surgeon General’s Call to Action to Prevent and Decrease Overweight and Obesity (United States Department of Health and Human Services 2001). For NAAFA, the data sources included: fourteen official documents from NAAFA; a 1998 book by Wann titled: Fat! So? – argued to be a ‘manifesto for the fat rights movement’ (Wann 1988); and, twelve of NAAFA’s information brochures (Kwan 2009). For the CCF the documents included seven obesity and food related print advertisements and a CCF publication titled: An epidemic of obesity myths (Center for Consumer Freedom 2004). Three separate frames were identified: a ‘medical’ frame (used by the CDC); a ‘social justice’ frame (adopted by activists from NAAFA); and, a ‘market choice’ frame used by food industry representatives from the CCF (Kwan 2009).

To assist in identifying the abovementioned frames, Kwan’s analysis was structured by the use of a framing matrix that identified ‘signature features’ of frames. These signature elements were classified as reasoning devices (or arguments) or framing devices: “an array of descriptors to facilitate frame articulation and description” (Kwan 2009: 29). The framing matrix used by Kwan is presented in Table 9.
Table 9: Signature features of a frame according to Kwan’s framing matrix

<table>
<thead>
<tr>
<th>Reasoning devices</th>
<th>Framing devices</th>
</tr>
</thead>
<tbody>
<tr>
<td>causal roots</td>
<td>metaphors (analogies &amp; symbols)</td>
</tr>
<tr>
<td>appeals to principle (core values)</td>
<td>exemplars (events to illustrate a key point)</td>
</tr>
<tr>
<td>consequences (policies)</td>
<td>catchphrases (theme statements, taglines, or slogans)</td>
</tr>
<tr>
<td>depictions (characterisations of principal subjects eg: opponents and allies)</td>
<td>depictions (events to illustrate a key point)</td>
</tr>
<tr>
<td>visual images (icons &amp; other visual images)</td>
<td>depictions (characterisations of principal subjects eg: opponents and allies)</td>
</tr>
</tbody>
</table>

Source: (Kwan 2009:29).

Kwan noted that not all of the signature elements are necessarily present in a given frame. The following tables show the signature features of the frames used by the three groups analysed in Kwan’s research. Table 10 presents the signature features of the frames in relation to the reasoning devices, and Table 11 presents the signature features of the frames in relation to the framing devices.

Table 10: Reasoning devices used in the three frames identified by Kwan

<table>
<thead>
<tr>
<th>Frame</th>
<th>Medical</th>
<th>Social justice</th>
<th>Market choice</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Cultural producer</strong></td>
<td>US Government Center for Disease Control (CDC)</td>
<td>National Association to Advance Fat Acceptance (NAAFA)</td>
<td>Food industry Center for Consumer Freedom (CCF)</td>
</tr>
<tr>
<td><strong>Position</strong></td>
<td>Medical research using the Body Mass Index shows that obesity is a growing health epidemic resulting in serious consequences Overweight &amp; obesity afflict two-thirds of the population &amp; this health problem has large medical, social &amp; economic costs</td>
<td>Fat individuals suffer social stigma, stereotyping, &amp; discrimination because of narrow medical &amp; cultural conceptions of health &amp; beauty Critical of the Body Mass Index for being a misleading indicator of health Research shows that fat does not necessarily mean unhealthy Weight-loss drugs, weight loss, surgery &amp; diets are ineffective &amp;/or dangerous</td>
<td>Obesity ‘facts’ are actually myths, e.g., research shows that obesity does not have dramatic health costs; a lack of physical activity (&amp; not overeating alone) causes obesity; individuals can be overweight &amp; healthy; obesity is not a disease; &amp; soda does not cause childhood obesity Individuals should be able to consume whatever they personally think is sensible Critical of the Body Mass Index for being a misleading indicator of health</td>
</tr>
<tr>
<td><strong>Causal roots</strong></td>
<td>Obesity is caused by many factors such as genetic, metabolic, behavioural, environmental, cultural &amp; socioeconomic influences</td>
<td>Obesity is caused by many factors such as genetics, metabolism &amp; dieting history</td>
<td>Obesity is not a disease &amp; is not caused by overeating alone Lack of physical activity &amp; sedentary living are (implied to be) major contributors</td>
</tr>
</tbody>
</table>
### Core values

<table>
<thead>
<tr>
<th>Frame</th>
<th>Medical</th>
<th>Social justice</th>
<th>Market choice</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health is desirable to live a long productive life, where health is defined primarily in physiological terms</td>
<td>Health is desirable, where health is defined in part as health-at-every-size &amp; psychological well-being Human rights should be protected Fat individuals should be able to live free from stigma &amp; discrimination</td>
<td>Individual choice &amp; rights should be protected</td>
<td></td>
</tr>
</tbody>
</table>

### Policies

<table>
<thead>
<tr>
<th>Frame</th>
<th>Medical</th>
<th>Social justice</th>
<th>Market choice</th>
</tr>
</thead>
<tbody>
<tr>
<td>CARE: Communication with the public about the goals of a healthy public; Action including interventions &amp; activities that encourage changes in behavioural (consumption &amp; activity) patterns; Research &amp; Evaluation into the causes, prevention, and effective treatment of obesity Encourage efforts to maintain a healthy weight starting in childhood &amp; continuing throughout adulthood Dietary &amp; physical activity recommendations</td>
<td>Dispel common myths about fat persons. Educate the public about the sociological, psychological, medical, legal, medical, &amp; physiological aspects of being fat Advocate &amp; sponsor responsible research Fight size-based discrimination in all realms of social life Include height &amp; weight as protected legal categories</td>
<td>Mobilization against government regulation of industry Rejection of proposed laws that would tax certain high-fat, low-nutritional value foods</td>
<td></td>
</tr>
</tbody>
</table>

Source: (Kwan 2009:32-34).

**Table 11: Framing devices used in the three frames identified by Kwan**

<table>
<thead>
<tr>
<th>Frame</th>
<th>Medical</th>
<th>Social justice</th>
<th>Market choice</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cultural producer</td>
<td>US Government Center for Disease Control (CDC)</td>
<td>National Association to Advance Fat Acceptance (NAAFA)</td>
<td>Food industry Center for Consumer Freedom (CCF)</td>
</tr>
<tr>
<td>Metaphors</td>
<td>The healthy body symbolises accomplishment</td>
<td>The fat (especially female) body as a symbol of beauty &amp; empowerment</td>
<td>The evils of ‘big government’</td>
</tr>
<tr>
<td>Catchphrases</td>
<td>Obesity is a major public health problem</td>
<td>Fat is not a four-letter word Fat! So? Health at Every Size Diets don’t work War on fat</td>
<td>Obesity hype Obesity myths Personal responsibility Common sense Junk science</td>
</tr>
</tbody>
</table>
In comparing the reasoning devices used by the three groups in Table 10, it is clear that the ‘medical frame’ situated the problem of obesity in the context of an ‘epidemic’, with serious medical, social and economic consequences. Both those who are overweight and obese were included in the problem definition (two-thirds of the population according to the CDC). The causes suggested by the ‘medical’ frame were multiple and operating at the individual, biological and environmental levels. The solution, however, appeared to be focused on addressing the individual level causes, for instance, by providing information (communication) and ‘encouraging’ behavioural change (by encouraging individuals to maintain a healthy weight and by providing dietary and physical activity advice). This solution assumes that the problem is unhealthy behaviour caused by knowledge deficits. In this framing of the issue, the identified causes do not match the solutions – a disconnect that was noted by Kwan (2009).

In comparison, the ‘social justice’ frame sponsored by ‘fat acceptance activists’ frames the problem as one of discrimination faced by fat people. The association between health and weight was questioned (the BMI is criticised) as was the efficacy of various strategies to promote weight loss. The solution was therefore, to fight size-based discrimination and negative stereotypes of fat people.
In contrast, the ‘market choice’ frame suggested that the obesity epidemic was a myth, in which obesity was not a disease, nor indicative of poor health. According to Kwan (2009: 41):

The CCF outlines and refutes a total of seven myths (primarily with the use of counter-research) in *An Epidemic of Obesity Myths* such as Obesity kills 400,000 Americans a year; You can’t be overweight and healthy; Overeating is a primary cause of obesity; and Soda causes childhood obesity. Most of these myths, the group says, are government-generated hype that stem from ‘junk science’ fuelled by a $40 billion weight-loss industry.

In the ‘market choice’ frame, *lack of physical activity* was implicated as the major contributor to obesity (and not food consumption alone), although Kwan noted that causes were not explicitly stated by the CCF: “The CCF does not articulate what it thinks are the causes of obesity. Instead, it openly states what are not causes” (Kwan 2009: 41). To support its emphasis on physical activity rather than food consumption, the CCF cited evidence that *physical activity had declined* in recent years:

*An Epidemic of Obesity Myths* details the decline of physical activity in the United States showing, for example, that only one-half of young people regularly participate in vigorous activity and that a quarter of the population reports no vigorous physical activity (Kwan 2009:41).

The CCF also cited evidence that one can be ‘fit and fat’:

[A] fit man carrying 50 pounds of body fat had a death rate less than one-half that of an unfit man with only 25 pounds of body fat (Kwan 2009: 41).

Active obese individuals actually have lower morbidity and mortality than normal weight individuals who are sedentary (Kwan 2009: 41).

Solutions to the obesity issue were not identified by the CCF in the material Kwan analysed (unlike the other two organisations). This is likely to be due to the fact that the group did not accept that *there was* an obesity problem. Nonetheless, the CCF emphasised that food taxation or regulation of the food industry were *not* solutions.

The ‘market choice’ frame, according to Kwan (2009: 42):

endorse a laissez-faire philosophy, demanding minimal government intervention and promoting economic autonomy. Like other industry actors, the group readily mobilizes and canvases to weaken and eliminate government regulation. Individuals, the group argues, as responsible
adults, are able to make their own decisions about consumption. The CCF thus protests food taxes and what the group feels is excessive regulation of industry. Supply and demand should regulate the free market and consumers should make their own choices in a capitalist, consumer-driven society.

In discussing the implications of the ‘medical’ frame endorsed by the government officials at the CDC, Kwan (2009:43) noted that:

> Although government documents claim that obesity is a national, state, community, and individual problem, the CDC admits that much intervention can take place at the individual level . . . . the frame’s focus on individual behavior detracts from larger structural efforts that encourage healthier living such as increased access to safe and affordable public recreational facilities; increased availability of inexpensive, fresh, and healthy foods; and greater regulation of the food industry.

And on the implications of the ‘market choice’ frame, it was noted by Kwan (2009:44) that:

> while the market choice frame challenges the medical frame, it poses few challenges to current social and cultural structures. Just like Big Tobacco and its response to smoking related litigation, the market choice frame emphasizes responsibility and stresses neoliberal rhetoric. The market choice frame works within, and is an integral part of, the capitalist economic system. The CCF proffers no critique of prevailing body norms. These norms are seemingly outside and irrelevant to the frame and its promoters. At bottom, the market choice frame is morally ambivalent when it comes to bodies. It makes no claims about what bodies are right or wrong, beautiful or ugly. All bodies are tolerated, so long as they consume [my emphasis].

One of Kwan’s conclusions was that the current cultural discourse around obesity was largely dominated by the ‘medical’ frame. This, she argued, was partly to do with the established status of medical knowledge as an ‘authoritative knowledge’. Kwan explained (2009: 45) that:

> The concept of authoritative knowledge illustrates that despite competing knowledge systems, some systems carry more weight than others. So even when fat acceptance activists point out that individuals can still be healthy and fat, or when the food industry lobbyists say that it is not overeating alone that leads to obesity (and both rely on scientific evidence), there is a sense that this counters one’s natural beliefs, even though these beliefs are culturally constructed. Often when one kind of knowledge establishes legitimacy, alternative knowledge systems are dismissed and seen as ignorant. Similar to a master frame, authoritative knowledge comes to be seen as part of a natural order, the way things are and ought to be [my emphasis].

In other words ‘authoritative knowledge’ can become internalised as the legitimate truth.
Another reason for the dominance of the medical frame suggested by Kwan, is its alignment with the powerful ‘master frame’ of American individualism: “the belief that just by pulling ourselves up by our bootstraps we can achieve infinite goals, including redesigning our bodies” (Kwan 2009: 45). Nonetheless, Kwan (2009: 45) highlighted how the ‘market choice’ frame also drew on the same American individualism master frame – although in a different way:

while the individualism of the medical frame encourages healthy lifestyles for a person’s own good, the individualism of the consumerist frame is presented as libertarian rhetoric. That is, the market choice frame argues that individuals should be empowered to make whatever choices, good or bad, they wish to make. It is entirely up to the individual whether he or she wants to lead a healthy lifestyle.

Researchers examining frame effectiveness have also identified frame resonance as a key determinant of a frame’s success (Snow & Benford 1988; Ryan 1991). The concept suggests that the more a “frame resonates with familiar cultural themes, the more likely it will be accepted as a natural way to interpret reality” (Kwan 2009: 3). Thus, the alignment of a frame with a dominant ideological ‘master frame’ is thought to increase its effectiveness as it does not challenge the dominant worldview.

In conclusion, Kwan suggested that it is possible that the alignment of the industry frame with the master frame of individualism may result in a successful challenge to public health messages. It is also interesting to note that Kwan’s research revealed that, on the matter of solutions, both the government official position and that of the food industry were focused at the individual level (environmental causes remained unaddressed). However, Kwan’s analysis, as noted previously, is focused on the US context.

3.2.4 Lang and Rayner’s explanatory models

Lang and Rayner’s (2005) review of explanations of the obesity epidemic also provides an important contribution to the research on obesity frames. Their understanding of the problematisation of obesity comes from a public health perspective where the epidemic of obesity is considered as a critical public health issue. Lang and Rayner (2005) identified eight key explanatory models, their core arguments, the associated evidence and their implicated solutions. Although the evidence for each of these models is not examined here, a brief overview of their core positions is given in Table 12. No methodological detail was provided by the authors of this review.
<table>
<thead>
<tr>
<th>Explanation</th>
<th>Core position</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Genetic model</strong></td>
<td>Humans have a genetic predisposition to lay down fat, a trait that is now dysfunctional in the context of food oversupply.</td>
</tr>
<tr>
<td><strong>Economic transition</strong></td>
<td>Physically active work &amp; leisure activities have been replaced with sedentary ones. Increased workforce participation has led to increased reliance on outsourced foods. Obesity is considered as the ‘downside’ of generally rising affluence.</td>
</tr>
<tr>
<td><strong>Convergence</strong></td>
<td>Due to globalisation consumers adopt similar tastes &amp; dietary patterns (in particular the American style of eating) &amp; similar health &amp; obesity profiles follow.</td>
</tr>
<tr>
<td><strong>Food supply &amp; technological change</strong></td>
<td>Obesity is a result of 20th century changes in farming &amp; food policies. These policies have supported “the over production of fats &amp; sugars leading to a revolution in food processing, distribution systems &amp; logistics. This in turn has resulted in the “unprecedented availability of high calorie foods . . . . [and] ‘snacking opportunities’ in daily life” (Lang &amp; Rayner 2005: 310).</td>
</tr>
<tr>
<td><strong>Cultural transition</strong></td>
<td>Marketing &amp; advertising have transformed food consumption norms – what to eat &amp; how much (for instance increased portion sizes &amp; snacking).</td>
</tr>
<tr>
<td><strong>Psycho-social</strong></td>
<td>Changes in how &amp; what people eat are personal &amp; dependent on a number of psychological variables: “rising numbers of obese people suggests a society with inappropriate confidence in what and how to eat . . . . eating becomes indulgence to alleviate alienation, feelings of worthlessness or as compensation for stresses and strains in modern living” (Lang &amp; Rayner 2005: 311).</td>
</tr>
<tr>
<td><strong>Obesogenic environment theory</strong></td>
<td>Multiple environmental factors – physical, social, economic &amp; political – now constitute an obesogenic environment in which obesity has become the normal response.</td>
</tr>
<tr>
<td><strong>Nutrition transition</strong></td>
<td>As a result of societal convergence &amp; twentieth century consumer capitalism there has been “a shift not just in what people eat but how and where, and who makes, procures, and profits from it” (Lang &amp; Rayner 2005: 312).</td>
</tr>
</tbody>
</table>

Source: (Lang and Rayner 2005).
Note: Explanations highlighted in bold were argued by Lang and Rayner to be supported by more substantial evidence.

In discussing the details of the various models outlined above, Lang and Rayner recognised that rather than being discrete models, in reality there is considerable overlap between the various explanations. Outlining the differences between the various models, according to Lang and Rayner (2005:313):

> helps explain why obesity raises so many problems for governance. Differences of attribution of cause imply differences of strategy and implied solutions. And, vice versa, different interests are drawn to models that reinforce or suit their predilections.

Examples of the various interests and their preferred models were also provided by the authors (Lang & Rayner 2005: 313):
Public-health specialists tend to argue that the failure to stem the tide of obesity derives from reliance in public policy based on individualized approaches . . . . Governments subscribing to the power of individualism tend to propose public health strategies nuanced around consumerist ethics. It is rhetorically simpler to appeal to consumers to make ‘healthy choices’ in the marketplace (than to change environments) [my emphasis].

Lang and Rayner (2005: 313) also noted, that:

Policy take-up of the various models outlined above comes with clear commercial ties. The reflex of powerful food and advertising industries in Europe like the USA is to resist any imposition of regulatory burdens, or at least to minimize them. These industries tend to support individualization of healthy lifestyles rather than altering baseline behaviour for all. The mutual needs of food processors and the consciousness industries [marketing and advertising industries] are thus a key barrier to take-up of the more cultural or environmental approaches [my emphasis].

Thus, it would appear that governments (subscribing to an ideology of individualism), and the food and advertising industries, are likely to support an individual rather than a systemic frame. Evidence for this was also provided by Kwan’s investigation.

**Summary**

**Framing concepts**

This chapter has so far examined framing theory and research on obesity frames. Bacchi’s approach suggests that key aspects of problem representation include: the overall description of the problem; who is included or excluded from the problem representation; the identified causes (and their underlying assumptions and interpretations); and, the solutions (explicit or implicit).

In comparison, Lawrence (2004) emphasised, that in addition to the importance in a frame of the identified causes, blame is also a critical feature of a frame (particularly whether an issue is framed in individualising or systemic terms) because of its link with accountability for a problem. Saguy and Riley’s (2005) research highlighted the importance of the claimants and of credibility struggles. They noted that the two opposing groups (the fat acceptance and anti-obesity camps) framed the problem of obesity in different ways as either a medical or a political issue. Kwan’s research is particularly useful in that it provides a framing matrix for identifying signature features of a frame. This matrix incorporated the use of rhetorical devices (causes, core values and consequences) and
framing devices (metaphors, exemplars, catchphrases, depictions of subjects and visual images).

These concepts, together with Bacchi’s problem representation approach, helped inform the rationale behind the framing matrix used in this thesis (outlined in Chapter 4) for identifying the key features of obesity frames.

Frame effectiveness

Various authors have also suggested that there are important features of a frame (or the framing process) more critical in terms of a frame’s effectiveness for influencing policy or wider political discourse. For Lawrence (2004), important features of a frame, in terms of its likely effectiveness for supporting a public health approach, were: whether a public health issue is framed as a voluntary or deliberately acquired risk; a universal or particular risk; a risk caused by the individual or the environment; and, whether the risk is knowingly or intentionally created by others. In contrast, Saguy and Riley (2005) suggested that a frame’s effectiveness may be in part due to the rhetorical skill or credibility of claimants. Kwan introduced the notions of authoritative knowledge and frame resonance (alignment of a frame with a master frame) as potential explanations for a frame’s success in dominating cultural and political discourse.

Obesity frames

As well, the research reviewed has identified many potential obesity frames that industry and public health groups could draw upon and use. These frames have been investigated from different disciplinary perspectives, addressing different research questions. This explains why different frames are suggested by the authors of the various research efforts as the most worthy of inquiry.

Saguy and Riley (2005) for instance, identified four ‘fat frames’ used by the anti-obesity and fat acceptance camps, with the anti-obesity camp drawing on the ‘obesity as a risky behaviour’, ‘obesity as disease’ and ‘obesity as an epidemic’ frames, while the fat acceptance camp drew on the ‘fatness as body diversity’ and the ‘obesity as disease’ frames.

Lang and Rayner (2005) identified eight model explanations of the obesity epidemic: genetic; economic transition; convergence; food supply and technological change; cultural transition; psycho-social; obesogenic environment theory; and, the nutrition transition.
Lawrence and Kwan each identified three other types of obesity frames. For Lawrence these frames could be simply classified as: biological, behavioural; or, environmental/systemic, while Kwan identified ‘social justice’; ‘market choice’; and, ‘medical’ obesity frames. As noted by Lang and Rayner (2005), in reality there is considerable overlap between the various model explanations of obesity, with various interests inevitably drawn to frames that suit their predilections.

Based on the current literature on obesity frames and knowledge of the different interests of the industry and public health sectors, it is argued here, that there are four key frames likely to be drawn upon by public health and industry groups. For industry, based on the precedent from Kwan’s research and the suggestions by Lang and Rayner, these are: the ‘obesity epidemic as a myth’; and the ‘individual behaviour’ obesity frames. For the public health sector, on the basis of its emphasis on a population approach to public health issues and its focus on wider determinants of health, key obesity frames likely to be drawn upon include: the ‘obesogenic environment’ obesity frame (identified by Lang and Rayner 2005), and a ‘structural’ frame. To date, a ‘structural’ framing of obesity which attempts to explain inequalities in obesity prevalence has not yet not been clearly outlined in the literature, although aspects of it can be found in the other model explanations of the obesity epidemic as outlined by Lang and Rayner (2005). These key obesity frames likely to be drawn upon by the industry and public health sectors are outlined in the next section.

3.3 Key obesity frames

This section describes the four key obesity frames likely to be drawn upon by industry or public health groups. Three of these frames have been selected from the literature on obesity framing: the ‘epidemic as a myth’; the ‘individual behaviour’; and, the ‘obesogenic environment’ frames. The fourth ‘structural’ frame has been developed from the health inequalities literature and applied to the issue of obesity. The rationale for choosing these frames as key was based on: 1) preliminary reading of the public health and industry submissions where these four frames were identified as those most commonly articulated in the submissions’; and, 2) theoretical understanding of industry and public health perspectives which indicated that a number of alternative frames would not appeal to these groups. The four key frames are examined in turn below, beginning with an exploration of their core arguments. This is followed by a summary of the main features of each frame and a consideration of the policy implications and the interest groups likely to benefit from such frames. It is also noteworthy that while the number of published authors espousing each of the four frames varies, and in some cases was low, this is not necessarily problematic in that a more
important issue is how widely promulgated a frame is in influential forums (e.g., conferences, policy circles and the media).

### 3.3.1 The ‘epidemic as a myth’ frame

A number of critiques of the epidemiological and scientific literature argue that the obesity epidemic is merely an illusion (Campos 2004; Campos et al. 2006; Gaesser 2002; Guard & Wright 2005; Jutal 2006; Oliver 2006). Many of the central arguments contained in this frame, as previously discussed in section 3.2, have been used by the US food industry group – the CCF (Kwan 2009). At the same time though, many of the arguments contained in this frame are used frequently by what Saguy and Riley (2005) termed ‘fat acceptance’ researchers and activists (in particular Campos 2004).

Advocates of the obesity ‘epidemic as a myth’ frame highlight as problematic: the definition and measurement of obesity; the classification of obesity as a disease; and, the use of the term epidemic to describe what is argued to be only modest gains in weight for the average person. Also questioned are the reported associations between weight and health. These issues are examined below.

#### The BMI is faulty

The BMI is criticised on three grounds: first, that it is a measure of body weight and not body fat; second, that it lacks specificity at the individual level; and third, that the scientific rationale behind the categorisation of the various weight classes is believed to highly problematic and influenced more by vested interests – the weight-loss and pharmaceutical industries – than science. These three criticisms are outlined below.

Critics contest what they note is the underlying assumption behind the BMI, that variation in weight for persons of the same height is due to fat mass (Campos 2004; Gaesser 2002; Guard & Wright 2005; Oliver 2006). Instead they argue that there is evidence of a great many individual variations in fat composition between people of the same height and weight, and argue that these variations can be due to differences in muscle mass.

Critics of the BMI also point out, if obesity or overweight are to be defined scientifically, in health risk terms, that there are other factors critical to consider such as body fat distribution (since abdominal fat carries a greater health risk than fat on the thighs or buttocks), or type of body fat – with visceral (internal) fat (attached to organs) posing a greater health risk than subcutaneous body fat (fat more evenly distributed just under the
skin). In other words, the ratio of muscle to fat, the type of body fat and its location on the body – all important components of disease risk – can vary considerably for people of the same height and BMI.

Oliver (2006: 22) offers an alternative interpretation of the obesity epidemic; that vested interests from the weight-loss and pharmaceutical industries were behind recent changes to the BMI classification for obesity and overweight:

Over the past two decades, the BMI thresholds for these terms have yo-yoed, sometimes being pegged at one level, sometimes at another. For example, between 1980 and 2000, the U.S. Dietary Guidelines (a joint report from the Departments of Agriculture and Health and Human Services) have defined overweight at various levels ranging from a BMI of 24.9 to 27.1. In 1985, the National Institutes of Health (NIH) consensus conference recommended that overweight be set at a BMI of 27.8 for men and 27.3 for women . . . Then, in the 1990s, the World Health Organization (WHO) came out with a recommendation that a BMI of 25-29 should be considered as overweight and a BMI of 30 or more ‘obese’ . . . Partly to sort through these conflicting measures, in 1998 the NIH convened a panel of more than two dozen experts from the fields of health research, epidemiology and nutrition to review the ‘evidence-based’ research of the past twenty years. This NIH report concluded that the official designations of overweight should be set at a BMI of 25 and obesity at a BMI of 30, the same standards established by WHO.

According to Oliver (2006: 22), a controversy followed the release of the 1998 National Institutes of Health report because “overnight, more than 37 million Americans suddenly became ‘overweight’, even though they had not gained an ounce”. Oliver asserted that the guidelines for determining overweight were not based on the evidence and were in fact in the opposite direction of the primary source of evidence cited in the National Institutes of Health report – a study by Troiano (1996). Oliver claimed that the Troiano study, which illustrates the typical U-shaped curve between mortality and BMI (where mortality was the highest among the very thin as well as the very heavy), revealed no increased mortality until a BMI well beyond 30, and, even at BMI’s as high as 40, the differences in mortality were still within the limits of statistical uncertainty. Oliver argued that political, rather than scientific influences were operating to lower the BMI threshold for overweight. He claimed that the 1995 WHO report (which set the lowest standard BMI threshold for classifying ‘overweight’) was written largely by the International Obesity Task Force (IOTF), an organisation which he claimed was primarily funded by Hoffman La Roche (the maker of the weight loss drug Xenical) and Abbott Laboratories (producers of the Meridia weight-loss drug and previous producer of the diet drug Phen fen). Thus, according to Oliver, the IOTF, far from being a neutral scientific group, was in fact a lobby group for weight-loss and pharmaceutical companies. Oliver argued that the initial mission of the IOTF was to get the
lower BMI standard imposed on the WHO report as this would result in a phenomenal increase in the population at risk – by another 40 million in the US alone (Oliver 2006:32). Thus, for Oliver, much of the ‘epidemic’ has been constructed by the vested interests of those who are in the position to profit from the ‘epidemic’ framing of obesity. This argument was also used by the food industry group, the CCF (see Figure 5).

Source: (Center for Consumer Freedom 2004: 158).

Figure 5: Graphic taken from the CCF publication: An epidemic of obesity myths

Obesity is not a disease but it has been medicalised

Advocates of the ‘epidemic as a myth’ frame and ‘fat acceptance activists’ in particular, argue that human variation in fatness is normal, representing harmless body diversity, rather than a pathological condition worthy of the disease label. Obesity was first incorporated in the International Classification of Disease in 1948 (Rigby 2006), and by 2000, the WHO went one step further and explicitly labelled obesity as a ‘chronic disease’ (World Health Organization 2000). The transformation in status, of (what fat acceptance activists call) a human trait, into a medical condition, has be described as medicalisation. Medicalisation is a concept used by some to describe the process whereby a human quality or trait acquires ‘disease status’ not on the basis of scientific factors but because of changing norms, morality or vested interests (Jutal 2006). Fat acceptance activists have noted that giving obesity ‘disease’ status has a number of positive flow on effects for those with a stake in obesity treatment (weight-loss companies, gyms, the medical profession,
pharmaceutical companies involved in obesity treatment and health insurance companies). This suggests that there may be vested interests and potential commercial gain to be made from the medicalising of obesity. Similarly, there are a number of flow on effects for those individuals affected by obesity, some of them positive and some not (access to medical cover for conditions associated with obesity may be desirable but increased medical insurance premiums for those carrying extra weight would not).

Modest average weight gains not an ‘epidemic’

One interpretation of the epidemiological data on obesity trends supported by Campos (2006), Guard & Wright (2005), and Saguy and Riley (2005), suggests that rather than an epidemic the picture (in the US) is one of only modest average gains in body weight, and a shift in the distribution of weight towards the higher end of BMI (that is very overweight people gaining most of the weight). Campos in particular, has argued that rather than an unprecedented rise in obesity rates, there has only been modest weight gain at the individual level with “the majority of people [in the US] weighing only 3-5kg more than they did a generation ago” (Campos 2006:55). He suggested that “the average Americans’ weight gain can be explained by 10 extra calories a day” (Campos 2006:55). Thus, the argument holds that while those at the high end of the BMI distribution may have gained considerably, the average person has not.

Some have suggested that the very successful uptake of the concept of an ‘obesity epidemic’ by the media is fuelled by the fact that in the eyes of many, obesity and immorality are intertwined. Regular media reporting of the scientific findings of links between health and obesity began in the 1990’s (Saguy & Almeling 2008), and the scientific ‘consensus’ of an epidemic was evident in the title of a recent WHO report: ‘Obesity: Preventing and managing the global epidemic’ (WHO 2003). However, critics note, that precisely what is referred to when the term epidemic is used by scientists, the medical profession, or the media, is ambiguous. In other words, it is not clear whether the term has been used metaphorically – to infer a sense of grand scale and urgency, or literally – to some statistically quantifiable definition. For most of us the use of the term epidemic conjures up emotive and sensationalised notions of a dramatic and unprecedented increase, perhaps because of the historical association of the term epidemic with sudden outbreaks of contagious disease. In any case, the constant use of the phrase ‘obesity epidemic’ has been suggested by some as fuel for a mass ‘moral panic’ (Guard & Wright 2005; Campos & Saguy et al. 2006).
The association between weight and health has been exaggerated

Most sponsors of the ‘epidemic as a myth’ discourse accept that extreme obesity or extreme underweight may have adverse consequences for health. However, they debate, issue by issue, study by study, the strength of the associations between weight and health for everyone else. Various critiques of the design of specific epidemiological studies are offered, for example: demographic aspects of the particular population under study (social class, gender, ethnicity, age, current smoking and health status); the exclusion of specific groups from the study; and, the failure to control for other factors that may potentially explain the weight/health association. This led Oliver (2006) to conclude that the strength of the associations between weight and health outcomes vary considerably by health outcome, gender and age. Campos (2004) goes as far as to suggest that scientists and epidemiologists manipulate their data (he does not elaborate as to whether this is intentional) by excluding most of the ‘fat and healthy’ and ‘sick and thin’ participants leaving only the ‘fat and sick’ and ‘thin and healthy’, invariably leading to conclusions consistent with the ‘excess weight is bad for your health’ paradigm. Other critics within this perspective also cite research demonstrating that a higher than optimum BMI (BMI >24.9) is protective against some health outcomes (Gaesser 2002; Guard & Wright 2005; Oliver 2006).

It is not fat that causes poor health but underlying diet and exercise patterns

Another argument within the ‘epidemic as a myth’ frame suggests that it is not fatness per se that causes adverse health outcomes, but rather the underlying dietary and exercise patterns that determine health outcomes (Campos et al. 2006a; Gaesser 2002; Oliver 2006). A critical issue for advocates of this argument is the failure of numerous epidemiological studies to control for diet and exercise factors when demonstrating an association between BMI and health outcomes (Campos 2004). This point is crucial, because if poor diet and inadequate exercise are the true causes of poor health, then the focus for intervention should be on these factors (and their determinants) rather than weight loss or weight control. To support their contention, these researchers cite studies where improvements to exercise and nutrition, regardless of weight loss, have resulted in improvements in specified health indicators. Gaesser (2002) supports this argument, adding that, improvements to diet and physical activity patterns do not always translate into weight loss for all people. In other words, one can be ‘fit and fat’, just as one can be unfit and thin.
Weight-loss is not the solution

Another theme consistent in this discourse is the emphasis on the dangers of dieting. Specifically, there is a concern that, if slimness is dependent upon caloric restriction, ‘yo-yo’ dieting, the consumption of potentially harmful diet drugs, excessive exercise, or constant obsession about weight, it may not equate with healthy outcomes at all. To support this claim, advocates cite evidence of the numerous adverse effects associated with dieting behaviour such as: compromised immunity; adverse skeletal integrity; decreased dietary quality; poor body image; detrimental impact on children’s eating; low mood, eating/purging/smoking; and, decreased exercise and increased cardiovascular risk (Aphramor 2005; Rich & Evans 2005). This has led to the argument that some of the association between overweight and obesity and ill-health may in fact be due to the health damaging effects of various weight control methods adopted more frequently by those who are overweight. Thus, it is argued that it is far from clear whether the weight-loss solution will, in itself, bring about reductions in morbidity and mortality from diseases associated with overweight and obesity. Although this perspective rejects a focus on weight-loss, many advocates still strongly urge improving personal lifestyles to improve health.

Social justice variation

A variant on the obesity ‘epidemic as a myth’ is the ‘social justice’ explanation of obesity (identified as such by Kwan), and what Saguy and Riley (2005) term the ‘fatness as body diversity’ frame. Claims common to these frames (typically utilised by ‘fat acceptance’ researchers and activists) include: dieting is hazardous to health; the association between weight and health has been exaggerated; and that one can be healthy at any size. A ‘Health At Every Size’ movement supporting such claims exists in a number of countries including the US and Australia. However, the problem for advocates of the social justice frame, is weight-based discrimination in social and economic life (Kwan 2009). Many ‘social justice’ advocates also argue that there is a considerable genetic or biological component to obesity. Nonetheless, as with any framing of an issue, there are overlaps with other frames. For instance, as noted by Saguy and Riley (2005), some advocates of the ‘fatness as body diversity’ frame also draw on the medical ‘disease framing’ of obesity used by what they refer to as ‘anti-obesity activists’.
Summary and discussion

The problem representation inherent in the ‘epidemic as a myth’ frame is this: there is no epidemic of obesity – rather it has been socially and culturally constructed. In the first instance the BMI is claimed to be a faulty measure and not an accurate indicator of body fat. Advocates argue, that fat is not pathological but a human trait that has been medicalised by vested interests. The association between weight and health is argued to be unsupported by the science in general, with the exception there is an acceptance of real health risks for those at the extremes of the weight distribution (underweight and very obese individuals). Thus, the average person (the majority of the population) does not have a problem. For some advocates of this perspective, where some of associations between weight and health are accepted (and the argument has been that they have been greatly exaggerated), these are likely to be due to underlying dietary and physical activity patterns – irrespective of body weight. The public health issue, if there is one, is about nutritious diet and adequate physical activity for all.

Policy implications and likely sponsors

Under the ‘epidemic as a myth’ framing, as obesity is not a problem there is no need to find a solution. This framing of the problem has the fewest additional policy prescriptions. The key additional policy suggested is the need to address widespread fat phobia. This could be achieved through the promotion of messages supportive of body diversity and health and fitness at every size (except perhaps for those at the extreme ends of the weight distribution).

The abovementioned solutions are aligned to two particular groups, the ‘fat acceptance’ researchers and activists, and the food industry. Evidence that many of the arguments contained in the ‘epidemic as a myth’ frame were drawn upon by the fat acceptance camp was documented by Saguy and Riley (2005). Kwan (2009) noted similar arguments evident in both the ‘social justice’ frame (used by fat activists at NAAFA) as well as the ‘market choice’ frame sponsored by the US food industry group (the CCF). That the food industry group supported the ‘epidemic as a myth’ is frame is not surprising, given that the solutions implicit in this framing of obesity are unlikely to be detrimental to their core business of selling food. On the contrary, many of the arguments in the ‘epidemic as a myth’ frame have direct benefits for the food industry. These include: the general denial of the epidemic; the emphasis on those at the extreme ends of the weight distribution (the average person does not have a problem and therefore the majority of people can continue to consume as they have been); the claims that one can be ‘fit and fat’; that weight-loss is
not the solution; and, that other factors explain the association between BMI and health outcomes. In comparison, most of the claims that feature throughout the ‘epidemic as a myth’ frame seem unlikely to be supported by the public health sector.

3.3.2 The ‘individual behaviour’ frame

Advocates of the ‘individual behaviour’ explanation of the obesity epidemic accept that there are health risks associated with excess weight. The individual behaviour frame examined here, is similar in many respects to Lawrence’s (2004) conceptualisation of the ‘behavioural’ frame identified from news media discourses in the US, and shares some of the features of Saguy and Riley’s (2005) ‘obesity as a risky behaviour’ frame. Aspects of the ‘individual behaviour’ frame were also evident in the ‘medical frame’ identified by Kwan as belonging to the US government health agency, the CDC.

Within the ‘individual behaviour’ explanation of the obesity epidemic, obesity is framed as a consequence of particular lifestyle choices. Lifestyle choices are generally attributed to: ‘cultural preferences’; individual ‘character deficits’; or, ‘knowledge deficits’ (Attree 2006). These themes are examined further below.

Obesity as a lifestyle choice

A common view, particularly in some media representations of the obesity epidemic, emphasises the role of individual ‘choice’ as the underlying determinant of overweight and obesity. This ‘choice’ is expressed via the individual’s adoption of their preferred ‘lifestyle’. Lifestyle, is a term which encompasses a whole host of different factors: the neighbourhood we ‘choose’ to live in; employment ‘preferences’; educational ‘choices’; friendship and partnership ‘choices’; and so on. Lifestyle factors related to obesity are thought to include: food tastes and preferences; food purchasing and consumption behaviours; physical activity patterns; and, leisure pursuits.

Generally, advocates of the lifestyle explanation of obesity argue that people are fat because they choose, either to eat too much, or eat too much of the wrong foods, without compensating with adequate physical activity. Choice, in this sense, is epitomised in the following quote from a nurse commenting about some of her patients:

Every day . . . . they make a choice to buy the Big Mac and French fries instead of a salad or roasted chicken (Saguy and Riley 2005:885) [authors’ emphasis].
Proponents of an individual lifestyle explanation may argue that whether one chooses the fast food or the roast chicken and salad, may be explained, at least in part, by ‘cultural preferences’.

Cultural preferences

The ‘cultural preference’ argument is often invoked to explain cultural differences in consumption patterns. These cultural preferences are generally implied to be of a social class or ethnic group origin. Evidence of cultural differences in consumption can be traced back to the work of French sociologist Bourdieu (1984), who documented class-based differences in food consumption and other aspects of lifestyle. Evidence of cultural differences in consumption is interpreted by advocates of the ‘individual behaviour’ frame as evidence of preferences however, and not (as some argue), as a consequence of social and economic constraints.

Thus, it is not uncommon in media reporting to see ‘choice’ or ‘preference’ implied as the primary factor underpinning the (presumably) unhealthy diets of particular ethnic groups and the poor (Crotty & Germov 2004). For instance, an article in the Australian headed: ‘Fast Food Fashion Fuels Nutritional Underclass’, noted the claims of ‘leading experts’, that wealthier and better educated people chose ‘nutrient dense’ takeaways like Indian, Thai and Japanese foods, while those on low incomes chose KFC, McDonalds, pizza, and hot chips – foods which are lower in nutrients and higher in fat. This led to the conclusion by the ‘experts’, that a ‘nutritional underclass’ was emerging (Crotty & Germov 2004). Thus, the poorer diets of the poor are explained by their poorer ‘choices’.

Obesity due to character deficits

A number of character deficits have been put forward as explanations for the (supposed) unhealthy lifestyles of the obese. In particular, lack of motivation or laziness is often implied as causes for excess weight:

[people] know if they were to get up off the couch and do some more walking . . . . it would be helpful to them, but they just don’t feel like it (Saguy and Riley 2005:885).
Saguy and Riley noted a comment made by a prominent nutritional epidemiologist, Walter Willett, as an exemplar of the individualistic explanation of obesity. Willett was quoted as saying that he was:

yet to be convinced that there are very many people that if they are really serious about controlling their weight, can’t get their weight down under a BMI of 25. The main excuse regardless of why they don’t get exercise is because they don’t have enough time, and you look at all the national surveys, and they say the average amount of television watching per week is 29 hours (Saguy and Riley 2005:884).

The above example illustrates another common theme underlying individualistic explanations of obesity, that it is not lack of time that prevents people from engaging in exercise, but lack of priority. Some people, it appears, have plenty of time for exercise but would rather spend it watching television.

Immorality is another character deficit often attributed to the obese. This notion has been identified by Saguy and Riley (2005) as another character flaw underpinning the ‘obesity as a risky behaviour’ frame.

**Obesity as a ‘risky behaviour’**

Under the obesity as a ‘risky behaviour’ frame, obesity is positioned as a deviant behaviour. The presence of the obese body is taken as evidence of engagement in unhealthy (deviant) behaviours. From this perspective, adopting behaviors knowingly dangerous to your health is considered not only immoral but also irresponsible. Some advocates of the ‘risky behaviour frame’ imply that becoming fat is a violation of an individual’s civic duty not to burden the health system or society with health costs that could have been prevented (Saguy and Riley 2005). Other advocates of the risky behavior frame talk about obesity in particularly moral overtones and are vehemently opposed to ideals held by the fat acceptance movement:

The fat acceptance people . . . . have turned what have been two of the Seven Deadly Sins – sloth and gluttony – into both a right and a badge of honor . . . . That’s a sin in and of itself (Fumento 1997: 130).

Fumento argues elsewhere that such anti-fat sentiments are a healthy and helpful prejudice to have (Saguy & Riley 2005).
To add weight (or some would say insult) to their argument, Saguy and Riley (2005) also note how advocates of the ‘risky behaviour’ frame may also highlight the clustering of overweight and obesity amongst particular ethnic and socioeconomic groups to reinforce preexisting negative stereotypes by providing further ‘evidence’ of cultural, moral and educational deficits amongst these groups.

**Obesity as a knowledge deficit problem**

Aside from choice, cultural preference, or character deficit explanations, there is also the *knowledge deficit* explanation. Lack of education and knowledge are frequently invoked as explanations for adopting unhealthy behaviour. This lack of knowledge may be variously conceptualised as: a general lack of education; specific nutritional ignorance; failure to comprehend the health consequences of excess weight; or, skill deficits (especially in food selection, budgeting, preparation, menu planning and cooking). This knowledge deficit view is evident in the assessment of the situation by one medical doctor (Xavier Pi-Sunyer who runs his own weight-loss clinic in the US), who noted:

> Why does the average American woman gain weight with each pregnancy and end up [after] four kids, fifty pounds heavier? It’s because nobody alerts her to the fact that this may happen and it may not be good for her to end up fifteen to twenty years later fifty pounds heavier (Saguy and Riley 2005: 886).

In other words, the doctor identified the cause of the woman’s weight gain was her lack of knowledge that excess weight is bad for health.

Sometimes, within the ‘individual behaviour’ frame, there is a slant towards a more ‘structural’ view where other factors are recognised as contributing to public misinformation. Misleading food labeling, together with continuing controversies in dietary advice (eg, to eat butter or margarine) are for instance, thought to confuse the public and undermine their knowledge and understanding of good nutrition. Under the ‘individual behaviour’ frame however, once the knowledge deficit is addressed, any failure for this to translate into changes in behaviour, appears to result in advocates reverting back to *cultural preference* or *character deficit* explanations of unhealthy behaviours.

**Summary and discussion**

The ‘individual behaviour’ framing of obesity does not explicitly challenge the notion of the obesity epidemic and supports the notion that excess weight is bad for health. Based on the notion of choice, the ‘individual behavior’ frame suggests that obesity is a consequence
of freely chosen lifestyles. These lifestyles are conceived of as resulting from individual or
cultural preferences (for certain foods, physical activities and leisure pursuits), individual
character traits (such as laziness, lack of motivation or immorality), or knowledge deficits.
A more extreme version of the individual behaviour perspective frames obesity as a ‘risky
behaviour’. This framing of the issue rests on the assumption that those engaging in risky
behaviour choose to do so with the full knowledge and understanding of the adverse health
consequences. In this version of the individual behaviour frame, engaging in risky
behaviour is viewed as both immoral and irresponsible, rather than as a consequence of
knowledge deficits.

**Policy implications and likely sponsors**

Under the ‘individual behaviour’ frame obesity is positioned as a lifestyle choice or a risky
behaviour due to cultural preferences, character flaws or knowledge deficits. To address
knowledge deficits, education and information-based strategies are indicated. Such
strategies are likely to include policies or initiatives focused on nutrition and dietary
education, budgeting and cooking skills. Addressing the issues of cultural preferences or
character flaws might indicate policies to increase motivation, either to lose weight or
maintain a healthy weight, possibly via the provision of information on the health risks of
excess weight. Other incentives could include tax breaks or subsidies for participation in
physical activity, or the use of disincentives, such as increased health insurance premiums
or reduced health cover for those in the unhealthy weight range. The ‘risky behaviour’
framing of obesity may also support a stance that obesity is a form of self harm and
childhood obesity a form of child neglect or abuse, which has further implications for the
‘treatment’ of those affected. Out of the four frames considered in this section, the
‘individual behaviour’ framing of obesity is the frame most likely to contribute to increased
stigmatization of those with excess weight. As noted in Chapter 2, increased stigmatization
leads to increased discrimination. It has also been suggested that the dominance of the
‘individual behaviour’ frame in the US is a key factor behind the increase in weight-based
discrimination (Andreyeva & Puhl et al. 2008).

As noted previously, features of the ‘individual behaviour’ frame were identified by Kwan as
characteristic of the ‘medical’ frame adopted by US government officials from the CDC.
However, these were more common in their framing of the solutions to obesity than the
framing of the causes which acknowledged wider environmental factors. Similarly, Kwan
(2009) also noted some features of the ‘medical’ frame evident in the ‘market choice’ frame
used by the food industry group, the CCF. Although, it appears that the real frame
common the US government officials (and their particular ‘medical’ perspective) and the
food industry group is in fact the ‘individual behaviour’ frame. On the basis of this precedent, we might expect the food industry, as well as drawing on arguments from the ‘epidemic as a myth’ frame, to draw on aspects of the ‘individual behaviour’ frame. Also, based on Kwan’s findings, we might expect the Government to draw on the ‘individual behaviour’ framing of obesity, particularly on the matter of solutions. As suggested by Lang and Rayner (2005) and Lawrence (2004), some groups are more likely to sponsor individualistic frames, as it is “simpler to appeal to consumers to make ‘healthy choices’” than to alter the environment (Lang & Rayner 2005: 313). Such groups include the food and advertising industries and governments of particular ideological persuasions. Furthermore, by placing the blame at the level of the individual, the individual behaviour frame removes the responsibility from industry and governments to address the issue. Because of these factors, we would expect the food and advertising industries, and potentially also the Government at the time of the Inquiry, to be attracted to arguments from the ‘individual behaviour’ frame.

3.3.3 The ‘obesogenic environment’ frame

The ‘obesogenic environment’ frame was identified by Lang and Rayer (2005) as one of a number of model explanations for the obesity epidemic. The concept of an obesogenic (obesity promoting) environment as a driver of the recent increases in obesity is a popular obesity frame within public health circles.

The ‘obesogenic environment’ frame draws on the obesogenic environment model developed by Swinburn and colleagues (1999) to conceptualise obesogenic environments and to identify possible interventions. The model focuses on the links between human physiology and the environment and is based on the notion that humans are predisposed to lay down fat – a physiological function that is no longer necessary in an environment characterised by the abundance of food. Obesity is therefore viewed as a “normal response to an abnormal environment” (Egger & Swinburn 1997: 477).

The obesogenic environment is defined by Swinburn and colleagues as “the sum of the influences that the surroundings, opportunities, or conditions of life have on promoting obesity in individuals or populations” (1999: 564). There are four key aspects of the environment that potentially promote leanness or obesity: the physical; the economic; the political; and, the socio-cultural. Respectively, these refer to: “what is available, what are the costs, what are the rules, and what are the attitudes and beliefs” (Swinburn & Egger et al. 1999: 564). The obesogenic environment model also examines macro and micro settings in relation to the four environmental aspects. Micro settings, for instance, may
include homes, schools, and neighbourhoods as well as festive occasions, while macro sectors include for example, transport systems, health regulatory systems, industries and services. The four aspects of the environment and their relationship to macro and micro settings are described in more detail below.

Physical environment

In discussing the physical environment, or ‘what is available’, the authors identify a number of physical factors impacting on the ‘energy in’ (food consumption) and ‘energy out’ (physical activity) aspects of the population’s energy balance. According to the developers of the obesogenic environment model, the physical aspect of the environment refers not only to:

- the visible world but also less tangible factors such as the availability of training opportunities, nutrition and exercise expertise, technological innovations and information (Swinburn & Egger et al. 1999: 566).

Physical features of the environment that are considered to have an important impact on physical activity include: the availability, accessibility, and safety of public recreation spaces; safe cycle and walk ways; and, cycle stands or showers in workplaces for those who choose active over motorised transport. On the food side of the equation, what is available in the supermarkets, schools, workplaces, vending machines, and other public venues is important. The type of food technology available and the type of information on packaged food are also factors influencing consumption patterns.

Economic environment

Economic aspects of the environment impacting on the energy balance include the costs of food and physical activity. Although Swinburn and colleagues (1999) note that food cost is largely determined by market forces, they suggest that there may be some obesity promoting aspects of the food supply and production process amenable to intervention. In particular, they highlight food production subsidies and food taxation as potential policy areas for promoting healthy diets. They also note, in relation to exercise, that the cost of exercise varies from very little – for basic activities, to much greater costs – for gym memberships, organised sporting activities and elite sports. They suggest that subsidies for physical activity are likely to encourage participation; while the higher costs of other activities (such as skiing) may make them prohibitive, especially for those on low incomes.
At the macro level, the distribution of income in the population therefore has a critical impact on the affordability of healthy eating and opportunities for physical activity.

**Political environment**

Political determinants of obesity include the regulations, policies and institutional rules (formal or informal) impacting on food consumption and physical activity (Swinburn & Egger et al. 1999). These include, at the macro level: national government regulations on the advertising and marketing of food; whether there is a national nutrition policy; policies on food labeling and health claims; nutritional composition requirements of foods; and, rules about the fortification of food. Local government rules and by-laws governing the sale of food in public places, as well as the policies that promote active or passive transport, are also part of the political aspect of the environment. Other similar aspects include urban planning regulations about the placement of parks, recreational centres, fast food outlets, restaurants and supermarkets.

In the school setting, children’s food consumption patterns are affected by rules regarding food industry sponsorship of sports, curriculum materials, foods sold for fund-raising, as well as rules about the food sold in schools via commercial vending machines and the school cafeteria. Similarly, school rules about physical activity and the physical education curriculum impact on the amount and type of exercise taken by children while at school, as well as influencing their preferences and involvement in physical activity outside of school time. The home is also a critical micro setting, where the informal rules of the family (such as those surrounding food purchase and consumption, time allowed in front of television and computer screens), all have impacts on the obesogenicity of the home environment.

The political rules governing what food is sold where, to whom, and on what terms, as well as the urban planning side of the equation, are important in other respects – they influence societal norms and can facilitate behavioural change. For instance, in the tobacco arena, the ‘smoke free environment’ policy in New Zealand, which has banned cigarette smoking in many public places, has facilitated a norm of the social undesirability of smoking (Swinburn & Egger et al. 1999).

**Socio-cultural environment**

Societal norms, attitudes, beliefs, and values, are argued by Swinburn and colleagues (1999) to be the final aspects of the obesogenic environment model worthy of consideration. They argued that collectively, such norms, attitudes and values, constitute a
particular ‘ethos’ or sub-culture for different groups in different settings (for instance, schools, workplaces or neighbourhoods), and these can either be counter productive or supportive of healthy behaviours. Role models and role modelling are also held to be part of the socio-cultural aspect of the environment exerting an important influence on community values. At the macro level, the mass media and marketing sectors exert powerful influences on human behaviour, attitudes and norms:

they directly and indirectly influence society’s attitudes, beliefs, and values. They not only reflect and reinforce the ‘common culture’ but also shape it, particularly through the effects of advertising and marketing (Swinburn & Egger et al. 1999: 567).

Summary and discussion

Under the obesogenic environment frame, based on the assumption that humans are predisposed to lay down fat, obesity is considered as the normal physiological response to the ‘abnormal’ obesogenic environment. Advocates of this model suggest that the causes of the obesity epidemic lie in the obesogenic features of the physical, economic, political and socio-cultural aspects of the environment. These obesogenic features of the environment are held to operate in both micro and macro settings.

Policy implications and likely sponsors

The obesogenic environment model is essentially a multi-causal framing of the obesity problem which does not suggest any one fundamental cause of obesity or any hierarchy of causes. Because of this, there are potentially multiple, and theoretically, equally important solutions to the problem. As such, the model may have wide appeal. For example, one can easily find, in micro and macro settings, obesity promoting aspects of all the four environmental dimensions – physical, socio-cultural, economic and political. Policy proposals relating to economic and political aspects of the obesogenic environment, such as food labelling and marketing and fat or sugar taxes, are much more likely to be opposed by the food industry than policies geared towards addressing the built environment or socio-cultural aspects. Similarly, policies to address other environmental aspects, such as altering the built urban environment to promote active transport, may be more problematic for governments because of the difficulty and cost involved, not to mention possible opposition from other vested interests such as those who benefit from the public’s reliance on motorised transport.
However, the extent to which the obesogenic environment frame aligns with various interests is likely to depend on the definition of the ‘environment’. Some would argue that many of the socio-cultural aspects, such as norms, are in fact individual rather than environmental determinants of obesity. Nonetheless, one would expect that the obesogenic environment model would appeal more to public health advocates than those from the food and advertising industries, simply because overall, it is a systemic rather than individualistic model.

Recent examples of the take up of the concepts articulated by the ‘obesogenic environment’ frame suggests that indeed the model has particular appeal in public health, epidemiology and social science circles. For instance, a recent publication by Dixon and Broom (2007): *The seven deadly sins of obesity: How the modern world is making us fat* articulates seven aspects of the obesogenic environment identified by a team of researchers in Australia from the National Centre for Epidemiology and Population Health in 2003. These were identified as: the commodified environment; the harried environment; the pressured parenting environment; the technological environment; the car-reliant environment; the marketed environment; and, the environment of competing interests (Dixen & Broom 2007). Other references to the obesogenic environment model are also emerging in the health science literature suggesting increasing support in public health circles for Swinburn and colleagues obesogenic environment model – or at least its key themes (Maher & Wilson et al. 2005; Lake & Townshend 2006; Schäfer Elinder & Jansson 2008; Sacks & Swinburn et al. 2009; Kirk & Penney et al. 2010).

### 3.3.4 A ‘structural’ frame

The distribution of obesity along lines of social stratification (socioeconomic status, ethnicity and gender), suggests the need for an alternative explanation of the obesity epidemic, one that is informed by an understanding of the generation of inequalities in health and of underlying social inequalities in general (Friel & Broom 2007). Researchers examining obesity frames do not appear to have identified an overarching ‘structural’ framing of obesity that specifically attempts to explain the inequalities in obesity that characterise the obesity epidemic (although some have described some of the arguments likely to be contained within it). Furthermore, a coherent explanation for inequalities in obesity prevalence does not appear to have been clearly articulated in the public health literature – although a recent attempt (Friel & Broom 2007) has been made. This is surprising given that the discipline of public health has been suggested by some (Beauchamp 1976; Baum 2002; Dorfman & Wallack et al. 2005) as being underpinned by an ethic of *social justice*. It is equally surprising, given that there are a number of theoretical explanations for health
inequalities in general, that these have not been systematically applied to the issue of obesity to shed some light on the matter of its unequal distribution along lines of social stratification.

This section considers some potential explanations for inequalities in obesity (described in Chapter 2) by drawing on what is termed a ‘structural’ explanation of health and health inequalities. This structural explanation is focused on explaining socioeconomic inequalities in obesity, although possible explanations for ethnic and gender differences in obesity are considered briefly at the end of this section.

This section therefore represents an attempt to outline the key features of a ‘structural’ obesity frame which has potential for being drawn upon by advocates from the public health sector (assuming that public health is in fact underpinned by an ethic of social justice). It is important to note however, that the ‘structural’ frame as conceptualised here is not the same as the ‘social justice’ frame identified by Kwan (2009) sponsored by the ‘fat acceptance’ activists at the NAAFA in the US. For example, a key difference is that the ‘structural’ frame conceptualised here accepts that there are important individual and public health consequences attributable to obesity (obesity is bad for individual and population health) and that there are additional policy implications (obesity exacerbates existing inequalities) due to the unequal distribution of obesity.

A structural explanation of health

According to Tesh (1988), a ‘structural’ explanation of health locates the cause of health problems in the social structure (outside of individual control). Specifically, it is argued that it is the structural conditions in which one lives that are the primary determinant of health. The idea that the causes of health lie in the social structure is not new, and can be traced back to Rudolf Virchow in the 1800's, who recognised that underlying the unequal distribution of disease was unequal access to the products of a society (Tesh 1988). Virchow held that many of the sources of disease stemmed from unemployment, lack of education, poverty and political disenfranchisement (Tesh 1988). Engels, around the same time, after documenting the abysmal living conditions of the working class in England, agreed with Virchow that disease was caused by the social conditions in which one lived, although for Engels (who was drawing on the earlier work of Karl Marx) the fundamental cause of the unequal social conditions lay in the capitalist mode of production (Tesh 1988). More recently, Navarro (1983) has argued that poor health can be traced to unequal access to political and economic power. Since this time, a rich history of research documenting socioeconomic inequalities in health has emerged (Cockerham 2007; Dew &
There are a number of theoretical models which have attempted to explain the phenomenon of socioeconomic inequalities in health (Macintyre 1997). Some key explanations were outlined in a 1980 UK Health Department publication, which later became known as the Black Report (Macintyre 1997). In the Black Report, the various explanations of socioeconomic inequalities in health were classified into four ideal types: artefact; natural or social selection; materialist or structural; and, cultural or behavioural. This classification system is presented in Table 13.

**Table 13: Four models to explain socioeconomic inequalities in health**

<table>
<thead>
<tr>
<th>Explanation</th>
<th>“Hard” version</th>
<th>“Soft” version</th>
</tr>
</thead>
<tbody>
<tr>
<td>Artefact</td>
<td>No relation between [social] class &amp; mortality: purely an artefact of measurement</td>
<td>Magnitude of observed [social] class gradients will depend on the measurement of both class &amp; health</td>
</tr>
<tr>
<td>Natural/Social selection</td>
<td>Health determines [social] class position, therefore class gradients are morally neutral &amp; explained ‘away’</td>
<td>Health can contribute to achieved [social] class position &amp; help to explain observed class gradients</td>
</tr>
<tr>
<td>Materialist/Structural</td>
<td>Material, physical conditions of life associated with the [social] class structure are the complete explanation for class gradients in health</td>
<td>Physical &amp; psychosocial features associated with the [social] class structure influence health &amp; contribute to the observed gradients</td>
</tr>
<tr>
<td>Cultural/Behavioural</td>
<td>Health damaging behaviours freely chosen by individuals in different social classes explain away social class gradients</td>
<td>Health damaging behaviours are differentially distributed across social classes &amp; contribute to observed gradients</td>
</tr>
</tbody>
</table>

Source: (Macintyre 1997:727).

As can be seen from Table 13, as well as the four types of explanation for socioeconomic inequalities in health, there are ‘hard’ and ‘soft’ versions of these explanations to illustrate that within each of the four explanations there are a range of perspectives which operate along a continuum. The ‘soft’ and ‘hard’ versions of these explanations reflect the positions found at each end of the continuum. Of particular importance here, is the materialist/structural explanation of health inequalities highlighted in bold. Both the ‘soft’ and ‘hard’ versions reflect key features of the structural explanation of socioeconomic inequalities in health. That is, that the material and physical conditions of life associated with the socioeconomic structure (and according to the ‘soft’ version the psychosocial
features associated with them), either completely or partially explain socioeconomic inequalities in health. Such a view of health inequalities is consistent with Virchow's claim that unequal access to society's products (particularly income, education, employment, political power and social status) explains the unequal distribution of health.

Research informed by the ‘hard’ version of the structuralist explanation of socioeconomic inequalities in health has identified a number of critical ‘structural’ determinants of health. These include: socio-economic position (of origin and current); educational achievement; occupational position; and, income (Davis & Jenkin et al. 2003). Research informed by the 'soft' version of the structural explanation emphasises the importance of differences in social status and social capital and their impacts on health (Islam & Merlo et al. 2006). The structural explanation also, on occasion, draws on the ‘soft’ version of the ‘cultural/behavioural’ explanation of health inequalities (see Table 13), although the differential distribution of various ‘health risk behaviours’ (such as smoking) amongst the socioeconomic strata is viewed as a consequence of socioeconomic constraints (rather than ‘preference’ or ‘choice’), and, as only part of the overall explanation of health inequalities.

A structural explanation of obesity

The structural explanation of health provides a number of plausible explanations for the differential distribution of obesity by socioeconomic position. The unequal distribution of income is one plausible mechanism for explaining socioeconomic patterns in obesity because of its potential impact on diet and physical activity patterns. According to the ‘hard’ version of the structural explanation, income is considered as the key explanatory factor for socio-economic inequalities in health (Macintyre 1997). Under the ‘soft’ version of the structural explanation however, psychosocial and social factors associated with socioeconomic position are considered as key factors producing socioeconomic inequalities in health. Thus, socioeconomic inequalities in obesity may be explained, under the soft version of the structural explanation, as due to psychosocial and social factors associated with socioeconomic position, or, as indicated by the hard version of the structural explanation, they are explained by inequalities in income. These factors, income, and psychosocial and social factors associated with socioeconomic position, are considered below in relation to one of the key contributors to obesity: diet. Structural explanations for other contributors to obesity such as physical activity are not considered here, as the focus of this thesis is on food and nutrition aspects of obesity.
Income and obesity

There are two key discourses linking income and obesity. One of these focuses on income inequality at a societal (or geographic) level, the other focuses on the link between income and socioeconomic differences in dietary patterns. These two discourses are examined below.

**Income inequality at a societal level**

One structural view arises out of the social fact that health inequalities, such as lower life expectancy, higher homicide rates and lower self-rated health, are associated with income inequalities in a given country (Wilkinson 2005; Wilkinson & Pickett 2009). In this view, it is argued that countries with the greatest income inequalities tend also to have the greatest health inequalities (Wilkinson & Pickett 2009). This theory also suggests that increases in income inequality within a country will result in corresponding increases in health inequalities. Although there have not been many studies examining the relationship between income inequality and obesity, two studies have revealed some interesting patterns.

The MONICA study (which analysed data from twenty-six countries) reported that, as rates of obesity have increased the socioeconomic gradient in obesity has become steeper (Molarius & Seidell et al. 2000). Another study by Pickett et al (2005), exploring the relationship between income inequality and obesity in twenty-one countries, revealed that the degree of income inequality within a country was positively correlated with the percentage of obese adults (Pickett & Kelly et al. 2005). The researchers’ explanation for this finding, was that obesity may be a consequence of the *psychosocial* impact of living in a more hierarchical society (Pickett & Kelly et al. 2005). The idea that health inequalities are a consequence of the psychosocial impacts of stress due to one’s unfavourable location in the social hierarchy has been developed by Marmot (2004) in *Status Syndrome*. Lang and Rayner (2004: 54) note that this also applies to inequalities in dietary patterns:

> WHO researchers have noted that changes in dietary patterns can be driven not just by rising incomes and affluence but also by the immiseration that accompanies other’s rising wealth.

An alternative explanation of the association between obesity and income inequality may be found in the relationship between income and changing food prices. It has been noted that obesity in ‘developed’ countries was once more common amongst higher
socioeconomic groups (Stearns 1997; McLaren 2007), while now (as noted in Chapter 2) it is more common amongst lower socioeconomic groups. In countries characterised as ‘developing’ however, obesity is more common amongst higher socioeconomic groups (McLaren 2007). One explanation for the historical association of obesity with higher socioeconomic status in ‘developed’ countries and the replication of this pattern in currently ‘developing’ counties, is that it is a consequence of a global ‘nutrition transition’ (McLaren 2007).

The nutrition transition is a term used to describe recent shifts in dietary patterns. Countries undergoing a transition from ‘developing’ to ‘developed’ appear to experience a shift “from a restricted diet to one that is high in saturated fat, sugar and refined foods, and low in fibre” (Lang & Heasman 2004: 54). The WHO has noted that rising incomes in the developed world have led to “an increase in the availability and consumption of energy-dense high-fat diets” (World Health Organization 2003: 18). Thus, a key feature of the food supply of ‘developed’ countries, where the obesity epidemic is more advanced, is the abundance of cheap, processed EDNP foods (and the comparatively high cost of healthy diets). In contrast, in ‘developing’ countries, processed foods are expensive compared to local fare (McLaren 2007). These differences in the food supply (cost and nutritional quality) offer a plausible explanation for the opposite socioeconomic patterns in obesity observed in ‘developing’ and ‘developed’ countries (McLaren 2007).

**Income and dietary patterns within ‘developed’ countries**

According to the WHO, there is ‘convincing’ evidence of a link between the consumption of EDNP foods and obesity (World Health Organization 2003). Research from a number of ‘developed’ countries, where obesity is more prevalent amongst lower socioeconomic groups, has also found that EDNP foods are purchased and consumed more regularly by people of lower socioeconomic status (Cooper & Arber et al. 1999; Hunt & Nichols et al. 2000; Henderson & Gregory et al. 2002; Turrell & Hewitt et al. 2002; Power 2005; McLaren 2007), and that the diets of lower socioeconomic groups are less nutritious than those of higher socioeconomic groups (Giskes & Turrell et al. 2002; Power 2005). Lower socioeconomic status adults also typically consume more fat, sugar and processed meat, and eat less vegetables and fruit than their higher socioeconomic counter parts (Irala-Estévez et al. 2000; Trichopoulou 2002). Given that obesity is more prevalent amongst the lower socioeconomic groups, and that there appears to be a link between the type of diets more common amongst lower socioeconomic groups and obesity, this would seem to be a reasonable explanation for socioeconomic differences in obesity. However, these facts appear to be more of an observation than an explanation.
An important explanation for these dietary patterns may be found in the pricing structure of the modern food supply in developed countries. In particular, there is evidence, that nutrient-dense (healthy) foods are more expensive than unhealthy foods in the UK (Davey 2001), the US (Drewnowski & Darmon et al. 2004; Drewnowski 2007) and in New Zealand (Woodham 2009). For example, recent research undertaken by Drewnowski (2004) on food cost in the US revealed that the cost per calorie of unhealthy food was much lower than the cost per calorie of healthy food. In a similar study, ‘diets high in fats and sweets’ were found to:

represent a low-cost option to the consumer, whereas the recommended ‘prudent’ diets [based on vegetables, fruit, whole grains, poultry, and fish] cost more (Drewnowski & Darmon et al. 2004: 1555).

Together, this evidence suggests that one of the reasons for the higher rates of obesity amongst lower socioeconomic groups is that nutritious food is simply too expensive for those on limited incomes. Drewnowski (2004: 154) concluded:

If higher food costs represent both a real and perceived barrier to dietary change, especially for lower-income families, then the ability to adopt healthier diets may have less to do with psychosocial factors, self-efficacy, or readiness to change than with household economic resources and the food environment. Continuing to recommend costly diets to low-income families as a public health measure can only generate frustration and culpability among the poor and less-well educated. Obesity in America is, to a large extent, an economic issue.

In fact, there is research to support the view that, for those on low incomes, price is a critical issue. For instance, one New Zealand report concluded that the cost of food was much higher than what low income households had left available after meeting their basic expenses (New Zealand Network Against Food Poverty 1999). This view is in direct contrast to that proposed by advocates of the ‘individual behaviour’ frame, where ‘choice’ and ‘preference’ trump other explanations (such as price considerations) for consumption patterns.

At the bottom rung of the socioeconomic hierarchy, there is also the link between low income and food insecurity (Clinical Trials Research Unit 2008). Food insecurity “is characterised by anxiety about not having enough food to eat, running out of food, and having no money to purchase more” (Ministry of Health 2003a: 89). Food insecurity is linked to undesirable health outcomes such as obesity, diabetes and micronutrient
deficiencies (Clinical Trials Research Unit 2008). As well, it can result in disordered eating, reduced meal sizes, skipping meals and buying cheaper and nutritionally undesirable foods that may contribute to the development of obesity (Rush & Puniani et al. 2007). That there is a link between food insecurity and obesity has been described as a paradox (Cummins & Macintyre 2006). Cummins and Macintyre explain that this paradox may be due to the “relatively low cost of energy dense foods, the high palatability of sweets and fats associated with higher energy intakes, and the association of lower incomes and food insecurity with lower intakes of fruit and vegetables” (Cummins & Macintyre 2006: 100).

So far, structural explanations emphasising income differences at the societal level, and some of those operating at the social level have been examined. However, there are other factors embedded in the social environment worthy of consideration.

Other structural constraints embedded in the social and cultural milieu

Other valid explanations of socioeconomic patterns in obesity can be found in the differing social milieu of the various socioeconomic groups. As well as income restraints, lower socioeconomic groups live in a social milieu that is more often characterised by unfavourable living and working conditions. Many of these conditions are detrimental to health in general, and likely to be conducive to poorer diets and other factors promoting obesity. Critser (2003: 111) has been particularly sensitive to the lived realities of disadvantaged groups that put them at a higher risk for obesity:

The poor, after all, lead lives that are more episodic than those of the more affluent. They are more likely to experience disruptions in health care, interruptions in income. Food, and the ability to buy it, comes in similar episodes – periods of feeling flush, periods of being on the brink of an empty pantry. The impulse is to eat for today, tomorrow being a tentative proposition at best . . . . There is another factor driving the [Washington] D.C. poor toward obesity as well, one rarely talked about in public health circles, let alone in the mainstream media. It is what might be called the pain of poverty.

As well, an increasing body of research has emerged documenting social and cultural influences on diet that could be linked to underlying socioeconomic position. For instance, more deprived neighbourhoods may be more obesogenic in their local availability of food. Some researchers have examined the existence of ‘food deserts’ (areas with limited access to healthy food) in more deprived areas (Alwitt & Donley 1997; Lang & Caraher 1998), while others have examined greater access to healthy foods in more affluent neighbourhoods (Morland & Wing et al. 2002; Baker & Schootman et al. 2006; Giles-Corti
This research has suggested access to unhealthy foods, in particular the number of retail fast food outlets, is greater in more deprived neighbourhoods in the US (Burdette & Whitaker 2004), the UK (Cummins & McKay et al. 2005), Australia (Reidpath & Burns et al. 2002) and New Zealand (Pearce & Blakely et al. 2007; Woodham 2009).

Poorer people may also be more exposed to unhealthy food marketing (Lobstein & Dibb 2005) – a factor that has been linked to increased obesity amongst television viewers (Coon & Tucker 2002; McGinnis & Gootman et al. 2006). Television viewing, a major factor in exposure to unhealthy food marketing, may be one of the few viable forms of entertainment for those constrained by lack of resources.

On the matter of employment, there are also considerable socioeconomic differences in employment contexts. Those from lower socioeconomic backgrounds are more likely to be concentrated in ‘shift work’ positions and casualised occupations. These are less likely than the professions or government service positions to offer workplace environments and policies conducive to health promoting behaviours. Furthermore, the autonomy in particular occupations for employees to leave their workplaces to seek healthy food (or engage in physical activity) is unlikely to be available to many of those in low paid employment. Thus, opportunities for healthy living are constrained or enhanced depending on one’s position in the occupational hierarchy.

A structural explanation for ethnic and gender inequalities in obesity

As noted at the beginning of this section, with the exception of some work by Friel and Broom (2007) a coherent model for explaining inequalities in obesity is not evident in the public health literature. There is however, a substantial body of health inequalities literature which has examined various explanations of socioeconomic inequalities in health which can be applied to the issue of obesity as has been demonstrated. Yet, given the high prevalence of obesity amongst particular ethnic groups in New Zealand, and the higher prevalence of obesity amongst women (in developed countries), the structural explanation of socioeconomic inequalities in obesity may be insufficient for explaining gender and ethnic differences in obesity. Of particular importance from a structural perspective, when examining such inequalities, are power and status differences in society, for instance the social status of women relative to men, and of disenfranchised ethnic groups relative to the dominant ethnic group. These power differences may operate, through a variety of mechanisms such as racism or sexism (and their interaction with socioeconomic status), in a somewhat circular system reproducing the same unequal
social structure that gave rise to them. This section considers what a structural framing of health may offer as a way of explaining ethnic and gender inequalities in obesity.

**Ethnic inequalities in obesity**

In New Zealand, ethnic inequalities in health are not limited to obesity but extend to almost all other health outcomes (Ministry of Health 2007). According to McCreanor (2008), contemporary explanations for ethnic inequalities (in New Zealand), have so far be dominated by arguments from the ‘individual behaviour’ frame (which generally imply a cultural deficit explanation of the situation). However, one potential explanation for ethnic inequalities in health is racism.

**Racism**

Racism has been conceptualised by Jones (2000) as operating at three levels: institutional; interpersonal (personally mediated); and, internalised. *Institutionalised racism* has been defined as:

> differential access to the goods, services, and opportunities of society by race. Institutionalized racism is normative, sometimes legalised, and often manifests as inherited disadvantage. It is structural, having been codified in our institutions of custom, practice, and law, so there need not be an identifiable perpetrator (Jones 2000: 1212).

Interpersonal racism has been defined as prejudice and discrimination, where prejudice means “differential assumptions about the abilities, motives, and intentions according to their race”, and discrimination means “differential actions toward others according to their race” (Jones 2000: 1212-1213). Interpersonal racism may or may not be intentional and can include “acts of commission as well as acts of omission” which may result in lack of respect, inferior service, avoidance, suspicion, devaluation and dehumanisation (Jones 2000: 1213).

*Internalised racism* has been defined as “acceptance by members of the stigmatised races of negative messages about their own abilities or intrinsic worth” (Jones 2000: 1213). Internalised racism manifests itself in many ways, including:

> an embracing of whiteness (the use of hair straighteners and bleaching creams, stratification by skin tone within communities of colour . . . ); self devaluation (racial slurs as nicknames, rejection of ancestral culture, and fratricide); and resignation, helplessness, and hopelessness (dropping out
of school, failing to vote, and engaging in risky health practises) (Jones 2000: 1213).

There are many avenues though which the various forms of racism can impact on social and economic outcomes including health. Krieger (2003: 196) has suggested that racism can impact on health though five key pathways:

1. Economic and social deprivation.
2. Exposure to hazardous substances and conditions.
3. Socially inflicted trauma (mental, verbal, physical or sexual abuse).
4. Targeted marketing of commodities that can harm health such as junk food and psychoactive substances (alcohol and tobacco).
5. Inadequate health care.

The above list may not be exhaustive, but it does provide some indication of the potential links between racism and health. However, in terms of explaining ethnic differences in obesity, some of these pathways (pathways 1, 2, and 4) appear more plausible than others (pathways 3 and 5). For instance, that racism, particularly institutional racism, has impacts on the socioeconomic position of minority ethnic groups (pathway 1) has been noted by Jones (2000: 1212):

> it is because of institutionalized racism that there is an association between socioeconomic status and race in this country [the US].

While other forms of racism are also likely to exacerbate the association between low socioeconomic status and ethnicity (as racism operates as a mechanism for social and economic exclusion), New Zealand researchers have also suggested that institutional racism is a particularly powerful explanation of *ethnic differences in socioeconomic position* (Harris & Tobias *et al.* 2006; Harris & Tobias *et al.* 2006). For Māori in particular, British colonisation (and the consequent confiscation of lands and suppression of Māori language, culture and power) is a clear example of institutionalised racism producing Māori disadvantage in almost all aspects of social and economic life. In New Zealand, Māori (in comparison with non-Māori) have: lower levels of home ownership and income producing assets (Te Puni Kokiri 2000); lower levels of education (Smith and Simon 2002; Hattie 2003); and, are over-represented amongst lower income occupations (Davis & Jenkin *et al.* 2003), in unemployment figures (Robson 2004) and living in poverty (Easton & Ballantyne 2002). Māori also have lower overall living standards than non-Māori and are more likely to experience: financial problems; accommodation problems; and, lack essential items for children’s social wellbeing (Krishnan & Jensen *et al.* 2002). McCreanor has argued that many of the inequalities experienced by Māori are a result “at least in part, of political and
bureaucratic practises established in the colonisation of the country by Britain” (McCreanor 2008: 85). This has been argued by others who have suggested that Māori over-representation amongst lower socioeconomic groups is a consequence of colonisation (Reid & Robson et al. 2000; Robson 2004; Ministry of Social Development 2005).

The second pathway between racism and health, ethnic differences in exposure to hazardous substances and conditions, is also a plausible explanation for a number of ethnic inequalities in health. In relation to obesity, although there is a paucity of empirical evidence, it is possible that the neighbourhood, home and work environments of Māori are more obesogenic than those of their European counterparts. The association between ethnicity and numerous social and economic indicators – the Pacific population is also disadvantaged across the spectrum of socioeconomic indicators (Easton & Ballantyne 2002; Ministry of Social Development 2005) – means that the contribution of obesity promoting factors previously outlined (such as income and other structural constraints embedded in the social milieu), are even more salient for explaining ethnic inequalities in obesity.

It is also feasible that racism has effects on obesity via the targeted marketing of unhealthy food, the fourth pathway. While there does not appear to be any published evidence revealing ethnic specific targeting of unhealthy food in New Zealand, there has been some US-based research into marketing practises which has revealed that ethnic specific targeting does occur (Schor 2004).

The other two pathways between racism and health identified by Krieger (2003), socially inflicted trauma and access to quality health care, may also impact on obesity, although in a less obvious ways. New Zealand research has revealed ethnic differences in health care treatment for the same conditions (Tukuitonga & Bindman 2002), and research suggests that minority ethnic groups in New Zealand also suffer a greater proportion of socially inflicted trauma (Harris et al. 2006a; 2006b). While socially inflicted trauma may not be linked to obesity in any direct way, it adds to the other social and economic stresses already suffered disproportionately by minority ethnic groups. In turn, this is likely to put factors such as healthy eating further down the list of priorities for action for some groups. Racial discrimination in health care treatment may also impact on obesity by reducing opportunities for early intervention. As well, the under-representation of minority ethnic groups in the health workforce is probably linked to ethnic disparities in health care and health outcomes.
To date however, research investigating the impacts of various forms of racism on health is in its infancy. While we have some understanding of the impacts of colonisation (a key form of institutional racism) on a range of social and economic outcomes for Māori, we know less about other forms of institutional racism that impact on Pacific populations as well. There is some recent New Zealand evidence which has shown that experience of interpersonal racism is higher amongst Māori (Māori were almost ten times more likely than Europeans to report experiencing racial discrimination in the form of verbal attacks, unfair treatment by health professionals, at work or in seeking accommodation), and that this discrimination was associated with poorer health outcomes (Harris et al. 2006a; Harris et al. 2006b). However, research into internalised racism and its impacts on health appears to be non-existent. Understanding the health effects of internalised racism may provide essential insights into this important mechanism for maintaining or reproducing inequalities in health.

It has been argued here, that the various forms of racism offer some potential for explaining some of the observed ethnic differences in obesity. However, internationally, the issue of ethnic differences in obesity is much more complex than the New Zealand picture suggests. For instance, rates of obesity amongst Tongans in Tonga are amongst the highest in the world and these can not be attributed to racism (Aranceta & Moreno et al. 2009). Racism therefore, offers only one potential explanation for ethnic differences in obesity. Other factors may be more important determinants of ethnic differences in obesity. These factors might include differences in the food supply, cultural patterns of consumption and physical activity, and for migrants the degree of assimilation into the dominant culture. The issue is certainly a complex one and further research is needed to elucidate the determinants of obesity amongst different ethnic groups in different countries around the world.

**Gender inequalities in obesity**

As noted in Chapter 2, in ‘developed’ countries obesity is more common amongst women, and in New Zealand, as with many other high income countries, is more prevalent amongst (non-Māori) women from lower socioeconomic groups. The same pattern has been observed in Australia (Friel & Broom 2007). Little is known as to why this pattern exists as there is a paucity of research in this area. Friel and Broom noted from their examination of the relationship between socioeconomic position, gender and obesity that the socioeconomic gradients in obesity vary according to the measure of socioeconomic position:
Women with low education levels and low income are clearly more liable to be obese, but this inverse relationship is less consistent for occupational status... indicators of inequality in obesity among men show a similar pattern to women for education, and a broadly inverse relationship for occupational status (Friel & Broom 2007: 160-161).

Clearly more research is needed to understand how gender interacts with socioeconomic position to produce variations in obesity. For instance it would be useful to know whether these women are in employment or not, whether they are single or living in a partnership, and their parental status. This would provide useful information on the economic status of these women which is necessarily to determine whether their obesity is caused in part by their low income, or other factors. For instance, sole parents and women on welfare may be particularly at risk of obesity because of the dynamics between low income and the high cost of healthy food and other living expenses.

Alternatively, given the cultural ideal of female thinness, the gendered nature of body politics (in high income countries) and their detrimental impact on women (Wolf 1991; Bordo 1993), it is possible that obese women are discriminated against in a way that it not experienced by obese men (sexist weight-based discrimination). This may lead to reduced employment opportunities for obese women as well as reduced marriage and partnership opportunities – both important factors linked to women’s economic position. These scenarios suggest that, rather than low socioeconomic status being a cause of obesity (for women of low socioeconomic status), it may be a consequence of obesity related discrimination. It is also possible that sexism (and its patriarchal roots) operates in ways similar to racism (at the institutional, interpersonal and internalised level) to discriminate against women. Yet such explanations are at this stage speculative, and further research into the relationship between gender, socioeconomic status and obesity is needed.

**Summary and discussion**

The structural explanation outlined above is primarily concerned with explaining the unequal distribution of obesity between and within countries. It suggests that the distribution of obesity along lines of social stratification is a result of unequal access to society’s valued resources – be they economic, social or political. In terms of explaining obesity, the structural explanation emphasises income as a critical structuring influence – both at the societal level and the socioeconomic group level, via its impact on dietary patterns. It is also plausible that physical activity patterns are similarly influenced by income, although this explanation for the socioeconomic gradient in obesity was not examined here. On the influence of income on dietary patterns, the structural frame
suggests that, in developed countries, the low cost of EDNP food (and the relative high cost of healthy food) is likely to be a major contributor to obesity amongst lower socioeconomic groups. Other factors embedded in the social and cultural milieu of lower socioeconomic groups are also likely to limit health promoting opportunities that are likely to be protective against obesity (such as unfavourable living and working conditions).

A structural frame also holds promise for helping to understand the higher rates of obesity amongst Māori and Pacific populations who are over-represented amongst lower socioeconomic groups. However, explaining ethnic inequalities in health may also require a consideration of racism and the consequent discrimination. For Māori in particular, colonisation as been identified as a key form of institutional racism contributing to Māori over representation amongst lower socioeconomic groups. Other forms of racism may also adversely impact on the health of Māori and Pacific groups as well, particularly through greater exposure to obesogenic environments and possibly though ethnic specific targeting of unhealthy food. Gender inequalities in obesity and their structural determinants also need to be considered. However, while there are a number of potential explanations for ethnic and gender differences in obesity, the paucity of research in this area means that potential explanations are yet to be empirically tested.

**Policy implications and likely sponsors**

The structural perspective locates the *cause* of the ‘problem’ of ‘inequalities in obesity’ in the unequal distribution of valued social, economic and political resources. From this perspective, reducing socioeconomic differences in obesity (as with other health risk factors) requires addressing the structural conditions that give rise to these factors. The policy implications of a structural frame of obesity suggests that the required policy responses should be those that promote a more equal distribution of valued resources, particularly income.

National taxation policies are the most obvious mechanism for redistributing income from higher to lower socioeconomic groups. Other mechanisms for redistributing income include death duties and capital gains taxes. Policies which address unequal access to other valued resources, such as education, good housing and safe neighbourhoods, especially for those currently disadvantaged (for instance, Māori, Pacific and lower socioeconomic groups), would also assist in creating a more equal society. A structural perspective also indicates policies to address racism (in all its forms), promote political equality and policies to facilitate greater political participation of disadvantaged groups.
At the same time, policies limiting access to unhealthy foods while at the same time promoting greater access to healthy affordable foods for disadvantaged groups are indicated. Factors which influence the supply of healthy food, in particular its price, but also the many other factors from farm to plate (ownership of food production, manufacturing, marketing and distribution methods and arrangements), also offer critical areas for policy intervention.

Any programme of policies promoting income redistribution from the wealthy to the poor, is likely to be opposed by those who have the most to lose. Thus, a structural explanation of the obesity epidemic is unlikely to receive support from the rich and powerful. Furthermore, ‘Big Food’ in particular is unlikely to support a structuralist examination of food supply influences, because of its potential for highlighting the extent of their profit and control of the market and other commercially sensitive issues. Policies emanating from a structural perspective are however, very likely to appeal to a number of public health advocates. The focus on reducing income and other socioeconomic inequalities is likely to be viewed as having numerous other public health benefits.

Summary of Chapter 3

This chapter has examined framing theory and the relevant literature on obesity frames. It examined Bacchi’s problem representation approach to understanding policy problems. Key features of problem representation highlighted by Bacchi included: the overall description of the problem; the type of problem; who is affected by the problem; the identified causes; and, the implicit or explicit solutions to the problem.

Research on obesity frames by Lawrence (2004), Saguy and Riley (2005), Kwan (2009) and Lang and Rayner (2005) was also reviewed. These authors identified a number of different obesity frames adopted by different interest groups. Key concepts useful for understanding framing identified by these authors were: the notion of attribution of blame as a critical element of a frame; and in terms of assessing a frame’s effectiveness: public health risk dimensions of framing; rhetorical skill; credibility of claimants; and, frame resonance. The framing matrix used by Kwan (2009) was also outlined.

Based on the literature reviewed, there are four key frames likely to be drawn upon by the industry or public health sectors. While three of these frames were evident from the literature on obesity framing, the fourth ‘structural’ frame was developed from the health inequalities literature. It was suggested that two of these frames – the ‘epidemic as a myth’, and the ‘individual behaviour’ frames – contained arguments most likely to support
the interests of the food and advertising industries. It was also suggested, that the second two frames – the ‘structural’ frame and the ‘obesogenic environment’ frame – appeared to have more appeal to public health advocates. The key difference between the latter two frames is the emphasis on inequalities in obesity under the structural frame, and the environmental focus of the obesogenic environment frame where there are multiple causes with no particular emphasis on one dimension of the ‘environment’.

The frame or frames likely to be supported by the Government are less clear. One possibility, judging from the results reported by Kwan (2009), and suggestions made by Lang and Rayner (2005), if individualistic ideological leanings were dominant in the Labour-led Government at the time of the Inquiry, we might expect it to support the ‘individual behaviour’ frame – at least on the issue of solutions.
Chapter 4: Methods and methodology

This chapter describes the methods and methodology used in this thesis. It opens by providing some contextual background to the overall aim of this research (section 4.1). This necessarily involves outlining the specific focus of this thesis – on food and nutrition related aspects of obesity – and the rationale behind this. I then outline my own stance adopted in this research.

In section 4.2, the specific research questions driving this thesis are revisited and the definitions used in this thesis are outlined. The data sources, the data collection process and the methods for identifying the key industry and public health submitters are described in section 4.3.

The case study methodological approach used in this research is covered in section 4.4. This involves outlining the components of case study research design including a description of the framing matrix used to code and analyse the data in this thesis and the rationale behind its development.
4.1 Research aim and focus

As noted in the introduction, the general aim of this thesis is to explore industry and public health framing of obesity in the context of food and nutrition policy in New Zealand. This means there is an explicit focus in this thesis on obesity within the context of food and nutrition policy. Other policy areas relevant to obesity, such as physical activity, ‘treatment’ options for obesity, and health service and workforce issues, are therefore outside the boundaries of this case study. There are two reasons for this focus.

One of these reasons was practical. It was simply outside the scope of this study to consider all policy issues relating to obesity. A more important reason however, was that unlike the food and advertising industry sector, there were no equivalent industry interests from other sectors opposing the public health agenda. For instance, in the domain of physical activity, fuel companies clearly have a vested interest in maintaining or promoting motorised transport – an interest that might reasonably be expected to clash with a public health agenda to promote physical activity through active transport. Yet, no such (commercial) interest group appeared before the Inquiry. This does not mean that there are no vested interests behind the physical activity side of the obesity issue, but they are not obvious and their views do not appear to be articulated or even covered in media discourses around the obesity issue. In the area of treatment options for obesity, other groups such as the pharmaceutical and weight-loss industries have been identified by some fat acceptance researchers as having vested interests in the obesity epidemic. However, with the exception of two submissions from individual bariatric surgeons, there was no representation in the Inquiry from the weight loss and pharmaceutical industries. Furthermore, the interests of the latter groups do not necessarily oppose the public health agenda to address obesity. Hence, the focus in this thesis is on food and nutrition policy and some of the key players therein.

4.1.1 The stance adopted in this research

I agree with McKinlay and Marceau (2000) that all research, including public health research, is not value free or neutral. They note for instance, that all scientists:

make basic assumptions about the nature of social life, the reasons for individual behaviours, what is an acceptable research approach, who is a legitimate source of research support, where it is appropriate to publish results, and so forth. While these assumptions are often unstated and taken for granted, they strongly influence what is actually studied and direct the way research is conducted, the sources of data, the means of their
Furthermore, I agree with McKinlay and Marceau (2000) that claims of objectivity in research are themselves a reflection of an ideological position.

In the interests of transparency, it is important to outline my particular stance as a researcher. It has been suggested by Bourdieu and Wacquant (1992) that there are three potential biases that may affect a researcher’s perspective: the researcher’s academic field; their intellectual bias; and, the social origins of the researcher. These issues are addressed below, together with some other factors potentially influencing the stance taken in this research.

**Academic field and intellectual bias**

I have worked and studied for a number of years in the field of public health. My disciplinary background prior to this was sociology. This thesis is however, situated within the academic discipline of public health. As such, it draws on the fundamental principles underpinning public health. These are described below.

The discipline of public health has been defined as:

> the science and art of preventing disease, prolonging life, and promoting health through the organised efforts of society (Acheson 1988:1).

One feature of the above definition of public health is the emphasis on prevention rather than treatment (Baum 2002). Another feature of public health, not captured by the above definition, is that it takes a population approach to health, rather than the individual approach taken in medicine. This approach recognises that determinants of a population’s health are not usually the same as individual determinants of health (Baum 2002). This means that, in the discipline of public health, public policy is an important focus for improving the health of populations.

Baum (2002:531) also notes that the term public health is “associated with values of equity, public provision of services and a social structural understanding of the determinants of health.” Public health is also underpinned by an ethos of social justice. Also, as outlined in Chapter 2, Beauchamp notes that the focus of public health should be on controlling statistical manipulation, and any action that is recommended (McKinlay & Marceau 2000:66-67).
hazards rather than behaviours, prevention rather than treatment, collective action and responsibility for health and a fair sharing of the burdens and benefits of health and health risks (Beauchamp 1976).

Social background

My perspective is also likely to be influenced by my social background. My social class of origin, based on my father’s occupation as a carpenter, would be described as working class. However, my mother was middle class and from a family of professionals. My schooling and my upbringing I believe are more aligned to middle class values and aspirations. I am also female and Pākehā (of European descent), and I am a solo parent.

Some researchers examining obesity issues have suggested the weight status of the researcher has some bearing on their perspective on obesity. Saguy and Riley (2005) have noted how ‘fat acceptance’ researchers can easily be discredited if they are known to be fat. Others have argued that there is also a bias that stems from being slim or ultra slim (Campos 2004). My BMI is 25, which puts me just in the category of overweight, and I have in the past had a BMI much higher than this. I have also had close family members affected by obesity – although, given the current global obesity epidemic – this situation is hardly unusual.

My particular view on the causes and framing of obesity may in part be informed by features of my social background outlined above. However, it is also informed by my particular public health perspective and leanings toward structural explanations for health, together with the evidence that obesity is distributed along lines of social stratification.

Other influences

Other factors that may have some bearing on the stance and methods adopted in this thesis are the funding source for this research, and the timing of my enrolment in the doctoral programme. During the course of this research I also worked for short periods for the Ministry of Health. These potential influences are considered next.

Funding

This research was funded by a scholarship from the Health Sponsorship Council of New Zealand. The scholarship itself, which was advertised though the University of Otago, was
accompanied by a research brief noting that the funding was earmarked for a doctoral dissertation into policy related aspects of obesity.

My interest in applying for the scholarship was twofold. In the first instance, I wanted to work or study in the Public Health Department of the Wellington School of Medicine because of their expertise and focus in health inequalities research – a focus that had informed my previous public health research when living in Christchurch. Secondly, I was interested in policy research, in particular: what policy is; who makes it; how it is made; what influences policy; and most importantly; how can we influence policy to improve public health?

Although the brief for the scholarship provided a general subject area, the specific research topic chosen was ultimately my own decision – the funder of this work had no direct input into the research question or the design of this research.

Timing of this research

Within weeks of my arrival in Wellington to begin my doctoral research into obesity related policy, my supervisor alerted me to the fact that the Inquiry was about to begin. The Inquiry struck me as a unique opportunity from which to begin my investigations into obesity, food and nutrition policy. Thus, the real world situation influenced my choice of research question as well as the sources of data for this investigation.

Work for the Ministry of Health

During my doctoral study, I deferred from my enrolment for two months to work for the Ministry of Health as a Senior Policy Analyst in the Public Health Directorate. I worked with the HEHA team responsible for much of the Government’s national obesity strategy. As I was required to abide by the public service code of conduct, which prohibits public servants from publically criticising policy they have been involved in developing, I had an agreement that I would not be working on issues related to the Inquiry. The work I undertook was in relation to the preparation of a project to develop national guidelines, for use by health professionals, for the treatment and management of obesity and overweight. This was largely administrative work, and I did not have any input into the results of this guidelines project. My contract ceased before the consultation process began.

At another time I also worked part-time on contract to the Ministry of Health. This work involved the application of two nutrient profiling models to food advertised on television (to
assess their suitability for differentiating healthy from unhealthy foods). The work resulted in two publications (Jenkin & Hermanson et al. 2007; Jenkin & Wilson et al. 2009).

My work for the Ministry of Health on these occasions gave me some insights into the policy processes that I otherwise would not have had. In particular, this experience revealed to me the considerable bureaucracy involved in a government ministry and how this lengthens the policy process. It also became evident how small the HEHA policy team was, considering the objectives of this national obesity strategy.

It could be argued that my time spent working for the Ministry of Health is a potential source of bias. However, apart from alerting me to some of the realities of policy making I do not think that this experience, and the insights gained, impact on the forthcoming analyses. This is because this thesis research involved documenting frames and measuring the extent to which these were reflected in a government stance, rather than critiquing government policy.

4.2 Research questions and definitions

4.2.1 Research questions

The specific research questions underpinning this investigation, also noted in Chapter 1, are repeated here. They were:

1. How do industry and public health groups frame the issue of obesity?
2. To what extent are these frames evident in the New Zealand Government’s declared stance on food and nutrition policies?

To answer the first question, this thesis documents and describes, using a framing matrix developed for this purpose (outlined in section 4.4), the industry and public health obesity frames evident from written and oral submissions to the Inquiry. To answer the second question, this thesis examines, how closely these frames match, or are reflected in, the Government’s official stance on food and nutrition policies as documented in the Government Response to the Inquiry into Obesity and Type 2 Diabetes 2007 (New Zealand Government 2007).

There is a critical qualification that needs to be made here, and this is, that in assessing the extent to which the industry and public health frames are evident in the Government’s stance, the purpose is not to determine whether there is a causal association with one or
either of these frames causing the Government’s stance. As noted in Chapter 3, there are numerous influences on policy making, many of which are likely to be operating simultaneously alongside framing, and these other influences are not examined in this thesis.

Addressing the research questions posed in this thesis requires some clear definitions, of industry and public health groups, and of what is meant by food and nutrition policies. These definitions are outlined below (further information on the specific criteria for the inclusion of public health and industry submitters is given in section 4.3.6).

4.2.2 Definition of industry

There are two related industries of interest in this thesis: the food industry and the marketing industry. The term food industry is used in this thesis in a wide sense. It covers:

- individual commercially operated companies involved in the manufacture or sale of food or food stuffs and beverages, and
- food industry associations representing commercially operated companies.

The term marketing industry is used in this thesis in a much wider sense, and refers not only to the commercial marketing and related communications sectors, but also to advertisers, commercial broadcasters and their industry associations. In this thesis, where the term industry is used on its own, it refers to both the food and marketing industries combined.

4.2.3 Definition of public health sector

The public health sector comprised of public health groups and the public health oriented independent advisors to the Health Select Committee. For the purpose of this thesis, public health submitters were required to be:

- an independent advisor to the committee or
- a health oriented national level non-government organisation (NGO) or a health oriented national level professional association with a public health focus (and not focused on breastfeeding or physical activity).
It was important that the public health submitters were not from the government sector as employees of such agencies, for a number of reasons, may not be able to freely criticise current government policy. That is, as groups from the government sector are directly funded and controlled by the government via the Ministry of Health, they have less independence to speak out than groups not solely funded or controlled by the government.

Nonetheless, it is recognised that, as some health NGOs receive some of their funding from the government via the Ministry of Health, and as many of the health groups (including professional associations) are likely to want to remain included in the food and nutrition policy network, such groups may be somewhat more measured in their criticisms of government policy than they would be if they were entirely independent from government or its agencies. This is one of the reasons for the inclusion, with the public health groups, of the three public health oriented independent advisors selected by the Health Select Committee. The views of these independent advisors are noted separately in the forthcoming analysis of the framing of obesity by the public health sector. Public health groups and individual submitters focused solely on breastfeeding or physical activity were also excluded as these topics are outside the focus of this investigation. The term public health sector is used in the forthcoming analyses as an umbrella term covering both the public health groups and the independent advisors.

### 4.2.4 Definition of public policy

Public policy in this thesis is conceived of in broad terms as not just what governments do, but also what they do not do. More specifically, public policy is defined in this thesis as:

- a system of laws, regulatory measures, courses of action [or inaction], and funding priorities concerning a given topic (Kilpatrick 2009).

There is also a focus in this thesis on policy at the national level. Policies unique to the various local government authorities and other individual regional organisations are not explored, unless there is an overarching national directive or scope for one. This means for example, that individual school policies are not explored, but a direction from government to all schools to implement a particular policy is. This focus on national policy is justifiable because the centralised nature of government in New Zealand means that most options relating to food and nutrition policy (food and marketing regulation, food labelling, food pricing and taxation) are in the hands of the national level of government, rather than other levels such as local authority councils.
Definition of food and nutrition policy

Food and nutrition policy options covered in this thesis are limited to those that have been discussed by the industry and public health submitters; with the exception that breastfeeding of infants was an area of policy deemed to be beyond the scope of this thesis. The remaining food and nutrition policy options covered include the following:

- the national obesity strategy (HEHA) at the time of the Inquiry
- legislation and regulatory options
- broader social and economic issues
- proposed Bills and legislation – specifically the proposed Public Health Bill and the proposed trans-Tasman Nutrition, Health and Related Claims legislation (outlined in Chapter 2)
- marketing, advertising and promotion of food and beverages including sponsorship
- food supply issues – food composition, labelling, availability, accessibility and price
- public information and education on food, nutrition and obesity
- school environments – curriculum and food policies.

Clearly the above list is not exhaustive, but these policy issues represent those that were identified as critical to either the industry or public health sectors, or both.

4.3 Data sources and data collection

This section describes the data sources for this thesis and the access to them. It also details the methods for identifying and selecting the industry and public health submitters – the two groups of interest in this investigation.

There were five sources of data for this thesis. These were:

1. The industry and public health (non-government) written submissions to the Inquiry.
2. The industry and public health oral submissions.
3. Direct observations of the Inquiry hearings and informal conversations in the corridors of Parliament (‘corridor conversations’).
4. Documentary data on the submitters.
5. The subsequent official reports of the Inquiry: Inquiry into Obesity and Type 2 Diabetes in New Zealand: Report of the Health Committee (Health Committee
Other sources that may have also answered the research questions were not used for a variety of reasons. These possible sources include: additional information requested by the committee from submitters and government agencies; media statements by the major players; other documentary sources outside the Inquiry process; and, interviews of the key players from the industry and public health sectors, the committee members, and government officials. However, due to the size of the dataset and the quality of information provided in the submissions, in terms of the depth of information and its scope, these additional sources of data were not necessary to answer the research questions posed in this thesis. Furthermore, this thesis is concerned only with obtaining the official stances of the key groups involved, so various individual perspectives on obesity, food and nutrition policy are outside the scope of this investigation.

4.3.1 Ethics process

As all the data used in this thesis were publically available, no formal ethical approval was required.

4.3.2 The written submissions

By convention, the written submissions to a public select committee inquiry are publically available though the Parliamentary Library at the close of the inquiry. However, in the case of the Inquiry into obesity, the staff of the committee made the written submissions available to the public when the submitters presented their oral submission. Thus, like other members of the public attending the Inquiry, I had access to many of the written submissions incrementally as the hearings proceeded. The remainder of the written submissions (those where the submitter did not provide an oral submission), were obtained at the close of the Inquiry, upon request to the staff of the committee.

As noted in Chapter 2, a total of 313 written submissions were received by the committee (Health Committee 2007:38). These submissions ranged in size, from one to more than two-hundred pages (including appendices).
4.3.3 The oral submissions

As noted in Chapter 2, of the 313 submitters, 142 attended the Inquiry to give oral submissions. All of the twenty public hearings (of 142 oral submissions) were attended in person. Permission to digitally record the proceedings from the Inquiry was obtained after a request to do so was approved by one of the committee clerks (who obtained permission from the Chair of the Health Select Committee). With the exception of the very first public session—the evidence presented to the committee by the Ministry of Health—the nineteen remaining public sessions were recorded (the digital recorder had not been purchased in time for the first session).

Transcribing of oral submissions

The digital recordings, after being transferred to a computer and copied onto compact disc, were couriered to a private transcribing agency, and the completed transcripts were returned some weeks later via email. The transcripts of the oral submissions were checked against the original recordings for accuracy and minor editing modifications were made where necessary.

Where possible, while checking the accuracy of the transcripts, the names of the speakers were incorporated into the transcripts. Most of the speakers, particularly the committee members, were generally readily identifiable by myself—as I was familiar with their voices having attended all of the public hearings.

The names and details of the submitters giving oral evidence (there were frequently several individuals appearing before the committee for a single submission) were recorded wherever possible, although on some occasions these were inaudible due to background noise. In such instances, in the results chapters, the submitters are simply referred to as representative, followed by the name of the organisation presenting the submission. There were also instances (2-3 times during each of the 20 public sessions) where it was not possible to hear exactly what was said, due either to excessive background noise (people entering and leaving the venue where the Inquiry was being held), or a number of people talking at once. These instances are noted in the excerpts used in the results chapters simply by a question mark in parentheses (?). Despite the missing data the recordings still proved to provide a rich source of data.
4.3.4 Direct observation of the Inquiry and informal ‘corridor conversations’ during the Inquiry

While observing the hearings during the course of the Inquiry, I sat in the public area alongside other interested members of the public and submitters waiting to be called upon to give evidence. Although I took some notes during the hearings, these were mainly to record the submitters names in cases where many submitters were present, and to note when select committee members were absent from the hearings.

Prior to the hearings, while waiting in the corridors with submitters and other interested parties, I was involved in a number of informal conversations. During these ‘corridor conversations’ I usually introduced myself (to representatives from various NGO organisations), and explained the nature and purpose of my research. These conversations assisted me to get an overview of the policy community, the issues for various players, and the history of various organisations (at least from their point of view). There was no equivalent opportunity to speak to representatives from the industry sector prior to the public hearings simply because they did not linger in the corridors.

One of the advantages of attending the Inquiry in person was being able to observe the informal communication occurring. For instance, I was able to observe the body language, the shoulder shrugs, the eyebrow raising and other facial expressions, and the attempts to contain laughter or mask disbelief – all of which provided rich contextual information about the various interests and issues at hand. It was not possible to record these aspects of the Inquiry while observing them at the same time, but they enhanced my understanding of the politics involved between the various interest groups and the committee members nonetheless.

4.3.5 Documentary data on the submitters

Additional background information on the submitters was obtained from organisation websites and organisation publications.
4.3.6 The official reports

The Health Select Committee report

The Health Select Committee report of the Inquiry was obtained from the Parliamentary website. As noted in Chapter 2, select committee reports are prepared by the committee staff, although the actual recommendations are decided by the committee members (G. Hill, personal communication, August, 2008).

The report writing process involved the presentation to the committee members of a series of ‘issue’ papers drafted by the staff of the committee (G. Hill, personal communication, August, 2008). The committee members then negotiated these issues and the resulting recommendations, and where necessary, the staff of the committee redrafted the issues papers and recommendations (G. Hill, personal communication, August, 2008). These issue papers formed the basis of the final report which itself went through eight or nine drafts (G. Hill, personal communication, August, 2008). By convention, where there are major disagreements between the committee members, a party can put in a dissenting view. The final report contained fifty-five recommendations to Government (agreed to by the majority of the committee), and a separate dissenting view put forward by the four National Party committee members.

The committee did not use its power to send for persons, papers and records in relation to the Inquiry as information requested by them was provided willingly (personal communication, G. Hill, November, 2009).

The Government Response to the committee recommendations

In accordance with Standing Order 253, the Government, on 27 November 2007, presented to the House of Representatives its formal response to the recommendations from the Inquiry. The Response was coordinated and led by the Ministry of Health. It acknowledged the contribution of twenty-four government agencies (New Zealand Government 2007). This official report was also obtained via the internet (from the Parliamentary website).
4.3.6 Criteria and process for the selection of industry and public health submitters

The 313 written submissions were read and sorted into various groups, based on the background information and contact details provided by the submitters. The 259 submitters not meeting the definitions of industry or public health submitters (outlined in sections 4.2.2 and 4.2.3), were automatically excluded from the dataset. These automatically excluded groups of submitters are listed in Appendix E. This left fifty-four potentially eligible submitters. These are listed in Table 14.

Table 14: Potentially eligible industry and public health submitters

<table>
<thead>
<tr>
<th>Sector</th>
<th>Submitter description</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Industry</td>
<td>Food &amp; beverage companies, broadcasters, &amp; industry groups</td>
<td>19</td>
</tr>
<tr>
<td>Public health</td>
<td>National Health NGOs</td>
<td>19</td>
</tr>
<tr>
<td></td>
<td>National Professional Associations</td>
<td>13</td>
</tr>
<tr>
<td></td>
<td>Independent advisors:</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Professor Boyd Swinburn</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Dr Robert Beaglehole</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Professor Jim Mann</td>
<td></td>
</tr>
</tbody>
</table>

|                  | Total                                                      | 54     |

The above fifty-four submissions were further scrutinised on the basis of the content of the submission and the relevant documentary data, to determine eligibility for inclusion in the final dataset.

For industry submitters, the submission itself had to meet the following criterion:

- the submission contained sufficient data to assess framing (at the very least identified causes of, or solutions to obesity).

For public health submitters, the submitters also had to meet the following criteria for inclusion in the analysis:

- their submission contained sufficient data to assess framing (at the very least identified causes of, or solutions to obesity), and
- the submission was on the public health aspects of food and nutrition policy and obesity (as opposed to other issues such as workforce shortages or the treatment of obesity and related comorbidities), and
• the submitter was not funded by the food or marketing industries.

The process of applying the abovementioned selection criteria involved a number of steps. This process is described below, beginning with the food and marketing industries.

Food and marketing industries

In total, nineteen industry submitters were identified as commercially run companies or industry associations. Two of these were excluded from the final dataset on the basis that their submissions contained insufficient information to assess framing (the Green Monkey – a small manufacturer of organic baby food, and the New Zealand Infant Formula Marketers – which was focused solely on the issue of breastfeeding versus the use of infant formula). The seventeen remaining industry submitters included in the final dataset are listed in Table 15.

Table 15: Industry submitters included (and type of submission)

<table>
<thead>
<tr>
<th>Company or organisation name</th>
<th>Written</th>
<th>Oral</th>
</tr>
</thead>
<tbody>
<tr>
<td>Association of New Zealand Advertisers</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Advertising Standards Authority</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Beer, Wine and Spirits Council of New Zealand</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Communications Agencies’ Association of New Zealand</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>CanWest Television</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Confectionery Manufacturers of Australasia</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Coca-Cola Amatil New Zealand</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Fonterra</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Food and Grocery Council of New Zealand</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Food Industry Group</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Foodstuffs</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>McDonalds</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>New Zealand Television Broadcasters’ Council</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>New Zealand Sugar</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>New Zealand Retailers’ Association</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Radio Broadcasters’ Association</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Television New Zealand</td>
<td>✓</td>
<td>✓</td>
</tr>
</tbody>
</table>

| Total                                                    | 17      | 10   |

Table 15 shows that ten of the seventeen industry submitters also presented oral evidence (oral submissions) to the committee. Therefore, the final data set for the industry sector comprised of seventeen written submissions (535 pages of data including appendices) and
Public health sector

There were thirty-five potential public health sector submitters, comprising of nineteen national level health oriented NGOs, thirteen professional associations, and the three independent advisors. The three independent advisors: Professor Boyd Swinburn; Dr Robert Beaglehole; and, Professor Jim Mann were automatically included in the final dataset for the public health sector. The remaining thirty-two national health groups (NGOs and professional associations) were further scrutinised and selected for inclusion (i) if the content of their submission contained sufficient data to assess framing, and (ii) if the submission was focused on the public health aspects of obesity, food and nutrition policy.

Fifteen of the national health NGO and professional association submissions were either not focused on the public health aspects of obesity, food and nutrition policy, or contained insufficient information to determine their framing of obesity (these are listed in Appendix F). For example, some of these groups were primarily concerned about workforce and professional training issues or health service delivery, while others were focused on specific health conditions such as diabetes and its complications. Those that focused exclusively on alcohol were also excluded, as their submissions contained insufficient data from which to identify an obesity frame.

This left a total of seventeen health groups potentially representing the national level non-government public health sector. However, information obtained during ‘corridor conversations’ with submitters during the Inquiry, suggested that some of these so-called health groups received considerable funding from the food industry. Such funding could clearly constitute a form of bias that may impact on the group’s framing of the obesity issue, as food industry funding may be accompanied by an expectation of particular loyalties to the food industry, resulting in a biased perspective on food and nutrition issues. Another possibility is that some of these groups may have been established by the food industry (industry front groups) to defend industry interests in the area food and nutrition policy.

This issue was investigated further by collecting additional background information on these groups, such as their sources of funding, most of which was found on the websites of the respective organisations. This exercise confirmed that six submitters were from groups that either received money from, or were funded by, the food industry.
One of the corporate sponsors of the New Zealand Dietetic Association for instance, which represented the interests of registered dieticians and nutritionists in New Zealand, was New Zealand Sugar (one of the industry submitters in the Inquiry). The New Zealand Nutrition Foundation was another organisation suggested by some representatives from the public health oriented NGOs as having food industry funding. This was difficult to confirm until an update of its website in 2009, when the corporate sponsors were publically listed. These sponsors were numerous and included: Cadbury; Coca-Cola; Fonterra Brands; McDonalds; Nestle New Zealand; and, New Zealand Sugar (New Zealand Nutrition Foundation 2010). Because of their food industry funding and because the purpose of this thesis was to identify public health and industry frames and not nuanced frames, the six industry funded health groups were excluded from the final dataset (these groups are listed in Appendix G).

The eleven remaining national level health NGO’s and professional associations (not known to be receiving funding from industry) were eligible for inclusion in the final dataset for the public health sector. They are listed in Table 16 along with the three independent advisors.

Table 16: Public health sector submitters included (and type of submission)

<table>
<thead>
<tr>
<th>Submitter</th>
<th>Written</th>
<th>Oral</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetes New Zealand</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Agencies for Nutrition Action</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>National Heart Foundation of New Zealand</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Cancer Society of New Zealand</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Te Hotu Manawa Māori</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Obesity Action Coalition</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Fight the Obesity Epidemic</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Public Health Association of New Zealand</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>New Zealand Medical Association</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>New Zealand Nurses Organisation</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Australasian Faculty of Public Health Medicine</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Professor Boyd Swinburn</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Professor Jim Mann</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Dr Rob Beaglehole</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Total</td>
<td>14</td>
<td>14</td>
</tr>
</tbody>
</table>

As can be seen from Table 16, the public health sector (as defined for this research) comprised of fourteen submitters. All fourteen of these submitters presented a written and
oral submission. The written submissions totalled 438 pages of data (including appendices), and the transcripts from the oral submissions provided an additional 172 pages of data (total pages for the public health sector n=610). Thus, the size of the total dataset for both industry and public health was 1,270 pages.

4.4 Case study methodology

This thesis draws on the case study methodology. The appropriateness of this methodology for the research question within the context of the Inquiry is outlined below.

4.4.1 The case study approach

A case study, according to Yin (2003:13), is:

an empirical inquiry that investigates a contemporary phenomenon within its real life context, especially when the boundaries between the phenomenon and context are not clearly evident [my emphasis].

This definition is relevant to the situation at hand, in that the Inquiry is a real life situation, and the contemporary phenomenon under investigation, is obesity framing. Furthermore, the boundaries between the context (the Inquiry) and the phenomenon (obesity framing) are also unclear, in that it would be difficult to separate the particular framing of obesity by the submitters from the context of the Inquiry.

Moreover, the case study is the appropriate research strategy for the topic under investigation as it meets the case study criteria set out by Yin (2003:1) in that: (i) the research poses ‘how’ or ‘why’ questions; and, (ii) “the investigator has little control over events”.

4.4.2 Components of the case study research design

Yin (2003:21) suggests that aside from the research question, other important components of a case study research design are:

- its propositions
- its units of analysis
- the logic of linking the data to the propositions, and
- the criteria for interpreting the findings.
Each of these four components of the research design are addressed below.

Propositions

The key proposition underpinning the current research is that the public health and industry submitters presenting at the Inquiry will frame obesity in different ways on the signature features of a frame. The signature features of a frame are outlined in the framing matrix in Table 17.

It was also hypothesised at the end of Chapter 3 that, on the basis of the review of the literature and the likely interests of the public health and industry sectors: (i) industry submitters would be most likely to draw on arguments from the ‘epidemic as a myth’ and the ‘individual behaviour’ frames; and, (ii) submitters from the public health sector would be most likely to use arguments from the ‘obesogenic environment’ and the ‘structural’ frames. Although there was some indication from the literature that the stance taken by a government on the matter of obesity is likely to depend in part upon its ideological position – with neo-liberal governments more likely to use arguments from an ‘individual behaviour’ frame – no specific hypothesis was suggested for the Government’s response. The ideological position of the Labour-led Government at the time of the Inquiry could not be clearly determined.

Units of analysis

This case study is best described as an embedded case study. This embedded case study, for the purpose of addressing the first research question (how do industry and public health sectors frame the issue of obesity?), has two main units of analysis. These are the obesity frames evident in the public health and industry submissions (see Figure 6).

Figure 6: Embedded case study design to address first research question
Addressing the second research question (to what extent did these frames influence the New Zealand Government’s declared stance on food and nutrition policies?), requires an additional unit of analysis (the committee framing of obesity), and an additional unit of analysis in another context (the framing of obesity by the Government in the context of the committee recommendations). This is because the Government framing of obesity was a response to the committee recommendations, and not a direct response to the submitters in the Inquiry. This means that any apparent ‘influence’ of the industry and public health frames on the Government Response was essentially mediated by the Health Select Committee. A pictorial representation of the case study design for addressing the second research question is given in Figure 7.

![Figure 7: Case study design to address second research question](image)

Link between the data and propositions: the framing matrix

The logic linking the data to the propositions was facilitated by the use of a framing matrix for identifying the signature features of the obesity frames. This framing matrix and its application to the submissions and the official documents from the Inquiry is described below.

Drawing on Bacchi’s (1999) problem representation approach, the framing schema used by Kwan (2009), and the knowledge gained from the literature on obesity framing, a framing matrix was developed. This framing matrix was applied to the four key obesity frames (outlined in Chapter 3) to assess its validity for identifying signature features of frames. This framing matrix was developed further and modified in an iterative process as it was
repeatedly applied to the data from this case study (the submissions and the two official reports). The final framing matrix is depicted in Table 17.

**Table 17: The framing matrix**

<table>
<thead>
<tr>
<th>Signature features</th>
<th>Key aspects</th>
<th>Prompts</th>
</tr>
</thead>
</table>
| **Problem representation** | Overall description | How is the issue described – what words or terms are used?  
What is the emphasis? |
|                     | Type of problem | Why is the issue a problem?  
What type of problem is it – health, social, economic or moral problem? |
|                     | Affected groups | Who the issue is a problem for – obese, overweight, normal or underweight?  
Is it an individual, specific community or whole population problem?  
Are gender, ethnicity & socioeconomic dimensions mentioned?  
Who is excluded from or not affected by the problem?  
What arguments are provided to support the claims? |
| **Causes** | General causes | What general causes are mentioned or acknowledged?  
Is there any hierarchy to the causes identified?  
What arguments are provided to support the claims? |
| | Main cause | What is identified as the main cause?  
Is the cause environmental or individual?  
Is there any additional focus or emphasis in the discussion of causes?  
What arguments are provided to support the claims?  
Who is blame for the problem? |
| | Non-causes | What are dismissed as causes or identified as non-causes?  
What arguments are provided to support the claims? |
| **Solutions** | Perspectives on the existing policy environment at the time of the Inquiry | What are the perspectives on the existing policy environment?  
Do they support change or the status quo?  
What issues are included and excluded?  
What arguments are provided to support the claims? |
| | Additional policy prescriptions | What additional solutions are proposed?  
Who is responsible?  
What issues are included and excluded?  
Do they suggest targeted or universal policies?  
What arguments are provided to support the claims? |
| | Non-solutions | What solutions are opposed?  
What arguments are provided to support the claims? |
Drawing on Bacchi’s problem representation approach, the first column in Table 17 contains the three signature features of the framing matrix: the problem representation; the causes; and, the solutions. The column on the far right lists prompts which are essentially questions to assist in identifying the critical data needed to adequately describe framing. These prompts are partly informed by the literature on obesity framing and partly derived from repeated applications of the matrix to the data.

Some aspects of this matrix are recognisable from those used in Kwan’s (2009) analysis of obesity frames from three US organisations (as outlined in Chapter 3). For example, the framing matrix here includes most of the ‘reasoning devices’ (or arguments) from Kwan’s matrix (the position, the causal roots and the consequences), although ‘core values’ were not examined as these proved too difficult to determine in an objective manner. The ‘framing devices’ used in Kwan’s framing matrix (metaphors, exemplars, catchphrases, and depictions of opponents and allies), were not explicitly included in the framing matrix outlined above, as they were not frequently found to feature in the submissions or the two official documents arising from the Inquiry. However, where these framing devices were clearly evident in the documents, they are mentioned in the results chapters.

In the second column of Table 17, the signature features have been sub-divided further into key aspects. Noteworthy key aspects of problem representation are, according to Bacchi: the overall description of the problem; the type of problem; and, who is affected by the problem. The overall description of the problem is also equivalent to Kwan’s concept of ‘position’, and includes the words used to describe the issue, and the emphasis, if any. The type of problem is also similar to Kwan’s concept of ‘position’, and includes whether the problem is framed in moral, health, economic or social terms. The final aspect of problem representation, who is affected by the problem, is a new feature which was absent from Kwan’s framing matrix but considered important according to both Bacchi (1999) and Lawrence (2004) for identifying blame and therefore accountability.

On the matter of the second signature feature of the matrix in Table 17, the causes, it became apparent upon repeated applications of an earlier version of the matrix to the data, that there were several levels of causes worthy of documenting. Therefore, this signature feature of the framing matrix was subdivided into three key aspects to reflect varying levels of emphasis in the data. These are: the general level causes; the main cause (or causes); and, non-causes – factors explicitly noted by some submitters as not causing the problem.
A similar distinction was also evident on the final signature feature of the framing matrix, the proposed solutions. Here it was found that submitters not only proposed solutions but also identified policy options to which they were opposed. As well, there was considerable discussion by submitters on the existing food and nutrition policy situation. Therefore, the three key aspects of: perspectives on the existing policy environment at the time of the Inquiry; additional policy prescriptions; and, non-solutions (explicitly identified), were incorporated into the matrix to reflect this distinction in the data.

Data analysis: applying the framing matrix to the data

The analytic steps involved in applying the framing matrix to the submissions involved:

1. Reading the submissions.
2. Noting what the individual submitters had to say on the various aspects of the framing matrix.
3. For each aspect of the framing matrix, looking for common themes and arguments, exploring the range of perspectives, identifying areas of agreement or disagreement, noting what was emphasised, down played or ignored, and noting any exceptions to the general rules.
4. For each aspect of the framing matrix, constantly comparing what submitters had to say (for both public health and industry groups).
5. Comparing the public health and the industry submissions (as groups) and re-reading the submissions again to check what themes (particularly policy options) were absent or included in the submissions.
6. At each stage, checking the adequacy of the framing matrix in relation to the findings and iteratively adding and modifying the matrix prompts.
7. From the themes that emerged in the above steps, organising the key themes by emphasis and importance given to them by the submitters for each key aspect of the signature features of the framing matrix.

Criteria for interpreting the findings

The final component of the case study research design are the criteria for interpreting the findings. In other words, how similar or different do the frames need to be, to be considered a match or mismatch, and how will this be determined?
In relation to the first research question (how do the industry and public health sectors frame the issue of obesity?), the results could show that:

1. The industry and public health frames are indistinguishable from each other.
2. The industry and public health frames are sufficiently different.
3. Some aspects of industry and public health framing are similar and others are different.

The first of the above scenarios was very unlikely, given what is known about the different interests of the two groups. The second and third scenarios were more plausible. The degree of match between the frames sponsored by industry and public health can be assessed by examining each sector’s respective arguments on the signature features of the framing matrix.

In addressing the second research question (to what extent were these frames evident in the New Zealand Government’s declared stance on food and nutrition policies?), several possibilities were considered. If the results of the first research question revealed that the industry and public health frames were sufficiently different (and there is every reason to think they would be), a comparison of the signature features of the industry and public health frames with those evident in the Government Response should reveal which frame is most closely aligned with the Government’s position. This raises the question of how closely does one frame have to resemble another frame to be considered a match? If the signature features of either the industry or the public health frames are sufficiently similar to those evident in the Government Response, then it is relatively simple to interpret this finding as a match. However, it is more complex if the results show a mixed pattern. That is, if the Government’s stance reflects a mix of both industry and public health frames. If this is the case then additional questions need to be addressed, such as:

- do the frames have to be similar on all signature features?
- or are some signature features more important than others?

If the results reveal a mixed pattern, one possible way of determining which frame was more evident in the Government’s stance would be to focus on the solutions agreed to by the Government. This is because, regardless of differences in problem representation and the identification of the causes, it is likely that ultimately, it is the actions taken by the government as ‘solutions’ to the problem that reveal where the Government’s true position lies. These issues are revisited in Chapter 8.
4.4.3 Criteria for judging the quality of research design

A final aspect of the research methodology not so far discussed, are the criteria for judging the quality of the research design. A generic system for assessing the quality of the research typically includes an assessment of four criteria (Bryman 2008). These are:

- construct validity
- internal validity
- external validity
- reliability (Bryman 2008).

The criteria listed above are applied to the research conducted in this thesis and discussed in detail in the Chapter 8.

As well as the four generic criteria for assessing the quality of the research design, there are additional factors suggested by Yin (2003) specific to assessing the rigour of a case study. These are also discussed in Chapter 8, and they include: the significance and completeness of the case study; the need to consider alternative perspectives; and, the use of sufficient evidence.

Summary of Chapter 4

This chapter has re-examined the research questions underpinning this thesis, noted the specific focus on food and nutrition aspects of obesity, and described the philosophical stance informing this investigation. Key definitions of industry, the public health sector and public policy were outlined. The data sources and the data collection process were also described, paying particular attention to the criteria and process for selecting the key industry and public health sector submitters included in the final dataset for analysis. This chapter has also described the methodology of the case study research design and outlined the framing matrix used to code and analyse the data and the rationale behind it. The key criteria for evaluating the research design, and the case study design in particular, were also noted. These criteria are revisited and further discussed in Chapter 8.
Chapter 5: Results I: Industry framing of obesity

This chapter examines the way that obesity was framed by the food and marketing industries. An overview of the industry submitters and the relationships between them is provided in section 5.1.

The industry framing of obesity is examined in sections 5.2-5.4. The examination of the problem representation in section 5.2 explores industry’s stance on the three aspects of the framing matrix: (i) the overall description of the problem; (ii) the type of problem (why the issue of obesity is a problem); and, (iii) the affected groups (those identified as affected by the problem). In section 5.3, consistent with the framing matrix outlined in Chapter 4, the causes identified by industry submitters are organised under the key aspects: (i) the general causes; (ii) the main causes; and, (iii) the non-causes (explicitly identified). The examination of the solutions identified by industry (section 5.4) is presented under the three key aspects: (i) perspectives on the existing policy environment at the time of the Inquiry; (ii) additional policy prescriptions; and, (iii) non-solutions. All these sections are further organised under italicised subheadings indicating the key themes.

Throughout this chapter the frames themselves are not critically examined or discussed, so as not to interrupt the flow of the arguments. The substantive discussion is presented in Chapter 8.
5.1 Industry submitters

The submitters from the *food* industry comprised of five individual companies (manufacturers and retailers) and five industry associations. The submitters from the *marketing* industry were predominantly from industry groups (five submissions), with the exception of two submitters from individual television broadcasting companies. The relationship between the industry submitters is shown in Figure 8.

![Diagram of Industry Submitters](image)

Submitters in bold type indicate the industry associations.

NZ = New Zealand.

**Figure 8: Submissions from industry**

At the top of Figure 8 is the Food Industry Group (FIG), an industry association representing the combined interests of its members from the *food* and *marketing* industries. With the exception of the Advertising Standards Authority, *all* the industry submitters were members of the FIG (although CanWest Media Television and Television New Zealand...
were linked to the FIG *indirectly* via their membership of the New Zealand Television Broadcasters’ Council. The two industry sectors, *food* (depicted on the left), and *marketing* (depicted on the right), are therefore linked together by their membership in the FIG.

The *food* industry submitters were all members of the Food and Grocery Council of New Zealand. Three of these submitters were industry associations and five were individual companies (four of which were trans-national in that they conduct business across countries).

The *marketing* industry submitters were all members of the Advertising Standard’s Authority – the industry body responsible for the self-regulation of advertising in New Zealand. With the exception of the two television broadcasting companies, these submitters were industry associations.

The two television companies, Canwest MediaWorks (CMW) and Television New Zealand (TVNZ), were the two main free-to-air television broadcasters in New Zealand covering the four main free-to-air television channels: TV1 and TV2 (TVNZ); and, TV3 and C4 (CMW). At the time of the Inquiry, CMW was a privately owned television company and TVNZ was a State Owned Enterprise. As noted in Chapter 2, since State Owned Enterprises are required to run as commercial businesses (returning profits to the State), TVNZ was classified as an industry submitter.

To put the industry framing of obesity in context, it is useful at this point to outline the relevant background information on the critical submitter *groups* (background information on individual companies – Coca-Cola Amatil NZ, McDonalds, Fonterra, NZ Sugar, and Foodstuffs – is provided in the forthcoming text where necessary). This background information draws mainly on self-described information provided to the committee by the industry submitters, supplemented with (self-described) information sourced from industry websites. Where information is from other sources, it is referenced.

### 5.1.1 Background of key submitters

This section provides contextual background information on the industry *groups*. Note, that further groups could be of interest to an exploration of industry framing of obesity, but are excluded as they were not submitters.
Food Industry Group

Formed at the end of 2005 (Food Industry Group 2009), the FIG was perhaps one of the most crucial submitters in this sector. This is both because the FIG was the official representative of all other food and marketing industry submitters, and because many industry submitters explicitly stated their support for the views represented in the FIG submission (the Food and Grocery Council, the Beer Wine and Spirits Council, New Zealand Sugar, Coca-Cola, and the Communications Agencies’ Association of New Zealand). For instance, the Communications Agencies’ Association of New Zealand, in its brief one page submission, stated that “the views of the FIG represent the views of CAANZ” (CAANZ s250:1).

The FIG claimed to be a ‘unique world leading partnership’ between the New Zealand industry and the New Zealand Government, and a signatory to the national obesity strategy HEHA (FIG s157). The FIG described its organisation as a “coalition of the food, manufacturing, and marketing community, their communication partners and the media” (Bree, FIG transcript). The stated role of the FIG was “to act as the coordinator of industry self-regulation” (Food Industry Group 2009). The FIG was funded by member levies amounting to NZ$200 000 per annum (Food Industry Group 2006: 24).

The main initiative arising out of the FIG was the Food Industry Accord (the ‘Accord’), launched in September 2004. The Accord was essentially an agreement between a number of food industry groups and advertisers who “acknowledged that obesity was a major issue in New Zealand” and “wanted to find ways to contribute to the overall solution” (Food Industry Group 2009). Signatories to the Accord agreed to its mission “to do all that is possible to encourage all sectors of the food industry to create commercially successful products and services that will make a positive contribution to the health of New Zealanders” (Food Industry Group 2005: 4).

Numerous submitters in the Inquiry referred to the Accord and the various initiatives arising from it, as it was relevant to the third Term of Reference for the Inquiry, which sought comment on voluntary initiatives by the food industry to address obesity.

Food and Grocery Council of New Zealand

A critical player in the food industry sector was the Food and Grocery Council of New Zealand (FGC) – an industry group representing forty-seven member organisations (FGC s163). The FGC claimed that its major food and beverage manufacturers supplied over
95% of processed food and beverages to the grocery and retail industry (FGC s163). As an industry association, the FGC described its role as both a forum for this sector and a lobby group which makes representations to Government and other relevant organisations on matters of interest to the industry (Food and Grocery Council 2008). Some submitters from the food industry highlighted their support for the FGC submission (BWSC s139; NZ Sugar s84).

**Beer Wine and Spirits Council of New Zealand**

The Beer Wine and Spirits Council of New Zealand (BWSC) represented the non-competing interests of two leading beer companies in New Zealand, Lion Nathan and DB Breweries Ltd (BWSC s139). According the BWSC, these two companies comprised the majority of the New Zealand beer market and had “significant interests in other sectors of the drinks market” (BWSC s139:1). One of the stated goals of the the BWSC was to support the “minimisation of harm to the community through the promotion of a moderate and responsible drinking culture” (BWSC s139:1).

**Confectionery Manufacturers of Australasia**

Another industry group was the Confectionery Manufacturers of Australasia (CMA) – a group representing the Australian and New Zealand confectionery industry. At the time of the Inquiry, the CMA represented nineteen New Zealand manufacturing companies (including for example, Cadbury, Cookie Time, Nestle, Nice and Natural, Wrigley Co etc), with annual retail sales of over NZ$400 million (CMA s252:7). The CMA noted that the confectionery industry was a major consumer of domestic agricultural raw materials, especially dairy (CMA s252). The stated objectives of the CMA were “to assist confectionery manufacturers in areas dealing with health perceptions, government and public affairs, regulatory issues, technical services, training, market development, member services and environmental matters” (CMA s252:3).

**New Zealand Retailers’ Association**

The New Zealand Retailers’ Association (NZRA) claimed to be the largest trade association in the country and a retail industry lobby group (New Zealand Retailers' Association 2009). Its members included: major supermarket and general merchandise chains; specialised chains; department stores; and, thousands of owner operators (NZRA s7). According to the NZRA, the retail food sector had sales in excess of NZ$14 billion and employed “some 60,000 people in more than 10,000 outlets” (NZRA s7:2). These outlets also included four
major oil companies which were noted by the NZRA to be increasingly offering food in their stores (NZRA s7). According to its website, the NZRA assisted members by “providing retail advice, member benefit savings, industry information, education and [was] the main retail industry lobby group to Government” (New Zealand Retailers’ Association 2009).

**Advertising Standards Authority**

A critical player in the marketing industry sector was the industry-funded Advertising Standards Authority (ASA) – the New Zealand self-regulatory body responsible for “regulating the content of advertisements across all media” (ASA s31:2). All submitters from the marketing industry were members of the ASA. As many submitters discussed the ASA self-regulatory system in detail, it is important here to provide a brief overview of the system to place some of the forthcoming discussions in context.

Formed in 1973, the stated role of the ASA was “to regulate advertising of products and services as permitted by law, including the right to freedom of information under the New Zealand Bill of Rights Act 1990” (ASA s31:2). Drawing on the International Chamber of Commerce Code of Advertising Practice, the ASA developed the Advertising Codes of Practice, providing the rules by which all advertisements in all media should comply. These include the Code of Ethics and twelve specialised codes. Two of these codes – the Code of Advertising to Children and the Code of Advertising of Food – are of particular relevance to the Inquiry. These two codes were under review at the time of the Inquiry and due for release in March 2006 (shortly after the hearings began). This review involved a consultation process that sought submissions from stakeholders and members of the public (ASA s31).

Under the ASA system at the time of the Inquiry, members of the public could complain (at no cost) about any advertisement in any media that they believed breached the Codes. The complaints were then heard by the Advertising Standards Complaints’ Board (funded and resourced by the ASA), and there was a right of appeal to the Advertising Standards Complaints’ Appeal Board. Both boards were claimed by the ASA to be ‘independent’ (of industry) with public member majorities. In the event of a complaint being upheld, the advertiser, agency and media were requested to withdraw the advertisement immediately. These decisions were documented and publicly available.

A Cabinet Minute in 1992 formally set out the arrangement between the Government and the ASA, in which the ASA was the authorised body to regulate advertising (ASA s31). The
ASA was monitored by the Commerce Commission and was required to report to the relevant government ministries (ASA s31).

**Association of New Zealand Advertisers**

The Association of New Zealand Advertisers (ANZA) claimed to provide New Zealand advertisers with “a collective voice in dealing with government, media, advertising agencies and other agencies integral to the advertising industry” (ANZA s158:1). Its mission statement includes a number of objectives, one of which is “to promote and advocate for an industry environment of free and legitimate commercial communication guided by industry self-regulation” (Association of New Zealand Advertisers 2009).

ANZA had 101 members from industry, services and government organisations. Its food and beverage sector members included: Cadbury Confectionery; Caltex New Zealand; Mobil Oil New Zealand; BP Oil New Zealand; Shell Oil New Zealand; Coca-Cola Oceania Ltd; McDonalds Restaurants (NZ Ltd); Griffin’s Foods; Kelloggs; Fonterra Brands (NZ) Ltd; Tip Top Ice cream Co Ltd; Nestle New Zealand Ltd; Progressive Enterprises Ltd; Restaurant Brands NZ Ltd; Sanitarium Health Food Co; and, The Warehouse (ANZA s158:1). ANZA claimed that the advertising expenditure of its members accounted “for the majority of National Brand Advertising including 70 percent of expenditure on television advertising” (ANZA s158:1).

**Communication Agencies’ Association of New Zealand**

The Communication Agencies’ Association of New Zealand (CAANZ) represented the interests of sixty-five communications and advertising agencies (CAANZ s250:1). These agencies ranged from very small to the large multinationals. Some of their better known corporate members included: Fairfax Media NZ (New Zealand’s largest publishing group, with two national and nine daily newspapers, fifteen magazines, and more than fifty community newspapers); TVNZ; New Zealand Post; Microsoft New Zealand; Neilson Media Research; New Zealand Magazines; Sky TV; TV3; Yahoo!Xtra; and, the National Business Review (Communication Agencies’ Association of New Zealand 2009). The stated purpose of CAANZ was “the protection and advancement of its members through lobbying, advocacy and provision of services” (CAANZ s250:1). CAANZ also claimed to work with: the Government; industry leaders; other industry associations; and, the media to represent its members’ interests (CAANZ s250).
Radio Broadcasters’ Association

The Radio Broadcasters’ Association (RBA) represented the non-competing interests of the commercial radio industry to its stakeholders within government, business and the community (RBA s187). Claiming that its membership accounted for approximately 97% of radio advertising revenue in 2005 (NZ$255 million), the RBA noted that radio advertising expenditure on fast food, confectionery, and soft drinks amounted to NZ$5 million, or 2.5% of its total advertising revenue (RBA s187:1). The RBA was funded by member organisations to represent member interests in a variety of ways including: providing advice on industry codes and government issues; representing the industry before the Broadcasting Standards Authority and NZ On Air; providing research to members; and, ‘defending self-regulation’ (Radio Broadcasters’ Association 2009).

New Zealand Television Broadcasters’ Council

The New Zealand Television Broadcasters’ Council (NZTBC) was an industry organisation representing the non-competitive interests of the two national free-to-air television networks (CMW and TVNZ). According to the NZTBC, these two networks accounted for 94% of the annual television advertising revenues of NZ$666 million reported for 2005 (NZTBC s293:2). During the Inquiry, the NZTBC produced a policy on advertising to children (the ‘Five Point Plan’) which is outlined in a document titled: ‘Advertising on television: Getting it right for children’ (New Zealand Television Broadcasters’ Council 2008). This policy document contains information on the ‘agreed’ limits to advertising during designated ‘children’s viewing times’ (as defined by the broadcasters), and highlights the relevant ASA codes that deal with issues such as the advertising of ‘treat’ food to children (the Five Point Plan is described in more detail in Chapter 7).

5.2 Industry problem representation

This section outlines the problem representation aspect of framing by the food and marketing industries. The first section examines industry’s perspective on the three key aspects of the problem representation and includes: the overall description of the problem (section 5.2.1); the type of problem (why obesity was a problem – section 5.2.2); and, those affected by the problem (section 5.2.3).
5.2.1 Overall description

**Obesity as an ‘issue’, a ‘concern’ and a ‘complex’ issue**

The most common overall description of the obesity situation by the food and the marketing industries, was the framing of obesity as a ‘concern’ or an ‘issue’:

- We share the committee’s concern over the growing levels of poor health among parts of our community (FIG s157:5).
- It is recognised that the increasing rates of obesity and type two diabetes is a major concern around the world (FGC s163:1).
- We share the Health Committee’s concern about increasing levels of obesity in New Zealand (McDonalds s192:2)

Some industry groups also framed obesity as a ‘complex’ issue or matter (BWSC s139; NZ Sugar s84; FIG s157; McDonalds s192). McDonalds for instance, noted that:

- because obesity is a complex issue with many contributing factors, it is very difficult to identify and isolate any one factor (McDonalds s192:15).

One interpretation of the ‘complex’ issue description of the obesity problem is that no one factor (whether that is a food, a business or a retail sector) is responsible.

Less frequently, obesity was framed as a ‘challenge’ (CMA s152) and a ‘social problem’ (NZRA s7). One key submitter, the FGC, in its opening presentation to the Inquiry, framed the issue as a ‘debate’:

- We welcome this opportunity to discuss this issue because we believe the food industry has a very important role to play in this debate (Cutress, FGC transcript).

Exactly which aspects of the obesity issue were held to be the subject of debate were not made explicit. However, later comparisons of the public health sector and industry frames revealed that the ‘debate’ was over many factors, including, those affected (obese versus overweight and obese), the causes (individual versus environmental), and, in particular, the solutions (individual versus environmental).

It is noteworthy that the term ‘epidemic’ did not appear in any of the industry submissions. Instead, industry made use of the terms ‘rising’ or ‘increasing’ rates when describing recent
trends in obesity. In summary, industry descriptions of the problem of obesity appeared to have a minimising effect.

5.2.1 Type of problem

*Obesity as a ‘health problem’ and an ‘economic burden to the health system’*

There was generally very little discussion in the industry submissions on why obesity constituted a problem. A couple of industry submitters (ANZA and RBA) noted that they did not have the “necessary technical and medical knowledge” (RBA s187:3) to comment on the health costs or consequences of obesity. Nonetheless, the terms ‘health threat’ and ‘health problem’ were commonly used when referring to the consequences of obesity. In cases where there was some limited discussion of the consequences of obesity, it was generally agreed that obesity was a concern because of the potential economic burden to the health system.

However, the economic burden to the health system was viewed by industry as being largely attributable, not to obesity itself, but to Type 2 diabetes and its complications. Some submitters argued that although obesity and diabetes were associated, the exact causal direction of the association was unknown:

> We accept that there is a correlation but do not possess the knowledge or expertise to comment on whether obesity is a causative factor (ANZA s158:2).

Arguments about the direction of the association between obesity and diabetes were brought up by a number of industry submitters during the Inquiry, and some submitters suggested that weight gain and obesity may be a result of (undiagnosed) diabetes. Such arguments appear to shift the blame away from obesity and on to diabetes. This contrasts with the dominant medical view of weight gain and obesity as risk factors (or essentially causes) for diabetes.

Another industry submitter (NZRA s7) suggested that obesity was a cause of social and socioeconomic problems. This view contrasts with some alternative framings by some of the public health submitters (outlined in Chapter 6) where obesity was seen by many as a consequence of socioeconomic factors.
5.2.2 Affected groups

*Obesity but not overweight is the problem*

The food industry in particular, explicitly separated the concept of overweight from obesity:

> Although the two categories [obesity and overweight] are often grouped together, it is important to appreciate that they are considerably different in scale and risk – which is why the Inquiry’s focus on only obesity is wise (FIG s157:8).

For the food industry, overweight and obesity were two separate issues because the health risks were claimed to be different. Drawing on BMI definitions of obesity and overweight, the FIG (s157:8) argued that while the health risks increase with increasing BMI, the health risks associated with overweight were comparatively low:

> compared with women whose BMI is under 21, those with a BMI of 21 to 23 (not officially overweight) have a 20 percent increase in risk of coronary heart disease, rising to 46% for a BMI of 23-25. For people with a BMI of 25 to 29 (officially overweight) there is a doubling of risk. Obese people are four times more likely than those at the standard BMI to have heart problems and diabetes. So the real concern and focus should be on the increase in people who are obese.

Coca-Cola (s160:4) also supported the position held by the FIG that the health risks of obesity and overweight were different, and was critical of the ‘conflation’ of overweight and obesity by lobby groups and the media:

> We support the Food Industry Group submission’s view that the main focus of this inquiry should be on the increase in people who are obese. We further note that the oversimplification by lobby groups and in media reporting have resulted in overweight and obesity statistics being lumped together, despite the health risks of the two being considerably different.

The FGC (s163:10) also suggested that the associations between weight and health were *more complex* than had been suggested by health advocates:

> Why do some obese children and adults appear to suffer few or no metabolic complications? Why is a moderately active larger person likely to be healthier than a thin sedentary person and why do fat active people have half the mortality rates as thin sedentary people and the same mortality as thin active people?
Implicit in the above quote is the notion that the role of fitness and physical activity in the association between weight and health had have been overlooked.

One industry submitter argued that recent medical advances may alleviate some of the concerns about the health consequences attributed to overweight (FIG s157:8):

According to research by Flegal 2005, although the proportion of overweight people is increasing, it looks like advances in health care are reducing the effect of health problems associated with overweight people.

In summary, the industry’s perspective then, was clearly one that emphasised the obese sub-population as the group most at risk from ill-health, and constituting the biggest potential economic burden to the health system. Those who are overweight, normal weight, and underweight, are not implicated as problematic in the industry framing of the problem. Such framing suggests that the appropriate public health response would be one targeted to the obese population group.

**Obesity as an ethnic problem**

As discussed above, for the industry, the ‘affected’ population is limited to those who are obese. Additionally, although not all of the industry submissions identified particular sub-populations as having a greater risk of obesity, the FIG noted (s157:2) that this group were:

a readily identifiable section of the community, broadly described as the lowest income earners, and predominantly Pacific Islanders and Maori.

Coca-Cola (s160:17) described the obesity issue as a community-wide problem, although again, specific subgroups were singled out:

Coca-Cola is well aware of the increased levels of obesity among the Māori and Pacific Island community.

The RBA (s187:2) was also specific in identifying those most at risk:

there is a strong association between obesity and lower socioeconomic groups and in New Zealand amongst Maori and Pacific families. There is a regrettably strong cross correlation but ethnicity (e.g. genetic makeup, cultural environment) is a significant factor in its own right, pointing to appropriate strategies for targeting. In a small country like New Zealand with limited resources, this seems particularly important since resources to tackle the problem on a ‘whole of population’ basis are unlikely to ever be readily available [my emphasis].
To interpret the above quote, the RBA was suggesting that *ethnicity* was the dominant risk factor for obesity rather than socioeconomic status. The association of obesity with particular ethnic groups was then used to justify, on the basis of limited resources (a principle of *economic rationality*), a targeted approach to the problem (an approach which assumes that a whole of population approach would be a cost to government rather than industry).

The following comment about the association between socioeconomic status and obesity was made by the FIG (s157:8-9):

> It is often said that the poor are obese. But the most quoted research about this actually shows economic status not to be central, but simply a common factor alongside diet, knowledge, habits and norms . . . . Food activists have misused the ‘economic’ status research in combination with the ethnic prevalence in New Zealand to make causal claims about the effect of socioeconomic status. They are forced to make these links because there is no research that explains exactly what behaviours are common to the people in this group who are obese.

In other words, for the FIG, the link between ethnicity and obesity was not due to poverty or economics, but due to the “diet, knowledge, habits and norms” of particular (ethnic) groups. Again, this suggested that an ethnically targeted approach was the most ‘logical’ solution. It also suggests that the solution needs to address the diets, knowledge, habits and norms of particular groups, rather than economic factors. Note also, the food industry’s depiction of their opponents (presumably certain health-oriented NGOs) as ‘food activists’, and the claim that food activists have misinterpreted the data on economic status.

The FGC also defined the ‘at risk’ groups as Pacific and Māori’ and noted (s163:9) that since:

> *people living in deprived areas* have poorer nutrition, face greater health risks and have poorer health outcomes . . . . it is particularly important to focus primarily on the most at risk groups and target interventions accordingly [my emphasis].

In this instance, a principle of *equity* or *social justice* was invoked to justify a targeted response to the obesity epidemic, although the target group in this instance appears to be *those living in deprived areas*.

Another argument for a targeted approach, this time in relation to public health nutrition messages, was made by NZ Sugar (s84:3):
there are many members of the public who are not obese, and who are listening to current messages about certain foods and beverages and making radical dietary change when it is not necessary (e.g. increased development of disordered eating, denying people who need the energy or palatability such as the elderly). We need to therefore ensure that responsible messages are targeted to those who most need to change their behaviour and not take a blanket approach such as legislation/taxation, which would adversely affect many members of the public for whom obesity is not an issue [my emphasis].

The above quote, by emphasising the risk of unintended adverse consequences for vulnerable groups, such as those at risk of disordered eating or the elderly, illustrates yet another industry argument (drawing on the principle of no harm) against a ‘universal’ approach to public health nutrition messages.

Finally, children were another subgroup of the population singled out as a ‘concern’ by some submitters (Fonterra, Foodstuffs and the FIG):

we hold even greater concern for the percentage of young people who are overweight (FIG s157:5).

**Summary of industry problem representation**

In their overall description of the problem, industry submitters predominantly framed obesity as: an ‘issue’; a ‘concern’; and, a ‘complex’ issue. Other terms used included: ‘challenge’; ‘social problem’; and, ‘debate’. There was a notable omission of the term ‘epidemic’, with the terms ‘rising’ or ‘increasing’ rates used instead. Thus, while industry did not explicitly deny the existence of the obesity epidemic, they nonetheless, minimised the significance and scale of the issue.

In describing the type of problem, despite the limited discussion by industry submitters on the health consequences of obesity (another notable omission), there was recognition that obesity constituted a ‘health problem’ (or ‘health threat’). The main concern regarding the consequences of the obesity problem was not the health consequences, but the potential economic burden to the health system. However, the health problems associated with obesity were attributed, by some submitters, to diabetes and its health consequences rather than obesity itself.
In describing those groups most affected by the problem, industry explicitly separated overweight and obesity, arguing that obesity, but not overweight, was the problem. To support this claim, some submitters provided evidence that the health effects were much greater for obese people (as defined by BMI) than for those who are overweight. Other submitters argued that that the association between weight and health was more complex that health advocates would have us believe. Implicit in this argument was that the role of fitness and physical activity had been overlooked. This framing appears to shift the blame for poor health, from excess weight to poor levels of fitness.

Māori and Pacific people were identified by the industry submitters as the groups most likely to be (directly) affected by obesity. Although the industry recognised the association between socioeconomic status (or those earning low incomes) and obesity, it argued that this association was not causal, but merely a common factor alongside ‘diet, knowledge, habits and norms’. Thus, obesity was framed as predominantly an ‘ethnic problem’. Industry then suggested that the appropriate policy response would be a targeted response, and arguments to support this approach drew on the principles of: equity or social justice (many people living in deprived areas also have other adverse health outcomes); economic rationality (would be too costly to take a whole of population approach); and, no harm (whole population approach may have adverse consequences for ‘restrictive eaters’ and the elderly). There was no mention by industry submitters of the gender differences in obesity and overweight. Finally, some industry submitters noted their concern for overweight children. The next section examines the industry framing of the causes of obesity.

5.3 Industry framing of the causes

Many causes of obesity were identified by industry and some were clearly emphasised over others. These causes are examined below under the following subheadings: general causes; the main causes; and, non-causes.

5.3.1 General causes

This section examines two themes that emerged from the industry submissions as general causes of obesity: ‘energy imbalance’ and ‘multiple societal determinants’ (the main causes identified by industry submitters are presented in section 5.3.2).
At the physiological level, industry argued that energy imbalance was the most basic cause of obesity:

Overconsumption of energy from food and drink, if coupled with insufficient physical activity will lead to weight gain (representative, Coca-Cola transcript).

it is about energy in, energy out . . . (Cutress, FGC transcript).

Clearly, with the cause of obesity identified as one of energy imbalance, the logical solution is to achieve energy balance:

There is a need to balance energy intake with appropriate levels of physical activity (Coca-Cola s160:2).

The focus on balance, between energy in and energy out, suggests that it is not only food but compensatory physical activity that is important in the energy equation. This allows for the possibility that food intake need not be reduced in the presence of adequate physical activity. However, the causes of the energy imbalance were described as complex and multiple.

At the societal level, there was recognition that there were multiple determinants of obesity. One advertising association noted that:

there is a vast range of causes or drivers and include people moving away from home, genetics, decrease in the relative cost of food, increase in the relative cost of physical activity, mothers working, formula fed babies and technological changes (ANZA s158:2).

The multiple societal influences for many industry submitters included: affluence; abundance of food; technological change leading to increased sedentary occupations and sedentary leisure pursuits; reliance on motorised transport; and, increased time pressures on families resulting in increased reliance on convenience foods. The view of the FIG on this matter was typical of the industry perspective:
In order to address the problem of increasing BMI it is useful to reflect for a moment on the causes as they have emerged in the last thirty years. Put quite simply we are eating more than we need and exercising less than we need. The affluence of the late twentieth century gave rise to easy access to convenient, popular foods. Increasing technology enabled us to become more sedentary, spend more time in front of our screens, and in our cars, and less time moving about (Bree, FIG transcript).

Thus, for the FIG, affluence was a key factor influencing consumption patterns, and technological change was a key influence on physical activity.

On the issue of increasing affluence (called ‘affluenza’ by the FGC) as a cause of obesity, the FGC noted that:

At one time only the rich could afford to be overweight; now everyone can (FGC s163:1).

On the abundance of food, the FIG listed ‘unrestrained access’ to ‘indulgence’, ‘treat’ or ‘comfort’ foods, and the absence of ‘limiting factors’ as some of the reasons why we are ‘getting heavier’ (Bree, FIG transcript). It was notable that some sectors of the industry (food industry associations and manufacturers) did not describe particular foods as ‘unhealthy’. Instead, these groups used terms that suggested that such foods were luxuries.

Technological change was also seen as a factor impacting on obesity. On the contribution of technology to obesity the FIG argued that:

we became a society which demands everything to be done easily and quickly – from transport to work, to leisure and food preparation (FIG s157:11).

However, the focus in industry submissions when discussing the contribution of technology to obesity, was on its impact on physical activity patterns (rather than aspects of the food supply). The use of technology, as a labour-saving strategy and as an influence on leisure pursuits, was highlighted as a ‘driver’ of obesity (FIG s157:11). Industry cited increases in non-physical work and leisure pursuits (including a move from sports participant to spectator), growth in entertainment sectors, and increased time in front of computer screens and television, as consequences of recent societal technological changes.

Some industry submitters highlighted increased time spent in front of screens, focusing on the use of game consoles and the internet (rather than television) as a consequence of modern technology. The ANZA (s58), for instance, provided data on the use of ‘new
technologies’ implicating the internet, console games, texting, and computer games, as the screen-time leisure pursuits linked to sedentary lifestyles. This emphasis on the contribution of new technologies to obesity, minimises the role of existing technologies, such as television (and by implication television advertising).

Other submitters mentioned the more sedentary nature of contemporary occupations, with the increase in desk jobs combined with reliance on motorised transport, as additional technological changes underpinning sedentary lifestyles and contributing to weight gain.

Although the wider societal forces operating to influence population rates of obesity were acknowledged by the industry submitters, they were not considered to be overwhelming:

The environment offers numerous opportunities and conditions that can lead to excessive energy intakes and sedentary lifestyles. In the same environment however, why does half the population succeed in maintaining a healthy body weight? (FGC s163:10).

Thus, while industry acknowledged the wider societal factors contributing to obesity, it was argued that since half the population manages to maintain a healthy weight, other factors must be responsible for increases in obesity.

5.3.2 Main causes

Overall, industry emphasised ‘obesogenic lifestyles’ as the dominant cause of obesity. These ‘obesogenic lifestyles’ were characterised by overconsumption and lack of physical activity. Overconsumption in particular, was thought to be mainly a result of: poor attitudes; lack of motivation; denial of weight problems; knowledge deficits; and, family influences. Lack of physical activity however, was argued to be the more dominant cause of the energy imbalance. This was thought to be largely driven by technological changes, but the role of some individual factors was noted, including knowledge deficits and family (and school) influences. The evidence for these causal themes is presented below.

Individual behaviours – ‘obesogenic lifestyles’

For industry, the real cause of obesity could be attributed to lifestyle choices made by individuals:

The dominant factors associated with obesity are personal lifestyle factors that are not readily amenable to regulation and restrictions (FGC s163:10).
people are obese because they do not have a balanced diet, they eat too much too often and they do not exercise enough (McDonalds s192:3).

the cause of obesity is simple – personal decisions taken that lead to calorific intake in excess of burn off, thus leading to storage in the form of fat (RBA s187:1).

For industry then, with ‘obesogenic lifestyles’ implicated as the critical underlying determinant of obesity, the solution, as proposed by NZ Sugar (s84:1) was:

to address the overall dietary choices, activity levels, and the underlying lifestyle determinants of these.

Similarly, the NZTBC (s293:3) suggested that:

fundamental changes to the way people eat and exercise are critical to success.

**Overconsumption caused by poor attitudes, lack of motivation, and denial**

Attempts to explain the ‘energy in’ part of the obesity issue were focused on individual explanations for ‘overconsumption’. It is noteworthy that industry’s emphasis was on explaining overconsumption in general and not the consumption of specific (unhealthy) foods.

In general, there was agreement amongst the food industry submitters that attitudes were the driving factor behind overconsumption, not food or its environment (there are parallels with the argument from the gun lobbyists: ‘guns don’t shoot people, people shoot people’; and the alcohol lobbyists: ‘it’s not the drinking it’s how we’re drinking). The following excerpts are illustrative of this point:

The single biggest drivers of over-consumption lie in social and personal attitudes, not in food itself, or communication about it (FIG s157:3).

Research tells us that over-consumption lies in personal and social attitudes, not in food itself (BWSC s139:3).

Operating alongside attitudes, lack of motivation and denial were also suggested as drivers of over-consumption. In particular, the FGC argued that one of the barriers to healthy weight was denial by some people of their overweight status. It cited evidence from a Massey University working paper that found:
underlying the obesity problem is widespread inertia amongst a population that fails to see a problem relating to themselves or their family. There is lack of personal relevance and widespread apathy (FGC s163:8).

The idea that the issue of obesity lacks personal relevance amongst affected groups of the population suggested to some submitters a degree of denial amongst the affected groups. The issue of denial was also raised numerous times by the National Party shadow Minister of Health as he questioned submitters about whether they thought obese people were ‘aware’ of their weight problem. The response by the Executive Director of the FIG to this question was:

It’s a complex area Mr Ryall [National shadow Minister of Health]. Um, I would say that consumers generally are aware that there is a need for change, ah, consumers are aware that overweight is not healthy (?) um, certainly there seems to be a lack of understanding about what constitutes overweight, um, so in working with Counties Manakau [a high deprivation area with a high concentration of Māori and Pacific people] for example, one of the problems that they face is that people who grow up in a large family where most of the people around them have high BMI’s do not see themselves as overweight, um, and um, so the issue there seems to be one of helping consumers to actually understand the situation (Bree, FIG transcript).

In other words, the response by the FIG suggested that it was not so much that people were in denial about their weight, but rather that the commonality of large body size amongst their peers appeared to normalise obesity. The Māori Party MP (Tariana Turia) also noted during the Inquiry the existence of a ‘big is beautiful’ cultural norm amongst the Māori community.

However, for the industry submitters, although attitudes and norms were considered as critical influences on overconsumption, a more important influence was believed to be lack of knowledge amongst certain sectors of the population.

**Knowledge deficits**

The industry’s argument about knowledge deficits took several forms. Some argued that there was a lack of nutrition-specific knowledge or a lack knowledge of what constitutes a healthy balanced diet, while others emphasised the general lack of understanding, by some people, of the relationship between ‘energy in’ and ‘energy out’. For instance, the CMA (s252) noted that parents (and ‘carers’) lack of understanding of good nutrition was a barrier to improving nutrition. Foodstuffs, one of the two major supermarket retailers in New Zealand, identified (the supposed) ‘loss of cooking skills’ and not knowing which foods
are healthy, as barriers to healthy eating (Foodstuffs s283). On the issue of the general lack of understanding of what constitutes a healthy lifestyle, the FGC (s163:8) argued that:

it is of concern that the basic concepts of ‘energy in’, energy out’ are not well understood by the general population.

The FGC (s63:8) went on to cite New Zealand research which recognised that:

there appears to be a lack of appreciation that constant eating of large quantities of high energy foods will result in obesity.

The BWSC (s139:5) concluded that:

People need to understand what constitutes a healthy, balanced lifestyle, engaging in good diet, exercise, which for many will involve considerable behavioural change.

However, Foodstuffs (s283) presented evidence contrary to its own argument. Consumer research contracted by Foodstuffs in 2005 (and summarised in its submission), suggested that consumers do have a good understanding of the role of eating and exercise in health, despite some consumers suggesting the need for more information on nutrition, label reading, menu planning and cooking.

Although poor attitudes and knowledge deficits were pin-pointed as critical drivers of overconsumption, the real emphasis by the food industry, when it came to explaining the population increase in obesity, was on the role of physical activity:

Ultimately, though, the most important challenge is in the actual choices of people and what they do to on the energy-out side of the equation (FIG s157:14).

**Emphasis on lack of physical activity**

The emphasis on lack of physical activity as the dominant cause of the energy imbalance was a common theme amongst industry submissions. This emphasis was noted in the oral submission given by the FGC, where a Professor of Food Technology gave evidence that the recent population level increase in obesity was due to *declining physical activity* rather than increased energy consumption:

The average energy consumption of foods has little changed since 1950, it is still around 2000 kilo-calories per person per day . . . . What has changed is a dramatic reduction, is the energy expenditure. We have gone from 1950 [the year], when there were 2000 calories per day [expended] to 1600 calories per person today (Professor of Food Technology, FGC transcript).

This focus on physical activity was also supported by Coca-Cola (s160:4):
over-consumption of energy from food and drink, if coupled with insufficient physical activity, will lead to weight gain.

Again, here is the recurring theme that overconsumption is not a problem if you compensate with adequate physical activity (as opposed to restricting consumption).

Some industry submitters noted that a gradual decline in mandatory structured physical exercise in schools was a significant contributor to childhood obesity ( Fonterra s138; Foodstuffs s283). Others suggested that children of the current generation were less active than those in the previous generation. Foodstuffs for example, noted how children ‘nowadays’ are less likely to walk to and from school than previously (Foodstuffs s283).

The knowledge deficit argument used to explain overconsumption was also employed by industry to explain the lack of physical activity attributed to those with weight problems. McDonalds for instance, argued that in addition to the lack of knowledge about the importance of a balanced diet, people lacked information about the need for physical activity and about the overall benefits of being fit, healthy, and a sensible weight (McDonalds s192).

**Family influences**

Some of the early ‘family influences’ on later obesity noted by industry submitters were heavy birth weight and mothers not breast-feeding their infants. As factors contributing to obesity however, these were not especially emphasised by industry. The main emphasis, when it came to what were considered to be ‘family influences’, was on parental role modelling – the transmission of learned behaviours from parent to child.

The family was seen as critical to the establishment of both eating and exercise patterns. Market research commissioned by Foodstuffs found a number of family related factors influencing dietary patterns. In particular, they cited the following factors acting as ‘barriers’ to making healthy dietary choices:

- indulging children with treat foods due to parental guilt
- regular treating of oneself or family to a reward of ‘naughty foods’ (an indulgence most are reluctant to give up)
- social norms (friends and relations may be offended)
- both parents working (resulting in less supervision over children’s eating)
- disappearance of vegetable gardens
• fast paced life and time shortages and the consequent ease of reliance on convenience foods
• eating sugary foods or drinks to provide a quick ‘energy fix’

Some submitters believed that ‘family influences’ should be interpreted widely to include friends, the community, and, to some extent, the school (FIG s157). However, when discussing the influence of schools, the emphasis was on the lack of physical activity (noting the lack of structured exercise in the school curriculum) rather than aspects of the school food environment that promote consumption. Some submitters also noted genetic factors as a family influence contributing to familial cases of obesity.

5.3.3 Non-causes

This section considers two types of ‘don’t blame us’ defences used by the food and marketing industries: ‘it’s not advertising’ and a series of ‘it’s not our product’ arguments. These are examined below.

‘It’s not advertising’

Four main arguments were presented to defend advertising. These are considered below and they include: (i) the argument that there is ‘no correlation between television advertising and obesity’; (ii) the ‘fish and chip’ argument; (iii) the ‘influence of new technologies’; and, (iv) the argument that ‘it is difficult to define unhealthy foods’.

No correlation between television advertising and obesity

Evidence that there was no link between television advertising and obesity was presented by the marketing industry associations and the FIG. One argument put forward by the FIG (s157:11), was that the timing of the increase in obesity:

discredits some of the easy answers about the underlying cause of obesity, such as television . . . . [which was] already available in 1980 and before.

On the relationship between food advertising on television and obesity, arguments ranged along a continuum, from those who accepted there was some association between the two, to those who argued that there was no correlation at all. These arguments relied on various submitters’ interpretations (FIG, ANZA, and the RBA) of ‘evidence’ presented in an industry-funded (White 2007) research report: Advertising’s role in diet and exercise in
New Zealand and Australia (Harker & Harker 2006) from the industry-funded research group: the Foundation for Advertising Research. This report, hereafter referred to as the Harker Report, was used extensively by the FIG and the marketing industry associations to support a number of claims. The Harker Report drew on a 2005 World Federation of Advertisers’ research report (which does not appear to be publicly available) into ‘responsible advertising’. This data, which compared televised food advertisements (per hour) with obesity levels in a number of countries, was reproduced, by FIG, ANZA, and the RBA in various formats as evidence that there was no correlation between food advertising and obesity. As an example, the following table (Table 18) was used by ANZA in their written submission:

<table>
<thead>
<tr>
<th>Country</th>
<th>Food advertisements per hour</th>
<th>Percent obese</th>
</tr>
</thead>
<tbody>
<tr>
<td>Australia</td>
<td>12</td>
<td>19</td>
</tr>
<tr>
<td>Poland</td>
<td>11</td>
<td>19</td>
</tr>
<tr>
<td>UK</td>
<td>11</td>
<td>22</td>
</tr>
<tr>
<td>France</td>
<td>8</td>
<td>18</td>
</tr>
<tr>
<td>Greece</td>
<td>7</td>
<td>31</td>
</tr>
<tr>
<td>Norway</td>
<td>2</td>
<td>21</td>
</tr>
<tr>
<td>Sweden</td>
<td>&lt;1</td>
<td>18</td>
</tr>
<tr>
<td>New Zealand</td>
<td>12.8</td>
<td>21</td>
</tr>
</tbody>
</table>

Source: (ANZA s158:6-7).

The table was accompanied by the following text:

Scandinavian countries are often advanced as examples of restrictive advertising regulation including bans which should be followed in New Zealand. However, the research does not reveal any causative effect or correlation between the rate of obesity and the number of television advertisements for food . . . . The data for a selection of countries is interesting with no correlation revealed (ANZA s158:6).

Other ‘evidence’ used by the submitters from the same source, drew on food advertising expenditure data and obesity levels in selected countries. This data, as presented by ANZA, is shown in Table 19.
ANZA concluded that this ‘evidence’ confirms that there is no relationship between advertising expenditure and obesity.

The NZTBC’s (s293:4) position on television advertising and obesity highlighted a lack of evidence of correlation as well:

> the Council has not been provided with any evidence which shows a clear and direct connection between the level of television advertising of ‘unhealthy’ foods and obesity.

The FIG (s157:17), who also supported the contention that there was no link between advertising and obesity, did however, note one exception:

> The only apparent link between advertising and obesity is that already obese children seem to be engaged by television advertising in a more emotional/physical way than children of a normal weight.

This suggests, that although the FIG did not accept that television advertising of food causes obesity, they did accept that such advertising may reinforce overconsumption in people where it is already an established pattern. This view was also accepted by ANZA (s159:4):

> Advertising does not cause obesity but it may help support and maintain it for some people.

This finding is significant in that it represents an acknowledgment amongst some industry sectors that advertising reinforces unhealthy consumption patterns amongst at risk groups including children.

ANZA (s158:4) also argued that the two main evidence-based claims supported by Ofcom (the UK government agency responsible for advertising and communications): that

### Table 19: Evidence presented by ANZA: Food and drink advertising and obesity levels

<table>
<thead>
<tr>
<th>Country</th>
<th>Food &amp; drink advertising expenditure</th>
<th>Obesity levels</th>
</tr>
</thead>
<tbody>
<tr>
<td>UK</td>
<td>In decline</td>
<td>Increasing, currently 23%</td>
</tr>
<tr>
<td>Germany</td>
<td>Plateauing</td>
<td>Increasing, currently 12.9%</td>
</tr>
<tr>
<td>Italy</td>
<td>Fluctuating, currently in decline</td>
<td>Increasing, currently 8.5%</td>
</tr>
<tr>
<td>USA</td>
<td>In decline</td>
<td>Increasing, currently 30.6%</td>
</tr>
</tbody>
</table>

Source: (ANZA s158:6-7).
‘television advertising affects children’s food choices in a modest way’; and that ‘most television food advertising is for unhealthy products’:

falls a long way short of establishing a causal link between advertising and obesity [my emphasis].

Thus, ANZA’s position was that the evidence was not strong enough to show causation (even though it accepted that advertising reinforced existing behaviours).

The ‘fish and chip’ argument – blaming the ‘informal’ fast food market

Another argument used by industry to defend advertising, is what may be most appropriately described as the ‘fish and chip’ argument. A few industry submitters made the claim that the most popular ‘take out’ foods in New Zealand, are those that are never advertised. A Professor of Food Technology from Massey University, appearing as a witness for the FGC, illustrated this point:

Food is everywhere, obviously. The majority of food which is eaten today is not advertised, I will make that quite strong, in fact research shows that the great majority of food eaten outside of the home (?) it is in fact either Asian food or fish and chips. In New Zealand more than 60% by recent surveys, made up those products (Professor of Food Technology, FGC transcript).

This argument was also used by ANZA, where evidence was provided that fish and chips constituted a disproportionate share of the take-away food market, despite not being advertised (ANZA s158). This evidence, which was a replication of a table from a January issue of the NZ Herald, listed Digi-Poll results on the most frequently purchased takeaways. At the top of the list of the most frequently purchased takeaway foods, was Asian food (31.6%), followed by fish and chips (28.7%), pizzas, hamburgers, and other foods. In their oral submission to the Inquiry, the Executive Director of ANZA reiterated that:

Asian takeaways and fish and chips account for 60% of the fast food market, while advertised brands, branded products such as KFC, Pizza Hutt, Burger King and McDonalds account for 25.6% (Irwin, ANZA transcript).

The Executive Director of ANZA then went on to make the point:

If for example advertising of branded fast food was banned, there would be no appreciable reduction in obesity with such a predominance of unbranded fast foods purchased (Irwin, ANZA transcript).
ANZA, in its written submission concluded that:

There is no direct link between advertising and consumption and indeed the converse appears to be the case (ANZA s158:8-9)

In summary, these industry submitters distinguished between the ‘branded’ and ‘unbranded’ (small local takeaway outlets) fast food retailers and laid much of the blame on the informal fast food sector that does not engage in heavy marketing or advertising.

*Influence of ‘new technologies’*

A number of marketing industry submitters noted that research linking television watching to obesity was problematic, in that it could not separate out the effects of the sedentary nature of television viewing from the potential effects of exposure to food advertising on television. This issue was highlighted by ANZA, again drawing on the conclusions reached in the Harker Report:

> weight gain is not due to television advertising per se but a combination of: The sedentary nature of television viewing which decreases metabolic rates and is a time substitute for other healthier activity, the creation of a positive energy balance from frequent snacking, prepared meals and/or food and soft drink consumption during TV viewing, increased TV viewing time offering increased possible exposure to food and soft drink product advertisements (ANZA s158:5 citing Harker and Harker 2006:73).

Thus, from the industry point of view, the effects on weight gain of exposure to unhealthy food advertising via television, was unclear. This was because of confounding by other correlated factors, in particular the displacement of physical activity by time spent in front of the television screen. On this issue, as noted previously, industry provided statistical data from a number of sources to illustrate that television viewing is only one of a number of inducers of sedentary behaviour. Time spent in front of computers due to increased internet access in New Zealand households was emphasised as an important contributor to sedentary behaviour, as were other activities, such as listening to music, playing console games, mobile phone text messaging and watching DVDs.

*Difficult to define ‘unhealthy’ foods*

Another argument, although not limited to defending advertising, was around the concept of ‘good’ and ‘bad’ foods. The usual food industry argument, that there is no such thing as a ‘healthy’ or ‘unhealthy’ food – only unhealthy diets, was clearly evident in the submissions
from industry and this argument has been well-documented by others (Nestle 2002; Simon 2006). Examples of this argument are provided below:

The majority of nutritionists and dieticians do not accept the ['good' and 'bad' food] definition (FGC s163:4)

No one food is inherently 'bad'. If it was dangerous or truly a chemical cocktail then that particular food would not be allowed to be sold for consumption (FGC s163:5 citing the New Zealand Dietetic Association).

Food is not 'unhealthy' or 'junk' per se, if it is consumed in the context of a balanced diet and an active lifestyle (McDonalds s192:20).

The point is that it is not the ingredients in a meat pie, but how much is consumed and how often. It is not a matter of unhealthy foods as a matter of unhealthy food choices within the context of a person's overall diet (McDonalds s192:18).

there are no 'good' or 'bad' foods (Coca-Cola s160:2).

There is no such thing as a food that is good or bad for health; it's the overall diet that affects health (FGC s163:4).

Defining food as 'good' or 'bad' is clearly problematic for some sectors of the food industry, because one of the likely implications is the translation of this information by policy makers into restrictions on the availability or marketing of 'unhealthy' foods.

On the matter of restricting foods, the FGC (s163:4) provided research evidence that restricting children's food choices had a number of negative impacts including:

- enhanced preference for the food
- increased requests for the food, increased intake of the food
- eating even when the children are not hungry
- negative self-evaluation after eating extra food.

The FGC argued that rather than restricting particular foods, 'parents, politicians, and experts alike' should adopt a 'common sense approach' to healthy eating (FGC s163:5), meaning:

It's what you eat most of the time that matters [and] . . . . any food, if consumed in excess, can be detrimental to our health [and] . . . . the basis of a healthy diet is variety, balance and moderation (FGC s163:5 citing the New Zealand Dietetic Association).

The FGC also highlighted the approach taken by the French Government to tackle obesity – which it claimed encouraged the enjoyment of ‘treat’ foods. Part of this approach
evidently includes policy advice to health professionals and educators to avoid ‘negative restrictive talk’ about ‘foods children enjoy’ on the basis that it ‘could do more harm than good’ (FGC s163:4).

One submitter used the ‘forbidden fruit’ argument to warn the committee that restricting certain foods or beverages would make them more attractive to young people:

A teenager’s life is full of prohibitions and rebelling them is a way of exerting independence and growing up. Bans or restrictions of fizzy drinks could potentially make them even more desirable (Adams, Coca-Cola transcript).

However, it was noted later by Coca-Cola, on reaching teenagers, that:

bans won’t work, brands do (Coca-Cola s160:18).

Other industry submitters, when discussing the ‘problem’ of defining foods as ‘good’ or ‘bad’, emphasised the practical difficulties this would present:

Definitions of healthy and unhealthy would present huge definitional challenges for law drafters (McDonalds s192:20)

no reputable authority or government agency has yet been able to define ‘unhealthy’ foods (NZTBC s293:4).

‘It’s not our product’ arguments

Five industry submitters, Coca-Cola, NZ Sugar, the BWSC, McDonalds, and the CMA, presented ‘evidence’ and various arguments that their products (or their major components) were not major contributors to the obesity epidemic. These arguments are considered below.

Coca-Cola – defending carbonated beverages and sugar

Many of Coca-Cola’s arguments to defend their products centred on the defence of Carbonated Soft-Drinks (CSDs) in particular, and of sugar in general. In defending CSDs, Coca-Cola minimised the contribution of CSDs to the daily diet:

Based on current media commentary, one would assume that fizzy soft drinks or carbonated soft drinks are the most popular drink and the largest contributor to energy intake in this country. They are frequently singled out as a ‘bad’ or ‘unhealthy’ drink choice . . . . New Zealander’s actual
consumption habits . . . clearly show that CSDs are not the highest contributor to energy intake in adults or children (Coca-Cola s160:6).

Coca-Cola then presented evidence, in the form of a table taken from a New Zealand nutrition survey, showing that ‘breads and their spreads’ are the most significant contributor to New Zealander’s dietary energy intake, at 13%, compared to 2% for CSDs (amongst children). Continuing along this line of argument, Coca-Cola (s160:7) went on to argue that:

Removing the 2% energy supplied by sweetened CSDs will not necessarily result in a reduction in overall energy intake by 2% because . . . . Children will replace this with other food or beverage options which could potentially cause more harm (i.e., if the replacement energy source is high in fat). A phenomenon known as the fat-sugar see saw exists within populations – which says that efforts to actively decrease one will often result in increasing intakes of the other, without very careful planning.

Other beverage options, not part of the Coca-Cola range, were singled out, in both the written and oral submissions, as equally or more calorific than many sweetened CSDs. These included whole milk, Milo, Ribena, many fruit juices, and powdered drinks in particular. Note that this focus on the energy content detracts from the point that the nutritional value and sugar content of these beverages varies widely.

Another defence used by Coca-Cola was to implicate fat rather than sugar as the more important contributor to obesity. Fat, it was noted contained more kilojoules, at nine kilojoules per gram compared to the four kilojoules contained in a gram of sugar or protein.

Finally, Coca-Cola emphasised its range of products. This was achieved in the first instance by lining up a large display of its beverages in front of the committee. The beverages were ordered from highest to lowest energy content. It was clear that there were a number of no calorie options, including bottled waters, as well as the traditional (full-sugar) Coca-Cola, and the new Coke Zero. There were a number of other instances during Coca-Cola’s oral submission where the range of products was emphasised, especially the low or no calorie options. Furthermore, the written submission highlighted that:

Coca-Cola manufactures, markets and distributes more than 100 beverage brands in New Zealand (Coca-Cola s160:1).

The point being made, by the emphasis on the range of beverages on offer, was that the consumer has many choices. Indeed, in the marketing material supplied to the committee
by Coca-Cola (where the range of products is referred to as ‘the Coca-Cola system’), was accompanied by the slogan ‘Life’s full of choices. What’s yours?’ (Coca-Cola s160). The implied statement appears to be, all that is required, is for the consumer to make the choice that’s right for them. Interestingly, the choice of beverage made by the Managing Director (representing Coca-Cola) when he appeared in front of the committee, was tap water.

Coca-Cola also emphasised that beverages fulfil several functions, some essential, such as hydration:

> the eight glasses of water per day recommended for good health can in fact include any liquid (representative, Coca-Cola transcript);

and other less essential functions:

> drinks, like food, fulfill many physiological and other needs (representative, Coca-Cola transcript).

**NZ Sugar – the ‘fat sugar see-saw’**

Two of the arguments used by Coca-Cola, were, not surprisingly, also used by NZ Sugar. These were: implicating fat (rather than sugar) as the ‘suspect’ macronutrient in the obesity issue; and the ‘fat sugar see-saw’ argument. Like Coca-Cola, NZ Sugar also pointed out that sugar contains four kilojoules per gram compared to nine kilojoules per gram for fat. In deploying the ‘fat sugar see-saw’ argument, NZ Sugar (s84:11) referenced research into the ‘food preferences of the obese’:

> It has been found that obese women prefer sweet-fat combinations while obese men prefer salt-fat tastes. In both instances fat is the common factor in their food preferences.

NZ Sugar also provided ‘evidence’, in the form of an ‘in press’ journal publication that, on the basis of cross-sectional data from a New Zealand survey, there was no association between BMI and sugar consumption. The same study was also referenced by Coca-Cola. The study has since been published, and the article acknowledges that NZ Sugar conducted the data analyses (Parnell & Wilson et al. 2008). This raises the questions about the potential bias of this ‘evidence’. Interestingly, the contact person identified by NZ Sugar for any queries regarding this evidence was a representative of a large public relations company (whose clients aside from NZ Sugar included Coca-Cola, Nestle, Watties and Diabetes NZ).
Another defence of sugar employed, was the argument that sugar, in moderation, is part of a healthy balanced diet. This claim was supported by a reference to the collective opinions of a panel of ‘independent’ nutritionists, claimed by NZ Sugar to oversee the Sugar Research Advisory Service (the educative and consumer information arm of NZ Sugar). This panel of independent nutritionists was claimed by NZ Sugar to include Professor Jim Mann (one of the three independent advisors to the Inquiry), Winsome Parnell (the Otago university academic whose name appeared as first author of the ‘in press’ journal article referred to above), and Jenny Reid (an official advisor employed by the NZFSA). Coca-Cola also referred to these experts to support its claim that sugar has a place in a balanced diet.

**BWSC – The ‘beer belly’ is a myth**

The BWSC provided evidence that the ‘beer belly’ was a myth. This evidence was in the form of peer reviewed journal articles. One of these found that:

> regular small amounts of alcohol are associated with the smallest abdominal girths (BWSC s139:1).

The BWSC did not elaborate on what constitutes a small amount of alcohol, although the article they referred to (Dorn & Hovey et al. 2003) concluded that the smallest abdominal girths were associated with a drinking pattern of *less than one alcoholic drink per drinking day*. This detail was omitted by the BWSC.

Another study cited by BWSC (Jequier 1999) was provided as ‘evidence’ that there was:

> no clear association between light and moderate alcohol intake and body weight (BWSC s139:1).

Other arguments advanced included: ‘there is no fat in beer’ and, ‘beer has less calories than most other drinks’, “such as milk, fruit juice and carbonated soft drinks” (BWSC s139:4). Furthermore, the BWSC argued that consumption of alcohol actually reduces insulin resistance. The BWSC concluded (like NZ Sugar did about the place of sugar in a healthy balanced diet) that “moderate alcohol intake can be part of a healthy lifestyle” (BWSC s139:4).
CMA – ‘It’s not confectionery’

Similar to the argument put forward by Coca-Cola about carbonated beverages being only a very small contribution to the energy intake of New Zealanders, the CMA (s252:6) argued that confectionery:

> is acknowledged as no more than two percent of an average dietary intake [my emphasis].

It is important to note that the reference to the average dietary intake however, obscures variations in consumption patterns which may reveal increased consumption amongst some sectors of the population.

The CMA also argued that:

> Consumption figures over the past decade demonstrate that growth in confectionery sales does not echo the significant rise in the incidence of obesity in New Zealand (CMA s252:6).

However, no evidence was provided to support this claim. As with a number of other manufacturers of unhealthy food, the CMA concluded that its products had a place in a healthy balanced lifestyle:

> confectionery remains a legitimate treat food that can be included in a balanced diet when combined with exercise, without adverse impacts (CMA s252:6).

McDonalds – ‘Our foods are everyday foods’

McDonalds drew on a number of arguments to defend its products. These included:

- highlighting the complexity of defining ‘good’ or ‘bad’ foods; emphasising the ‘everyday’ nature of their foods (including the sourcing of its ingredients from local suppliers);
- recent menu diversification (to include a range of ‘lighter’ options); and noting that McDonald’s was only a small part of the ‘eating away from home market’ (McDonalds s192).

Like a number of industry submitters, McDonalds suggested that attempts to define ‘good’ and ‘bad’ food were fraught with complexity. During its oral submission to the Inquiry, the Managing Director noted that:

> the terminology junk food will be used with regard to McDonald’s, with regard to food within our sector. But how do you define that? When we
say, take our best selling Happy Meal . . . . which is a chicken Happy Meal . . . . with a small fries and a soft drink . . . . it actually has less fat, less sodium, less calories, less sugar than a banana, a glass of milk and a peanut butter sandwich. So again, we get into this difficulty of how do we define? How do we draw the line? What do we do? (Troughten, McDonalds transcript).

In other words, the most popular children’s meal from McDonalds was claimed to be no less healthy than what children may have been fed at home. In fact, according to McDonalds, it may actually be healthier than other ‘everyday’ food.

A subset of the ‘our food is everyday food’ argument used by McDonalds, was the emphasis on the sourcing of ingredients from local suppliers (this is a marketing strategy known as ‘glocalisation’):

Moving specifically on to our food, the meals that we offer within McDonald’s. We source 95% of our ingredients locally. So when we talk about our products we are very much talking about the sort of products that people will buy in their supermarket. Like tomatoes, our ‘Bee-kissed’ tomatoes, potatoes are processed in Timaru, our chickens from Inghams and Tegal, our fish is from Talley’s down in the South Island, cheese is Mainland cheese, eggs are Farmer Brown eggs, our bread is North’s Bread, our yoghurt is Fresh and Fruity Yoghurt, we have Kellogg’s cereal, Just Right and Nutragrain. Very much the brands that you would see in your local supermarket and that people buy in their supermarkets everyday (Troughten, McDonalds transcript).

Like Coca-Cola, McDonalds drew attention to the diversification of its product range. In addition to their traditional burgers and fries, McDonalds emphasised the expansion of its menu to include ‘lite’ and salad options. Again, the concept of providing a range of options was emphasised.

Another point made by McDonalds, in defence of the ‘eating out market’ in general, was that its brand only accounted for one or two of the ninety or so meals per month eaten by the average person:

if we are to talk about our market in New Zealand, we very much consider that our market is the entire eat away from home marketplace. So in New Zealand, 74% of people’s meals are eaten at home. The remainder are eaten away from home. Branded quick service restaurants, which is I guess, the category that we fall into, account for about 5% of all meals consumed in New Zealand. And if we consider that most people have three meals a day, so ninety meals a month, between one and two of those meals each month on average would come from McDonald’s.

When we think about the informal eat-out market, so that’s our competitive set, all eating away from home occasions that aren’t fine dining, so that
includes fish and chips, takeaways, casual restaurants, cafes, the kind of prepared takeaway food that you might buy for example from the supermarket or a petrol station. That is our entire informal eat out market. And we, the quick service restaurant, make up 30% of that informal eat out occasion, with other choices in the market, as I said being fish and chips, cafes, Chinese and ethnic takeaways (Troughten, McDonalds transcript).

Quick service restaurants (like McDonalds) therefore, because they are only a small part of the ‘eating out market’, are apparently not a major contributor to obesity. Note that the term fast food is not used. Again, as was the case in one of the arguments in defence of advertising, the blame for the consumption of fast food (not the preferred term for industry) is shifted away from the big brand franchises to the small informal fast food sector.

It is noteworthy that McDonalds, like a number of other industry submitters, used statistics based on averages or referred in their general discussions to the average consumer. This reference to averages, obscures the fact that the consumption of such products by their most frequent customers is likely to be much higher.

**Summary of industry framing of the causes**

Industry submitters were in broad agreement that the basic fundamental cause of obesity was an energy imbalance. Wider societal level causes identified were multiple and included: affluence; abundance of food; and technological changes leading to sedentary lifestyles. Despite acknowledging these wider environmental factors however, industry argued, on the basis that only part of the population were affected directly by obesity, that these factors were not overwhelming.

Obesogenic lifestyles were then identified to be the main cause of obesity. These obesogenic lifestyles were characterised by overconsumption and lack of physical activity. Overconsumption was argued to be predominantly a result of poor attitudes, lack of motivation (inertia and apathy), denial about weight problems, and knowledge deficits. Lack of physical activity was however emphasised as having a greater influence on the population’s energy imbalance. Industry provided evidence and arguments that physical activity was in decline. This decline in physical activity was believed to be caused both by technological changes and individual factors such as knowledge deficits and family influences (particularly family role modelling). Declining physical activity in schools or amongst children was also noted as an influence on obesity. Genetic factors were also thought to have a role in some familial cases of obesity, although this issue was not discussed in any depth by industry submitters.
Other arguments (non-causes) adopted by industry related to food advertising and particular food and beverage products. On the issue of the association between food advertising and obesity, industry views ranged along a continuum. Some submitters acknowledged that such advertising may reinforce pre-existing behaviours, some acknowledged that there was a correlation but that this did not constitute evidence of causation, and another submitter denied that there was even a correlation. Arguments also minimised the role of the branded fast food sector in the obesity epidemic by highlighting the greater market share taken up by the informal fast food sector.

Evidence and arguments were used by various industry submitters to defend their specific products, although they did not explicitly deny that their products may be a cause of obesity. These arguments nonetheless minimised the contribution to obesity of branded fast foods, confectionery, alcohol, and carbonated beverages. Industry also argued that there was no such thing as a good or a bad food, only bad diets, although this appears to be at odds with arguments from some aspects of food industry that ‘demonised’ particular macronutrients (for instance fat instead of sugar).

5.4 Industry framing of the solutions

This section outlines the key themes and arguments presented by industry submitters in their framing of the solutions to the obesity problem. These are organised according to: perspectives on the existing policy environment (at the time of the Inquiry); additional policy prescriptions; and, non-solutions (explicitly noted as such by the industry). Within each of these three sections the findings are organised according to the relevant areas of policy (as identified by industry submitters), the key themes identified and their corresponding arguments. To assist the reader in following this section, an overview of these policy areas, the key themes and arguments are provided in Table 20. The specific arguments put forward by industry are presented in Table 20 in *italics*. 
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<th>Policy area</th>
<th>Key themes &amp; specific arguments (in <em>italics</em>)</th>
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<td><strong>HEHA strategy</strong></td>
<td>Unanimous support for HEHA – A ‘state of the art plan of action’</td>
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<td>The Accord Voluntary initiatives are already underway</td>
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<td>Collaboration &amp; partnership Support for HEHA’s collaborative approach</td>
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<td>Marketing Legal right to disseminate information</td>
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<td>Advantages of the Advertising Standards Authority framework</td>
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<td><strong>Additional policy prescriptions</strong></td>
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<td><strong>Education &amp; information</strong></td>
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<td><strong>Schools</strong></td>
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<td>Nutrition education in the curriculum</td>
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<td>Voluntary food policies in schools</td>
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<td>Support for free Fruit in Schools initiative</td>
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<tr>
<td><strong>Nutrition, Health &amp; Related Claims legislation</strong></td>
<td>Progressing legislation will encourage the promotion of healthy food</td>
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<td><strong>Non-Solutions</strong></td>
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<tr>
<td><strong>Marketing</strong></td>
<td>Advertising bans Potential loss of revenue</td>
</tr>
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<td></td>
<td>Remove opportunities for health messages</td>
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<td></td>
<td>Denying consumers information</td>
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<td></td>
<td>Television advertising bans would be discriminatory to the specific media</td>
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<td></td>
<td>Voluntary measures already underway</td>
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<td></td>
<td>Regulating industry sponsorship Potential loss of revenue</td>
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<td></td>
<td>Sponsorship is socially responsible</td>
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<tr>
<td></td>
<td>Food supply Mandatory Front of Pack food labelling</td>
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<td></td>
<td>We have our own Front of Pack labelling</td>
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<td></td>
<td>Opposition to Traffic Light labelling</td>
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<td></td>
<td>Regulating food composition Voluntary initiatives underway (the Accord)</td>
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<td></td>
<td>Voluntary guidelines not regulation</td>
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<td></td>
<td>Market demand should control supply not regulation</td>
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<td></td>
<td>Limits to product reformulation</td>
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<td></td>
<td>Fat taxes Are unpopular, regressive &amp; may increase compliance costs</td>
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<tr>
<td></td>
<td>Regulating vending machines Is contrary to property rights, free choice &amp; consumer demand</td>
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</tbody>
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5.4.1 Perspectives on the existing policy environment

This section examines industry perspectives on the national obesity strategy HEHA and the self-regulatory environment in the areas of food supply and marketing. Specifically, there were two key themes identified: (i) unanimous industry support for HEHA; and, (ii) unanimous industry support for the self-regulatory systems governing food supply and marketing.

HEHA strategy

Unanimous support for HEHA – A ‘state of the art plan for action’

The HEHA strategy, claimed by the FIG to be based on the WHO ‘collaborative approach’, was believed to have brought the Government, industry and consumers ‘together’. The industry was unanimous in its support for HEHA:

the Governments’ Healthy Eating Healthy Action Strategy (HEHA) represents a state of the art plan for action (NZTBC s293:2).

We see this Ministry of Health initiative to be well researched, well analysed and well ‘strategized’ (RBA s187:4).

the Healthy Eating/Healthy Action strategy is an extremely good one . . . . If we were to aim to implement all the findings and objectives of that strategy we would be a long, long way to addressing obesity . . . . So healthy eating, I think, you’ve got it made here at this committee really, if you can only get that implemented you are home and dry (Cutress, FGC transcript).

More specifically, McDonalds (s192:6) noted:

We believe the Government, the Ministry of Health and the wider health sector have already established a sensible and workable strategic framework for tackling obesity – it has the following elements:

• recognition that it is a significant challenge requiring an ongoing response
• an educational rather than a prescriptive response
• a commitment to working with the food sector, encouraging a voluntary and shared response to an issue affecting all New Zealanders, both now and in the future.

The unanimous support for HEHA then, appeared to stem from industry’s perception of HEHA as a collaborative and educational approach (rather than a prescriptive or regulatory one). Industry was also supportive of the long-term focus of the HEHA strategy, although
some submitters suggested that additional government resources were needed to progress HEHA strategies. Some submitters suggested more time was needed:

HEHA runs until 2010 and we believe we will begin to see some significant results from the initiatives undertaken so far. We believe that this joint approach needs time to realise its goals and ask the Select Committee for the opportunity to see this out (FIG s157:23).

Such a view appears to indicate a preference by the FIG for delaying further Government action on obesity.

The Accord

*Voluntary initiatives are already underway*

Industry argued that the Accord was industry’s response to HEHA (the mission of the Accord was outlined in section 5.1.1). As noted in Chapter 2, the HEHA Implementation Plan was developed in consultation with industry stakeholders. It focuses on a number of areas for industry to progress and a number of these were outlined by the FIG (s157). The NZTBC (s293:3) noted that:

> the basic premise of the Accord is that obesity will be successfully addressed by NZ if government enables private enterprise to work together when needed to find commercially successful solutions to the drivers of obesity.

Numerous examples of ‘voluntary initiatives’, claimed by industry to have arisen from the Accord agreement, were provided by submitters. Examples of these initiatives, taken from a number of industry submissions, are summarised in Table 21.

**Table 21: Examples of Accord ‘initiatives’ provided by various industry submitters**

<table>
<thead>
<tr>
<th>Product reformulation/expanding product range</th>
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<tbody>
<tr>
<td>Cadbrys</td>
<td>introduction of treat size packs of chocolate</td>
</tr>
<tr>
<td>McDonalds</td>
<td>reduction of sugar in hamburger buns</td>
</tr>
<tr>
<td></td>
<td>option of fruit bags with children’s ‘Happy Meals’</td>
</tr>
<tr>
<td>Fonterra</td>
<td>increased range of products with reduced sugar or fat, smaller portion sizes</td>
</tr>
<tr>
<td>Foodstuffs</td>
<td>85 Pams label products endorsed with the Heart Foundation Tick</td>
</tr>
</tbody>
</table>

**Labelling & provision of nutrient information on food & beverages**

<table>
<thead>
<tr>
<th>McDonalds</th>
<th>more nutrient information on their packaging, tray mats, brochures, &amp; website</th>
</tr>
</thead>
<tbody>
<tr>
<td>FGC</td>
<td>Provision of communication tools, websites, 0800 lines, &amp; education kits for kids</td>
</tr>
<tr>
<td></td>
<td>some companies have Front of Pack labelling &amp; improved guidelines on serving sizes</td>
</tr>
</tbody>
</table>
Sponsorship of health, community, sporting & physical activities

Coca-Cola: unbranded sponsorship of the Out of School Care (OSCAR) programmes sponsoring the Olympic Games, the All Blacks, provincial netball & rugby

McDonalds: Ronald McDonald House charities, provision of a mobile dental surgery in Northland, sponsorship of athletes & community activities to increase kid's physical activity

Education & dissemination of information

Coca-Cola: produced a nutrition & activity brochure (titled: “Activity, Balance, Choice”)

Foodstuffs: ran a ‘six a day’ cereal promotion in conjunction with the Nutrition Foundation

Television Broadcasters: increased programming to ‘educate the public’ about healthier lifestyles (eg: twenty-one full reports on obesity & related topics, various documentaries & entertainment programming (examples of programming to promote better nutrition & physical activity included: Downsize Me; Honey we’re Killing the Kids; Supersize Kids; Supersize Me; Jamie’s Schools Dinners; & Dancing with the Stars [no joke!].

Marketing & advertising polices

Coca-Cola: have a policy of no direct marketing to children under age twelve

Foodstuffs: some stores have introduced confectionery free checkouts

Many more examples of voluntary initiatives were detailed in the industry submissions, including various actions to increase participation in physical activity and employee policies related to food, nutrition and exercise. On the basis of these Accord initiatives, industry submitters argued that no further interventions were required. Fonterra also argued that the food industry was driven by demand, and that as demand for healthy products increases, the food industry will respond:

"No further interventions are required because the food industry will respond to a growing demand for healthier food as it arises (Fonterra s138:6)."

Collaboration and partnership

Support for the collaborative approach of HEHA

The industry frequently praised the collaborative partnership approach that it aligned with HEHA:
We believe that this cooperation is the best and most effective way to make a difference (FIG s157:23).

Co-operation has proved to be more constructive than conflict and we will continue to seek opportunities to work with those who understand the huge potential of co-operation between the food industry, media and the health sector (Coca-Cola s160:2).

McDonalds too, agreed that shared commitment was important and better than legislation, which it claimed could increase the cost of doing business. However, no evidence was provided to support the industry assertion that cooperation was an effective strategy to reduce obesity.

It was also emphasised that the collaborative approach was consistent with recommendations by the WHO:

Industry is often accused of having a vested interest when it sponsors, supports or takes initiatives to promote healthy lifestyles. It is important to note however that the WHO Global Strategy on Diet, Physical Activity and Health calls for the private sector to ‘promote healthy diets and physical activities’ (FGC s163:7).

Some industry submitters highlighted the lack of cooperation with industry by some NGOs. The FIG (s157:32-33) for instance, drawing on a recent experience with some NGOs from the public health sector, noted that:

The attitude of some of the more confrontational NGOs makes it challenging for industry to participate effectively and makes the development of the collaborative initiatives difficult. To help develop a more constructive relationship with NGOs in this area, an invitation was issued to a jointly hosted meeting, in conjunction with the National Heart Foundation, to share information on FIA [the Accord] activities. The NGOs collectively refused to participate. The FIG subsequently took the initiative to arrange meetings with individual NGOs in an attempt to break down some of these barriers. This approach is very resource intensive and hampers effective cross-NGO communication.

The ANZA and the RBA were also critical of some groups who they claimed to be sabotaging their best efforts to address obesity. ANZA noted (s158:9) that it did:

not expect praise but . . . . unfair and uninformed criticism, particularly when it comes from government agencies and government funded agencies, is not helpful and in the end undermines the long-term commitment of FIG to implementing the HEHA policies.

In their conclusion, the RBA identified some ‘problematic’ health groups:
Despite numerous vitriolic attacks on industry from taxpayer funded groups such as FOE [Fight the Obesity Epidemic] and OAC [the Obesity Action Coalition] we continue to believe that industry can make a significant contribution to [the] reduction in obesity rate[s] in New Zealand (RBA s187:10).

Some industry submitters (ANZA and RBA) suggested that the Government should intervene to facilitate cooperation with ‘more difficult’ health groups. Submitters also reiterated their commitment to collaboration:

the NZTBC will continue to work closely with government to ensure that our efforts are in alignment (NZTBC s293:3).

In closing, I would like to emphasise FIG’s willingness to work in partnership to achieve commercially feasible change through voluntary measures thus avoiding the need for expensive, resource consuming legislation (Bree, FIG transcript).

Self-regulation

Support for self-regulation

All industry submitters supported continued self-regulation of the advertising and food industries. In defending self-regulation submitters drew on a number of arguments, and the majority of submitters also provided numerous examples of industry-led initiatives to address obesity, in both the areas of marketing and food supply, as ‘evidence’ that self-regulation was working. In this manner industry appeared to frame their activities as effective in addressing obesity, while at the same time positioning themselves as helpful, cooperative, and responsible. In defence of marketing and advertising, industry submitters invoked arguments about their legal rights to disseminate information and outlined the advantages of the existing self-regulatory ASA framework. These arguments are considered below.

*Persuasion is better than forced compliance*

The basic argument put forward in support of self-regulation, was that persuasion is better than forcing compliance. This was argued to be so because persuasion was claimed to be cheap compared to punishment. Punitive strategies were thought to waste resources in litigation, and to encourage:
a game of regulatory cat and mouse whereby firms defy the spirit of the law by exploiting loopholes, and the state writes more and more specific rules to cover loopholes (ASA s31:7).

McDonalds (s193:8) argued that “short-term prescriptive or legislative measures do not result in long term solutions” as rules can be by-passed or broken, whereas “voluntary commitment puts an organisation’s integrity on the line”. McDonalds also noted its concern that legislative measures could increase the cost of doing business.

Food supply

The Accord is industry’s initiative to address obesity

Industry supported continued self-regulation of the food supply, and referred back to examples of recent voluntary initiatives as ‘evidence’ that self-regulation in this area was working. Examples of these initiatives were provided in Table 21 and they included: various efforts to reformulate products and expand product ranges to include healthier options; improvements to food labelling; the provision of nutrient information and education; and, the sponsorship of physical activity. The FGC (s163:2) concluded that:

voluntary steps being undertaken and developed by processed food manufacturers are effective and can make a valuable contribution to reducing obesity.

The RBA (s187:4) reiterated industry's commitment to addressing the obesity issue via voluntary initiatives:

FIG has been a leader in the implementation of HE-HA policies and it is doubtful whether any other Government or Non-Government agencies has done more or spent as much.

Furthermore, the RBA claimed that the substantial resources and money contributed by industry to the activities of the Accord “would amount already to several million dollars” (RBA s187:10).

The NZTBC (s293:3), as a founding member of (and a signatory to) the Accord, emphasised that:

no further interventions are required considering the success of the Accord so far in less than 2 years.
Yet, the concluding remarks by the RBA (s187:5) on the issue of voluntary industry initiatives to address obesity, revealed its concession to the fact that the actual impact of these initiatives remained to be seen:

[we] can not yet tell if interventions made by industry under the Food Industry Accord are effective or not . . . . what can be said is that the combined expertise available in understanding consumer behaviour in relation to food decisions is substantial, and promises a reasonable chance of success.

Industry submitters therefore suggested that more time was required to evaluate the effect of the Accord initiatives.

Despite industry’s assertions that it had done more and spent more than Government agencies on initiatives to address obesity, and that industry initiatives were likely to be successful, industry did not provide any evidence of their effectiveness. Nor did industry acknowledge that the costs of obesity-related health problems were largely borne by the Government and not industry.

**Marketing**

It was accepted by the marketing industry that advertising needed regulation, due to the international nature of advertising and the realities of cross-border advertising (ASA s31). However, it was argued that advertising was already well-regulated by the self-regulatory ASA system. Industry defended the self-regulation of advertising and marketing by (i) reference to its legal right to disseminate information; and, (ii) by describing the efficacy and advantages of the existing ASA self-regulatory framework. There were also some other arguments put forward by industry against advertising bans, although these are considered under non-solutions (section 5.4.3).

**Legal right to disseminate information**

The ASA, ANZA, and the RBA, emphasised that the legal right to impart and receive communication (or advertise) was enshrined in Section 14 of the Bill of Rights Act. The RBA (s187:8) noted that:

any fetters on such freedoms are required to be logical and proportionate.

According to the RBA (s187:8):
even the present fetters self-imposed by industry would almost certainly fall short of the ‘proportionality’ test (RBA s187:8).

Thus, it was the conclusion of industry that any ban on food advertising would contravene this section of the Act. Furthermore, the FIG (s157:15) argued that:

legislating for change would be an unfounded restriction on free activity and private property, without any proof of just cause and likely benefits to society.

Also highlighted by these submitters was Section 5 of the Bill of Rights Act which suggests that a ban can only be imposed if there were:

reasonable limit(s) prescribed by law as can be demonstrably justified in a free and democratic society (ASA s31:10).

In other words, according to the industry submitters, a ban could only be justified where the level of proof was high. In the absence of evidence to suggest that advertising was in any way responsible for obesity, which was the position of industry on this matter, industry asserted that Section 5 of the Act would not be applicable.

**Advantages of the ASA framework**

Industry submitters noted that advertising in New Zealand is already well regulated by the ASA framework and its advertising codes. As outlined earlier in this chapter, the ASA was the industry-funded body responsible for regulating advertising and marketing in New Zealand. It had a number of codes by which advertisers are expected to comply, and operated a complaints system open to the public should there be any concerns about breaches of the advertising codes. Submitters, predominantly from the advertising and marketing sector (ASA s31; RBA s187; ANZA s158), highlighted the advantages of this self-regulatory advertising system over alternatives (legislation in particular). These advantages included:

- no cost to the complainant or Crown – the ASA system was fully funded by industry
- fast and efficient processing – the ASA was claimed to process complaints in twenty-five working days on average
- flexibility – response time to changes in codes was quicker than introducing new legislation
- some codes required considering ‘social responsibility’ (spirit and intention) – this was argued to be a concept that could not be legislated
less proof was required under the self-regulatory system – ‘balance of probabilities’ rather than ‘beyond reasonable doubt’ (as in a prosecutions system)

• burden of proof was on the advertiser (to prove they comply with the codes) once the complaint has been made.

It was also noted that the ASA system was monitored by the Commerce Commission, and was required to report to the relevant government ministries (implicit in such framing is the notion that the Government is already a watchdog for industry advertising). Although the ASA system was acknowledged to lack ‘punishment powers’, the industry claimed it had become very competent and effective in the use of ‘persuasion powers’ (ASA s31). In summary, the ASA system was thought by industry to be consumer friendly, fast, efficient, flexible, cost effective, and practical in comparison with an alternative legal regulatory system.

5.4.2 Additional policy prescriptions

The main additional policy prescription from industry was education and the provision of information in the community and in schools. As well, some submitters voiced their support for progressing the Nutrition, Health and Related Claims legislation. These are discussed below.

Education and information

The ‘knowledge task’

For industry, the provision of education and information on healthy lifestyles, was central to the obesity solution. The following comments made by the FIG (s157:2) are illustrative of this emphasis:

The single biggest effort must go into the ‘knowledge task’ – helping people know more about what constitutes balanced diets and exercise, and changing behaviour.

The only way to encourage people to make healthy selections is through education and choice.

The key is in giving people the knowledge and ability to make healthy choices.
Other submitters supported the FIG’s emphasis on the provision of information and education:

Dissemination of information about healthy diets is essential (FGC s163:10).

We believe the strategic response must focus on education and information (McDonalds s192:3).

An educative approach to battling obesity will be the strategy that will make a difference (McDonalds s192:7).

The above quotes represent a framing of food and nutrition issues that reflect and resonate with the ideology of (informed) individual choice. Such a framing assumes that ‘poor choices’ in food and diet are a result of lack of knowledge and education.

Exactly what type of education, information, or messages was required to address the knowledge deficit was also elaborated:

Education should emphasise there is no ‘bad’ food but encourage the enjoyment of all foods providing they are eaten in the right proportion (FGC s163:10).

It comes down to teaching people the basic principles of how much they consume vs. how much they move (FIG s157:15).

People need to understand what constitutes a healthy balanced lifestyle (BWSC s139:5).

Information about food choices and the role of exercise is needed to help people apply their choices wisely (McDonalds s192:3).

The important message to convey is to eat foods in the amounts that are good for health (FGC s163:4).

Industry did not provide any information on what constitutes a healthy balanced lifestyle or diet, or (with the exception of the CMA), suggest any maximum intakes of ‘luxury’ (unhealthy) foods and beverages. Nor did industry argue that it would be difficult to define a balanced diet. Presumably, these are matters for the informed consumer to define.

A number of submitters were also supportive of government funded social marketing. The FIG in particular, claimed that this strategy would be a useful contribution (FIG s157). This view was supported by Fonterra (s138:3):

...
Government should play a supportive, facilitative and educational role in the provision of information so that consumers can make healthy food choices.

And on the responsibility of industry:

The Food industry’s responsibility lies in ensuring that it offers and advertises healthy options (FIG s157:15).

NZ Sugar already has a lasting commitment to education on appropriate consumption of sugar (NZ Sugar s84:2).

The FIG also commented on the responsibility of the individual:

At the centre of the solution is the individual (FIG s157:15). We must start with ourselves (FIG s157:2).

Yet, given the industry’s emphasis on the centrality of education and information as a solution to obesity, it was surprising to find, in a handful of industry submissions, evidence undermining this argument.

For instance, as noted earlier, consumer research commissioned by Foodstuffs (s283) found evidence that consumers were well aware of the role of eating and exercise in health but that other factors influenced consumer behaviour (such as time shortages and convenience of some foods and the taste of food). Another example of industry undermining its emphasis on education as the central solution was evident in the oral submission by the FGC. Drawing on the results of an evaluation of a US-wide education campaign to raise awareness of the relationship between Coronary Heart Disease and the impact of low-fat foods, the Executive Director of the FGC elaborated on the relationship between consumer knowledge and purchasing behaviour:

They interviewed housewives going into supermarkets, and the awareness of the relationship between low fat and coronary heart disease was 95-98%, it was extremely high, it was a fantastic educational program. They asked these people if they had options on the shelf, would they buy the high fat or the low fat? and they all said going in they would buy the low fat, they looked at the trolleys coming out, they did not buy the low fat, they bought the high fat. Why? Because I’ll tell you why, (?) [when they took] the low fat stuff home, people didn’t like it and didn’t consume it again. That is the sort of thing that drives the development of these sorts of products (Cutress, FGC transcript).

In other words, while education may have addressed a knowledge deficit, this did not translate into behavioural change. Here industry was acknowledging that other factors are at work mediating the relationship between education and behaviour, namely, how good
the food tastes. Industry then conceded that these were the sorts of things that drive product development.

Finally, some submitters argued that consumer education would result in increased demand for healthier foods. Fonterra in particular, reiterated on many occasions, that industry was merely responding to demand, whether that be for unhealthy foods, larger portion sizes or other characteristics of food. Alternative explanations, to do with the food and marketing industries’ roles in creating demand for such products, were absent from industry submissions.

**Schools**

**Structured exercise in schools**

On the issue of the school environment, the main suggestion by industry was to increase the level of structured exercise in the school curriculum. As noted previously, industry asserted that the decline in structured physical activity was one of the factors contributing to increases in childhood obesity.

**Nutrition education in the curriculum**

On the matter of education in the curriculum, the NZRA (s7:4) suggested that:

> greater attention to educational programmes, primarily within both primary and intermediate schools, could assist to convince young New Zealanders that there is a better way to a healthier life style.

Fonterra and the FIG also proposed increased nutrition education in the school curriculum (FIG s157; Fonterra s138). Some submitters from the marketing sector suggested that media literacy education would be useful for young people and ‘empower’ consumers generally. Again, these views suggest support for the theme of informed choice.

**Voluntary food policies in schools**

In contrast, whether food-related policies in schools should be subject to regulation, for instance the food available for sale in school tuck shops or vending machines and food products used for school fundraising, was mostly argued by submitters to be an issue for each school to determine for themselves. However, Foodstuffs, the supermarket retailer, made the point in its submission, that its consumer surveys revealed that consumers would
support restrictions on unhealthy food sold in schools (the sale of food in schools may be seen as a competing retail sector for Foodstuffs), although its own position on this was not forthcoming (Foodstuffs s283). Fonterra supported only the voluntary uptake of school canteen programmes – to educate children and teenagers on healthy food choices.

One such programme, the Waitemata District Health Board beverage guidelines for schools, which is essentially a ‘Traffic Light’ based signposting system designed to inform the consumer of the healthiness of particular products, was discussed by some submitters. The Traffic Light system is a FOP food labelling scheme with red, amber or green symbols that identifies (on the basis of specific nutritional criteria) which products should be eaten less often (red light), those which are low in energy density (green symbol) and those products which are in between (amber symbol).

Fonterra believed there was potential for expanding the Traffic Light guidelines to all schools although they had an issue with full-fat milk being classified under the guidelines with the red traffic light:

Fonterra believes that listing full-fat milk under the same section as Coca-Cola sends a message to children that full fat milk is as nutritious as Coca-Cola, which is incorrect (Fonterra s138:7).

Fonterra believed that the Traffic Light guidelines’ focus on sugar was problematic and suggested that the guidelines be amended. Coca-Cola, commenting on the same Traffic Light guidelines for schools, also had concerns and said that it was ‘alarming’ that sugar free options were not given the green Traffic Light symbol (Coca-Cola s160:23).

The CMA also defended the confectionery industry, claiming, that:

the majority of manufacturers do not sell products to school canteens . . . . [although] . . . . intermediary wholesalers may do so (CMA s252:6).

Here the CMA deferred the blame for the presence of confectionery in schools to the retail (rather than the manufacturing) sector. As well as deferring the responsibility to retailers, the CMA noted that:

Due to the range of small pack sizes available, canteens have access to appropriate portions for young people (CMA s252:6).

On the matter of food products used for school fundraising, the CMA claimed, that:

the majority of companies are not engaged in direct fundraising with schools beyond requests to supply products for prizes from time to time.
From research undertaken by those that do [manufacturers who are engaged in school fundraising] there is evidence that the parent is the main purchaser and provides all the necessary controls to ensure that consumption by children is regulated (CMA s252:5).

Thus, the responsibility for regulating food consumption, according to the CMA, lies with parents.

In defending companies who are engaged in school fundraising, the CMA claimed that these companies have clear sales policies to “avoid situations where consumption by children might be promoted” and rather, that “a sharing environment is encouraged” (CMA s252: 5). However, no sales policy documents were provided by the CMA to support its claim.

Another issue relevant to the school setting was the presence of vending machines in schools. It was revealed by Coca-Cola in its oral submission that there were sixty-eight vending machines in high schools, nine of which were situated in staff rooms (Coca-Cola transcript). It was also emphasised later that these were not branded with Coke but with ‘water or alternative brands’ (Coca-Cola transcript). This rebranding of the vending machines was also emphasised in the written submission by the use of photographs to illustrate:

Coca-Cola systems willingness to relook at the way we approach our presence in schools (Coca-Cola s160:24).

On being questioned by the committee, Coca-Cola also revealed that schools themselves could make up to NZ$50,000 per year from these vending machines, depending on sales volume (Representative, Coca-Cola, transcript).

**Support for the free Fruit in Schools initiative**

Finally, several food industry submitters noted their support for the free Fruit in Schools programme, a Government initiative where a free piece of fruit is provided each day to each child in the lowest decile (low socioeconomic) primary schools around New Zealand.
**Progress Nutrition, Health and Related Claims legislation**

*Progressing legislation will facilitate the promotion of healthier foods*

Several industry submitters (Fonterra, the FIG and the FGC) supported progressing the Nutrition, Health and Related Claims legislation. As outlined in Chapter 2, at the time of the Inquiry, this legislation was undergoing consultation with stakeholders (and had been for some time). If progressed, the legislation would enable manufacturers to make health claims about individual foods where there was evidence of a health benefit (subject to some criteria).

The RBA and ANZA argued that the current ‘ban’ on advertising the benefits of nutritious food was problematic as it created an unlevel playing field in food advertising that favoured the promotion of less healthy products:

> Food standards prohibit advertising the benefits of nutritious food . . . . The word ‘healthy’ is banned. This state of affairs is a nightmare for advertisers – so such advertisements are avoided for fear of prosecution – the playing field is tilted against advertising nutritious food (ANZA s158:8-9).

Removing the advertising ban would, according to ANZA (s158:14), lead to:

> an immediate increase in the number of advertisements for nutritious food.

The progression of the Nutrition, Health and Related Claims legislation was therefore positioned as having potential public health benefits. This position was also supported by the FGC (s163:6). Thus, despite arguments by the food industry that there is no such thing as a ‘good’ or ‘bad’ food, on the matter of promoting the health benefits of foods, apparently there are good foods.

Fonterra however, disputed the finer details around the proposed exclusion criteria being developed for the proposed Nutrition, Health and Related Claims legislation (which would disqualify foods containing high amounts of sugar and saturated fat from making health claims):

> Fonterra does not agree with the disqualifying criteria . . . . 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 (Fonterra s138:8).
Following the logic of Fonterra’s argument, if health claims could be made for yoghurt on the basis of the criterion that it may be a healthier substitute for an alternative product (such as cream), the potential for other products to make a health claim on this basis would be great.

5.4.3 Non-solutions

Solutions explicitly opposed by industry in the area of marketing included:

- advertising bans
- regulation of industry sponsorship

Solutions opposed by industry of relevance to the food supply included:

- mandatory Front of Pack (FOP) labelling
- regulation of product composition
- fat taxes
- regulations regarding the placement or contents of vending machines.

These six non-solutions and the arguments used by industry to justify their opposition to these policy options are considered below under the relevant headings of marketing and food supply.

Marketing

Advertising bans

According the FIG (s157) and the RBA, bans on advertising and promotion of food would:

reduce the ability of media to pay for content; remove the opportunity for child health, safety and well-being messaging funded by food advertisers; [and] deny consumers an important source of information on their food choices (RBA s187:7).

Thus, arguments invoked by industry against advertising bans included: the potential loss of revenue; the removal of opportunities for health promotion messages; and, denying consumers information. Another argument was the claim that television advertising bans would be discriminatory to this media (creating an unfair commercial advantage for other advertising media not subject to advertising bans). Other submitters provided yet more examples of their voluntary efforts as evidence that self-regulation was working and
therefore there was no need for additional interventions such as advertising bans. The evidence for these arguments is considered below.

**Potential loss of revenue**

The issue of the potential loss of revenue was raised by a number of industry submitters. Generally, it was held that banning unhealthy food advertising on television would reduce the ability of broadcasters to purchase children's television programmes and support local programme content. The NZTBC, speaking on behalf of the non-competitive interests of the two major New Zealand broadcasters (TVNZ and CMW), summarised what industry submitters considered to be critical issues on this matter:

How much food advertising is there on our main free to air channels? . . . . The answer is about 20% of all advertising on [channels] One, Two and Three is for food, fast food, beverages and sweets. . . . That’s worth about 140 million dollars to the two television broadcasters sitting at this table [CMW and TVNZ] . . . . we are not convinced that a television ban is going to make any difference to the obesity levels in New Zealand. In fact, we think it would turn it into a forbidden fruit. We also believe it would be most unfair to cut our income by 140 million when you aren’t considering cutting the income of the other media and that’s where the spend will go. It will severely reduce our ability to fund New Zealand programmes, therefore it affects the New Zealand production industry and a ban of advertising in children’s programs is likely to cause the end of those very programs (representative, NZTBC, transcript).

Clearly, although the NZTBC claimed that food advertising on the main television channels amounts to only 20% of their revenue, this proportion is substantial to them in monetary terms. Should this revenue stream be lost, due to restrictions on the advertising of particular foods, it is possible that this will impact on the broadcasters’ ability to purchase local programming content. This, together with the fact that TVNZ has a mandate as a public broadcaster to feature local programme content (according to the principles outlined in the TVNZ Charter), suggests that an alternative source of revenue, potentially from government, would probably be required to make up the shortfall to ensure TVNZ continued to meet its broadcasting responsibilities. Although this point was not explicitly stated, some reading between the lines suggests that this was the intention of the argument being made.

**Remove opportunities for health messages**

A few submitters also believed that banning unhealthy food advertisements would result in the removal of opportunities for health, safety and wellbeing messages. However, it is not
clear why this was assumed to be a logical consequence of potential advertising restrictions. The RBA noted its concern that advertising bans would remove opportunities for health and safety messages funded by the food industry. However, this does not mean that government funded health messages would necessarily be affected.

Denying consumers information

The argument that consumers have a right to information, is an extension of the argument already outlined in relation Section 14 of the Bill of Rights Act. Under Section 14 of the Act consumers have the legal right to receive communication. If advertising can be considered as a form of communication under Section 14, then, it could be argued, that consumers have a legal right to receive advertising. However, it is not clear whether the intention of the Act was to cover forms of communication such as advertising. What is clear, is that for industry, advertising and information are seen as synonymous. This is not surprising, given that it is in industry’s interests to blur any distinction between the two.

Consumer power was also used as an argument to defend the status quo of the self-regulatory advertising system. Here it was argued that consumers would not support particular advertising media if they found it to be engaged in socially irresponsible advertising (ASA s31). This lack of consumer trust would result in loss of advertising revenue – a consequence that opposes the interests of the media and advertisers. In other words, consumer power is one of the market mechanisms purported to regulate advertising behaviour.

Television advertising bans would be discriminatory to the media

Other submitters noted that singling out television advertising (as opposed to advertising in other media such as radio, internet or magazine) was discriminatory to the media (an appeal to the market justice principle of a level playing field). McDonalds for instance, argued that, in designing legislation to restrict the marketing of unhealthy food, all forms of marketing would have to be considered otherwise it would not be a level playing field. Thus, it was argued that legislation would have to consider how to restrict marketing in other areas such as ‘in-store display’ in supermarkets, shelf-placement, direct-to-consumer marketing, as well as ‘aggressive pricing strategies’ (McDonalds s192:19).

Furthermore, imposing restrictions on television advertising alone, while leaving other media unregulated, was argued to have other unintended consequences. For instance, some submitters suggested that a decrease in food advertising on television would simply
be replaced with an increase in the advertising or marketing of such food across other advertising media.

**Voluntary measures are already underway**

Voluntary measures taken by broadcasters were used as evidence both of industry’s willingness to be part of the solution and of the effectiveness of advertising self-regulation. The NZTBC (s293) highlighted its adherence to the existing ASA codes, and provided the committee with information on its new protocol for children’s television titled: ‘Advertising on television: Getting it right for children’ (outlined briefly in section 5.1.1).

On the issue of television advertising, TVNZ (s81:8) claimed that it had already voluntarily reduced advertising and that 45% of programming aimed at children was already designated as ‘non-commercial’. TVNZ also claimed that food advertising accounted for just 20% of commercials in ‘children’s viewing time’ (as defined by industry).

The RBA suggested that advertising bans were a *populist response* and were critical of some comments made to the media by members of the Health Select Committee who were proposing bans or restrictions on the advertising of particular foods:

> The RBA is not surprised at this since advertising is highly visible, often intrusive, and occasionally irritating and thus is likely to gain much support from the public at large . . . . But advertising’s convenience as a ‘lightening rod’ does not mean that it has any impact on obesity (RBA s187:6).

Other industry submitters also drew on the ‘evidence’ and arguments used in their defence of advertising as a *cause* of obesity, as reasons why advertising restrictions or bans will not work. These included the arguments: that there was no causal link between advertising and obesity; that fish and chips continue to be popular despite their lack of advertising; that sedentary behaviour was influenced by the uptake of other (new) screen-time technologies; and that in any case, it would be very difficult to define unhealthy foods.

**Regulation of industry sponsorship**

With the exception of tobacco, sponsorship of sports and community activities is not subject to regulation in New Zealand. On this issue, both the food and the advertising industry submitters were unanimous in their support for maintaining the status quo. Two arguments in defence of the status quo were evident from the industry submissions: the
potential loss of revenue and the notion that sponsorship of sport was socially responsible.
The evidence for these arguments is considered below.

**Potential loss of revenue**

The main argument against regulation or restriction of industry sponsorship was the
potential loss of revenue to sporting bodies and the community, should food industry
sponsorship become restricted. The RBA argued that:

> bans on involvement of the food sector in sports would also have far
> reaching consequences (RBA s187:7).

The FIG estimated that a ban on food sponsorship of sports would remove NZ$100 million
income a year from sports bodies (FIG s157:17). Similarly, McDonalds, as a big corporate
sponsor of sport, especially children’s sport, had this to say to the committee when being
questioned by a National Party representative on the issue:

Coleman (National Party): I'll just ask, how much did McDonald's spend
sponsoring children’s sport in the last financial year?

McDonalds’ representative: The value of our commitment is close to 1.2
million dollars last year, when you look across the soccer association and
touch rugby and the netball association I guess there’s a little bit in terms of
the association, but most of it is about making it fun for kids . . . . So there’s
coaching brochures, there’s certificates to encourage participation, there’s
balls, there’s cones . . . . And then an example would’ve been, recently we
have a world cup competition where we were able to offer a young kiwi kid
the opportunity of a lifetime to travel to Berlin to walk out in the world cup
final holding a player’s hand. And the criteria for entering that was simply to
register as a Small White player. And so the uptake was pretty strong and
um the excitement around that (representative, McDonalds, transcript).

The FIG also appealed to equity arguments, noting, that:

Sporting bodies report that without such sponsorship their player fees
would be higher. If as food activists claim, income is a major factor behind
obesity, then higher sport participation costs would surely heighten the
obesity risk for low income people (FIG s157:18).

This argument was made despite industry’s claim that economic factors (income) did not
have a causative role in obesity.
**Sponsorship of sport is socially responsible**

Sponsorship of sport in particular, was also justified by reference to industry arguments about the need to balance ‘energy in’ with energy expended:

> Frankly, we believe it to be sensible and reasonable for food companies to sponsor sports. Food is the source of human energy. Sport players are expending energy. This is the recipe for a balanced diet (FIG s157:18).

Thus, sponsorship it appears, is a socially responsible activity for industry to be engaged in. Later in its submission, McDonalds admitted that sponsorship is not just an exercise in social responsibility and public relations, but also a *marketing strategy*:

Kedgely (Green Party and Chair): And do you consider, you talked a lot about your sponsorship activities and so on, is that part of your marketing budget?

McDonalds’ representative 1: Absolutely.

Kedgely: That comes out of that twenty million dollar spend?

McDonalds’ representative 1: Yes.

Kedgely: So sponsorship, you consider sponsorship, you consider sponsorship as marketing?

McDonalds’ representative 2: It’s a way to talk to its audiences.

McDonalds’ representative 1: Yes we see it as a subset of that.

Later in the same session, another positive advantage of sponsorship (for industry) was revealed:

Street (Labour Party): If in fact, there was a recommendation from this committee to ban advertising to children under thirteen, as in overseas, then clearly you are already sufficiently buffered against that with sponsorship arrangements, if that’s part of your marketing strategy. Are you not? It would be a very minimal impact on you, is that fair?

McDonalds’ representative: The associations we have in grassroots sport, are, I guess, keep our brand top of mind . . .

Thus, sponsorship, it appears, performs a number of important functions for industry. Positioned by industry as a public relations exercise in community contribution (social responsibility), sponsorship functions: to create dependence and grassroots support by otherwise under-resourced community and sporting groups; is an exercise in ‘top of mind’
brand marketing; and, acts as an insurance against potential advertising restrictions in other media.

Food supply

This section considers the four policy options opposed by industry in the area of food supply. These were:

- mandatory Front of Pack food labelling
- the regulation of food composition
- fat taxes
- regulation of vending machines.

**Mandatory Front of Pack (FOP) food labelling**

The FIG suggestion regarding labelling, was that the food industry should be *encouraged* to use a range of guidelines, for instance, ‘Pick the Tick’, the ASA guidelines or the Ministry of Health guidelines. The FGC, emphasising that food labelling is already extensive, stated that:

> The FGC does not support a regulatory approach, placing restrictions and bans, and defining food products as ‘good’ and ‘bad’ (FGC s163:2).

Two key issues emerged on the issue of FOP labelling. The first of these was the emphasis placed by submitters on their own, recently developed FOP labelling systems. The second issue was the Traffic Light labelling system recently adopted in some sectors of the UK. Industry perspectives on these issues are outlined below.

**We have our own FOP labelling**

Some submitters (Coca-Cola and McDonalds), perhaps in anticipation of a mandatory FOP labelling, provided detailed descriptions of their own FOP labelling systems (using the percent Recommended Daily Intake model).

Pictorial examples of the new Recommended (percentage) Daily Intake labelling (RDI) under development by McDonalds was also provided to the committee. McDonalds noted that it was, in the next month "introducing percentage RDI labelling progressively across all
of our packaging” (Representative, McDonalds Transcript). Again, this framing suggests that the food industry is already addressing the issue, which in turn implies, no further action is required.

**Opposition to Traffic Light FOP labelling**

Traffic Light food labelling in particular, was a major issue of concern for the food industry sector, although this was only apparent from the oral submissions (the issue of Traffic Light labelling was absent from the written submissions). Industry was vehemently opposed to the suggestion by some committee members that the Traffic Light FOP labelling system, currently being trialled in the UK, be adopted here as the following excerpt revealed:

Kedgely (Green Party and Chair): basically they have done research in the UK and they are saying actually what most consumers want is – actual Traffic Lights, red, green, and orange – a simple system such as the UK has come up with. Are you happy with the idea of a Traffic Light system?

Bree: Not really. No. Generally we are uncomfortable with the Traffic Light system because we feel it is overly simplistic and I think for every piece of research that says the Traffic Lights work there is another piece of research that says they don’t. They are – they’re helpful – they are a bit like a weight watchers guide – they are helpful for people who are already obese – they are not helpful in terms of helping people to make a balanced diet decision, and we believe that the RDI system does actually help that.

Kedgely: In the UK, they are actually saying, that they are finding that the consumers are finding that . . .

Cutress: there is also evidence – it is controversial – not all the evidence says that – and a simple example might show why it can be confusing, you can put, and I saw this just last week in Europe where I was at a meeting where this was all being discussed at, you can put a mayonnaise on the market that is high fat, and would have to have a red label. The manufacturer had the same mayonnaise on the shelf that was reduced fat and it had almost two-thirds less calories, that also had to have a red sticker. Now that’s not helpful to consumers, because if you are trying to reduce weight, you would like to be able to choose a lower fat mayonnaise, and that’s the problem that’s indicative.

The discussion continued for a while, with the FIG arguing that the Traffic Light system would be confusing to the consumer. The committee were concerned however, over the complexity of the RDI front of pack labelling system currently being adopted by industry and raised this issue with the FIG:

Maroney (Labour Party): [the RDI system] requires a few calculations to be made . . . . it strikes me that the mother traipsing around the supermarket with three young children . . .
Cutress: The individual companies that have implemented the RDI around the world, Coca-Cola, Nestle, Kelloggs and McDonalds, they would not have done that without very good, and their research told them, so when this was researched, and believe me, Unilever was another one, it costs a lot to re-label packets, and all those big companies found this to be the most helpful thing to consumers because if you, then it helps you know whether they can eat the ice cream, the meat and the vegetables, because all those percentages add up.

Mahoney: Its very complex . . .

Bree: [back on the issue of Traffic Light labelling] the basic definition of red is eat occasionally, what is your definition of occasional? Some people treat occasional as daily . . .

Thus, the Traffic Light system was argued by industry to be potentially confusing for the public to interpret and potentially costly to manufacturers. In contrast, the industry designed voluntary FOP labelling system was positioned as well-researched and already implemented. Yet, some members of the committee appeared unconvinced.

**Regulating food composition**

*Voluntary guidelines not regulation*

Industry submitters were also opposed to government regulation of food composition. Instead they favoured adherence to voluntary guidelines. The FIG for instance, recommended that industry be ‘encouraged’ to use existing guidelines, such as Pick the Tick (the Heart Foundation endorsement for ‘heart healthy’ products) or the Ministry of Health guidelines for product development, rather than regulating for mandatory changes to products (FIG s157:4).

*Market demand should control the food supply not regulation*

Fonterra, appealing to market principles, argued that market demand rather than regulation should determine the nature of the food available to consumers:

the demand for low or reduced fat and sugar options should control the food that is put on the market, not legislation. This demand has been met so far by the food industry. Legislation or policy to restrict the food industry is likely to be implemented to restrict the sale of individual food items, when it is an individual’s diet and lifestyle as a whole which is the issue. Legislation or policy tends to be too rigid and cannot be amended easily in order to keep up with changing conditions and research – a voluntary code of practice for industry can be more easily updated (Fonterra s138:7-8).
Limits to product reformulation

It was interesting, given industry’s emphasis on the voluntary initiatives arising out of the Accord, that the expert witness appearing before the committee on behalf of the FGC noted that there were limits to product reformulation as a strategy to address obesity:

If we want to target food energy consumption reduction, to meet that change of energy expenditure, we are going to have to remove more than 20% of the energy from foods. That is literally impossible to do by reformulation. We have only got four things that we can remove from daily food; protein; fat; carbohydrates; and, water. And if you take any one of those things away from food you’ve got to add something else to it – and with the low fat foods, you have to add carbohydrate back into that food. There’s very little change that you end up doing at the end of the day. Take something out, replace it with something, and [the] change is not really that dramatic. So a major change in the energy consumption is unlikely to be achieved (Professor of Food Technology, FGC, transcript).

Such an argument appears to undermine industry arguments that voluntary efforts in the area of product reformulation were one of a number of promising voluntary initiatives arising out of the Accord. Furthermore, FIG noted that product reformulation was only one of the available solutions to obesity, since in its view, it was not the primary cause.

Fat taxes

Fat taxes are unpopular, regressive, and may increase compliance costs

Food taxation, as a mechanism for altering food purchasing behaviour, was opposed by a few industry submitters, predominantly from the food retail sector. The Retailers’ Association (s7:3), had this to say on the issue:

Calls for action such as ‘fat taxes’ were raised as a matter of principle in a 2003 discussion paper relating to public health legislation [the proposed Public Health Bill]. At the time we proffered the view that the principle of including regulatory making powers in such legislation was neither sensible nor desirable.

Foodstuffs, although it was aware that consumers (it surveyed) would be supportive of discounts on healthy foods (as an option to remove barriers to healthy eating), argued that consumers were not supportive of excise taxes (which Foodstuffs equated with fat taxes). Furthermore, Foodstuffs asserted (s283:7) that a fat tax would be retrograde, difficult to design (due to the difficulty in establishing workable definitions of healthy and unhealthy), and, largely ineffective in changing purchasing behaviour:
To be successful the tax would have to be very large, significantly increasing the purchase cost of the target foods. Such a tax would be highly regressive – penalising the people the Government most wants to help. It would also be hugely unpopular as our market research has shown. A low level tax would do nothing more than increase compliance costs for food businesses. In our view a ‘fat tax’ is unworkable.

The FGC (s163:3) noted that:

If someone is prepared to spend $1.50 on a chocolate bar, will imposing a 20% tax to make it $1.80 dramatically change consumption patterns? Logic and science strongly suggests that the desire will override the barriers to pleasure. Who would suffer from such a tax? Those that can lease [sic] afford it.

Similarly, McDonalds (s192) referred to fat taxes as ‘pigouvian’, meaning, making the person producing the problem pay for the resulting effects. Thus, according to industry, fat taxes would essentially be regressive.

**Regulating vending machines**

*Regulating is contrary to property rights, free choice and consumer demand*

The FIG, again drawing on market justice principles, voiced their opposition to the removal or regulation of products available though vending machines in public places:

Some food activists have suggested that vending machines be removed from certain locations, or that their products are controlled. This is naïve, as it is contrary to property rights, free choice, and consumer demand, and impractical to administer. Primarily, such bans are easily circumvented by consumers who will simply change behaviour to find the food products from other outlets. The lengths normal people will go to circumvent bans has been shown many times in the history of regulation. The answer lies not in bans and restrictions but in offering healthier alternatives and effective advertising of those choices (FIG s157:18).

The CMA also had something to say about vending machines in general:

very few manufacturers distribute through vending machines. Where this does take place, efforts are being made to include healthier product options in smaller sizes (CMA s252:6).

**Summary of the industry framing of the solutions**

There was overall, *unanimous support* for maintaining the existing policy environment – characterised by self-regulation in general; self-regulation of advertising and marketing in
particular; and, the existing national obesity strategy (HEHA). In defending the self-regulation of marketing, industry invoked legal arguments about its right to disseminate information and noted the advantages of the ASA framework over a regulatory system. In defending self-regulation of the food supply, industry outlined numerous voluntary initiatives as evidence that self-regulation was working. In support of the national obesity strategy, industry praised HEHA for promoting collaboration and partnership between industry and the Government, although some called for Government assistance to facilitate collaboration with some NGOs. This collaboration was promoted by industry as a critical mechanism for coordinating efforts to reduce obesity. The Accord was held up as an example of successful partnership and collaboration, and, as one of the most promising strategies to address obesity to date – although it was argued by some submitters, that more time was needed to assess the impact of the Accord initiatives.

Almost all industry submitters argued that the provision of information and education – ‘the knowledge task’ – was the central solution to the obesity problem. In the school environment there was support from industry for structured exercise and nutrition education in the curriculum, although food policy in schools was deemed an issue for each school to determine. Some industry submitters also voiced their support for the free Fruit in Schools scheme. Another policy prescription was to progress the proposed Nutrition, Health and Related Claims legislation. Progression of this legislation was argued to be in the interests of public health as it was claimed that allowing health claims on food would encourage manufacturers to promote healthier food. This was despite earlier arguments that there was not such thing as ‘good’ or ‘bad’ food.

Much of the discussion in the industry framing of the solutions to the obesity issue was however, not around policy prescriptions, but around policy options industry was opposed to. These were, broadly speaking, any form of regulation of the food and marketing industries. Specifically, the industry was opposed to: advertising bans; regulation or restriction of industry sponsorship; mandatory FOP labelling; regulation of food composition; fat taxes; and, any regulation to the placement or contents of vending machines.

A number of arguments were put forward to justify why these policy options were not feasible solutions to the obesity problem. Arguments against advertising bans included: potential loss of revenue; the removal of opportunities for health promotion messages; denying consumers information; that television advertising bans would be discriminatory to the media; and, that many voluntary measures were already underway. In defending industry sponsorship of community and sporting activities, the arguments included: the
potential loss of revenue; and that sponsorship of sport was a socially responsible activity for industry to be engaged in. Mandatory FOP labelling was opposed on the grounds that Traffic Light labelling would be confusing to the public and potentially costly to manufacturers, and also that industry had developed their own FOP labelling systems. Fat taxes were argued to be unpopular with the consumer, potentially regressive, and undesirable because they would potentially involve heavy compliance costs. On the final matter of regulating the placement or contents of vending machines, it was argued that this would be contrary to property rights, free choice, and consumer demand. The final section of this chapter summarises the overall framing of obesity by industry, using the framing matrix outlined in Chapter 4.

Summary of Chapter 5

This chapter has examined the industry sector as defined for the purposes of this thesis, and described the framing of obesity by the food and marketing industries using the framing matrix developed in Chapter 4. Key aspects of the framing of obesity by the industry are provided in Table 22 and summarised below.
Table 22: Summary of industry framing of obesity

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<td>Obesity but not overweight is the problem</td>
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<tr>
<td></td>
<td>A problem for affected individuals or communities</td>
</tr>
<tr>
<td></td>
<td>Predominantly an ethnic problem for Māori &amp; Pacific communities</td>
</tr>
<tr>
<td></td>
<td>Socioeconomic factors a correlation &amp; not a cause</td>
</tr>
<tr>
<td></td>
<td>No mention of gender differences</td>
</tr>
<tr>
<td></td>
<td>Children a risk group for some submitters</td>
</tr>
<tr>
<td><strong>Causes</strong></td>
<td><strong>General causes</strong></td>
</tr>
<tr>
<td></td>
<td>Energy imbalance</td>
</tr>
<tr>
<td></td>
<td>Multiple societal factors: affluence, abundance (of food), &amp; technological changes leading to sedentary lifestyles</td>
</tr>
<tr>
<td><strong>Main cause</strong></td>
<td>Obesogenic lifestyles characterised by over-consumption &amp; sedentary lifestyles</td>
</tr>
<tr>
<td></td>
<td>Overconsumption due to individual traits including: poor attitudes; lack of motivation (inertia &amp; apathy); denial about weight problems; knowledge deficits; &amp; family influences</td>
</tr>
<tr>
<td></td>
<td>Sedentary lifestyles due to technological changes but individual factors also contributed</td>
</tr>
<tr>
<td></td>
<td>Emphasis on physical activity as the dominant cause</td>
</tr>
<tr>
<td></td>
<td>Emphasis on knowledge deficits</td>
</tr>
<tr>
<td><strong>Non-causes</strong></td>
<td>Not genetics</td>
</tr>
<tr>
<td></td>
<td>Not advertising (although it may reinforce behaviour in some)</td>
</tr>
<tr>
<td></td>
<td>Not the branded fast food sector</td>
</tr>
<tr>
<td></td>
<td>Not sugar, carbonated soft drinks, confectionery or alcohol</td>
</tr>
<tr>
<td><strong>Solutions</strong></td>
<td><strong>Perspectives on the existing policy environment</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Support for HEHA</strong>: Unanimous &amp; uncritical support of HEHA (viewed as a educational &amp; collaborative rather than a prescriptive &amp; regulatory approach)</td>
</tr>
<tr>
<td></td>
<td><strong>Support for self-regulation of the food supply</strong>: support for continued self-regulation of the food supply. Accord is industry’s response to HEHA but it needs more time to realise its goals</td>
</tr>
<tr>
<td></td>
<td><strong>Support for self-regulation of the marketing sector</strong>: support the existing system</td>
</tr>
<tr>
<td><strong>Additional policy prescriptions</strong></td>
<td>Education &amp; information: ‘the knowledge task’, Government &amp; industry should be involved in the ‘knowledge task’</td>
</tr>
<tr>
<td></td>
<td>Schools: support structured physical activity &amp; nutrition education in the curriculum &amp; voluntary (not mandatory) food polices in schools</td>
</tr>
<tr>
<td></td>
<td>Progress the Nutrition, Health &amp; Related Claims legislation</td>
</tr>
<tr>
<td></td>
<td>Targeted policies: policies should be targeted to those affected</td>
</tr>
<tr>
<td><strong>Non-solutions</strong></td>
<td>Advertising bans, regulation of industry sponsorship, mandatory Front of Pack labelling, regulation of food composition, fat taxes, regulation of vending machines</td>
</tr>
</tbody>
</table>
The common themes identified in the food and marketing industry framing of obesity were: (i) in their overall description of the problem, defining obesity as an ‘issue’, a ‘concern’ and a ‘complex issue’; (ii) in identifying the type of problem, emphasising obesity as a ‘health problem’ and an ‘economic burden to the health system’. In identifying who was affected, industry emphasised the obese population and identified Māori, Pacific and low socioeconomic groups as the population subgroups most affected.

In industry discussions of the general causes of population increases in obesity, industry was in broad agreement that ‘energy imbalance’ was ultimately the underlying physiological cause of obesity. To explain causes of this energy imbalance, the industry noted that there were multiple factors operating at the societal level contributing to obesity. Here the emphasis was on affluence, abundance (of food) and technological change. However, these societal level causes were not considered overwhelming, and industry identified individual obesogenic lifestyles as the main cause of increased obesity. Key characteristics of obesogenic lifestyles identified by industry included: attitudes; lack of motivation; denial of weight problems; inertia and apathy; and, knowledge deficits. Family influences (in particular family role modelling) were also considered to have an impact on individual dietary and physical activity habits.

There was also a clear emphasis amongst industry submitters on declining physical activity, as opposed to increased consumption, as the dominant cause of the energy imbalance. Industry presented ‘evidence’ and arguments to support this contention.

There were also a number of ‘non-causes’ explicitly identified by many of the industry submitters. These non-causes (or ‘don’t blame us’ arguments) were specific to advertising, and to particular food and beverage products that have been implicated in the obesity epidemic. For instance, the advertising industry presented ‘evidence’ to support its claim that advertising does not cause obesity. It was argued that there was no correlation between advertising (predominantly television advertising) and obesity. Other arguments put forward to defend advertising included: the ‘fish and chip’ argument (blaming the informal fast food sector); the ‘influence of new technologies’ on sedentary behaviour; and the supposed complexity in defining the term ‘unhealthy’ as it applies to food. Likewise, various food and beverage companies (NZ Sugar, Coca-Cola, McDonalds, the CMA and the BWSC), presented arguments and ‘evidence’ to support claims that their products (sugar, CSD’s, confectionery, and alcohol), or sector (the branded fast food sector) were not major contributors to obesity.
On the matter of solutions, industry was unanimous in its support for HEHA and its collaborative rather than regulatory approach – described by one submitter as a ‘state of the art plan for action’. The Accord agreement between industry and the Government was positioned as a promising partnership to address obesity. Industry provided numerous examples of voluntary initiatives throughout the food supply and marketing sectors as ‘evidence’ of industry’s commitment to addressing obesity as a rationale that no further action was required. Also apparent was industry’s overwhelming support for a collaborative and partnership approach (between industry, government and non-government sectors) to addressing obesity.

Industry was also supportive of continued self-regulation in both the marketing and food sectors. Again industry submitters highlighted the numerous voluntary initiatives arising out of the Accord to demonstrate that self-regulation was working. Furthermore, in the area of marketing and advertising, industry outlined the advantages of the ASA self-regulatory framework over a regulatory approach.

Additional policy prescriptions made by industry submitters were few. The main focus was on the provision of education and information. The school environment was another area where some submitters proposed that structured exercise should be mandatory in schools and there was some support for nutrition education in the curriculum. On the matter of school food policies (the food available for sale in schools), industry argued only for voluntary policies. Some industry submitters also proposed that the Nutrition, Health and Related Claims legislation be progressed to encourage the promotion of healthy food.

Non-solutions identified by industry submitters included: advertising bans or regulations; regulation or restriction of industry sponsorship; mandatory FOP labelling; fat taxes; and, the regulation of the placement or contents of vending machines. Numerous arguments were provided by industry to justify its position on these policy options.
Chapter 6: Results II: Public health framing of obesity

This chapter examines the framing of obesity by the public health sector, following the same format as the previous chapter. It begins with an overview of the public health submitters (section 6.1) and provides relevant background information as context for examining the obesity frames.

The signature features of the public health framing of obesity are examined in sections 6.2-6.4, following the same format as Chapter 5. This involved an examination of the framing of the problem, its causes and the solutions.

The stances taken by the independent advisors on the key themes identified by the public health groups are presented separately throughout this chapter. This is because many of the public health groups obtained some of their funding from the Ministry of Health, and, as noted in Chapter 4, this may have constrained the freedom of such groups to be critical of existing policy. Where there is no subsection indicating the views of the independent advisors, this is because there was no relevant comment made by any of them. This was more evident on the matter of specific solutions.
6.1 Public health submitters

Fourteen public health sector submitters are covered in this chapter. These submitters are shown in Figure 9.

![Figure 9: Submitters from the public health sector](image)

NGOs = Non-Government Organisations
NZ = New Zealand

Figure 9 shows that the public health sector (as defined for this thesis in Chapter 4) was comprised of: three obesity and nutrition focused NGOs; four ‘other health issue’ NGOs; four professional associations (with public health focused submissions); and, the three independent advisors selected by the committee. There were numerous links between many of these NGOs as many were members of other NGOs (these links are noted under the relevant organisations in section 6.1.1).
6.1.1 Background of public health submitters

This section provides critical background information on the eleven public health submitter groups included in this research. This information includes their: objectives; main sources of funding; membership; and, activities engaged in at the time of the Inquiry. A brief biography of each of the three independent advisors is also provided.

Public health groups

Fight the Obesity Epidemic

Founded in 2001, Fight the Obesity Epidemic (FOE) was a voluntary organisation promoting policies to stop and reverse the rise of Type 2 diabetes and obesity in children (Fight the Obesity Epidemic 2008). Based in Wellington, with 270 members, FOE was partly funded by the Ministry of Health and by individual member subscriptions. FOE’s vision was to change the obesogenic environment to ‘make healthy choices the easy choices’ (Fight the Obesity Epidemic 2008). FOE’s stated policy prescriptions included: banning or severely restricting the marketing of unhealthy food to children; introducing compulsory labels on food (e.g. a Traffic Light labelling system); ending sponsorship of schools and children’s sport by ‘junk food companies’; introducing tax changes and/or subsidies to make healthy food more affordable; and, making changes to the built environment to promote active transport (Fight the Obesity Epidemic 2008). FOE conducted research, engaged with the media, made submissions to government, and distributed information and research to interested parties (Fight the Obesity Epidemic 2008).

Obesity Action Coalition

The Wellington based Obesity Action Coalition (OAC) was an advocacy organisation that aimed to reduce the prevalence and impacts of obesity by promoting environmental (physical, social and legislative) changes (Obesity Action Coalition 2008). OAC was part-funded by its sixty-nine non-profit member organisations (which included national health organisations, Public Health Units, Māori groups, consumer, education, and recreation and physical activity groups), but the bulk of OAC’s funding came from a contract with the Ministry of Health (Obesity Action Coalition 2004) who supported its formation in 2002 (L. Sturgiss, personal communication, July, 2009). In addition to its lobbying activities, OAC
provided a forum for discussion and sharing of information, conducted research and provided regular newsletters and occasional seminars.

**Agencies for Nutrition Action**

Located in Wellington, Agencies for Nutrition Action (ANA) was established in 1992 by: the Heart Foundation; the Cancer Society; Te Hotu Manawa Māori; the National Diabetes Forum; the New Zealand Dietetic Association; and, the New Zealand Nutrition Foundation (Agencies for Nutrition Action 2008). Since then a number of other associations had joined the ANA. The ANA represented the combined interests of a number of NGOs in public health with a focus on nutrition, physical activity and obesity. Its mission was to “support New Zealanders to achieve and maintain a healthy weight throughout life through good nutrition and physical activity” (Agencies for Nutrition Action 2008). ANA organised a number of activities including a national conference, and provided regular newsletters to update members of current news and research in this sector. ANA was funded in part by the Ministry of Health (for specific projects) and through member subscriptions (Agencies for Nutrition Action 2008). ANA also supported the establishment of the OAC in 2002 to provide “a strong and united voice to advocate for government policy, regulations and legislation that will positively influence obesity rates” (Agencies for Nutrition Action 2008).

**Te Hotu Manawa Māori**

Established in 1997, the Auckland based Te Hotu Manawa Māori (THMM) was a national health promotion and advocacy organisation aimed at reducing heart-related illness and death among Māori (THMM s100). THMM provided health services ‘by Māori for Māori’, reinforcing the principles and values of both tikanga and kaupapa Māori imperatives (Te Hotu Manawa Māori 2008). Its vision was that “Māori determine for themselves their health and wellbeing” (Te Hotu Manawa Māori 2008). THMM had a prevention focus geared at improving nutrition, physical activity, smoking cessation and encouraging smoke free environments (THMM s100). As well as providing a forum to facilitate networking, THMM was engaged in: advocacy; the development and dissemination of resources and information; and, the provision of training courses for health promoters. THMM worked with the OAC to develop a strategic plan to address obesity amongst Māori. This plan had two priority areas: workforce development and food security (Te Hotu Manawa Māori 2008). THMM was funded by the Ministry of Health (M. Seath, personal communication, July, 2009).
Cancer Society of New Zealand

Formed in 1963, the Cancer Society of New Zealand (Cancer Society) was made up of six Divisions and a National Office located in Wellington (Cancer Society of New Zealand 2008). Funded by donations and bequests, the Cancer Society did not receive any government funding for its work (Cancer Society of New Zealand 2008). In addition to its health promotion work, the Cancer Society was engaged in advocacy for cancer patients and the provision of education, information, research, and support services. Nutrition, physical activity, and obesity were priority areas within the Society’s health promotion programme, as were reductions in cancer disparities between Māori and non-Māori (Cancer Society of New Zealand 2008).

Diabetes New Zealand

Located in Wellington, Diabetes New Zealand (Diabetes NZ) represented 14,000 members and 39 diabetes societies (Diabetes NZ s18). Established in 1962, the aim of the organisation was to support its members, societies and health professionals involved with diabetes (Diabetes New Zealand 2008). Diabetes NZ provided advocacy and local support for those with diabetes, raised awareness of diabetes and interventions, provided education and information, and supported diabetes research (Diabetes New Zealand 2008). Diabetes NZ was funded by: member fees; donations; grants and bequests; and, a diabetes product distribution and mail order service (Diabetes New Zealand 2008). Additional funding was sourced from the Lottery Grants Board, and some targeted funding was provided by government agencies.

National Heart Foundation of New Zealand

Established in 1968, the Auckland based National Heart Foundation (NHF) was a non-government, not-for-profit organisation with the aim of reducing suffering and death from diseases of the heart and circulation (NHF s47). The NHF was funded by: bequests; legacies; a number of fund-raising initiatives; and, royalties from manufacturers involved in their Pick the Tick programme (Heart Foundation of New Zealand 2008). The organisation also received funding from the Ministry of Health. The NHF provided individual and population health programmes and funded research and scientific endeavours to reduce the prevalence of diseases of the heart and circulation (NHF s47).
Public Health Association of New Zealand

The Public Health Association of New Zealand (PHA) was “a voluntary organisation taking a leading role in promoting public health and influencing public policy through submissions, seminars, speaking engagements, the annual conference and a communications and media strategy” (Public Health Association 2008). It was funded in part by member subscriptions from over 300 members (from the public, private and voluntary sectors) and by a contract with the Ministry of Health “to encourage and facilitate informed debate on key public health issues (PHA s156:2). The central office of the PHA was located in Wellington.

Australasian Faculty of Public Health Medicine – New Zealand branch

Established in 1990, the Australasian Faculty of Public Health Medicine (AFPHM) was a professional organisation for medical practitioners who specialise in public health (AFPHM s159). The New Zealand Branch of AFPHM had as members, 130 active public health physicians working in a range of positions: in health service planning and management (mainly in the Ministry of Health and in District Health Boards); in the provision of public health services (mostly through the Public Health Units); in academia; and, as consultants and clinicians (AFPHM s159). Some of these members had key roles in addressing obesity as: senior officials and advisors to the WHO; researchers; advisors to government, the health sector and industry; and, as practitioners (AFPHM s159). The New Zealand branch of AFPHM held a funding contract with the government to deliver the public health medicine training programme (Australasian Faculty of Public Health Medicine 2006). The AFPHM was part of the Royal Australasian College of Physicians.

New Zealand Medical Association

Formed more than a century ago, the New Zealand Medical Association (NZMA) was New Zealand’s largest pan-professional medical organisation with around 4000 members, including medical students, General Practitioners and specialists (NZMA s128:2). As well as providing leadership for the medical profession, the NZMA provided advocacy on behalf of doctors and patients, provided support and services to members and published the New Zealand Medical Journal (NZMA s128:2). With the national office of NZMA based in the capital, Wellington, the organisation claimed to be “a strong advocate on medico-political issues, with a strategic programme of advocacy with politicians and officials at the highest levels” (New Zealand Medical Association 2008). The NZMA was funded by membership fees.
New Zealand Nurses’ Organisation

Based in Auckland, the New Zealand Nurses’ Organisation (NZNO) was the largest union and professional organisation representing 39,000 nurses, midwives and caregivers on employment and professional issues (NZNO s130:2). The NZNO aimed to improve the health status of all people in New Zealand “through participation in health and social policy development” (New Zealand Nurses’ Organisation 2008). It worked with its members to provide industrial, professional and legal services. As well, the NZNO provided information via seminars and workshops and campaigned on the key issues affecting its members (New Zealand Nurses' Organisation 2008).

Independent advisors

Dr Robert Beaglehole

At the time of the Inquiry, Dr Robert Beaglehole was a New Zealand public health physician and the Director of the Department of Chronic Diseases and Health Promotion for the WHO in Geneva (Beaglehole s307). In his role as Director of the Department for Chronic Diseases, Beaglehole was responsible for “WHO’s global technical programmes on health promotion and the surveillance, prevention and management of chronic diseases (principally heart disease, stroke, cancer, chronic respiratory diseases and diabetes) and their major common risk factors” (Beaglehole s307:1). Beaglehole advised extensively on the various drafts of the Health Select Committee’s report and the structural format used for the final committee report was based on that used in his written submission (G. Hill, personal communication, August, 2008).

Professor Jim Mann

Jim Mann was the Professor of Human Nutrition at the University of Otago. He had been involved in WHO Expert Consultations and was on the panel of experts for the WHO report: *Diet, nutrition and the prevention of chronic diseases* – also known as Technical Report 916 (World Health Organization 2003). This report was the subject of some controversy over intense lobbying by the sugar industry. This lobbying was investigated in the BBC Panorama documentary (Voisey 2004): ‘The trouble with sugar’ (Mann, transcript).
At the time of the Inquiry, Professor Mann was working on a report from the World Cancer Research Fund (World Cancer Research Fund & American Institute for Cancer Research 2007), which included an update of the evidence on the causes of obesity.

As noted in Chapter 5, NZ Sugar, in its submission to the Inquiry, noted that Jim Mann was one of the ‘experts’ on the Sugar Research Advisory Service – the educative arm of NZ Sugar. Jim Mann also had special expertise in the field of diabetes.

**Professor Boyd Swinburn**

At the time of the Inquiry, Professor Boyd Swinburn was the Chair in Population Health at the School of Exercise and Nutrition Sciences, Deakin University, Melbourne, Australia (Swinburn s189:2). Professor Swinburn noted in his written submission that he had researched for twenty years “the metabolic, clinical and public health aspects of obesity in the US, New Zealand, and Australia, and the Pacific” (Swinburn s189:2). As well, Professor Swinburn was formerly Medical Director of the NHF in New Zealand (Swinburn s189). He was also involved as a consultant to the WHO (and was a lead author of the background paper on obesity prevention) for the 2004 *WHO Global strategy on diet, physical activity and health* (Swinburn s189:2). Professor Swinburn was also one of the developers and promoters of the ‘obesogenic environment’ model of the obesity epidemic (as outlined in Chapter 3).

6.2 Public health problem representation

This section examines the problem representation feature of framing by the public health sector. As with the previous chapter, the problem representation includes: the overall description of the problem by the public health sector (section 6.2.1); the type of problem (section 6.2.2); and, the groups identified as affected by the problem (section 6.2.3).

6.2.1 Overall description

*An obesity ‘epidemic’ and a ‘complex issue’*

In their overall description of the problem, the majority of public health groups described obesity as an ‘epidemic’:

The obesity and type II diabetes epidemics are among the largest and most complex challenges facing New Zealand society (AFPHM s159:2)
An epidemic of obesity and type 2 diabetes is leading to a new wave of heart and vascular disease around the world (NHF s47:2).

On occasion, a couple of public health submitters also described the situation of obesity as a ‘pandemic’ (AFPHM, transcript: NHF s47).

Like industry, many public health groups also described obesity as a ‘complex issue’:

Obesity is a complex problem requiring complex solutions in a range of areas outside of health, including transport, education, food marketing, food supply, and urban design (ANA s38:2).

The epidemic is complex and will require a long-term approach to solutions (NHF s47:2).

To support the epidemic framing of obesity, public health groups emphasised the size and scale of the obesity epidemic by reference to obesity prevalence and trend data (sourced mainly from the Ministry of Health publications). The following quote, from the FOE submission (s136:15), was typical of this sectors’ description of the scale of the problem:

In all, 56% of adult New Zealanders were overweight (35%) or obese (21%) . . . . Obesity levels have risen from 10% of adult New Zealanders in 1977 to 21% in 2003, while levels of overweight have remained much the same.

The same statistics were cited by ANA, and OAC, although OAC added:

In children, rates of obesity have tripled, and in adults they have doubled – in less than one generation (OAC s129:7).

Some submitters from the public health groups (OAC, AFPHM, ANA and the NZMA) cited sex or ethnic specific data on obesity prevalence and trends). This illustrated the higher rates of obesity amongst Māori and Pacific people compared with their European counterparts, and revealed sex differences in overweight versus obesity statistics – with men overrepresented in the overweight category, and women overrepresented (compared to men) in the obese category (AFPHM s159; NZMA s128). A few submitters provided ethnic or sex specific data on obesity prevalence amongst children.
Independent advisors

Two of the independent advisors, Professors Beaglehole (s307) and Mann (s256), described obesity as an ‘epidemic’. However, only Beaglehole (s307:2) cited statistics to emphasise the scale of the problem:

- Over one billion adults (1 in 6 of the world’s population) were overweight . . . [and] Over 300 million adults were obese . . . . Women and populations disadvantaged on ethnic or socio-economic grounds are most at risk. Approximately 22 million children under the age of 5 years are overweight. The prevalence of obesity in adults increased in New Zealand from 10% in 1990 to 20% in 2003 with the rates being a little higher in adult women.

In quoting the above statistics, Beaglehole has suggested that both overweight and obesity were important, and, women, children, and ethnic and socioeconomically disadvantaged populations were more ‘at risk’.

6.2.2 Type of problem

In discussing why obesity and overweight constituted a problem, three key themes emerged: the human health burden; the economic burden to the health system and the economy; and, the notion that excess weight was an inequalites problem. Representative examples from submitters of these themes are given below.

‘Human health burden’

The public health sector highlighted numerous health consequences of obesity (and sometimes overweight). Submitters argued that obesity was either a cause of, or at least a major contributor to, early death and disease:

- Obesity kills and disables tens of thousands of New Zealanders each year. It contributes substantially to our nations’ biggest killers and most devastating diseases: heart disease, stroke, cancer, asthma and depression. 40% of all deaths may be attributed to unhealthy diets and inadequate exercise. This represents 11,000 deaths each year. By comparison road deaths in 2005 were 404 (OAC s129:7).

- 11,000 deaths in 1997 (40% of all deaths or 37% of years of life lost) may be attributed to unhealthy diets and inadequate exercise. This is 29 times higher than the road toll (PHA s156:5).

The NZNO (s130:3) noted that:
Obesity has a wide range of both medical and psychosocial problems and is specifically associated with conditions such as heart disease, stroke, cancer, asthma and depression.

THMM (s100:1) emphasised the health costs of obesity for Māori:

Obesity contributes to our communities most frightening and devastating diseases; heart disease, type 2 diabetes, and cancer to name a few, are all to common in the minds of Māori . . . . These higher rates of obesity are reflected in the fact that cardiovascular disease and type 2 diabetes are more common among Māori when compared to NZE [New Zealand European]. Privileged? Yeah Right.

The Cancer Society added, on the basis of US data, that 15-20% of all cancer deaths were attributable to overweight and obesity (Cancer Society s72:5). The ANA’s emphasis was on the contribution of overweight and obesity as the main ‘modifiable risk factors’ for Coronary Heart Disease (ANA s38).

One health consequence of particular concern, given the nature of the Inquiry, was diabetes. Many submitters provided statistical data on diabetes, its growth over recent years and its devastating health effects, with submitters in agreement that obesity and overweight were both ‘preventable risk factors’ for diabetes.

Diabetes was (unsurprisingly) the focus of the submission by Diabetes NZ (s18:2) where it was argued that obese people are:

at increased risk of Type 2 diabetes, which commonly leads to heart disease.

Diabetes NZ also noted that around 85% of people with Type 2 diabetes are overweight (Diabetes NZ s18:1)

Psychological health effects to individuals, resulting from their overweight or obese status, were also mentioned by some submitters as additional adverse health consequences. These psychological risks, were noted by FOE (s136) to be particularly marked for children, who were argued to be more likely to experience isolation, stigmatisation and bullying as a consequence of obesity. Depression was another psychological outcome associated with obesity mentioned by the OAC (s129).
Independent advisors

Beaglehole (s307) noted that raised BMI was a major risk factor for chronic diseases such as heart disease and stroke, diabetes, musculoskeletal disorders and some cancers. Obesity was also noted by Beaglehole as having serious consequences for children. Swinburn (s189:3) emphasised the health effects of obesity and its impacts on children:

The current and future burden is enormous and overweight/obesity is probably the greatest single threat to the health and wellbeing of New Zealand children – it is highly prevalent, it is highly persistent from childhood/adolescence into adulthood, and it carries with it substantial physical and psychosocial consequences.

‘Economic burden to the health system and the economy’

Public health submitters highlighted their concern over the impacts of obesity on the health system. For instance, submitters noted:

The epidemic could inundate clinical services (NHF s42:2).

The health system is overwhelmed by the increasing need for expensive treatments for diabetes and other illnesses associated with overweight and obesity (OAC: s129:5).

A number of public health groups cited estimates of the economic costs to the health system. The AFPHM referred to a conservative estimate (dating back to the 1990’s) suggesting that the cost to the country of obesity-related illness and death was NZ$135 million per year or around 2.5% of total health expenditure (AFPHM s159:15). Given the increase in obesity and consequent illnesses, the AFPHM argued that such costs would be:

a major driver in health services cost into the future (AFPHM s159:15).

Several other submitters cited similar estimates for the economic costs of obesity and some included estimates of the health costs for diabetes (FOE, ANA, NZNO, Diabetes NZ). Diabetes NZ (s18:1) suggested that:

In 2001, diabetes costs were conservatively estimated at $250 million per year. They are likely to rise to $1 billion annually by 2021 as the incidence of diabetes increases.

Wider economic and societal costs of the epidemic were also noted by submitters:
The financial costs on society are tens of millions of dollars, workforce and economic productivity is affected, children are not reaching their full educational potential, and the health system is overwhelmed by the increasing need for expensive treatments for diabetes and other illnesses associated with overweight and obesity (OAC s129:5).

Conditions such as type two diabetes directly impact the economy through high medical costs and indirectly through decreased work productivity (THMM s100:1).

Some submitters highlighted intangible costs as well. FOE (s136), for instance, suggested that intangible costs to the individual from obesity included reduced employment opportunities due to limited mobility.

**Independent advisors**

Like many of the public health groups, two of the independent advisors noted the economic costs to the country from *increased health expenditure*:

The growing economic costs of obesity to national economies account for between 5% of national health expenditure in the USA, to 2% in Australia (Beaglehole s307:3).

The Select Committee will be aware of the consequences of obesity and type 2 diabetes which have the potential to cripple the health care systems of even relatively affluent societies (Mann s256:3).

Professor Mann also suggested there would be intangible costs:

although the direct health costs will be high, there are also socioeconomic impacts – there will be employment and family consequences (Mann s256:3).

**Obesity as an ‘inequalities problem’**

The third key theme evident from the public health sector submissions was the notion of obesity as an ‘inequalities’ problem (noted by the Cancer Society, the PHA, THMM, AFPHM, and the NZMA). The following quotes are typical of the inequalities framing of obesity:

Inequalities in the social, economic, and physical environment are significant factors in obesity (PHA s156:5).

Significant inequalities are present. Socioeconomic deprivation is strongly associated with obesity. Maori and Pacific people and economically disadvantaged groups are most severely affected (AFPHM s159:2).
Maori are over represented in lower socioeconomic groups (less educated, in low skill occupations or unemployed, have lower incomes and live in deprived neighbourhoods). People living in more deprived areas in NZ, in particular Maori, are most likely to have poor nutrition and report running out of food or be unable to eat properly (THMM s100:2-3).

The incidence of obesity and diabetes is not evenly distributed across the socioeconomic spectrum of New Zealand society. Both are particularly prevalent in New Zealanders of low socioeconomic status (NZMA s128:4).

The NHF (s47:2) noted its concern, that because of obesity:

the present large inequalities in health risk and outcomes could increase futher.

**Independent advisors**

Although the three independent advisors were clearly aware of the higher rates of obesity among particular popuatlon subgroups – they did not explicitely say anthing to indicate that obesity was an inequalities issue.

**6.2.3 Affected groups**

On the issue of who was affected by obesity, four key themes emerged from the public health sector submissions. These were, that: (i) **both overweight and obese** population subgroups were ‘at risk’ from adverse health outcomes; (ii) the **whole population was affected** (in some way) by the epidemic of obesity; (iii) the **burden was appreciably greater for some groups** (Māori, Pacific and lower SES communities); and, (iv) **children** were particularly at risk of obesity. The evidence for these four themes is outlined below.

**Both overweight and obesity a problem**

In health terms, all but one of the public health submitters considered both overweight and obesity to be problematic. Many public health submitters (OAC, NHF, Cancer Society, ANA, FOE, NZMA, Diabetes NZ, NZNO) provided statistical data on overweight and obesity prevalence (either separately or combined), or included both the terms overweight and obesity in their discussions, suggesting that both weight classes were considered problematic. Despite this, the term obesity was more frequently used in submissions from the public health sector.
However, unlike the submitters from industry, most public health submitters *did not* argue that the health risks for overweight and obesity were different. The one exception to this was found in the submission by FOE (s136:26):

> There is ongoing controversy about the relationship between obesity and risk of earlier death. While it is generally accepted that the risk of death is substantially higher for the obese (BMI over 30), it is much less clear whether this applies to the overweight (BMI of 25-30).

Many public health submitters emphasised the effects of excess weight on factors other than mortality. For instance, that diabetes risk appears to increase with increasing BMI even from within the ‘normal’ BMI range, was a point noted by the AFPHM (s159).

**Independent advisors**

Two of the independent advisors, Beaglehole and Mann, also noted that the health risks associated with BMI were progressive, beginning at a BMI of 21. Thus, even those in the normal weight range were recognised as having health risks.

**The whole population is affected**

The perspective from public health groups was generally that, although the health burden of obesity was suffered disproportionately, the whole population was affected by the obesity epidemic:

> All New Zealanders are at risk of this health crisis (NZNO s130:9).

> Everyone knows someone affected by obesity outcomes: heart disease, cancer, stroke, depression and asthma, to name just a few (OAC s129).

> Obesity impacts on all aspects of New Zealand society and people – life expectancy, quality of life, health services, economy and productivity (AFPHM s159:2).

**Independent advisors**

Of the three independent advisors only one noted the ‘whole population’ impact of the obesity epidemic:

> [it] affects us, our children, and our grandchildren (Beaglehole, transcript).
The burden is greater for Māori, Pacific, and low socioeconomic communities

Those likely to suffer greater than their share of the burden of disease were identified by the public health sector as more likely to be from Māori or Pacific communities and/or of low socioeconomic status:

The burden of disease from obesity affects everyone, but is disproportionately greater for low socio-economic people of New Zealand, Māori and Pacific peoples (NZNO s130:3).

In 2003, those people in the most deprived fifth of the population were almost twice as likely to be obese as those in the most privileged fifth (PHA s72:5-6).

On the issue of Māori over-representation amongst obesity statistics, THMM noted that Māori overrepresentation among lower socioeconomic groups added to the risk profile for Māori. THMM also pointed out that the health differences between Māori and non-Māori persist even after controlling for socioeconomic and behavioural factors.

Independent advisors

Beaglehole noted that women and ethnic (Māori and Pacific) or socioeconomically disadvantaged populations were the groups most at risk from obesity (s307). These groups (Māori, Pacific and low income groups) were also noted as priority populations (for targeted intervention) by Swinburn (s189). Swinburn (s189:3) also highlighted the fact that 60% of Pacific children were overweight or obese was ‘astounding’ and ‘undoubtedly the highest in the world’. Furthermore, Swinburn noted that ‘adult Pacific populations have the highest obesity prevalence of any region’, suggesting that the groups’ high prevalence of obesity was not confined to New Zealand (Swinburn s189:3).

Children at risk

A number of public health submitters emphasised children as a vulnerable population group:

obesity is a child health issue (NZNO s130:3).

Of even more concern are the obesity rates of our children, which are among the highest in the world (NZMA s128:4).
Independent advisors

Two of the advisors, Beaglehole and Swinburn, emphasised children as the group most at risk of obesity. Swinburn argued, that if there were to be target groups, it should be children and adolescents first and then their parents. Beaglehole’s entire submission was focused on children, because in his view:

- the potential for prevention is greater
- the overwhelming role[s] of the social and economic environmental factors in causing the childhood epidemic are clearer
- the issue of ‘individual responsibility’ is much less distracting when considering the prevention of obesity in children and youth
- the childhood epidemic underscores the failure of the ‘market’ to protect the health of children and assist parents in their efforts to raise children in a healthy environment (Beaglehole s307:1).

Summary of public health problem representation

The problem of obesity was described by the public health submitters as an epidemic, a pandemic and a complex issue. The obesity epidemic was considered as problematic, first, because of the human health burden attributable to conditions associated with obesity and overweight, and second, because of the the potential financial costs to the health system and the wider economy. Many public health submitters also suggested that obesity was an inequalities problem. In this respect, some submitters were concerned that obesity may be a result of existing social inequalities, while others appeared to be concerned that the unequal distribution of obesity may exacerbate existing health inequalities.

In describing who was affected by the problem, those classified as overweight and obese were included in the problem representation. This was because both overweight and obesity were considered as health risk factors. Public health submitters also noted that although not all members of the population were directly affected by the personal experience of overweight or obesity, the whole population was affected indirectly. Furthermore, some submitters noted that even those within the normal weight range were at risk of Type 2 diabetes. Public health submitters agreed however, that the burden of obesity was greater for Māori, Pacific, and lower socioeconomic communities. Children were also identified by public health submitters as a group particularly vulnerable to obesity and its effects.
6.3 Public health framing of the causes

This section examines the causes identified by the public health sector submitters. It follows the same format as the previous chapter, examining the general causes (section 6.3.1); the main causes (section 6.3.2); and the non-causes identified by public health submitters (section 6.3.2).

6.3.1 General causes

Energy imbalance

Like the industry submitters, those from the public health sector accepted that an imbalance between ‘energy in’ and ‘energy out’ was the primary cause of obesity:

In general the obesity epidemic is caused by an imbalance of calorie intake over exercise (NZMA s128:5).

Some submitters (Diabetes NZ, ANA, FOE) suggested that the imbalance takes place over time:

Obesity is the result of excess food energy intake over expenditure, over a prolonged period (Diabetes NZ s18:3).

Despite agreement between public health submitters that the basic cause of obesity lay in the energy imbalance, the AFPHM (s159:8) argued that:

a simplistic view that energy intake in excess of energy needed for daily activity produces weight gain and eventually obesity, so people should eat less and exercise more, misses the point that there is an array of inter-dependent factors which heavily influence both nutrition and activity.

Independent advisors

Beaglehole (s307:4) noted that the underlying cause of obesity and overweight was a combination of:

an energy imbalance between calories consumed, and calories expended.
Multiple societal determinants

The majority of public health submitters acknowledged that there were *multiple societal determinants* of the energy imbalance:

As in other countries there have been dramatic societal and environmental shifts such as: urbanisation; economic changes that have changed the employment, housing and welfare climates; the make up of the food supply has changed; the marketing and availability of food has increased and the cost of energy dense low nutrients [sic] food has fallen relative to the cost of healthy food. All these things have changed food consumption and energy expenditure patterns (OAC s129:8).

New Zealanders live with a constant barrage of inducements to consume foods and drinks that are not good for their health, while at the same time spending more time in sedentary activities and facing barriers to traditional forms of physical activity such as walking (FOE s136:7).

Other societal factors identified by public health submitters included: systems of food production and distribution; international legal and trading frameworks; time constraints; increased reliance of food prepared outside the home; increased portion sizes; sedentary behaviour; and, lower levels of physical activity.

Independent advisors

Beaglehole noted that as well as reductions in physical activity related to school, employment and leisure, there have been dramatic changes to the social and cultural patterns of purchasing, preparation and consumption of food over the last few decades, driven by:

- commercial and marketing practices
- changes in employment, especially of women
- changes in transportation systems
- systematic and long term increases in energy intake across the entire population (Beaglehole s307:5).

6.3.2 Main causes

Two key themes were identified as the main causes of the obesity epidemic: (i) the *obesogenic environment*; and, (ii) *socioeconomic factors and wider determinants of health*. As well, there was a explicit *emphasis* on the ‘energy in’ component of the energy equation as the dominant cause of obesity. These themes are explored below.
The obesogenic environment

For public health submitters the dominant driving force behind the obesity epidemic was argued to be environmental:

Many of the determinants of obesity are structural and environmental and are outside the control of the families/whānau and individuals (NHF s47:4).

The majority of public health submitters (and all three of the independent advisors), referred to the ‘obesogenic environment’ as the key driver behind the obesity epidemic. Various descriptions of the obesogenic environment were put forward by submitters, and the following description put forward by the AFPHM was typical:

We now live in a physical and social environment where physical activity is largely optional for every day living, and energy-dense, low nutrient value food is relatively cheap and easily available, and requires much less effort to prepare and consume than in the past. This is commonly termed the ‘obesogenic environment’ (AFPHM s159:8).

The majority of public health submitters (NHF, AFPHM, ANA, FOE, OAC Diabetes NZ, NZNO, Cancer Society) referred to the causes of obesity outlined in the WHO Technical Report 916 (outlined in Chapter 2). In particular, it was noted that there was convincing evidence that sedentary lifestyles and high intake of EDNP foods contributed to obesity, and probable evidence that the following factors contributed to obesity:

- heavy marketing of energy-dense foods and fast food outlets
- high intake of sugar-sweetened soft drinks and fruit juices
- adverse socioeconomic conditions (especially in developed countries and particularly for women).

Some submitters noted the possible evidence (from Technical Report 916) that: large portion sizes; consumption of a high proportion of food prepared outside the home; and, rigid/restrained eating patterns (dieting) also contributed to excess weight gain.

THMM (s100), although it did not explicitly refer to Technical Report 916, highlighted many of the same factors as causes of increased obesity amongst Māori. These included: the ready availability and promotion of high fat/high sugar products; labour saving devices (in the home and in workplaces); and, lack of opportunities for physically active leisure pursuits. The low cost of high fat/high sugar foods was an additional cause of increased
consumption of unhealthy foods identified by THMM. THMM emphasised that socioeconomic and ethnic factors were critical for Māori. On the matter of ethnic disparities, THMM noted that society perpetuates these inequalities by favouring the majority population. For instance, THMM highlighted the differences between Māori and European in the distribution of resources, access to health care and income assistance and Māori participation in the health sector.

The PHA listed five environmental factors as causes of obesity. These included:

- the high cost of healthy food
- intensive marketing of energy-dense products
- globalisation of food production and marketing (normalising unhealthy food)
- work-home imbalance (specifically too much time at work), and
- poor urban design and transport systems (PHA submission 156:3-5).

As well, the PHA noted that inequalities in the social and economic environment caused inequalities in obesity.

Thus, while many public health groups noted the causes outlined in the WHO Technical Report 916 when describing the key aspects of the obesogenic environment, they also added to this list of causes, the issue of food cost, specifically, the low cost of energy-dense foods compared to the high cost of healthy foods.

**Independent advisors**

While Professors Swinburn and Mann referred to Technical Report 916 for the causes of obesity, Beaglehole listed what he believed to be the key environmental causes of obesity. These were:

- the increased availability (accessibility and affordability), promotion and marketing of energy dense, micronutrient poor foods
- changes in social and cultural patterns in purchasing and the preparation and consumption of food
- the ‘reduction in energy expenditure because of fewer opportunities for children to engage in regular physical activities’ (Beaglehole s307:4).

Beaglehole also implicated the food and advertising industries as having a causal role in the obesity epidemic when he emphasised that:
the food and beverage industries have a major role in the development of the obesity epidemic [and that] marketing and promotion also has a direct influence on the diets of children and youth (Beaglehole s307:4).

Professor Mann referred to the causes identified in the WCRF report (Mann was on the expert panel of this report which was ‘in press’ at the time of the Inquiry). As noted in Chapter 2, the WCRF report concluded that there was convincing evidence that sugary drinks and frequent large portions of energy-dense foods contributed to obesity.

**Socioeconomic factors and wider determinants of health**

Another reoccurring theme in the public health submissions, although not as prevalent as the obesogenic environment theme, was the emphasis on the socioeconomic dimensions of obesity, and the wider determinants of health. This theme was evident in the submissions from: the OAC; the NZMA; the PHA; ANA; and, THMM. Some public health submitters (OAC, ANA, PHA) included with their submission a diagram by Dahlgren & Whitehead (1991) of the ‘determinants of health’ to illustrate that point that obesity, like other health outcomes, was largely a result of wider societal (rather than individual) factors.

In placing obesity in the context of wider determinants of health, obesity was seen as a largely a consequence of social and structural constraints. The OAC, for instance, explained:

> While those on high salaries have a great deal of choice about where they live, for example, those on low incomes may have very little choice about the safety of the neighbourhood they live in, the type and quality of housing, or proximity to recreation opportunities. To give another example, people on high incomes have a great deal of choice about how to give themselves and their families ‘treats’ e.g. overseas holidays, outings, beauty treatments etc. People on low incomes have much more limited options, with food, cigarettes and alcohol some of the most obvious and available options for ‘treats’ (OAC s129:19).

The NZMA agreed that social inequalities promoted obesity:

> One of the things that our submission brings out is that obesity is in large measure a social problem. Social inequality is one of the promoters of obesity, and one of the promoters of ill health, and there are graphs in there [referring to their written submission] showing the relative incidence of obesity related to income inequality (representative, NZMA transcript).

The NZMA argued that the association between income inequality and obesity could be explained by greater psycho-social and economic stressors experienced by lower
socioeconomic groups (particularly those associated with a feeling of status inferiority), which led to their greater propensity for obesity. Furthermore, in its oral submission, a representative for the NZMA noted that perhaps eating EDNP food was one of the few comforts available to lower socioeconomic groups to console them for their unsatisfactory living conditions.

THMM suggested that some of the inequalites experienced by Māori lay in the:

- distribution of resources including investment in appropriately targeted initiatives for Māori; access to and effectiveness of health care and income assistance; [and] Māori participation at all levels of the health sector (THMM s100:3).

**Emphasis on ‘energy in’**

Some public health submitters argued that both physical activity and energy intake were important causes of the energy imbalance leading to obesity. For instance, the ANA noted:

> There is a dispute that the decline in physical activity is more significant to obesity than changes in the diet, although this suggestion is most loudly voiced by the food industry who have a vested interest in diverting the attention away from food. However, both diet and physical activity are important and linked (ANA s38:4).

FOE argued however, that while both energy intake and energy expenditure were important, the evidence did not support the industry contention that energy intake had not increased:

> on occasion, food industry advocates have argued from a selective use of research results (usually from trends in national food production) that energy intake is not rising, and that therefore we should look to changes in physical activity as the villain behind the obesity epidemic. The evidence, and in particular that from New Zealand and Australia, does not support this view (FOE s136:16).

Although physical activity was recognised as an important contributor to increased rates of obesity amongst the population, in contrast to the industry emphasis on physical activity, several of the public health submitters explicitly made the point that it was more feasible to focus on determinants of increased consumption (energy in) rather than on factors influencing physical activity:
Much of our built environment – roads, houses, shopping centres, workplaces – and our car-dominated transport systems are difficult to change sufficiently to have major impacts on physical activity levels. In the short term, reducing energy intake, especially reducing energy-dense food production, marketing and consumption, present the most practical strategies (AFPHM s159:2).

The NZMA noted:

it takes an awful lot of walking to get rid of the energy in one ice cream (representative, NZMA transcript).

**Independent advisors**

One of the independent advisors used the example of how long it takes to ‘walk off’ an energy drink as an argument for focusing on reducing energy intake rather than increasing physical activity:

The answer to this epidemic is not going to come from physical activity. How many hours of walking would it take a kid to walk off this? [Beaglehole held up a small bottle of Coke] About two to three hours, yep about, can only address this epidemic by addressing energy intake (Beaglehole, transcript).

Beaglehole’s emphasis on addressing energy intake was also noted in his written submission:

Physical fitness alone is not sufficient to protect against obesity [and that] . . . Systematic and long term reductions in energy intake across the entire population will be essential (Beaglehole s307:5).

Swinburn, in his written submission also explicitly made the point that action on food intake would be more powerful than action on physical activity. This was because in his view, higher weight was due to *excess energy intake* and not (as industry argued) a decrease in energy expenditure:

Our recent study found that ¾ of the high weight of children could be explained by higher energy intakes (rather than low energy expenditure) – ie obese people have high energy intakes which are matched by high energy expenditures because of their high body masses (Swinburn s189:3).

Furthermore, Swinburn argued that significantly increasing physical activity would not sufficiently alter the energy imbalance:

Physical activity makes up only 20-30% or total energy expenditure. The part of that which is able to be influenced (mainly by recreational activity
and active transport) is only a fraction of that again. For a population of children to reduce their energy intake by 10% would mean a reduction of about 785kJ/d or about 450ml of soft drink. To achieve the same 10% energy balance deficit by increasing physical activity, it would require them to walk for an extra 2.5 hours a day to burn the 785kJ/d. Either of these behavioural changes would reduce their weight by about 4.5% or 1.4kg (Swinburn s189:6).

Public health submitters then emphasised that it was the increased consumption of particular foodstuffs (not overconsumption in general as industry argued) that was largely responsible for increased caloric intake in the population.

**Increased consumption of energy-dense/ nutrient-poor (EDNP) foods**

The majority of public health submitters held that EDNP foods were largely responsible for the increased energy intake in the population. Actual definitions of EDNP foods were however, not featured in the majority of the public health submissions, although FOE provided some definition and explanation of their role in contributing to obesity. In particular, it noted that energy-dense foods have a high fat and/or high sugar content (and are generally low in fibre) and, they:

Supply a large number of calories relative to their volume and weight. According to the WHO [referring to Technical Report 916], there is convincing evidence that a high intake of energy dense foods promotes weight gain. Energy dense foods are less filling than other foods that supply the same amount of energy but with greater volume and weight. Further because they are highly processed and require little chewing, they can be eaten faster with the result that the body has less opportunity to signal satiety via feedback mechanisms (FOE s136:16).

Some submitters highlighted specific macronutrients, in particular, sugar and fat, as especially problematic (NHF, Diabetes NZ, and AFPHM, NZMA). For instance:

the average New Zealand diet has a higher proportion of fat and processed sugar than in the past, despite health education programmes (AFPHM s159:9).

The AFPHM singled out processed food as particularly problematic:

 Manufactured food products have higher fat, sugar and salt than home prepared food; the sweetness, high fat, enhanced flavour and saltiness of manufactured food products are part of their attractiveness, along with the convenience (AFPHM s159:9).
As well, many public health submitters highlighted *specific foods and beverages* as particularly EDNP, and directly linked to obesity. These included ‘fast foods’ (which were also described as takeaways, outsourced foods, or convenience foods), and ‘sugary’ drinks (also described as fizzy drinks, soft drinks, and full-sugar carbonated drinks):

Changes in eating patterns include increase [sic] consumption of fast foods, pre-packaged foods and sugary drinks (ANA s38:3).

Full-sugar carbonated beverages (or ‘sugary drinks’ as some public health submitters called them), were singled out as highly obesogenic by many public health submitters (NHF, FOE, OAC, ANA, Diabetes NZ, NZNO, Cancer Society). ANA drew attention to research undertaken by its Scientific Committee which suggested that there was extensive evidence that sugary drinks contribute to weight gain in children. Some submitters also provided evidence that soft-drink consumption had increased in New Zealand (FOE and Diabetes NZ).

On the matter of *fast foods* or takeaway foods, public health submitters who highlighted in their submissions, the causes of obesity as outlined in Technical Report 916 (NHF, AFPHM, ANA, FOE, OAC, Diabetes NZ, NZNO, Cancer Society, Swinburn and Mann), reiterated the conclusions from the reports – that there was *probable* evidence that the marketing of fast food outlets and *possible* evidence that increased consumption of food prepared outside the home – contributed to excess weight in the population. The NZMA noted that:

People are dining more and more at fast food restaurants. Associated with this are a higher calorie intake, higher fat intake, lower fibre and calcium intake compared with a home prepared meal (NZMA s138:10).

Similarly, FOE noted that there has been an increase in the consumption of fast food, and that:

More frequent consumption of fast food has been shown to result in increased energy and decreased micronutrient consumption. Fast food is typically energy-dense, and there is substantial evidence that consumption of foods with high energy density result in higher energy intake that can lead to obesity (FOE s136:17).

**Independent advisors**

All three of the independent advisors had unfavourable things to say about ‘sugary drinks’. Mann (s256) noted how the WCRF working group found *probable* evidence that sugary drinks promoted excess energy intake, and furthermore, that:
a wealth of observational data supports a negative relationship between sugary drinks and bodyweight in children (Mann s256:4).

Beaglehole, who had attended the oral submission earlier by Coca-Cola, had this to say to the committee:

The Chief Executive Officer of Coke who lined up with his bottles here, he drank water. I am going to drink Coke. And in this bottle of Coke there are sixteen teaspoons of sugar. And what are the health benefits of that sugar. Absolutely nothing. There is no reason why our kids should be drinking this stuff. They should be out of schools instantly. I will actually drink the water (Beaglehole, transcript)

Swinburn explained in his oral submission that one of the reasons why sugary drinks contributed to obesity was because the body does not register beverages in the same way as it does food:

There’s a lot of experimental evidence that supports that fact, that when energy comes in, in a drink form, it doesn’t cause the same level of gastric distention (?) that sort of thing, and therefore is not picked up by the body as energy coming in (Swinburn, transcript).

**Causes of increased consumption of EDNP foods**

There were three common themes identified as causes of the increased consumption of EDNP foods: (i) its *increased availability*; (ii) its *low cost* (relative to the cost of healthy food); and, (iii) its *heavy marketing*. These themes are explored below.

**Increased availability of EDNP foods**

Public health submitters noted that EDNP or unhealthy foods had become increasingly available and were now ubiquitous (NZNO, PHA, FOE, OAC, ANA and AFPHM):

intimate accessibility (food is now available in non-traditional sources such as libraries, garden centres, vending machines, delivery of fast food, telephone and internet grocery shopping) all designed to permit individuals to have rapid access to foods with a minimum of effort (ANA s38:3).

Another recurring theme in discussing the increased availability of EDNP food was its greater availability in lower socioeconomic or more deprived neighbourhoods. This phenomena was noted by THMM, PHA and the AFPHM. For example, THMM noted:
There is evidence to suggest that food and drinks most available and most heavily marketed in high-deprivation areas tend to be less healthy options, making the unhealthy choice the easy choice in poor areas (THMM s100:3).

**Low cost of EDNP food**

The low cost of unhealthy food (and the relative high cost of healthy food) was recognised by the majority of public health submitters as a barrier to good nutrition (NZNO, FOE, OAC, ANA, AFPHM, THMM, NHF, PHA):

Research has shown that foods that are high in fat and sugar tend to be cheaper than healthy options (OAC s129:22).

Some of these submitters suggested that the price of food was *one of a number of reasons* for the increased consumption of EDNP foods:

The relative prices of food have changed also, with energy-dense processed foods often being cheaper than more nutritious foods (AFPHM s159:9).

the cost of low energy dense low nutrients [sic] food has fallen relative to the cost of healthy food (OAC s29:8).

Other public health submitters suggested that the high cost of healthy food relative to the low cost of EDNP food was one of the *major reasons* for the increased consumption of EDNP food. The PHA for example, listed first in their list of *five main environmental causes* of obesity, ‘the high cost of healthy food’, noting:

Sadly, foods that are high in fat and sugar tend to be cheaper than healthier options (PHA s156:3).

A few submitters did not list the cost of healthy food as a *specific cause* of obesity, although in their discussions of the solutions to obesity, they recommended addressing the cost differential between healthy and unhealthy food. This suggests that they recognised that cost was a potential barrier to good nutrition faced by those on low incomes.

At the same time, some public health submitters (THMM, PHA and the Cancer Society) argued that the food price issue was really an issue of *inadequate income*:

It is well documented that income is a key factor which determines access to good nutrition. Low income is a major reason why families are not getting enough healthy food to eat (THMM s100:3).
the situation for many families, working long hours in low paying work, who are both time and money poor, is that unhealthy energy-dense food is available and meets the hunger of families. It is clear that families in New Zealand are making rational short-term economic choices to eat obesogenic food (PHA s156:5).

Sometimes the food cost issue was framed as a *food insecurity* issue, with some submitters citing statistics on the number of food insecure households which revealed that food insecurity, like obesity, is unequally distributed. Both the OAC and the AFPHM noted the apparent paradox between hunger and obesity. The OAC explained that:

> For many households the lack of money can contribute to both hunger and obesity. This apparent paradox is driven in part by the economics of buying food. Households without money to buy enough food often have to rely on cheaper, high calorie foods to cope with limited money for food and starve of hunger (OAC s129:22).

ANA reiterated this view (s38:8):

> Research shows that when times are tough, families tend to reduce the quality of food they eat, before reducing the quantity, thus avoiding hunger but compromising nutrition.

Other public health submitters (THMM and PHA) also noted that lack of income was associated with food insecurity.

**Independent advisors**

Two of the independent advisors, Swinburn and Mann, included food cost as one of (ie not necessarily key) the determinants of increased energy intake. Swinburn supported the notion that changes to the economic environment – for instance the cost of services and the level of incomes to pay for them – are part of the wider enviromental changes potentially powerful in combating obesity. Beaglehole described the issue as one of affordability.

**Heavy marketing of EDNP foods**

Heavy marketing of EDNP food was identified as a critical cause of the increased consumption of EDNP foods by public health submitters (NZNO, PHA, AFPHM, THMM, OAC, FOE):
A further social change has been the intense marketing (by advertising and other means) of energy dense foods (including drinks), often aimed specifically at children (PHA s156:4).

There is no dispute that marketing of food products affects food purchasing and consumption patterns. The debate is about how much (AFPHM s157:11).

To support the claim of an association between the heavy marketing of EDNP food and excess weight, many public health submitters referred to the WHO Technical Report 916 conclusion, that marketing of energy-dense foods was a probable contributor to excess weight gain:

Advertising of energy-dense foods and fast-food outlets is a probable cause of obesity (OAC s129:34).

Public health submitters also provided evidence from international and local research to show that EDNP food was more heavily marketed than healthy foods, that such marketing had increased in recent times and influenced purchasing and consumption patterns. Often this evidence was taken from the Hastings Review – a technical paper prepared for the WHO by the UK Food Standards Agency (Hastings & McDermott et al. 2006), and the Institute of Medicine report: *Food marketing to children and youth: Threat or opportunity* (McGinnis & Gootman et al. 2006). For instance:

In the most comprehensive systematic review of evidence prepared for the British Food Standards Agency [the Hastings Review], it was concluded that food advertising influences children’s preferences, their purchase behaviours and what they eat (OAC s129:34).

Some submitters (PHA and the OAC) made the point that marketing normalises the regular consumption of EDNP foods making it appear as an ‘everyday’ food:

This normalisation is particularly damaging – high fat and sugar foods and drinks are promoted as the obvious choice for all situations, and are available in all social situations. Healthy foods are not marketed to the same degree, and are now the exception rather than the rule. Choosing a healthy option is now ‘not an obvious option, normal, cool or socially desirable’ (OAC s129:28).

Many public health submitters also noted the marketing was much wider than television advertising and suggested that the whole range of marketing mechanisms was problematic. These included: sponsorship of community and sporting activities; supersizing; product placement; discounting; and, food industry presence in schools
(though tuck shops, vending machines and also via fundraising and food industry sponsorship of curriculum materials, community and sporting events).

Another point made by some public health submitters (FOE and the AFPHM), in response to the position taken by industry – that marketing only affects consumer’s choice of *brand* within a particular *category* of product but not their choice of a particular category – was that:

> food promotion increases both brand and category sales, and is not limited to brand switching (AFPHM s159:11).

Marketing in schools, and food marketing generally targeted to children, was particularly opposed by public health submitters (AFPHM, FOE, OAC, Diabetes NZ):

The most common forms of commercial activity in schools are product sales of food and drink though the school tuck shop, canteen or vending machines; direct advertising via sponsorship of school sports teams, event or publications and indirect advertising via voucher schemes and donation of company products as prizes . . . . Many teachers accept and welcome food industry sponsored educational material in schools . . . . However these sponsored curriculum resources typically present biased or incomplete nutritional information with the result that schools inadvertently end up promoting inappropriate messages and foods to children (OAC s129:42).

Concerns were also raised about the ethics of targeted advertising to children:

> Advertising directed at children is inherently deceptive, and exploits children under eight years of age (Diabetes NZ s18:3).

AFP HM also noted in its submission an important finding of the UK House of Commons inquiry into obesity:

> The committee required advertisers to produce documents on a range of campaigns, which clearly showed deliberate targeting of young children to undermine parental control of children's diets, strategies to mislead children and marketing to promote heavy use of energy dense food products. This directly contradicted what industry representatives had told the committee; the Committee's report infers that industry representatives had attempted to deceive the Committee (AFPHM s159:12).

Several public health submitters also cited evidence of an association between hours spent viewing television and increased childhood weight.

A final theme on the issue of marketing, was the *heavier marketing of EDNP foods in lower socioeconomic areas*. For instance, the PHA argued that energy-dense food:
is more readily available and more widely marketed in poorer parts of towns. This has been borne out by a range of studies (PHA s156:4).

This view was supported by the OAC and THMM:

> There is also evidence to suggest that the food and drinks most available and most heavily marketed in high-deprivation areas tends to be less healthy options, thus making the unhealthy choice the easy choice in poor areas (THMM s100:3; OAC s129:22).

**Independent advisors**

Beaglehole pointed to the evidence from the Institute of Medicine Report (McGinnis & Gootman *et al.* 2006) noting that food and beverage marketing was out of balance with dietary guidelines, and, that such marketing influenced the preferences and diets of children and young people. Swinburn (s256:4) noted:

> 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 [author’s emphasis].

Swinburn also provided evidence to the committee from a project he had been involved in: ‘ACE Obesity’ (Assessing the Cost Effectiveness of obesity interventions) in Victoria, Australia, which suggested that one of the most cost effective interventions to address obesity was restricting food marketing (Swinburn, transcript).

**6.3.3 Non-causes**

Factors commonly discounted as causes of the obesity epidemic by public health submitters included: genetics; character deficits; and, knowledge deficits (or lack of education). The following section explores the evidence for these key themes.

**Genetics**

On the contribution of genetics to the obesity epidemic, some public health submitters (PHA, THMM, FOE) acknowledged that while they may play a role in some cases of obesity, genetics were not a plausible cause of the population increase in obesity:
Increases in obesity have been occurring much too rapidly to be explained by changes in the gene pool (FOE s136:15).

The PHA (s156:3) referred to a migrant study to discount genetic explanations for obesity in favour of environmental causes:

The Tokelau Island Migrant Study (concerning people who have migrated to New Zealand from the Tokelau Islands) clearly demonstrated the importance of the environment for obesity. These studies followed families who migrated to western societies (and who sometimes returned back home again). In these studies there were dramatic negative changes in the migrants, compared with family members who remained at home. The migrants had not changed their genetic makeup. They had changed their environment and with that came obesity and related diseases, in particular type II diabetes, hypertension and heart disease.

The AFPHM (s159:8) argued that neither genes nor human nature could be held responsible for the obesity epidemic:

Human genetics and physiology haven’t changed significantly in many millennia. We are adapted to the relative food scarcity of our ancestors, who needed considerable energy expenditure to obtain and prepare their food. Our physiology is not well adapted to situations of prolonged plenty, and we have poor mechanisms to stop weight increasing. While some nutrients such as protein, can satisfy hunger, fat eludes these control mechanisms, so as dietary fat increases, we passively over-eat and put on weight. Similarly, human nature has not changed significantly over the period when the obesity epidemic has emerged.

**Independent advisors**

While Professor Mann (s256:2) recognised that genetic factors played a role in obesity (and Type 2 diabetes), he argued that the rapid population increase in obesity:

must reflect environmental, principally lifestyle changes since the gene pool cannot have altered over a short time span.

Beaglehole (s307:4) argued that both genetic susceptibility or other ‘ill defined social or psychological factors’ played ‘insignificant’ roles in obesity.
Character deficits

The dominant character deficits singled out by public health submitters (OAC, NHF, ANA, FOE and THMM) as not causing obesity via their impact on lifestyles, were irresponsibility and lack of willpower:

[while] individual lifestyles are clearly important, the population on New Zealand has not suddenly and collectively lost their willpower to exercise and eat a healthy diet (OAC s129:8).

Nor is obesity increasing because of a lack of personal responsibility. As Marion Nestle (American public health nutrition expert) stated in 2004, “the prevalence of obesity increases year after year. Are people less responsible in 2002 than in 2001? Obesity is also a global problem – is irresponsibility an epidemic around the world?” (ANA s38:3) [ANA’s emphasis].

Some submitters (ANA and THMM) argued that although lifestyle choices relating to diet and exercise were important, they were not the driving factor:

Parental responsibility and individual lifestyle factors are important, but the social, structural and environmental determinants of obesity which lie outside the control of the individual need also be addressed and are considered most important when looking at making influential changes to curb the obesity epidemic among Maori (THMM s100:1).

Another theme running though a number of the public health submissions when discussing the issue of lifestyle choices was the notion that choices were subject to structural constraints, particularly for vulnerable sub-population groups:

Many of the factors contributing to obesity are beyond the control of the parent and individual, particularly for low socioeconomic status groups whose choices are severely limited by cost, availability and location (OAC s129:8).

Lifestyle decisions that are the major risk factor of obesity (notably poor nutrition and lack of physical activity) are often attributed to individual free choice and parental responsibility while little emphasis is placed on the social, structural and environmental determinants of obesity which lie outside the control of the individual, particularly individuals of low socioeconomic status since their choices are constrained by cost (THMM s100:2).
Independent advisors

Personal irresponsibility was noted as a non-cause of obesity by one of the independent advisors:

it is most unlikely that there has been an epidemic of ‘personal irresponsibility’ which might explain the childhood epidemic of obesity (Beaglehole s307: 2)

Education and knowledge deficits

All public health submitters were of the view, that although education or the provision of information was an important part of the overall strategy to address obesity, it would not be effective as a strategy on its own:

Education, information, awareness campaigns will fail unless environmental changes which support and encourage increased daily physical activity and improved nutrition are also implemented (NZNO s130:11).

Focusing interventions solely on educating individuals, or just educating the population as a whole, and urging them to be more responsible ignores what is known about the factors that determine health and wellbeing. Education alone is known to be ineffective in changing health behaviours (OAC s129:5).

Robyn Toomath, a clinical endocrinologist representing FOE, highlighted however, that even the most educated people could not usually manage to lose weight:

my experience in the clinical setting is what drove me to adopt this position that I have now. And the experience was one of seeing highly educated, highly intelligent, highly capable individuals, with the absolute best reason in the world to lose weight . . . . these were people who had access to healthy food, who had access to personal trainers, but they couldn’t do it, they could not do it. They were overweight and they could not lose weight despite the fact that they had the very best reasons to do so . . . . So the interventions, which rely on people becoming better educated, more steel willed, they will not, will not work. They do not work (Toomath, FOE transcript). [her emphasis]

This suggests then, if obesity is not just a problem for the uneducated, it can not be a knowledge deficit problem.
Although public health submitters were clear that obesity was not a knowledge deficit problem, there was an exception made by some submitters (FOE and AFPHM) when it came to the issue of food preparation and cooking skills:

Even when eating at home, pre-prepared foods are more commonly used, rather than preparation from basic ingredients. This is compounded by a loss of food selection, nutrition and cooking skills and knowledge. Intergenerational transfer of these skills, at home or at school is declining (AFPHM s159:10).

**Independent advisors**

All three independent advisors agreed that obesity was not a knowledge deficit problem and that education on its own was not a sufficient strategy to address obesity:

Most people, including children, know what is healthy food and what is junk food and that regular exercise is good for health (Swinburn s189:5).

obesity fundamentally is not a knowledge deficit problem (Swinburn, transcript).

educational measures and programmes aimed at individuals or groups are unlikely to succeed at a national level unless complimented by additional measures which may have policy or legislative implications (Mann s256:7).

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 (Beaglehole s307:6).

**Summary of public health framing of the causes**

Like the industry submitters, the general causes of obesity identified by public health submitters were: energy imbalance and multiple societal determinants. The main causes identified by public health submitters were very different to those identified by industry.

The obesogenic environment – characterised by a whole range of physical, social and economic features contributing to increased energy intake and reduced energy expenditure – was considered as the key cause of obesity. Socioeconomic factors and wider health determinants of health were also considered as important contributors to, or causes of obesity. This contrasts with the industry view that socioeconomic factors were not implicated in the obesity epidemic.
There was also an emphasis on ‘energy in’ determinants of obesity, although the contribution of physical activity to obesity was acknowledged. In emphasising the role of consumption, the increased consumption of EDNP foods, especially those high in fat and sugar and low in fibre, was identified as the key cause of increased energy intake in the population. Specific foods were singled out as highly obesogenic. These included: processed foods (in general); fast foods; and, sugary drinks. There was also considerable discussion around the causes of increased consumption of EDNP foods. These were noted to be: their increased availability (especially in lower socioeconomic areas); their low cost; and, their heavy marketing. Specific non-causes identified by public health submitters included: genetics; character deficits (particularly lack of will power and irresponsibility); and, knowledge deficits.

6.4 Public health framing of the solutions

Following the same format as the previous chapter, this section examines: public health perspectives on the existing policy environment (at the time of the Inquiry); additional policy prescriptions; and, non-solutions. As before, there were a number of key policy areas relevant to each of these framing aspects. Thus, like Chapter 5, this section is organised according to the key policy areas, and the key themes and arguments as identified by the submitters (see Table 23).
### Table 23: Overview of key themes and arguments in the public health framing of solutions

<table>
<thead>
<tr>
<th>Policy area</th>
<th>Key themes &amp; specific arguments (in <em>italics</em>)</th>
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<td><strong>Perspectives on the existing policy environment</strong></td>
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| National obesity strategy (HEHA)   | Lack of leadership, coordination & limitation to the health sector  
Implementation under-resourced, haphazard & limited  
Lacks regulatory measures to address the obesogenic environment  
The Accord – sceptical of Government & industry collaboration  
Failure to address wider determinants of health & social inequalities |
| Role of food and marketing industries | Food industry: The Accord 'token' efforts by the food industry  
Food labelling is problematic  
Marketing industry: Generic criticisms  
Criticism of the Advertising Standards Authority’s framework – 'the wolves are guarding the henhouse' |
| **Additional policy prescriptions**                                                 |                                                                                                                                                                               |
| National obesity strategy (HEHA)   | Establishment of a national obesity taskforce  
A whole-of-government response  
Regulatory measures to address obesogenic environment  
Address wider determinants of health & social inequalities |
| Role of food and marketing industries | Food industry: Mandatory Front of Pack labelling  
Address the low cost of unhealthy food & high cost of healthy food  
Reformulation of food products (guidelines, targets, & monitoring)  
Limit the availability of energy-dense/nutrient-poor foods  
Marketing industry: Regulate advertising & marketing |
| School environments                | Mandatory food & nutrition policies  
Inclusion of nutrition & cooking in the curriculum  
Extension of the Fruit in Schools initiative  
A ban on the sale of unhealthy food & unhealthy food sponsorship |
| Non-solutions                      | Not education or information in isolation  
Nutrition, Health & Related Claims legislation |

### 6.4.1 Perspectives on the existing policy environment

This section explores public health perspectives on two policy areas in the food and nutrition policy environment at the time of the Inquiry: (i) the national obesity strategy HEHA; and, (ii) the roles of the food and marketing industries. Generally, unlike the industry, the public health sector was critical of the existing policy environment and argued for considerable change and government intervention.
National obesity strategy HEHA

Common criticisms of the national obesity strategy included: (i) HEHA’s lack of leadership and coordination and its limitation to the health sector; (ii) HEHA’s implementation was under-resourced, haphazard and limited; (iii) HEHA lacked regulatory measures to address the obesogenic environment; (iv) scepticism over the collaborative/partnership approach between government and industry; and, (v) the failure to address wider determinants of health and social inequalities. Public health views on these five themes are outlined below.

**HEHA’s lack of leadership, coordination and its limitation to the health sector**

Many submitters (NZNO, FOE, THMM, NHF, ANA) felt that the HEHA strategy lacked leadership:

> Despite its complexity and comprehensiveness, a lack of leadership and strategic planning at the Ministry of Health level has seen the implementation of this strategy delayed (NHF s47:6).

> Some initiatives are being developed in individual regions and local communities, but in the absence of government leadership and strategic progress with the national HEHA obesity strategy, they are fragmented and not as effective as they could be (ANA s38:4).

Similarly, a number of submitters noted that the strategy lacked coordination between different government sectors, and the strategy was limited to the health sector:

> Inter-sectoral aspects are weak – important factors such as transport, urban development and the education sector are identified as lying outside the health sector’s responsibility, but with little indication of how these could be addressed . . . In its present form, HEHA is unlikely to deliver the outcome of halting the obesity epidemic. There are a number of reasons for reaching this conclusion. First and foremost is that the strategy’s primary driver is the Ministry of Health, with little or no commitment from other ministries. Whilst the burden of costs of obesity falls within the health sector, the causes are largely outside it. Only a true across sector commitment to a national strategy has a chance of being successful (AFPHM s159:17).

**HEHA’s implementation is under-resourced, haphazard and limited**

Many public health submitters complained that the implementation of HEHA was haphazard; and implementation limited due to insufficient resources:

> Currently, government strategy in relation to obesity is fragmented and level of priority patchy and too often the problem is left to the Ministry of
Health who cannot be expected to tackle the prevention of obesity alone (as many of the health determinants are outside of health such as education, health and housing) (ANA s38:4).

The implementation of HEHA has been limited, with relatively little resource being allocated within or by the Ministry of Health, given the magnitude of the obesity situation. Responsible agencies are not identified for Key Actions. DHBs are expected to implement the strategy with limited resource (AFPHM s159:17).

Similarly, THMM had this to say:

HEHA is a wonderful strategy. Its implementation however has lacked national direction and is presently fragmented. This is due to it being largely under resourced reflecting the commitment from the highest level of government (THMM s100:3).

Such views were reinforced by other public health submitters (NZNO, OAC, NHF, PHA).

For instance both NZNO (s130:4) and OAC (s129:8) used this quote:

HEHA implementation is presently fragmented, under-resourced and haphazard at best.

**HEHA lacks regulatory measures to address obesogenic environment**

Another major criticism of HEHA was the lack of regulatory measures to address the obesogenic environment. FOE explained, that of the eighty-seven actions listed in the HEHA strategy, the level of action attached to those most relevant to altering the obesogenic environment was ‘completely inadequate’. FOE noted for instance, that the lack of commitment under HEHA to address the issue of marketing was problematic:

The only action relating to the promotion and marketing of unhealthy foods, for example is to ‘Investigate and analyse policy options regarding the advertising of food to children’ (FOE s136:37).

FOE further commented that:

The current Implementation Plan for the Healthy Eating Healthy-Action Strategy (HEHA) includes many actions that will be a necessary part of the total effort needed to significantly reduce obesity, but that it is *virtually silent on the major interventions required* to significantly reduce obesity-promoting features of the New Zealand environment (FOE s136:19-20) [my emphasis].

This sentiment was reinforced by other public health submitters (THMM, OAC, PHA, NHF, AFPHM, and Diabetes NZ). For instance:
The significant legislation which would change the social determinants which promote obesity is not documented in HEHA (THMM s100:3).

Environmental changes 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 will require simultaneous national action and is unlikely to be achieved with the present strategy. 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 . . . . The health, education and social policy sectors, while critical, will not be able to generate enough of a change in obesity, unless the social, physical and legislative environment also changes (NHF s47:7).

The HEHA plan contains measures previously tried such as health promotion and encouraging the food industry to adapt best practice in food preparation, reduce sugar, fat and salt content in manufactured foods and replace saturated fats and unsaturated fats. The HEHA plan contains no incentives for industry to adopt these suggestions or restrict their advertising aimed at children (Diabetes NZ s18:5).

The AFPHM added:

HEHA’s key messages concentrate on reducing energy intake and increasing activity by individuals, families/whanau and communities. Its sections on key causal factors such as social and physical environments are general but mention, without detail or specific commitment, the use of regulatory options as well as urban development. Food production and the availability and marketing of obesogenic food products are mentioned only briefly (AFPHM s159:17).

**The Accord – sceptical of Government and industry collaboration**

Another concern raised by some (but not all) public health submitters, was the potential conflict of interest resulting from the collaborative partnership between the Government and the industry in relation to the HEHA strategy. This criticism was most often directed at the Accord agreement between the industry and the Ministry of Health.

The OAC (s129:16) in particular, singled out the relationship between the food industry and the Ministry of Health via the Accord as highly problematic, arguing that:

International evidence shows that the food industry slows down and delays effective action by forming partnerships with government ministries that work together on ineffective programmes.

Furthermore, OAC (s129:16-17) argued that:

There is a serious conflict between the resources and power of those who try and treat and prevent obesity and those who profit from a vested
interest. OAC sees that it is the responsibility of government to alter that balance in favour of those who seek to improve the nations’ health.

Similarly, ANA (s38:4), in recognition of the potential conflict of interests likely to arise from government and industry working together, noted that:

Government has a vital role to play in leading and bringing cross ministry and other parties together to support the common goal of public health, while at the same time balancing conflicting interests.

However, another submitter, the AFPHM (s159:19), noted the mixed opinions of its members:

Faculty members have diverging opinions on the Accord, from those who see it as an important industry initiative which the public health sector should be actively supporting and engaging with, to those who are skeptical about the underlying motives of a previously recalcitrant industry, and doubtful about the potential for the Accord to have an appreciable impact on obesity, given for instance, the lack of commitment to reducing fat and sugar content and the high proportion of advertising of high fat/high sugar products.

Other problematic health and food industry relationships were also noted (such as the sponsorship by McDonalds of the Northland DHB dental vans).

At the other end of the continuum of perspectives on health and industry collaboration was the position taken by the NHF who argued that it was better to work with industry than work ‘against them’ (representative, NHF transcript).

**Failure to address wider determinants of health and social inequalities**

Many public health submitters, in identifying the causes of obesity, highlighted socioeconomic factors as either important or even critical determinants of obesity. For the public health sector, these wider determinants of health generally included factors such as education, income, living and working conditions, as well as social and community networks. There were concerns raised by a number of submitters that the existing HEHA strategy did not adequately address these wider determinants of health:

The New Zealand Government must urgently look at strategies to improve health and wellbeing which improve the environmental and social determinants of health. Strategies should not contribute to the widening of inequalities in New Zealand society (Cancer Society s72:8).

To improve health there needs to be significant changes to the resources that New Zealand families have and the incentives they face (PHA s156:5).
Finally, the NZMA (s128:17) noted the need for:

a whole of society approach that reduces socio-economic inequalities and increases social bonding.

**Independent advisors**

Of the three independent advisors only Swinburn had any comment specific to HEHA and this was that the strategy suffered two fundamental failings:

It is not funded in any significant, long-term way nor is it currently supported by the backbone of policies needed to make healthy choices the easy choices (Swinburn s189:4).

He went on to note that the most serious interventions have their roots in policy, and that the environmental changes needed to address the issue of the heavy marketing of food, required government regulation.

**Role of the food and advertising industries**

The general view of public health submitters was that the food industry made a considerable contribution to causing the obesity epidemic (via increasing the consumption of EDNP foods) but was insufficiently engaged in activities to reduce obesity. The criticisms were centered around two key sectors, the food industry and the marketing industry.

**Food industry**

The food industry in New Zealand, it was noted by the AFPHM, is problematic in that it is generally unregulated, in the sense that food manufacturers did not have any limits on the nutritional content of food products (such as fat and sugar), although there were technical rules pertaining to food safety and labelling (AFPHM s159). The AFPHM (s159:18).also noted that the food industry had defended self-regulation of the food supply:

The food industry internationally has over many decades generally opposed, or at best reluctantly accepted, regulation on matters of food contamination, adulteration and safety, and truthfulness of labelling except where there are market requirements.
The Accord – ‘token’ efforts by the food industry

Some public health submitters acknowledged that the food industry had made some efforts (most recently via the Accord) to reformulate their products or develop new healthier alternatives to existing products, although generally such moves were argued to represent only ‘token’ efforts to address obesity:

FOE provided detailed comment on many of the initiatives outlined as ‘key achievements’ of the Accord in one of the FIG’s reports to the Minister of Health. FOE (s136:34-35) concluded, on the basis of these, that:

there is a strong focus on sponsorship of sport and community projects by companies whose major products are among those that should be eaten only occasionally if at all. In all, 25 sponsorship programmes are listed in the report . . . . This compares with four initiatives relating to improvements to the composition of food and beverages, none of which involve changes to existing products to reduce their energy density. No initiatives aimed at reducing the advertising and promotion of less healthy foods are mentioned in the report . . . . There is no evidence in the report to suggest that the food industry is taking new steps, in response to the Accord, to changing the composition of food or the way that food is promoted. ‘Key achievements’ reported are typically normal commercial activities that were happening anyway. Many of them predate the Accord.

The NHF (s47:5), an NGO reasonably expected to be aware of industry efforts in the area of product reformulation given its close association with the food industry via its Pick the Tick endorsement programme noted, there had been limited progress:

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.

Furthermore, NZMA (s128:14) commented:

We do not consider that the voluntary steps taken by the Food Industry have had any significant impact. For any steps undertaken are undermined by the fact that advertising of food products is still heavily targeted at children.
Independent advisors

On the role of the food and beverage industries, Beaglehole argued that as these industries had a major role in the development of the obesity epidemic they should have a central role in preventing it. He was critical of many of the strategies used by the food industry to address obesity, such as: the focus on education; promoting physical inactivity as the primary cause; laying the blame on bad diets rather than bad foods; other tactics to prevent the targeting of specific foods and drinks; and, the focus on self-promotion rather than action. At the same time he suggested that some of the steps taken by industry were positive, such as: the reformulation of products (to lower the fat, sugar, and salt content); a reduction in portion sizes; and, the development of new healthier products (Beaglehole s307).

Professor Mann (s256) also suggested that steps so far taken by the food industry were ‘encouraging’, although he recommended they needed monitoring.

Food labelling is problematic

Food labels were considered problematic by a number of public health submitters (OAC, FOE, THMM, AFPHM, NZMA, NZNO), who argued that at best, they were either too complex or confusing, and, at worst, misleading. Sometimes the public health submitters were referring to the nutrient information provided by food manufacturers as required by law in the format of Nutrient Information Panels (usually in small font on the back or underside of products), and other times submitters criticised the general nutritional claims (usually on the front of products), such as ‘low fat’, ‘95% fat free’, or ‘high in fibre’.

The NZMA explained that rather than assessing the overall nutritional value of the product (which is presumably desirable from a nutritional perspective), consumers commonly only examined the energy or fat content. The AFPHM raised the same point.

The AFPHM (s159:21) also highlighted a commonly identified problem (by public health submitters) with the National Heart Foundation’s Pick the Tick endorsement:

Food manufacturers, whose products meet defined nutritional criteria and pay fees (to the Heart Foundation), are able to display the Pick the Tick logo on food labels. Food companies are encouraged to reformulate product if they fail to meet the 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 difference.
Other submitters claimed that the text on food labels was often too small to read at a glance, and that it was difficult and time consuming for consumers to assess whether a product was healthy or not.

**Marketing industry**

There were a number of criticisms of the self-regulatory advertising and marketing system in New Zealand. Aside from the issue of the influence of unhealthy food advertising and marketing on consumer purchasing and consumption patterns, there were other concerns raised by a number of public health submitters. Some of these were generic to self-regulatory systems, and others were specific to the ASA framework in New Zealand.

**Generic criticisms**

Some submitters noted that self-regulation served industry rather than public health interests:

> Voluntary self-regulation of marketing doesn't protect population wellbeing (particularly of children), it serves industry interests (NZNO s130:9; OAC s129:10).

Several submitters directly addressed industry arguments against regulation, for instance:

> Arguments against regulation have included denying or down-playing the extent of the problem, opposition to restricting rights on legal activities; interference with market mechanisms; cost of compliance; loss of competitiveness; invoking consumer choice and responsibilities; and the superiority of self regulation to government regulation (AFPHM s159:18).

The AFPHM (s159:18) noted that, in retrospect:

> these arguments have turned out to be either invalid or not outweighing consumer or public interest.

One submitter also presented an argument to counter the advertising industry argument for *freedom of information*. FOE pointed out that, under the United Nations Convention on the Rights of the Child (UNCROC), it is recognised that the child has the right to the 'highest attainable standard of health'. As the New Zealand Government is a signatory to UNCROC, FOE (s136:43) argued that they have a duty to:

> encourage the development of appropriate guidelines for the protection of the child from information and material injurious to his or hell wellbeing (Article 17(e)), and must provide protection 'against all . . . . forms of exploitation prejudicial to any aspects of the child’s welfare' (Article 36)).
FOE argued that the child’s right to health outweighed the ‘right’ (claimed by the ASA), to receive information (by reference to Article 13 of UNCROC – which states that children should have the ‘freedom to seek, receive and impart information of all kinds’):

There is substantial evidence that advertising of unhealthy food to children will detrimentally affect their attainment of optimum health, is potentially injurious, exploits children’s inability to interact with advertisements in a mature way, and works against the efforts of parents to act in their children’s best interests (FOE s136:44).

The ANA (s38: 5) had this to say to justify the regulation of advertising:

It is true that such interventions might limit individual freedom a little, but in return intervention brings significant benefits to individuals and society.

Criticisms of the ASA’s framework – ‘the wolves are guarding the henhouse’

A number of public health submitters had concerns over the ASA self-regulatory system. As noted in Chapters 2 and 5, New Zealand has a similar self-regulatory environment to other countries, where the agencies that create the advertisements also set the rules by which they are judged and selects the jury that assesses any breaches. OAC and ANA quoted the WHO report (World Health Organization 1984) describing the situation as one in which: ‘the wolves are guarding the hen-house’ (OAC s129:33; ANA s38:6).

OAC presented case histories of consumer complaints to the Advertising Standards Complaints Board to illustrate the range of problems with the system. These demonstrated that the ASA complaints system suffered from the following shortcomings:

- it is limited to television advertising and does not include marketing in other media
- it is reactive and not proactive
- the complaints process is prolonged and resource intensive
- there are concerns about bias due to the makeup of the Complaints Board (that it lacked sufficient consumer representation, and that public representatives on the Board had previously worked for the food or advertising industries)
- that complaints are not usually upheld and that the decisions of the Complaints Board were reduced to technical and legal issues
- that is was not widely understood by the public
Independent advisors

Swinburn (s189:4) argued that the purpose of the advertising industry codes was:

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.

6.4.2 Additional policy prescriptions

This section focuses on additional policy prescriptions suggested by the public health sector. It examines four key policy areas: (i) the national obesity strategy HEHA; (ii) the regulation of the food and marketing industries; and, (iii) policies relevant to the school environment.

National obesity strategy (HEHA)

There was consistent support by public health submitters for the following solutions to strengthen the national obesity strategy:

- the establishment of a national obesity taskforce
- a whole-of-government response
- regulatory measures to address the obesogenic environment
- address wider determinants of health and social inequalities.

Support for these recommendations is discussed below.

Establish a national obesity taskforce

Many submitters recommended the establishment of an obesity taskforce to provide the leadership and coordination claimed to be absent from the HEHA strategy. Although there was general agreement amongst these submitters that the objective of such a taskforce was to provide strategic direction for the obesity strategy, there were varying perspectives on the details around the taskforce. In particular, public health submitters had different ideas about the specific roles for the taskforce, and the preferred membership of the
taskforce – whether it should be a cross-government taskforce, an NGO taskforce or a combination of the two, and, whether or not industry should be involved:

an Obesity Taskforce should be established **across central and local government** . . . . The Taskforce needs a clear mandate, accountability and resources . . . . and must have a strong focus on reducing inequalities in health (AFPHM s159:3). [my emphasis]

The primary purpose of the Obesity Taskforce will be to create a unified framework with clear accountability . . . . [to] assist in directing policy, research and the promotion of food and nutrition issues, both within the health and non-health sectors **in the New Zealand government** (NHF s47:8). [my emphasis]

By comparison, the NZMA (s128) recommended the need for a ‘nutrition taskforce’ to coordinate a **multi-government department** approach.

Some submitters (NZNO, OAC) suggested that the taskforce be a **NGO expert taskforce, independent of industry**, to provide independent strategic advice and direction to government on obesity related policies. OAC further added that such a taskforce should be **independent of government** as well, so that it would be free to challenge government policy if necessary (OAC s129).

**Whole-of-government response**

There was consistent support for a ‘whole-of-government’ approach, primarily to address the fact that, from the public health point of view, many of the determinants of obesity lay outside the health sector:

To prevent obesity there must be societal environmental changes, and this must be supported by a broad, whole-of-government response. Strong leadership and co-ordination are needed to get obesity onto non-health sector organisations’ agendas and to make the breadth of measures required happen (NZNO s30:5-6).

Obesity is a complex issue requiring a whole-of-government response, including efforts to influence food supply, marketing, income inequalities, housing and transport for example (OAC s129:24).

A ‘whole of government approach’ as for other public health issues (ANA s38:2).

Many submitters also suggested that the use of Health Impact Assessment tools to assess the health impacts of various central and local government policies would compliment the
‘whole-of-government’ approach (NZNO, AFPHM, NZNO, ANA, Cancer Society, THMM, and the PHA).

**Regulatory measures to address the obesogenic environment**

Generally, measures to address the obesogenic environment, meant legislation or regulatory measures to reduce the availability and marketing of EDNP foods. These included regulation of the food and marketing industries and fiscal measures to address the cost differential between healthy and unhealthy foods.

Legislation and other incentive mechanisms such as taxation will inevitably be needed to support healthy choices (PHA s156:9).

Public health action requires the implementation of a full range of educational, economic, technological and legislative measures (Diabetes NZ s18:5).

FOE made the point that measures to address the obesogenic environment need to be measures that impact on the whole population and not ones focussed on changing the behaviours of individuals or groups. The AFPHM (s159:16) agreed:

In general, strategies which address up-stream factors, including public policy and environments, would be expected to have more influence than those which, for instance, only address individual people and families.

Some submitters (ANA, PHA, FOE, OAC) suggested that the Public Health Bill (being drafted by the Ministry of Health at the time) should be progressed as a vehicle for regulating these industries in the interest of promoting and protecting public health. The ANA (s38:6) noted that the existing public health legislation was out of date, covering communicable diseases but offering no protection for non-communicable diseases – the major cause of death and ill health in New Zealand:

Work on revision of the Public Health Bill has happened intermittently for more than a decade with no result. In the decade that the bill has been languishing, the incidence of obesity and diabetes has risen and there remains no legislative framework for non-communicable disease.

The PHA (s156:9) noted that implementation of the Public Health Bill being drafted by the Ministry of Health:

May be adequate to support healthy choices, and this should be considered closely by the Committee.
Address wider determinants of health and social inequalities

A core recommendation of some public health submitters was to address inequalities (PHA, Cancer Society, NZMA):

As many of the drivers of the obesogenic environment are to be found in the unaffordable cost of healthy food it is important that social inequality in affordability be addressed (PHA s156:8).

The NZMA (s128:15) argued that a ‘whole of society’ approach to obesity would be:

one that reduces socio-economic inequalities, increases social bonding and affiliative behaviours.

Likewise, the Cancer Society, recognising that many of the determinants of health were beyond individual control, recommended that the Government focus on the broader determinants of health, particularly adverse socioeconomic conditions, and urged the Government to reduce inequalities in health.

Other public health submitters also recognised the need to address inequalities, although this was not always central to their recommendations. For example, the AFPHM noted that one of the roles of the proposed taskforce should be to address inequalities in obesity and its determinants.

Role of the food and marketing industries

Food industry

Policies raised by the public health sector as potential solutions to the low cost and increased consumption of EDNP products included:

- mandatory FOP labelling
- address the low cost of unhealthy food and high cost of healthy food
- reformulation of food products with guidelines, targets, and monitoring
- limit the availability of EDNP foods.

Examples of the range of public health recommendations on these solutions are given below.
Mandatory FOP labelling (Traffic Lights)

Many of the public health submitters that highlighted labelling as problematic, suggested the need for a mandatory Front of Pack (FOP) labelling system to assist consumers to easily differentiate healthy from unhealthy foods (OAC, FOE, THMM, NZNO, AFPHM, NZMA). Generally public health submitters suggested that the committee consider recommending the adoption in New Zealand, of the Traffic Light FOP labelling system being trialed in some areas of the UK at the time of the Inquiry:

- Labelling of food products needs further review and favourable consideration needs to be given to introducing a ‘Traffic Light’ system (AFPHM s159:3).
- Simplify food labelling for consumers and focus on improving health rather than increasing food industry sales. This requires implementation of a traffic light food labelling system that is easy for consumers to use (NZNO s130:10).
- Food labels are currently very difficult for consumers to understand. Industry needs to implement a traffic light food labelling system that is easy for consumers to use (THMM s100:6).

One public health submitter, the NHF, was however skeptical of the Traffic Light labelling scheme as the following excerpt from its oral submission illustrates:

- it is unclear how it will improve the food supply. It is unclear how it will change consumer purchasing behaviour. It is unclear what impact it will have on reducing the obesity epidemic. Traffic Lights – it is unproven in the wider food environment. We definitely see Traffic Lights being useful in defined environments like school canteens or workplace cafeterias, with limits on what foods can and can’t be sold. It is less suitable for supermarkets and for wider food environments with a free market choice. Traffic Lights, we know from consultation within the industry it will be widely opposed by the industry. There is no commercial incentive to manufacturers to make healthier foods. We would need to legislate to enforce change on manufacturers and I guess the question we bring: is it better to work with the food industry, rather than regulate the food industry? The question will need to be decided because currently our approach is working with the food industry thereby changing the food supply (representative, NHF transcript).

Address the low cost of unhealthy food and high cost of healthy food

The low price of EDNP food relative to the high cost of healthy food was recognised by many public health submitters as an important determinant of the increased consumption of EDNP foods – particularly for low-income households. The AFPHM (s159:20) noted that:
Price reductions in food groups have been demonstrated as an effective strategy to increase the purchase of more healthful foods. Community based interventions have demonstrated that making healthy options cheaper increases their sales . . . . 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. Denmark, for instance, reduced taxation of vegetables and fruit while increasing taxation on some high fat foods, which increased fruit and vegetable purchasing without changing total food taxation. Considering the impact price 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 in New Zealand.

Many other public health submitters recommended that the issue of the cost differential between healthy and unhealthy food be addressed and suggested a range of strategies. These included:

- imposing levies or taxes on unhealthy foods or removing Goods and Services Taxes from healthy foods (or preferably a combination of both)
- imposing fat, sugar, or energy density taxes
- subsidising the cost of fruit and vegetables (or their distribution or marketing)
- reviewing tax exemptions given to the marketing of energy-dense foods to children
- providing food vouchers to those on low incomes
- subsidising healthy foods in schools and workplaces.

FOE (s136) noted that while a fat tax on its own may be regressive, in that it would impact more heavily on those with low incomes, this impact could be negated by simultaneously decreasing the price of healthy foods. Furthermore, FOE argued that a tax on unhealthy food or its constituents (fat or sugar) would provide an incentive for industry to reformulate their products.

A few public health submitters also suggested that the issue of the high cost of healthy foods should be addressed by reducing socioeconomic disparities (PHA, Cancer Society, THMM, NZMA). However, they did not say how this should be done.

**Food reformulation, guidelines, targets and monitoring**

A number of public health submitters recommended the reformulation of unhealthy products:
Regulation of fat, sugar and salt content in food products should be considered in the face of the obesity epidemic, as a potentially necessary step up from food safety regulation. While this presents many technical and regulatory challenges, various regulatory options need to be considered seriously, unless industry initiatives such as the Food Industry Accord are highly successful in reducing obesogenic food product availability and purchase (AFPHM s159:20).

It was recommended that this area of food industry activity (food composition) needed independent monitoring (and evaluation), and that an improved food supply would require industry to follow guidelines and meet targets (with timeframes):

- Independent evaluation of the Food Industry Accord should continue against clear goals and targets (AFPHM s159:3).
- Develop national nutrition targets, and develop food standards to help industry meet those targets (NHF s47:9).

Other recommendations included:

- a reduction in the use of organoleptic additives (additives that enhance the sensory properties of a product such as taste, colour, odour and feel) in energy-dense foods (NHF, ANA)
- development of healthy convenience foods and healthier snacks, confectionery, and soft drinks for children (NHF).

It was also noted that a mandatory Traffic Light labelling system would act as an incentive to industry to reformulate their products to obtain a ‘healthier rating’.

**Limit the availability of EDNP foods**

Most submitters made a number of recommendations to limit the availability of unhealthy food and increase the availability of healthy food. The AFPHM (s159:10) suggested, for instance, that:

- Land use planning could potentially be used to limit the location of unhealthy food outlets, away from schools for instance, as is commonly done for alcohol retailers and other harmful activities.

Other submitters (THMM, OAC and NZNO) suggested that the Government explore options for improving access to low-cost healthy foods and decreasing access to energy-dense foods at a neighbourhood level, for instance, by:

- zoning of fast food outlets, promotion of local produce markets, ensuring public transport services to food stores especially in low SES
[socioeconomic status] areas, discontinuing drive-thru, discouraging mega-stores on outskirts of towns, etc (NZNO s130:10).

The PHA supported this recommendation and added that there may be a need for incentives to promote greater visibility of healthy food. Some submitters suggested that healthy food should be promoted in public places and in the workplace.

**Marketing industry**

The criticisms raised by public health submitters over the self-regulatory framework governing advertising in New Zealand, together with their claim that the marketing of EDNP foods led to its increased consumption, led to overwhelming support for government regulation of the marketing and advertising of EDNP foods, particularly to children.

**Regulate advertising and marketing**

Public health submitters used the term marketing in its widest sense to include not only television advertising, but all forms of marketing, advertising and promotion, including sponsorship of community and sporting activities by the food industry. The following quotes illustrate the range of public health recommendations on the issue of advertising and marketing:

Regulate to prevent the marketing of ‘all high fat, sugar, and salt foods, across all media types and most especially those which target children’ (NZNO s130:7).

Support controls on the promotion and marketing of energy-dense foods (NHF submission 47:10).

Some of the recommendations regarding marketing and advertising were specific to children:

introduce measures to control marketing to children of foods with high energy density (NZNO s130:8).

A ban on advertising of unhealthy food and beverages targeting children (Diabetes NZ s18:2).

[we recommend that] no advertisements for unhealthy foods be shown on television during the times when programmes intended for those aged 16 and under are being shown, or when a substantial proportion of the viewing audience is likely to be aged 16 and under (FOE s136:45).
Many other submitters (FOE, OAC, NZNO) reiterated that bans or regulations needed to be comprehensive and cover multiple marketing media:

Need legislation/regulation to target the promotion of excessive consumption – discount pricing, bundling, large serving sizes, give-aways, upsizing, multiple discount vouchers (NZNO s130: 9).

Legislation/regulation is needed to prohibit marketing of energy-dense, low nutrient foods, across all types of media, at all times of the day (OAC s129:10).

Other general recommendations included:

- the use of public service media to promote healthy food
- revision of tax exemptions given to the marketing of energy-dense foods to children
- regulating or prohibiting sponsorship associating unhealthy products with activities
- independent monitoring of marketing activity and strategies.

On the specific issue of the ASA framework, there were also a number of recommendations made by some public health submitters. These included:

- extending ASA mandate to cover the full range of marketing activity
- increasing consumer representation on the Complaints Board
- require statutory rather than voluntary codes
- independent monitoring of ASA Codes and guidelines
- adequate monitoring and enforcement.

School environments

The key policies recommended by public health submitters that were specific to the school environment included:

- mandatory food and nutrition policies
- the inclusion of nutrition and cooking in the curriculum
- extension of the Fruit in Schools initiative
- ban on the sale of unhealthy food and unhealthy food sponsorship.

The evidence for these key recommendations is examined below. A range of other recommendations were made by submitters, including: developing reward schemes for choosing healthy food; subsidising healthy food options; universal feeding programmes
(such as breakfast programmes for all children); provision of free clean drinking water to all students; a range of strategies to support increased physical activity amongst children; and, multi-component school based programmes in general. However these recommendations were not key (not mentioned by more than two submitters) so they are not considered further.

**Mandatory food and nutrition policies**

Public health submitters were unanimous in their recommendation that schools needed *mandatory* food and nutrition policies. Submitters generally agreed that school food and nutrition policies should be comprehensive:

> food and nutrition policies would exclude all foods (and promotion of them) that are not appropriate for everyday consumption . . . . This would include tuck shop sales, soft drinks sales, chocolate bar fundraising, fast food sponsorships deals, sponsored curriculum materials etc. This needs to be set in legislation/regulation . . . . Food outlets within walking distance must be included in the above strategy (NZNO s130:11).

Some submitters suggested the the National Administration Guidelines (NAGs) for Schools should be altered to promote healthy environments in schools.

**Inclusion of nutrition and cooking in the curriculum**

Some public health submitters suggested that nutrition, food preparation and cooking skills should be a compulsory part of the school curriculum:

> Nutrition, food selection and food preparation skills should be a required component of the national education curriculum (AFPHM s159:4).

> Nutrition curricula and basic cooking skills need to be priority subjects in schools (NZNO s130:11).

**Fruit in Schools**

There was support from some public health submitters to continue (or expand to more schools) the free Fruit in Schools initiative (described in Chapter 5 as the Government-funded initiative that provides one piece of fruit per day to each child in the lowest decile primary schools across New Zealand).
**Ban sale of unhealthy food and unhealth food industry sponsorship**

Submitters were also supportive of bans (or controls) on the sale of unhealthy food in schools as well as controls or bans to food industry sponsorship or other forms of commerical presence in schools:

- The Ministry of Education should require schools and early childhood education centres to stop sale of high sugar drinks (AFPHM s159:4).
- Controls on the promotion and availability of foods high in salt, sugar and fats in the school environment (ANA s38:7).
- Review the use of vending machines in secondary schools and the types of foods and drinks promoted in vending machines (OAC s129:48).

### 6.4.3 Non-solutions

There were two policy options explicitly opposed by many public health submitters. These were the use of education or information as a strategy on its own, and the upcoming Health, Nutrition, Health and Related Claims legislation being drafted by FSANZ at the time of the Inquiry. Public health perspectives on these two policy options are explored below.

**Education and information in isolation**

Public health submitters were opposed to education and the provision of information as isolated strategies. However, there was support for public education and information in the form of social marketing as part of the wider strategy to address obesity. FOE (s136:30) for example, on the matter of population-level health education, concluded that:

> Stemming the rise of obesity by population-level measures aimed at changing individual behaviours, but without accompanying environmental and societal changes, does not seem achievable given the evidence from well-resourced interventions in the United States.

It was also proposed by a number of public health submitters that any social marketing should provide consistent and culturally appropriate messages on healthy eating and physical activity.
Nutrition, Health and Related Claims legislation

A number of public health submitters (OAC, NZNO, ANA) opposed the pending Nutrition, Health and Related Claims legislation, arguing that it was not in the interests of public health nutrition for manufacturers to be allowed to make health claims on food products. This was because:

- consumers may be led to believe the food has more value in its overall diet that it really does (OAC s129)
- research verifies that consumers do not understand health claims and are misled and confused by them (OAC s129)
- health claims may lead to the increased consumption of processed food – since such foods were thought to be more likely to need the ‘marketing advantage provided by health claims’ (ANA s38:2).

Summary of public health framing of solutions

Public health submitters were critical of the HEHA strategy. Although actions identified in the HEHA implementation plan were thought to be a necessary part of the overall package of policies to address obesity, for many submitters the HEHA strategy suffered some fundamental flaws. These included: lack of leadership and coordination between the various government sectors and HEHA’s limitation to the health sector; lack of adequate resources for HEHA implementation which was criticised as haphazard and limited; the lack of regulatory measures to address the obesogenic environment; and, the failure of HEHA to address wider determinants of health and social inequalities. There were also some mixed views on the collaborative approach between the Ministry of Health and the industry, with many public health submitters sceptical of this relationship.

The food and marketing industries were also considered problematic. The Accord was felt by most submitters to represent only a ‘token’ effort by the food industry which was undermined by the heavy marketing and advertising of unhealthy foods. Food labelling was also considered as problematic. In the area of marketing, there were a number of criticisms made regarding the ASA system which was seen as fundamentally flawed for a number of reasons, in particular because the rules by which advertisers must comply were set by advertisers.
To address the problems identified by submitters with the HEHA strategy, submitters made a number of key recommendations. These were: to establish a national obesity taskforce to promote increased leadership, collaboration and a ‘whole-of-government’ response; the use of regulatory measures to address the obesogenic environment; and, policies to address wider determinants of health and social health inequalities.

To address problems with the food industry, submitters recommended: a mandatory FOP labelling system; the setting of guidelines, targets (with monitoring) for the reformulation of unhealthy food products; limiting the availability of EDNP foods; and, policies to address the price differential between healthy and unhealthy food. In the area of marketing and advertising, submitters suggested that government regulation was required and some recommendations specific to the ASA framework were put forward by some submitters.

A number of recommendations relevant to school environments were also made. These included: mandatory food and nutrition education in schools; support for extending the (free) Fruit in Schools initiative; the inclusion of nutrition and cooking in the curriculum; and, banning the sale of unhealthy foods and unhealthy food sponsorship in schools.

**Summary of Chapter 6**

This chapter has described the submitters from the public health sector as defined in this thesis and described the sector’s framing of obesity. The signature features and key aspects of the public health framing of obesity are presented in Table 24 and summarised below.
Table 24: Summary of public health framing of obesity

<table>
<thead>
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<th>Signature features</th>
<th>Key aspects and public health position</th>
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| **Problem representation** | Overall description  
An ‘epidemic’ & a ‘complex’ issue (& sometimes a ‘pandemic’) |
|  | **Type of problem**  
A ‘human health burden’  
An ‘economic burden to the health system & the economy’  
An ‘inequalities’ problem |
|  | **Affected groups**  
Overweight & obesity are a problem  
The whole population is affected  
The burden is greater for Māori, Pacific & lower socioeconomic communities  
Some mention of gender differences  
Children a risk group for some submitters |
|  | **Causes**  
**General causes**  
Energy imbalance  
Multiple societal factors influencing consumption & physical activity (urbanisation, economic changes, food supply changes & sedentary behaviour) |
|  | **Main cause**  
Obesogenic environment  
Socioeconomic factors & wider determinants of health  
Focus on ‘energy in’  
Increased consumption of energy-dense/nutrient-poor foods due to: their increased availability; low cost & heavy marketing  
Some foods are highly obesogenic (sugary drinks, processed foods, foods high in fat & sugar) |
|  | **Non-causes**  
Not genetics  
Not character deficits (lack of willpower & irresponsibility)  
Not a knowledge deficit problem |
|  | **Solutions**  
**Perspectives on the existing policy environment**  
**Critical of HEHA:** Lacks leadership & coordination & limited to the health sector; under-resourced & haphazard & limited implementation; lacks structural measures; sceptical of collaborative approach (Government & industry); & fails to address wider determinants of health & health inequalities  
**Critical of the food industry:** Food industry plays a major role in causing the epidemic but is not taking enough responsibility to address it. Food supply: the Accord represents mainly ‘token’ efforts by industry; food labelling is problematic  
**Critical of the marketing industry:** generic criticisms & critical of the Advertising Standards Authority self-regulatory system |
|  | **Additional policy prescriptions**  
**HEHA:** national obesity taskforce; whole-of-government response; structural measures to address the obesogenic environment; address wider determinants of health  
**Food industry:** mandatory Front of Pack labelling; address food cost; reformulate unhealthy food products; limit availability of unhealthy foods  
**Marketing industry:** regulate advertising & marketing  
**Schools:** mandatory food & nutrition policies; include nutrition & cooking in the curriculum; support Fruit in Schools; ban sale of unhealthy food & unhealthy food sponsorship |
|  | **Non-solutions**  
Not education or information in isolation  
Nutrition, Health & Related Claims legislation |
As can be seen from Table 24, in their overall description of the problem, the public health submitters largely framed the issue of obesity as an epidemic, a pandemic, and a complex issue. The obesity epidemic was considered problematic because of the human health burden and the economic burden to the health system and the economy. The obesity issue was also framed as an inequalities problem.

On the matter of who was affected by the obesity epidemic, public health submitters were generally of the view that both overweight and obesity were problematic in terms of the health risks. Submitters also argued that although some subgroups of the population were more affected by the burden of obesity (Māori, Pacific and those from lower socioeconomic communities), the whole population was affected by the indirect and intangible costs of obesity. There was also a real concern among public health submitters over the recent increases in childhood obesity with children seen as a particularly vulnerable population group.

In their discussion of the general causes of population increases in obesity, like the industry submitters, the public health submitters agreed that energy imbalance was the fundamental physiological cause of obesity. Similarly, like industry, public health submitters acknowledged that there were multiple societal determinants of obesity.

The main causes identified by public health submitters were: the obesogenic environment and socioeconomic factors and wider determinants of health. There was also an explicit emphasis on ‘energy in’ (consumption) as the key factor contributing to obesity, rather than physical activity, although the role of physical activity was acknowledged.

Increased consumption was attributed, by the majority of public health submitters, to the increased consumption of EDNP foods (not overconsumption in general as argued by the industry submitters). The increased consumption of EDNP food, was in turn, argued to be due to its: increased availability; low cost; and, heavy marketing.

In their identification of factors that were not causes of obesity, three themes emerged. Public health submitters agreed that genetics, character deficits (such as lack of will-power), and knowledge deficits were not causes of obesity.

On the matter of the existing policy environment, a number of criticisms were raised. These were to do with the existing HEHA strategy and the roles of the food and marketing industries. The HEHA strategy was believed to lack leadership and coordination and be under-resourced in its implementation. As well, HEHA was criticised as lacking the
necessary regulatory measures to address the obesogenic environment and lacking in policies to address social inequalities. The food industry was criticised for not being sufficiently engaged in addressing the obesity epidemic despite having a considerable role in causing it. Specifically, the Accord was thought to represent only ‘token’ efforts to address obesity which were argued by public health submitters to be undermined by the heavy marketing of EDNP food. Food labelling was thought to be problematic and inadequate, and the marketing industry in general was thought to be problematic because of its self-regulatory nature.

Key policy prescriptions proposed by the public health sector were to address the shortcomings of the HEHA strategy and the problems attributed to the food industry. Policy prescriptions were also made for improving the school environments. The public health sector argued for a national obesity taskforce to lead the national obesity strategy and promote a ‘whole-of-government’ response. Regulatory measures to address the obesogenic environment were called for and submitters highlighted the need to address wider determinants of health and health inequalities. Specific actions to address problems with the food industry included: mandatory FOP labelling; addressing the issue of food cost; reformulation of unhealthy products with the establishment of guidelines, targets, and monitoring; and, proposals to limit the availability of EDNP foods. Additionally, submitters called for regulations to food marketing to restrict or ban the marketing of unhealthy food, particularly to children. In the area of school environments, public health submitters suggested that food and nutrition policies in schools should be mandatory, that nutrition and cooking be included in the school curriculum, and that the Government ban the sale of unhealthy food and unhealthy food sponsorship in schools. There was also some support for extending the Fruit in Schools programme.

The only solutions explicitly opposed by public health submitters was the use of education and the provision of information as a strategy on its own, and the progression of the proposed Nutrition, Health and Related Claims legislation.
Chapter 7: Results III: The Health Select Committee and the Government framing of obesity

This chapter outlines the framing of obesity by the Health Select Committee and the Government based on two official reports: the Inquiry into Obesity and Type 2 Diabetes: Report of the Health Committee (Health Committee 2007); and, the Government Response to the Inquiry into Obesity and Type 2 Diabetes (New Zealand Government 2007).

To place the committee’s recommendations in context, the chapter opens with an overview of the two official reports (section 7.1). As noted in Chapter 4, the committee’s position was not unanimous. Specifically, the four National Party committee members disagreed with a number of the recommendations agreed to by the ‘majority’ of the committee. Its dissenting view was presented separately at the back of the report. Therefore, throughout this chapter there are three sub-headings indicating the two views of the committee (the ‘majority’ view and the ‘minority’ view) and that of the Government. However, for consistency with the previous two chapters, this chapter is organised according to the three signature features of the framing matrix: the problem representation (section 7.2); the causes (section 7.3); and, the solutions (section 7.4).

Section 7.4 begins with an overview of the key policy recommendations made to the Government by the committee. It examines the framing of the solutions, the committee’s stated rationale for these and the Government’s response. This section is organised according to five key policy areas: (i) the HEHA strategy; (ii) the food industry; (iii) the marketing industry (including advertising and promotion); (iv) public education and information; and, (iv) school policies. These categories were used as they corresponded with the key areas of policy commented on by the industry and public health submitters and addressed by the recommendations of the majority committee. Policy solutions not addressed by the committee recommendations, but put forward as solutions by either the public health or industry sector submitters, are considered in Chapter 8.
7.1 Overview of the reports

This section examines the format of the official committee and Government reports. It describes their overall content, the general objectives and principles outlined by the majority committee and the Government’s response to these.

7.1.1 Health Select Committee report

The Health Select Committee report contained fifty-five recommendations to the Government. According to the report, these recommendations were based on: a synthesis of the evidence presented to the Inquiry; the written and oral submissions; a review of relevant international literature; specialist advice from the three independent advisors; and, expert evidence from the Ministry of Health. The National Party committee members disagreed with a number of the recommendations in the report, and its view was presented separately (in two pages) at the end of the report. The format of the report (taken from the contents page) is presented in Table 25.

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Source: (Health Committee 2007:2).

As can be seen from Table 25, the report was forty-nine pages long including appendices. The executive summary outlined: a number of key points, objectives and targets for
reducing obesity: five **principles** for action; and, provided a brief **summary** of some of the recommendations. Aside from the executive summary, the first half of the report was organised under subheadings relevant to each of the five Terms of Reference. These sections outlined: the salient issues identified by the committee; provided brief summaries of the main perspectives and the evidence acknowledged by the committee; and, presented the majority committee’s stance on these issues. This section provided much of the data relevant for assessing the majority committee’s framing of the obesity issue and its causes. Some of the commentary in this section of the report also provided some of the committee’s justification for its recommendations outlined in subsequent sections of the report.

The specific recommendations were outlined in eight sections (beginning on page 29 of the report), corresponding to the relevant sectors to which the recommendations were directed: the Government; the food, drink and marketing industries; the health sector (and DHBs); schools and early childhood education centres; workplaces, communities, families and individuals; breastfeeding; media related industries; and, research funding agencies. Target dates for initiating and completing various parts of some of the recommendations were also included in these sections. These eight sections provided most of the data for assessing the committee’s framing of its proposed solutions (outlined in section 7.4). It is important to note though, that not all of the issues discussed in these sections were translated into specific recommendations. For instance, although food price was identified as a critical issue and a contributing cause of the increased consumption of energy-dense food, and some policy options were outlined, no specific recommendation was made by the committee on this issue.

On the matter of the specific recommendations made by the committee, there were a number of phrases used in the committee's report. For instance, the committee frequently used the phrase ‘the majority of us’ in relation to specific recommendations, and a couple of times the phrase ‘some of us’ was used. In other cases the committee report referred to ‘we’ when making recommendations. As there was no explicit definition given for the use of these phrases, their meaning remains somewhat ambiguous. The phrase ‘the majority of us’ could mean either the numeric majority of the committee members, or all of the committee members except the four National Party committee members. The term ‘some of us’ also appeared ambiguous, although its use was limited to the recommendation to establish an independent commissioner (and a related recommendation outlining the proposed tasks of the independent commissioner). These recommendations were explicitly opposed in the dissenting view put forward by the National Party committee members.
Therefore, in this chapter, where the term ‘majority’ is used, it has been interpreted to mean all of the committee members except for the four National Party committee members. For accuracy however, the specific recommendations examined in this chapter use the exact phrasing as that found in the committee’s report.

Objectives, targets and principles outlined by the majority committee

As noted above, the executive summary contained some overall objectives, targets and principles that should, according to the majority committee, underpin the Government’s response to the obesity epidemic. The two overarching *objectives* identified by the committee were:

- to create an environment in New Zealand that encourages and maintains healthy eating and physical activity patterns (especially amongst children and young people), and
- to develop and implement a coordinated national cross-sectoral response to address the risk factors that impact on the development of non-communicable diseases including diabetes (Health Committee 2007: 3).

The *outcome targets* suggested by the majority committee included:

- reduce the increase in the rate of obesity in children and youth to zero by 2010, and cut by 20 percent the prevalence of obesity in children and youth by 2015
- narrow the ethnic gaps in childhood obesity rates so that by 2015 the rates are equally low in Māori, Pacific, and other New Zealand children (Health Committee 2007: 4).

A number of *principles* which should, in the majority committee’s view, underpin any specific action were also outlined:

- a concerted, whole of government response
- an urgent, but sustained response
- an integrated and comprehensive response
- a stepwise approach, and,
- an environmental approach (Health Committee 2007: 4-5).

The committee also summarised some of the evidence presented during the Inquiry. Overall, it was held that there was ‘reasonable consensus’ on many important points and disagreement in two major areas (Health Committee 2007: 7). The *consensus* related to the “causes, nature, and importance of the issue, and the need for a large-scale, concerted
public health response as a matter of urgency” to address the consequences of obesity and related conditions (Health Committee 2007: 7). The disagreement was over “the relative contribution of physical inactivity to obesity (and related conditions)”, and “the role of the food, beverage, advertising, marketing and promotion industries in causing and combating obesity and type 2 diabetes” (Health Committee 2007: 7). The committee also noted that: the overwhelming weight of the submissions supported the need for policy and legislative mechanisms to encourage the adoption and maintenance of healthy eating and activity patterns, especially by children.

7.1.2 The Government Response to the Health Select Committee report

The Government Response to the Health Select Committee report was released on 27 November 2007. It was led by the Ministry of Health and acknowledged the contribution of twenty-four government agencies. The report itself was sixty-seven pages and, “to facilitate the Response to the 55 recommendations”, was organised into subgroups described as “like and logical groupings” (New Zealand Government 2007: 5-6). The format of the report, taken from the table of contents, is presented in Table 26. The bold type in Table 26 indicates where the recommendations relevant to food and nutrition policy were found in the report.

Table 26: Contents of the Government Response

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In the executive summary, the Government claimed to ‘largely agree’ with all but eight of the fifty-five recommendations. Of these eight recommendations, in some cases the Government agreed with parts of a recommendation, in other cases recommendations were under consideration, and three recommendations were rejected outright (New Zealand Government 2007). The target dates for action on the recommendations provided by the committee were not discussed in the Response.

A matrix of the fifty-five recommendations from the committee, the abbreviated Government response to these, and the names of the key agencies consulted for each of the recommendations was also provided in Appendix 1 of the report. In this appendix, the abbreviated Government’s response took a number of forms:

- agree
- largely agree (and ‘largely agree progress is necessary’; ‘largely agree, with provisos’)
- partially agree
- disagree
- to be considered at a later date
- would agree if . . .
- agree in principle with . . .
In the background section of the Response, the Government noted that it agreed with the ‘intent’ of the committee’s overarching objectives and principles.

The Government outlined current actions to address obesity as well as recent initiatives implemented over the past eighteen months and noted that there had been recent substantial increases to the Government funding of initiatives and health infrastructure to improve nutrition and increase physical activity. The Government also commented that many submitters to the Inquiry may have not been aware of these recent developments.

The background section also outlined the Government’s 2005 strategic direction for the next ten years which prioritised: ‘economic transformation’; ‘families young and old’; and, ‘national identity’ (New Zealand Government 2007: 7). It was also noted that along with addressing inequalities across population groups and improving Māori health, that:

improving nutrition, increasing physical activity and reducing obesity are three of the 13 population health objectives covered in the Government’s New Zealand Health Strategy (New Zealand Government 2007: 9).

The various Government responses to the majority committee’s recommendations were covered in subsequent sections of the report. These were addressed under the eight relevant subsections (the ‘like and logical groupings’) which, as can be seen from Table 26, were differentiated according the responsibilities of various Government and industry sectors. The food and nutrition related recommendations considered in section 7.4 of this chapter (outlined in bold in Table 26), were predominantly covered under the sections: Leadership and Coordination (which addressed recommendations related to the governance of the HEHA strategy); Food Labelling (the responsibility of NZFSA); Education/Children and Young People (recommendations relevant to the school environment); Food and Beverage Industries (recommendations relevant to the food industry); and, Media and Advertising. One relevant recommendation (Recommendation 41 relating to Government funded social marketing) was found under the section headed Sport and Recreation Council (SPARC) of New Zealand and physical activity. The report also contained five appendices with more detailed information relevant to various aspects of the Government Response.

In addressing the committee’s recommendations, the Response first outlined the relevant recommendations and provided a summary of the Government’s response to these, followed (in most cases) by a justification for the response. This was typically followed by an examination of current and recent actions relevant to the recommendations. There
were a number of ‘New Actions’ agreed to by the Government in response to the committee recommendations, and these were numbered and emphasised in capitals throughout the report. In total, there were twenty-three New Actions. Of these, seven were relevant to food and nutrition policy. These New Actions are noted under the relevant recommendations examined in section 7.4.

7.2 Health Select Committee and Government problem representation

7.2.1 Overall description

The majority committee

The majority committee predominantly framed obesity (and Type 2 diabetes) in ‘epidemic’ and ‘pandemic’ terms. Obesity was also described as a ‘complex’ issue. The majority committee referred to the doubling of obesity prevalence amongst adults between 1977 and 2003, noting that the increase began relatively slowly between 1977 and 1989, and accelerated rapidly from 1989 to 1997 (Health Committee 2007).

The minority committee

In contrast, the National Party committee members framed obesity (and Type 2 diabetes) as a ‘serious medical problem’ (Health Committee 2007: 35).

The Government

The obesity problem was described by the Government, as a ‘complex’ issue, an ‘epidemic’ and an ‘emerging’ issue:

The Government is committed to addressing the obesity epidemic, while recognising that this is an emerging issue (New Zealand Government 2007: 5).

In addition, the Government used the terms ‘increasing’ or ‘rising rates’ in several places (instead of the term ‘epidemic’) to describe the growth of obesity in the population.
7.2.2 Type of problem

The majority committee

The majority committee described the epidemics of obesity and Type 2 diabetes as important health and economic issues for New Zealand. Noting that these epidemics had "severe health, social, and economic effects on individuals, communities, and the country", the majority committee was concerned about their "potential to rapidly overwhelm the health system" (Health Committee 2007: 7).

Focusing on the economic burden to the health system, the majority committee cited a conservative estimate of the direct costs of obesity to the health care system of NZ$135 million per year (in 1991), equivalent to 2.5% of total health expenditure (Health Committee 2007: 10). It was noted that, based on these figures, an estimate for 2000/2001 would be at least NZ$247.2 million (Health Committee 2007: 10). Estimates of the higher health care costs associated with Type 2 diabetes were also provided, including a prediction that costs would increase from NZ$540 million for the 2006/07 year – 3% of state health spending – to $1.78 billion by 2021 – 15% of state health spending (Health Committee 2007: 11).

In examining the consequences of Type 2 diabetes, the majority committee, after citing diabetes statistics that highlighted the hugely disproportionate burden currently experienced by Māori and Pacific communities, noted some of the indirect costs:

- like obesity, diabetes incurs substantial social costs, and employment and household disruption often requires publicly-funded interventions. The loss of leaders and mentors, especially among Māori and other ethnic groups, erodes social capital (Health Committee 2007: 10).

The ‘epidemics’ particularly burden already disadvantaged groups in New Zealand. Increasingly they affect children (Health Committee 2007: 9).

Thus, for the majority committee, as well as the economic burden to the health system, obesity was also problematic because of the human health burden (to those concerned) and because there was a range of other social and economic costs.

The minority committee

Like the majority committee, the minority committee viewed obesity as problematic because of the potential economic burden to the health system. It noted that along with
chronic disease, obesity and Type 2 diabetes “threaten to overwhelm the health system” (Health Committee 2007: 35). However, unlike the majority committee, there was no mention of other social, economic or human health costs associated with obesity.

The Government

Similarly, for the Government, the epidemic was primarily a problem because of the potential economic burden to the health system. It was noted that “approximately 2000 deaths per year are attributable to type 2 diabetes”, suggesting that much of the health system burden from obesity stems from diabetes (New Zealand Government 2007: 6). Other social economic and health costs were not mentioned by the Government.

7.2.3 Affected groups

The majority committee

The majority committee included both overweight and obese groups in its problem description. This was evident in the committee’s use of data from the 2002/03 New Zealand Health Survey revealing the proportions of the New Zealand population who were overweight or obese.

Like the public health sector, the majority committee recognised that obesity had impacts on the whole population, not just those directly affected:

Obesity and type 2 diabetes are crucial issues for New Zealand; they adversely affect the health of many and the social and economic welfare of all New Zealanders (Health Committee 2007: 3).

It was also acknowledged that the burden of the epidemics was greater for ‘disadvantaged groups’, with a higher incidence of obesity amongst Māori and Pacific peoples (and their children) compared to New Zealand Europeans. Childhood obesity statistics were also provided and these showed the highest rates of obesity and overweight were amongst Pacific children, followed by Māori children and then children of New Zealand European or ‘other races’ (Health Committee 2007: 9). The majority committee were particularly concerned about obesity amongst children, describing the recent trends as ‘particularly worrying’ (Health Committee 2007: 3).
The minority committee

The minority committee also used the terms obesity and overweight interchangeably in its description of the problem. However, although the minority committee argued that only certain groups were affected by the problem, it did not explicitly identify who these groups were. Instead, it was argued that “action must be targeted at those identified as being at risk” (Health Committee 2007: 35). There was no mention of children as a vulnerable population group.

The Government

In the Response, although the Government referred, in its general discussions, to both overweight and obesity, suggesting that it considered both ‘conditions’ as problematic, it only provided statistical data for the obese population.

On the issue of whether the whole population or just some population sub-groups were affected, the Government referred to ‘affected communities’ suggesting that the epidemic was not an issue for the whole population (New Zealand Government 2007: 7). It was also noted (in the background section of the Response) that ‘community ownership’ of the ‘health issues’ was an important component of the solution, as was the ‘engagement’ and ‘involvement’ (in the solutions) of those affected by the issue (New Zealand Government 2007:7).

The Government acknowledged the wide ethnic disparities in obesity. Lower socioeconomic groups and children were also identified as vulnerable population groups although; the Government conceded that these groups were already key priority groups under the HEHA strategy.

**Summary of the Health Select Committee and Government problem representation**

While the majority committee framed obesity in epidemic and pandemic terms and as a complex issue, the minority committee framed obesity as a serious medical problem. The position of the Government was that obesity was: a complex issue; an epidemic; and, an emerging issue.

The majority committee, the Government and the minority committee agreed that obesity was problematic because of the potential economic burden to the health system. The
Government, like industry, emphasised that much of the economic burden associated with obesity was in fact attributable to diabetes rather than obesity per se. However, only the majority committee highlighted the wider social and economic costs of obesity.

The majority committee, the minority committee and the Government, all recognised that both obesity and overweight were problematic in health terms. Only the majority committee noted that obesity had effects on the whole population, although like the Government, it recognised that the burden of obesity was greater for Māori, Pacific and lower socioeconomic groups. However, the Government and the minority committee framed the obesity issue as a problem for affected communities. Children were also identified as vulnerable group by the Government and the majority committee, but not the minority committee.

7.3 Health Select Committee and Government framing of the causes

This section examines the framing of the causes of the obesity epidemic by the committee and the Government. It is noteworthy, that the Government and the minority committee did not explicitly examine the causes of obesity or specifically identify factors that were not causes. Although, as noted in section 7.1.1, there was some indication of the Government’s stance on the main causes of obesity implicit from its comments on the committee’s report. However, the distinction between the general causes, the main causes, and the non-causes was not evident in all three perspectives examined in this chapter.

7.3.1 General causes

The majority committee

The majority committee argued that ‘energy imbalance’ was at the heart of the obesity epidemic and that there were ‘multiple’ causes for this:

The fundamental cause of the rapid rise in obesity is an imbalance between energy intake and energy expenditure . . . . but there are multiple risk factors for obesity (Health Committee 2007: 3).

Multiple factors also encourage lifestyle choices that are unhealthy, especially for people at high risk (Health Committee 2007: 8).
Some of these factors were discussed under the headings ‘physical inactivity’ and ‘childhood factors’. For instance, in the area of physical inactivity, the majority committee argued:

Physical inactivity and sedentary habits have become more common. There is generally far less need to expend physical energy than there was 30 years ago. Urbanisation is associated with less walking and cycling and more use of motor vehicles. Social and economic changes have reduced the opportunities for physically active work and leisure (Health Committee 2007: 8).

Childhood factors identified by the majority committee as contributing to obesity (aside from limited breastfeeding) included: (i) increased television viewing; (ii) reduced physical activity; and, (iii) the lack of nutrition and cooking education in schools. The committee also noted that:

Safety concerns, time constraints, and being driven to school have reduced the time children spend on outdoor activity, along with an increase in sedentary pastimes (Health Committee 2007: 9).

The majority committee also acknowledged some wider societal changes (for instance increased workforce participation) and some individual factors influencing energy intake including ‘parental habits’ and knowledge and skill deficits related to seeking out and preparing healthy affordable food. Although, these factors were considered as secondary to the main causes of increased energy intake (outlined in section 7.3.2.).

The minority committee

The dissenting view put forward by the National Party committee members did not explicitly mention the causes of obesity. However, it was clear from its perspective on the solutions, that individual attributes, rather than the environment, were the driving force behind increases in obesity. This is discussed further in section 7.3.2.

The Government

The Government in its response did not specifically address the causes of the obesity epidemic (although there was some support for the obesogenic environment model which is noted in section 7.3.2.).
7.3.2 Main causes

The majority committee

Two key themes emerged as the main causes of obesity: the **obesogenic environment** and the emphasis on increased energy intake as the dominant cause of the energy imbalance. The evidence for these two themes is presented below.

**The obesogenic environment**

The obesogenic environment was held by the majority committee to influence both energy intake and physical activity:

> Social, cultural, and economic changes that influence eating and activity patterns have created an ‘obesogenic environment’ (Health Committee 2007: 8).

**Emphasis on energy intake**

The majority committee also explicitly emphasised that energy intake was the dominant cause of the energy imbalance:

> small but sustained increases in energy intake in individuals and the whole population are the main culprit (Health Committee 2007: 8).

> Excessive food intake is the major cause, but there are multiple risk factors for obesity which interact to create an environment where unhealthy food is more visible, more readily available, and far more heavily promoted than healthy food. As a result less healthy choices have become the easy choices (Health Committee 2007: 3).

The committee also reinforced its emphasis on energy intake when discussing the contribution of physical activity to the energy imbalance:

> promoting physical activity will not by itself reverse the trend. Physical activity accounts for only 20 to 30 percent of total energy expenditure, only a small part of which can be influenced by increasing activity. Dietary changes to reduce energy intake are therefore critically important (Health Committee 2007: 8).

> What is known of the physiology of activity and metabolism indicates that increasing activity can make only a relatively small contribution to achieving energy balance (Health Committee 2007: 23).
**Increased energy intake due to changes in food availability, composition, marketing and pricing**

Although multiple factors were acknowledged as influencing energy intake (including societal changes and individual factors), increased energy intake was predominantly argued to be due to changes in food availability, composition, marketing and pricing (Health Committee 2007). Of these four factors, the majority committee highlighted *marketing* (including advertising and promotion) as a major influence on food preferences and eating habits, especially amongst children. As well, later in the report (under a subheading ‘Private Sector Actions’), the majority committee implicated the *food and beverage industry* as an important *cause* of the obesity epidemic:

> the food and beverage industry is not sufficiently engaged in the prevention of obesity despite having an important role in causing it (Health Committee 2007: 12).

**The minority committee**

There were three main themes implicit from the dissenting view which indication that National Party position on the key cause of obesity. These were: attitudes; lack of skills; and, knowledge deficits. As well, lack of motivation was implicated as another reason for increases in obesity. These themes are considered below.

**Attitudes**

Obesity amongst ‘affected groups’ was argued to be largely caused by *socio-cultural attitudes* to food, exercise and obesity:

> In western, Māori, Pacific Island and Asian cultures, food is often central to social interaction, and a marker of hospitality. Basic attitudes to food have to change before the tide of overweight and obesity will begin to reverse. Our ‘cultural hard drive’ has to alter, so that healthy choices are the choices of preference (Health Committee 2007: 35).

**Lack of skills**

Lack of cooking and food preparation skills were also identified as a contributing cause:
Skills for selecting and preparing healthy foods have been lost across large segments of New Zealand society (Health Committee 2007: 36).

**Knowledge deficits**

A lack of knowledge of the benefits of being a healthy weight was another causal factor implied by the minority committee:

> Obesity rates will only decline once there is a cultural shift amongst those groups affected, and people place such a high value on the benefits of maintaining a healthy weight that they will make consistently healthy lifestyle choices (Health Committee 2007: 36).

As well, the identification of a lack of knowledge as a cause of obesity was evident in the solutions proposed by the minority committee to the problem of obesity:

> A successful long-term response will provide people with the education, skills and desire to make these healthy dietary and lifestyle choices (Health Committee 2007: 25).

Implicit in the added suggestion in the above quote, that people need to have the *desire* to address the issue, is the idea that *lack of motivation* is also a factor in the obesity issue.

There was no indication of any particular emphasis on energy intake or physical activity evident from the minority committee view.

**The Government**

**Obesogenic environment**

Although the Government did not address the causes of the epidemic in obesity, its position was implicit from the following statement:

> the need to address the obesogenic environment is vital if we are to make progress in reducing obesity (New Zealand Government 2007: 6).

Thus, the Government appeared to accept the majority committee’s obesogenic environment perspective of the obesity epidemic.
The Government did not specifically note whether energy intake or physical activity was the more dominant cause of the energy imbalance. However, the Government did note its concern that the committee was largely focused on food-related aspects and advertising, rather than how to create environments conducive to physical activity. It also noted that the committee had not given any consideration to the social determinants of health, such as education and income.

### 7.3.3 Non-causes

The majority committee

The role of genes was dismissed as an explanation for the population level increases in obesity, although it was accepted that genes have a role in some individual cases. Education as a strategy on its own, was also noted (three times throughout the report) to be insufficient for addressing obesity as it did not address the obesogenic environment (Health Committee 2007: 3,4,15). This suggests that the majority committee did not view the obesity issue as a knowledge deficit problem.

The minority committee

There was no explicit identification of non-causes evident in comments made by the majority committee.

The Government

As the Government did not outline its perspective on the causes of obesity, there was no evidence of its stance on factors that were not causes. Solutions opposed by the Government were only evident from its direct responses to the specific recommendations of the committee. These are examined in section 7.4.

**Summary of Health Select Committee and Government framing of the causes**

For the majority committee, energy imbalance was deemed to be the simple cause of obesity and it was acknowledged that there were multiple determinants of this. These multiple factors included: increased workforce participation; physical inactivity; lack of food selection and preparation skills; lack of food and nutrition education in schools; and, for
children, parental habits and television viewing. However, the main cause was argued to lie in the obesogenic environment which made the ‘unhealthy choices the easy choices’. The focus however, was on energy intake. Critical factors leading to increased energy intake highlighted by the majority committee were changes to food composition, its marketing, availability and cost. The majority committee also discounted genetics as an explanation of increased obesity and did not endorse a knowledge deficit explanation of the obesity epidemic (although lack of cooking and food preparation skills were recognised as contributors).

For the minority committee, obesity, amongst affected groups, was believed to be caused not by factors in the environment but by individual factors. These were: attitudes (to food, exercise and obesity); knowledge and skill deficits; and, lack of motivation.

Although the Government did not explicitly discuss the causes (or non-causes) of obesity, it appears that it accepted the obesogenic environment perspective put forward by the majority committee. However, the Government did not commit to a position on the relative influence on obesity of energy intake and physical activity.

Examined next in section 7.4, are the Health Select Committee and Government perspectives on the solutions.

7.4 Health Select Committee and Government framing of the solutions

This section begins with an overview of the majority committee recommendations relevant to food and nutrition policy. This is followed by an examination of the majority committee’s recommendations in five main policy areas. These five sections outline the committee’s rationale for its recommendations, the specific recommendations, and the Government response to these. The minority view, which was only evident for a limited number of recommendations, is also noted throughout where relevant. The section concludes with a summary of the committee and Government framing of the solutions.

7.4.1 Overview of key committee recommendations

There were twenty-five key recommendations relevant to food and nutrition policy. They have been classified for the purposes of this thesis into the following categories:

- HEHA strategy
- the food industry
- the marketing industry
- public education and information
- schools.

As noted in the chapter outline, these categories most closely represent the key policy areas commented on by the industry and public health submitters and addressed by the specific recommendations of the majority committee. Some policy solutions identified by the public health or industry submitters were not addressed by the specific committee recommendations. These are examined in Chapter 8. An overview of the key policy areas and the corresponding twenty-five food and nutrition policy related recommendations are depicted, in an abbreviated form, in Figure 10.

![Figure 10: Key majority committee recommendations relevant to food and nutrition policy](image-url)
In Figure 10, the numbers given under each recommendation correspond with the numbering given to them (and the related recommendations) in the Government Response. Four of the five policy areas cover a number of recommendations. The majority (ten) of recommendations related to the ‘marketing industry’ (including advertising and promotion). Six recommendations related to the ‘HEHA strategy’, and four recommendations were related each to ‘schools’ and the ‘food industry’. The five policy areas, the relevant recommendations, and the Government response to these, are outlined next (in section 7.4.2).

7.4.2 The solutions (recommendations)

The HEHA strategy

There were four key (and three related) recommendations made by the majority committee that related to the HEHA strategy. The key recommendations were for the Government to:

- use the full range of public policy measures
- establish a cross-sector ministerial committee
- establish an external stakeholder advisory group
- establish an independent commissioner.

These and the related recommendations are examined below.

**Government to use the full range of public policy measures**

A major concern raised by the majority committee over the HEHA strategy, was that, as the main focus of the Government's response to the obesity epidemic:

its scale is not commensurate with the problem, nor is it well implemented; and its impacts have not yet been assessed (Health Committee 2007: 11).

The committee emphasised that there was an urgent need to ‘significantly scale up the public health response’ and that ‘many powerful potential interventions have not been fully used’ (Health Select Committee 2007:13). The majority committee recommended:
Recommendation 1: Government to use the full range of public policy measures
The majority of us recommend that the Government use the full range of public policy measures to ensure the development, promotion and maintenance of healthy diet and physical activity patterns, especially among children and young people. This should be done in the context of integrated programmes for the prevention and control of major chronic diseases (Health Committee 2007: 29).

Despite the recommendation to use the full range of public policy measures to improve diet and exercise patterns in the population, the majority committee was less clear on what these specific measures would be, although it was suggested that the Public Health Bill may be an appropriate vehicle:

There is an opportunity to ensure that the forthcoming Public Health Bill contains mechanisms for regulatory approaches to combat obesity, type 2 diabetes, and other chronic diseases associated with diet if self-regulation by the industry should prove insufficient. Existing public health legislation needs to be strengthened since the public health threat of chronic, non-communicable diseases clearly exceeds the threat of communicable diseases, on which public health legislation is currently focused (Health Committee 2007: 17).

The committee, in some places of its report, also recommended the use of Health Impact Assessments (a tool that examines the health impact of various policies).

The minority committee did not specifically comment on the recommendation for Government ‘to use the full range of public policy measures’. However, it did note that the proposed Public Health Bill “should not be a vehicle for regulation” and further, it had “concerns about the intent of the bill, and will be watching closely” (Health Committee 2007:35).

The Government’s response

The Government agreed that the full range of public policy measures was needed, but rather than proposing a new strategy, the Government (2007: 11) decided that:

it would be judicious to review the existing HEHA implementation plan and widen the current scope.

Highlighted as New Action 1 was the:
Revision of the HEHA implementation plan in 2008/09, with additional actions across the whole health continuum and the inclusion of process and outcome targets (New Zealand Government 2007: 11).

As well as agreeing to revise and widen the scope of the HEHA implementation plan, the Government outlined a number of recent initiatives and the recent increase in funding for HEHA:

- May 2006 – funding in the Government Budget to expand the implementation of HEHA
- September 2006 – the Government launched Mission On (a cross-government department campaign including a package of ten initiatives targeting children and young people)
- alignment of HEHA with other Government and health strategies
- October 2006 – funding of twenty-one DHB HEHA coordinator positions.

The Government did not address the majority committee’s suggestion that Health Impact Assessment would be a useful mechanism for addressing the obesogenic environment.

**Establish a cross-sector ministerial committee**

In its summary of the current approach to obesity (across all sectors – government, community programmes and private sector actions), the majority committee concluded:

> The many current initiatives are fragmented and poorly coordinated, and insufficient for the prevention and management of obesity (Health Committee 2007: 13).

The need for strong government leadership and coordination of government agencies was recognised by the majority committee and was addressed in Recommendations 2, 4 and 5 (Health Committee 2007: 29):

**Recommendation 2: Establish a cross-sector ministerial committee**

We recommend the establishment of a cross-sectoral ministerial committee, chaired by the Prime Minister or Minister of Health, with a high-level advisory group of independent experts, to implement the strategy (Health Committee 2007: 29).

The specific goals of the cross-sectoral ministerial committee were also outlined, and they included:
**Recommendation 4: Goals of the ministerial committee**

the stepwise implementation of a coordinated national strategy and plan of action incorporating existing initiatives (HEHA and Mission On)

the inclusion in this national plan of measurable and timed targets relating to healthy diets, physical activity and overweight and obesity (Health Committee 2007: 29).

The *minority* committee noted: “National cautiously supports the concept of a cross-sectoral ministerial committee backed by an expert advisory group to implement the response to obesity and diabetes” (Health Committee 2007: 35).

**The Government’s response**

The Government considered that high-level, accountable leadership was essential to ‘drive a strong strategic response to obesity’ (New Zealand Government 2007:12). It agreed, under *New Action 2*, to establish a cross-sector ministerial committee made up of the relevant ministers and chaired by the Minister of Health “with a supporting secretariat and implementation advisory group” (New Zealand Government 2007:13).

It was agreed that the ministerial committee would provide oversight for the strategic direction of the revision of the existing HEHA implementation plan, and monitor the progress of the existing plan. On the issue of the request by the majority committee that the proposed ministerial committee monitor progress and compliance to determine where industry self-regulation was or was not working, the Government agreed that the ministerial committee would identify targets *in consultation with industry*, and *consider* regulation if these targets were not met (New Zealand Government 2007). Thus, while the Government agreed to establish the ministerial committee, it was not clear whether the implementation advisory group would be comprised of independent experts as requested by the committee.

*External stakeholder advisory group*

To assist the ministerial committee in implementing the national obesity strategy, the majority committee recommended the establishment of an external stakeholder advisory group (Health Committee 2007: 15):
Recommendation 7: Establish an external stakeholder advisory group
irrespective of the form of leadership, an external advisory group be established to ensure that all stakeholders have input into the national strategy (Health Committee 2007: 30).

To promote cooperation and collaboration, the majority committee suggested that major stakeholders, such as industry and key NGOs, together with public health groups, be included in the advisory group.

Recommended tasks for the advisory group included the development and implementation of national standards and guidelines in food and nutrition, physical activity, education and healthcare.

The Government’s response

It was agreed that expert advice was desirable. The Government committed to establishing a HEHA Sector Steering Group (SSG) by expanding the existing steering group to include additional members from relevant government and non-government organisations, members from Māori and Pacific communities, obesity experts and food industry representatives. The SSG would provide a multi-disciplinary forum that would report to the ministerial committee on strategic issues (such as research, evaluation, monitoring, implementation, service development, service provision and collaboration and spreading new innovative approaches).

Establishment of an independent commissioner

One of the majority committee recommendations (Recommendation 3) related to the establishment of an independent commissioner:

Recommendation 3: Independent commissioner
Some of us also recommend the establishment of an independent commissioner to champion, monitor and evaluate the implementation of the strategy (Health Committee 2007: 29).

The proposed roles for the independent commissioner were to:
Recommendation 6: Roles of the independent commissioner

- Increase awareness of public health issues regarding obesity and type 2 diabetes, and champion preventive measures.
- Recommend policies, strategies and priorities to reduce the incidence of obesity and type 2 diabetes.
- Bring together major stakeholders including industry representatives, nongovernmental organisations and the health sector to promote the prevention of obesity and type 2 diabetes.
- Evaluate and monitor the implementation of policies and programmes to reduce the incidence of type 2 diabetes and obesity (Health Committee 2007: 29-30).

The minority committee was however, opposed to the establishment of an independent commissioner:

- We do not believe that establishing a post for an independent commissioner will increase the efficacy of that response (Health Select Committee 2007:35).

The Government’s response

The Government disagreed with Recommendations 3 and 6 on the grounds that the functions identified for a proposed independent commissioner would be addressed by the HEHA SSG, whose advice would underpin the work of the ministerial committee. The Government’s rejection of the recommendation for the independent commissioner suggests that it supported the minority view on this matter.

The food industry

Issues specific to the food industry were discussed by the majority committee under the heading ‘the role of the food and beverage industry’ (Health Committee 2007: 17). The majority committee emphasised the importance of the food industry to the New Zealand economy:

- [the food industry] accounts for almost 50 percent of the national economy, with the retail food sector employing 17 percent of the workforce and accounting for 25 percent of the total sales market (Health Committee 2007: 17).

The majority committee acknowledged the concerns raised by industry that some actions being called for could have adverse impacts on the economy. However, it countered this
with the argument that, at present the costs associated with the consumption of unhealthy food were borne by individuals and society and not the food industry.

On the issue of the Accord, the majority committee recognised that although it had engaged some effort in promoting health in New Zealand, these contributions were relatively small:

Despite some promising initiatives, such as actions by the Food Industry Group, the food and beverage industry is not sufficiently engaged in the prevention of obesity despite having an important role in causing it (Health Committee 2007: 12).

Furthermore, it was argued that::

The Food Accord and the Food Industry Group still have a great deal more to deliver on their parts of this strategy (Health Committee 2007: 11).

Criticisms of the Accord identified by the majority committee were: its voluntary nature; the focus of initiatives on educational strategies that emphasise bad diets rather than bad food as the problem; fostering the belief that physical inactivity is the major cause of obesity; and, industry sponsorship of community health projects such as mobile dental clinics (which led to the wide endorsement of the sponsor’s products).

The majority committee made a number of recommendations relevant to the food industry. These were:

- develop a FOP food labelling system (two recommendations)
- set targets for product reformulation
- informal fast food sector to encourage healthier options.

The majority committee recommendations to address these issues and the Government responses are outlined below.

The minority committee also agreed that the food industry had a role to play in addressing the obesity epidemic, and while it made no specific comment on the above recommendations it did make some general comments:

Harnessing the power of the food industry could assist in achieving the cultural changes required. The food industry has indicated it will take a leading role in the battle against obesity. Indeed consumers are demanding more healthy options. Industry wants to work with Government to develop uniform codes on labelling, marketing and promotion (Health Committee 2007: 36).
**Develop a FOP food labelling system**

In recognition of the problems with the existing labelling system, the majority committee noted that there was strong support by submitters for a user-friendly, FOP system for labelling food and beverages to assist consumers to quickly distinguish relatively healthy from unhealthy food (Health Committee 2007). The multiple ‘Traffic Light’ system, developed and being tested by the UK Food Standards Agency, was suggested as a viable option found to be acceptable to consumers (Health Committee 2007). The committee noted that although the food industry submitters argued that such a system would be confusing and unnecessary, in light the recent development of various FOP labelling systems by the food industry, the committee noted that a number of different industry inspired FOP labelling systems were operating simultaneously. These included some developed by industry and the Heart Foundation **Pick the Tick** endorsement on some products. However, the committee noted that these systems were not mandatory or consistent in their criteria, and they only applied to a limited range of processed products. The committee proposed that the Ministry of Health and the Food Industry Group, under direction from the proposed ministerial committee, develop a FOP labelling system:

**Recommendation 16: Develop a FOP labelling system**

The majority of us recommend that a traffic light system or comparable food labelling system should be developed by a national taskforce (including food industry representatives), and food and drink composition standards agreed for use on product information panels, and in the advertising, marketing, and promotion of products, and that progress and compliance are monitored and, if necessary, regulatory approaches adopted (Health Committee 2007: 31).

Recognising that a nutrient profiling system would be required to underpin a FOP labelling system, the majority committee made a number of suggestions about what the system should be based on. Specifically, that it should:

- be based on Food and Beverage Classification system developed by the Ministry of Health for food sold in schools
- ensure that fruit was not inappropriately labelled
- identify trans-fats separately
- include all major sources of unhealthy fats, salt, and sugar (Health Committee 2007: 22).

The committee also suggested, under Recommendation 17, that the system should be introduced gradually with children’s food prioritised.
The Government’s response

The Government agreed that it would ‘consider’ introducing a FOP labelling system if current research revealed that it would be effective as a public health strategy. The Government cautioned, that in identifying the key purpose of a FOP labelling system, it would have to identify the target population and process of implementation:

If the purpose of a new labelling system is to target a particular disease or risk factor, it is important to identify the process of implementation that delivers the best health outcome (New Zealand Government 2007: 36).

However, the Government asserted that:

If a food labelling system was mandated in New Zealand it would also need to be adopted in Australia, due to the nature of food regulation shared by the two countries . . . . the composition and labelling requirements for food in New Zealand are subject to the Agreement Between the Government of Australia and the Government of New Zealand Concerning Joint Food Standards System (the Food Treaty). The adoption of a New Zealand Standard, which would otherwise come within the scope of the Food Treaty, would be contrary to the intent of the Food Treaty (New Zealand Government 2007: 35).

On the issue of the need to develop food composition standards as a basis for a FOP labelling system, the Government outlined a number of current activities to investigate the feasibility of FOP labelling. These included: work being undertaken by a trans-Tasman working group (to advise the Australia and New Zealand Food Regulation Ministerial Council on options); work being undertaken by FSANZ (to assess the feasibility of various nutrient profiling systems); and, research being conducted locally (funded by the NZFSA) and the Ministry of Health.

Also emphasised, was the need for any such system to be consistent with other systems currently in use in New Zealand (such as the Ministry of Health Food and Beverage Classification system developed for use in schools, and any system likely to underpin the proposed Nutrition, Health and Related Claims legislation.

Set targets for product reformulation

On the matter of product reformulation, the majority committee recommended:
Recommendation 19: Product reformulation targets
[we recommend] that targets be set for the reformulation of energy-dense products, initially focusing on a limited number of high-volume products particularly influential in the diets of children, especially children from low-income families (Health Committee 2007: 31).

The Government’s response

The Government, noting that it had been encouraging the food industry to make these changes, stated that it was “keen to see specific time-bound targets” and proposed that the “FIG identifies specific, measurable targets and timeframes agreed to by the Ministry of Health, the SSG and the Committee” (New Zealand Government 2007: 49).

The Government then proceeded to recommend:

- the initial focus for reformulation efforts should be high-volume, energy-dense products that are consumed by children and low-income families . . .
- The Government is prepared to fund worthy initiatives to encourage the informal fast food industry to improve the nutrient profile of its products (New Zealand Government 2007: 49).

The Government stated under New Action 19, that it would establish six new DHB-based regional food industry coordinator positions (New Zealand Government 2007: 49). Their responsibilities would be to facilitate change with local food producers, distributors and retailers in relation to product reformulation (improving the nutritional quality of the food supply), and to encourage the food industry to increase the profile of healthy foods through marketing.

Informal fast food sector to encourage healthier options

The majority committee recognised that the informal fast food sector (small operators) also had a role to play in the obesity epidemic. The challenge was to encourage small fast food businesses to make their products healthier, for example, by following the National Heart Foundation’s ‘Tips on Chips’ and ‘Best Practice Frying Guidelines’. It was recommended by the majority committee:
Recommendation 22: Informal fast food sector
[we recommend] that the informal fast food industry, such as fish and chip businesses, should be engaged in the national effort to encourage the consumption of food and drinks low in fats, salt and sugar (Health Committee 2007: 31).

The Government’s response

The Government ‘largely agreed’, noting that some members of the food industry had formed the FIG and were signatories to the Accord. It was highlighted that one of the seven goals within the FIG strategy was to work with manufacturers and retailers “to find ways of reducing levels of fat, salt and sugar in the diet and increasing consumption of fruit and vegetables” (New Zealand Government 2007: 49). Other food reformulation initiatives listed as already underway were:

- the National Heart Foundation sodium reduction project
- the CHIP group initiative to reduce fat content of hot chips

Listed as New Action 20, was an increase in funding for additional Ministry of Health staff to work with the food industry to “facilitate change in the food supply and facilitate the industry DHB positions” (New Zealand Government 2007: 50).

Listed as New Action 21, was the Government agreement to fund ‘one-off’ projects “to facilitate food industry-led activities to support Recommendation 22” (New Zealand Government 2007: 50).

The marketing industry

According to the majority committee, the advertising, marketing and promotion sector:

has the potential to play a key role in the prevention of obesity but has not yet engaged seriously as part of the solution (Health Committee 2007: 12).
The committee recognised that support for some form of regulation was strong (from 120 submitters), with only ten submitters (nine from industry) opposed to regulation. It was the majority committee’s view that:

the public health evidence indicates that advertising, marketing, and promotion help to condition food preferences and choices in children, normalize unhealthy food, and undermine parental authority in this respect. Advertising establishes and reinforces behaviour, and if it did not the food industry would not spend its money on it. Recent evidence . . . [from an Australian project run by the independent advisor Professor Swinburn] indicated that restricting food marketing and particularly television advertising to children is likely to be the most cost-effective intervention available (Health Committee 2007: 18).

Thus, the majority committee made ten recommendations related to the advertising, marketing and promotion of unhealthy food. These related to four key areas:

- restrictions to broadcast advertising
- changes to the ASA self-regulatory system
- encouraging the promotion of healthy food
- setting targets for the promotion of energy-dense foods.

The recommendations relevant to the above key areas are explored below. However, it is important to note the minority view on the issue of marketing, advertising and promotion was different to that of the majority committee. It stated that:

Industry wants to work with Government to develop uniform codes on labelling, advertising, marketing and promotion. Similarly, any restrictions on advertising, promotion and marketing of unhealthy food and drink to children need to be agreed as part of a code driven by the relevant sectors (Health Committee 2007: 36).

**Restrict broadcast advertising**

On the issue of broadcast advertising, the majority committee recognised that any regulation would have financial implications as food and beverage advertising is worth NZ$140 million annually to broadcasters (Health Committee 2007: 20). However, the majority committee noted that restrictions on the advertising of unhealthy food would be countered by an increase in the advertising of healthy food. Although the committee commended the recent effort by the major television broadcasters for developing the Five Point Plan of advertising to children (described in Chapter 5), it wanted to see the time restriction in this plan extended to 8.30pm:
**Recommendation 20: Restrict broadcast advertising**

the majority of us recommend that ways of restricting all forms of unhealthy food and drink advertising, promotion and marketing to children be widely consulted on and agreed. We recommend that the broadcast media extend their present restriction on advertising products that do not meet the children’s food rating during screening of programmes directed at children, up to 8:30 pm (Health Committee 2007: 31).

However, the *minority* committee argued:

Rather than a focus on controls on advertising, National prefers an emphasis on active alternatives to television during daylight hours, and sensible levels of television watching overall. There should be support for ongoing monitoring, evaluation and research into the relationship between media advertising and obesity (Health Committee 2007: 36).

**The Government’s response**

The Government’s perspective on the issue of advertising was that there was “a substantial body of evidence” supporting the role of marketing as:

- a small but important contributing factor in the child obesity epidemic (New Zealand Government 2007: 17).

Although the Government agreed with the first part of Recommendation 20 “that ways to restrict all forms of unhealthy advertising, promotion and marketing be widely consulted on and agreed” (New Zealand Government 2007: 50), it was noted elsewhere in the Response (without any explanation) that the Government could not “direct industry to extend restrictions on advertising time” (New Zealand Government 2007: 57).

In its discussion of advertising, the Government highlighted the recent development by major broadcasters of the Five Point Plan, arguing that this was a response to Recommendation 20. According to the Government, the Five Point Plan was an agreement by the major broadcasters to:

1. provide free commercial airtime to the Health Sponsorship Council social marketing campaign aimed at improving children's healthy nutrition – to the value of $0.5 million per annum for the remaining two years of the programme
2. introduce a new 'Getting It Right' guide to children's television advertising which includes a new Children's Food (CF) rating. Only
food products that receive this rating will be able to advertise in programmes directed at children
3. work closely with Sports and Recreation New Zealand (SPARC) in the production of television programming aimed at improving diet and exercise practice of children
4. provide training for advertisers and agencies in the new Getting It Right guide which is related to the Ministry of Health's food classification system and the Codes for Food and Children approved by the Advertising Standards Authority (ASA)
5. participate in the government consultative group on food advertising which will include monitoring of food promotion (New Zealand Television Broadcasters' Council 2009).

Emphasising that it was the intention of the Government to ‘strongly encourage’ industry to reduce marketing of unhealthy foods to children, the Response noted:

at this stage the Government will review the position on legislative change based on the demonstration of the industry responsiveness and active progression on the five point plan (New Zealand Government 2007: 50).

**Changes to the ASA self-regulatory system**

On the issue of the existing ASA self-regulatory system the majority committee noted that:

The self-regulation system suffers from the disadvantage that it is difficult for the food industry to be impartial, given its interest in maximising market penetration. We were advised that the record to date for self-regulation was not encouraging. In 2005 the Advertising Standards Complaints Board considered 267 substantive complaints, and 54 percent of them were upheld. When a complaint is upheld the advertiser, advertising agency, and media involved are requested to withdraw the advertisement immediately, but there are no penalties for advertisers who are found to breach the code. There was full compliance with these requests. However, we were informed that the process for considering complaints is prolonged, and meanwhile the challenged advertisement continues to screen. We were informed that board decisions are typically made on technical and legal issues, rather than those of encouraging demand for and consumption of inappropriate foods in excessive amounts by children (Health Committee 2007: 19).

The majority committee also noted that another problem with the existing self-regulatory advertising system, was its limitation to advertising in the strictest sense as this excluded other forms of marketing such as sponsorship and endorsements. To address these issues the majority committee made the following recommendation:
Recommendation 23: Changes to the ASA self-regulatory system
The majority of us recommend a minimum of two members of the Advertising Standards Authority be consumer representatives appointed by the Minister of Consumer Affairs and that its mandate be extended to cover the marketing and promotion of foods and beverages to consumers (Health Committee 2007: 31).

The Government’s response

The Government claimed that it had already achieved Recommendation 23 “with the Advertising Standards Authority’s Complaints Board having four (consumer) representatives who are nominated by the Minister of Consumer Affairs” (New Zealand Government 2007: 17).

In its response to the issue of extending the ASA mandate (from strictly television advertising to cover marketing and promotion) the Government wrote:

The Ministry of Health and FIG will work with the [ministerial] Committee to determine the specific process and outcome targets around decreasing the marketing of unhealthy food to children (New Zealand Government 2007: 18).

As a minimum, the Government suggested that industry consider a number of changes to the ASA self-regulatory system, for instance:

- revising the relevant Code to explicitly cover marketing and promotion (eg: product placement, sponsorship and sales promotions)
- inclusion of a suitable food rating system within the Codes to objectively differentiate unhealthy foods and beverages
- promotion of the complaints system to the public, and examine how to make the process more transparent and accessible (New Zealand Government 2007).

Specific actions to address marketing and advertising highlighted by the Government were:

- The establishment of a monitoring system to measure all forms of marketing of unhealthy food to children
- A review of industry’s progress in reducing unhealthy food advertising to children
- The defining of targets for marketing by the ministerial committee (in consultation with the FIG and the Ministry of Health), and Government assistance to meet these targets (New Zealand Government 2007).
Finally, the Government also requested that the Ministry of Health “commence the preparatory work required to implement a co-regulatory framework for the regulation of marketing of food to children, should the self-regulatory system not result in reduced marketing of unhealthy foods to children” (New Zealand Government 2007: 18).

*Encourage the promotion of healthy food*

The majority committee made a number of recommendations to encourage the promotion of healthy food. One of these was directed at the fast food sector:

**Recommendation 14: Encourage the fast food sector to promote healthy food**

[we recommend] that fast food restaurants and takeaway services be encouraged to take more responsibility for the promotion of healthy meals, especially to children and youth (Health Committee 2007: 30).

Another recommendation to encourage the promotion of healthy food was directed at the advertising sector:

**Recommendation 50: Advertising sector be encouraged to promote healthy food**

[we recommend] that the food, media, and entertainment industries be encouraged to use their extensive power to promote healthy foods and beverages and physical activity for children and young people (Health Committee 2007: 33).

**The Government’s response**

The Government ‘agreed’ with Recommendation 14, that industry be *encouraged* “to continue to make positive changes to its products and to agree to targets that are recommended by the [ministerial] Committee” (New Zealand Government 2007: 48).

The response to Recommendation 50 was to restate that it was the intention of Government to “strongly encourage” industry to reduce marketing of unhealthy foods to children (New Zealand Government 2007:50). One way of improving the self-regulatory system suggested by the Government, was “to consider agreed-to restrictions on volumes of, times and places where, marketing of unhealthy food is permitted” (New Zealand Government 2007: 50). However, it was reiterated that the Government was waiting to
assess the industry responsiveness to the Five Point Plan before considering legislative change.

**Target setting recommendations (Recommendations 5, 11, 12, 13, 15, 21)**

It was noted by the majority committee that the existing strategy in relation to energy-dense products in New Zealand is one of self-regulation of all forms of marketing, advertising and sponsorship. The committee argued that it was “strongly of the view that specific targets need to be set and the industry’s self-regulation in this area strictly monitored” and that “research and surveillance of advertising, marketing, and sponsorship should be included in food and nutrition surveys” (Health Committee 2007: 20). To this end, six target setting and monitoring recommendations were made. These target setting and monitoring recommendations, to be the responsibility of the ministerial committee, included:

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<tr>
<th>Recommendation 11: Ministerial committee to set targets</th>
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<td>[we recommend] that the cross-sectoral ministerial committee set targets and timeframes for the advertising, marketing, and promotion of healthier diets, especially to children and young people (Health Committee 2007: 30).</td>
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<tr>
<th>Recommendation 12: Ministerial committee to define targets to be met by industry</th>
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<td>[we recommend] that the committee define and implement measurable targets to be achieved by the industry with strict and reasonably short timeframes, which should be monitored, and the majority of us recommend that regulation be considered if the targets are not achieved (Health Committee 2007: 30).</td>
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<th>Recommendation 13: Meeting advertising targets</th>
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<td>[We recommend] that the Food Industry Group, in association with the Ministry of Health, be given responsibility for achieving these [advertising and marketing] targets under self-regulation within the agreed timeframes (Health Committee 2007: 30)</td>
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<th>Recommendation 15: Stakeholders work together to meet agreed targets</th>
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<td>[we] recommend that the Government and scientific, public health, and consumer groups work with the food, beverage, restaurant, and marketing industries to meet agreed targets and timeframes regarding the advertising, promotion, and marketing of energy-dense products, especially to children and young people (Health Committee 2007: 30).</td>
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<th>Recommendation 21: Target setting to reduce advertising and marketing to children</th>
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<td>[We recommend] that targets for regulating advertising, marketing, and promotion to children of food and drinks high in unhealthy fats, salt and sugar should be set by the committee (Health Committee 2007: 31).</td>
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Recommendation 5: Monitor progress and compliance of self-regulation
The majority of us recommend that progress towards these targets and compliance with self-regulation be monitored to determine where voluntary regulation is working and where it is not, and that self-regulation be extended or legislation introduced depending on the results (Health Committee 2007: 29).

The Government’s response

The Government ‘largely agreed’ with the marketing-related target setting recommendations and said it would consider regulation if the targets were not met. It was agreed that the target setting would be the responsibility of the ministerial committee (who would consult with industry). The Government also indicated that work to decrease the marketing of unhealthy food had already been initiated, although it conceded that “more needs to be done and that the Food Industry Group (FIG) is well-placed to take further action” (New Zealand Government 2007: 17). In response to Recommendation 13, however, the Government stated while it strongly encouraged FIG to set and achieve targets, it was “unable to direct the Food Industry Group as proposed” (New Zealand Government 2007: 17).

Public education and information

Only one recommendation was made by the majority committee regarding public education or information provision. This is likely to be due to its view that information-based initiatives were already covered in the national obesity strategy and its view that knowledge deficits were not the cause of the obesity epidemic:

there is too much emphasis on education and the promotion of physical activity as the key preventive interventions. Consumers’ knowledge of these measures is already high (Health Committee 2007: 13).

Although the committee emphasised that educational strategies alone would not be likely to ‘achieve a good result’, it accepted that social marketing, if supported by wider environmental strategies to address the obesogenic environment, could be useful (Health Committee 2007). The committee also suggested, in response to concerns raised by some submitters during the Inquiry, that there may be adverse ‘unintended consequences’ if health promotion messages focus on weight and weight loss, that a general health promotion-focused social marketing campaign be supported by the Government. Additionally, it suggested that targeted health promotion messages and distribution systems would need to be developed to reach Māori and Pacific communities:
Recommendation 41: Social marketing
[We recommend that Government] encourage all stakeholders to work together to create and implement a sustained social marketing programme supporting parents, caregivers, and families in promoting healthy diets (including breastfeeding) and physical activity for children and young people (Health Committee 2007: 33).

The minority committee also appeared to support a social marketing information campaign, albeit in a targeted fashion:

The requirement is for socially and culturally appropriate promotion and education to enable people to make the right choices regarding their health (Health Committee 2007: 36).

The minority committee also noted that:

A successful long-term response will provide people with the education, skills and desire to make these healthy dietary and lifestyle choices. Interventions that eliminate choice and rely on control will not achieve the required attitudinal changes (Health Committee 2007: 35).

The Government’s response

The Government agreed with Recommendation 41, and noted its funding of the Health Sponsorship Council multi-media social marketing campaign: Feeding Our Futures (New Zealand Government 2007: 44). The campaign, which began in May 2007 (after the Inquiry), focused on the promotion of healthy eating through a series of messages targeted to parents and caregivers of children in Māori, Pacific and low socioeconomic households. A social marketing campaign run by Sport and Recreation New Zealand (Push Play), to promote physical activity was also noted as having Government support (New Zealand Government 2007: 44).

Schools

The majority committee recognised that schools were an influential environment for children and young people and acknowledged that a number of health promotion programmes were already operating in some schools. Concerns were raised by the majority committee that many school health promotion programmes were poorly coordinated, under-resourced, and only sporadically implemented. The committee also noted that some school policies undermined or contradicted health promotion messages.
A number of recommendations specific to the school setting were made to the Government. The key recommendations relevant to food and nutrition policy in schools were to:

- promote healthy diet and physical activity in schools
- remove unhealthy products from schools
- extend the Fruit in Schools initiative to all schools
- include nutrition and cooking in the curriculum.

These recommendations and the Government responses are examined below.

However, the *minority* committee was not in favour of universal food and nutrition policies for *all* schools, only schools where obesity was identified as a problem:

National believes Government should work with schools and communities where obesity is identified as a problem to reduce access to high energy foods at school, and to emphasise active lifestyles (Health Committee 2007: 36).

**Promote healthy diet and physical activity and remove unhealthy products from schools**

The majority committee recommended:

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<th>Recommendation 34: Promote healthy diet and physical activity in schools</th>
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<td>that national and local educational authorities, with support from parents, health authorities, and other stakeholders, promote healthy diets and physical activity in all aspects of the school environment (for example, commercial sponsorships, foods for sale, and curriculum). This includes early childhood education centres (Health Committee 2007: 32).</td>
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While the majority committee acknowledged that the removal of unhealthy food from schools may have financial implications, it nonetheless recommended that unhealthy food be removed from all schools. The majority committee also commended the recent move by the Government to change the National Administrative Guidelines (NAGs) for schools to require them to restrict the sale of unhealthy food in schools, although it noted that:

It remains uncertain, however, whether reducing their availability in schools results in a lower overall consumption of these unhealthy products (Health Committee 2007: 25).
Nonetheless, the majority committee recommended:

**Recommendation 35: Remove unhealthy products from schools**

the majority of us recommend the removal of unhealthy food and beverage products from schools (such as those high in unhealthy fats, salt, and sugar), and all agree that the regular evaluations of the performance of schools (including early childhood education centres) should include their efforts to promote healthy diets and physical activity (Health Committee 2007: 32).

The *minority* committee, on the other hand, did not support the removal of unhealthy products from all schools:

National notes that many schools already have effective food and drink policies, and not all schools have an overweight and obesity problem. National does not wish to limit the sensible consumption of treat foods on an occasional basis (Health Committee 2007: 36).

It was also noted:

National is not in favour of food and drink policies in public facilities and work places that remove individual choice (Health Committee 2007: 35).

Furthermore on the matter of industry sponsorship of sport, the minority committee noted:

As regards sponsorship of sport, if such advertising enables physical activity, the net effect is positive. There is nothing wrong with a food or drink treat after Saturday sport (Health Committee 2007: 36).

**The Government’s response**

The Government agreed with Recommendations 34 and 35 and listed relevant activities undertaken over the past twelve months. A key change agreed to by the Government, which was already underway (and scheduled for implementation in June 2008), was the change to the NAGs to require schools to “promote healthy food and nutrition for all students” and, “where food and beverages are sold on school premises, to make only healthy options available” (New Zealand Government 2007: 39).

Other initiatives *already* underway were also listed, including:

- September 2006 – A nutrition fund of NZ$5 million per annum to support schools and ECE services to make changes to promote healthy eating
• September 2006 – Mission On initiatives to help children to make ‘healthy lifestyle choices’
• December 2006 – a voluntary agreement between the Government and two of New Zealand’s largest beverage companies to withdraw full-sugar energy drinks from schools by the end of 2009
• July 2007 – launch of the Ministry of Health Food and Beverage Classification system for schools (with resource kits and staff support to schools to assist them in determining foods and beverages appropriate for ‘everyday’, ‘sometimes’ and ‘occasional’ consumption)
• A communication and education campaign run by the Ministry of Education to encourage schools, families and communities to provide healthy food and beverage choices to children and young people

**Extend Fruit in Schools to all schools**

As noted in Chapter 5, Fruit in Schools was a state funded initiative which provides a free piece of fruit every school day to every child in the lowest decile primary schools. In return, the school complies with a health promoting schools framework which promotes healthy eating, physical activity, Sunsmart and Smokefree policies. The committee argued that Fruit in Schools was an important initiative that encouraged increased fruit consumption and improved learning outcomes. It recommended that:

Recommadion 39: Extend Fruit in Schools

[We recommend] that the fruit in schools programme be progressively extended to include all schools (Health Select Committee 2007:32).

The Government’s response

The Government ‘partially agreed’ with Recommendation 39. It was noted that currently the Fruit in Schools programme operated in 260 primary schools providing free fruit to 56,000 students (New Zealand Government 2007: 41). Noted as New Action 17, was the Government’s intention to progressively extend (over 2008/09) the Fruit in Schools programme to 182 eligible decile two primary schools across the country (New Zealand
Government 2007: 41). No comment was made on why the programme could not be extended to all schools.

**Include nutrition and cooking in the curriculum**

The majority committee also recommended that nutrition and cooking be incorporated into the curriculum:

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<th>Recommendation 37: Nutrition and cooking in the curriculum</th>
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<td>[we recommend] that nutrition, food preparation, and cooking be integrated into the core curriculum so that children of all ages learn to choose and prepare healthy food (Health Committee 2007: 32).</td>
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The minority committee view appeared to support the majority committee on this recommendation:

Skills for selecting and preparing healthy foods have been lost across large segments of New Zealand society, and these need to be reinstituted through the education system (Health Committee 2007: 36).

**The Government’s response**

The Government agreed with Recommendation 37. It was noted that a revised New Zealand Curriculum was recently distributed to schools (in October 2007). It included, in the home economics component: nutrition education and the requirement for students to select, prepare, cook and serve food. The Government noted that “the curriculum is compulsory until Year 10, and schools are encouraged to include this essential area in their core curriculum” (New Zealand Government 2007: 43).

**Summary of the Health Select Committee and Government framing of the solutions**

This section examined the committee perspectives and recommendations and the Government’s response to these in five key policy areas: the HEHA strategy; the food industry; the advertising industry; public education and information; and, schools.
The Government agreed with most of the recommendations made by the majority committee on the issue of the HEHA strategy, with the exception of the recommendation to establish an independent commissioner.

On the role of the food industry, the Government noted it was waiting for evidence of the effectiveness of a FOP labelling system before it would consider implementing a mandatory FOP labelling system on foods. The Government also agreed that targets needed to be set for the reformulation of energy-dense products, although it noted that the food industry would be involved in the target setting process though the ministerial committee.

In the area of marketing, advertising and promotion, the Government claimed that it could not agree to the majority committee recommendation to place restrictions on broadcasting, but would continue to encourage industry to promote healthier foods and discourage the promotion of energy-dense foods. It was noted by the Government that some changes had already been made to improve the ASA self-regulatory system and that it would suggest to the ASA that it make some further changes. The Government also agreed that targets needed to be set for the promotion of energy-dense foods, although this was to be done in consultation with industry.

In the area of public information and education, the Government noted that two social marketing campaigns to address healthy eating and physical activity were already underway. This addressed the recommendation by the committee (the majority and the minority) for the Government to initiate a sustained social marketing campaign to educate the public on the need for healthy eating and physical activity.

Finally, on the matter of food and nutrition policies in schools, the Government agreed with the majority committee recommendation to promote healthy diet and physical activity in school environments. Specifically, it agreed to alter the NAGs to require schools to promote healthy nutrition and remove unhealthy products from schools. The Government also committed to extending the Fruit in Schools programme, although not to all schools as recommend by the majority committee. It was also noted by the Government that it had already required schools to include nutrition and cooking in the curriculum. The issue of sponsorship in schools was not specifically addressed by the Government.

**Summary of Chapter 7**

This chapter has provided an overview of the two official reports resulting from the Inquiry. The perspectives of the Health Select Committee (the majority and minority views), the key recommendations to Government of relevance to food and nutrition policy, and, the
Government's response to these was outlined. The key features of framing by the Health Select Committee and the Government are summarised in Table 27 (framing of the problem and its causes) and Table 28 (framing of the solutions).

**Table 27: Health Select Committee and Government framing of the problem and the causes**

<table>
<thead>
<tr>
<th>Problem representation</th>
<th>Health Select Committee</th>
<th>Government</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Overall description</strong></td>
<td><strong>Majority</strong></td>
<td><strong>Minority</strong></td>
</tr>
<tr>
<td><strong>Problem representation</strong></td>
<td>Epidemic Pandemic Complex issue</td>
<td>Serious medical problem</td>
</tr>
<tr>
<td><strong>Type of problem</strong></td>
<td>Economic burden to the health system</td>
<td>Economic burden to the health system</td>
</tr>
<tr>
<td><strong>Affected groups</strong></td>
<td>The obese and the overweight</td>
<td>The obese and the overweight</td>
</tr>
<tr>
<td></td>
<td>Whole population affected</td>
<td>‘Affected’ groups</td>
</tr>
<tr>
<td></td>
<td>Burden is greater for low SES, Māori &amp; Pacific communities</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Children at risk</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>General causes</strong></td>
<td>Energy imbalance</td>
<td>Not evident</td>
</tr>
<tr>
<td></td>
<td>Multiple causes</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Other causes identified included: increased workforce participation; physical inactivity; lack of food preparation and cooking skills; lack of food &amp; nutrition education in schools; parental habits and television viewing</td>
<td></td>
</tr>
<tr>
<td><strong>Main causes</strong></td>
<td>Obesogenic environment</td>
<td>Attitudes to food &amp; physical activity</td>
</tr>
<tr>
<td></td>
<td>Emphasis on increased energy intake</td>
<td>Knowledge deficits</td>
</tr>
<tr>
<td></td>
<td>Increased energy intake due to changes in food: availability; marketing; cost; &amp; composition</td>
<td>Lack of food preparation &amp; cooking skills</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Lack of motivation or desire</td>
</tr>
<tr>
<td><strong>Non-Causes</strong></td>
<td>Genetics</td>
<td></td>
</tr>
</tbody>
</table>

SES = socioeconomic status
As can be seen from Table 27, the majority committee framed the obesity problem as an epidemic, a pandemic and a complex issue, while the minority committee framed the issue as a serious medical problem. In contrast the Government used a mix of these terms framing the problem as an epidemic, a complex issue, an emerging issue and, in places, used the terms rising and increasing rates instead of epidemic to describe the growth of obesity in the population.

Both the majority and minority committee and the Government acknowledged that obesity was a problem because of the economic burden to the health system. However, only the majority committee highlighted other social and economic costs attributable to obesity.

The groups thought to be most affected by obesity were acknowledged by the majority committee and the Government to be particular ethnic groups (Māori and Pacific communities), lower socioeconomic communities and children. Nonetheless, the majority committee also emphasised that the whole population was in some way affected by the obesity epidemic. This contrasts with the minority committee and Government focus on ‘affected communities’. On the matter of obesity and overweight, the majority and minority committee and the Government recognised that both weight classes were problematic in health terms.

While the Government did not explicitly state the causes of obesity, it appeared to accept that the obesogenic environment was a major driver of obesity in the population. For the majority committee, while a number of general causes of obesity were noted, the main cause was identified as the obesogenic environment and there was an emphasis on increased energy intake rather than a decline in energy expenditure. This was thought to be due to changes in food availability, its composition, marketing and cost. In comparison, the minority committee attributed the increase in obesity to: attitudes to food and physical activity; knowledge deficits; lack of food preparation skills; and, lack of motivation or desire.

Other than genetics, noted by the majority committee as not contributing to the obesity epidemic, there was no identification of non-causes by the minority committee or the Government.
Table 28: Health Select Committee and Government framing of the solutions

<table>
<thead>
<tr>
<th>Majority (recommendations)</th>
<th>Minority</th>
<th>Government</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>HEHA strategy</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Government to use the full range of public policy measures</td>
<td>Disagree – has concerns about the Public Health Bill, and opposed to regulation of industry and availability of food</td>
<td>Agree with majority committee</td>
</tr>
<tr>
<td>Establish a cross sector ministerial committee</td>
<td>Agree (with caution)</td>
<td>Agree with majority committee</td>
</tr>
<tr>
<td>External stakeholder advisory group</td>
<td>Agree (with caution)</td>
<td>Agree with minority committee</td>
</tr>
<tr>
<td>Establish an independent commissioner</td>
<td>Disagree</td>
<td>Disagree with majority committee</td>
</tr>
<tr>
<td><strong>The food industry</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Develop a FOP food labelling system</td>
<td>Need to be agreed to by industry</td>
<td>Will consider if found to be effective</td>
</tr>
<tr>
<td>Set targets for product reformulation</td>
<td>Need to be agreed by industry</td>
<td>Agree with majority committee</td>
</tr>
<tr>
<td>Informal fast food sector to encourage healthier options</td>
<td>Need to be agreed by industry</td>
<td>Largely agree with majority committee</td>
</tr>
<tr>
<td><strong>The marketing industry</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Broadcast advertising restrictions</td>
<td>Disagree – need to be agreed to by industry</td>
<td>Can not do</td>
</tr>
<tr>
<td>Make changes to the Advertising Standards Authority self-regulatory system</td>
<td>Codes need to be agreed to by industry</td>
<td>Already achieved</td>
</tr>
<tr>
<td>Encourage the promotion of healthy food</td>
<td>Need to be agreed by industry</td>
<td>Agree with majority committee</td>
</tr>
<tr>
<td>Set targets for the promotion of energy-dense foods</td>
<td>Need to be agreed by industry</td>
<td>Agree to set targets with industry</td>
</tr>
<tr>
<td><strong>Public education and information</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Social marketing</td>
<td>Agree to targeted social marketing</td>
<td>Agree with majority minority committee (already done)</td>
</tr>
<tr>
<td><strong>Schools</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Promote healthy diet/physical activity</td>
<td>Disagree - support sponsorship of sports</td>
<td>Agree with majority committee (already underway)</td>
</tr>
<tr>
<td>Remove unhealthy products</td>
<td>Disagree</td>
<td>Agree with majority committee (already underway)</td>
</tr>
<tr>
<td>Extend Fruit in Schools</td>
<td>No comment</td>
<td>Partially agree with majority committee</td>
</tr>
<tr>
<td>Include nutrition and cooking in the curriculum</td>
<td>Agree</td>
<td>Agree with majority and minority committee (already done)</td>
</tr>
</tbody>
</table>
On the matter of the solutions (summarised in Table 28), the relevant recommendations from the Inquiry were explored under five key policy areas: the HEHA strategy, the food industry; the advertising industry; public education and information; and, schools.

On the issue of the governance of the HEHA strategy, the Government agreed with the majority committee recommendations to use the full range of measures and establish a cross-sector ministerial committee and, in response to the recommendation for an external stakeholder advisory group, agreed to expand the existing SSG to include additional members from a range of sectors (including industry, public health, NGOs, Māori and Pacific communities and various experts). However, the Government, like the minority committee, disagreed with the recommendation to establish an independent commissioner.

The Government’s response to the recommendation to use the full range of public policy measures however, appeared to be limited to extending the existing HEHA implementation plan. Although, as the Government noted, many initiatives to address obesity had begun since the start of the Inquiry. These included: greater Government funding of HEHA; the launch of the Mission On strategy (in conjunction with the Ministry of Education); and, the funding of twenty-one DHB coordinator positions to assist with HEHA implementation. The Government agreed that the cross-sector ministerial committee be given the responsibility of target setting in the area of food supply and marketing, with a view to considering regulation if such targets were not met. However, the target setting process was to involve consultation with key stakeholders including industry.

On the recommendations directed at the food industry, the Government said it was awaiting the results of existing research before it would consider developing a FOP labelling system. The setting of targets for product reformulation was supported by the Government in principle, although the responsibility for identifying the targets was left with the food industry (specifically the FIG). To assist the industry in making positive changes to the food supply, the Government agreed to establish six new DHB-based regional food industry coordinator positions and, to encourage the informal fast food sector to improve the food supply, it agreed to fund one-off industry-led initiatives. The Government noted that there were many initiatives underway already and that one of the goals of the FIG strategy was to reduce levels, or fat, sugar and salt in the food supply.

The Government also noted its agreement with recommendations directed at the advertising and the fast food sectors, to encourage the promotion of healthy food. Although again, the Government said it was waiting to assess the progress of the industry Five Point Plan before considering legislative change. On the six target setting
recommendations relevant to marketing, the Government stated that it largely agreed with these. The target setting process was agreed by the Government to be the responsibility of the ministerial committee, who would consult with industry on the development of targets.

In the area of marketing, advertising, and promotion, in response to the majority committee’s recommendation to extend broadcast advertising restrictions, the Government claimed that this was not possible. The Government argued that the Five Point Plan developed by major broadcasters was, in any case, a response to the committee’s recommendation to restrict broadcast advertising. On the matter of recommended changes to the ASA system, the Government noted that it had already achieved this recommendation, with four consumer representatives now on the ASA Complaints Board. It also noted some further recommendations for the ASA to ‘consider’. The Government also agreed to establish a monitoring system (to be the responsibility of the ministerial committee). Yet, the target setting process underpinning the monitoring system was to be developed in consultation with industry, suggesting that the Government shared the view of the minority committee on this matter.

The Government’s response to the recommendation by the majority committee to implement a social marketing campaign was that this issue was already being addressed by various campaigns, most notably, the Feeding Our Futures social marketing campaign which addressed healthy eating, and the Push Play campaign that promoted physical activity.

In the area of school environments, it was noted that changes to the NAG guidelines were underway, and these would require all schools to promote healthy diet and physical activity as well as requiring them to remove unhealthy food from the school environment. The minority view was that only those schools with an obesity problem should consider reducing access to high energy foods. The Government listed a number of current initiatives to improve nutrition and increase physical activity in schools, including: the ‘Mission On’ strategy; a nutrition fund to support schools to make changes to promote healthy eating; the recent launch of the Ministry of Health’s Food and Beverage Classification system; and, the voluntary agreement by between two large beverage companies to withdraw full-sugar energy drinks from schools. On the matter of the request by the committee to extend the Fruit in Schools programme to all schools, the Government partially agreed, noting that it would extend the programme to another 182 decile two primary schools around the country. Finally, in response to the committee’s recommendation to include nutrition and cooking in the curriculum, the Government agreed, noting that a revised curriculum to address this issue had recently been distributed.
Chapter 8: Discussion

This thesis set out to examine how industry and public health groups framed the issue of obesity in the context of the Inquiry into Obesity and Type 2 Diabetes and to assess the extent to which these frames were evident in the official stance taken by the Government in its response to the recommendations of the Health Select Committee. The rationale for this was that: obesity is a significant public health issue; food and nutrition policies are a significant contributor to obesity; and, the framing of obesity and related food and nutrition issues by key players in the food and nutrition policy arena is an important part of the rhetorical landscape surrounding nutrition policy in New Zealand.

In Chapter 2, the epidemiology of obesity was outlined revealing important social inequalities in obesity. In Chapter 3, the literature on framing theory and obesity frames was examined. Key concepts from framing theory and four key obesity frames likely to be drawn upon by industry and public health groups were outlined. One of these frames, the structural frame, had not been clearly articulated in the literature and was developed from the literature on health inequalities. It was suggested that the industry and public health groups would be likely to draw on particular frames that suited their predilections.

In Chapter 4, the framing matrix used to identify key features of the obesity frames was outlined. This matrix was applied, in Chapters 5 and 6, to the industry and public health submissions to describe the framing of obesity by these two sectors. Chapter 7 examined the committee recommendations and the Government’s response to these in five key areas of policy relevant to food and nutrition. So far, these results have not be critically discussed. This is the purpose of this final chapter.

Chapter 8 is presented in eight sections. To address the first research question which sought to describe how industry and public health groups framed the issue of obesity, the chapter begins in section 8.1 with a comparison and discussion of the industry and public health frames documented in Chapters 5 and 6. This reveals that while there were some minor similarities, overall there were stark contrasts in the way the public health and industry groups framed obesity.
Section 8.2 compares the signature features of the industry and public health frames with those of the four key obesity frames outlined in Chapter 3. Here, the key findings were that industry drew mainly on arguments from the ‘individual behaviour’ frame and also drew on selected arguments from the ‘epidemic as a myth’ frame, while the public health sector drew predominantly on arguments from the ‘obesogenic environment’ and ‘structural’ frames. However, there were some exceptions to this.

Section 8.3 addresses the second research question on the extent to which the industry and public health frames were evident in the Government’s stance on food and nutrition policy. To this end, the signature features of the industry and public health frames were compared with those evident in the official reports of the Health Select Committee and the Government. As there were some key issues highlighted by either the industry or public health submitters that were not explicitly addressed by the committee recommendations (which in turn meant they were not addressed by the Government), these are also considered (in section 8.3.4). This section concludes with a discussion of the key findings.

The key findings were that, although the Government’s stance on the various aspects of the problem representation reflected a mix of industry and public health frames, there was a bias towards the industry framing on some important aspects. On the matter of the causes, as these were not explicitly outlined by the Government, it was concluded that the Government’s stance was unclear. The Government’s stance on the solutions however, was aligned with industry in the majority of the most contested policy areas. Another finding of significance was that a number of key solutions identified by the public health sector were not addressed by the Government. This appeared to be due to the lack of significance attributed to these issues by the committee in its recommendations to Government. Overall, these findings suggest, since the stance taken by the Government was aligned to that of industry in the majority of the most contested policy areas, that the Government’s stance was dominated by the industry framing of the obesity issue.

Some potential explanations for the Government’s stance are explored in Section 8.4. This includes an examination of explanations offered by key concepts from framing theory, as well as some alternative explanations offered by relevant theories of interest group influence on the state. Section 8.5 explores the strengths and limitations of this research. This is followed by a discussion of the implications for public health policy and advocacy (section 8.6) and a discussion of the research implications (section 8.7). The overall conclusion is presented in section 8.8.
8.1 Comparison of industry and public health frames

To address the first research question posed in this thesis, this section compares and discusses the industry and public health obesity frames. There were stark contrasts in the way the public health and industry groups framed obesity. A summary of the signature features of these frames is presented in Table 29 and these are discussed throughout section 8.1.

<table>
<thead>
<tr>
<th>Table 29: Signature features of industry and public health frames</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Problem representation</strong></td>
</tr>
<tr>
<td><strong>Industry</strong></td>
</tr>
<tr>
<td>Overall description</td>
</tr>
<tr>
<td>An ‘issue’, a ‘concern’ &amp; a ‘complex’ issue &amp; a ‘debate’</td>
</tr>
<tr>
<td>Notable omission of the term ‘epidemic’</td>
</tr>
<tr>
<td><strong>Type of problem</strong></td>
</tr>
<tr>
<td>A ‘health problem’ or ‘health threat’</td>
</tr>
<tr>
<td>An economic burden to the health system</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td><strong>Affected groups</strong></td>
</tr>
<tr>
<td>Obesity but not overweight is the problem</td>
</tr>
<tr>
<td>A problem for affected individuals or communities</td>
</tr>
<tr>
<td>Predominantly an ethnic problem for Māori &amp; Pacific communities</td>
</tr>
<tr>
<td>Socioeconomic factors a correlation &amp; not a cause</td>
</tr>
<tr>
<td>No mention of gender differences</td>
</tr>
<tr>
<td>Children a risk group for some submitters</td>
</tr>
<tr>
<td><strong>General causes</strong></td>
</tr>
<tr>
<td>Energy imbalance</td>
</tr>
<tr>
<td>Multiple societal factors: affluence, abundance (of food), &amp; technological changes leading to sedentary lifestyles</td>
</tr>
<tr>
<td><strong>Main cause</strong></td>
</tr>
<tr>
<td>Obesogenic lifestyles characterised by overconsumption &amp; sedentary lifestyles</td>
</tr>
<tr>
<td>Overconsumption due to individual traits including: poor attitudes; lack of motivation (inertia &amp; apathy); denial about weight problems; knowledge deficits; &amp; family influences</td>
</tr>
<tr>
<td>Sedentary lifestyles due to technological changes but individual factors also contributed</td>
</tr>
<tr>
<td>Emphasis on physical activity as the dominant cause</td>
</tr>
<tr>
<td>Emphasis on knowledge deficits</td>
</tr>
<tr>
<td><strong>Non-causes</strong></td>
</tr>
<tr>
<td>Not genetics</td>
</tr>
<tr>
<td>Not advertising (although it may reinforce behaviour in some)</td>
</tr>
<tr>
<td>Not the branded fast food sector</td>
</tr>
<tr>
<td>Not sugar, carbonated soft drinks, confectionery or alcohol</td>
</tr>
</tbody>
</table>
### Solutions

<table>
<thead>
<tr>
<th>Industry</th>
<th>Public health</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Perspectives on the existing policy environment</strong></td>
<td><strong>Perspectives on the existing policy environment</strong></td>
</tr>
<tr>
<td><strong>Support for HEHA:</strong> unanimous &amp; uncritical support of HEHA (viewed as a educational and collaborative rather than a prescriptive and regulatory approach)</td>
<td><strong>Critical of HEHA:</strong> lacks leadership &amp; coordination &amp; limited to the health sector; under-resourced &amp; haphazard &amp; limited implementation; lacks structural measures; skeptical of collaborative approach (Government &amp; industry); &amp; fails to address wider determinants of health &amp; health inequalities</td>
</tr>
<tr>
<td><strong>Support for self-regulation of the food supply:</strong> support for continued self-regulation of the food supply, Accord is industry’s response to HEHA but it needs more time to realise its goals</td>
<td><strong>Critical of the food industry:</strong> Food industry plays a major role in causing the epidemic but is not taking enough responsibility to address it, the Accord represents mainly ‘token efforts’ by industry; food labelling is problematic</td>
</tr>
<tr>
<td><strong>Support for self-regulation of the marketing sector:</strong> support the existing system</td>
<td><strong>Critical of the marketing industry:</strong> generic criticisms &amp; critical of the Advertising Standards Authority self-regulatory system</td>
</tr>
</tbody>
</table>

#### Additional policy prescriptions

<table>
<thead>
<tr>
<th>Industry</th>
<th>Public health</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Education and information:</strong> ‘the knowledge task’, Government &amp; industry should be involved in the ‘knowledge task’</td>
<td><strong>Additional policy prescriptions</strong></td>
</tr>
<tr>
<td><strong>Schools:</strong> support structured physical activity &amp; nutrition education in the curriculum &amp; voluntary (not mandatory) food policies in schools</td>
<td><strong>HEHA:</strong> national obesity taskforce; whole-of-government response; structural measures to address obesogenic environment; address wider determinants of health</td>
</tr>
<tr>
<td><strong>Progress the Nutrition, Health &amp; Related Claims legislation</strong></td>
<td><strong>Food industry:</strong> mandatory Front of Pack labelling; address food cost; reformulate unhealthy food products; limit availability of unhealthy foods</td>
</tr>
<tr>
<td><strong>Targeted policies:</strong> policies should be targeted to those affected</td>
<td><strong>Marketing industry:</strong> regulate advertising &amp; marketing</td>
</tr>
<tr>
<td></td>
<td><strong>Schools:</strong> mandatory food &amp; nutrition policies; include nutrition &amp; cooking in the curriculum; support Fruit in Schools; ban sale of unhealthy food &amp; unhealthy food sponsorship</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Non-solutions</th>
<th>Non-solutions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Advertising bans, regulation of industry sponsorship, mandatory Front of Pack labelling, regulation of food composition, fat taxes, regulation of vending machines</td>
<td><strong>Not education or information in isolation</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Nutrition, Health &amp; Related Claims legislation</strong></td>
</tr>
</tbody>
</table>

### 8.1.1 Problem representation

**Overall description**

It is evident from the summary of the signature features of the framing matrix in Table 29, that, in their overall description of the problem of obesity, both industry and public health submitters framed the issue of obesity as a *complex issue*. However, public health submitters maximised the significance and scale of obesity by their *epidemic* (and occasionally *pandemic*) framing. In comparison, the food and marketing industries minimised the significance and scale of obesity by framing it as an *issue* or a *concern*. The industry sector’s omission of the term epidemic suggests that there was some denial of the scale of the obesity problem. The use by industry of the term *debate* to describe the
problem also suggests that, from the perspective of some industry submitters, there was a lack of consensus on important aspects of the obesity problem. Industry also, on occasion, used the terms *challenge* and *social problem* when referring to the obesity issue. The framing of the issue as a *social* problem also appears to have a minimising effect. One of the implications of the minimising language used by industry, is that in contrast to the epidemic framing, it implies less urgency for action.

**Type of problem**

The industry and the public health sectors recognised, in terms of why obesity was a problem, the potential *economic burden to the health system*. While industry noted that obesity was a *health problem* and constituted a *health threat*, it rarely elaborated on the health consequences, arguing that it was not well placed to do so. However, another reason for industry’s failure to mention the health consequences may be that it would be inconsistent with its attempts to minimise the significance of the issue.

Industry was also of the view that the potential economic burden of obesity was largely attributable to diabetes and its complications. In fact, some industry submitters questioned the direction of the association between obesity and Type 2 diabetes, implying that diabetes may in fact cause obesity, rather than the other way around, as the public health sector argued. This could be interpreted as an attempt by industry to lay the blame for the economic burden to the health system on diabetes rather than obesity per se. This framing of the issue also suggests that the health concern is diabetes and not obesity.

The public health submitters, in outlining in detail the various health consequences of obesity, emphasised the *human health burden* for those affected by obesity. As well, five of the public health submitters (but not the independent advisors) explicitly noted that obesity was largely an *inequalities* problem. The focus on the inequalities dimension of obesity not only highlights the economic or structural dimensions of the issue, it implies that inequalities may have a causal role in the obesity epidemic. Public health submitters also noted that the economic consequences of obesity were not limited to the health system, but extended across other sectors of the economy, for instance, affecting workforce productivity. Overall, public health submitters identified a much wider range of consequences attributable to obesity, for the individuals affected and for society as a whole, compared with the limited (largely economic) consequences identified by the industry sector. In summary, for industry, obesity was a concern because of the economic costs, whereas for public health submitters the economic costs were only one of a wide range of social, economic and human health consequences.
Affected groups

While public health submitters argued that both obesity and overweight were problematic in health terms (with the exception of one submitter), for industry, overweight was not a problem because the health risks were much lower than for obesity. This appears to be another attempt by industry to minimise the scale of the problem. As noted in Chapter 2, in 2006, 36.2% of the New Zealand adult population were classified as obese, and a further 26.5% were classified as overweight. To focus on only those who are obese is to suggest that just over a third of the population are affected by the problem, compared to almost two-thirds of the population if both overweight and obesity are included in the problem definition. The distinction made by industry between overweight and obesity, and the inclusion of both weight classes in the problem definition by the public health sector, was therefore a key difference in the framing of obesity by the two groups.

In submitters’ discussions around the demographic patterns in obesity, both public health and industry submitters agreed that Māori, Pacific, and lower socioeconomic communities were at greater risk of obesity. However, industry submitters, in dismissing any causal association between socioeconomic factors and obesity, essentially framed obesity as an ethnic problem. Many public health submitters on the other hand, argued that socioeconomic factors were an underlying issue impacting more on particular ethnic groups in part because of their overrepresentation amongst lower socioeconomic groups. The industry framing of obesity, as predominantly an ethnic problem, overlooks the reality of the situation. As noted in Chapter 2, while Māori and Pacific people are at greater risk of obesity, by far the great majority of those who are obese and overweight in the New Zealand population are not from Māori or Pacific communities. Specifically, the data in Table 3 (of Chapter 2) showed that of the 903,200 obese adults in the New Zealand population, 619,200 (more than two thirds) were ‘European/other’. So clearly, although rates of obesity are proportionally higher amongst Māori and Pacific populations, at the population level, obesity is not predominantly an ‘ethnic’ problem. Thus, ethnically targeted responses to the problem of obesity, although justifiable on grounds of equity, will not in themselves dramatically reduce the epidemic scale of obesity in the population. Therefore, industry’s focus on ethnicity and the public health emphasis on socioeconomic factors was a key difference between the two frames.

A few industry submitters and many public health submitters (including two of the independent advisors) also emphasised that rates of obesity amongst children were a particular concern. This suggests that both the industry and the public health sectors
should logically support strategies to address obesity amongst children. This was one of the few similarities between the industry and public frames.

On the matter of gender differences in obesity, specifically the slightly higher rates of *obesity* amongst women and the much higher rates of *overweight* amongst men (outlined in Chapter 2), none of the industry submitters and only a few public health submitters acknowledged these. Again, this reflects a key difference between the public health and industry frames, although no explanation was offered by public health submitters for gender differences in overweight and obesity.

The industry framing of the problem laid the blame for increasing rates of obesity with affected communities and individuals within these communities. There are two important implications of this framing. One is that it suggests that attributes of the individual or the affected communities are the source of the problem. This focus on affected communities, or those with the ‘problem’, shares similarities with the framing of alcohol problems by the alcohol industry, where the focus is on *overconsumption* of alcohol by some sectors of the population rather than the consumption of alcohol in general. The other implication of industry’s focus on affected communities is that it logically suggests a targeted response to the problem. Industry was explicit about this point, arguing that, as many people managed to maintain a healthy weight, there was no need for a population based approach to address obesity. In contrast, the public health sector, in framing the issue as one that affects the whole population albeit with particular groups more at risk, suggests support for a universal approach, and, potentially also a targeted approach to address inequalities.

### 8.1.2 Causes

**General causes**

Both industry and public health submitters acknowledged that energy imbalance was the basic physiological cause of obesity, and that there were multiple determinants of this. Similarly, both sectors accepted that these multiple causes influenced *both* energy intake and energy expenditure in the population. Modern urban design and many social and economic changes, such as increased time spent working (particularly by women) and the consequent time constraints, and increased reliance on motorised transport, were noted by *both sectors* as societal level determinants of obesity. For industry though, there was an emphasis on *affluence and abundance* (argued to affect energy intake) and *technological change* influencing physical activity. For public health submitters, multiple societal determinants also included: urbanisation; economic changes affecting employment,
housing and welfare; changes to the food supply and its marketing; systems of food production, distribution, and international trading frameworks; and, increased time spent in sedentary activities. In summary, although the two frames were similar in their identification of general causes of obesity, the two sectors were divided on the issue of the extent to which these factors determine, or merely influence, dietary and physical activity patterns.

Main causes

For the industry, the fact that some of the population have managed to maintain a healthy weight was interpreted as evidence that societal level causes of obesity were not overwhelming. Thus, freely chosen obesogenic lifestyles, characterised by overconsumption and lack of physical activity, were positioned as the overarching cause of increased obesity amongst those affected. In particular, industry argued that overconsumption was due to: poor attitudes; lack of motivation; denial about weight problems; knowledge deficits; and, family influences such as parental role modelling. The emphasis for industry though, was on a decline in physical activity as the dominant cause of the energy imbalance. The decline in physical activity itself was largely attributed by industry submitters to technological changes (including increased time spent in front of computers, mobile phone text messaging, and other forms of sedentary entertainment). Although again, individual factors such as knowledge deficits, lack of motivation, and denial of weight problems, were also noted as contributing to sedentary behaviour.

In contrast, public health submitters argued that the epidemic in obesity was due to an obesogenic environment and many submitters argued that its unequal distribution amongst particular ethnic and lower socioeconomic groups was due to socioeconomic factors and wider determinants of health. In discussing the obesogenic environment, while public health submitters acknowledged many of the structural influences on physical activity, their emphasis was on specific features of the obesogenic environment that promoted increased energy intake. Public health submitters identified the increased consumption of EDNP food, rather than overconsumption in general, as the key cause. This, they argued, was due to its increased availability, low cost, and heavy marketing. The issue of the low cost of unhealthy food as a key feature of the obesogenic environment is interesting, in that it does not appear in either of the key international reports (outlined in Chapter 2), on the evidence for the causes of increased weight gain although socioeconomic factors were identified as a probable cause in the WHO Technical Report 916.

It was also evident that while some of the public health submitters framed the issue of the cost of unhealthy food as a systemic food supply problem, others framed it as an issue of
inadequate income. Both framings have quite different policy implications. On implication would be to increase income (for those on low incomes), the other would be to regulate the cost of food or related determinants of food cost throughout the food supply system (such as international trade agreements and subsidies).

These key differences in the framing of the causes of obesity have different policy implications. The industry framing of the cause of obesity as due to individual obesogenic lifestyles indicates policies targeted at changing individual behaviours, while the public health framing of the cause as the obesogenic environment and underlying inequalities, indicates structural measures to change the environment and reduce inequalities. Furthermore, the public health emphasis on energy intake (food) and the industry emphasis on physical activity as the dominant cause of the energy imbalance leading to obesity, logically imply different areas of emphasis for the national obesity strategy, namely, food policies (and therefore the food industry), or physical activity policies.

Non-causes

The self-interested nature of the food and advertising industries was evident in the various defences of specific products and industry sectors put forward by industry submitters. Advertising agencies and some food industry submitters argued, for instance, that advertising was not a cause of obesity (although it was acknowledged that advertising may reinforce existing behaviour patterns). Industry provided, as evidence to support this claim, data on the consumption of food from the informal fast food sector (which does not engage in heavy marketing), and data on increased participation in sedentary leisure pursuits (other than television viewing). Several industry submitters also defended particular products, arguing that sugar, carbonated beverages, confectionery, and alcohol were not major contributors to increased energy intake. This framing suggests that the food and advertising industries are not to blame for the obesity problem. Industry’s position on the causes of obesity was therefore at odds with the international consensus on the factors contributing to weight gain documented in the two most recent international reports (outlined in Chapter 2).

This industry framing was contested by the public health submitters who argued, drawing on various sources of evidence including the WHO Technical Report 916, that particular foodstuffs and beverages were highly obesogenic. These included EDNP products in general, and specifically: sugary drinks; processed foods; and, foods high in fat or sugar. Public health submitters also provided evidence that advertising affects food preferences and consumption patterns.
Factors explicitly identified by public health submitters as not causing obesity were: character deficits such as a lack of will-power or irresponsibility; and, knowledge deficits. In other words, individuals were not to blame for the obesity epidemic – a point disputed by industry. The role of genetics was also dismissed by both public health and industry submitters as a cause of population level increases in obesity, although industry noted that it may explain some familial cases of obesity.

8.1.3 Solutions

Perspectives on the current situation

While industry was unanimous in its support for the HEHA strategy, with one key submitter describing it as a ‘state of the art plan for action’, public health submitters were critical. Specifically, they noted that the strategy suffered from: a lack of leadership and coordination and was limited to the health sector; was haphazard and limited in its implementation; lacked regulatory measures to address the obesogenic environment; and, failed to address socioeconomic inequalities and wider determinants of health.

A number of public health submitters were also skeptical of the collaborative approach between industry and the Government via the Ministry of Health. In comparison, the general level of satisfaction from the industry sector regarding the HEHA strategy appeared to stem from their preference for a collaborative approach (which they aligned with HEHA via the Accord), and their view of the strategy as an educational rather than a prescriptive approach to addressing obesity.

Industry’s frequent references to the many Accord initiatives appeared to be presented as ‘evidence’ that the industry and Government collaborative approach was working, and to demonstrate their willingness to be part of the solution. On the other hand, public health submitters viewed the Accord initiatives as ‘token’ efforts by the food industry to address obesity. They noted that many of the initiatives attributed to the Accord were undermined by the heavy marketing of unhealthy food and the sponsorship of sporting activities by food interests, and that many of these initiatives predated the Accord. Public health submitters also suggested that food industry activity in this area needed monitoring. Another key area of concern noted by public health submitters was food labelling, which was argued to be too complex, confusing and often misleading.
Industry also defended the ASA self-regulatory system of advertising, claiming that: it was flexible; free to the complainant; fast and efficient (at processing complaints); had a lower burden of proof than that required under a prosecutions system; and, that the system was able to consider factors that legislation could not, such as spirit and intention. Industry submitters also pointed out that the codes for advertising had been recently reviewed and that major broadcasters had agreed to the Five Point Plan of advertising which included a code on food advertising to children.

The public health sector found the ASA system to be unsatisfactory in many respects. The first criticism from the public health sector was that the mandate of the ASA system was limited to advertising and excluded other forms of marketing. The other criticisms were specific to the ASA complaints process and structure. In particular, it was argued that the ASA complaints system was not widely understood by the public and that laying a complaint was a prolonged and resource intensive process. There were also concerns about bias in the membership of the ASA Complaints’ Board, and over a number of decisions made by the Board. This led some submitters from the public health sector to conclude that “the wolves are guarding the henhouse” (OAC s129:33; ANA s38:6). Overall then, on the matter of the policy environment at the time of the Inquiry, industry supported the status quo while the public health sector did not.

**Additional policy prescriptions**

As industry was unanimous in its support for the HEHA strategy, and unanimous in its support for continued self-regulation of the food and advertising industries, industry provided few additional policy prescriptions. The key solution for industry was the ‘knowledge task’ – the provision of education and information (to affected communities) to encourage people to choose healthy lifestyles. Such education should focus, according to industry, on educating people about the role of all food in a balanced diet, and the benefits of physical activity and maintaining a healthy weight. Industry also supported nutrition education in the school curriculum as well as structured physical activity in schools, and there was some support for voluntary food policies in schools. Finally, some industry submitters recommended that the Nutrition, Health and Related Claims legislation should be progressed, on the grounds that it would allow food manufacturers to promote the benefits of healthy food.

Additional policy prescriptions supported by the public health sector were, by comparison more numerous and wide-ranging. On the matter of the HEHA strategy, to facilitate a whole of government response and provide strategic direction, submitters called for the
establishment of a national obesity taskforce. Public health submitters were however, divided on the matter of who should be involved in the national taskforce. Some submitters supported a cross-government and NGO taskforce. Others suggested that industry and other stakeholders should be involved, while a number explicitly opposed the involvement of industry, and one submitter suggested that the taskforce should be independent of Government.

Structural measures to address the obesogenic environment were also called for by the public health sector. The focus here was on legislative and regulatory options to restrict the heavy marketing and availability of EDNP foods and the use of public policy to increase the affordability, accessibility and availability of healthy foods. It was suggested by some public health submitters that the proposed Public Health Bill (opposed by the industry) may be an appropriate mechanism for addressing these issues. Finally, public health submitters recommended that the HEHA strategy include policies to address wider determinants of health and social inequalities, although submitters were vague on what these options should be.

More specific recommendations were for a mandatory FOP labelling system to assist consumers to easily and quickly identify healthy from unhealthy food. The Traffic Light FOP labelling system was one option supported by many of the public health submitters.

To address the issue of the high cost of healthy food and the comparatively low cost of EDNP food, a number of proposed strategies were outlined. These included: imposing various levies or differential taxes on healthy and unhealthy foods; reviewing tax exemptions for the marketing of unhealthy foods; food vouchers; and more generally, policies to address socioeconomic inequalities.

Submitters from the public health sector also recommended that: unhealthy foods be reformulated; that targets be set; and, progress towards these targets monitored. A mandatory FOP labelling system was suggested as one incentive to encourage the food industry to reformulate their products. Additionally, recommendations to limit the availability of unhealthy foods and increase the availability of healthy foods, for example by zoning fast food outlets or promoting fresh produce markets, were made by submitters from the public health sector.

In the area of marketing and advertising, public health submitters called for regulations, restrictions, or bans, across all media. Yet, unlike the ‘obesogenic environment’ frame, the public health frame prioritised environmental determinants of consumption over
environmental determinants of physical activity. The public health focus on factors influencing energy intake, and their specific focus on the causes of increased consumption of EDNP food, is therefore a departure from the multi-causal ‘obesogenic environment’ framing of obesity which does not identify any fundamental cause or suggest any hierarchy of causes for the multiple factors promoting obesity. Furthermore, the public health sector focused on the macro-level environmental influences rather than those as the micro-level (such as families). No such emphasis was evident in the ‘obesogenic environment’ frame. Many submitters emphasised that such regulations were particularly important to protect children. Public health submitters also called for additional policy recommendations in the area of school environments. They recommended that: all schools have mandatory food and nutrition policies; nutrition and cooking should be included in the school curriculum; the Fruit in Schools programme should be extended; and, bans be imposed on the sale of unhealthy food and unhealthy food sponsorship in schools.

Non-solutions

For industry, advertising bans, regulations or restrictions to industry sponsorship of sport and community activities, mandatory FOP labelling, regulation of food composition, and fat taxes, were explicitly opposed as solutions. Industry was also opposed to any regulation of the content and placement of vending machines. In short, industry was opposed to any regulation of the supply, availability, composition and marketing of foods.

The only policies explicitly opposed by the public health sector, were those that focused on education as a solution on its own (which they argued would be ineffective as obesity was not a knowledge deficit problem), and the proposed Nutrition, Health and Related Claims legislation. This was opposed on a number of grounds. In particular, the sector noted that consumers were misled and confused by health claims, and that health claims could lead to the increased consumption of processed foods.

Summary of key findings

Overall, there were stark contrasts in the framing of obesity by the public health and industry sectors. This was evident in all three signature features of the framing matrix (the problem representation, the identification of the causes and the proposed solutions). However, on some of the key aspects of the frames there were some minor similarities.

Although both sectors agreed that obesity was a complex issue, the problem representation put forward by industry, suggesting that obesity was merely a concern or an
issue, is a stark contrast to the epidemic public health frame. The industry framing of the issue appeared to have a minimising effect, suggesting less urgency for action. In contrast the Public health sector maximised the significance of the obesity issue by framing it as an epidemic.

The main concern for industry, on the issue of the consequences of obesity was the potential economic burden to the health system, although much of this was argued to be attributable to diabetes rather than obesity. In contrast, the public health sector highlighted wider social, economic, and human health consequences. The implication of this difference in emphasis was that, for industry, obesity was a health system problem, while for the public health sector it was a societal problem.

The industry framing of the problem also laid the blame for increasing rates of obesity with affected communities and individuals within these communities. There are two important implications of this framing. One is that it suggests that attributes of the individual or affected communities are the source of the problem. The other implication is that it logically suggests a targeted response to the problem. Industry was explicit about this point. Obesity was also positioned by industry submitters as predominantly an ethnic problem. In contrast, public health submitters argued that obesity was an issue for the whole population, although it affected some communities disproportionately because of underlying inequalities. The implication of this key difference between the public health and industry frames is that the industry frame logically suggest an ethnically targeted approach to obesity, while the public health frame indicates a universal population approach addressing both obesity and underlying social inequalities.

In the identification of the causes, the industry focus was predominantly on individual level causes while the public health sector focused on aspects of the obesogenic environment, particularly increased consumption of EDNP foods. The implication of industry’s framing of the causes suggests that the logical solution is to alter individual behaviour or the behaviours of affected communities, while the public health framing of the causes indicates changes to the wider environment, particularly those factors contributing to the increased consumption of EDNP foods.

Overall, the public health sector drew on many of the causes of increased weight gain evident in the two international reports (outlined in Chapter 2). However, they added to the list of causes, the low cost of EDNP foods. Industry contested these causes arguing that individual attributes were responsible for increases in weight gain. In summary, the public
health sector largely blamed the food and advertising industries for obesity, while the industry blamed individuals and ‘affected communities’.

The key solutions identified by public health submitters were those solutions explicitly opposed by industry, namely: the regulation of the food and marketing industries; and, mandatory food polices in schools. Furthermore, the specific foods defended by industry were the same foods identified by public health submitters as highly obesogenic (with the exception of alcohol which was not noted by public health submitters). The public health sector was also sceptical of industry collaboration with the Government, a partnership that was unanimously supported by industry. The only policy solutions supported by both the industry and public health sectors, were recommendations for schools to include nutrition education and cooking in the curriculum, and support for the free Fruit in Schools initiative. However, on the matter of overall food and nutrition policy in schools, industry supported only voluntary food and nutrition policies while public health submitters recommended that such policies should be mandatory.

Both sectors also supported the provision of information to the public in the form of social marketing, although there was a key difference in the emphasis. Compared to industry which argued that education was the key strategy, the public health sector was of the view that the provision of education and information while important would be ineffective as an isolated strategy without changes to the obesogenic environment.

### 8.2 Comparison of industry and public health frames with key obesity frames

This section examines the extent to which public health and industry frames drew on aspects of the four key obesity frames outlined in Chapter 3. At the end of Chapter 3, which examined framing theory and four key obesity frames likely to be of relevance to industry or public health groups, a number of hypotheses were suggested. The first of these was that within the forum of the Inquiry, industry would be most likely, for a number of reasons, to draw on features of the ‘epidemic as a myth’ and the ‘individual behaviour’ obesity frames. The second hypothesis was that public health groups would be most likely to draw on aspects of the ‘obesogenic environment’ and the ‘structural’ frames. This section revisits these issues in light of the results outlined in Chapters 5-6.

Table 30 outlines the signature features of the four key obesity frames outlined in Chapter 3. The framing matrix in Table 30 is a simplified version of that applied to the data in this thesis as the obesity frames identified from the literature did not contain the depth of
information that was available from the data sources in this case study. For example, some of the sub-themes, such as the overall description of the problem and the various levels of causes and solutions, were not evident or as clear in some of the key obesity frames identified in the literature. However, as noted by Kwan (2009), not all signature features are necessarily evident in a given frame.
Table 30: Signature features of the key obesity frames identified in the literature

<table>
<thead>
<tr>
<th></th>
<th>Epidemic as a myth</th>
<th>Individual behaviour</th>
<th>Obesogenic environment</th>
<th>Structural</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Problem representation</strong></td>
<td>Overall description</td>
<td>Overall description</td>
<td>Overall description</td>
<td>Overall description</td>
</tr>
<tr>
<td>Overall description</td>
<td>Epidemic is a myth</td>
<td>Not clear</td>
<td>Pandemic</td>
<td>Epidemic</td>
</tr>
<tr>
<td><strong>Type of problem</strong></td>
<td>Obesity is not a problem</td>
<td>A lifestyle issue</td>
<td>A health issue</td>
<td>A health issue</td>
</tr>
<tr>
<td>Only extreme obesity is a health issue</td>
<td>A health issue</td>
<td>A deviant behaviour (risky behaviour frame)</td>
<td>An environmental issue</td>
<td>A structural issue</td>
</tr>
<tr>
<td>Weight obsession is the problem</td>
<td>Moral panic</td>
<td></td>
<td></td>
<td>An inequalities issue</td>
</tr>
<tr>
<td><strong>Affected groups</strong></td>
<td>Those at the extreme ends of the weight distribution may have health risks</td>
<td>Specific ethnic groups &amp; the poor are more often affected</td>
<td>Everyone</td>
<td>Obesity is associated with social inequalities (in developed countries)</td>
</tr>
<tr>
<td>All people at some health risk if their lifestyles are unhealthy</td>
<td></td>
<td></td>
<td>Some people more at risk due to biology or environment</td>
<td></td>
</tr>
<tr>
<td><strong>Causes</strong></td>
<td>BMI is faulty</td>
<td>Freely chosen unhealthy lifestyles</td>
<td>Unhealthy lifestyles due to: cultural preferences; character deficits (lack of motivation, laziness; lack of priority, immorality); &amp; knowledge deficits</td>
<td>Unequal distribution of resources</td>
</tr>
<tr>
<td>Obesity is not a disease but it has been medicalised</td>
<td></td>
<td></td>
<td></td>
<td>Income inequalities</td>
</tr>
<tr>
<td>Epidemic has been socially constructed by vested interests</td>
<td></td>
<td></td>
<td></td>
<td>Income is a determinant of dietary &amp; physical activity patterns</td>
</tr>
<tr>
<td>Association between weight &amp; health has been exaggerated – moral panic</td>
<td></td>
<td></td>
<td></td>
<td>Healthy diets are more expensive &amp; low cost food is obesity-promoting</td>
</tr>
<tr>
<td><strong>Solutions</strong></td>
<td>Expose vested interests in the epidemic, expose myth of weight equating with health status, expose dangers of dieting</td>
<td>Education to address cultural, knowledge, &amp; skill deficits (consumer information, label reading, cooking &amp; budgeting classes, education about exercise)</td>
<td>Create a leptogenic (lean-producing) environment</td>
<td>Reduce social inequalities</td>
</tr>
<tr>
<td>De-medicalisation of obesity</td>
<td></td>
<td></td>
<td></td>
<td>Redistribute income</td>
</tr>
<tr>
<td>Address fat phobia &amp; promote health at any size/fat acceptance/body diversity</td>
<td>Incentives to eat healthily &amp; exercise, promote benefits of healthy weight, higher insurance premiums for those overweight, accept that some discrimination &amp; stigma may be healthy &amp; act as a deterrent</td>
<td>Address the economic, physical, socio-cultural, &amp; political promoters of obesity</td>
<td>Promote equality</td>
<td></td>
</tr>
<tr>
<td>Promote adequate diets &amp; physical activity</td>
<td></td>
<td></td>
<td></td>
<td>Address socioeconomic barriers to healthy diets &amp; opportunities for physical activity</td>
</tr>
<tr>
<td><strong>Non-Solutions</strong></td>
<td>Weight loss &amp; dieting</td>
<td></td>
<td></td>
<td>Address food supply issues especially the cost of healthy food</td>
</tr>
</tbody>
</table>

As expected, overall, the industry frame represented a mix of both the ‘epidemic as a myth’ and the ‘individual behaviour’ frames, while the public health frame most closely resembled a mix of features from the ‘structural’ and the ‘obesogenic environment’ frames.
There were however, some exceptions to this. The similarities and differences between the public health and industry frames, in comparison with the four key obesity frames, are considered below.

8.2.1 Industry frame

Comparison with the ‘epidemic as a myth’ frame

While the industry did not explicitly dispute the notion of an obesity ‘epidemic’ – as advocates of the ‘epidemic as a myth’ frame (Gaesser 2002; Campos 2004; Guard & Wright 2005; Campos & Saguy et al. 2006; Jutal 2006; Oliver 2006) have done – it minimised the significance of the issue. In this sense, the industry frame was closer to the ‘epidemic as a myth’ frame than the other key frames. Although, it was not clear whether the ‘individual behaviour’ frame positions obesity as an ‘epidemic’ as such.

Although industry did not question the validity of the BMI as a measure of excess weight or body fat as advocates Campos (2002; 2004) and Gaesser (2002) have, the distinction made by industry, between overweight and obesity, was supported by arguments similar to those contained in the ‘epidemic as a myth’ frame. Industry presented evidence to support its claim that the health risks of obesity and overweight were significantly different. It also argued that the association between weight and health was more complex and, like Gaesser (2002) in his argument that one can be ‘fit and fat’, industry suggested that physical activity was a key factor mediating the relationship between weight and health. In this sense, the industry frame lends some support for the fat acceptance camps’ notion of ‘health at every size’. Thus, the frame used by industry in the forum of the Inquiry was sympathetic to the ‘epidemic as a myth’ notion, that the association between weight and health has been exaggerated. Industry also provided other arguments to justify why the focus should be on obesity and not overweight – for instance, that recent medical advances had reduced the health risks for those who are overweight – although these arguments were not evident in any of the four key obesity frames outlined in Chapter 3.

However, this was where the similarities between the industry and the ‘epidemic as a myth’ frames ended. Industry did not make use of the argument that ‘obesity is not a disease’ – an argument used by the food industry group in Kwan’s (2009) research – or suggest as Oliver (2006) did, that the obesity epidemic had been constructed by vested interests – an argument also used by the food industry group in Kwan’s research. Nor did industry argue that there had only been ‘modest gains in weight’ rather than an epidemic increase, as Campos (2004) and others (Guard & Wright 2005; Saguy & Riley 2005; Campos & Saguy
et al. 2006) have claimed. Industry also did not make any reference to the key argument from the social justice variation of the ‘epidemic as a myth’ frame used by the fat acceptance camp (Saguy & Riley 2005; Kwan 2009), that weight-based discrimination was the ‘problem’. In this respect, the industry framing of obesity evident in this research did not appear to be sympathetic to this key concern of fat acceptance activists. However, the fact that industry did not mention the issue of weight loss as a solution may indicate some alignment with this concern of fat acceptance activists.

Comparison with the ‘individual behaviour’ frame

Most of the key features of the industry’s obesity frame, with its emphasis on individual attributes as the main cause of obesity, mirror the arguments evident in the ‘individual behaviour’ frame. Like the ‘individual behaviour’ frame, industry argued that lifestyles chosen by particular groups in society were the key cause of overconsumption and sedentary activity. Industry’s focus on attitudes and knowledge deficits is clearly aligned to the ‘individual behaviour’ frame’s focus on ‘cultural preferences’ and ‘knowledge deficits’ as the main causes of unhealthy behaviours. Thus, like advocates of the ‘individual behaviour’ frame, the industry positioned obesity as a consequence of poor lifestyle choices:

people are obese because they do not have a balanced diet, they eat too much too often and they do not exercise enough (McDonalds s192:3).

To some extent the industry also adopted aspects of the ‘risky behaviour’ frame identified by Saguy and Riley (2005), where obesity is interpreted as ‘evidence’ of prior engagement in unhealthy lifestyles. This was evident in the industry claims that lack of motivation, inertia and apathy were drivers of overconsumption and inactivity. Here though, the industry did not explicitly take on the ‘immorality stance’ of some of the more ‘extreme’ advocates of the individualistic perspective (Saguy & Riley 2005), preferring instead to argue that obesogenic lifestyles were due principally to knowledge deficits (or denial of weight problems). For instance, industry did not go so far as to cite laziness as a character trait behind obesogenic lifestyles (although it did suggest that lack of motivation was a factor). The absence of an explicit morality stance in the industry frame is not surprising given that such a stance could potentially alienate industry’s most regular consumers (and some politicians). Therefore, consistent with Kwan’s finding about the US food industry group, the industry sector in this case study appeared to be morally ambivalent on the issue of right or wrong bodies: “all bodies are tolerated as long as they consume” (Kwan 2009:44).
Comparison with the ‘obesogenic environment’ frame

Industry acknowledged some of the wider environmental determinants of obesity evident in the ‘obesogenic environment’ frame developed by Swinburn and colleagues (1999). In industry discussions about the ‘multiple societal determinants’ of obesity (outlined in Chapter 5), factors such as: decreasing food costs and increasing physical activity costs; reliance on motorised transport; and, technological change were cited as drivers of obesity. The identification of the costs of food and physical activity as societal determinants is consistent with the ‘economic’ dimension of the ‘obesogenic environment’ frame. The focus on technological change is consistent with features of the ‘physical’ aspect of the ‘obesogenic environment’ frame. However, on the matter of technological change, for industry, the focus was on its impact on physical activity and not consumption (and by implication not food production, availability and marketing). Moreover, the industry framed these multiple societal determinants in terms of affluence and abundance:

At one time only the rich could afford to be overweight; now everyone can (FGC s163:1).

Although there was acknowledgement by industry of these environmental determinants of obesity, it was argued that such factors were not overwhelming because many people managed to maintain a healthy weight.

Another similarity with the ‘obesogenic environment’ frame can be found in industry’s emphasis on attitudes and norms:

The single biggest drivers of over-consumption lie in social and personal attitudes, not in food itself, or communication about it (FIG s157:3).

This focus shares some similarities with the socio-cultural dimension of the ‘obesogenic environment’ frame which emphasises the importance of societal norms, attitudes and beliefs. Unsurprisingly though, industry explicitly denied the contribution of marketing to these attitudes and norms – a factor which is emphasised under the socio-cultural dimension of the ‘obesogenic environment’ frame.

There were less similarities between the industry frame and the ‘political’ aspect of the ‘obesogenic environment’ frame, where it is held that the formal and informal rules relating to food and physical activity have various impacts on obesity. Industry did not appear to accept the impact on obesity of the formal or macro-level rules relating to food (with the exception of its recommendation for progressing the Nutrition and Health Related Claims
legislation). Instead, industry emphasised the informal family rules as paramount, and to some extent also school rules. Although again, on the matter of school rules, the emphasis was on rules relating to structured physical activity and the provision of nutrition education, and not the food available in schools or food industry sponsorship of school activities.

Comparison with the ‘structural’ frame

Industry rejected potential explanations of obesity characteristic of the ‘structural’ frame. In particular, industry explicitly denied the role of individual economic circumstances as drivers of obesity amongst particular groups. The FIG, in particular, argued that higher rates of obesity amongst lower socioeconomic and particular ethnic groups were not due to underlying economic factors but due to ‘diet, knowledge, habits and norms’ common amongst such groups. This supports the contention by Saguy and Riley (2004: 154) where repeated references to the clustering of obesity amongst particular ethnic groups (and ruling out economic factors) has the effect of reinforcing pre-existing negative ethnic stereotypes by providing further ‘evidence’ of cultural, moral, and educational deficits amongst these groups. There was also no evidence in industry submissions to suggest support for other aspects of the structural frame. Namely, there was no acknowledgement of the relationship between income inequality and obesity (noted by Molarus & Seidell et al. 2000; Pickett & Kelly et al. 2005), nor any acknowledgement of income as a key determinant of diet (Drewnowski 2004), or any acknowledgement of other structural constraints embedded in the socioeconomic structure (as captured by Critser 2003). Moreover, there was no reference to the historical determinants of ethnic inequalities in New Zealand (Reid & Robson et al. 2000; Robson 2004; McCreanor 2008) and the role these have in shaping the opportunities and constraints experienced by Māori and Pacific communities in New Zealand.

8.2.2 Public health frame

Comparison with the ‘epidemic as a myth’ frame

The public health framing of obesity as an epidemic is a direct rejection of the notion that the epidemic is a myth. None of the arguments contained in the ‘epidemic as a myth’ frame were evident in the public health frame. Specifically, rather than criticising the BMI as a measure of body-fat, the public health frame unanimously accepted it (as did industry). The public health sector also did not argue, like advocates of the ‘epidemic as a
myth’ frame, that obesity was not a disease (it claimed obesity was a major *modifiable risk factor* for numerous health conditions).

On the matter of the association between weight and health, public health submitters – while accepting that the risks were different for overweight and obesity – did not argue that the association had been exaggerated. Instead, the public health submitters provided copious evidence of the adverse consequences of overweight and obesity. The argument that ‘weight-loss is not the solution’ was also not apparent in the public health frame (nor was it evident in the industry frame). This appears to be largely due to the public health focus on the prevention of obesity rather than treatment or management. Submitters from the public health sector also did not suggest that weight-based discrimination was the problem, although they recognised that this was an undesirable consequence of obesity. In this sense, public health submitters did not support the claim that one can be ‘healthy at every size’. Nor did the public health sector make recommendations to address fat phobia or promote social acceptance of body-size diversity. In summary, the public health sector did not support the ‘epidemic as a myth’ frame or the arguments contained within it.

**Comparison with the ‘individual behaviour’ frame**

The public health frame also rejected almost all of the key features of the ‘individual behaviour’ frame. It rejected the notion that unhealthy eating and physical activity patterns were determined by individual choice, arguing instead that such ‘choices’ were constrained by socioeconomic factors, in particular income, and, largely shaped by environmental factors outside of individual control. The public health sector was also explicit that obesity was not a knowledge deficit problem, although an exception to this was found in a couple of submissions where it was suggested that lack of cooking skills was a barrier to good nutrition for some people. Yet, one of the solutions suggested by public health submitters, the need to include nutrition and cooking education in the school curriculum appears inconsistent with the public health argument that obesity was not a result of knowledge deficits. This policy, to provide nutrition education, is however consistent with the ‘individual behaviour’ framing of the obesity problem as a result of knowledge deficits.

The public health sector was also explicit that obesity was *not* caused by character deficits. Specifically, it was argued that personal irresponsibility or lack of will-power were not responsible for obesity. Therefore, like industry, public health submitters rejected the more extreme morality stance of the ‘risky behaviour’ framing of obesity.
Comparison with the ‘obesogenic environment’ frame

As expected, the public health frame drew on key aspects (physical, economic, political, and socio-cultural) of the ‘obesogenic environment’ frame and argued that obesity was ‘a normal response to an abnormal environment’. Physical aspects of the obesogenic environment that featured in the public health frame included: the influence of technology on physical activity and the food supply; increased availability of food; and, the influence of a range of other factors on living conditions and physical activity patterns. At the micro-level, some of the evidence provided by the public health sector indicated that there were neighbourhood effects, in that lower socioeconomic neighbourhoods were more obesogenic than higher socioeconomic neighbourhoods. Economic aspects of the environment were also recognised as critical in the public health frame. At the macro-level, public health submitters highlighted the relative cost of healthy versus unhealthy food as a key feature of the obesogenic environment. As well, the public health frame noted the importance of the political aspects of the environment, such as: the rules around food availability, labelling, composition and marketing; food price (and taxation); and international legal and trading frameworks. Socio-cultural aspects such as norms and values were, by comparison, less emphasised as a cause of obesity, although marketing was recognised as a key factor creating demand for and acceptability of unhealthy foods.

Yet, unlike the ‘obesogenic environment’ frame, the public health frame prioritised environmental determinants of consumption over environmental determinants of physical activity. The public health focus on factors influencing energy intake, and their specific focus on the causes of increased consumption of EDNP food, is therefore a departure from the multi-causal ‘obesogenic environment’ framing of obesity which does not identify any fundamental cause or suggest any hierarchy of causes for the multiple factors promoting obesity. Furthermore, the public health sector focused on the macro-level environmental influences rather than those as the micro-level (such as families). No such emphasis was evident in the ‘obesogenic environment’ frame.

Comparison with the ‘structural’ frame

The argument put forward by a number of public health submitters, that social inequalities had an important role in obesity, is aligned with the dominant causal theme underpinning the ‘structural’ frame, that the unequal distribution of resources lies at the heart of the unequal distribution of health.
Like the ‘structural’ frame, public health submitters focused on income as a key factor underlying the unequal distribution of obesity. Here, public health submitters recognised both income distribution in the population and inadequate income amongst some ethnic and lower socioeconomic communities, as critical factors underlying socioeconomic differences in consumption patterns. The NZMA for instance, provided the committee with evidence of the correlation between the levels of income inequality in a given country and levels of obesity:

Social inequality is one of the promoters of obesity, and one of the promoters of ill health, and there are graphs in there [referring to their written submission] showing the relative incidence of obesity related to income inequality (representative, NZMA transcript).

On the issue of inadequate income, it was noted by public health submitters that low income was a major reason why families did not eat healthily, with one submitter noting that the decision to eat low-cost energy-dense food was rational for families on limited incomes. This is consistent with the point made by Drewnowski (2004: 154), that:

the ability to adopt healthier diets may have less to do with psychosocial factors, self-efficacy, or readiness to change than with household economic resources.

Consistent with the ‘structural’ frame, the issue of food insecurity was also evident in a number of public health submissions. Here public health submitters acknowledged the paradox between food insecurity and obesity noted by Cummins and colleagues (2005). Here though, public health submitters explained this paradox as a consequence of a rational decision to reduce the quality rather than the quantity of food, so as to avoid hunger.

Public health submitters highlighted, as the key determinants of increased consumption of EDNP foods: its low cost; increased availability; and, heavy marketing. These three factors are clearly structural in the sense that they are outside of the control of the individual. This is further evidence that the public health frame was consistent with the ‘structural’ framing of obesity.

On the issue of food cost, a number of public health submitters made references to the low cost of unhealthy food, relative to the high cost of healthy food. Some suggested that this was a systemic problem inherent in the food supply. This is also consistent with the arguments and evidence contained in the ‘structural’ frame, in particular the evidence that
healthy food is more expensive than unhealthy food (Davey 2001; Drewnowski 2004; Woodham 2009).

It is significant also, that the public health focus was on unhealthy food rather than overconsumption. This framing implicates specific foods as the culprit as opposed to the behaviour of overconsumption. This shift in emphasis away from the behaviour as the problem to the substance as the problem indicates support for a more structural (and systemic) explanation of obesity.

The public health frame also acknowledged, as promoters of obesity amongst lower socioeconomic groups, many of the ‘other structural constraints embedded in the social and cultural milieu’ suggested by the ‘structural’ frame. For instance, unfavourable living conditions, such as the greater availability and heavier marketing of unhealthy foods (and greater density of fast food outlets) and the reduced availability of fresh fruit and vegetables in poorer neighbourhoods, were noted to make “the unhealthy choice the easy choice in poor areas” (THMM s100:3; OAC s129:22). Other social, cultural, and structural constraints noted by the public health sector included: the safety of the neighbourhood; housing quality; proximity to recreation opportunities; and, available options for ‘treating’ oneself or one’s family.

However, two themes from the ‘structural’ frame were largely absent from the public health frame. These were the potential explanations for ethnic and gender differences in obesity. Gender differences in obesity and overweight were acknowledged by some public health submitters, but no explanation for these was offered. Similarly, the potential explanations offered by a theory of racism and its relationship to health, as conceptualised by Krieger (2003), were not explicitly considered by the public health submitters. THMM was an exception to this, noting that some of the inequalities experienced by Māori lay in the:

- distribution of resources including investment in appropriately targeted initiatives for Māori; access to and effectiveness of health care and income assistance; [and] Māori participation at all levels of the health sector (THMM s100:3).

Thus, THMM recognised some of the key avenues though which racism impacts on health. These included economic and social deprivation and inadequate health care (although THMM did not explicitly state that these were a consequence of racism). Two other avenues likely to link racism and health identified by Krieger (2003): exposure to hazardous substances and conditions (obesogenic environments); and, the targeted marketing of health-harming commodities, were mentioned by public health submitters in relation to
socioeconomic position or neighbourhood deprivation, but not explicitly ethnicity. In particular, public health submitters did not consider or provide any evidence to suggest that unhealthy food marketing was ethnically targeted. As noted in Chapter 3, Schor’s (2004) research into marketing practices found evidence that some unhealthy foods were ethnically targeted. Therefore, public health submitters did not argue that racism was an important determinant of obesity. In summary, the public health frame was consistent in most respects with the key themes and arguments characteristic of the ‘structural’ frame.

**Summary and discussion of key findings**

As expected, the food and advertising industries predominantly drew on arguments from the ‘epidemic as a myth’ and the ‘individual behaviour’ frames. However, of the two frames, the ‘individual behaviour’ frame was the dominant influence underpinning industry’s framing of obesity. That is, the industry’s frame drew on most of the arguments from the ‘individual behaviour’ frame (with the exception that it did not reflect the moral stance evident in the ‘risky-behaviour’ framing of obesity), and only some of the arguments from the ‘epidemic as a myth’ frame. It rejected the notions that: the epidemic was a myth; that it had been constructed by vested interests; that obesity was a disease; and, did not explicitly state that weight-loss was not the solution. The industry frame also rejected all of the core themes and arguments of the ‘structural’ frame. Yet, some features of the industry frame were consistent with elements of ‘obesogenic environment’ frame. These included the identification of the economic aspects of the environment in discussions around the general causes of obesity, and the emphasis on the micro-level aspects of the socio-cultural dimension of the ‘obesogenic environment’ frame (the focus on norms and attitudes and family influences).

In comparison, the public health frame was most consistent with the core themes of ‘obesogenic environment’ and the ‘structural’ frames. As expected, the public health framing of obesity did not draw on the arguments from the ‘epidemic as a myth’ frame and rejected almost all of the arguments from the ‘individual behaviour’ frame. Unlike the industry frame, the public health frame maximised the issue of obesity in its epidemic frame. The framing of obesity as an inequalities problem and the particular emphasis on food cost and income were consistent with the central themes of the ‘structural’ frame, although public health submitters did not explore any explanations for ethnic or gender differences in obesity.

Similarities between the public health and the ‘obesogenic environment’ frame included the framing of obesity as a ‘normal response to an abnormal environment’ and the identification
of macro-level, physical, economic, political, and socio-cultural elements of the obesogenic environment. However, unlike the ‘obesogenic environment’ frame, the public health frame prioritised environmental determinants of consumption over determinants of physical activity, and focused on macro-level rather than micro-level environmental influences.

The only similarity between the public health frame and the ‘individual behaviour’ frame, was the support given by two public health submitters for deficits in food preparation skills. Yet, this was an exception, as the remainder of public health submitters explicitly rejected the notion that obesity was a result of knowledge deficits. Nonetheless, the public health recommendation to include nutrition and cooking education in schools is consistent with the ‘individual behaviour’ framing of obesity as a consequence of knowledge deficits. This recommendation is therefore inconsistent with the public health stance that obesity was not a knowledge deficit problem.

It was also significant that the framing of obesity by the food industry in New Zealand was somewhat different to that adopted by the food industry group in the US as noted by Kwan (2009). Although there were parallels between the framing of obesity by the industry in this research and that of the food industry in the US, in that both groups appealed to market choice rhetoric and specifically used ‘not our product arguments’, the overall ‘epidemic as a myth’ argument was absent from the industry frame documented in this research. In other words, the food industry in New Zealand framed obesity in a different way to the US food industry group.

One possible explanation for this may be, that the context in which the framing occurs and the intended audience of the frame, has an impact on how the issue is framed. For instance, the frame used by the US food industry group appears to have been crafted for a public audience (as it is located on a consumer-oriented website), while the frame used by the industry in this research was crafted for the purpose of influencing politicians in the context of an obesity inquiry. It seems unlikely that the committee would have accepted, in the context of an inquiry into obesity, an argument that the epidemic was a myth constructed by vested interests. In fact, this argument was presented to the committee on a couple of occasions by submitters outside of the industry and public health sectors, and the response by some of the committee members was complete disbelief and laughter.

Another explanation for the differences in frames used by the New Zealand and the US food industries may be that, as the food industry in New Zealand had publically made a commitment to addressing obesity via the Accord, if it denied the existence of the problem, it would be difficult to position itself as part of the solution. The consequence of this would
be the exclusion of industry from the policy making process around the issue of obesity. The point being, the obesity frames sponsored by the US and the New Zealand industry were probably different because of the context and the intended audience (or purpose) of the frames.

It is difficult to ascertain whether the public health frame described in this case study would be internationally comparable to that of similar public health groups in other countries, as a public health obesity frame has not been documented in the literature. Although Kwan (2009) noted a ‘medical’ frame evident in the US government health agency, and this shares some of the features of the public health frame in that both frames recognise the health impacts of obesity and overweight, the ‘medical’ frame differs from the public health frame in its focus on individual and medical solutions to obesity rather than its prevention. Nonetheless, given that ‘social justice’ has been argued by some (Beauchamp 1976; Baum 2002) to be an ethos underpinning public health, it would be surprising if the public health framing of obesity in similar jurisdictions was distinctly different to the public health frame documented in this case study, although it is possible. As noted in Chapter 4, some have argued that the philosophy underpinning public health is contested, with some approaches to population health focused more on the individual than the systemic dimensions (Green & Raeburn 1988; Baum 2002).

The implications of this are that there appears to be some limitations to the generalisability of the frames documented in this research. These limitations appear to be related to the context in which framing occurs, the intended audience (or purpose) of the frame, and potentially, the ideological foundations of the frame’s sponsors. There may be other limits on the generalisability of the frames documented in this research that are largely to do with the different political and ideological environments in which particular frames are generated.

The next section considers the evidence for the public health and industry frames in the Government’s stance.

8.3 Evidence of public health and industry frames in the Government’s stance

This section addresses the second research question by examining the extent to which the industry and public health obesity frames were evident in the Government’s stance, as outlined in its official response to the recommendations of the Health Select Committee. Table 31 summarises the alignment between the Government’s stance and the industry
and public health frames on the signature features of the framing matrix. On the final aspect of the framing matrix, the solutions, only those policy issues recognised by the committee in its *formal recommendations* to the Government are listed. Solutions suggested by public health or industry submitters but *not* addressed by the Government (because they were not translated into specific recommendations by the committee) are not included in Table 31, as there was no official Government stance on these issues. These are discussed in section 8.3.1.

In assessing the match between the stance taken by the Government and the industry and public health frames, the data revealed four possible patterns. There were, that the Government’s stance was: (i) predominantly aligned with the industry frame; (ii) predominantly aligned with the public health frame; (iii) reflected a mix of elements from the public health and industry frames; or, (iv) unclear. To illustrate these differences a check mark has been placed in one or more of the final four columns headed: ‘industry’; ‘public health’; ‘mixed’; or, ‘unclear’. In two cases (under solutions), there are check marks under both industry and public health, as these policy solutions were uncontested by both sectors. Although a check mark has been placed in one of the columns, suggesting that the Government’s stance on particular points can be categorically aligned to a public health or industry position (or a mixed position), in reality, the exact position taken by the Government was sometimes more blurred. This is the difficulty in presenting what is essentially a continuous variable as a categorical variable, for the purpose of summarising the data to reach an overall conclusion. To address this issue, the findings summarised in the table are discussed in detail, and it is this discussion, rather than the simplified summary presented in Table 31, that should be considered as the ultimate assessment of the evidence of industry or public health frames in the Government’s stance.
Table 31: Government agreement with industry and public health frames

<table>
<thead>
<tr>
<th>Signature features</th>
<th>Industry*</th>
<th>Mixed†</th>
<th>Public Health‡</th>
<th>Unclear</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Problem representation</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><em>Overall description</em></td>
<td></td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td><em>Type of problem</em></td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><em>Affected groups</em></td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Causes</strong></td>
<td></td>
<td></td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td><strong>Solutions</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>I  The national obesity strategy HEHA</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Full range of public policy measures</td>
<td></td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Establish a cross-sector ministerial committee</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Widen the HEHA Sector Steering Group</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Establish an independent commissioner</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>II  Regulation of the food industry</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Front of Pack food labelling</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Food composition standards</td>
<td></td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Informal fast food sector</td>
<td></td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Set targets for product reformulation</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>III Regulation of marketing &amp; advertising industries</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Restrict broadcast television advertising</td>
<td></td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Increase consumer representation on the ASA§</td>
<td></td>
<td></td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Broaden the ASA mandate</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Promotion of fast food/ energy-dense products</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Encourage promotion of healthier alternatives</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Monitoring &amp; target setting</td>
<td></td>
<td></td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td><strong>IV Public education and information</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Social marketing</td>
<td></td>
<td></td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td><strong>V School environments</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mandatory food policy in schools</td>
<td></td>
<td></td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Remove unhealthy food from schools</td>
<td></td>
<td></td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Extend Fruit in Schools</td>
<td></td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Include nutrition &amp; cooking in curriculum</td>
<td></td>
<td>✓</td>
<td>✓</td>
<td></td>
</tr>
</tbody>
</table>

* Industry = Government’s stance most consistent with that of industry.
† Mixed = Government’s stance reflects elements of both industry and public health perspectives.
‡ Public Health = Government’s stance most consistent with that of public health.
§ ASA = Advertising Standards Authority.
8.3.1 Problem representation: Government’s stance mixed with an industry bias

Overall, taking into consideration the three key aspects of the problem representation (the overall description, the type of problem, and who was affected by it), the Government’s stance reflected a mix of the public health and industry frames, although with a bias toward the industry framing on some important aspects. These aspects included:

- the framing of the *type of problem*
- the framing of one of the two key themes evident in the framing of *those affected by obesity*.

The evidence for this conclusion is considered below.

Overall description: Government’s stance mixed

While the committee’s overall description of the obesity problem as: a complex issue; an epidemic; and, a pandemic, was aligned with the public health description of the problem, the Government’s description of the issue reflected a *mix* of the descriptions used by the industry and public health sectors. This was evident in the Government’s description of the obesity as: a complex issue; an epidemic; and, an ‘emerging issue’, and the use of the term ‘rising rates’ in a number of places (where the term epidemic could have been have been used). The Government therefore appeared to take a compromised position, neither maximising the significance of the issue (as the majority committee and the public health submitters did), nor did they minimise the significance of the issue (as the industry did).

Type of problem: Government’s stance aligned with industry

In discussing *why obesity was a problem*, the Government, like the industry, focused on the economic burden to the health system, and like industry, suggested that much of this was attributable to diabetes. This, together with the fact that the Government did not acknowledge the wider social and economic costs of obesity that were noted by the majority committee and the public health sector, suggests that on this aspect of framing, the Government’s stance was more aligned to that of industry. Furthermore, like industry submitters, the Government did not detail the range of health consequences attributable to obesity that were identified by the public health sector.
Affected groups: Government’s stance mixed

Two themes relevant to the identification of groups affected by obesity were identified in sections 8.1 and 8.2. These were: (i) the differences between industry and public health frames in their focus on obesity, or both overweight and obesity; and, (ii) the differences of opinion on whether obesity was an issue for the affected communities or the whole population. The Government’s stance most closely reflected the public health position on the first theme (implicating both overweight and obesity as problematic) and appeared to take the position of industry on the second theme (suggesting that obesity was a problem for affected communities). On balance, the Government’s stance on the issue of affected groups therefore reflected a mix of both the industry and public health frames. The evidence for this is considered below.

Focus on obesity and overweight: Government’s stance aligned with public health

On the issue of who was most affected by the problem, the Government appeared to agree with public health submitters that both overweight and obesity were problematic in health terms. This was evident in the use of both the terms ‘overweight’ and ‘obesity’ in the Response (although only statistical data on the obese population subgroup was included in the Response). In this respect, it appeared that the Government’s stance was more aligned with that of public health than that of industry.

Whole population or affected communities: Government’s stance aligned with industry

Like both the industry and the public health sectors, the Government accepted that particular groups, Māori, Pacific, and lower socioeconomic communities, were more likely to be affected by obesity. However, while the Government acknowledged the higher prevalence of obesity amongst lower socioeconomic groups – when it noted that such groups were a priority group under the HEHA strategy – the Response lacked the emphasis on the socioeconomic dimension that was evident in many of the public health submissions. This suggests that the Government, like industry, may have viewed obesity as predominantly an ethnic problem. The lack of emphasis on the socioeconomic dimension of obesity was also apparent in the committee report, suggesting that the committee framing on this matter was aligned to that of industry. This may constitute evidence of effective framing of this issue by the industry in its argument that although socioeconomic factors were common amongst groups affected by obesity, they were not causal.
Additionally, like industry, the Government (and the minority committee) also framed the issue as a problem for ‘affected communities’ rather than, as was suggested by public health frame (and that of the majority committee), an issue for the whole population. Evidence for this was found in a number of references made by the Government to ‘affected communities’ needing to take ‘ownership’ of the problem. The general absence of any discussion about the wider social consequences of obesity also appears to constitute evidence that the Government’s focus in terms of the consequences of obesity, was on those affected rather than its overall societal impacts. In summary therefore, on the matter of whether obesity was an issue for the whole population or affected communities, the Government’s stance was aligned with that of industry (and the minority committee).

**Summary of problem representation**

On the three key aspects of the problem representation (the overall description of the problem, the type of problem and those affected by the problem), the Government’s stance reflected a mix of industry and public health frames, although with an industry bias. On two of the three key aspects of the problem representation, the overall description and those affected, the Government’s stance was mixed. This was evident in its overall description of the problem, and on the issue of those affected the Government sided with public health in its view that both overweight and obesity were problematic, but sided with industry in their framing of the issue as one of affected communities. On the third aspect (the type of problem), the Government’s stance was aligned with industry in that its key concern around the obesity problem was the potential economic burden to the health system.

### 8.3.2 Causes: Government’s stance unclear

As the causes of obesity were not explicitly outlined by the Government, its stance on this matter was unclear. The absence in the Government Response of any reference to the causes of the obesity epidemic left only two overarching themes available for comparison. These were: (i) the extent to which the Government framing reflected the industry focus on individual level causes or the public health (and the majority committee) focus on environmental level causes; and, (ii) the difference in emphasis on energy intake (the public health and majority committee emphasis), or physical activity (the industry emphasis) as the dominant cause of the energy imbalance. On these two issues, the Government’s stance was unclear. The evidence for this conclusion is considered below.
Individual or environmental causes: Government’s stance unclear

On the first issue, whether there was any emphasis on individual or environmental level causes, it appeared that the Government accepted the environmental emphasis characteristic of the public health frame, in that it agreed that it was ‘vital’ to address the obesogenic environment. Yet, this does not mean that the Government rejected individual level influences. It appeared that the Government’s position on this matter was mixed (with both individual and environmental causes considered important). However, since there was no clear evidence to suggest that the Government’s stance prioritised either individual or environmental level causes, it can only be concluded that the Government’s stance on this matter was unclear.

Focus on energy intake or physical activity: Government’s stance unclear

On the second issue, the relative contribution of energy intake and physical activity to obesity, the Government’s position suggested that both should be considered. The evidence for this was implicit in its criticism (noted in Chapter 7), that the committee was overly focused on determinants of consumption rather than physical activity. This suggests that the Government’s stance was that both consumption and physical activity were important determinants of obesity. Yet, there was no suggestion that either energy intake or physical activity was more important. This position may reflect a compromise between the different perspectives of industry and public health. Although again, there was insufficient information to be certain. As such, it seems that the Government’s position on this matter was unclear.

8.3.3 Solutions: Government’s stance aligned with industry in most contested policy areas

The Government’s response to the committee recommendations on the solutions was aligned with industry in the majority of the most contested policy areas. These were the key policies relevant to: the HEHA national obesity strategy; the regulation of the food industry; and, the regulation of the marketing and advertising industry. The Government’s stance in the less contested area of ‘public information and education’ was unclear. As well, in the final policy area of ‘school environments’, the Government’s stance was, overall, aligned with that of public health (although two of the four school-related policies recommended were uncontested by the industry and public health sectors). Thus, overall, the Government’s stance was clearly aligned with that of industry in three of the five key policy areas. The evidence to support these conclusions is outlined below.
I The national obesity strategy HEHA

Full range of public policy measures: Government’s stance aligned with industry

The main public health criticism of HEHA, that it lacked structural measures to address the obesogenic environment (which for the majority of public health submitters meant regulation of the food industry, marketing and advertising), appeared to be accepted by the committee as indicated by its recommendation that the Government use the ‘full range of public policy measures’. However, without specific guidelines on what the full range of measures would include, the committee’s recommendation was vague (although it did note the Public Health Bill and Health Impact Assessment tools as potential mechanisms for addressing the obesogenic environment). The recommendation that Government use the full range of public policy measures appears to have been further undermined by statements throughout the committee’s report, that legislative and regulatory measures should only be adopted should the voluntary and self-regulatory measures prove to be inadequate.

Despite the agreement by Government to this recommendation, their only commitment was to revise and widen the scope of the HEHA implementation plan. The details were, nonetheless, vague. The Government, like the committee, argued that regulation would only be ‘considered’ in the event that industry self-regulation was found to be inadequate. Thus, there appears to be a disconnect between the Government’s agreement to use the ‘full range of public policy measures’ and their related statements. In other words, the Government’s rhetoric was unsupported by adequate commitment. This failure to commit to regulation of any kind is a stance supportive of industry interests. In this respect, it seems reasonable to conclude that the Government’s stance on this matter was aligned with that of industry.

Establish a cross-sector ministerial committee: Government’s stance mixed

The agreement to establish the ministerial committee (Recommendations 2 and 4) supported the public health call for greater collaboration between government sectors. Yet, the intention of Government to involve industry at this level of policy making (by identifying targets in consultation with industry) was not supported by the majority of public health submitters, and was not explicitly recommended by the majority committee. This action therefore, although addressing the public health concern over lack of cross-government collaboration and its call for an obesity taskforce, also supports industry’s
request for collaboration with the Government. It is therefore concluded that the Government’s stance reflected a mix of industry and public health interests.

**Widen the HEHA Sector Steering Group: Government’s stance aligned with industry**

The agreement by the Government to extend the membership of the existing HEHA SSG in response to the committee’s recommendation for the establishment of an *external stakeholder advisory group* (Recommendation 7) was aligned to industry’s request for Government assistance in collaborating with the NGO sector. At the same time, this decision was aligned with the public health request for an advisory group to coordinate various aspects of the obesity strategy. However, the public health submitters were, more often than not, of the view that an expert taskforce needed to be independent of industry. Because of the Government’s insistence that industry be involved in the expanded HEHA SSG, it seems reasonable to conclude that this move reflects an alignment of the Government’s stance with that of industry more than that of public health.

**Establish an independent commissioner: Government’s stance aligned with industry**

The failure of Government to agree to the majority committee’s recommendation for an independent commissioner (Recommendations 3 and 6), which appeared to stem from some public health submitters’ requests for an independent body to guide the obesity strategy, is a further example of Government alignment with industry. This is because the establishment of an independent commissioner would clearly indicate a commitment to excluding industry from a key aspect of the policy making process.

**Summary of the national obesity strategy: HEHA**

As the Government’s stance on three of the four key policy recommendations relevant to the national obesity strategy HEHA was aligned with the interests of industry and not public health, it can be concluded that overall, the Government’s stance on the national obesity strategy was aligned with industry. The only recommendation where it could be argued that the Government’s stance was *mixed*, was the establishment of the cross-sector ministerial committee. Yet even here, the involvement of industry in this crucial decision making group indicates that the Government conceded to the industry’s repeated requests for involvement and collaboration in government decision-making processes, and government facilitation with NGOs in the policy community.
II Regulation of the food industry

FOP Labelling: Government’s stance aligned with industry

Public health and industry submitters were divided on the issue of a mandatory FOP labelling system. Industry was opposed to mandatory FOP labelling on the grounds that it already had a FOP labelling system, and was explicitly opposed to the Traffic Light labelling system on the grounds that it would confuse the public and be potentially costly to manufacturers. Public health submitters, critical of the current food labelling rules, supported mandatory FOP labelling, and a number of these submitters (with the exception of the NHF which may have perceived the schemes as competition for their Pick the Tick programme), supported mandatory Traffic Light FOP labelling.

The majority committee sided with the public health sector by recommending that a Traffic Light or comparable labelling system be developed (in conjunction with food composition standards) and that progress and compliance be monitored. However, the committee’s recommendation that the system be developed in consultation with industry, suggests conceding to industry interests. It also appears to be problematic, in light of industry’s opposition to mandatory FOP labelling and Traffic Light labelling in particular.

The Government outlined a number of justifications for not implementing a FOP labelling scheme, such as the need for consistency with the Food Treaty (described in Chapter 2) and the need for further evidence of effectiveness, although these arguments appeared to be largely rhetorical. For example, the claim by Government that New Zealand could not adopt a Traffic Light system because it would be contrary to the Food Treaty, is not exactly true, as we have seen with the decision by the 2008 National Government to abstain from adding folate to bread in New Zealand despite this change being mandatory (for Australia and New Zealand) according to the joint Food Treaty (Clifton 2009, July 25). Furthermore, the claim by the Government that any FOP labelling system would have to be consistent with similar systems already in use in New Zealand (for instance, that proposed for the Nutrition, Health and Related Claims legislation and the Ministry of Health’s Food and Beverage Classification system for use in schools), is also flawed, as these two food classification systems are themselves completely different (Jenkin & Hermanson et al. 2007). The net result was that the Government did not commit to implementing a FOP labelling system. This result suggests again, an alignment of the Government’s stance with the interests of industry.
Food composition standards: Government’s stance aligned with industry

In the area of food composition, industry supported voluntary guidelines and drew attention to many initiatives that were already underway via the Accord. In contrast, public health submitters argued that the Accord initiatives were only ‘token’ efforts. They suggested that guidelines were needed for the reformulation of unhealthy products, and that progress towards these guidelines be monitored. Under Recommendation 19, the committee, agreeing with the public health sector, recommended that targets be set for the reformulation of energy-dense products.

Although the Government agreed that the ministerial committee would set targets for the reformulation of energy-dense products, the involvement of industry in this process (on recommendation by the committee) together with the apparent lack of incentive for industry compliance (for instance, public health submitters suggested that a mandatory FOP labelling system would act as an incentive to industry to reformulate their products), reflects Government’s support for continued self-regulation of the food supply. Again, this suggests that the stance of the Government was aligned to industry interests.

Informal fast food sector: Government’s stance aligned with industry

In the public health framing, the most problematic retail sector appeared to be the large branded fast food franchises who were engaged in heavy marketing of their products. Industry on the other hand, focused on the informal fast food sector as the major contributor to the obesity epidemic. That the committee made a recommendation specifically targeted to the informal fast food sector, without making a similar recommendation targeted to the branded fast food franchises, appears to reflect the successful framing of this issue by the industry. The presence of two of the food and beverage giants (McDonalds and Coca-Cola) at the Inquiry appears to have had a number of positive spin-offs for this sector of the industry. It allowed the sector to defer the blame for the obesity problem elsewhere (potentially damaging their competitors), while at the same time highlighting their own actions to address obesity. This was a framing that implied that the branded fast food sector was socially responsible and willingly engaged in the solution to obesity (while the informal fast food sector was not).

Like the industry, the Government referred to the Accord initiatives as evidence that industry was making progress in this area. The committee recommendation on this issue (Recommendation 22), to ‘encourage’ the informal fast food sector to promote the consumption of healthier foods, was met by the Government’s agreement to fund ‘one-off’
initiatives for industry to reformulate its products. The focus on the *informal* fast food sector, and *encouraging* and *assisting* this sector though Government funded product reformulation, may have some potential public health benefits, but it leaves unaddressed the need for change to the food supplied by the branded fast food sector – which are assumed to be addressed by the Accord. Furthermore, even though this action was directed toward the *informal* fast food sector, it is nonetheless characterised by *encouraging* and *working with* industry rather than *regulating*, and as such, is clearly aligned with industry preferences.

**Set targets for product reformulation: Government’s stance aligned with industry**

Industry was opposed to government regulation of food composition. It suggested instead that industry should be encouraged to adhere to voluntary guidelines such as the Heart Foundation’s Pick the Tick endorsement or the Ministry of Health guidelines. A number of public health submitters on the other hand, recommended the reformulation of unhealthy products. This included the development of clear food composition standards and targets (to reduce the fat, sugar, and salt content of unhealthy foods), together with independent monitoring of progress towards these targets. It was also suggested that a mandatory Traffic Light labelling system would be a useful incentive to encourage the food industry to reformulate their products. The majority committee agreed with the public health sector and recommended that targets be set for the reformulation of energy-dense products. The majority committee did not make any comment as to whether these product reformulation targets should be set *independently of*, or *in consultation with* industry. The minority committee also did not comment on this specific target-setting recommendation.

The Government noted that it had already been encouraging the food industry to reformulate its products and that it was “keen to see specific time-bound targets” (New Zealand Government 2007: 49). It proposed that the FIG (in consultation with the proposed ministerial committee) identify and set specific measurable targets with timeframes for achieving these targets (New Zealand Government 2007: 49). The commitment made by the Government on this matter, was to establish six new DHB-based regional food industry coordinator positions, to work with industry to improve the nutritional quality of their products. Again, this response by the Government is indicative of its overall approach of working with, rather than regulating industry. In this respect, on the issue of product reformulation, the Government’s stance was clearly more aligned with industry than public health.
Summary of regulation of the food industry

The four committee recommendations directed at the food industry were opposed by the food industry and supported by the public health sector. This key area of policy was therefore a highly contested issue. The Government’s stance (in terms of its actual commitment), was in all four cases, aligned with industry interests, although rhetorically at times, it appeared to agree with the public health stance.

III Regulation of the marketing and advertising industry: Government’s stance aligned with industry

Restrict broadcast advertising: Government’s stance aligned with industry

The Government took a compromised position on the role of advertising in the obesity epidemic, but one that essentially favoured industry. This is despite the Government stating that advertising was a “small but important contributing factor in the child obesity epidemic” (Health Committee 2007: 36). Although the Government ‘agreed’ or ‘largely agreed’ with the committee’s recommendations on advertising, marketing and promotion, its actions supported industry’s preference for self-regulation. For instance, while the Government agreed that the ministerial committee would (in consultation with industry) set targets to reduce advertising and monitor progress towards these targets, they did not agree with the recommendation to restrict television advertising of unhealthy food to children up till 8.30pm.

Instead, the Government referred to the major broadcasters’ Five Point Plan as industry’s response to this issue, noting that regulation on this matter was not possible (presumably under existing legislation), and would only be considered should industry self-regulation prove to be ineffective. The Government’s commitment to ‘work with industry’ and their ‘wait and see’ approach to industry initiatives to reduce the advertising of unhealthy food, was indicative of the Government’s stance on this matter. In this sense, the Government sided with the view of the minority committee which argued that:

any restrictions on advertising, promotion and marketing of unhealthy food and drink to children need to be agreed as part of a code driven by the relevant sectors (Health Committee 2007: 36).

Thus, the Government’s stance on the issue of restricting broadcast advertising was aligned with that of industry (and the minority committee).
Increase consumer representation on the ASA – Government’s stance aligned with public health

The issue of the need for greater consumer representation on the ASA Complaints Board, raised by the public health sector, was addressed in the Response, with the Government noting that half of the Board were now consumer representatives. This action may help alleviate one of the problems identified by the public health sector over the potential bias in the decision-making process due to lack of consumer representation on the Board. However, it was noted by one public health submitter that many of the public members on the Board had worked with organisations linked to the media. Nonetheless, the agreement by the Government to this recommendation appears to be aligned with the public health sector recommendation on this issue.

Broaden the mandate of the ASA: Government’s stance aligned with industry

The committee took on board the concern raised by the public health sector regarding the narrow mandate of the ASA system, and recommended that its mandate be broadened to cover all forms of advertising, marketing and promotion (Recommendation 23). While the Government agreed to work with industry (the FIG) and the ministerial committee to determine the process and outcome targets for decreasing unhealthy food marketing to children, its commitment on this matter was limited to making suggestions to the ASA. These suggestions included: the expansion of the relevant ASA codes to cover other forms of marketing and promotion; the use of a food rating system to differentiate healthy from unhealthy foods within the codes; and, greater promotion of the complaints system to the public. The Government provided no incentives to the ASA to improve the self-regulatory advertising system. This provides further evidence of the Government’s support for advertising self-regulation – a position that is consistent with industry interests.

Promotion of fast foods and energy-dense products: Government’s stance aligned with industry

The heavy promotion of fast food was considered by public health submitters as an important contributor to the increased consumption of EDNP foods. On this matter, the industry argued that many popular fast foods were not advertised and were still heavily consumed. Industry also argued that healthy options were available and that industry simply responds to demand. The committee recommended (under Recommendations 14 and 15) that the fast food sector needed to act more responsibly and promote healthy meals (especially to children and youth), and that all sectors work with industry to meet agreed targets for advertising, marketing and promotion of energy-dense products. While
the Government ‘agreed’ to these recommendations, its commitment was limited to
directing the ministerial committee to set targets for the fast food sector and encouraging it
to agree to recommended targets. This was to be helped by the establishment of six food
industry co-ordinator positions in DHBs to facilitate positive changes to the food supply.
Both the committee and the Government differed from the public health stance, in arguing
that encouragement rather than regulation was needed. These actions taken by the
Government are therefore aligned to industry interests, as they reflect the Government’s
commitment to working with and assisting industry, rather than regulating.

**Encourage promotion of healthier alternatives: Government’s stance aligned with industry**

The stance taken by industry on the matter of promoting healthier alternatives was that it
was already making progress via the Accord initiatives, although it called for the
progression of the Nutrition, Health and Related Claims legislation arguing that this would
courage industry to promote healthier alternatives. The public health sector on the other
hand, was generally of the view that regulation was required rather than encouragement.

The committee suggested, under Recommendation 50, that the media and the advertising
industry be encouraged to use its power to promote healthy foods and physical activity.
The Government ‘agreed’. It noted that broadcasters had already agreed: to provide free
commercial airtime to the Health Sponsorship Council; to participate in a consultative group
on advertising; and, to work with Sport and Recreation New Zealand in the production of
television programming aimed at children and young people.

The recommendations by the committee to encourage the food and advertising industries
to promote healthier products and lifestyles were weak and without any incentive for
compliance, or penalty for non-compliance. Although, there was some concession made
by the major broadcasters, in that they agreed to provide free commercial air time to the
Health Sponsorship Council for their healthy food social marketing campaign, this was
modest and appears unlikely to result in any substantial gain for public health in the
absence of any measures to reduce the heavy marketing of unhealthy food. As such, the
Government’s stance on this recommendation appeared to be aligned with the interests of
industry.
Monitoring and target-setting: Government’s stance mixed with an industry bias

As part of the revised HEHA structure, the Government agreed that the ministerial committee would perform (in consultation with industry) a number of target-setting functions. Six of these recommendations related to the setting of targets for the promotion of energy-dense foods (Recommendations 5, 11, 12, 13, 15, and 21). To assess whether industry was meeting these targets, the committee recommended the surveillance and strict monitoring (with reasonably short timeframes) of industry’s progress towards these targets, with a view to regulation if such targets were not met. The public health sector also made similar recommendations regarding the need for targets and monitoring of progress in achieving such targets.

The Government ‘largely agreed’ with five of the target-setting recommendations (with the exception of Recommendation 13 – to direct the FIG to be responsible for achieving the targets), noting that the ministerial committee would set targets (in consultation with industry) in a number of areas related to food marketing and food supply. The ministerial committee would monitor industry progress to determine where industry self-regulation was and was not working. Although this target-setting and monitoring function was a new action on the part of the Government (and necessary to determine where self-regulation is effective), it was somewhat tempered by the Government’s invitation to industry to be involved in this process. While this commitment addresses some criticisms raised by public health submitters, the involvement of industry in the target-setting and monitoring process might seriously compromise the public health efficacy of the process.

In terms of compliance with targets set by the ministerial committee (and the industry), the Government’s emphasis was on ‘encouraging’ industry to meet targets. As there was no mention of penalties, the only incentive for industry to meet the ‘agreed’ targets appeared to depend upon the ‘threat’ of impending regulation if they did not. Overall, while this new initiative addressed the public health call for monitoring of the marketing and advertising sector, it failed to address the issue of the need for independent monitoring and it lacked measures to ensure industry compliance. This suggests that the Government’s stance although mixed, was biased towards industry interests.

Summary of regulation of the marketing and advertising industries

Overall, on policies relevant to the marketing and advertising industries (one of the most contested issues arising out of the Inquiry), it seems reasonable to conclude that the Government’s stance was more aligned with industry preferences for self-regulation than
the public health submitters’ calls for regulations and bans on unhealthy food marketing. This appeared to be in part a response to a number of weak recommendations by the committee which, with the exception of the recommendation to restrict broadcast advertising on television, also appeared to support industry preferences for self-regulation and working with government. The solutions proposed by the committee were also inconsistent with its positioning of advertising and marketing of energy-dense food a key contributor to the obesity epidemic. This in itself suggests an illogical disconnect between the identified causes of the problem and the solutions. This inconsistency may suggest that the committee was constrained by the political acceptability (to industry) of such solutions.

IV Public information and education

Social marketing: Government’s stance unclear

The committee, under Recommendation 41, suggested that the Government undertake a sustained social marketing programme to promote healthy diets and physical activity. For industry, the provision of information and education was the key strategy to address obesity, while for public health submitters, the provision of education and information was but one small component of a much larger strategy that would need to address the obesogenic environment. In this sense, there was support from both the public health and industry sectors for social marketing, although there was a key difference in the significance attributed to this as a strategy to address obesity.

The response by the Government to the committee’s recommendation to undertake a sustained social marketing campaign was that this was already underway. It outlined two social marketing campaigns, one addressing physical activity and the other addressing healthy eating. In light of the absence of any commitment by the Government to regulatory measures to address the obesogenic environment, the concerns raised by public health submitters about the limited efficacy of social marketing (as a strategy in isolation from wider environmental change), remained unaddressed. In this sense, it can not be argued that the stance taken by the Government was aligned with that of public health. However, the Government also did not emphasise that social marketing (or the provision of information and education) was the key strategy, so it would be difficult to conclude that the Government’s position was aligned with that of industry. Thus, the Government’s stance on this matter can not be categorically aligned with either industry of public health. It is for this reason that it is concluded that the Government’s stance in this area of policy remains unclear.
V School environments: Government’s stance aligned with public health

Mandatory food policies in schools: Government’s stance aligned with public health

While industry was opposed to mandatory food policies in schools suggesting that it should be for each school to decide for itself whether such policies were indicated, public health submitters argued for mandatory food policies in schools. The public health sector suggested that mandatory school policies should cover a range of issues, not only the food available in schools, but also food industry sponsorship of school activities and industry-generated curriculum resources as well as products used for fundraising. The majority committee sided with the public health sector in its recommendation to promote healthy diets (and physical activity) in all aspects of the school environment, including commercial sponsorships, foods for sale, and the curriculum. The Government agreed with this recommendation, noting that changes to the National Administrative Guidelines were already underway, and that these would require all schools and early childhood care centres to “promote healthy food and nutrition for all students” (New Zealand Government 2007: 39). Thus, on the recommendation for mandatory food policies in schools, the Government’s stance was aligned with industry.

Remove unhealthy food from schools: Government’s stance aligned with public health

Industry opposed restrictions to the sale of unhealthy food in schools, suggesting (like the minority committee) that this was an issue for each school to determine. The majority committee sided with public health submitters in their recommendation that unhealthy food be removed from all schools. The Government agreed with this recommendation and took action to alter the National Administration Guidelines (by which schools must comply) to require all schools (where food and beverages were available) to “make only healthy options available” (New Zealand Government 2007: 39). The Government also outlined a number of recent actions taken to improve school environments, including: the NZ$5 million nutrition fund to support schools, and the launch of the Mission On initiatives in September 2006 (to help children to make ‘healthy lifestyle choices’). Thus, the stance taken by the Government on this matter was sympathetic to that of public health and not industry.

Fruit in Schools: Government’s stance aligned to both industry and public health

The free Fruit in Schools initiative was particularly supported by the public health sector, who argued for its extension to all schools. There was also some support from the industry
for the Fruit in Schools programme. As a policy option, the Fruit in Schools programme was uncontested. Although the Government did not agree to extend the Fruit in Schools Programmes to all schools as recommended by the committee, they did agree to extend it to an additional 182 decile two primary schools around the country. Although this did not fulfil the public health or committee requests entirely, the commitment to extend the programme at all reflects a stance that was aligned with both industry and public health.

**Include nutrition and cooking in the curriculum: Government’s stance aligned to both industry and public health**

The inclusion of cooking and nutrition in the curriculum was supported by both public health and industry submitters. Like the Fruit in Schools programme, this policy recommendation was therefore uncontested by industry or public health. The Government agreed to this recommendation (as did the minority committee), noting that a new curriculum, including nutrition and cooking, had recently been distributed to schools (shortly after the committee’s report was released). Thus, the Government’s stance on this issue was aligned with both industry and public health.

**Summary of school environments**

Taking all four policies relevant to the school environment into consideration, two of the policy options were uncontested by the industry and public health sectors (the Fruit in Schools initiative and the inclusion of nutrition and cooking in the curriculum), while the other two policies (mandatory food policies and the removal of unhealthy food) were contested. That the Government sided with public health on these two contested policies, suggests that the Government’s stance on food and nutrition policy in the school environment was aligned with that of public health.

Before drawing an overall conclusion on the evidence of public health and industry framing in the Government’s stance, it is important to examine key policy issues identified by industry or public health submitters that were not addressed by the Government (as they did not translate into specific recommendations by the committee). These policy issues are considered next.
8.3.4 Policies not addressed by the Government

This section considers the industry and public health perspectives on four policy issues that were not addressed by the Government. These were: (i) the proposed Nutrition, Health and Related Claims legislation; (ii) policies to address food price; (iii) policies to address the availability of EDNP foods; and, (iv) policies to address social inequalities and wider determinants of health. These are addressed because silence on issues may be seen as support for a stance.

Nutrition, Health and Related Claims legislation

As noted in Chapter 2, the proposed Nutrition, Health and Related Claims legislation, which would allow food manufacturers to make specific health claims on manufactured products (where there was evidence of a health benefit), was undergoing consultation at the time of the Inquiry. A number of the public health and industry submitters had been part of this consultation process and, in their submissions to the Inquiry, offered clear opinions on whether the proposed legislation should be progressed.

Industry submitters who commented on the proposed legislation argued that it was in the interests of public health that the proposed legislation be progressed. Submitters noted that manufacturers and advertisers were unable to market products using the term ‘healthy’, and that this created a legal barrier preventing the promotion of healthy products. This ‘ban’ (as it was described by some industry submitters) on the use of the term ‘healthy’ was argued to be “a nightmare for advertisers” (ANZA submission 158:8-9), and unfair, in that it created an unlevel playing field in food advertising. This situation was argued by industry submitters to be responsible for the heavy bias in food advertising towards the promotion of ‘less nutritious’ products.

Public health submitters disagreed with the industry perspective. The progression of the Nutrition, Health and Related Claims legislation was a ‘non-solution’ explicitly identified by some groups from the public health sector. These submitters argued that health claims were merely marketing tools, and not in the interests of public health because they would be likely to confuse the consumer into believing that products with health claims had more value in the overall diet than they really do, and would be likely to increase the consumption of processed foods (which they suggested would be the foods most likely to need the marketing advantage provided by health claims).
The proposed health claims legislation was not mentioned by the Health Select Committee anywhere in its report. Thus, the Government was not prompted to respond to the issue. However, the nutrient profiling system being developed to underpin the proposed legislation was discussed by the Government in relation to the need for an evidence-based system to underpin any proposed FOP labelling system.

The omission of this issue by the committee suggests that the public health arguments on this matter were either overlooked or ignored, despite the fact that there had been ongoing debate between public health advocates and the food industry over the proposed legislation. As a consequence, the proposed Nutrition, Health and Related Claims legislation remained unchallenged by the committee and the Government – an outcome that supports industry interests. However, whether this indicates the successful framing of this issue by the industry, or an oversight on behalf of the committee, remains unclear.

Food price

On the matter of food price, public health submitters identified the high cost of healthy food relative to the low cost of unhealthy food, as either a key factor, or one of a number of factors contributing to the increased consumption of EDNP food. Public health submitters suggested a number of potential solutions to the food price problem. One public health submitter noted their concern that increasing the cost of unhealthy foods, for instance via fat taxes, could be regressive as a policy on its own. To negate this effect of increased food cost, public health submitters were generally more in favour of taxing unhealthy food while simultaneously decreasing the price of healthy food. It was noted also that imposing a tax on unhealthy food would provide industry with an incentive to reformulate their products. Other recommendations to address the food price issue highlighted by the public health sector included: subsidising the cost of fruit and vegetables (or their distribution or marketing); reviewing tax exemptions given to the marketing of energy-dense foods to children; food vouchers for those on low incomes; subsiding healthy foods in schools; or more generally, addressing wider socioeconomic disparities, especially in income.

Industry submitters only made a passing reference to the issue of the overall cost of food (this was found in some of the submitters’ overall discussion of the general causes of obesity) however, industry did not note the issue of a price differential between healthy and unhealthy foods. This was due, at least in part, to the fact that industry did not accept the notion of healthy and unhealthy foods (except when it came to making health claims). Therefore, for industry, the problem was not increased consumption of EDNP food but overconsumption of food in general, in combination with lack of physical activity (with the
emphasis on the latter). Overconsumption, highlighted by industry submitters as more problematic for particular ethnic and lower socioeconomic groups with higher rates of obesity, was attributed not to economic factors (such as low income), but to individual level factors (attitudes; lack of motivation; denial; inertia; apathy; family modelling; and, knowledge and skill deficits).

Despite industry’s lack of acknowledgement that the price differential between healthy and unhealthy food was an issue, industry was well aware that food taxation may be on the policy agenda. In their discussions around non-solutions, some industry submitters (mainly those from the food retail sector), noted their opposition to food taxes (specifically excise taxes and fat taxes). In defending this position, industry submitters argued that fat taxes would be difficult to design and administer and would increase compliance costs. They also argued that fat taxes would be highly regressive – in that they would penalise “the people the government most wants to help” (Foodstuffs s283:7) and ‘pigouvian’ – making the person producing the problem pay for the resulting effects (McDonalds s192). Industry did not mention that such taxes were also likely to have a significant impact on food industry profits by reducing sales.

Recent changes to food pricing were identified by the committee as a critical cause of increased energy intake in the population (alongside changes in the availability, composition, and marketing of food). Despite the committee’s acknowledgment of food price as an important determinant of increased consumption of energy-dense products, they made no specific recommendation to the Government on this issue. They did nonetheless acknowledge two of the policy options raised by submitters: removing Goods and Services Taxes from healthy foods; and taxing unhealthy foods. However, these two options were dismissed by the committee on the basis that they raised ‘complex issues’ (New Zealand Government 2007: 9):

Some submitters were skeptical of the potential of food taxes to alter consumption because it was considered that a significant price increase would be needed to change purchasing behaviour, and low-level taxation would simply increase the food industry’s compliance costs without achieving the desired effect [my emphasis].

The committee’s statement that any price increase (through tax) would have to be significant to alter consumption and that a food tax would increase compliance costs, mirrors the arguments of the industry sector. No evidence was provided to support this claim. In this respect, the committee accepted the industry framing of the issue and used it as a justification for excluding food taxation from the recommended policy options. There was no mention by the committee of the potential regressive nature of a tax on unhealthy
food. While the committee made some suggestions under the heading ‘Pricing and other mechanisms’, these generally related to the availability and visibility of food, and none of these suggestions related to altering the price structure of the food supply.

Consequently, in the Government Response, there was no acknowledgement of a food price issue, nor any comment on the public health suggestion to alter the price differential between healthy and unhealthy food that was acknowledged by the committee. Therefore, food taxation was excluded from the policy agenda. This result favours industry interests on this matter.

**Availability of EDNP foods**

Another issue not specifically addressed by the Government was the ubiquitous presence of EDNP foods in the environment. This was one of the key factors identified by public health submitters as contributing to the increased consumption of EDNP foods. The public health sector was especially concerned about the increased availability of ENDP food in public places and in lower socioeconomic neighbourhoods. To address this problem a number of recommendations were made, ranging from the zoning of fast food and other retail food outlets (limiting their placement around schools and in lower socioeconomic areas), to the promotion of local produce markets, regulations on the placement or contents of vending machines in public places, and the provision of incentives to businesses to promote greater visibility of healthy food.

The increased availability of unhealthy foods was not a concern noted by the food and advertising industries. There was nonetheless, some discussion amongst some industry submitters on the issue of vending machines. Coca-Cola, for instance, noted that, although it did not have vending machines in primary schools – consistent with its policy of not targeting children under age twelve – it did have vending machines in secondary schools and conceded that schools sometimes made considerable money from the sale of beverages sold though vending machines. Industry was opposed to any regulation of the placement or contents of vending machines. This opposition was articulated by the FIG, who argued that such a move would be “contrary to property rights, free choice, and consumer demand, and impractical to administer” (FIG submission 157:18). Some industry submitters noted that efforts were being made to include healthier alternatives in vending machines.

Aside from the committee’s recommendations in the area of school environments, the committee made no specific recommendations to reduce the availability of EDNP foods in
the wider environment. This was despite the committee acknowledging that changes in the availability of food had, along with food composition, marketing and pricing, contributed to increased energy intake in the population. Some of the potential policy options highlighted by public health submitters, such as: the zoning of fast food outlets; the promotion of fresh produce markets; the location of supermarkets in lower socioeconomic areas; and, encouraging the provision of healthy food in public places and at public events, were however, outlined by the committee in the main text of their report, where it was suggested that these and other policy options to help control consumption 'should be explored' (Health Committee 2007: 22). Although the Government addressed some aspects of the availability of unhealthy food in the school environment, the abundant supply of EDNP food in public places and at public events was not specifically addressed. This result fails to address the recommendations of the public health sector in this area of food policy, and instead supports industry interests.

Inequalities and wider determinants of health

Many public health submitters viewed the issue of obesity as arising out of socioeconomic and wider inequalities. It was noted that lower socioeconomic groups have their choices constrained by cost. Low incomes in particular, coupled with the high cost of healthy food, were argued to be a critical contributor to the increased consumption of unhealthy food by lower socioeconomic groups, who were more likely as a consequence to be overweight or obese compared with their wealthier counterparts. Some public health submitters suggested that the food price issue – the differential between the cost of healthy versus unhealthy food – was really an issue of inadequate income. Therefore, many public health submitters made recommendations to address the wider issue of social inequalities. This would include addressing not only the unequal distribution of income, but also educational differences and inequalities in living and working conditions.

No specific recommendation was made by the committee to address social inequalities or wider determinants of health. This appears to reflect an alignment of the committee’s perspective with that of industry who denied the contribution of individual economic factors to obesity. Alternatively, it may reflect a lack of understanding of the social determinants of health. As has been discussed previously, industry was of the view that the association between obesity and socioeconomic factors was spurious, and due to other factors (such as diet, habits, knowledge and norms), common amongst groups with a higher prevalence of obesity. This led to its framing of the obesity issue as largely an ethnic problem (which as discussed previously is not the case in reality).
In the Government Response, it was acknowledged that socioeconomic factors and wider determinants of health were part of the obesity issue. It noted that the committee appeared not to have considered “addressing the social determinants of health, like income and educational qualifications” (New Zealand Government 2007). Despite the Government’s observation of this omission by the committee, the issue of wider inequalities and determinants of health was not discussed further in the Government Response. Although the Government may have been taking action in a number of areas to address the social determinants of health, no specific commitment to this policy strategy was made by the Government. In this sense, this represents a failure to address key concerns of the public health sector and indicates again, support for the industry framing of obesity.

**Summary of policies not addressed by the Government**

The four key policy issues not addressed by the Government in the Response (the Nutrition, Health, and Related Claims legislation, food price, availability of EDNP foods, and policies to address the social determinants of health) led to the exclusion of these issues from the policy agenda set by this process. Two of the policy options not addressed by the Government (food price and food availability) were acknowledged by the committee, but were not translated into specific actions. This appeared to be due either to the successful framing of these issues by the industry (or conversely the unsuccessful framing of these issues by the public health sector), or the lack of significance attributed to these issues by the committee. The other two issues not addressed by the committee in their recommendations, the Nutrition, Health and Related Claims legislation, and the need to address the social determents of health, were not even acknowledged by the committee. These omissions may also suggest successful framing of these issues by the industry. However, there may be alternative explanations for these findings. For instance, the committee may have been advised by the Ministry of Health (or other advisors) not to pursue particular policy options. As noted in Chapter 2, the Ministry of Health was requested by the committee to provide additional evidence or advice on sixteen occasions and this data was not examined in this research. Nonetheless, the net result, was that four policy options, supported by public health and opposed by industry, were absent from the Government’s stated policy agenda. This result supports a food and nutrition policy environment that reflects industry rather than public health interests.
Summary of key findings from section 8.3

The first key finding was that the Government’s problem representation reflected a mix of industry and public health frames, although with an industry bias, in that it framed the problem of obesity as an issue for ‘affected communities’.

The second key finding, on the matter of the causes, was that the Government’s stance was unclear. This was because the causes were not explicitly outlined by the Government, and the only evidence of any declared stance was found in a statement that it was ‘vital to address the obesogenic environment’. However, this did not mean that the Government denied the role of individual level causes.

There were several key findings on the matter of the solutions. The first of these was that in the majority of the most contested policy areas (the HEHA strategy, the regulation of the food industry and the regulation of the marketing and advertising industries), the Government’s stance was overwhelmingly aligned to that of industry. This means that key areas of food and nutrition policy in New Zealand at the time were dominated by industry interests. The second finding on the matter of solutions, was that the Government’s stance in the area of ‘public information and education’ was unclear. The third key finding was that in the area of ‘school environments’, food and nutrition policy was dominated by public health interests (although two of the four school-related policy issues were uncontested by industry or public health).

On the issue of policies not addressed in the Government Response, in all four cases the consequent Government inaction supported the continuance of a food and nutrition policy environment that reflected industry rather than public health interests. This may have been due to the effective framing of these issues by the industry. Overall, it seems reasonable to conclude, that the Government’s position in the majority of the most contested policy areas (including those that were not addressed by the committee), was dominated by industry interests.

Discussion of key findings

Relative importance of signature features of a frame

In Chapter 4, a number of questions were raised regarding the criteria for interpreting the findings. The central question was how closely does one frame have to resemble another frame to be considered a match? In the earlier sections of this chapter (section 8.1) where
the industry and public health frames were compared, and the subsequent section comparing these frames to the four key frames identified from the literature (section 8.2), this process was relatively straightforward. This was because the frames were sufficiently distinguishable from each other on the signature features. However, the results in this section have revealed that the ‘match’ between the industry and the public health frames and the stance taken by the Government, was at times, more ‘mixed’.

This raises the question, as noted in Chapter 4, as to whether the frames have to be similar on all signature features to be considered a match? And, the related question: are some signature features more important than others? It is suggested here, as it was in Chapter 4, that in a situation where a mixed pattern emerges, the solutions may in fact be the most important signature feature of a frame. This is because, despite differences in the problem representation or the framing of the causes, it is ultimately the solutions agreed to by the Government that reveal its true position (as other aspects of framing may simply be rhetorical). Furthermore, it is the potential consequences of framing that inspires an investigation into framing in the first place. For this reason, the focus from here on is on the Government’s stance on the solutions which, as noted previously, revealed that overall, in the majority of the most contested policy areas, was aligned with industry interests.

Framing as a cause of the Government’s stance?

Although the key findings in this case study revealed that, with the exception of policies relevant school environments, the Government’s position (in terms of its actual commitment) was overwhelmingly dominated by industry interests, this does not mean that the industry framing caused the Government’s stance in these areas of policy (or that the public health framing caused the Government’s stance in the area of school environments). There are two reasons for this.

First, there is the issue of the temporal sequencing of policies initiated by the Government prior to, during, and after the Inquiry. This is explored below. Second, there are a number of other potential explanations for the alignment between industry interests and actions agreed to by the Government, and these are explored in section 8.4.

Temporal sequencing of policies

Some of the policy initiatives ‘agreed’ to by Government were already underway (or in the planning stages) before the Inquiry. These included:
• the ‘Push Play’ social marketing campaign (predated the Inquiry)
• the ‘Feeding Our Futures’ social marketing campaign (began shortly after the Inquiry ended)
• investigations into FOP labelling schemes and the feasibility of nutrient profiling models
• the nutrition fund of NZ$5 million for schools (although released during the Inquiry, was part of the existing Confidence and Supply agreement)
• planning of the revised school curriculum to include cooking and nutrition education (not launched until after the Inquiry).

The abovementioned policies therefore, can not be attributed to the influence of framing within the context of the Inquiry (although the Inquiry process may have helped ensure policy continuance).

As the Government had access to the written submissions at the start of the Inquiry, policies not already initiated, or in the planning stages at the start of the Inquiry, were potentially subject to the influence of framing within the forum of the Inquiry. These included:

• extra funding for HEHA implementation (announced in the May 2006 Budget – the same month the Inquiry began)
• Mission On (the cross-government campaign including ten initiatives targeting children and young people)
• Government funding of twenty-one HEHA project manager positions
• the voluntary agreement between two large beverage companies and the Government to remove full energy beverages from schools
• the major broadcasters’ Five Point Plan of advertising to children (initiated at the close of the Inquiry)
• the Ministry of Health’s Food and Beverage Classification System for schools.

That so many of the total number of actions agreed to by the Government were launched or being planned during the Inquiry, indicates that the Inquiry itself may have provided ‘a window of opportunity’ for action on obesity. It is also significant that extra funding for HEHA was provided by the Government in the Budget shortly after the Inquiry began. This may have happened in the absence of the Inquiry, although one might speculate that this was preparation for demonstrating the Government’s responsiveness to the obesity issue in anticipation of the recommendations from the Inquiry.
It is also important to examine the policies agreed to by the Government in its response to the committee’s recommendations. Such policies were also potentially subject to the influence of framing by the industry and the public health sector, although in this case, the framing of obesity by these two sectors was mediated by the committee framing of the problem (this was depicted graphically in Figure 7 of Chapter 4). These policies are listed below.

1. Revision and widening the scope of the HEHA implementation plan, including development of process and outcome targets (highlighted by the Government as New Action 1).
2. Establishment of a cross-sector ministerial committee with a mandate for target setting and monitoring of the self-regulatory system (highlighted by the Government as New Action 2).
3. Establishing the HEHA SSG by widening the membership of the current HEHA steering group.
4. The establishment of six food industry co-ordinator positions in District Health Boards to facilitate change in the food supply (highlighted by the Government as New Action 19), and an increase in funding to assist with this (highlighted as New Action 20).
5. Funding for one-off, industry-led initiatives for healthier product reformulation (highlighted by the Government as New Action 21).
6. Change to school guidelines to require schools to promote healthy foods and offer only healthy foods for sale in schools (this was a new action although it was not noted as such by the Government at is was planned for implementation in June 2008).
7. Extension of the Fruit in Schools programme (over 2008/09) to 182 eligible decile two primary schools (highlighted by the Government as a New Action 17).
8. Improvements to the ASA self-regulatory system and setting targets (highlighted by the Government as New Action 3).

With the exception of the changes to the school guidelines (6), which was an initiative aligned with public health recommendations, the extension of the Fruit in Schools programme (7), and the establishment of the cross-sector ministerial committee (2) which was an initiative that represented both industry and public health interests, the remainder the new actions agreed to by Government in response to the committee recommendations were heavily biased in favour of industry. These actions supported industry preference for working with Government and providing industry with resources from the public purse to encourage positive changes to the food supply.
Therefore, an analysis of the temporal sequencing of new food and nutrition policies agreed to by Government during the Inquiry and after the release of the committee recommendations, does not appear to alter the fact that the Government’s position on the majority of the contested policy areas was dominated by industry interests. The next section explores potential explanations for the Government’s stance, particularly its alignment with industry interests.

8.4 Potential explanations for the Government’s stance

As in the majority of the most contested policy areas the Government’s stance was dominated by industry interests, the question could be asked ‘why was this the case?’ Was it due to the more effective framing of these issues by the industry (in which case effective framing could be said to constitute an important political influence on policy), or are there alternative explanations for the alignment of the Government’s stance with industry interests? Although answering the ‘why’ question was not the aim of this thesis, it is worthwhile in the interests of understanding the potential effects of framing, to consider possible explanations for this finding.

This section considers two sets of potential explanations for the dominance of industry framing in the Government’s stance. The first of these are the set of explanations offered by concepts from framing theory (as outlined in Chapter 3), and the second set of explanations draws on relevant theories of interest group influence on the state. However, as noted in Chapter 3, there are many other factors likely to influence policy making such as: previous policy; public opinion; fiscal constraints; the evidence base; the influence of policy elites; institutional factors; and, so on. These are not considered further as they are outside the scope of this thesis.

8.4.1 Explanations offered by framing theory

According to framing theory, possible explanations for the dominance of a particular frame in a policy domain (as noted in Chapter 3) include: the rhetorical skill and credibility of the claimants (Saguy & Riley 2005); the ‘attribution of blame and accountability’ (Lawrence 2004); ‘public health risk dimensions’ (Lawrence 2004); and, ‘frame resonance’ (Snow & Benford 1988; Ryan 1991; Kwan 2009). These explanations are considered below.
Rhetorical skill and credibility of claimants

Saguy and Riley (2005: 873) have suggested that “when there is ambiguity or the empirical reality is complex”, a frame’s effectiveness depends largely on the rhetorical skill and credibility of the claimants. These two explanations for the influence of framing are considered below.

Rhetorical skill

If rhetorical skill is critical, as Saguy and Riley (2005) have suggested, then one would expect to find that the persuasive skills of the industry were superior to those of public health. However, argumentative skill was not assessed in this research, and it is not clear how one might assess this. Possible criteria might include an assessment of: the internal logic of the frame (for instance: whether the identified causes are consistent with the identified solutions and whether the arguments are consistent and rational); the empirical credibility (evidence to substantiate the claims and the strength of this evidence); or, as suggested by Kwan (2009), the use of various rational or emotional rhetorical devices (appeals to commonsense, emotion, economic rationality, equity and other values). Both the industry and public health sectors used a number of these rhetorical devices.

On the matter of the internal logic of the frame, specifically whether the identified causes matched the proposed solutions, both industry and public health frames appeared to be generally consistent. Industry argued that obesity was a knowledge deficit problem and proposed that education was the key solution. The public health sector, on the other hand, identified the obesogenic environment and social inequalities as the key drivers of obesity and proposed addressing crucial aspects of the obesogenic environment and wider determinants of health. In this sense, both the public health and industry frames appeared to be internally consistent.

However, there were a number of exceptions. For instance, the claim by industry that there was no such thing as a healthy or unhealthy food, was inconsistent with their support for legislation to legalise the use of health claims on food products. There were also instances where industry undermined its own arguments. For example, although industry argued that knowledge deficits were the root cause of obesity, some industry submitters acknowledged that knowledge did not necessarily translate into behaviour when it came to healthy eating (other factors were involved such as the taste of food). Similarly, two public health submitters, despite their argument that obesity was not an knowledge deficit problem, noted that lack of cooking skills was a barrier to healthy nutrition amongst some groups.
Some of the solutions identified by public health submitters, such as the call for mandatory FOP labelling also tended to suggest, at least implicitly, that lack of information was the problem (although FOP labelling may also act as an incentive to industry to reformulate their products). Thus, internal inconsistencies were evident in the framing arguments used by both industry and public health, although the overall identification of the causes and the proposed solutions was consistent and logical. Since these features were common to both industry and public health frames, it does not appear that the internal logic of the frame offers a total explanation for the dominance of industry framing in the Government’s stance in this case study.

On the issue of empirical credibility, although the strength of the evidence presented by public health and industry submitters was not assessed in this research, some of the ‘evidence’ presented by the industry on the matter of the causes of obesity appeared to be either selective, potentially biased, or just plain dubious. For instance, on the matter of potential bias, the ‘in press’ journal article referenced by NZ Sugar and Coca-Cola demonstrating no relationship between BMI was based on an analysis conducted by NZ Sugar. Selective and misleading evidence was also provided by the BWSC in its claim that “regular small amounts of alcohol are associated with the smallest abdominal girths” (BWSC s139:1) where the BWSC omitted to note that the original article defined small amounts of alcohol as less than one drink per day.

The ‘evidence’ to support industry’s claim, that advertising and obesity were not linked, has been discredited by White (2007) as based on inaccurate obesity data. Furthermore, the report containing the original source of the data is not publically available for scrutiny (White 2007). Thus, a rigorous assessment of the evidence presented by industry would require access to documents that are not readily available. Many of the claims made by industry also appeared to be assertions unsupported by any evidence. Some arguments used by the industry also appeared to stretch commonsense credibility, in particular the argument that advertising does not increase consumption, seems illogical given industry’s financial investment in advertising and marketing – NZ$140 million annually for food and beverage advertising on television (Health Committee 2007:20) and NZ$5 million for unhealthy food advertising on the radio (RBA s187:1). Furthermore, that the marketing industry associations and the television broadcasters turned up at an inquiry into obesity in support of the food industry, suggests just how much they have vested in this source of revenue.

On the other hand, the evidence presented by the public health sector on the causes of obesity appeared more robust. Public health submitters frequently referenced peer
reviewed scientific journals and referred to the WHO international reports for the causes of
weight gain (WHO Technical Report 916), and other reputable evidence-based reviews.
Although the strength of evidence presented by the two sectors was not systematically
assessed in this case study, the general observations outlined above tend to support a
conclusion that the evidence provided by the public health sector was more rigorous.
Therefore, it does not appear that empirical credibility is a plausible explanation for the
dominance of industry framing in this case study. As well, the limited role of evidence in
influencing policy was noted by Nathan and colleagues (2005) in an assessment of the
evidence presented to a childhood obesity summit in Australia.

On the matter of the use by public health and industry submitters of various rational or
emotional rhetorical devices, submitters from both sectors appealed to particular values
and principles. The industry in general, appealed to principles underlying market rhetoric,
such as freedom of choice, informed choice, individual (or parental) responsibility, and
economic rationality. On occasion, industry also appealed to the principle of equity. For
instance, industry argued that removing industry sponsorship of sporting activity would
increase the cost of sports which would unfairly impact on those most at risk of obesity.

In contrast, the framing of obesity by public health submitters appealed largely to social
justice principles in their framing of the issue as an inequalities problem, and to public
health principles in their framing of the issue as an environmental problem affecting the
whole population, and seldom drew on principles found in market rhetoric. Perhaps this
was a weakness in the public health framing of the issues. However, whether such
rhetorical devices contributed to the dominance of the industry frame in the Government’s
stance remains unclear. It may to a large extent depend upon whether the values inherent
in the industry and public health frames were aligned with the perspectives of the politicians
and institutions contributing to the Government Response. This is discussed later in this
section under the heading ‘frame resonance’.

Credibility of claimants

On the issue of the credibility of claimants, one could examine the credentials and
expertise of the frame sponsors or the organisations they represent. This might involve
examining factors such as professional status, ethical codes of conduct (policy on
marketing to children for instance), social responsibility, and potentially, associations with
other organisations. However, such an assessment would require a clear definition of
credibility. What is considered as credible, and to whom, are important considerations in
this respect. For example, in terms of being ‘qualified’ to speak on some matters of
obesity, public health groups may be considered as more credible, while on matters of business, it is likely that industry representatives would be considered as more credible. However, independence from vested interests could also constitute an important measure of credibility. On this measure, industry would have some difficulty, as their self-interested nature was readily evident in its various ‘not our product’ claims and arguments in defence of advertising.

Both the industry and the public health sectors engaged in what Saguy and Riley (2005) termed ‘credibility struggles’. In their depictions of their ‘opponents’, as a number of the quotes in Chapter 5 revealed, industry, on several occasions, attempted to discredit public health advocates by accusing them of misinterpreting the data (for instance on the association between socioeconomic status and obesity), making alarmist claims, and referring to them as extremists or food activists. Public health advocates were similarly engaged in attempts to discredit their industry opponents by pointing out the profit motive of the industry sector, critiquing the food and advertising industry efforts to address obesity as ‘token efforts’ and an attempt to stall government regulation, and by suggesting that industry forms partnerships with government ministries to delay effective action. As efforts to discredit opponents were made by both sectors, further research would be needed to establish the effect of the efforts (for instance, though interviews with policy makers).

On the matter of the credibility of these two groups in the eyes of the committee – it was apparent (through observation of body language and the committee members’ line of questioning to the submitters), that the relative credibility of the industry and public health submitters often varied along party lines. Generally, on most policy matters, the four National Party MPs appeared to view the industry submitters as the more credible witnesses, while the four MPs from the Labour Party and the Chair of the committee (representing the Green Party) appeared to view those representing public health groups as more credible witnesses. These differences between the National Party and rest of the committee were evident in the perspectives outlined in the dissenting view of the committee’s report.

The expert witnesses selected by the committee were nonetheless from the public health sector and not the industry. This suggests that the dominant parts of the committee may have viewed this sector as more credible, or at least as being in a position to advise the committee without potential conflicts of interest. Assuming for a moment that the committee, or at least the majority of the committee, viewed the public health submitters as more the credible witnesses, and that, as suggested by Saguy and Riley (2005) that the credibility of the claimants is an important aspect of effective framing, then the public health
frame should have dominated in the most contested policy areas. Yet, since the reverse was found to be the case, this would suggest that the majority of the committee found the industry groups or their representatives as the more credible witnesses to the Inquiry. This seems unlikely, in light of my own observations of the Inquiry, and the committee’s appointment of the independent advisors from the public health sector. Thus, it appears that the credibility of the claimants was not, in this case, a very tenable explanation of the dominance of the industry frame in the Government’s stance.

Attribution of blame and accountability (individual vs systemic frames)

According to Lawrence (2004), where the blame is laid in relation to a policy problem is a crucial element of a frame, because of its link with accountability. Lawrence suggests that of particular importance is whether an issue is framed in ‘systemic’ or ‘individualising’ terms. Industry’s framing of the issue was clearly individualising, placing the blame for obesity on affected individuals who were then explicitly identified as predominantly of Māori or Pacific origin. The industry also focused on the obese subpopulation as the group at risk. Public health submitters on the other hand, adopted a systemic frame, blaming the obesogenic environment in which the heavy marketing of low-cost EDNP food was the key factor. Additionally, many public health submitters blamed wider societal forces for social inequalities which were also implicated as a key cause of obesity.

As noted by Lawrence (2004), one of the consequences of an individualising frame is that it suggests limited government responsibility and therefore limited government intervention. In comparison, a systemic frame assigns responsibility to larger forces in society such as industry and the government. A key aspect of the industry’s individualising frame was the focus on the obese population as the at risk group. This shares some similarities with the focus of the alcohol industry where heavy drinkers, rather than social drinkers are problematised (Gusfield 1996). Part of the apparent success of the industry framing in this instance could plausibly be explained by the fact that the individualising nature of the industry’s frame alleviates the Government from responsibility for resolving the problem. As noted by Lang and Rayner (2005) it is easier (and cheaper) for a government to appeal to its citizens to make healthier choices, than it is to make changes to the environment. This is especially so in the case of obesity, where addressing environmental causes of obesity, such as the obesogenic food supply and marketing environment, would require the Government to commit to a potential battle with the powerful food and advertising industries. Such a battle is likely to be difficult and potentially costly given that, as outlined in Chapter 5, the food and marketing industries have well-resourced industry associations dedicated to defending self-regulation (funded by member levies, supported by strategic...
advisors and public relations advisors), and, as noted by the committee, the food industry alone accounts for 50% of the national economy (1999). Thus, the explanation offered by the ‘attribution of blame’ (systemic or individual framing) seems to be a valid explanation for the alignment between the Government’s stance and the interests of industry in the most contested policy areas (but not necessarily the total explanation).

Public health risk framing

Other features of framing, believed by Nathanson (1999) and Stone (1997) and Lawrence (2004) to offer useful explanations for the successful framing of an issue (in terms of policy impact), are the four types of public health risk framings. As outlined in Chapter 3, these relate to whether a frame portrays a health risk as:

- involuntarily or deliberately acquired (person innocent or guilty)
- universal or particular risk (a risk to everyone or just oneself)
- caused by the environment or the individual
- when the health risk is well known “whether that danger was knowingly or intentionally created by others” (Lawrence 2004: 59).

According to Lawrence (2004: 57), the experience of public health risk framing in the area of tobacco control suggests that the more an issue is framed in terms of involuntary, universal, environmental, and knowingly created risks: “the more likely the opinion environment is to be conducive to public policy solutions that burden powerful groups”.

Industry framed obesity as predominantly an involuntarily rather than deliberately acquired risk (in so much as they argued that people were obese due to knowledge deficits rather than knowingly engaging in risky behaviour), a particular risk (only relevant for some groups of the population), and, as predominantly caused by the individual. The final dimension, whether the risk was knowingly or intentionally created by others, was not apparent in the industry framing of the issue.

In contrast, public health submitters framed obesity as a universal risk (affects the whole population even though sub-groups are disproportionately affected), an environmental risk (obesogenic environment), and, to some extent, an involuntary risk (obesity was framed as a ‘normal response to an abnormal environment’). However, they did not explicitly frame the issue as a knowingly created risk. To argue that the risk of obesity was knowingly created, for instance by the food or marketing industry, would probably require, as it did
with tobacco, evidence that industry was deliberately engaging in practices known to contribute to obesity.

For instance, in relation to the manufacturing of food, if it was found that industry knowingly modifies unhealthy food products to encourage their excessive consumption (for instance though the use of addictive additives or flavour enhancers to override normal appetite mechanisms), or if food labelling was found to be deliberately misleading, this could provide justifiable evidence for regulating these aspects of the food supply. Similarly, in the area of marketing and advertising, evidence that industry deliberately targeted their unhealthy products to groups with higher rates of obesity, in particular Māori, Pacific, lower socioeconomic groups or children, could assist public health groups to convince the policy makers to regulate advertising (especially as the industry identified these groups as those most affected by the problem). Although public health submitters pointed out some of the mechanisms by which the food and marketing industries promote unhealthy foods, such as via larger portion sizes, misleading labelling, discounting etc, this did not extend to claims that industry may be deliberately altering food composition or deliberately targeting groups at high risk of obesity (although industry conceded that advertising may reinforce unhealthy behaviours in some).

Thus, a viable explanation for the apparent failure of the public health framing to convince the committee to regulate the food and advertising industries may be that it lacked one of the essential features of an effective public health risk frame, namely, evidence that obesity was knowingly caused by others (deliberate practices used by the food and advertising industries to promote overconsumption). This is a potential area for future research which is discussed further in section 8.8.

Frame resonance

Another concept suggested by Kwan (2009), which may help explain why industry framing was more dominant in the Government’s stance, is the notion of frame resonance. The basic premise of frame resonance is that the more a frame ‘resonates’ with familiar cultural themes or master frames, the more likely it is to be accepted as the natural interpretation of reality (Kwan 2009). Kwan (2009) has suggested that this is because a frame that resonates with a dominant master frame does not pose a challenge to the dominant view (and therefore presumably does not require significant change).
For frame resonance to be a valid explanation for the dominance of the industry frame, one would expect to find, first, an identifiable master frame underpinning the industry framing of obesity, and second, that this master frame resonated with the politicians and Government officials involved in the Inquiry and related areas of food and nutrition policy. Conversely, one might expect that the master frame underpinning the public health framing of obesity was less compelling for the committee (or alternatively, perhaps it was perceived by the committee members or policy makers as threatening in some way).

As noted in Chapter 2, underpinning public health and corporate interests are two very different ethos (Hancock 1998). Dorfman and colleagues (2005) and others (Beauchamp 1976; Baum 2002) have suggested that public health is underpinned by a social justice master frame, while the business sector draws on a competing master frame of market justice. The key values informing these master frames, as suggested by Dorfman and colleagues (2005), are replicated in Table 32.

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<tr>
<th>Table 32: Market justice values compared to social justice values</th>
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<tr>
<td><strong>Market justice</strong></td>
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<tr>
<td>Self-determination and self-discipline</td>
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<tr>
<td>Rugged individualism and self-interest</td>
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<tr>
<td>Benefits based solely on personal effort</td>
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<tr>
<td>Limited obligation to collective good</td>
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<td>Limited government intervention</td>
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<td>Voluntary and moral nature of behaviour</td>
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Dorfman and colleagues (2005), argue that the market justice frame presents the biggest barrier to achieving social justice. These authors are of the view that support for a policy issue will be largely dependent upon whether the target audience can identify with the core values inherent in the master frame, rather than other aspects of a frame, such as the policy details noted in identifying the solutions to the problem.

A brief examination of the values listed in Table 32 suggests that some of these values did underpin the different frames presented by the public health and industry sectors. For instance, industry framing clearly supported limited government intervention (except in the provision of education and information), and hinted at the moral nature of unhealthy behaviour in suggesting that poor attitudes and lack of motivation were drivers of obesogenic lifestyles (generally a ‘market values’ framing). The self-interested nature of industry was also evident in arguments about the ‘non-causes’ of obesity. As well, implicit in the industry’s framing of the causes of the obesity, was the notion that all that was
required (aside from information and education), was self-discipline. The notion of individual responsibility, and in the case of children, parental responsibility, was also inherent throughout the industry submissions.

Submitters from the public health sector in contrast, argued for increased government intervention and suggested that the public as a whole (the collective good) would benefit from addressing the problem at the population level via altering key aspects of the obesogenic environment. That industry framing dominated in the most contested policy areas, which were those most likely to require changes to the obesogenic environment, may then suggest that the ‘market justice’ master frame resonated more with the politicians than the ‘social justice’ master frame. Certainly, it was apparent from the lack of recommendations to address the social determinants of health, that the committee failed to accept the role of social inequalities in the obesity epidemic. However, while frame resonance may be a plausible explanation, a definitive answer would require further research on master frames and their resonance with politicians.

**Summary of explanations offered by framing theory**

It does not appear that either rhetorical skill or the credibility of claimants totally explain the Government’s stance. Rhetorical skill, empirical credibility and the internal logic of the frame also did not appear to offer complete explanations for the Government’s stance in this case. However, it is possible that the rational or emotional devices, in particular the values promoted in a frame, may provide some explanation for the apparent success of the industry frame. It was noted that the industry frame, although dominated by market justice values also invoked social justice values such as fairness and equity (where this was beneficial to industry), while the public health frame was limited to social justice values.

Attribution of blame did appear to be a plausible explanation for the alignment of the Government’s stance with that of industry. That industry framed obesity as a problem for the individual is likely to have been attractive to the Government, as individualised solutions are likely to be less costly, require less effort on behalf of the Government, and not involve opposition from powerful industries.

Another viable explanation for the apparent failure of the public health frame, was that it lacked a critical feature of an effective public health risk frame. This was the lack of evidence of intentional harm (or knowingly created risk) by industry. Finally, frame resonance (with a dominant master frame) may also provide a plausible explanation for a
frame being accepted or rejected. However, there is no way of assessing frame resonance from the data sources used in this case study.

8.4.2 Alternative explanations for the Government’s stance

There are a number of theories or models of interest group influence on the state (Tenbensel & Gauld 2001) which may help to explain why the stance taken by the Government was more aligned to that of industry in this case study. Two of these theoretical explanations are relevant here: pluralism (and neo-pluralism) and neo-Marxism.

Pluralist theory of interest group influence on the state

It is possible that part of the Government’s stance may be explained by the influence of frames used by other interest groups that were excluded from this case study. Under classical pluralism, in recognition of the many varied interests in society, it is argued that no one interest group has a monopoly on power and influence (Heywood 2002). Assuming that this model is accurate, other interest groups involved in the Inquiry would also have had an influence on the Government’s stance. These groups were outlined in Chapter 2. Since these groups were outside the boundaries of this case study, their frames were not documented and therefore their alignment with the Government’s stance was not assessed.

However, a pluralist explanation seems unlikely, as the initial reading of all the submissions revealed, that by far, the majority of the submitters called for regulatory options and opposed industry self-regulation. This was confirmed by White’s (2007) analysis of the submissions and by the committee in its summation of the evidence (Health Committee 2007). This suggests that although the select committee process appears to be open in terms of public participation, the outcome, in terms of the committee recommendations and the Government Response, did not support the concerns of the majority of the submitters.

Neo-Pluralist theory of interest group influence on the state

Modern pluralists however, recognise a power imbalance between interest groups. Neo-pluralists for instance, acknowledge the privileging of business interests in government decision making (Heywood 2002). Lindbolm (1977) has highlighted how the business sector, as a large investor and major employer in society, and as the major provider of financial credit to the government, has considerable influence over the state, regardless of the ideological position of the government of the day.
Industry’s contribution to the economy was also emphasised in the industry submissions, and the fact that the food industry accounts for 50% of the national economy, employs a large section of workforce and accounts for a quarter of the total national sales market was also noted by the committee (Health Committee 2007). Thus, one explanation for the alignment of the Government’s stance with industry interests in the most contested policy areas may be, as suggested by some neo-pluralists, that the Government is to a large extent, dependent upon the contributions to the national economy from the food and advertising industries. If this explanation is valid, then it is likely that it is the economic power base of the frame’s sponsor rather than the frame itself, that accounts for its apparent ‘influence’.

A parallel potential neo-pluralist explanation for the apparent influence of industry framing on the Government’s stance lies in the considerably greater capacity of business groups, given their wealth and human capital resources, to engage in a wider range of interest group strategies such as lobbying. Some of the more formally recognised strategies and tactics adopted by interest groups to influence policy include: direct lobbying of politicians and policy officials; making donations to political parties; networking with policy makers; conducting media campaigns; writing opinion editorials and releasing statements to the media. Less obvious strategies and tactics used by business interest groups have also been documented. In the area of food and nutrition these have included: various covert strategies to silence or discredit critics (Nestle 2001); the creation of grass-roots support though sponsorship of community activities (Simon 2006); industry sponsorship of food and nutrition research (Nestle 2001), co-opting experts (Nestle 2002); lobbying members of scientific committees involved in assessing evidence for international reports (Voisey 2004); and, altering the content of such reports (Cannon 2004).

Some evidence that these strategies were adopted by the food and marketing industries in New Zealand was found in this case study. Experts were ‘co-opted’ by industry groups. For instance, one of the independent advisors to the Inquiry (Professor Mann) was listed by NZ Sugar as an expert on its Sugar Research Advisory Service, and a Professor of Food Technology appeared before the committee as a witness for the FCG (to support industry’s argument that obesity was due to a decline in physical activity rather than an increase in energy consumption). Other examples of tactics adopted by industry in this case study included: commissioning research into the role of advertising in the obesity issue (Harker & Harker 2006); sponsoring research into the relationship between sugar consumption and BMI (Parnell & Wilson et al. 2008); food industry sponsorship and funding of nutrition oriented NGOs (for instance the New Zealand Nutrition Foundation and the New Zealand
Dietetic Association); funding of industry focused research groups (the Foundation for Advertising Research) and numerous examples of cultivating grass roots support via industry sponsorship of community, sporting and school activities. As well, as noted in Chapter 5, there was also evidence that industry employed the services of public relations companies (NZ Sugar), and employed regulatory strategists (Fonterra). This research also revealed that there were extensive networks between the various industry players involved in the Inquiry (as shown in Figure 9 of Chapter 5), in that they had well-established, organised industry associations dedicated to representing their interests, namely, defending self-regulation. This industry activity reflects wider business association activity in New Zealand (Roper 2006).

The food and marketing industry also appeared to be firmly entrenched in the policy making process, having access to policy makers via their membership on the HEHA steering group, and though the formation of the FIG and the Accord agreement with the Government. This level of industry collaboration with Government existed prior to the Inquiry, and appears to have been further strengthened after the Inquiry, with the Government reiterating its commitment to ‘work with’ industry.

However, public health advocacy groups also used a number of strategies to influence food and nutrition policy. Advocates of various NGOs were frequently involved in producing press releases, and appeared in the broadcast media. A number of public meetings and seminars were also advertised and held. One NGO (FOE), commissioned their own analysis of industry and public health submissions after the close of the Inquiry, in an attempt to influence the Government Response. Many NGOs also conducted their own research (for instance the ANA conducted research in to the role of carbonated sugary drinks in obesity). As well, informal corridor conversations revealed that a number of these advocates had met with the Minister of Health, and had directly approached members of the committee in an attempt to exert influence. The public health sector was also represented on the initial HEHA steering group, which means that presumably it had the same level of access to policy makers as did industry in that forum.

Thus, both industry and public health groups had considerable expertise and appeared to be well rehearsed and organised in their advocacy and lobbying efforts and, had access to policy makers. However, a key difference between the industry and public health sectors lies in the economic resources available to these groups to ‘buy’ influence. In other words, although similar strategies and tactics were used by the industry and public health sectors, the strategies adopted by industry may have been more influential because it was better resourced. A critical aspect of this influence, as suggested by the neo-pluralist theory of
interest group influence on the state, is the greater bargaining power available to industry because of its greater significance to the economy.

**Neo-Marxist theory of interest group influence on the state**

Roper (2006) has argued that Marxist theory explains the power of business interests in New Zealand better than pluralism. While under the traditional Marxist model, the state is believed to be essentially a committee for managing the affairs of the capitalist class (Heywood 2003), neo-Marxism suggests that a critical mechanism of influence used by business interests is the ideological control of the masses. Specifically, it is suggested that there exists a system of “ruling ‘hegemonic’ ideas and values which encourage people to pursue the interest of capitalists without overt coercion” (Mulgan 2004: 8).

While sceptics might frown on the idea that capitalists exert influence over social and political life through a system of a ruling hegemony, such a view is not inconsistent with the concepts of master frames and frame resonance. One likely ruling hegemony supporting the interests of the business sector in New Zealand is *neo-liberalism*.

**Neo-liberalism as a ruling hegemony**

Neo-liberalism, due to its assumption of the economic superiority of the market over other forms of state or political control, has been described as a form of market fundamentalism (Heywood, 2002: 2007). The rhetoric of neo-liberal ideology is characterised by a focus on: individual rights, liberties, and responsibilities; reduced state intervention in social and economic life; self-regulation of markets and businesses; and, an overall emphasis on the economic superiority of the market over other forms of state or political control (Heywood 2007). Neo-liberal discourse has at times been very pervasive in the public domain and dominated policy making in New Zealand from the mid 1980’s through to the 1990’s (Kelsey 1993; Easton 1997). Although neo-liberal rhetoric in the public domain appears to have declined somewhat since this time, its views are still espoused by the business sector in New Zealand (Roper 2006). Neo-liberalism, also shares many of the characteristics of the ‘individual behaviour’ frame which dominated the industry framing of obesity.

Examples of neo-liberal rhetoric and its ideological principles were particularly evident in the submissions from industry. There was for instance, unanimous support from industry submitters for self-regulation and limited government intervention, and the rhetoric of consumer choice, level playing fields, and individual responsibility, was used frequently. Potential costs to business of various proposed policies were also emphasised. That the
Government (and to some extent the committee) also supported self-regulation suggests that neo-liberalism may well be a ruling hegemonic ideology which might explain the apparent greater influence of industry’s frame in this case.

Furthermore, neo-liberal ideology pervades other areas of social life relevant to creating master frames. A key avenue for this is the media. Powerful industries, through their advertising expenditure may exert considerable influence over the framing of key issues in the media. Although obesity frames in the media were not explored, a key example of the pervasiveness of the ‘individual behaviour’ framing of obesity (which supports the neo-liberal agenda through its focus on individual responsibility for health) can be found in the rhetoric of almost all of the reality weight-loss programmes screened on prime time television. Examples of such programming were provided to the committee by the major broadcasters (as noted Chapter 5) as voluntary initiatives to address obesity.

When thinking about the problematisation of obesity, the very naming of the problem as ‘obesity’ automatically suggests that obesity, and therefore obese persons, are the problem. This, in itself, can be considered as an example of a neo-liberal framing of the issue. An alternative problematisation of the issue, for instance as an issue of ‘unhealthy food’ would suggest that the problem was the unhealthy food supply. The search for the causes of an unhealthy food supply might require investigations into the mechanisms behind the manufacture, distribution and marketing of unhealthy food. This might then lead to a conclusion that suggests that profit was a key determinant of increased consumption and therefore obesity. It is in this sense that the epidemic in obesity can be seen ultimately as a market success. However, this type of conclusion can not be reached while the issue is framed as the obesity problem.

Thus, the neo-Marxist argument, that a ruling (neo-liberal) hegemony supporting commercial interests acts as a mechanism for ideological influence over political and public life, appears to be another plausible explanation for the greater influence of industry in this case. Such an explanation is even more plausible when one considers the economic significance of the food industry in terms of its enormous contribution to the New Zealand economy.

**Summary of explanations for the Government’s stance**

Potential explanations for the Government’s stance, in particular its alignment with the industry in the majority of the most contested policy areas, have been considered in this section. These included explanations offered by framing theory and relevant theories of
interest group influence on the state. Some of the explanations offered by framing theory offered more plausible explanations than others. These were the explanations offered by the concepts of ‘attribution of blame and responsibility’ and ‘public health risk framing’.

On the matter of the attribution of blame and responsibility, it did appear that industry’s obesity frame may have been more attractive to the Government for the simple reason that it suggests that individuals are responsible and therefore less Government intervention is required. On the issue of ‘public health risk framing’, the absence of evidence of knowingly created risk, may also be a plausible explanation for the apparent ‘failure’ of the public health frame in a number of contested policy areas.

Other key framing concepts that were examined but found to offer little in the way of explaining the Government’s stance in this case, included rhetorical skill and the credibility of claimants. However, the data sources used in this case study were not designed to assess these factors. Frame resonance may also provide a viable explanation for a frame’s influence, although again, the data sources in this case study were not suitable for assessing this.

Relevant theories of interest group influence on the state were also explored. The neo-pluralist explanation suggested that the significance of the food industry to the economy provides it with a bargaining power that is unavailable to public health groups because of their apparent relative insignificance to the economy. Another neo-pluralist argument for the privileging of business interests by the state was the greater capacity of business groups to exert influence through lobbying activities, given their greater wealth and resources. The first neo-pluralist argument seems more plausible than the second, as it was noted that both industry and public health groups were similarly engaged in various strategies to influence – although it was noted that this does not occur on a level playing field. Finally, the neo-Marxist concept of a ruling ideological hegemony was explored. The history of neo-liberal ideology in New Zealand and its pervasiveness in social, public and political life, provides an alternative explanation for the apparent effectiveness of industry framing, and one that compliments the explanation suggested by frame resonance. The concept of a ruling neo-liberal hegemony as an explanation for the influence of the food industry on food and nutrition policy is particularly salient in this case given that in New Zealand the food industry accounts for fifty percent of the economy (Health Committee 2007). These alternative explanations of interest group influence on the state suggest that perhaps it is not the framing of issues that influences policy, but rather the power, both economic and ideological, of the frame’s sponsors, that ultimately influences Government policy.
8.5 Strengths and limitations

This section examines the strengths and limitations of this research. It is presented in two parts. The first of these applies four commonly used criteria for assessing the strengths and limitations of research in general, namely: construct validity; internal validity; external validity; and reliability. The second part explores the case-study specific criteria suggested by Yin (2003) for assessing the strengths and limitations of the case study design. This includes: the significance and completeness of the case study; the consideration of alternative perspectives; and, the demonstration of sufficient evidence.

8.5.1 General research criteria for assessing strengths and limitations

Construct validity

To address the issue of construct validity, it is important to answer the question: does the framing matrix usefully describe frames? The framing matrix used in this study is not original, but based on Bacchi’s (1999) concept of ‘problem representation’, the framing matrix used by Kwan (2007), and informed by useful concepts from framing theory and the actual data used in this case study. As Kwan (2009) used a similar matrix for a similar purpose (to document the food industry and government agency framing of obesity in the US) this provides some precedent of the validity of a similar framing matrix for identifying the signature features of a frame. A similar framing matrix has also successfully been used to document competing framings of other public health issues (Siegel & Lotenberg 2007).

To assess the validity of the framing matrix, a simplified version of the final framing matrix, used in this research was initially tested on the four key obesity frames identified from the literature. This initial version of the matrix was easily applied to the obesity frames and could readily identify their signature features. The final framing matrix was more detailed, due to the depth of the data from the submissions to the Inquiry. This detail allowed additional key aspects of the frames to be documented (particularly from the industry and public health frames) and included prompts to assist with the identification of key themes that emerged from the data.

While there are other features of frames that could have been included in the framing matrix these were not explicitly included in the framing matrix used in this case study. These included metaphors, catch phrases and visual depictions. These features were seldom evident in the data sources used in this case study, although they were mentioned
in the results chapters (Chapters 5-6) where they were found. Some scholars who have examined the framing of issues within social movements also emphasise different aspects of framing as more critical than others (Noakes & Johnston 2005). Although that work did not inform the current study, and this may be construed as a limitation, framing by social movements appears to be different in that it is intended to mobilise sectors of the public rather than influence politicians and government policy. In summary, the matrix used to document the frames evident in this case study was a valid measure for the specific research questions posed and, as it was tailored to the data sources in this case study, it maximised the value of this data.

**Internal validity**

According to Yin (2003) internal validity is only an issue of concern for explanatory studies where causal inferences are being made. This issue is not relevant to the research questions posed in this thesis. The first question was designed to be descriptive and exploratory only. The second question sought to determine which frame was more evident in the Government’s stance, not whether the framing by industry of public health caused the Government’s stance. Nonetheless, the issue of the influence of industry and public health framing on the Government’s stance, and possible explanations for this, was explored in the previous section.

**External validity (generalisability)**

The extent to which the key findings and conclusions reached in this study are generalisable to other contexts is addressed in three parts. These are:

- the generalisability of the industry and public health frames
- the generalisability of the framing matrix
- the generalisibility of the apparent ‘influence’ of framing.

**Generalisability of the frames**

Evidence has been produced in this thesis that suggests that many of the signature features of the frame used by industry may be generalisable to similar food and marketing industries (and potentially other commercial sectors) in other countries. This is particularly relevant to the signature features that drew on the ‘individual behaviour’ framing of obesity. These themes were also noted by Kwan (2009) as characteristic of the framing of obesity by a food industry group in the US. However, it was also evident that unlike the food
industry group in the US, the food industry in New Zealand did not draw on a number of the arguments from the ‘epidemic as a myth’ frame and that this may be due to a number of factors. These factors included the specific context in which the framing occurs, the intended audience of the frame, and wider political and ideological environments in which frames are crafted. This means that the generalisability of the industry frame documented in this study is somewhat limited to the context of the Inquiry and the political situation at the time of the Inquiry. For example, the framing of food and nutrition issues by the food industry may be quite different in a trade forum (such as trade magazines or seminars), in broadcast media, in publications distributed to shareholders, or in private meetings with politicians, compared to its more public stance presented in the forum of the Inquiry. Nonetheless, a similar industry, wishing to influence government policy or public discourse in similar jurisdictions, is likely to frame issues in a similar manner to the ‘individual behaviour’ frame documented in this study, simply because it suggests solutions that do not burden industry (or government).

For instance, the findings from a recent analysis of media framing of the regulation of fast food advertising in the Australian print media revealed similar findings as those reported in this case study:

> The Federal Government, food and advertising industries and free to air broadcasters favour industry self-regulation and personal responsibility for fast food consumption while the proponents of government regulation include consumer groups, state government health ministers, nutrition and public health academics and medical and health foundations (Henderson & Coveney et al. 2009: 1402).

As well, some of the specific claims and arguments made by the food industry in this case study are the same as those documented by Nestle (2002), and Brownell and Battle-Horgen (2004), and Simon (2006) for sectors of the food industry in the US. These included: (i) the claims that there are no ‘good’ or ‘bad’ foods; (ii) the focus on physical activity rather than consumption; and, (iii) the emphasis on individual responsibility. In this respect, there appears to be some universal features of the food industry framing of food and nutrition issues. Some of the arguments put forward by the advertising industry have also been documented elsewhere, for example Brownell and Battle-Horgen (2004: 261) note that the claim *that advertising affects brand share and not consumption* is “an old and tried argument used by many industries, tobacco and food included”.

The framing of obesity by the public health sector may also be generalisable to public health groups outside of New Zealand. However, a specific analysis of the public health
framing of obesity has not been found in the literature, so there is no data providing a basis for comparison internationally. In this respect, this case study appears to be the first research to document a public health framing of obesity. Like the industry frame, the public health frame documented in this case study may differ in other contexts. For instance, a number of authors have suggested that the philosophy underpinning public health itself is contested (Green & Raeburn 1988; Baum 2002). Green and Raeburn (1998) believe that public health is characterised by two ideologically different approaches to population health which they describe as the ‘individual versus the system’. While the public health frame documented here clearly reflects the systemic approach to population health, it is possible that in other contexts where (or if) the philosophy underpinning public health is more individualistic, that the public health framing of obesity might look quite different (presumably it would then be more similar to the individualist frame used by industry). In summary, although some features of the frames documented in this research are generalisable to similar sectors in similar jurisdictions, the extent of this generalisability is likely to be dependent on a number of factors that include: the context; the purpose of the frame and its intended audience; and potentially, the underlying philosophical stance of the frame’s sponsors.

**Generalisability of the framing matrix**

The framing matrix potentially has numerous applications within and outside of policy research. Within policy research, the matrix can be used to assess the framing of policy problems by the various parties in any policy community (including the media), and then applied to official policy documents to assess which frames are accepted or rejected. Outside of the policy research field, the framing matrix could be used as a descriptive tool to describe key features of various theories, for example it could be applied to various perspectives on health or social inequalities. Most significantly, the framing matrix used in this thesis appears to be particularly suited to identifying the interests of various groups, and assessing whose interests are served by particular government policies.

**Generalisability of the apparent ‘influence’ of framing**

One of the key limitations of the findings from this study is to do with the apparent influence of the industry and public health frames on the Government’s stance. It is possible and highly likely that the apparent influence of public health and industry framing would vary according to the ideological leanings of the government of the day. The findings here are, to a large extent, specific to the 2008 Labour-led Government in New Zealand. However, the findings revealed in this case study may provide some insight into likely perspectives
on obesity of governments with similar ideological views. For instance, Lawrence noted that public policy issues in the US faced “political resistance to claims of ‘systemic causation’ and governmental responsibility for solutions (Lawrence 2004: 57).

The MMP environment and party composition on the Health Select Committee is another contextual factor likely to affect the direction of the committee’s recommendations, and therefore the Government’s response. As noted in Chapter 2, the minor parties were proportionally overrepresented on the committee compared to their composition in Parliament. However, it is not clear what effect this may have had on the resulting recommendations. The apparent influence of industry and public health framing on the committee may have been different had the composition of the committee been proportional to their party composition in Parliament.

The findings are also limited to the timeframe in which the Inquiry was conducted. Should the scientific evidence on food, nutrition and obesity issues change substantially (in support of either industry or public health arguments), then the influence of the respective frames may alter. Finally, the issue of alternative explanations also applies here. This research only assessed framing and not other influences on the policy process. In summary, the generalisability of the finding that the Government’s stance was more aligned to industry in most of the contested policy areas, is limited because of the political context and the specific Government at the time of the Inquiry. A postscript at the end of this thesis details the different stance on food and nutrition policy taken by the National-led Government that superseded the Labour-led Government of 2005-2008.

Reliability

As the written data sources in this thesis are publically available though the Parliamentary library, the exercise of documenting the framing of obesity can easily be replicated. As well, the audio recordings are publically available through the Parliamentary library (personal communication, G. Hill, February, 2010). The procedures for identifying the relevant public health and industry submitters were clearly documented in Chapter 4, as was the framing matrix used to identify the signature features and key aspects of the frames. The only aspect of this research that is not replicable, is the direct observations of the Inquiry. Although the direct observations were important for providing context to this case study, it is unlikely that the absence of this source of data would significantly alter the overall findings of this case study.
8.5.2  Case study specific criteria

Yin (2003:160-166) has listed four criteria of features that characterise an *exemplary* case study. These are that the case study:

- must be significant
- must be complete
- must consider alternative perspectives, and
- must display sufficient evidence.

These criteria are discussed below.

Significance

According to Yin (2003) there are a number of features of a case study that make it significant. These are:

- that the case is *unusual* and of *general public interest*
- that in *theoretical, practical or policy* terms, the underlying issues are *nationally important*, or
- both of the above.

This case study clearly meets the above criteria for significance. In the first instance, the *policy topic* of the case study is significant as outlined in Chapter 2. In both practical and philosophical terms, obesity is a topic of considerable public interest. The obesity issue is also of national and international importance, not only because of the potential adverse health, social and economic impacts, but also because it raises fundamental questions over who should influence what and how much we eat – individuals, industry, or the state?

There are a number of *unique* aspects to this research. The use of written and oral submissions to a select committee inquiry to assess framing is, as far as I am aware, original (at least in New Zealand). There has been some research in New Zealand which has included an analysis of some of the *written* submissions from select committee inquiries (Dew 2003; Debski & Buckley *et al.* 2009) and some unpublished research analysing the submissions the Health Select Committee Inquiry into Obesity and Type 2 diabetes (White 2007; White 2008). However, this research has been limited to an analysis of written submissions and none of the research has examined framing or included an analysis of the Government’s response.
The Inquiry also provided a unique situation, in that it is very unusual (in New Zealand and possibly elsewhere) to see public health and food and marketing industry groups presenting their views in the same forum. It is also unusual to have industry and public health groups cross-examined on significant policy issues by members of Parliament. In this sense, the Inquiry presented a rare opportunity to listen, observe, and document the official stances of these two groups.

The documentation of the public health frame, as noted previously, is an original feature of this research. As well, although a food industry frame has been documented elsewhere, this study is unique in that it also included the related advertising and marketing sector.

This case study is also unique in that, by documenting the positions taken by the committee and the Government, it has examined some of the consequences of a select committee inquiry. The analysis from this case study is important in this respect, as it revealed the extent to which industry and public health frames were reflected in the Government’s declared stance on various food and nutrition policies, as well as their alignment with actual food and nutrition policy.

The two sectors scrutinised in this study, industry and public health, are also theoretically significant in that they offer rival explanations of the obesity issue and propose very different solutions. In terms of relevance to assessing the influence of framing, rival explanations of an issue, because they are distinctive, provide clarity. Furthermore, these dichotomous views are not specific to the issue of obesity, but mirror much greater longstanding philosophical dichotomies between the public good and commercial interests, and between the individual and the state. In this respect the findings and issues identified in this research, particularly the tensions between industry and public health are generalisable to other areas of policy where there are similar tensions between business and health, such as alcohol, tobacco and gambling.

Finally, this research also adds a new dimension to the literature on obesity framing, in that it provides an interesting comparison between the key obesity frames identified from the health literature, and with those used by industry and public health groups in the real world situation of the Inquiry. An innovative extension to this was the addition of a ‘structural’ frame frequently invoked to explain health inequalities, which to date had not been applied, in any coherent form, to the issue of obesity and its food and nutrition related determinants.
In summary, this case study more than adequately meets the criteria for significance in that the case was unusual, of general public and national interest, and is significant in theoretical and policy terms.

Completeness

An exemplary case study should also demonstrate that the data collection process was exhaustive and the collection of evidence complete (Yin 2003). As all public hearings were attended in person (and digitally recorded), and, as all of the written submissions were collected and thoroughly read, the evidence upon which this case study rests is, in this respect, complete. It may have been helpful to have an additional observer attend the oral submissions however, as this would allow for more extensive note taking, as it was difficult to take notes and observe at the same time.

However, there were occasions where information was requested of the submitters by members of the committee. No attempt was made to request this extra data from the clerks. This may have been a limitation, although it generally appeared that such data would be kept confidential. For instance, the NHF was asked by the Chair of the committee for examples of the specific criteria used by the NHF to assess whether a food or beverage product would get a Heart Foundation Tick endorsement under the Pick the Tick Programme. It was made clear by the Heart Foundation in their oral submission that this information was confidential, and if given to the committee it should remain as such. Nonetheless, this does not affect the completeness of the data set of the publically available written and oral submissions.

Additional evidence was also (on sixteen occasions) requested by the committee of the Ministry of Health. This data was not obtained, as informal discussions with staff of the Ministry revealed that this data was generally outside the boundaries of this case study (the requests for information were not generally relevant to food and nutrition policy but focused on other areas such as health service provision and diabetes). Additionally, some information useful to the case study could have been obtained under the Official Information Act. For instance, the various drafts of the Government Response could have been obtained to examine which Government agencies altered the response and how. However, although including this data may have shed some light on the reasoning behind the Government's stance, the inclusion of this data would not alter the framing of obesity by the industry and public health groups.
Another source of data that was not examined was the successive versions of the issues papers drafted by the clerks of the committees. These were obtained, but permission to use them was not sought. This was because they would have been complex and time-consuming to analyse, and would involve further discussions and meetings with the clerks to provide the context around the development and editing of these papers. It is also possible that formal minutes of the committee proceedings may be publically available (via the parliamentary library or on request), although this was not investigated.

Considerable care was also taken in researching the background of the submitter groups. As noted in Chapter 4, identifying the funding sources of some of the nutrition oriented NGOs became critical to determine whether these groups represented the public health or industry sectors. Attempts to locate this information via emails, phone calls, internet searches, informal conversations at various gatherings and conferences, required a sustained effort throughout the duration of this research. An example of this was the New Zealand Nutrition Foundation, which appeared, at least to the layperson, to be a health-oriented organisation (as it provided nutritional advice to various sectors around the country). Although there was a hint during the oral submission from the New Zealand Nutrition Foundation that it did not wish to disclose their sources of funding to the committee (their spokesperson mumbled inaudibly when questioned by the Chair), hard evidence of its funding sources was difficult to obtain. This evidence only became available two years after the Inquiry, when it was included in the organisation’s new website.

A complete case study of framing could also have a wider array of data sources. In this case, media coverage, parliamentary speeches, and interviews with relevant stakeholders could have provided further data. This is discussed below under Sufficient evidence. However the focus on this study was the framing of obesity by industry and public health within the forum of the Inquiry, and frames evident within the Government’s formal response.

A complete case study is also, according to Yin (2003), complete because all the data have been collected and analysed, and not because of time or resource constraints or other artifactual conditions. This research was designed to fit the time constraints of a three year full-time PhD course of study, and it was adequately resourced with working expenses to cover the costs of transcribing and other expenses associated with the research. The supervision of this research by the two university supervisors was also uninterrupted and continuous throughout. The research was concluded only when all three parties were satisfied that the case study and its documentation (within the parameters noted above) was complete.
In summary, this case study was complete in terms of its assessment, in the context of the Inquiry, of the framing of obesity by the public health and industry sectors, the committee, and the Government. Although there were other potential sources of data that could have illuminated aspects of the committee procedures and those surrounding the writing of the Government Response, this data was not essential to answering the research questions posed in this thesis.

Consideration of alternative perspectives

An exemplary case study should also consider alternative perspectives. In this case study, alternative perspectives were considered: (i) within the data itself; (ii) in interpretations of the data; and, of relevance specifically to the second research question, (iii) in alternative explanations of the findings. Each of these issues is addressed in turn below.

Variations in perspectives within the data itself were reported in the three results chapters. Every effort was made to identify, in relation to the key aspects of the framing matrix, the range of perspectives across the public health and industry sectors, as well as areas of agreement and disagreement and exceptions to the generalisations. For example, in general, public health submitters agreed that obesity was not a knowledge deficit problem, although a couple of submitters suggested that lack of cooking skills may be a factor contributing to obesity. The various perspectives within the public health sector on the matter of ‘working with industry’ reported in Chapter 6, are another example where attention has been given to the range of perspectives. Areas of agreement and disagreement amongst the various industry submitters were also reported in Chapter 5. For instance, although most industry submitters agreed on the overall causes of and solutions to obesity, there were different perspectives held by individual companies on some of the details. This was evident in the various perspectives held by industry submitters on the contribution of particular types of food (or their constituents such as fat or sugar), to population increases in obesity.

On the issue of alternative interpretations of the data, there were a number of opportunities for this as various drafts were completed and read by the supervisors of this research. As noted in Chapter 4, there are a number of factors which may affect an investigators’ stance. These include the researcher’s academic field, their intellectual bias and the social origins of the researcher (Bourdieu & Wacquant 1992). My particular background and the public health focus of this PhD was outlined in Chapter 4 and it was also noted that I agree with McKinlay and Marceau (2000) that research is not value free or neutral. Although I do not
claim that this research is completely neutral or value free, a number of steps were taken throughout this research to ensure that the data was presented fairly. For instance, various discussions between myself and the supervisors took place to resolve any differences of opinion and perceptions of bias. Subsequent drafts were altered to address perceived investigator bias in interpretation, and to address any perception of selective use of data. This involved using more neutral language to describe the perspectives, and ensuring that the range of perspectives, as well as the exceptions to the generalities were reported. Thus, interpretations of the data were continually cross-checked with supervisors.

Alternative explanations of the findings were also considered in this chapter. It was noted that some of the potential influences on the Government’s stance, other than those suggested by framing theory, included two explanations offered by key theories of interest group influence on the state. These examined a range of influences such as: the potential influence of groups attending the Inquiry that were not examined in this case study (pluralism); the greater significance of industry to the economic and therefore the state (neo-Pluralism); and, the neo-Marxist notion of a ruling (neo-liberal) hegemony as a form of ideological influence over social and political life.

Sufficient evidence

Five sources of evidence were used for this research. These included: (i) the written submissions; (ii) the oral submissions; (iii) direct observations at the Inquiry and informal conversations in the corridors of Parliament; (iv) documentary data on the key submitter groups obtained from their websites and other sources; and, (v) the two official reports. Formal interviews were not used in this case study as the focus was on the framing of obesity in the context of the Inquiry.

Direct observation of the Inquiry provided rich contextual information. Some of this information was obtained by way of informal discussions with some of the key players in the food/nutrition/obesity policy community. This facilitated a more in-depth understanding of the key players, the policy issues and the politics involved at least from a public health perspective. The fact that there was no opportunity for informal conversations with any of the industry submitters to the Inquiry (as noted in Chapter 4 industry submitters did not linger in the corridors of Parliament), may suggest that the some of the background information on submitters obtained from this source may be subject to bias (in the direction of public health). However, information from these informal corridor conversations was validated with the evidence obtained from organisation websites and publications (from both industry and public health groups).
Attendance at the public sessions nonetheless provided a unique opportunity to witness and record the cross-examination of the submitters by members of the committee. This process revealed perspectives on issues, that for some reason or another, were not explicitly noted in the written submissions. A particularly useful example of this was the food industry’s perspective on Traffic Light FOP labelling, where its opposition to this policy option only became apparent upon questioning by the committee (noted in Chapter 5). In this respect, the inclusion in this analysis of the oral submissions to a select committee inquiry, together with the direct observation of the public hearings, provided a greater depth of evidence.

As well as sufficient sources of data, care was also taken in this research to present sufficient evidence. This was most apparent in the results chapters where attempts were made to strike a balance between being comprehensive (so as to describe the range of perspectives), and being selective (in providing the critical but not superfluous information). Efforts were also made to ensure that the perspectives of the industry and public health were presented neutrally. Thus, where critical, the original quotes themselves were presented rather than simply an interpretation of them. Quotes representative of supporting or challenging perspectives on key issues were included where they were found, so that the reader can decide independently whether the interpretations or conclusions provided are warranted. Issues that were not discussed by submitters, the committee or the Government, where such omissions were notable, were also considered in the results chapters and examined earlier in this chapter. Therefore, overall, sufficient sources of data were used in this case study and sufficient evidence was provided.

**Summary of strengths and limitations**

Three of the four criteria for assessing the strengths and limitations of research in general were particularly applicable to this case study. These included: construct validity; external validity; and, reliability. The issue of internal validity was less relevant for this research as the research questions were not intended to be explanatory. On the issue of construct validity, the framing matrix appeared to adequately identify not only the signature features of the frames, but also other important aspects of framing.

On the issue of external validity, some of the features of the frames appeared to be widely generalisable, while other features appeared to be subject to limitations of context, audience and purpose. On the matter of the findings regarding the Government’s stance, these may have some limitations of generalisability (to the Labour-led Government of 2005-
2008, the political context at the time of the Inquiry) although, it was noted that the findings from this case study may be relevant to an ideologically similar government in similar jurisdictions and there is some evidence to support his assertion (Henderson et al. 2009; Lawrence 2004). It was also noted that framing matrix itself appears to be useful for a wide range of applications in policy research and particularly suited to identifying the interests of various groups and the interests served by Government policies.

On the issue of reliability, with the exception of the direct observations of the Inquiry, the key sources of data from this case study are publically available. Furthermore, enough detail has been provided in Chapter 4 for this study, or its methodology, to be replicated.

Also examined were the case-study specific criteria of: significance; completeness; consideration of alternative perspectives; and, sufficient evidence. This case study met the criteria for significance in that the case was unusual, of general public and national interest, and was important in theoretical and policy terms. It was also complete in terms of using the publically available data from the Inquiry to assess the framing of obesity by the public health and industry sectors, the committee and the Government. Alternative interpretations of the data and the key findings were also explored, and sufficient sources of data and sufficient evidence were presented to illustrate the various obesity frames. In conclusion, this case study appears to meet Yin’s (2003) criteria for an exemplary case study, and in terms of meeting the general research criteria, although there were a few limitations, overall, the strengths were considerable.

8.6 Implications for policy and public health advocacy

This section considers the policy and public health advocacy implications of the key findings from this case study, bearing in mind that there are numerous potential influences on the stance taken by the Government that were not explored in this research.

Although the key findings from this study have been summarised throughout this chapter, the most significant of these were that:

- there were stark contrasts in the way the public health and industry sectors framed obesity – there were literally two world views with industry adopting an individualising frame and public health adopting a systemic frame
- in the majority of the most contested policy solutions to obesity (the overall HEHA strategy and the regulation of the food and marketing industries), the Government’s stance was aligned with industry interests
in the policy area of ‘school environments’ the Government’s stance was aligned with the interests of public health.

The policy implications of these key findings considered in this section include: (i) the implications of the two world views underpinning the public health and industry frames; (ii) the implications of framing as a strategy for public health advocacy; (iii) the potential significance of the power of the frame’s sponsor in influencing policy; and, (iv) implications for public health advocacy in the select committee process.

Implications of the two ‘world views’

Perhaps the most striking finding of this research was how very differently the two sectors framed the issue of obesity. Although there were some minor similarities between the industry and public health frames, overall there were key differences in the framing of obesity on all three signature features. It is not immediately apparent whether policy makers are aware of the extent of this difference, or of the extent and scale of the efforts and resources put into the framing of the obesity issue by these two key interest groups.

The most crucial public health implication of these competing obesity frames lies in the extent to which either of these frames are accepted, adopted, internalised, or institutionalised by a range of groups. In particular these groups include: politicians; bureaucrats in state agencies; the media; the public; various interest groups (medical and insurance industries and the weight-loss industry); and, individuals directly affected by obesity.

The individualising nature of the obesity frame sponsored by industry has a number of potential effects. Since it places the responsibility for addressing the issue with the individual concerned, if accepted by politicians and translated into policy, obesity promoting aspects of the environment are likely to remain unchallenged. This seems to have occurred in this case, and was evident in the alignment of the Government’s stance with that of industry in the majority of the most contested policy areas. While there was some concession made by the Government to public health interests in the area of school environments (and these policy changes, if implemented, may provide some protection to children from commercial pressures and the availability of unhealthy food in schools), overall, food and nutrition policy in New Zealand (at the time of the Inquiry) was dominated by industry interests. As a consequence, key features of the obesogenic environment remain. Unhealthy food is still ubiquitous, its composition is unregulated, and the rules relating to its availability and marketing are minimal. As well, the low cost of EDNP food
and the comparatively high cost of healthy food means that adhering to the national dietary guidelines is likely to be an unaffordable reality for many families.

Furthermore, if the individualising obesity frame sponsored by industry dominates the public discourse, or the discourse of particular groups (such as providers of medical and health care), it is likely to result in increased weight-based stigma and discrimination. As noted in Chapter 3, there is evidence (from the US) that weight-based discrimination in social and economic life has increased, and that this is largely driven by the dominance of the ‘individual behaviour’ frame in the public discourse (Andreyeva & Puhl et al. 2008). Also, if this framing of obesity is accepted by health insurers, there are likely to be consequences in terms of increased insurance premiums or reduced cover for obesity-related conditions.

The implications of an individualising obesity frame for overweight and obese individuals are also important to consider. Recent research has revealed that overweight individuals do in fact largely adhere to an individualising frame of obesity, at least in their identification of the causes of and solutions to obesity (Greener & Douglas et al. 2010). This research revealed that overweight individuals did not view the problem of obesity as arising from social, political and environmental factors, but rather from personal failure (lack of motivation and will-power in particular). This means that there may be scope for building support from those directly affected by obesity for public policy to address the obesogenic environment, although this would require a shift in understanding of the determinants of obesity amongst such groups.

On the other hand, it is important to remember which groups benefit from the dominance of the ‘individual behaviour’ frame. It benefits not only the food industry (since it shifts the blame away from food) but also the weight-loss industry (Andreyeva & Puhl et al. 2008). In this respect these two industries are likely allies. This is supported by recent partnerships between the weight-loss and food industries reported in the media. For instance, in 2008, the American weight loss company Jenny Craig was purchased by Swiss chocolate manufacturer Nestlé (Sorkin 2006, June 19; Patel 2007), and more recently McDonalds announced a ‘partnership’ with Weight Watchers involving its endorsement of selected McDonalds products (McDonalds 2010). Unilever, is another large food company with links to the weight-loss industry through its ownership of Slimfast (Patel 2007).

There are also potential benefits to the state if the public internalise the ‘individual behaviour’ framing of obesity and take responsibility for their weight and health. In this manner, the ‘individual behaviour’ frame can serve as an ideology supportive of individual
self-regulation, as it cultivates “self-governing subjects who take an entrepreneurial approach to the management of their health and well-being” (Glasgow 2005: 32). In this sense, the ‘individual behaviour’ frame can operate, without direct state intervention or cost, as an ideological form of government of the people – in effect, a ruling hegemony. While it is not undesirable for individuals to take some responsibility for their weight and health, and indeed this would reduce the need for state intervention to address obesity, at some point if individuals fail to self-regulate (and the evidence so far suggests that they are failing in significant numbers), then ultimately the Government will be liable for the future health consequences and their associated costs (assuming the public health system remains intact).

It seems clear that while individualised solutions to the problem of obesity may work for a minority of the population (especially those higher up the social hierarchy) they are inadequate for the majority of the population. Given the scale of the obesity problem, a universal approach to addressing obesogenic aspects of the environment is clearly indicated. This approach needs to address key features of the obesogenic environment and the underlying causes of social inequalities. Many policy prescriptions for addressing the obesogenic environment were outlined by submitters from the public health sector. Policies to address the causes of social inequalities also need to be considered, and although some broad policy options to reduce inequalities were provided by some of the submitters from the public health sector, a comprehensive programme of policy options for New Zealand has not yet been developed.

It is also important to consider the potential effects of the systemic framings of obesity offered by the ‘obesogenic environment’ or the ‘structural’ frames should they come to dominate the policy or public discourses. In the policy domain, the adoption of these frames would translate into regulatory changes to the price of food, its composition, marketing and availability. The adoption of a structural understanding of the determinants of health would indicate changes to the overall tax system to redistribute income, and policies to address the power imbalances underlying ethnic and other social inequalities, particularly those that address racism and discrimination. A structural frame also indicates or encourages policies to increase political participation in policy making and the participation of disadvantaged groups in the health and social sectors.

Furthermore, if the systemic obesity frames were to dominate the public discourse, individuals directly affected by obesity would be held less accountable. This is likely to lead to a reduction in weight-based stigma and discrimination, which would remove one of the barriers to accessing health care for those who are overweight or obese. The obesogenic
environment frame, may also, if adopted in the public domain, lead to greater demand by consumers for industry to be held accountable for the health harms caused by its products and marketing practises.

Additionally, a successful ‘structural’ framing may lead to public support and therefore political pressure for policy changes to deal with structural causes (inequalities) of obesity. In the study by Greener and colleagues (2010) many of the overweight individuals did in fact cite material constraints as barriers to achieving a healthy weight, such as the cost of leisure facilities, healthy foods and transport (Greener & Douglas et al. 2010). The fear of physical violence and crime was also noted to present a barrier to physical activity in that it prevented them from leaving home after dark (Greener & Douglas et al. 2010). Yet, these individuals still attributed their overweight status to their own personal failure. In other words, despite acknowledgement of structural constraints to achieving a healthy weight, these groups appeared to have internalised the dominant individual obesity frame. Such groups would benefit from a shift away from the dominant individual behaviour discourse as it would alleviate the sense of personal failure felt by these groups and reduce weight-based stigma and discrimination. This, in turn, might lead to greater public support for addressing the structural determinants of health and wellbeing.

If policy makers are to successfully address the issue of obesity and reduce its prevalence, they face the task of either choosing between the various policy options supported by the key interest groups in the area of food and nutrition policy, or somehow reconciling the differences between the key interest groups. This latter option appears to be a challenge, given that underlying the two opposing frames are two disparate worldviews. These worldviews reflect wider tensions between the interests of the commercial sector and those of public health. It also reflects tensions between the apparent short term needs of industry, and the longer terms needs of the state for a robust economy and healthy workforce (although specific governments in New Zealand as we know appear to make plans in the three year term of the election cycle).

The implications of framing as a strategy for public health advocacy

Given that the two frames have dramatically different implications for the health of the population, it seems reasonable to recommend that public health advocates work strategically to get the ‘obesogenic environment’ and ‘structural’ frames into the public discourse, adopted by policy makers and translated into action. Yet, as this case study has shown, public health advocates dedicated considerable time and effort to the framing of the obesity problem, and the public health frame was not accepted by the Government (in the
majority of the most contested policy areas). This appeared to be due to a number of factors.

In particular, it was concluded that rhetorical skill (evidence and logic) and the credibility of claimants, did not appear to offer a complete explanation for the alignment of the Government’s stance with industry interests. However, one aspect of rhetorical skill – the values inherent in a frame – may play a part in the acceptability of a particular frame to government officials and politicians. This suggests that an effective frame may need to appeal to the values held by politicians with the power to determine policy. If the values of the intended audience are critical, and (Dorfman & Wallack et al. 2005) have suggested that they are, then it would be useful to know the values of those making policy and reframe the issue accordingly. If for instance, politicians were found to support principles of ‘market justice’ this would suggest that a reframing of the obesity issue in ‘market justice’ or neo-liberal terms may be useful. This might include for example, a greater focus on losses in economic productivity due to obesity. Reduced consumer choice (lack of availability of healthy food options), could also be a focus.

The issue of attribution of blame, in particular whether a problem is framed in individualising or systemic terms, was also suggested as a plausible explanation for the Government’s stance. This explanation suggests that the appeal of the individualising frame is greater for a government because it requires less government responsibility, and therefore less need for government action. One possible way of addressing this issue is to place more emphasis on the universal nature of the obesogenic environment and its impact on individual dietary patterns. The role of factors other than knowledge and education in dietary patterns should be highlighted. This might include an emphasis on factors such as the palatability of unhealthy foods – a determinant of dietary patterns noted by both the industry and public health sector in their submissions. The impact of time constraints (due to work-life imbalances) on diet and food preparation practises – another factor recognised by industry and public health submitters as influencing dietary patterns – is another almost universal feature of contemporary life that could be emphasised.

This brings us to the issue of the prerequisites for an effective public health risk frame. These include the need to frame the obesity issue in terms of: involuntary; universal; environmental; and, knowingly created risks. In this respect, while the public health sector framed obesity as an environmental and a universal risk and, as an involuntary risk, it lacked arguments and evidence that the risks for obesity were ‘knowingly or intentionally created by others’ (Lawrence 2004: 59). To address this issue, it may be particularly useful for public health advocates to reframe the issue drawing on evidence of ‘knowingly created
risk’. This would involve further research into food industry and marketing activity. This issue is discussed further under research implications.

The concept of ‘frame resonance’ may also offer a plausible explanation for the uptake of a particular frame by policy makers. If this is the case, a more effective public health frame might require a reframing of the obesity issue to align with a dominant master frame. This however, would involve further research in to master frames and, as noted above, potentially, research designed to assess the resonance of these master frames (or their inherent values), with policy makers.

However, it is not entirely clear that addressing these framing ‘defects’ will lead to public health oriented food and nutrition policy, given the other mechanisms available to industry through which it can exert influence. These were noted under the relevant theories of interest group influence on the state. These theories suggested that it may be the power behind the frame’s sponsors that influenced the Government’s stance on food and nutrition policy. The implications of this explanation are considered next.

The significance of the power of the frame’s sponsor

It was noted earlier (section 8.4.2) that while a pluralist theory of interest group influence on the state was an unlikely explanation for the Government’s stance (given that the majority of submitters to the Inquiry called for legislation and regulation of the food and marketing industries), a neo-pluralist explanation was plausible. This explanation suggested that business interests are privileged in government decision-making largely because of business’s greater significance to the economy. While both public health and industry groups were found to be engaged in similar strategies to influence policy, it was noted that this was not on a level playing field, because business groups have a larger economic base from which to fund their lobbying activities.

The neo-Marxist theory of interest group influence on the state also offered a viable explanation for the greater influence of business interests in government decision-making. This suggested that there exists a system of “ruling ‘hegemonic’ ideas and values which encourage people to pursue the interest of capitalists without overt coercion” (Mulgan 2004: 8). It was noted that one such ideology operating to serve business interests in New Zealand was neo-liberalism. Key features of neo-liberalism, were evident in the rhetoric used by industry, and the neo-liberal preference for self-regulation was reflected in both the industry’s submissions and some of the committee’s recommendations. It was also noted
that neo-liberal ideology has pervaded other areas of social life, particularly though the media, and is consistent with the ‘individual behaviour’ framing of obesity.

The implications of these alternative explanations lie in the extent to which they may account for the alignment of the Government’s stance with industry interests. If these explanations are more valid than those offered by framing theory, then this would suggest that the reframing of an issue may be a less useful strategy than addressing the issue of the power of business groups and the unlevel playing field this creates, and addressing the issue of a ruling hegemony of neo-liberalism. This raises the questions of how do we level the playing field and how do we address the pervasiveness of neo-liberalism? There are no easy answers to these questions.

While the issue of the economic power of business groups is difficult to address, dominant ideologies can be challenged in a number of ways. Public health advocates can make sure alternative perspectives are well-articulated and presented wherever possible through forums such as public inquiries, in policy circles, though the media and in public discourse. The myths of neo-liberalism can also be exposed, and so to can the interests that it serves. The challenge is for public health advocates to realise the importance of opposing ideologies, and the barriers presented to furthering the public health agenda. Only then can strategies to challenge opposing ideologies be fully investigated and their impact evaluated.

Although a reframing of the obesity issue has already been considered as one option for getting more effective public health policy on the Government’s agenda, another strategy that may be particularly useful, is a complete re-problematisation of the obesity issue – not just better framing but a whole rethink of the problem. For instance, rather than viewing obesity as the problem, which as noted previously appears to be a neo-liberal framing of the issue because it implies obese persons are the problem, one could re-problematise the issue as one of ‘unhealthy food’.

A focus on unhealthy food makes sense in light of the fact that poor nutrition is linked to numerous non-communicable diseases (World Health Organization 2002; World Health Organization 2003; World Cancer Research Fund & American Institute for Cancer Research 2007). Such a problematisation would shift the focus off obesity (and the distracting debate about the relative contribution of consumption and physical activity), and on to the food and food-related industries. Factors related to the manufacture of food, the sourcing of key ingredients, international trade agreements, and the marketing and distribution of food, would be important to examine in this respect.
Another potential re-problematisation might suggest that the ‘problem’ is the ‘high cost of healthy food’. Although public health submitters made a number of suggestions for addressing the high cost of healthy food, such as food taxation or food vouchers for those on low incomes, such policies do not address the determinants of the high cost of healthy food. If the real problem is the high cost of healthy food, then the factors that determine food price need to be understood. These might include: international trade agreements; agricultural subsides (or lack of); profit margins on different foods from the manufacturers though to the retailers; fuel costs; the impacts of climate change on weather patterns; and so on. Knowing which of these determinants of food price are key, and which ones are potentially modifiable at the national level, might indicate where policy makers could intervene. Further research in this area is clearly indicated.

An alternative re-problematisation of the obesity issue would be to place inadequate income or income inequality within a population at the centre of the ‘problem’. Solutions to the problem of income inequality could include the implementation of progressive taxation polices to redistribute income and various taxes on wealth (for instance, death duties and property taxes). However, such policies would require a political will that has been weak in recent New Zealand governments. Inspiring amongst politicians the political will to address income and other social inequalities is a challenging task, but one that is critical for addressing health inequalities. In this respect, the evidence that, on a whole range of health and social outcomes, the health of the population is better in countries with the least income inequality (Wilkinson & Pickett 2009), might assist public health advocates to persuade politicians to seek policies that promote greater equality. The evidence that more equal societies produce better outcomes for all, may also be useful for helping public health advocates build public support for more equitable policies.

Implications for advocacy in the select committee process

There are also some implications from this case study that are relevant for public health advocacy in the select committee process itself. From the point of view of the citizenry of New Zealand, the select committee process provides an opportunity for members of the public to communicate their views to Parliament and to participate in the decision-making process of government. However, it appears from this case study, that while to a great extent there was participation in the Inquiry by a number of groups and members of the public, this did not result in an outcome that reflected the majority of views put to the committee. For example, the vast majority of submitters to the Inquiry called for regulation of the food and advertising industries. Although the committee took this consideration on
board (in terms of its recommendation that Government restrict broadcast advertising to children), the Government did not agree. This raises questions about the real function of the select committee process in New Zealand. In this case, rather than being a mechanism for greater democracy, the select committee process may have diffused and diverted health sector concerns away from the real sources of decision-making. While effort in public forums such as select committee inquiries may be essential, work on building public support for change, and on exerting influence on more powerful levels of government (e.g., party caucuses, Cabinet) may be also be crucial.

Another important aspect of the select committee process worth noting is the fact that subject select committees in New Zealand only have the power to ‘send for papers or persons’ on application to the Speaker of the House. This means that there is a power imbalance between the information available from the state sector (which can be obtained with relative ease under the Official Information Act) and that obtainable from the private sector. For this reason, it would be useful to advocate for the strengthening of the powers of subject select committees to obtain relevant information from the private sector on request by the chair of the committee. For instance, the chair of the Australian Competition and Consumer Commission has wide-ranging powers to obtain from the private sector, information, documents or evidence relevant to its inquiries (Australian Competition and Consumer Commission 2008). In the interim, public health advocates could in the future, at the very least, ask the committee to request relevant information from the industry (for instance on marketing strategies and target audiences and sales trends of particular food products).

8.7 Research implications

This section considers some key areas for future research. This includes: (i) further research on framing and its effects; (ii) research into food and marketing industry activity; (iii) research on the determinants of food price and food supply issues; (iv) research on other influences on policy making (including interest group activity); and, (v) research on policy options to reduce social inequalities.

Framing research

One of the potential explanations for the apparent effectiveness of a frame explored earlier in this chapter (section 8.4), was frame resonance. It would be useful to explore this concept further. This would require identifying and documenting master frames prevalent in wider society and the alignment of these frames with various interest groups and politicians.
in particular. As well, assessing the resonance of particular frames amongst politicians could be useful. This could readily be assessed through: interviews; public record of speeches; parliamentary records; and, media interviews. Master frames could be identified through an analysis of various media (newsprint, radio and television) and other materials (academic literature, popular literature, trade journals and publications). Given the findings in this study in relation to the potential influence of neo-liberalism, a thorough examination of the prevalence and promulgation of a neo-liberal frame across all forms of media is also warranted. This should also include an investigation into the prevalence of frames that challenge the neo-liberal discourse.

Other concepts from framing theory that were not adequately examined in this case study included rhetorical skill and the credibility of claimants. For instance, some recent work by Hoek (2009), used a ‘logical analysis framework’ to identify various rhetorical strategies used by various interest groups. This framework could be used in conjunction with a framing matrix to assess the contribution of rhetorical skill to a frame’s effectiveness. Future framing research could also further investigate the concept of credibility. This could involve interviews with decision-makers in government to identify their perspectives on the relative credibility of different groups in the policy community in New Zealand and elsewhere. This research might also involve an assessment of how corporate ‘social responsibility’ actions contribute to the credibility of particular industries and what credibility means to different groups (McDaniel & Malone 2009).

Research on the food and marketing industries

If evidence of *knowingly created risk* is important to effective public health framing (as it was in the case of tobacco), then further research to investigate the extent to which the food and marketing industries are engaged in activities known to contribute to obesity may be particularly useful for convincing Government to hold industry accountable for their actions. The problem lies in locating this type of evidence, as it would likely require access to documents and information that are not in the public domain. One possible source of information is via interviews with former food industry employees. Another source can be found amongst the court-released tobacco files which have been found to contain internal food industry documents, due to the ownership of Kraft Foods by Philipp Morris Tobacco (Bond & Daube *et al.* 2009).

For instance, a recent exposé of food industry activity in the US (by the former head of the Federal Drug Administration) drawing on interviews with former food industry representatives, revealed that the food industry was engaged in the deliberate
manipulation of the fat, sugar and salt content of foods (and other sensory properties of food) to produce optimum palatability and promote increased consumption (Kessler 2009). Similarly, in the area of marketing, and drawing on interviews with former marketing representatives, Schor (2004) exposed the nature and extent of marketing strategies targeted to children (although not specific to food), and the deliberate targeting of unhealthy food by elements of the food industry to specific ethnic minorities in the US.

Evidence of industry engagement in deceptive or harmful practises would also constitute a direct attack on the credibility of the industry and its claims of social responsibility. As noted in Chapter 6, this situation occurred during the hearing of evidence in the UK House of Commons inquiry into obesity, where the advertising industry was found to have deliberately undermined parental control of children’s diets by promoting heavy consumption of energy-dense products to young children despite telling the committee otherwise. This deception appears to have damaged the credibility of the industry in the eyes of the UK committee, and may be one of the reasons why the committee was successful in obtaining Government agreement to regulate broadcast advertising to children.

Another important area where further research is needed, is into the links between researchers and industry (Nestle 2001). Evidence of such conflicts of interests are likely to further undermine the credibility of industry and industry ‘evidence’. A recent examination of the association between authors’ published positions on use of the fat substitute olestra, and their financial relationships with the food and beverage industry, revealed for instance, that the opinions of authors affiliated with industry were more supportive of the use of olestra than authors with no industry affiliations (Levine & Gussow et al. 2003). A further area of research might also examine the emerging partnerships between the food and weight-loss industries, and the consequences of these partnership in terms their contribution to increased sales of unhealthy food and public perceptions of healthy and unhealthy foods.

Research on the determinants of food price

Given that the price differential between healthy and unhealthy food was identified by the public health sector as a critical influence on dietary patterns, particularly amongst those on low incomes, it is important to conduct research into the determinants of food price. Such research could inform policy options for improving the dietary patterns of those on low incomes and the population in general. At the international level, this may involve the examination of trade agreements, national subsidies, regulations and fuel costs. At the
national level, it might require an investigation into retailer and manufacturer pricing strategies, profit margins, and food production and distribution costs. For instance, the recent Australian Competition and Consumer Commission inquiry into the competitiveness of retail prices for standard groceries (Australian Competition and Consumer Commission 2008) examined some of the factors contributing to recent increases in food prices in Australia, although this did not specifically examine determinants of the high cost of healthy food. Understanding factors influencing the price of healthy food may open up a whole new area of policy options for addressing the problem of the price differential between healthy and unhealthy food.

Research into other influences on policy making

There are a wide range of potential influences that may explain the position taken by a government on particular policies, and these are worthwhile areas for further investigation. In the area of food and nutrition policy, interviewing bureaucrats and politicians would be particularly useful for understanding such influences. For instance, interviews with policy makers in the public sector could provide useful information on individual policy maker perspectives, lobbying and advocacy efforts of interest groups, social networks in the policy community, institutional factors and the relevant ‘cultures’ of key departments (the Ministry of Health, NZFSA, FSANZ, and Treasury). Interviews with politicians (and ex-politicians) would also be useful for obtaining information on various aspects of lobbying activity, social and business networks between politicians and various interests, and political party donations. Access to government documents, where necessary though Official Information Act requests, may also help reveal patterns of influence.

Research on policy options to address social inequalities

Surprisingly few policy options to reduce social inequalities were outlined by the public health sector. As noted in Chapter 3, while it is generally accepted that wider determinants of health include income, there are numerous other avenues which produce unequal opportunities and outcomes in social, economic, and political life. These include those in the education, housing and employment sectors as well as social and political participation. Other critical mechanisms for maintaining and reproducing social inequalities include racism, sexism and classism. These areas need to be examined for their contribution to causing and maintaining existing social inequalities. Further research in this area would be useful in this respect, and may led to a better programme of policy options for reducing disparities. This in turn, could provide the public health sector with specific strategies for action to reduce inequalities, which if implemented, could have wide-ranging positive public
health benefits not just for obesity, but also other health outcomes. Some policy options for addressing inequalities that may be useful for informing a programme of options to address inequalities in New Zealand, were outlined in two recent UK reports: *Fair society, healthy lives: The Marmot review* (Marmot & Atkinson et al. 2010); and, *An anatomy of economic inequality in the UK* (Hills & Brewer et al. 2010).

### 8.8 Conclusion

The epidemic of obesity remains a critical public health issue. Obesity alone directly affects over 900,000 New Zealand adults and its unequal distribution in the population mirrors existing social inequalities and is likely to exacerbate them. As well, obesity is very costly to the country, economically and socially.

This thesis was informed by a public health stance that food and nutrition policy is an area worthy of investigation, because of its potential influence on dietary patterns and because of the role of current dietary patterns in the obesity epidemic. The food industry, because it decides what food will be most profitable to it, and the advertising industry, because it profits from the marketing of food, play key roles in influencing the dietary patterns of the population, and thus obesity.

It was suggested that the *framing* of such a public health issue by key groups within the food and nutrition policy arena may have a significant impact on food and nutrition policy. As noted by McKinlay and Marceau (2000: 51):

> If certain interest groups and individuals in society are able to socially pattern the health of the population, shape the scope of debate on health problems, and even determine the nature of government responses to them (social policy), then learning the approach of such groups is an essential component of public health.

This thesis used framing as a mechanism for investigating and documenting the approaches of industry and public health groups in their attempts to influence food and nutrition policy in New Zealand. Using a case study approach outlined by Yin (2003), this research used the forum of the 2006-2007 Health Select Committee Inquiry into Obesity and Type 2 Diabetes as the context from which to examine the framing of obesity by submitters from the food and marketing industries and the public health sector. The specific research questions posed at the beginning of this thesis were:

- How do industry and public health groups frame the issue of obesity?
• To what extent are these frames evident in the New Zealand Government’s declared stance on food and nutrition policies?

The key findings relevant to the first research question, revealed stark contrasts in the way that the industry and public health sectors framed obesity. While public health submitters maximised the significance and scale of the obesity issue in its ‘epidemic’ framing of the problem, industry downplayed its significance and scale when it framed obesity as a ‘concern’. Overall, the industry predominantly drew on the ‘individual behaviour’ obesity frame, and drew on some of the arguments from the ‘epidemic as a myth’ frame, while the public health sector drew on features of the ‘structural’ and the ‘obesogenic environment’ frames.

Thus, industry blamed individuals for obesity and public health submitters blamed the environment – particularly the food industry. These distinct problem representations and causal arguments led to the proposal by industry that education offered the best solution to the problem of ‘obesogenic lifestyles’ amongst ‘affected groups’, and the proposal by public health that legislation and regulation of the food and marketing industry was required to address the problem of the ‘obesogenic environment’. The difference between these two frames reflects core ideological differences between public health and business interests.

The key finding relevant to the second research question, which sought to determine the extent to which the industry and public health frames were evident in the Government’s stance on food and nutrition policy was that, on the matter of solutions to the obesity epidemic, which were argued to be the most significant aspect of framing, the Government’s stance was aligned with the interests of industry in the majority of the most contested policy areas. The key implication of this was that food and nutrition policy in New Zealand, at the time of the Inquiry, was dominated by industry interests.

A number of explanations for the Government’s stance were considered. These included key concepts from framing theory and relevant theories of interest group influence on the state. The evaluation of these explanations suggested that either, the industry frame was more effective than that of public health (in the majority of the most contested policy areas), or, that the alignment of the Government’s stance with that of industry was due to the greater power of the food industry. In conclusion, it would appear that while framing may be an important part of the rhetorical landscape on which policy is formed, a critical factor to consider in any assessment of the relative effectiveness of a given frame, is the power, whether economic or ideological, of the frame’s sponsor.
The implications of this are twofold. First, although framing may still be an important tool for public health advocacy, the issue of the power of the frame’s sponsor also needs to be addressed. A number of suggestions were outlined to address potential ‘deficits’ in the public health frame that may have reduced its efficacy (such as aligning the public health frame with the values of the decision-makers, focusing more on the universal causes of obesity, or providing evidence of knowingly created risk). However, it appears on balance that the power of framing as a form of political influence on policy has been overstated, and this is because the power of the frame’s sponsor, in both economic and ideological terms, appears to have been overlooked.

A number of suggestions for addressing the power imbalance between public health and industry sector were outlined. These included various re-problematisations of the issue, and a number of methods for challenging the dominance of neo-liberalism in public and political discourse.

Looking further underneath the findings, a crucial aspect further revealed by the analysis of framing in this case study concerns whose interests were served by food and nutrition policies in New Zealand. The activity leading to the obesity epidemic has clear benefits for the food and marketing industries. Obesity in New Zealand is ultimately a symptom of an insufficiently regulated market, in economic jargon, a ‘market failure’. That is, in the short and medium term, more people consuming more, means more profits for the industry, but significant and increasing costs for the rest of society. Reversing the obesity epidemic may therefore result in substantial financial losses for the food industry. To expect that the food industry will voluntarily engage in activities that potentially threaten their bottom line, seems untenable.

Because of this, it is essential that the regulation of the food and marketing industries gets higher up the policy agenda and translated into action. The cost of healthy food remains a significant determinant of dietary patterns and this needs to be addressed. This issue of food cost can either be addressed directly (although this might require further research into the influences on food price), or indirectly by addressing the issue of income inequality. The latter option, although it will require a comprehensive programme of policy options and political will amongst decision-makers, promises wide-ranging and long-standing benefits for the health of the population. In the absence of any regulation of the food and advertising industries, or policies to address social inequalities in relation to obesity, the obesity epidemic may worsen and the present inequalities in obesity may exacerbate inequalities in a range of health outcomes. This will result in significant social and health costs for individuals affected by obesity, their families and society. While advocates of
public health may recognise that obesity, particularly wide-scale obesity, is not in itself a ‘personal problem’, the challenge remains to convince the decision-makers that obesity is in fact a public problem requiring a public response.

Postscript

It was noted in Chapter 1, that the Labour-led Government of 2005-2008 was superseded by the National-led Government in the election of 2008. The views of the four National Party MPs on the Health Select Committee relevant to the issues of obesity, food and nutrition related policies were described under the minority view in Chapter 7.

Shortly after the 2008 election a number of changes to the overall national obesity strategy were made. This first of these, was a change to the National Administration Guidelines for schools. This involved the removal of the requirement for schools to promote (and sell) only healthy food in schools. This is consistent with the minority view evident from the Inquiry and consistent with the minority committee’s omission of children as a vulnerable group in its framing of ‘those affected’ by the obesity issue. The second change, was a shift of emphasis in the national obesity strategy from a focus on both physical activity and nutrition, to a strategic focus on physical activity. This is consistent with the industry emphasis on physical activity as the dominant cause of obesity. Other changes included: OAC not having its funding contract with the Ministry of Health renewed resulting in its demise (this was one of the ‘problematic’ NGOs explicitly identified by industry); and, the disbanding of the FIG (and along with it the Accord agreement with Government).
References


Friel S. and Broom D. (2007). "Unequal society, unhealthy weight: The social distribution of obesity" In J. Dixon and D. Broom (Eds.) The seven deadly sins of obesity: How the
modern world is making us fat. New South Wales: University of New South Wales Press.


Robson B. (2004). *Economic determinants of Māori health and disparities: A review for Te Rōpū Tohuohu i te Hauora Tūmatarui (Public Health Advisory Committee of the National Health Committee).* Wellington: Wellington School of Medicine and Health Sciences, University of Otago.


Voisey K. (2004). The trouble with sugar. United Kingdom, Panorama, BBC.


Appendices
Appendix A: List of written submissions used in this thesis

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Appendix B: List of transcripts referenced in this thesis

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Appendix C: Key food and nutrition policy-related actions identified under the HEHA strategy

Regulation

• Continue to monitor international regulatory and policy options for the nutrition and physical activity environment (Ministry of Health)

• Progress public health legislation that includes provision for influencing the social and physical environments in relation to non-communicable disease (Ministry of Health)

• Public health principles are considered in review of existing and development of new food related legislation (NZFSA and FSANZ).

Marketing

• Investigate and analyse policy options regarding the advertising of food to children (Ministry of Health)

• Investigate options to increase the profile of healthy food choices and physical activity in media, advertising and promotions (industry, Ministry of Health, Sport and Recreation Council).

Food Supply

• Food service industry adopts best practice preparation, cooking and serving techniques consistent with the Ministry of Health’s food and nutrition guidelines (Ministry of Health and industry)

• Food industry replaces saturated fats with unsaturated fats in foods and reduces fat, salt and sugar content of manufactured foods by exploring innovative methods to enable changed formulations of commercially prepared foods and investigates the monitoring of change (industry and Ministry of Health)

• Industry to consider innovation to provide healthy nutritious choices to consumers at competitive prices (industry).

Schools

• Explore, and implement policy options, as appropriate, to improve the physical activity and nutrition environments in school (Ministry of Health and education sector)

• Investigate the feasibility of Fruit in Schools programme (Ministry of Health).
Public information and education
- Initiate the development and implementation of a range of social marketing strategies to facilitate behavioural change supporting healthy eating, healthy action and healthy weight (Ministry of Health, NGOs, hospitals, Sport and Recreation Council)
- Develop the concept of a brand for HEHA that can be applied to healthier choices (Ministry of Health).

Socioeconomic and community
- Investigate options for improving food security in low income families with children (Ministry of Health and Ministry of Social Development)
- Support community action initiatives that promote healthy eating and physical activity (Ministry of Health, NGOs, hospitals, Sport and Recreation Council, public health organisations)
- Promote the consumption of fruit and vegetables in a variety of settings (Ministry of Health, hospitals, NGOs, public health organisations, industry).
Appendix D: Members of the Health Select Committee

Sue Kedgley, Chairperson, Green Party
Maryan Street, Deputy Chairperson, Labour Party
Dr Jackie Blue, National Party
Dr Jonathan Coleman, National Party
Jo Goodhew, National Party
Ann Hartley, Labour Party
Sue Moroney, Labour Party
Tony Ryall, Shadow Minister of Health, National Party
Darien Fenton or Lesley Soper, Labour Party
Barbara Stewart, New Zealand First
Tariana Turia, Māori Party
## Appendix E: Automatically excluded submitters

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Appendix F: Non-government health groups excluded on the basis of insufficient data and lack of public health focus on food, nutrition and obesity

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