26 August 2012

Mr Arwel Hughes
Clerk of Committee
Health Committee
Parliament
Wellington

Dear Mr Hughes

Re: Health Committee Inquiry into preventing child abuse and improving children's health outcomes

Thank you for the opportunity to submit to this Inquiry. I attach an overview paper of policy options for Government to reduce childhood obesity along with a short article which was included in the background papers for this year’s Commonwealth Health Ministers’ meeting. I will be very pleased to be able to present this to the Committee and to answer any questions on it.

To give the committee a sense of my 25 years of research in this area, I insert a brief bio below:

Boyd Swinburn is the Professor of Population Nutrition and Global Health at the University of Auckland and Alfred Deakin Professor and Director of the World Health Organisation (WHO) Collaborating Centre for Obesity Prevention at Deakin University in Melbourne. He trained as a specialist endocrinologist and has conducted research in metabolic, clinical and public health aspects of obesity. His major research interests are centred on community and policy actions to prevent childhood and adolescent obesity, and reduce, what he has coined, the ‘obesogenic’ food environment.

He is Co-Chair of the International Obesity Task Force (IOTF) and was President of the Australia and New Zealand Obesity Society (ANZOS) from 2005-7. He has also contributed to over 30 WHO consultations and reports on obesity, authored over 300 publications and given over 400 presentations. Through these efforts he is significantly contributing to national and global efforts to reduce the obesity epidemic.

I look forward to presenting to the Committee on the 29th August.

Kind Regards

Boyd Swinburn
Creating healthy childhood environments

The burden and drivers of the childhood obesity epidemic

The rise of childhood overweight and obesity over the past 3 decades represents a visible failure of New Zealand society to provide the conditions necessary for its children to reach their full health and well-being potential. Of all the preventable burdens of disease and disability for children, overweight/obesity is probably the greatest. While child abuse, injuries and mental health problems are also very significant burdens, overweight/obesity is so much more prevalent (see the figure), long-lasting, and carries a multiplicity of physical, psychological and social consequences.\(^1\) The reduction in quality of life experienced by overweight and obese adolescents is equivalent to living with type 1 diabetes or being post cancer treatment.\(^2\) This large proportion of New Zealand children will carry this reduced quality of life, social stigma and long-term risk of metabolic and mechanical problems through into adulthood.\(^1\)

The ability to significantly reduce obesity prevalence has been demonstrated for pre-school children, primary school children and adolescents.\(^3\) Thus, the breadth of the approach for preventing obesity needs to be from preconception until late adolescence (ie extending the ‘1000 days’ to ‘200 months’), although the pre-school age group seems to be the most sensitive to interventions.\(^4\) It is clear that the drivers for this increase in obesity (childhood and adult) are the increasing obesogenic environments, especially food environments,\(^5\) and thus the epidemic will not be reversed without an active reduction in these drivers of the epidemic. Quite apart from society’s ethical responsibility to protect children and create safe, healthy environments for them, in pure economic terms, childhood obesity meets all the criteria of market failure,\(^5,6\) thus demanding government interventions.

Policy response options

While parents have the greatest individual influence over children, governments and the private sector (especially the food and entertainment industries) have the greatest societal influence over children’s environments. Public interest NGOs, academics, and the public have important roles to play, but by themselves have not been able to bring about changes. Since governments set the parameters within which the private sector operates, they have a special responsibility to provide the leadership in supporting parents and creating healthy childhood environments.\(^7\) The government has three broad options to address the obesity epidemic: Minimal Engagement; Selective Engagement, and; Full Engagement.

1. **Minimal Engagement.** This is the ‘Business as Usual’ scenario which assumes that the market will deliver the healthy choices and that children and their parents will take up those healthy choices. This is clearly the preferred option of the private sector and, thus, many governments. Despite signing up to WHO strategic agreements\(^8\) and having their own comprehensive strategic documents,\(^9\) most governments are implementing only the ‘soft’, ineffectual options like education.\(^10\) This approach will almost certainly lead to on-going increases in childhood obesity and its associated inequalities.
2. **Selective Engagement.** A not-unreasonable initial approach to complex problems, like obesity, is to identify the top 2-3 cost-effective, ‘sellable’ interventions to be implemented. At least it is a start to tackling a tough, long-term problem. There are lists of cost-effective policies which have been produced by researchers,\(^{10,11}\) OECD\(^ {12}\) and other authoritative bodies.\(^ {13,14}\) However, most of the cost-effective policy options such as restricting food marketing to children and fiscal food policies are heavily opposed by the food industry and, therefore, have not been implemented. This is despite strong public and health professional support for such measures and their good economic credentials. From the comprehensive list provided in the ‘Full Engagement’ approach, two key, uncontested interventions hold substantial promise for this selective approach – ‘Public sector healthy food service policies’ (government leading with institutional role modeling, as they did in the pre-legislation days of tobacco control) and ‘Community-based interventions’ (as is currently happening across Australia). Project Energize in Waikato\(^ {15}\) offers an excellent platform to grow a national community response, although this will require an injection of long term funding, as is now happening in Australia.

3. **Full Engagement.** This is the approach to the future health challenges recommended by the investment banker, Derek Wanless in his seminal report to the UK government in 2002.\(^ {16}\) In this approach, the investment in prevention is substantially increased and his modelling showed that it was not only the least expensive approach but also produced the best outcomes. This approach is also comprehensive, which is what is recommended for complex problems like obesity. It has been shown to be effective in combating other epidemics like smoking, road deaths, cardiovascular diseases, occupational injuries and so on.\(^ {7}\) The best practice example internationally of this comprehensive approach to improving food environments is that being led by Mayor Michael Bloomberg in New York City, although Health Ministers David Davis and John Hill from Victoria and South Australia, respectively, are also heading in this direction. The table below outlines the elements of a comprehensive, fully engaged approach and a brief description of the elements is attached in the recent short report to Commonwealth Health Ministers.\(^ {17}\)

<table>
<thead>
<tr>
<th>Structural Actions</th>
<th>Direct policy actions</th>
<th>Programs and services</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Leadership &amp; governance</td>
<td>1. Restricting food marketing to children</td>
<td>1. Community-based interventions</td>
</tr>
<tr>
<td>2. Intelligence &amp; evidence</td>
<td>2. Interpretive food &amp; menu labelling</td>
<td>2. Effective social marketing</td>
</tr>
<tr>
<td>3. Finances &amp; resources</td>
<td>3. Public sector healthy food policies</td>
<td>3. Obesity management services</td>
</tr>
<tr>
<td>4. Networks &amp; partnerships</td>
<td>4. Food fiscal measures</td>
<td></td>
</tr>
<tr>
<td>5. Workforce development</td>
<td>5. Active transport</td>
<td></td>
</tr>
<tr>
<td>6. Health-in-all policies</td>
<td>6. Urban development</td>
<td></td>
</tr>
</tbody>
</table>

**Conclusions**

There is a real opportunity to substantially lift the engagement level of the New Zealand response to childhood obesity to match the seriousness of the threat it poses to child health and well-being. A shift to the Full Engagement approach would clearly show government leadership and stewardship of children’s environments. It is not only the ethically responsible approach but it is also the economically smart approach. Such leadership from government will be very strongly supported by parents and health professionals.
 References

1 Lobstein T, Baur L, Uauy R. Counting the costs: the physical, psychosocial and economic consequences of childhood obesity. Obes Rev 2004;5:4-32
12 OECD. The Economics of Prevention: Efficiency and distributional impact of interventions to prevent chronic diseases linked to unhealthy diets and sedentary lifestyles. 2009, Paris
Reversing the obesity trend

Professor Boyd Swinburn and Dr Gary Sacks of the World Health Organization Collaborating Centre for Obesity Prevention show how obesity impedes economic development, and outline a framework for government preventive action.

Obesity rates are steadily increasing in almost all countries, including many countries in which more than one in four children are overweight or obese. The obesity epidemic increases the heavy burden of non-communicable diseases (NCDs), such as diabetes, cardiovascular diseases, and cancers.

In high-income countries, obesity became more common in the 1970s and 1980s when an already sedentary population started eating more owing to the increased supply of cheap, tasty, high-calorie food, improved food distribution, and increasingly pervasive and persuasive food marketing. Changes in transport and urbanisation have also contributed to the rise in obesity rates. Obesity is now sweeping through low-income and middle-income countries. This is impeding their development and leaving many countries with a double burden of overnutrition in some people and undernutrition in others.

The large-scale population changes in obesity across the globe are a sign of an environment that increasingly nudges everyone towards high-calorie foods and beverages, larger serving sizes, less physical activity and more sedentary behaviours. While support for individuals is important, the priority for governments is to implement policies to reverse the nature of these situations so that the healthy choices become the easy choices.

What can governments do?

Unlike other major causes of preventable death and disability, such as tobacco use, injuries and infectious diseases, there are no examples of populations in which the obesity epidemic has been reversed by public health measures. Nevertheless, there is a growing body of promising government policies and actions that can be used to tackle obesity. Furthermore, the successful reversal of the other above-mentioned epidemics provides a tried and true framework of public health principles to apply to the more complex problem of obesity.

The large-scale population increases in obesity levels across the globe are overweight or obese, which places a large current burden on the healthcare system.
However, the focus in this article is on the prevention of unhealthy weight gain. This necessitates a population-based, lifestyle approach with an emphasis on children and adolescents. Actions to prevent obesity need to be taken in multiple settings and sectors, at all levels of government, incorporating a variety of approaches, and involving a wide range of stakeholders.

“There are no examples of populations in which the obesity epidemic has been reversed by public health measures.”

Moreover, obesity prevention efforts need to be tightly integrated with other efforts to control the major NCD risk factors, such as tobacco use and alcohol consumption. Actions for a comprehensive population-based approach to obesity prevention can be divided into three broad components: infrastructure actions, direct policy actions, and community-based actions.

**Infrastructure actions**

The basic infrastructure, or ‘building blocks’, for prevention is essential for sustained preventative action. These building blocks are often neglected because they are less visible and immediate than health promotion programmes, events and social marketing campaigns.

Prevention infrastructure includes:

- **Leadership** – ministerial-level commitment to obesity and NCD prevention;
- **Intelligence** – obesity monitoring systems (e.g. population-wide dietary surveys and weight measurements) and policy evaluations;
- **Finances** – sufficient recurrent funding for health promotion (including the potential establishment of health promotion foundations, such as VicHealth in Australia);
- **Tools** – the application of technologies, such as nutrient profiling and cost-effectiveness assessments, to policies;
- **Networks** – including partnerships (e.g. across various sectors of government and with non-government organisations) for co-ordinated preventive action;
- **Overarching ‘health in all’ policies** – that actively consider potential health impacts of all new policy proposals across government, including health impact assessments;
- **Workforce development** – including the development of obesity and NCD prevention skills within, and outside, government.

These building blocks must underpin the more direct policy actions, which help create an environment of healthier choices, and community actions that encourage people to make those healthier choices.

**Direct policy actions**

The second component is direct government policy actions which help to create supportive environments for healthy eating and physical activity. These actions define the parameters within which markets operate, so that the food and built environments are more conducive to health.

Proposed obesity prevention regulations cannot actually dictate to people about specific eating and physical activity behaviours. Rather, they only seek to influence some of the environments within which these behaviours occur. Most of the determinants of obesity lie outside the health system and, therefore, most obesity prevention policy solutions focus on non-health sectors. Health can be a primary driver for policy change (e.g. the removal of taxes on fruit and vegetables), or it can be a secondary driver (e.g. investments to improve public transport systems and reduce traffic congestion).

There is strong evidence of cost-effectiveness and growing consensus supporting the implementation of a handful of key NCD prevention policies relating to food systems and urban design. The food policies contribute to healthier, more sustainable and more equitable food systems, and the transport and urban development policies contribute to healthier, more liveable, less congested cities. Priority policy actions include:

- **Marketing to children** – restrictions on the marketing of unhealthy foods and beverages to children and adolescents;
- **Labelling** – including nutrition information panels, front-of-pack ‘traffic light’ labels, controls on food claims, and energy content labelling on fast food menus;
- **Public sector healthy food service policies** – government departments and publicly-funded settings, such as schools and hospitals, leading by example by serving and providing healthy food choices;
- **Food fiscal measures** – aligning taxes and subsidies to make healthy food choices more affordable, and unhealthy choices less affordable;
Community-based actions

The third component of a comprehensive obesity prevention strategy is action at the community level (for example, childcare, schools, primary healthcare, religious settings, and sporting centres). The specific actions are determined in conjunction with local stakeholder groups, tailored to the local environment, and implemented locally. The types of actions typically include local food service policies, education and curriculum strategies, and health promotion programmes and messages. There is good evidence from longer-term demonstration projects that these approaches can significantly reduce unhealthy weight gain among pre-schoolers, primary school children and adolescents, although ethnic groups at high risk of obesity will need culturally-tailored approaches to achieve success.

“Another enormous contributor to government inaction is the heavy private sector investment in blocking the implementation of effective policies.”

Community-level action is greatly facilitated by having the above-mentioned infrastructure and direct policy actions in place, along with nationally co-ordinated social marketing programmes. While governments often see mass media campaigns as a way of achieving visibility, awareness and ‘quick wins’ for obesity prevention, more often than not these are expensive and ineffective, unless they are tied in with policies and local actions, and create behavioural changes in decision-makers as well as the population.

Next steps for governments

Most governments already have strategic plans drawn up for improving nutrition and physical activity, preventing obesity, and reducing NCDs. While many plans fall short by failing to include infrastructure and direct policy actions (as outlined above), the biggest problem to date is not the lack of plans but the lack of their implementation. Part of this is budgetary, with very few governments willing to invest more than 1 per cent of their health budget on the primary prevention of NCDs. However, another enormous contributor to government inaction, especially with respect to food policy interventions, is the heavy private sector investment in blocking the implementation of effective policies such as restrictions on unhealthy food marketing to children, nutrition labelling, and taxes on sugar-sweetened beverages. This has many parallels in the difficulties of creating action on climate change, resource depletion and global inequalities.

The big challenge for governments is to re-capture public policy for public and planetary benefits by defining prosperity much more broadly than the current, narrow focus on GDP growth. Instead, governments need to define prosperity to include health, social, environmental and economic outcomes, for current and future generations.

Contact Details

**Professor Boyd Swinburn** is Director of the WHO Collaborating Centre for Obesity Prevention at Deakin University, Australia, and co-chair of the International Obesity Taskforce.

**Dr Gary Sacks** is a Research Fellow at Deakin University, Australia. His research focuses on policies for the prevention of non-communicable diseases.

The **World Health Organization (WHO)** Collaborating Centre for Obesity Prevention is based at Deakin University, Australia. The Centre is building a large base of high-quality research to inform the decisions which will lead to reversing the obesity epidemic. Since inception in 2003, the research team has conducted extensive studies on obesity prevention in children and adolescents. A large portfolio of activities has been established in research, training, knowledge translation, advocacy and expert advisory services for WHO and government agencies.

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