Fact Sheets about the Public Health Bill

In 2008, FOE produced five “fact sheets” to assist with preparation of submissions on the Public Health Bill to the Health Select Committee. All five have been collected into this document.

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Public Health Bill

FACT SHEET 1

25 February 2008

Recent Health Committee and Government reports relating to regulation of risk factors for non-communicable diseases

In August 2007 the Health Select Committee reported on its Inquiry into Obesity and Type 2 Diabetes. In this report the Committee set out its view on the role of regulation in reducing risk factors for obesity, type 2 diabetes and other chronic diseases.[1]

The Government response to the Select Committee report produced late in 2007[2] provides a summary of the Government position relating to regulation that is missing from the Explanatory Note at the front of the Public Health Bill.

This paper is intended to assist those writing submissions to the Health Select Committee in support of Clause 374 of the Public Health Bill (allowing the making of regulations) by documenting the relevant views of the Committee as expressed in their 2007 report, and Government views in responding to that report. Rather than having to cite other literature, submitters might find it useful when making points to refer to the Committee's and Government's own statements.

In summary, a majority of the Health Select Committee believed that changing the obesogenic environment is central to preventing obesity and type 2 diabetes. They favoured giving the food and advertising industries a short time-frame to achieve measurable outcomes addressing risk factors. They wanted the Public Health Bill to include regulation-making powers that could be used if the industry failed to meet the performance targets.

The National Party, in a minority report, favoured a preventive approach based on education and personal choice. They opposed regulation-making powers relating to non-communicable diseases being included in the Public Health Bill.

The first three sections below (on the main text of the Committee's report, the Committee's recommendations, and the National Party's minority view)

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[1] Inquiry into Obesity and Type 2 Diabetes: Report of the Health Committee. August 2007. Available at http://www.parliament.nz/NR/rdonlyres/47F52D0D-0132-42EF-A297-6AB08980C0EA/62831/DBSCH_SCR_3868_5337.pdf

[2] Government response to the Inquiry into Obesity and Type 2 Diabetes 2007. Available from http://www.parliament.nz/en-NZ/PB/Presented/Papers/1/4/a/48DBHOH_PAP16044_1-Government-Response-to-Report-of-the-Health-Committee.htm.

consist of quotations from the Select Committee report illustrating the views expressed relating to regulation. This is followed by a section containing quotations from the Government response. The final section sets out FOE's position on the approach to regulation adopted by the Committee and generally accepted by Government.

If you wish to use any of the quotations you would be best to check them against the original. You can use the links in the footnotes on page 1 of this document. Because the quotations were re-typed from pdf documents they could possibly contain errors.

The main text of the Health Select Committee Report

On the role of obesity as a cause of non-communicable diseases:

> Obesity and type 2 diabetes have severe health, social, and economic effects on individuals, communities, and the country (p9).
>
> The rise of obesity and type 2 diabetes challenges the health system, because they are major causes of chronic illness such as heart disease, stroke, kidney disease, and some cancers (p10).

On the need for lifestyle intervention:

> There is strong international evidence that lifestyle intervention (diet and activity) can radically reduce the progression of pre-diabetes (glucose intolerance, which is almost invariably associated with obesity) to type 2 diabetes (pp10-11).

On private sector actions to date:

> 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 (p12).
>
> The advertising, marketing and promotion industry has the potential to play a key role in the prevention of obesity but has not yet engaged seriously as part of the solution (p12).

On the inadequacy of current measures and the need to apply more powerful interventions:

> The many current initiatives are fragmented and poorly coordinated, and insufficient for the prevention and management of obesity and type 2 diabetes in New Zealand. In general, 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 (p13).
>
> There is an urgent need to significantly scale up the public health response to obesity and type 2 diabetes. Many powerful potential interventions have not been fully used (p13).

On the need for environmental change:

> From a public health perspective, environmental measures are needed to make healthy behavioural choices easier and cheaper. This conclusion

is disputed by some submitters, particularly members of the food and advertising industries, who favour educational campaigns rather than environmental change, citing the principles of informed choice, freedom of choice, and individual or parental responsibility (p13).

Modifying the environmental determinants of eating and activity patterns, especially in children, will require measures in several areas:

- increasing the availability, accessibility, and affordability of healthier foods, while reducing the availability of energy-dense products
- increasing the advertising, marketing, and promotion of healthier food options, and reducing the advertising, marketing, and promotion of energy-dense products
- providing more opportunities for regular physical activity at school, on the way to and from school, and in leisure time (p13).

On the role of education and social marketing:

No single approach will be sufficient to prevent and control obesity and type 2 diabetes. We understand that environmental approaches have the greatest potential… Such approaches should be directed to all aspects of the obesogenic environment, including the social, cultural, physical and economic environments (p15).

We were informed that social marketing, or efforts to change behaviour through mass media campaigns, is of limited use unless it is well supported by environmental changes… Educational strategies by themselves are not likely to achieve good results (p15).

On the need for regulation-making powers in the Public Health Bill that can be applied if voluntary changes by industry are insufficient:

The key issue regarding the food and beverage industry is whether self-regulation is sufficient to protect children from the adverse effects of the advertising, marketing, and promotion of energy-dense foods. Opinions on this issue were divided between those of the industry groups and those based on reviews of public health evidence. Given this division of opinion, we recommend that the committee set up to drive the obesity strategy should set measurable targets to be achieved by the industry, with strict and reasonably short timeframes. These targets should be monitored, and regulation introduced if the targets are not achieved (p17).

If self-regulation does not meet the specific targets within the agreed time, the majority of us consider that regulation will be necessary (p20).

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 (p17).

On what the Select Committee said about submissions relating to regulation:

Submitters were polarized on this issue. Support for some form or regulation was strong, with support from 120 submitters, while ten submitters, all but one from the industry sector, expressed opposition to regulation. Submissions in favour of regulation called for stronger action

> to restrict the exposure of children to these [food marketing] influences; many argued that self-regulation and industry codes of practice are ineffective and ultimately operate to protect the industry rather than public health (p18).
>
> The tobacco industry, which went through a period of self-regulation before state controls were imposed, was cited as an example of the failure of self-regulation. Attempts to control tobacco promotion and sponsorship may provide a lesson relevant to the protection of children and young people from the advertising, marketing, and sponsorship of energy-dense products (p19).

Recommendations relating to regulation

The Report includes two recommendations relating to regulation, both covering much the same ground:

> The majority of us recommend that progress towards … 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 (p29).
>
> We recommend …that the [cross-sectoral ministerial] 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 (p30).

The New Zealand National Party view on regulation

In a minority report the National Party distanced itself from the majority view on the need for environmental change by focussing on education and individual choice:

> A successful long-term response will provide people with the education, skills and desire to make … healthy dietary and lifestyle choices. Interventions that eliminate choice and rely on control will not achieve the required attitudinal changes… The emphasis should be on practical approaches that change attitudes to food and exercise. The necessary changes in diet and exercise habits will not occur through Government pressure (p35).

The National Party opposed inclusion of regulation-making powers relating to non-communicable diseases in the Public Health Bill:

> The upcoming Public Health Bill should not be a vehicle for regulation, but the committee indicates in this report that “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.” National has concerns about the intent of the bill, and will be watching closely (p35).

The Government response to the Select Committee recommendations

In its formal response to the recommendations from the Health Select Committee the Government largely agreed with the approach recommended by the Select Committee majority with respect to regulation:

> The [Ministerial] Committee [to oversee HEHA], in consultation with industry, will set agreed targets for reducing the advertising, marketing and promotion of foods high in fat, sugar and salt… The Government is aware that there is now a substantial body of evidence that supports the role of marketing as a small but important contributing factor in the child obesity epidemic. The Government has already initiated work to decrease the marketing of unhealthy food through the implementation of the HEHA implementation plan and the Mission-On initiatives, however, the Government considers that more needs to be done and that the Food Industry Group (FIG) is well-placed to take further action (p17).
>
> In recognition of the timeframe required to enact legislative changes, if these are necessary, the Government has requested the Ministry of Health to commence the preparatory work required to implement a co-regulatory framework[3] for the regulation of marketing of food to children, similar to international jurisdictions (such as Australia and the United Kingdom). This work will provide the basis for action should the improved self-regulatory system identified above and other industry-led activities not result in substantial measurable reductions in the marketing of unhealthy foods to children (p18).

In addition to the above which refers to food marketing, there is also a later statement on the food supply:

> The Government notes that the food and beverage industry has bee identified in both the HEHA strategy and implementation plan and the Mission-On Campaign as a key to influencing the food supply. Further industry action is required if the food supply is to become healthier. The Government agrees with [Select Committee recommendations] …to encourage industry to continue to make positive changes to its products and to agree to targets that are recommended by the [Ministerial] Committee (p48).

FOE's position on the approach adopted by the Health Select Committee and Government

In its 2006 submission to the Health Select Committee Inquiry into Obesity and Type 2 Diabetes, FOE called for regulation of the food and advertising industries on the grounds that both industry performance to date and the public health evidence showed that self-regulation will not work. Developments since 2006 have confirmed FOE in this belief.

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[3] A co-regulatory framework involves government working with industry with the focus on achieving outcomes through a mix of mechanisms including industry self-regulation and, if required, legislation.

That said, the Health Select Committee and Government approach of giving industry a short time-frame to achieve measurable targets, to be followed by regulation if required, is the best of the options under consideration by our parliamentarians at present. It is probably the best option achievable before the 2008 election.

It will not, however, result in progress unless the targets to be met by industry bring a large and prompt shift away from the marketing of unhealthy food, particularly to children, and steady and substantial progress in reducing the energy-density and improving the nutritional quality of foods and drinks sold to the public.

The inclusion of regulation-making powers relating to non-communicable diseases in Clause 374 of the Public Health Bill is an essential step if the Government approach of encouraging industry to make the required changes through self-regulation is to have any chance of success. Without the real threat of regulation, industry responses will continue be more window dressing than substance. Should industry not measure up, Clause 374 would enable the necessary changes to be made through regulation.

Public Health Bill

FACT SHEET 2

27 February 2008

Clause 374: Regulation-making powers in Bill relating to non-communicable diseases

FOE strongly welcomes the Public Health Bill because it includes, in Clause 374, regulation-making powers to reduce obesity and other risk factors for non-communicable diseases.

Clause 374 gathers together general regulation-making powers relating to public health. The main focus is on infectious diseases. There are, however, two subclauses that relate to non-communicable diseases:

Subclause 374(r) allows "the prohibition or regulation of the importation, manufacture, packing, or sale of any thing likely to introduce or increase a risk to public health".

Subclause 374(x) enables the issuing of regulations for the purpose of "reducing, or assisting in reducing, risk factors (within the meaning of section 79) associated with, or related to, non-communicable diseases".

A risk factor is defined in clause 79 as:

> a thing or substance that, on its own or together with other things or substances or conditions, may, whether immediately or over time, give rise to, or increase the incidence of, non-communicable diseases (such as cancer cardio-vascular disease, or diabetes) in the general population or in communities or in sections of the general population or communities.

Weaknesses in Clause 374

On paper Clause 374 contains, from FOE's perspective, some very commendable and badly needed provisions. There are, however, concerns about how useful the relevant subclauses will prove to be in practice for reducing risk factors for non-communicable diseases.

One weakness is that the Bill imposes no obligation on governments to use subclauses 374(r) and 374(x) under appropriate circumstances. This is discussed in more detail in Fact Sheet 3.

A second weakness is that attempts to issue regulations under subclauses 374(r) or 374(x) might be thwarted by legal challenges from affected sectors or industries. Legal challenges might include arguments that a regulation was

not within the purposes of the Act, or that the process of developing the regulation (for example, consultation) was inadequate.

Experience from the regulation of risks to public health such as tobacco shows that industries contributing to risk factors, which may include major multinational companies with huge resources, may well attempt to overturn or slow down the process of addressing risk factors through regulation when they see this as having a detrimental effect on their profits.

Strengthening Clause 374: The need for overarching principles

Attempts to make regulations under subclauses 374(r) and (x) might fare better against legal challenge if they were more explicitly tied to the purpose of the Bill, and supported by principles in the Bill.

The Bill contains principles in Clause 80 relating to codes of practice and guidelines that the Director-General of Health may issue to reduce risk factors for non-communicable diseases. These include taking into account the importance of "improving and enhancing the health of communities by addressing broad determinants of health, including, in particular, risk factors" (subclause 80(a)), and "promoting, maintaining, and enhancing the health status of the general population and communities" (subclause 80(f).

The same or similar principles as in Clause 80 need also to apply to the issuing of regulations relating to non-communicable diseases under Clause 374. Such principles need a strong focus on advancing the public good.

At present principles, including those in Clause 80, are scattered through the Bill. There is a case that, rather than duplicate something like Clause 80 to apply to Clause 374, a set of overarching principles covering the entire Bill be included at the beginning in Subpart 1 of Part 1.

FOE supports inclusion in the Bill of a principle stating the need to protect the health of vulnerable sections of the population, including children. This would provide a sounder base for making regulations such as restrictions on advertising unhealthy food to children.

In Clause 82 the Bill provides for prior consultation on voluntary codes of practice and guidelines. A similar statement relating to regulations made under 374(r) and 374(x) might help ensure that these were based on appropriate consultation.

Arguments for regulation-making powers relating to non-communicable diseases

Submissions supporting retention of subclauses 374(r) and 374(x) will in general be more effective if they make the case as to why there needs to be provision for the regulation of risk factors for non-communicable diseases in the Bill, rather than just expressing support for retention of the subclauses or suggesting some modification to their wording. FOE's general argument for

their retention is set out in the Information Sheet. Some suggestions about further arguments that might be used are included in Fact Sheet 4.

A note on “clauses” and “sections”

Readers of the Bill will note that it contains “sections”, whereas the debate at present is about “clauses”. This is because a Bill is in fact a draft Act. Acts have sections, not clauses. They only become “sections” on enactment.

For this reason, what are labelled “sections” in the Bill are better referred to as “clauses” in submissions.

Public Health Bill

FACT SHEET 3

Revised 2 March 2008

The failure of the Public Health Bill to impose a duty to reduce risk factors for non-communicable diseases

The purpose of the proposed Act

The purpose of the proposed Act is "to improve, promote, and protect public health in order to help attain optimal and equitable health outcomes for Māori and all other population groups" (Clause 3(1)).

The Bill states that features designed to achieve this purpose include provisions "setting out clear and specific responsibilities for the identification and effective management of risks to public health, … and in particular, risks to public health arising from – (i) communicable conditions; and (ii) non-communicable conditions; and (iii) the environment" (Clause 3(2)(a)).

These provisions also include "placing responsibilities on territorial authorities to improve, promote, and protect public health within their districts" (Clause 3(2)(e)).

Duties in the Bill

There are numerous duties imposed by the Public Health Bill relating to infectious diseases and environmental health. The Director-General of Health, for example, must appoint suitable medical practitioners as medical officers of health (clause 12(1)). But the Bill imposes no duties relating to non-communicable diseases. This is in spite of the recognition, in the Bill's Explanatory Note, that:

> Public health legislation traditionally focuses on communicable diseases and environmental health. Although communicable disease and environmental health issues remain very significant, they are no longer the major causes of death and illness in New Zealand. The major causes of population ill-health today, and the major drivers of health care expenditure, are those broadly categorised as non-communicable diseases, such as cardiovascular disease, diabetes, cancers, mental illness, and addictions (pp5-6).

FOE believes that the Bill needs to place explicit duties on the Minister of Health and Director-General of Health to reduce risk factors for non-communicable diseases.

Functions and duties of the Minister of Health

Clause 6 sets out the function of the Minister of Health ("ensuring the effective and efficient administration of this Act"). Nowhere in the Bill is there reference to the Minister having any obligations or duties with respect to non-communicable diseases. Effective administration of an Act the purpose of which is to improve, promote, and protect public health might imply a duty to use available provisions to achieve the purpose, but FOE prefers to see this spelled out. This needs to be worded so that it places an obligation on the Minister to propose regulations relating to non-communicable diseases under Clause 374 when such regulations are the most appropriate response to protect public health.

Functions and duties of the Director-General of Health

Codes and guidelines to reduce risk factors for non-communicable diseases

Clause 7 lists the functions of the Director-General of Health. There is no explicit statement imposing a duty on the Director-General to use her or his powers under the Act to further the Act's purpose (improving, promoting and protecting public health). This is particularly relevant to the functions of the Director-General relating to non-communicable diseases set out in Subpart 3 of Part 3 of the Bill (Codes of practice and guidelines).

Clause 81 in Subpart 3 states that the Director-General <u>may</u>

> issue a code of practice or guidelines to a sector on a particular activity that the sector undertakes if the Director-General has reason to believe that the sector can reduce, or assist in reducing, a risk factor associated with, or related to, the activity.

The definitions of "risk factor" and "sector" show that this gives the Director-General very wide scope to issue codes and guidelines for purposes such as reducing levels of obesity in the population. As defined in Clause 79 of the Bill:

> **risk factor** means a thing or substance that, on its own or together with other things or substances or conditions, may, whether immediately or over time, give rise to, or increase the incidence of, non-communicable diseases (such as cancer cardio-vascular disease, or diabetes) in the general population or in communities or in sections of the general population or communities
>
> **sector** means a group of individuals, associations of persons, departments, local authorities, or bodies corporate involved in –
>
> (a) the manufacture, importing, distributing, or retailing of goods or substances of a particular kind; or
> (b) the provision of a service of a particular kind; or
> (c) the formulation or implementation of policies for consideration or adoption by central government or local government; or
> (d) the design, construction, or maintenance of buildings, infrastructure, or works of any kind; or

(e) the advertising, promoting, sponsoring, or marketing of goods or substances of a particular kind or services of a particular kind.

From FOE's perspective the scope of activities for which the Director-General can issue codes or guidelines is admirable. But there is a serious problem with the word "may" in Clause 81. Whatever the wording, there needs to be something in the Bill that imposes a duty on the Director-General to issue codes or guidelines under Clause 81 when doing so materially assists the purpose of the Act, or appears on reasonable grounds to be the best way of reducing a substantial risk factor.

FOE favours the inclusion, in Clause 7, of an additional function of the Director-General: words having the effect of ensuring that any function and power of the Director-General available under the Act is exercised when this is the most appropriate response to protect the public against non-communicable diseases.

The failure to impose any obligation on the Director-General in Clause 81 may relate to the Government's philosophy to rely, at least initially, on self-regulation by sectors such as the food and advertising industries.[4] In the perfect world, these industries would, in consultation with Government, voluntarily control their own activities to effectively reduce risk factors arising from those activities. The Government would prefer that effective codes and guidelines are developed by sectors themselves. As Clause 81 is currently worded, however, self-regulation could fail but the Director-General is still not obliged to issue codes or guidelines.

A further weakness of Clause 81 is that the codes and guidelines are not legally enforceable. Further, the Ministry of Health expects that they will not be complied with when manufacturers or suppliers judge that the cost of compliance is too high. The Ministry has stated:

> The codes and guidelines … will not be mandatory and any costs associated with their implementation will be one factor among others that the manufacturer or supplier would take into account in deciding whether and the extent to which compliance would be appropriate.[5]

Health impact assessments

Clause 83 of the Bill specifically mentions "the development, completion, and review of health impact assessments"[6] as one area in which codes or guidelines might be issued under Clause 81. The general points made about codes and guidelines in the section above apply here. The Director-General is not obliged to issue these with respect to health impact assessments and,

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[4] This philosophy is described in Fact Sheet 1.

[5] Ministry of Health. Regulatory impact and compliance cost statement for the Public Health Bill. Available from http://www.moh.govt.nz/moh.nsf/indexmh/ris-public-health-bill.

[6] Health impact assessments for the purpose of the Bill are defined in Clause 4.

should she or he do so, affected parties such as territorial authorities may chose to ignore them.

Health impact assessment is defined in Clause 4 of the Bill as:

> a combination of procedures, methods and tools –
>
> (a) by which a proposal, policy, plan, strategy, project, rule, consent, standard, guideline, or programme is assessed as to the effect it is likely to have on the health of a population or part of a population and the distribution of the effects within the population; and
>
> (b) that indicates whether the thing assessed is likely to have a positive or negative effect on the health of the population or part of the population.

The list of areas to which a health impact assessment might be applied in (a) is impressive, but has one notable omission: statutes and regulations. FOE believes that these are at least as important as anything else that should be subject to health impact assessment, and will be saying so in its submission.

Clauses 323 to 325 in the Bill specifically address health impact assessments. Clause 323 reads:

> The purpose of a health impact assessment is, in general terms, to enable departments of State, Crown entities, and local authorities to identity and assess whether proposed actions have a positive or negative effect on public health objectives before those actions are taken.

There is nothing in the Bill that obliges agencies to conduct health impact assessments in appropriate circumstances. The only requirements relating to health impact assessments stated in the Bill are that if undertaken they must have regard to any criteria specified by the Director-General of Health (Clause 324), and a copy of the health impact assessment must be supplied to the Director-General (Clause 325).

FOE supports the inclusion in the Bill of provisions setting out circumstances under which health impact assessments would be required. These circumstances might include when the consequences of a project include a reasonably foreseeable risk to public health that could be mitigated. Provisions are also required relating to the place played by health impact assessments in final decisions. Health impact assessments are of little value if their findings are not taken into account by decision makers.

One can envisage circumstances when Crown entities or local authorities might regard having to supply the Director-General with a copy of any health impact assessment as a disincentive to conducting an assessment. This adds to the case for setting out the circumstances under which health impact assessments are required.

An excellent source of further information on the potential role of health impact assessments under the Public Health Bill is contained on pages 46 to 49 in

the Ministry of Health's 2004 report on the outcome of earlier consultation on the Bill.[7]

Clause 374: Lack of a duty for government to make appropriate regulations[8]

Clause 374 of the Bill provides for the making of regulations about public health generally. Two subclauses are of particular interest to FOE.

Subclause 374(r) allows "the prohibition or regulation of the importation, manufacture, packing, or sale of any thing likely to introduce or increase a risk to public health".

Subclause 374 (x) enables the issuing of regulations for the purpose of "reducing, or assisting in reducing, risk factors … associated with, or related to, non-communicable diseases".

FOE strongly supports the retention of these subclauses in the Bill while at the same time arguing that they are insufficiently supported. As with the voluntary codes and guidelines, one of the weaknesses of Clause 374 is that it imposes no obligation or duty on Government to use its powers under the clause in appropriate circumstances. This weakness needs to be rectified in the Bill.

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[7] Ministry of Health. Summary of submissions on public health legislation. Available from http://www.moh.govt.nz/moh.nsf/pagesmh/5660/$File/summary-submissions-public-health-legislation.pdf.

[8] See Fact Sheet 2 for a fuller discussion of Clause 374.

Public Health Bill

FACT SHEET 4

2 March 2008

The case for retention of regulation-making powers to reduce risk factors for non-communicable diseases

We know that there will be powerful opposition to retaining the regulation-making powers set out in subclauses 374(r) and 374(x) of the Bill. For this reason, FOE believes that making the case for their retention is critical.

The Information Sheet about the Public Health Bill on the FOE website contains a general argument about why it is critical that the regulation-making powers for reducing risk factors for non-communicable diseases remain in the Bill. This Fact Sheet provides some supplementary material for making the case.

What to regulate, and why

Chapter 7 of FOE's submission to the Health Select Committee Inquiry into Obesity and Type 2 Diabetes[9] sets out arguments for regulation of a number of activities, including:

- advertising of unhealthy foods to children
- sponsorship of schools and children's sport by companies associated with unhealthy foods and drinks
- distribution of free samples of unhealthy food, or free gifts, tokens or vouchers that are associated with unhealthy food, to children aged 16 and under
- the sale of unhealthy foods or drinks in schools and pre-schools, including in vending machines
- minimum requirements relating to the provision of play areas, parks, footpaths, cycleways and walkways in urban areas to encourage greater physical activity.

One point made in the FOE submission is particularly pertinent to the need for regulation-making powers. New ways of marketing to children are developing quickly along with advances in communications technology, and the high use

[9] Available from http://foe.org.nz/foe-publications

of the internet by children. Regulatory powers are required to enable quick responses to new forms of marketing unhealthy foods to children as these appear.

Submissions to the Inquiry into Obesity and Type 2 Diabetes heavily favoured use of regulations in some areas

Chapter 5 of John White's initial report on submissions to the Health Select Committee Inquiry into Obesity and Type 2 Diabetes analyses what submitters had to say about regulation.[10] Most calls for regulation related to:

- the marketing of unhealthy food, particularly to children, and
- sponsorship of schools and children's sport by organisations associated with unhealthy foods and drinks.

There was a clear dichotomy between submissions from the health sector on one hand, and the food and advertising industries on the other. As an example, 120 submissions, most from the health sector, explicitly supported some form of regulation by Government of the advertising of less healthy food. The only opposition to this came from industry submissions.

Of particular note, 76 of the 141 health sector submissions (54%) sought some form of regulation on advertising of less healthy food. As John White's report states:

> This is a massive figure given the context – almost all the remaining 46% simply did not address the advertising issue in their submissions, presumably for many because this was well removed from their expertise or direct concern. No submission from the health sector stated opposition to some form of advertising restriction. This leaves a very clear outcome: the health sector was strongly of the view that the advertising of less healthy food needed to be regulated (pp.39-40).

Chapter 5 contains substantial further information relevant to the need for regulation-making powers in the Public Health Bill. It can be accessed via the link in footnote 2.

The New Zealand public firmly favours regulation of food marketing to children

The New Zealand public recognises the need for marketing unhealthy food to children to be regulated, with a ban on advertising unhealthy food to children having wide public support.

The Chronic Disease Prevention Peak Group recently released the results of a survey conducted in 2007 showing a large majority of New Zealand parents

[10] Available from http://foe.org.nz/foe-publications

and grandparents would like to ban television advertising to children of unhealthy food and drink products. Eight-two percent of the survey respondents agreed or strongly agreed that advertising unhealthy products "using ads appealing to children" should be stopped.[11]

A survey in 2005 by BRC Marketing and Social Research commissioned by FOE shows similar results. Almost three-quarters (71%) of New Zealand adults surveyed by BRC Marketing and Social Research in 2005 agreed or strongly agreed that "advertisements for unhealthy food and drink products should be banned during children's television programmes". And 84% of those surveyed agreed or strongly agreed that unhealthy food and drink products should not be sold in school canteens and vending machines.[12]

The need for a comprehensive mix of measures including regulation

There are lessons from experience with the use of legislation or regulations in areas other than obesity, nutrition and physical activity that provide a useful guide as to the strategies needed to reduce the prevalence of non-communicable diseases.

The evidence from tobacco control shows that successful strategies involve a comprehensive mix of interventions, including regulatory measures. A major report by the World Bank[13] summarises the global evidence on what works for tobacco control. In discussing advertising bans, this report formed a "key conclusion" relevant to controls on the marketing of unhealthy food to children: "bans on advertising and promotion prove effective, but only if they are comprehensive, covering all media and all uses of brand names and logos". Without comprehensive bans, the industry merely shifted its advertising and promotion from banned activities, such as television advertising, to other forms of promotion, such as sponsorship.

This example from tobacco points to an important reason why regulation-making powers are needed. The food and advertising industries, if left to self-regulate, may make small steps in one direction, such as not showing advertisements for unhealthy food around designated children's programmes on television, while shifting the focus to other forms of marketing these foods, such as sponsorship of schools or children's sport.

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[11] Further information on the Peak Group survey can be obtained from http://www.nhf.org.nz/news.asp?pageID=2145820705&RefID=2141735835.

[12] More details about the BRC poll can be found at http://foe.org.nz/foe-publications

[13] World Bank. Curbing the epidemic: Governments and the economics of tobacco control. Washington DC, World Bank, 1999. Available from http://www1.worldbank.org/tobacco/book/pdf/tobacco.pdf.

A New Zealand report commissioned by Diabetes New Zealand also points to the need for a comprehensive approach. [14]

In a 2006 paper[15] British academic Karen Jochelson refers to evidence for a number of types of legislative or regulatory action that have been used successfully to reduce risk factors for non-communicable diseases:

> *Taxation:* "International studies show that increasing the price of alcohol generally leads to a decrease in consumption, with a positive follow-on effect for public health… A similar pattern is evident when looking at tobacco use… Price increases induce some smokers to quite and prevent others from becoming regular or persistent smokers."
>
> *Regulation to restrict access:* "restricting access to alcohol and tobacco seems to reduce consumption rates, and brings wider social and health benefits… Research shows that bans on smoking in public places reduce non-smokers' exposure to tobacco smoke, and reduce consumption so encouraging smokers to quit".
>
> *Advertising bans:* "Total advertising bans are associated with declining consumption of alcohol and tobacco which leads to declining morbidity and mortality from related illnesses… A … study with data from 20 countries spanning a 26-year period … found that banning alcohol advertising resulted in a decrease in consumption. Tobacco advertising bans also have a direct impact on consumption rates."
>
> *Proscribing behaviour:* "wearing seatbelts and not driving when drunk depend on the state proscribing permitted behaviour and using surveillance and penalties to ensure compliance."

Jochelson also comments on the role of education in reducing risks factors:

> Education programmes are ineffective on their own, but as part of a comprehensive control policies including high taxation, advertising bans, and restricted access to alcohol or tobacco, or mandatory behaviour with penalties and surveillance, it is likely that they can help shape positive attitudes to healthier or safer behaviour.

She concludes:

> Almost every government intervention in the public health arena has been criticized by commentators of the time as a sign of tyranny, nanny statism, or the end of individual freedom. yet the evidence discussed above illustrates the considerable individual and public health benefits of once-contested interventions …

Jochelson's views on the need for a comprehensive approach and the limitations of education as the primary focus are echoed by the Health Select Committee in its report on the Inquiry into Obesity and Type 2 Diabetes.[16]

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[14] Allen & Clarke Ltd. Tobacco control: What can be learnt and applied to nutrition policy. Available from www.diabetes.org.nz/resources/docs/research_and_reports/DiabetesTobPolicy.doc.

[15] Jochelson, K. Nanny or steward: The role of government in public health. *Public Health* 2006; 120(12):1149-55. As it is not readily available, this paper is quoted from at some length.

> No single approach will be sufficient to prevent and control obesity and type 2 diabetes. We understand that environmental approaches have the greatest potential… Such approaches should be directed to all aspects of the obesogenic environment, including the social, cultural, physical and economic environments (p15).
>
> We were informed that social marketing, or efforts to change behaviour through mass media campaigns, is of limited use unless it is well supported by environmental changes… Educational strategies by themselves are not likely to achieve good results (p15).

Using this information in submissions

FOE has provided the information in this and other Fact Sheets so that people and organisations concerned about obesity prevention and reducing risks for non-communicable diseases have information on hand that they can use in making submissions.

This information can probably best be used if drawn on selectively to support points that are of particular concern to you or your organisation.

[16] Inquiry into Obesity and Type 2 Diabetes: Report of the Health Committee. August 2007. Available at http://www.parliament.nz/NR/rdonlyres/47F52D0D-0132-42EF-A297-6AB08980C0EA/62831/DBSCH_SCR_3868_5337.pdf .

Public Health Bill

FACT SHEET 5

3 March 2008

Reducing risk factors for non-communicable diseases through increasing physical activity

Much of the focus in submissions on the need for regulation-making powers to reduce risk factors for non-communicable diseases will undoubtedly be on nutrition, and particularly the need to regulate the marketing of unhealthy food to children. But these powers are equally important for making physical activity easier, including through changes to the built environment.

Subclause 374x (see Fact Sheet 2) enables the issuing of regulations to reduce virtually any risk factor for non-communicable diseases such as heart disease, cancer and type 2 diabetes. In theory at least, this subclause would enable regulations to be made on matters as varied as:

- setting requirements on territorial authorities for better provision of safe footpaths and cycleways
- requiring employers to provide opportunities for minimum levels of physical activity by employees during the working day
- requiring health impact assessments to be conducted prior to the making of decisions that shape the built environment.

It is not clear how workable subclause 374(x) would be, in part because it is not well supported by provisions and statements elsewhere in the Bill (see Fact Sheet 3). As well, use of subclause 374(x) is under attack by powerful opponents on the grounds that it is an unwanted intrusion by the 'nanny state'. Support for subclause 374(x) from the physical activity sector would help greatly in convincing the Health Select Committee that the subclause must remain in the Bill, and be strengthened.

Health impact assessments under the Public Health Bill are discussed more fully in Fact Sheet 3. Health impact assessment (HIA) is a tool for central and local government agencies to identity and assess the positive and negative aspects on health of proposed actions before these actions are taken. Greater use of HIA would make the need to facilitate walking and cycling a more prominent consideration in urban and transport planning. The Public Health Bill refers to HIA (Clauses 323 to 325), but not in a way that encourages their greater use. It merely states that if undertaken they must have regard for any criteria specified by the Director-General of Health, and a copy of the completed HIA must be forwarded to the Director-General.

Submissions on the Bill need to press for mandatory use of HIA under defined conditions, and provision for the findings of HIA to be given substantial consideration in making planning decisions.

Submissions on the Bill are due with the Health Select Committee by 7 March 2008. It is important that strong submissions are received from the physical activity sector making the case for retention of regulation-making powers relating to non-communicable diseases, and for a strengthening of HIA provisions. A new Public Health Act might then become an effective tool for placing requirements on the future behaviour of urban designers and transport planners among others.