



Libraries and Learning Services

# University of Auckland Research Repository, ResearchSpace

## Version

This is the publisher's version. This version is defined in the NISO recommended practice RP-8-2008 <http://www.niso.org/publications/rp/>

## Suggested Reference

Swinburn, B., Vandevijvere, S., Woodward, A., Hornblow, A., Richardson, A., Burlingame, B., . . . Blakely, T. (2017). Proposed new industry code on unhealthy food marketing to children and young people: will it make a difference?. *New Zealand Medical Journal*, 130(1450), 94-101.

## Copyright

Items in ResearchSpace are protected by copyright, with all rights reserved, unless otherwise indicated. Previously published items are made available in accordance with the copyright policy of the publisher.

For more information, see [General copyright](#), [Publisher copyright](#), [SHERPA/RoMEO](#).

# Proposed new industry code on unhealthy food marketing to children and young people: will it make a difference?

Boyd Swinburn, Stefanie Vandevijvere on behalf of submitting health professors\*

## ABSTRACT

Reducing the exposure of children and young people to the marketing of unhealthy foods is a core strategy for reducing the high overweight and obesity prevalence in this population. The Advertising Standards Authority (ASA) has recently reviewed its self-regulatory codes and proposed a revised single code on advertising to children. This article evaluates the proposed code against eight criteria for an effective code, which were included in a submission to the ASA review process from over 70 New Zealand health professors. The evaluation found that the proposed code largely represents no change or uncertain change from the existing codes, and cannot be expected to provide substantial protection for children and young people from the marketing of unhealthy foods. Government regulations will be needed to achieve this important outcome.

## Viewpoint

New Zealand has an unacceptably high prevalence of childhood obesity,<sup>1</sup> and the Minister of Health, Dr Jonathan Coleman, has made it one of his priorities to reduce this rate through the government's childhood obesity plan.<sup>2</sup> Achieving this goal will require a significant reduction in the marketing of unhealthy foods and beverages to children and young people.

The WHO Commission on Ending Childhood Obesity, which is co-chaired by the Prime Minister's Chief Science Advisor, Professor Sir Peter Gluckman, had its report<sup>3</sup> endorsed by all Member States, including New Zealand, at the World Health Assembly in May 2016. This report supports a strong regulatory approach to reduce unhealthy food marketing to children, as do New Zealand public health experts.<sup>4,5</sup>

In 2015, the Advertising Standards Authority (ASA), the industry body responsible for the self-regulatory codes on advertising, pre-empted the launch of the

government's 22-point plan<sup>2</sup> by announcing a review of the two ASA codes which relate to advertising to children. In September 2016, the ASA's independent Review Panel submitted its report to the ASA Board, recommending including the amended code provisions to be included into a new single, combined ASA code.<sup>6</sup> Dr Coleman commented that the revised ASA code would make significant improvements to protect children and young people from exposure to the marketing of unhealthy food products.<sup>7</sup> This analysis critically assesses whether the revised ASA code will achieve that outcome.

The ASA Review Panel received 91 submissions, including 52 from public health and nutrition organisations that called for substantially strengthened codes, and 15 from the food and beverage industry sector, which largely opposed stronger codes.<sup>8</sup> For example, the Food and Grocery Council called for a lowering of the age to which the ASA code would apply from 14 years to 12 years.<sup>9</sup> Six weeks after the release of the Review Panel report, ASA asked submitters

to comment once again on two issues: the nutrient profiling system to use (see point 6 below) and the definition of targeting children (see point 7 below).

Although there is no evidence that industry-controlled, voluntary codes are effective in reducing marketing to children,<sup>10</sup> public health groups actively participated in the ASA review in the hope of strong outcomes. A group of over 70 health professors provided a submission with eight outcomes (in bold below) that they would use to assess the strength of the revised code.<sup>11</sup> How well does the proposed new code meet these outcomes?

1. **The UN Convention on the Rights of the Child (UNCROC) is expressed throughout the code.** As in the existing ASA codes, UNCROC is recognised in the introduction of the proposed combined code. However, the rules of the proposed code do not take a rights-based approach, which would give primacy to children's interests. Instead, they are a compromise between protecting the interests of children and protecting the interests of the private sector, which advertises unhealthy foods to children. Assessment: no change, outcome not achieved.
2. **The definition of children aligns with UNCROC (under 18 years).** Despite widespread agreement in the submissions from public-interest groups that a child should be defined as under 18 years, as per UNCROC, the review recommended no change from the current age of 14 years. For children aged 14–18 years, the review suggested that 'a special duty of care be taken', but did not further define what such a duty would entail. As a result, none of the new provisions in the proposed ASA code apply to adolescents 14–18 years. Assessment: no change, outcome not achieved.
3. **The objectives of the code are to reduce the exposure and power of unhealthy food marketing to children.** While the purpose of the ASA review stated that 'the best interests of children are a primary consideration', the code remains focused on the appropriateness of single advertisements rather than the overall marketing to which children are exposed. The revised code, thus, fails to address the crux of the public health concern. Although the code mentions restrictions on the use of celebrities and licensed characters popular among children, it is unclear how these restrictions will be operationalised, as commercial sponsorship and advertising on the packaging have been excluded from the proposed code. Assessment: small changes, outcome not achieved.
4. **Recommendations are made to government to significantly invest in achieving reductions in marketing to children.** Many submissions to the ASA review called for government involvement in co-regulatory arrangements because of the failure of self-regulatory approaches in New Zealand and internationally to significantly reduce unhealthy food marketing to children. The Review Panel ruled that it was out of scope for it to make any recommendations to government. Instead, they used soft language to suggest that 'advertisers be encouraged to discuss' unresolved issues such as sponsorship, advertising on packages and an appropriate nutrient profiling system with government. Despite a large number of submissions calling for independent monitoring, the Review Panel recommended that the ASA be responsible for monitoring the code. Assessment: no change, outcome is not achieved.
5. **The code covers all forms of marketing.** As in the existing ASA codes, the term advertising is defined very broadly in the proposed code, but sponsorship and advertising on product packaging are exempted. These are major forms of marketing unhealthy foods to children. The protection from the forms of advertising which are covered within the code is highly dependent on the definition of targeting children (see point 7 below). Assessment: no change, outcome is not achieved.

**6. The code defines unhealthy foods using a robust nutrient profiling (NP) system (WHO NP system recommended).**

WHO is the world's most important standard-setting organisation for health. The WHO Europe NP system has been specifically designed for marketing to children, and was the most highly recommended NP system by public health submitters.<sup>12,13</sup> The Review Panel received specific testimony from world experts who recommended the WHO Europe NP system and provided the Panel with comprehensive comparisons of various NP systems using New Zealand data.<sup>12</sup> The Panel said it could not decide on this point and recommended the Ministry of Health food and beverage classification system<sup>14</sup> be used in the interim. The Ministry's NP system has three levels (everyday, sometimes and occasional foods), and was designed for food sold in schools so would require modification to ensure suitability for this purpose. By contrast, the WHO NP system was designed specifically to limit marketing of unhealthy food to children, and has two levels (acceptable or not). **Assessment:** improvement since previous code had included no nutrient profiling system, outcome partially achieved, but pending the further round of consultations.

**7. The code clearly defines 'marketing to children' (Quebec model recommended).**

The Review Panel recommended that 'targeting' means the advertisement has 'principal appeal to children and/or young people' with the nature of the product, theme, language and images 'taken into account'. The operationalisation of these definitions is unclear. The Panel also recommended that an advertisement is 'deemed to be targeting children or young people if they are likely to comprise 25% or more of the likely audience' (although children aged 5–14 years comprise only about 20% of the total population). This figure of 25% appears to have been chosen arbitrarily. The

Review Panel had not evaluated any children audience data for the various media when it made this quantitative recommendation, and it is unclear how this rule will be operationalised. Following further inquiries on these issues to the ASA by the authors, the ASA has requested further submissions on this point. In addition, because adult viewership is in the denominator, having more adults in the audience will reduce the *percentage* of children watching but not the *total number* of children watching. The highest number of children exposed to unhealthy food advertising is during evening television (figure), which is also when the frequency of unhealthy food advertisements peaks. Indeed, in peak viewing times, 6–7pm, more than 120,000 5–13 year olds are exposed to over 15 unhealthy food advertisements an hour, creating over 2 million 'impacts' (ad impressions x viewers) per hour. Using children's viewership is a more logical and robust way to define marketing to children (see markers A and B in the figure) than including adult viewership in the metric. In Quebec, the Consumer Protection Act defines advertising as targeting children based on a) the nature and intended purpose of the goods advertised; b) the manner of presenting such advertisement; c) the time and place it is shown.<sup>15</sup> The Office of Consumer Protection has decades of experience in implementing these definitions, which are now tightly defined through multiple case judgments. The table addresses the third of these criteria for various media as they might apply in New Zealand. **Assessment:** great uncertainty in the operationalisation of the proposed definition, outcome uncertain.

**8. The code covers marketing in child and youth settings.**

The proposed ASA code states that 'Settings where children gather must be free from all forms of occasional food and beverage product advertisements'. This is an improvement in wording

**Table 1:** Suggested criteria, by media type, for determining if the timing and placement of marketing of unhealthy foods is likely to result in significant exposure to children.

Medium	Suggested criteria for excluding marketing of unhealthy foods	Comments
Television	<ol style="list-style-type: none"> <li>1. During specified children’s programming hours</li> <li>2. When a certain percentage (eg 10% or 15% see figure) of the childhood population is viewing (all channels combined).</li> </ol>	The current restrictions on marketing unhealthy foods during specified children’s programs should remain (mainly children watching but in low numbers and almost free from unhealthy food advertising). The highest children’s viewership is in the evening (mainly adults watching but also high numbers of children), and this is when the most numbers of ads for unhealthy foods are broadcast (Figure 1).
Internet	Food and beverage company websites should not have sections which market to children.	Food company websites often feature engaging techniques targeting children in branded marketing games and activities (18). Food advertising on non-food websites popular with children is very low, and is therefore not currently important.
Social media	Since marketing through social media is highly tailored to the individual, a total ban on marketing unhealthy foods to children below 14 years of age is feasible. The monitoring of compliance will, however, be more challenging than for the other media.	Children spend significant time on social media (YouTube, SnapChat, Facebook etc), and WHO has just called for urgent action on this matter in a new report. <sup>19</sup>
Magazines	Magazines which specifically cater to children and young people should not include marketing of unhealthy foods to children (including in advertorials).	Magazines specifically targeted to children and adolescents (such as Dolly, Crème and Girl-friend) contain a higher proportion of unhealthy food advertising compared to the women’s magazines which were also popular among 10–17 year olds. <sup>20</sup>
Outdoor advertising	A zone of 500m around a school is designated as free from advertising for unhealthy foods.	Children’s settings need to be expanded to cover the near school zone. <sup>21</sup>
Children’s settings	Children’s settings including early childhood settings, schools and junior sports should be free from marketing of unhealthy foods, including through sponsorships.	Disallowing marketing of unhealthy foods in children’s settings is covered in the revised ASA code, but it needs to be expanded to include sponsorship, sports settings and proximal school zones.
Super-markets and other retailers	Marketing for unhealthy foods should not specifically target children (eg in check-out aisles).	The retail sector has pledged to adhere to the proposed new code, <sup>22</sup> but how it applies in supermarkets has not been specified.

Other important criteria of the nature of the product and the manner of its presentation are not considered here.

over existing codes. However, more than 95% of schools report that they are free of food advertising (unpublished data). Sponsorship activities are the main form of marketing in children's settings, yet are exempted under the proposed code. Thus, Ronald McDonald teaching road safety to six-year-olds is not considered by the proposed code to be marketing to children. In addition, the full extent of settings included is not clear. The actual impact of this improved wording is likely to be small.

Assessment: improvement in wording, outcome uncertain.

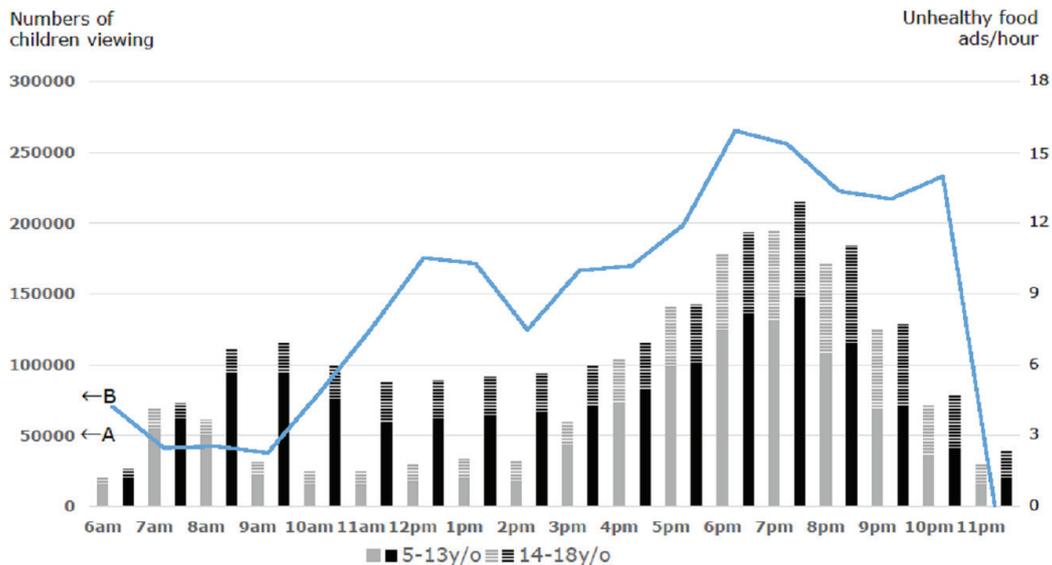
From our assessment, the revised ASA code cannot be expected to have a significant effect on restricting unhealthy food marketing to children and young people, and there is no indication that independent monitoring will be implemented to assess the code's effects. The code reflects problems endemic to self-regulation where

commercial interests conflict with public interests,<sup>10,16</sup> and falls far below current international best practice.<sup>17</sup>

In summary, we recognise the ASA's initiative in instigating a review of its codes, but we consider that, while the proposed code appears to be a small step in the right direction, it does not provide adequate protection of children and young people's interests. A further potentially serious downside is that the revised ASA code will be given as a reason by the Government for not implementing the regulations that would effectively reduce children and young people's exposure to marketing of unhealthy foods.

In our view, the Review Panel has missed a major opportunity to introduce meaningful changes that would help to reduce childhood obesity. Government regulation is urgently needed to create a policy framework which privileges children's health and well-being above commercial interests.

**Figure 1:** Numbers of children aged 5–13 years (solid bars) and 14–18 years (striped bars) in weekdays (grey bars) and weekend days (black bars) watching television (all channels combined).



A and B mark 10% and 15% respectively of the total children aged 5–13 years in New Zealand. The line represents the number of unhealthy advertisements per hour (weighted average of weekdays and weekends) as defined by WHO criteria.<sup>13</sup>

---

**Competing interests:**

Nil.

**Author information:**

Boyd Swinburn, Epidemiology & Biostatistics, University of Auckland, Auckland; Stefanie Vandevijvere, Morrin Road, Auckland.

\*Alistair Woodward, School of Population Health, University of Auckland; Andrew Hornblow, School of Medicine, University of Otago, Christchurch; Ann Richardson, Wayne Francis Cancer Epidemiology Research Group, University of Canterbury; Barbara Burlingame, School of Public Health, Massey University, Wellington; Barry Borman, Centre for Public Health Research, Massey University, Wellington; Barry Taylor, School of Medicine, University of Otago, Dunedin; Bernhard Breier, School of Food and Nutrition, Massey University, Albany; Bruce Arroll, School of Population Health, University of Auckland; Bernadette Drummond, Department of Oral Sciences, University of Otago, Dunedin; Cameron Grant, Department of Paediatrics, University of Auckland; Chris Bullen, National Institute for Health Innovation, University of Auckland; Clare Wall, School of Medical Sciences, University of Auckland; Cliona Ni Mhurchu, National Institute for Health Innovation, University of Auckland; David Cameron-Smith, Liggins Institute, The University of Auckland; David Menkes, Waikato Clinical Campus, University of Auckland; David Murdoch, Department of Pathology, University of Otago, Christchurch; Dee Mangin, Department of General Practice, University of Otago, Christchurch; Diana Lennon, School of Medicine, University of Auckland; Diana Sarfati, Department of Public Health, University of Otago, Wellington; Doug Sellman, Department of Psychological Medicine, University of Otago, Christchurch; Elaine Rush, School of Sport and Recreation, Auckland University of Technology; Faafetai Sopoaga, Department of Preventive and Social Medicine, University of Otago, Dunedin; George Thomson, Department of Public Health, University of Otago, Wellington; Gerry Devlin, Department of Medicine, University of Auckland, Waikato; Gillian Abel, Department of Population Health, University of Otago, Christchurch; Harvey White, School of Medicine, University of Auckland; Jane Coad, Massey Institute of Food Science and Technology, Massey University, Palmerston North; Janet Hoek, Department of Marketing, University of Otago, Dunedin; Jennie Connor, Department of Preventive and Social Medicine, University of Otago, Dunedin; Jeremy Krebs, Edgar Diabetes and Obesity Research Centre, University of Otago, Wellington; Jeroen Douwes, Centre for Public Health Research, Massey University, Wellington; Jim Mann, Edgar Diabetes and Obesity Research Centre, University of Otago, Dunedin; John McCall, Department of Surgical Sciences, University of Otago, Dunedin; John Broughton, Department of Oral Diagnostic and Surgical Sciences, University of Otago, Dunedin; John D Potter, Centre for Public Health Research, Massey University, Wellington; Les Toop, Department of General Practice, University of Otago, Dunedin; Lesley McCowan, School of Medicine, University of Auckland; Louise Signal, Department of Public Health, University of Otago, Wellington; Lutz Beckert, Department of Medicine, University of Otago, Christchurch; Mark Elwood, School of Population Health, University of Auckland; Marlena Kruger, School of Food and Nutrition, Massey University, Palmerston North; Mauro Farella, Department of Oral Sciences, University of Otago, Dunedin; Michael Baker, Department of Public Health, University of Otago, Wellington; Michael Keall, Department of Public Health, University of Otago, Wellington; Murray Skeaff, Department of Human Nutrition, University of Otago, Dunedin; Murray Thomson, Sir John Walsh Research Institute, University of Otago, Dunedin; Nick Wilson, Department of Public Health, University of Otago, Wellington; Nicholas Chandler, Department of Oral Rehabilitation, University of Otago, Dunedin; Papaarangi Reid, Department of Maori Health, University of Auckland; Patricia Priest, School of Medicine, University of Otago, Dunedin; Paul Brunton, Department of Oral Rehabilitation University of Otago, Dunedin; Peter Crampton, Division of Health Sciences, University of Otago, Dunedin; Peter Davis, COMPASS Research Centre, University of Auckland; Philip Gendall, Department of Marketing, University of Otago, Dunedin; Philippa Howden-Chapman, Department of Public Health, University of Otago, Wellington; Rachael Taylor, Edgar Diabetes and Obesity Research Centre, University of Otago, Dunedin;

---

Richard Edwards, Department of Public Health, University of Otago, Wellington; Robert Beaglehole, School of Population Health, University of Auckland; Robert Doughty, School of Medicine, University of Auckland; Robert Scragg, School of Population Health, University of Auckland; Robin Gauld, Otago Business School, University of Otago, Dunedin; Robert McGee, Department of Preventive and Social Medicine, University of Otago, Dunedin; Rod Jackson, School of Population Health, University of Auckland; Roger Hughes, School of Public Health, Massey University, Wellington; Roger Mulder, Department of Psychological Medicine, University of Otago, Christchurch; Ruth Bonita, School of Population Health, University of Auckland; Rozanne Kruger, School of Food and Nutrition, Massey University, Albany; Sally Casswell, SHORE and Whariki Research Centre, Massey University, Auckland; Sarah Derrett, Department of Preventive and Social Medicine, University of Otago, Dunedin; Shanthi Ameratunga, School of Population Health, University of Auckland; Simon Denny, School of Population Health, University of Auckland; Simon Hales, Department of public health, University of Otago, Wellington; Sue Pullon, Department of Primary Health Care and General Practice, University of Otago, Wellington; Susan Wells, School of Population Health, University of Auckland; Tim Cundy, School of Medicine, University of Auckland; Tony Blakely, Department of Public Health, University of Otago, Wellington.

**Corresponding author:**

Boyd Swinburn, Epidemiology & Biostatistics, University of Auckland, 261 Morrin Road, Auckland 1072.

boyd.swinburn@auckland.ac.nz

**URL:**

<http://www.nzma.org.nz/journal/read-the-journal/all-issues/2010-2019/2017/vol-130-no-1450-17-february-2017/7163>

**REFERENCES:**

1. Ministry of Health. Annual Update of Key Results 2014/15: New Zealand Healthy Survey. Wellington: Ministry of Health; 2015.
2. Ministry of Health. Childhood obesity plan Wellington: Ministry of Health; 2016. Available from: <http://www.health.govt.nz/our-work/diseases-and-conditions/obesity/childhood-obesity-plan>
3. World Health Organisation. Report of the Commission on Ending Childhood Obesity. Geneva: World Health Organisation; 2016.
4. Vandevijvere S, Swinburn B. Time to move beyond industry self-regulation of food marketing in New Zealand. *N Z Med J.* 2015; 128(1423):93–4.
5. Vandevijvere S, Dominick C, Devi A, Swinburn B. The healthy food environment policy index: findings of an expert panel in New Zealand. *Bull World Health Organ.* 2015; 93(5):294–302.
6. Advertising Standards Authority. Report on the review of the Children's Code for Advertising Food and the Code for Advertising to Children, 2016. Available from: <http://www.asa.co.nz/wp-content/uploads/2016/10/Final-Report-Childrens-Codes-Review.pdf>
7. Johnston M. New restrictions proposed on advertising food to children, Health Minister says. *NZ Herald.* 2016, 20 October 2016. Available from: [http://www.nzherald.co.nz/health/news/article.cfm?c\\_id=204&objectid=11732810](http://www.nzherald.co.nz/health/news/article.cfm?c_id=204&objectid=11732810)
8. Advertising Standards Authority. Submissions Received for the Review of the Children's Code for Advertising Food and the Code for Advertising to Children; 2016. Available from: <http://www.asa.co.nz/submissions-childrens-codes-reviews/>
9. New Zealand Food and Grocery Council. Comments from the NZFGC on the Consultation on the Review of the Code for Advertising to Children and the Children's Code for Advertising Food; 2016. Available from: <http://www.asa.co.nz/wp-content/uploads/2016/10/82.-NZ-Food-and-Grocery-Council.pdf>
10. Galbraith-Emami S, Lobstein T. The impact of initiatives to limit the advertising of food and beverage products to children: a systematic review. *Obes Rev.* 2013; 14(12):960–74.
11. Advertising Standards Authority. Submission to the Consultation on the review of the Code for Advertising to Children and the Children's Code for Advertising Food.

- From a group of 73 health professors. 2016. Available from: <http://www.asa.co.nz/wp-content/uploads/2016/10/86.-Professor-Boyd-Swinburn-on-behalf-of-73-Health-Professors.pdf>
12. Ni Mhurchu C, Mackenzie T, Vandevijvere S. Protecting New Zealand children from exposure to the marketing of unhealthy foods and drinks: a comparison of three nutrient profiling systems to classify foods. *N Z Med J.* 2016; 129(1441):41–53.
  13. World Health Organisation. WHO Regional Office for Europe nutrient profile model Copenhagen: WHO Regional Office Europe; 2015. Available from: [http://www.euro.who.int/\\_\\_data/assets/pdf\\_file/0005/270716/Nutrient-Profile-Model.pdf?ua=1](http://www.euro.who.int/__data/assets/pdf_file/0005/270716/Nutrient-Profile-Model.pdf?ua=1)
  14. Ministry of Health. Food and beverage classification system for years 1-13.; 2007.
  15. Quebec Government. Advertising directed at children under 13 Years of Age: Guide to the Application of Sections 248 and 249, Consumer Protection Act. In: *Consommateur OdIPD*, editor. Quebec 2012.
  16. Lumley J, Martin J, Antonopoulos N. Exposing the Charade: The failure to protect children from unhealthy food advertising. Melbourne: Obesity Policy Coalition; 2012.
  17. World Cancer Research Fund. WCRF International Food Policy Framework for Healthy Diets: NOURISHING 2014. Available from: [http://www.wcrf.org/policy\\_public\\_affairs/nourishing\\_framework/food\\_marketing\\_advertising](http://www.wcrf.org/policy_public_affairs/nourishing_framework/food_marketing_advertising)
  18. Vandevijvere S, Sagar K, Kelly B, Swinburn B. Unhealthy food marketing to children through the Internet in New Zealand. *N Z Med J.* 2016; 130(1450):32–43.
  19. World Health Organization Europe. Tackling food marketing to children in a digital world: trans-disciplinary perspectives Geneva: World Health Organization Europe; 2016. Available from: <http://www.euro.who.int/en/health-topics/disease-prevention/nutrition/publications/2016/tackling-food-marketing-to-children-in-a-digital-world-trans-disciplinary-perspectives-2016>
  20. No E, Kelly B, Devi A, Swinburn B, Vandevijvere S. Food references and marketing in popular magazines for children and adolescents in New Zealand: A content analysis. *Appetite.* 2014; 83:75–81.
  21. Vandevijvere S, Sushil Z, Exeter DJ, Swinburn B. Obesogenic Retail Food Environments Around New Zealand Schools: A National Study. *Am J Prev Med.* 2016 51(3):e57–66.
  22. Countdown. Countdown Health and Nutrition Targets 2016. Available from: [http://s3-ap-south-east-2.amazonaws.com/countdownnz/Countdown+Health+and+Nutrition+Targets\\_2016\\_FINAL.pdf](http://s3-ap-south-east-2.amazonaws.com/countdownnz/Countdown+Health+and+Nutrition+Targets_2016_FINAL.pdf)