Better health or better business: a critique of the childhood obesity plan

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Dr Jonathan Coleman, Minister of Health, announced on 12 February 2015, that he would lead the development of a comprehensive plan to address New Zealand's obesity crisis. This was celebrated by those working with obesity and its related consequences, who have long called for action. Here, we critically examine the plan and its strategies to reduce obesity.

FIZZ New Zealand is a Public Health Advocacy group that aims to address child and adult obesity by reducing sugary drink consumption to zero by 2025. Sugar sweetened beverages (SSBs) are the largest contributor of added sugar to the diets of New Zealanders (children and adults); evidence shows SSB intake is strongly associated with the onset of obesity.[1]

On 19 October 2015, the Childhood Obesity Plan (ChOP) was announced. The **ChOP** comprises 22 initiatives (9 new) that seek to achieve two broad goals: i) target obese individuals and those at risk of developing obesity, and ii) create broad opportunities to make healthier choices easier.

1. Critique of Initiatives in the Childhood Obesity Plan

More than half (12) of the 22 initiatives that comprise the **ChOP** are educational, and a further four focus on treating obesity in children and pregnant women. Increased activity and sport opportunities as well as policy initiatives each comprise another two initiatives. Healthy Families NZ (HFNZ) is the only whole-of-community intervention (**table**).[2]

The majority of the **ChOP** initiatives are *'business as usual'* and are unlikely to make a difference to NZ's obesity crisis. Evidence shows that we cannot educate or exercise our way out of the obesity epidemic.[3,4] Identification and treatment of obese pre-schoolers and pregnant mothers does not address the causes of obesity. Instead, it is the *'ambulance at the bottom of the cliff'*.

The use of a food labelling system offered promise; however, the Government adopted the most industry-friendly labelling system. The current health star labelling system is flawed, because it is voluntary, confusing, and rates many foods with high concentrations of sugar as healthy. For example, Sanitarium Natural Muesli breakfast cereal is rated 4.5 stars (out of 5), and has 20g sugar/100g (which equates to 2 teaspoons per 40g serve). Conversely, macadamia nuts, which contain little sugar, instead are rated near the bottom of the scale at 2.5 health stars. These examples illustrate that the system that is heavily weighted toward saturated fat and salt content and underestimate the role of sugar.

Research has shown that policy and regulation is the most effective approach to change behaviours by creating a more health-promoting environment to reduce obesity prevalence.[3] These regulations need to be targeted at the major cause of the epidemic, which is increasingly shown to be excess sugar. Targeted regulation is the most cost-effective type of initiative in obesity prevention.[3]

The **ChOP** has two initiatives in the policy area. Firstly, the **Advertising Standards Authority** (ASA) have been instructed to review their codes of advertising to children and code of advertising food to children. The ASA is funded by industry and there is no monitoring of these codes by an independent party which means improvements are unlikely to be made.

Table: Childhood Obesity Plan – 22 Initiatives.

INFORMATION	TREATMENT	ACTIVITY	POLICY	INTERVENTION
22. Eating + activity guidelines				
18. ERO report on schools				
17. Teachers learning/develop				
12. Public awareness campaign	NEW			
11. Info / resource for public				
8. Health star rating label.		NEW		
19. Health promoting schools				
16. PM Education Awards				
15. Sport in education extension	1. Child obesity B4SC check - referrals			
14. PA guidelines for under 5s	7. refer to GRx at risk pregnant women			
5. Guidance for healthy weight in pregnancy	6. Gestational diabetes guidelines	13. Play sport	9. Marketing / Advert to kids	
4. Guidance for weight management in children and YP	2. Activity and PA programmes for families	3. Kiwisport	21. DHB beverage policy	20. Healthy Families NZ (HFNZ)

Note: Initiative 10. *Partnership with Industry* – not included at conceptual stage.

From our perspective, the only policy initiative that shows promise in the **ChOP** is the beverage policy which bans the sale of sugary drinks in hospital premises throughout NZ. HFNZ is a whole of community initiative that may also show promise.[3]

2. The ChOP focuses on energy density rather than sugar

The plan is focused on a philosophy and apparent evidence that "*Energy (kilojoule) intake is key – the amount of food consumed and its energy density is the single biggest driver of obesity*".[5]

The greatest determinant of energy density is fat content, making a low-energy focus a low-fat approach.[6] However, trials of low-fat approaches are not effective for weight loss in individuals[7] and are unlikely to be successful for populations. Furthermore, over the last few decades, a low-fat approach has underpinned obesity treatment and prevention efforts in New Zealand as well as other Western countries. Despite this, the prevalence of obesity and type 2 diabetes has risen. New trial and observational evidence has highlighted the unique role of sugar (concentrated fructose) in the development of unhealthy weight gain,[8] type 2 diabetes,[9] gout,[10] cardiovascular disease[11] and dental caries.[12] Considering this new evidence, sugar restriction needs to be prioritised.

Recently, the Government evaluated the utility of a sugar tax. However, seen through the lens of energy density, policy advisors have been lukewarm toward this strategy. Importantly, the evidence linking sugar intake with a wide range of diseases was absent from these reports.[5]

With a renewed focus that prioritises sugar (concentrated fructose), initiatives included in the **ChOP** would be transformed. ***Education and information***—initiatives would be centred around communicating risks of a high sugar diet, highlighting maximum daily intake of sugar, and raising health literacy to enable consumers to calculate sugar content based on back of pack nutrition labels. A simple label that gives the number of teaspoons of sugar per serve, we believe, would be more effective than the current confusing star system.

In ***treatment*** settings, brief opportunistic screening of sugar and SSB intake could be adopted, as is done with smoking cessation. ***Policy and regulation*** need to prioritise sugar restriction, making SSBs and products with concentrated sugar content absent in schools and other education providers.

Perhaps the most effective measure would be introducing fiscal measures to deter intake of sugary products, as well as incentivising industry to reformulate their products to reduce sugar content or offer zero sugar alternatives.

3. The case for a sugar sweetened beverage tax

An initiative that was not included in the **ChOP**—despite being called for by many authorities—was a sugar-sweetened beverage tax (SSB tax). An SSB tax is the second recommendation made by the World Health Organization (WHO) Ending Childhood Obesity Commission and was recommended by the Technical Advisory Group (a group of New Zealand experts in the field of obesity prevention established by the Ministry of Health). However, it was not supported by the Industry Forum Group who contributed to the development of the **ChOP**. Other organisations that also recommend a SSB Tax include the New Zealand Medical Association and the NZ Beverage Guidance Panel.[13,14] Renewed calls for an SSB tax in NZ have been fueled since the UK announced that it would implement a SSB tax from 2018. Our Minister of Health and Government remain unconvinced about an SSB tax, stating instead that they are awaiting 'definitive evidence' before they consider action.

The most recent and comprehensive evidence on SSB taxes (in Mexico) was reported in the British Medical Journal in January 2016.[15] The study found a 12% reduction in sales following the introduction of a 10% sugary drink tax.[15] Here in NZ, an open letter was submitted to cabinet ministers—supported by 74 health professors—calling for an SSB tax.[16] Most importantly, New Zealand public support for a SSB tax has increased dramatically. A recent NZ Herald poll reported 83% support for a SSB tax from 11,700 respondents.[17]

Conclusion

The Childhood Obesity Plan is unlikely to solve New Zealand's obesity crisis. It is based on a dated paradigm of energy density and does not address what we believe to be the greatest cause of the epidemic: excess sugar intake. The Government's plan lacks meaningful regulation of food and drink containing concentrated sugar, instead listing soft initiatives that are unlikely to be beneficial.

It shows that the Government values corporate profit over public good. The New Zealand public are becoming increasingly vocal in their support of a SSB tax, and frustrated with the complacent attitude of decision makers tasked with addressing NZ's growing obesity crisis.

We reiterate that the introduction of an SSB tax is an important step toward addressing obesity, and will make a strong statement that NZ, as a society, value health over corporate profits. We call for the current Minister of Health and government to embrace the opportunity to reduce NZ's worsening obesity epidemic by adopting such a step. There is no question that a SSB tax will come, the only question is who will initiate it?

Competing interests:

Nil.

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