Supplementary Submission No 9a

INQUIRY INTO INQUIRY INTO CHILDHOOD OVERWEIGHT AND OBESITY

Organisation: Charles Perkins Centre, The University of Sydney

Date Received: 21 October 2016

NSW Legislative Council's Standing Committee on Social Issues
Parliament House
6 Macquarie Street
Sydney
NSW 2000

10 October 2016

Dear Honourable Committee members,

Inquiry into childhood overweight and obesity

We are pleased to provide this document to complement our earlier submission and in support of the opening verbal statement to the Committee by ***Professor Ian Caterson*** and ***Professor Bill Bellew***. We anticipate and address four important questions: (i) what is the rationale for government intervention? (ii) why is a sugar-sweetened beverage tax needed? (iii) why are marketing regulations required? and (iv) why is it important to commence our prevention efforts in the early years?

We were pleased to provide for your consideration a submission (19th August 2016) prepared by a scientific team of world leading authorities on obesity prevention and control. The team harnesses expertise from five key research teams based at The Charles Perkins Centre: the World Health Organization Collaborating Centre for Physical Activity, Nutrition and Obesity; the World Obesity Federation; Obesity Australia; The University of Sydney's Boden Institute of Obesity, Nutrition, Exercise & Eating disorders and the Prevention Research Collaboration.

The Baird government is to be commended for strong and decisive leadership in recognising the complexity and severity of childhood obesity. By tackling this problem now and by adopting the issue as one of the 12 Premier's Priorities, the government has recognised the huge social, health and economic importance of this issue.

We make four key recommendations based on the proven "best buys" in the prevention of Childhood Obesity; additionally we make 10 recommendations (four in 'maintain and expand' and six in 'new investment' categories).

Yours sincerely,

PROFESSOR STEPHEN J. SIMPSON AC FAA FRS
Academic Director, Charles Perkins Centre

Boden Institute of Obesity, Nutrition
Exercise & Eating Disorders

Submission to the Standing Committee on Social Issues, Parliament of New South Wales Inquiry into Childhood overweight and obesity

EXECUTIVE SUMMARY

- This submission is the work of five research teams based at The Charles Perkins Centre: the World Health Organization Collaborating Centre for Physical Activity, Nutrition and Obesity; the World Obesity Federation; Obesity Australia; The University of Sydney's Boden Institute of Obesity, Nutrition, Exercise & Eating disorders and the Prevention Research Collaboration.
- The economic impact of obesity in NSW alone is estimated to be $19 billion annually, consisting of $2.7 billion in financial costs (including productivity losses) and $16.3 billion in costs due to lost wellbeing.
- Meeting the NSW Government target to reduce child overweight and obesity by 5% within 10 years (by 2025) will require more intensive implementation of some current programs and policies, together with substantial new investment overall for a comprehensive set of initiatives, delivered at scale and sustained for the decade.
- Whilst no individual policy or program can in itself create sufficient impact to reverse obesity (only a systemic, sustained, comprehensive portfolio of cumulative initiatives, delivered at scale, is likely to be effective) it is nonetheless possible within the required comprehensive approach to identify the policies and programs known to be most impactful and cost-effective for the NSW government and beneficial for the NSW community.
- Four "best buys: are recommended:
  1. Implement an effective tax on sugar sweetened beverages (SSBs);
  2. Reduce children's exposure to the marketing of SSBs and other energy-dense nutrient-poor foods by implementing internationally agreed recommendations;
  3. Provide programs to support parents before, during and after pregnancy, at home as well as in childcare, paediatric healthcare and in educational settings.; and
  4. Strengthen existing initiatives of the NSW Government and of non-government organisations which have been proven effective (four specific initiatives); use new investment to build the comprehensive strategy needed to meet the Premier's 2025 target for childhood obesity (six specific initiatives).

The rationale for government intervention

Obesity is the result of people responding normally to the obesogenic environments they find themselves in. Governments have largely abdicated the responsibility for addressing obesity to individuals, the private sector and non-governmental organisations, yet the obesity epidemic will not be reversed without government leadership, regulation, and investment in programmes, monitoring and research.

There are considerable challenges to introducing regulatory measures to curb the obesity epidemic. Our complex and multilayered system is often used as an excuse for inaction. Industry opposition is understandable and reminiscent of the opposition to interventions to reduce tobacco consumption. In the face of the powerful industry lobby, governments are reluctant to take decisive action opting for ineffective soft options. Voluntary action alone will not solve this problem [1].

Support from international organisations

Increasingly international organisations acknowledge taxation as an important tool in tackling unhealthy diets. The 2016 report of the World Health Organization Commission on Ending Childhood Obesity recommended implementing an SSB tax and recommendations on the marketing of unhealthy foods [2]. It's time for decisive government intervention and for Australia to have an informed and comprehensive dialogue on a range of regulatory interventions to address the obesity epidemic.

Four well-established 'market failures' justify government intervention

There is ample justification for protecting children's health from the predatory effects of markets, yet almost universally, governments are failing in this responsibility. The charge of so-called 'nannyism' almost inevitably arises in relation to regulatory interventions, yet for children, and even for adults, governments have a fundamental role in helping to make healthy choices the easy choices [1]:

1. Children are a vulnerable group that warrant societal protection. They are not mature, they do not have nutritional knowledge, are unable to perceive the risks of their behaviour, and their choices are readily affected by marketing.
2. They do not have the information necessary to make fully informed decisions about their food selection.
3. They prioritise immediate gratification over potential long-term negative results – a hallmark of childhood.
4. The spill-over effects (or externalities); although yearly health-care costs to the taxpayer are higher for obese than for non-obese people, reduced life expectancy due to obesity makes it uncertain whether the life-time social costs are actually higher. Externalities may impact at the family level through reduced household income or additional carer duties.

Why a sugar-sweetened beverage tax is needed

How much autonomy do we really have in our food choices? There are numerous examples of our choices being constrained. Over the years food manufacturers have increased the size of a standard portion in the knowledge that larger containers alter the norm of an appropriate portion size and increase consumption. Opposition to taxing food has also been framed in the context that unlike other public health threats which are uniformly harmful, food is not. However, consumption of SSBs comes with no nutritional benefits. In this respect an SSB tax is best compared with alcohol taxes since alcohol is also not uniformly harmful with health harm related to heavy or excessive consumption, while limited consumption may pose little health risk.

It has been successfully implemented in Mexico

The introduction of a sugar tax in Mexico in January 2014 resulted in a marked difference in consumption patterns. After the introduction of a 10% tax, the purchase of sugary beverages fell by 12% in the first year; sales of bottled water and beverages with no added sugar increased by 4%. Among the poorest households, which tend to drink more soda and have higher obesity rates, the annual average sale of sugary drinks dropped by 9% and by December 2014, sales had decreased by 17% [3].

There is little or no unfair disadvantage to vulnerable groups

Concern has been expressed that an SSB tax will unfairly disadvantage lower socio-economic groups who will continue to consume SSBs but pay more. This is true. The analysis of the Mexico tax found that while all socioeconomic groups purchased fewer taxed beverages, the reductions were higher in low socioeconomic households [3].

The overall impact of an SSB tax has also been challenged on the basis that consumers will substitute SSBs with cheaper equally unhealthy options. There is little direct evidence on substitution and data rely on models based on self-reported consumer purchase data and price elasticity. Overall these studies find a reduction in energy intake and weight with no evidence of substitution with other sugary beverages but that almost half the reduction in SSB calories may be compensated for by an increase in fat intake [4].

There are considerable economic benefits

At a national level in Australia, an additional 20% tax on SSBs would generate an estimated AUD400 million in revenue each year. Extrapolating this for the NSW population, a 20% tax on SSBs would generate AUD128 million in revenue each year [5].

Why marketing regulations are required

Commercial speech is entitled because it provides valuable information to consumers and the overall marketplace but not when it is misleading.

Advertising to children is misleading

Advertising to children is misleading because it is misunderstood by its intended audience, or inherently misleading because under no circumstances could the intended audience properly comprehend it [6]. The evidence indicates that for a child to fully comprehend advertising requires the mastery of at least three progressively more sophisticated levels of understanding [6]:

1. The child must be able to distinguish program content from commercial advertising; until about age 4 or 5, most children do not reliably make this distinction.
2. The child must recognise the basic selling intent of advertising messages; until about age 8, most children do not consistently demonstrate such knowledge.
3. The child must recognise the inherent bias that necessarily underlies commercial advertising; until about age 11 or 12, children generally lack effective understanding of advertising tactics such as exaggeration, embellishment and "puffery."

An inability to master any one of these concepts means that the child cannot effectively comprehend advertising. This renders the advertising inevitably misleading. Given this, government regulation relating to advertising to children younger than age 12 is required [6]; a self-regulatory system is not enough [7].

The importance of starting at the beginning – the early years of life

Early-life influences, beginning with the intrauterine environment and continuing through the first few years of life, also shape the trajectory of weight gain and body fatness throughout the life course. The evidence is now substantiated, demonstrating as association with obesity, diabetes and other chronic diseases relating to mismatches occurring during the preconception period as well as many critical periods of foetal and infant development. The evidence supports the notion that obesity prevention should start *before conception and extend at least through the first 1 to 2 years of life*. Acting early can change lifetime predisposition for obesity not only effectively but also cost effectively [8]. More women are beginning pregnancy overweight or obese and excessive weight gain during pregnancy is more now very common. An excessive weight gain during pregnancy is related more than four times the risk of being overweight at age 3 [9]. This is not dismissing the role genes clearly play a role in driving an individual's propensity to gain excess weight. In general, obese parents are more likely to have obese children, and genetic makeup plays a role. The tremendous increase in obesity prevalence in the past decades, however, cannot be explained by genetic change alone. The change in prevalence over time has simply been too fast. The environment has changed and it is likely that a combination of genetic susceptibility to obesity with an obesogenic environment explains a large part of the rise in paediatric obesity [8]. As Professor George Bray (an obesity researcher from Harvard) said, "the genetic background loads the gun, but the environment pulls the trigger".

REFERENCES

1. Swinburn BA, Sacks G, Hall KD, McPherson K, Finegood DT, Moodie ML, Gortmaker SL. The global obesity pandemic: shaped by global drivers and local environments. Lancet 2011; 378: 804-814.

2. World Health Organization. Report of the Commission on Ending Childhood Obesity. World Health Organizarion: Geneva; 2016. Available from http://www.who.int/end-childhood-obesity/final-report/en/

3. Colchero MA, Popkin BM, Rivera JA, Ng SW. Beverage purchases from stores in Mexico under the excise tax on sugar sweetened beverages: observational study. BMJ 2016; 352: h6704.

4. Chaloupka FJ, Powell LM, Chriqui JF. Sugar-sweetened beverages and obesity: the potential impact of public policies. J Policy Anal Manage 2011; 30: 645-655.

5. Veerman JL, Sacks G, Antonopoulos N, Martin J. The impact of a tax on sugar-sweetened beverages on health and health care costs: a modelling study. PLoS One 2016; 11: e0151460.

6. Graff S, Kunkel D, Mermin SE. Government can regulate food advertising to children because cognitive research shows that it is inherently misleading. Health Aff 2012; 31: 392-398.

7. Potvin KM, Wanless A. The influence of the Children's Food and Beverage Advertising Initiative: change in children's exposure to food advertising on television in Canada between 2006-2009. Int J Obes 2014; 38: 558-562.

8. Gahagan S, Uauy R, Roseboom TJ. Developmental origins of pediatric obesity. Int J Pediatr 201: 309863

9. Oken E, Taveras EM, Kleinman KP, Rich-Edwards JW, Gillman MW. Gestational weight gain and child adiposity at age 3 years. Am J Obstet Gynecol 2007; 196: 322.