



**Submission to the Senate Select Committee
into the obesity epidemic in Australia**

Obesity Policy Coalition

July 2018

Terms of Reference

The Select Committee into the obesity epidemic in Australia, established on 16 May 2018 to inquire into and report on 14 August 2018, on the following matters:

1. The prevalence of overweight and obesity among children in Australia and changes in these rates over time;
2. The causes of the rise in overweight and obesity in Australia;
3. The short and long-term harm to health associated with obesity, particularly in children in Australia;
4. The short and long-term economic burden of obesity, particularly related to obesity in children in Australia;
5. The effectiveness of existing policies and programs introduced by Australian governments to improve diets and prevent childhood obesity;
6. Evidence-based measures and interventions to prevent and reverse childhood obesity, including experiences from overseas jurisdictions;
7. The role of the food industry in contributing to poor diets and childhood obesity in Australia; and
8. any other related matters.

Executive Summary

This submission highlights the need for a comprehensive approach supported by a long-term national strategy to improve diets and tackle the spiralling impact obesity, and associated chronic disease, are having on our healthcare system, economy and society as a whole.

This epidemic has also reached Australian children. More than a quarter of Australian children are now in an unhealthy weight category, equating to more than 1 million children in Australia who are overweight or obese. These children have a much greater chance of becoming obese adults, and consequently face increased risks of developing a chronic condition such as type 2 diabetes, heart disease or cancer. The situation is so serious that many of the current generation of children are expected to die at an earlier age than their parents.

The consumption of energy dense, nutrient poor foods has increased significantly among adults and children over the past 30 years. This trend is fuelled by the increased availability and marketing of unhealthy food and drinks, and their decreased relative costs.

The problem of overweight and obesity cannot be tackled by focusing solely on the individual. It is not merely a product of poor individual choices, but is heavily influenced by a person's social, physical and economic environment.

There is increasing support and impetus from the international community and peak health bodies to take decisive policy action on overweight and obesity, particularly in children. In addition, there is significant public support from Australians for the adoption of recommended policy measures by the government.

Australia currently lacks a coherent, sustained obesity strategy at a time when the country's future health, wellbeing and productivity is being threatened by weight related illness. In the long term, it is expected that the economic costs of obesity will increase significantly. We have clear recommendations and pathways to tackle the issue. The federal government needs to integrate these into a long-term national obesity prevention strategy to ensure that our children have the best opportunities to lead healthy and productive lives.

Summary of Recommendations

The Obesity Policy Coalition recommends that the Federal Government:-

- **Makes the following changes to the Health Star Rating System (HSRS):-**
 - **Makes the HSRS mandatory.**
 - **Modifies the HSRS calculator to correct inappropriately high ratings for some foods with relatively high levels of added sugar, sodium and saturated fat.**
 - **Replaces the current 'as prepared' rules with a new option whereby the HSR of products would be calculated on the basis of products 'as sold', apart from products that are required to be drained or reconstituted with water prior to consumption.**
 - **Allocates significant funds to promote the key messages of the HSRS firmly in the context of a healthy diet across a wide range of media.**
- **Introduces a whole-of-government obesity prevention strategy comprised of the measures outlined below.**
- **Sets clear, specific nutrient reformulation targets, with a fixed timeframe for each target to be met.**
- **Requires manufacturers to identify added sugars on food labels, where sugars are added as a separate ingredient.**
- **Introduces advisory labels on foods which are high in unhealthy ingredients, such as sugary drinks.**
- **Introduces a 20% levy on sugary drinks.**
- **Regulates to reduce the volume and influence of unhealthy food marketing reaching children. A new scheme must have the following features:-**
 - **It must be mandatory and apply equally to any organisation advertising food and beverage products, including manufacturers, retailers or restaurant chains.**
 - **It must be comprehensive and apply to all forms of marketing, media and promotion.**
 - **It must restrict marketing that appeals to children in either its content or placement, including effective control of digital marketing.**
 - **It must clearly define 'unhealthy food' by reference to an appropriate nutrient profiling model.**
 - **It must apply to children under 16 years of age, at a minimum.**
 - **It must include strong governance, compliance and enforcement provisions. A new scheme must be administered and enforced by an independent agency and impose meaningful disincentives and sanctions for breach.**
- **Updates the Australian Dietary Guidelines.**
- **Only includes those parties whose sole interest is in the promotion of public health in obesity prevention policy formulation.**

Senate Select Committee into the obesity epidemic in Australia

The Obesity Policy Coalition (OPC) is pleased to have the opportunity to comment on the Terms of Reference for the Senate Select Committee into the obesity epidemic.

The OPC is a partnership between Cancer Council Victoria, Diabetes Victoria and the Global Obesity Centre at Deakin University, a World Health Organization (WHO) Collaborating Centre for Obesity Prevention. The OPC advocates for evidence-based policy and regulatory change to address overweight, obesity and unhealthy diets in Australia, particularly among children.

Introduction

There is increasing support and impetus from the international community and peak health bodies to take decisive policy action on overweight and obesity, particularly in children. The World Health Assembly's *Global Action Plan for the Prevention and Control of Non-communicable Diseases 2013–2020* provides guidance on a range of evidence-based policy interventions that governments should consider to reduce the burden of Non-communicable diseases. Further, the WHO's Commission on Ending Childhood Obesity Report provides a model comprehensive strategic approach, strategic objectives and policy options.

The problem of overweight and obesity cannot be tackled by focusing solely on the individual. It is not merely a product of poor individual choices, but is influenced by a person's social, physical and economic environment.

A comprehensive approach supported by a long-term national strategy is required to improve diets and reduce overweight and obesity in Australia. There is an urgent need for the federal government to demonstrate leadership in relation to overweight and obesity through the adoption of a whole-of-government obesity prevention strategy. There is significant support for regulatory measures from the public.

Terms of Reference

1. *The prevalence of overweight and obesity among children in Australia and changes in these rates over time;*

Australia is in the midst of a childhood obesity epidemic that threatens our children's health and wellbeing. Childhood overweight and obesity has escalated to the point that over 27.4% of Australian children aged 5-17 are now overweight or obese,¹ up from 21% in 1995. The obesity rate has risen from 5% in 1995 to 7.4% in 2014-15.^{2 3} Put another way, there are currently over 1 million children in Australia who are overweight or obese. These children have a much greater chance of becoming obese adults, and consequently face increased risks of developing a chronic condition such as type 2 diabetes, heart disease or cancer.⁴ As a result of this obesity epidemic, many of the current generation of children are expected to die at an earlier age than their parents.⁵

Adults and children from a low socio-economic background experience higher rates of overweight and obesity.⁶ The gap in obesity rates between those with a tertiary education and those with lower levels of educational attainment is widening and modelling suggests

that if no further action is taken this will grow to a 14% gap in obesity rates between the highest and lowest education groups by 2025.⁷

Aboriginal people are also at increased risk of overweight and obesity as well as the impact of unhealthy diets.⁸ Almost two thirds (66%) of Aboriginal and Torres Strait Islander adults and almost one third (30%) of Aboriginal and Torres Strait Islander children are overweight or obese.⁹ Aboriginal and Torres Strait Islanders also experience disproportionate rates of type 2 diabetes compared to non-indigenous Australians.

2. The causes of the rise in overweight and obesity in Australia;

Minimising consumption of discretionary (energy dense, nutrient poor) food and drink and engaging in physical activity is the best way to maintain a healthy weight. Modelling indicates that the increased energy intake that has occurred over the past few decades is more than enough to explain the parallel increase in body weight.¹⁰ This increased energy intake has occurred mainly as a result of increased consumption of energy-dense, nutrient poor (high fat and/or sugar) foods and beverages.¹¹

The consumption of energy dense, nutrient poor foods has increased significantly among adults and children over the past 30 years. For example, one third of adults and almost half of children drink sugary drinks daily.¹² Young Australians, in particular adolescent boys, are commonly high consumers of energy dense, nutrient poor products such as soft drink, burgers and chips, for example 51 per cent of teenage males consume soft drinks and one in four teenage males consume a burger on any given day.¹³

Within Australian adults' diets, 35% of the energy consumed comes from 'junk' food including sugary drinks and alcohol (termed 'discretionary' choices in the Australian dietary Guidelines). Amongst children, 39% of the energy in their diets comes from 'junk' food.¹⁴ Australian households spend 58% of their food budget on unhealthy foods and drinks and just 15% on fruit and vegetables.¹⁵ Data from the National Health Survey 2014–2015 has shown that only 7% of Australian adults, and 5.4% of children, meet the recommended 5 serves of vegetables per day, with fruit consumption being higher but also generally falling short of recommended serves.¹⁶

These patterns of consumption are fuelled by the increased availability, decreased relative costs and the increased marketing of food and drinks that are energy dense and nutrient-poor. Other socio-environmental factors contributing to the rise in overweight and obesity in Australia include an increased reliance on car travel due to urban design, an increase in sedentary jobs, longer working hours, and reduced perceptions of safety leading to fewer opportunities for physical activity.¹⁷

3. The short and long-term harm to health associated with obesity, particularly in children in Australia;

3A Short term effects of obesity in children

Obesity carries additional, short-term health effects in childhood including gastrointestinal, musculoskeletal and orthopaedic complications, hyperinsulinaemia, poor glucose tolerance and a raised risk of type 2 diabetes, hypertension, sleep apnoea, and depression.^{18 19}

Obesity in childhood also has social impacts for children. It can contribute to behavioural and emotional difficulties, such as stigmatisation, poor socialisation and reduced educational attainment.²⁰ An international meta-analysis examined associations between overweight and obesity and likelihood of bullying. Sixteen studies focusing on children and adolescents from 13 countries were included in the review. The researchers found that being overweight or obese was associated with increased likelihood of being a victim of bullying in both boys and girls.²¹

3B Long term effects in children and adults

Childhood obesity is also associated with a range of very serious health problems and increases the risk of premature illness and death later in life.²² Research shows that 25–50% of obese adolescents remain obese into adulthood.²³ Studies also suggest that the risk of cardiovascular disease and all-cause mortality is elevated among those who were overweight during childhood.²⁴

Overall, poor diets and high body mass index are the major risk factors contributing to Australia's significant disease burden, ahead of smoking-related illness.²⁵ High body mass now contributes 5.5% of the total burden of disease in Australia while dietary risk factors account for 7.2%, the third and second major contributors after tobacco use (9%).²⁶ Overweight and obesity lead to heightened risk of developing chronic diseases including cancer, cardiovascular disease and type 2 diabetes. If current trends continue, approximately 1.75 million deaths will have been caused by overweight and obesity between 2011 and 2050, with an average loss of 12 years of life for each Australian who dies before the age of 75 years.²⁷

Cancer risk factor

A recent review of more than one thousand studies by International Agency for Research on Cancer found that that being overweight or obese increases risk for at least 13 types of cancer, including common cancers such as breast and colon.²⁸ A large 2015 Australian study estimated the population attributable fraction (PAF) (or prevented fraction) of cancers associated with exposure to causal (or preventive) factors. They found that in Australia inadequate (unhealthy) diet was attributable for 7,000 (6.2%) cancer cases and overweight and obesity was attributable for 3,900 (3.4%) cancer cases each year.²⁹

Prevention of obesity is also important for cancer survivors. There is convincing evidence that obesity is associated with an increased risk of breast cancer recurrence, and recent similar evidence on obesity is accruing for other cancers including prostate cancer.³⁰ A number of studies have also shown that physically active cancer survivors have a lower risk of cancer recurrence and improved survival rates.³¹

Heart Disease and Type 2 Diabetes risk factors

Obesity is also the leading risk factor for type 2 diabetes.³² Even being overweight significantly increases the risk.³³ The contribution of overweight and obesity to cardiovascular disease and type 2 diabetes is significant. Dietary risk factors are estimated to contribute 35% and 33% of the disease burden respectively and high body mass contributes 21% and 49% respectively.³⁴

Increased disability

The direction of causation between obesity and disability is not always clear; however there are a number of studies that do provide insights into the fraction of disability attributable to obesity. The 2012 AusDiab study found that the rate of disability in people over 60 years was more than twice as frequent amongst people who were obese compared to those of a healthy weight (46% v 22%).³⁵ A 2012 PWC report estimated that 1.5% of people under 65 years with very severe obesity (BMI > 40kg/m²) receive the disability support pension due to obesity, at a cost of \$133 million to the federal government annually.³⁶

4. *The short and long-term economic burden of obesity, particularly related to obesity in children in Australia;*

Currently in Australia investment to prevent ill health is at extremely low levels with less than \$1 in \$50 of the allocation on health used for public health and prevention measures.³⁷ Current modelling estimates that if no further investment is made by 2025, 83% of males and 75% of females over 20 will be overweight or obese.³⁸ This would have an enormous impact on health care spending, chronic disease and quality of life. Each additional percentage increase in the rate of obesity costs an additional \$4 billion per year.³⁹ The costs of overweight and obesity are already very significant with the total annual cost of obesity in Australia in 2011–2012 has been estimated to be \$8.6 billion, including \$3.8 billion in direct costs and \$4.8 billion in indirect costs.⁴⁰ Using a measure that includes loss in wellbeing, estimates reach around \$120 billion a year, which is equivalent to 8% of the economy's annual output.⁴¹

In the long term, it is expected that the economic costs of obesity will increase significantly. Work commissioned by the Heart Foundation reveals that based on current trends, the number of obese adults in Australia is expected to nearly double by 2032. The total extra expenditure for cardiovascular disease and type 2 diabetes attributable to this excess weight, between now and 2032, is estimated to be \$187 billion.⁴²

5. *The effectiveness of existing policies and programs introduced by Australian governments to improve diets and prevent childhood obesity;*

In 2008 the Australian Government announced the formation of the National Preventative Health Taskforce (Taskforce) to develop strategies to tackle chronic disease caused by tobacco, alcohol and obesity.⁴³ In September 2009 the Taskforce released a final report which outlined recommended actions designed specifically to reduce and control obesity in Australia. The recommendations focused on preventative health measures and were proposed to be implemented in a staged manner from 2009. Nearly a decade has passed since the recommendations were released, and there has been limited implementation of the 27 obesity specific targets with three completed, 17 progressing and no progress made against seven by 2016.⁴⁴

In 2017 a systematic analysis of Australia's policies for addressing unhealthy diets and obesity was conducted. It looked at how national policies measure up against international best practice and identified recommendations in Australia. This project found that Australia is leading the world in some policies to improve population nutrition, including:-

- key aspects of food labelling (such as regulations regarding health claims, the development of the Health Star Rating system);
- keeping nutritious food GST-free; and
- the regular monitoring of population body weight.

It looked at how national, state and territory policies measure up against international best practice and identified recommendations for each jurisdiction. Australia is falling behind international best practice in other critical areas and the analysis identified several critical areas for action including:-

- developing a national strategy and implementation plan to improve population nutrition,
- imposing taxes to increase the price of unhealthy foods (especially sugary drinks); and
- introducing regulations to reduce exposure of children to marketing of unhealthy food.⁴⁵

Although state and territory governments' approaches to obesity prevention vary, there are several examples of strong leadership at this level. Important initiatives include the NSW Government's commitment to reduce childhood obesity by engaging the whole-of-government including through actively monitoring rates of overweight and obesity. This includes increasing community education, and ensuring that healthy food is more available and unhealthy food is reduced in a range of settings, including schools and healthcare.⁴⁶ The Australian Capital Territory's *Towards Zero Growth – Healthy Weight Action Plan 2013*, sets out cross-sectoral responsibilities, priorities and goals for the improvement of health within the Territory.⁴⁷

Local governments have also become key drivers of health promotion and prevention policy. For instance, the Victorian Public Health and Wellbeing Plan include actions by municipalities to reduce sugary drinks. Victorian municipalities are becoming leaders in creating healthy environments by adopting strategies to increase access to water and reduce consumption of sugary drinks⁴⁸ with the assistance of the Victorian Government's Healthy Choices guidelines.

The current Federal Government measures to encourage healthy eating are restricted to the Health Star Rating System (HSRS) and the Healthy Food Partnership. The OPC supports these measures but believes that a strategy encompassing a broad range of recommended measures should be implemented to guide a comprehensive national approach in the long-term. In the short-term, a number of improvements could be made to both the benchmarks for the Healthy Food Partnership and modifications to the HSRS to have greater impact.

5A Health Star Rating System

The HSRS is a voluntary, interpretative, front-of-pack labelling (FoPL) system which rates the healthiness of products using a 5-star scale and aims to encourage people to make healthier food choices. The HSRS was developed through a collaborative process involving government, industry, public health and consumer stakeholders. This process began in 2011, following the 2011 Comprehensive Review of Food Labelling Law and Policy.⁴⁹

When the government introduced the HSRS in July 2014 as a voluntary scheme, it committed to review the HSRS after five years and consider making the HSRS mandatory if the system was not widely and consistently adopted.⁵⁰ The Health Star Rating Advisory Committee (HSRAC) has commenced the five year review of the HSRS and has engaged in a public consultation process. The HSRAC has also implemented a review of the 'as prepared' rule which is described below.

Impact of the HSRS

In implementing the HSRS Australia has satisfied one of the key global recommendations of reports such as the WHO's recent Commission on Ending Childhood Obesity, to implement an interpretive front-of-pack labelling scheme supported by public education of both adults and children for nutrition literacy.⁵¹ Australia has been assessed as meeting best practice with the adoption of the HSRS when considering implementation of policies to improve population nutrition.⁵²

The two year review of the impact of the HSRS found that the HSR was displayed on over 5,500 products in Australia and over 800 products in New Zealand in 2016, with the majority of packaged products not using the system.⁵³ It was also noted that food manufacturers are selectively applying HSRs to their products. The result is that the most prevalent HSR used on packaging is four stars,⁵⁴ with food manufacturers choosing to display HSR on products that score more highly and choose not to display stars on lower rating products, even in the same product range.

There is also evidence that the HSRS is having an impact on consumers and is creating behaviour change. The two year review noted that awareness of the HSRS is increasing and that the HSRS is increasingly being used to help make healthier choices when shopping, with 16% (or one sixth) of respondents changing their shopping behaviour based on the HSRS.⁵⁵ Further, almost three in five respondents who reported purchasing a product with a HSR reported that the rating scale had influenced their purchasing decision. More than half of those who had been influenced purchased a different product to what they would normally purchase and would continue to buy it.⁵⁶ Despite this positive impact, a large number of consumers do not have, or have lost confidence in the HSR system; only 52% of surveyed respondents said that they trust in the system.⁵⁷

Problems with the HSRS

While the HSRS is effective overall, there are significant flaws that prevent its widespread implementation and impact on its public credibility. The following is a brief description of the problems with the HSRS. Please refer to the [OPC's submission to the five year review](#) for a full discussion.

I. *Voluntary application.*

The uptake of the system by industry has been limited, with the two year review noting that only 14.4% of products in the nominated database of eligible foods were displaying HSRs at the end of the 2 year evaluation period.⁵⁸ As a result, the capacity of consumers to successfully make comparisons between products is hampered by the voluntary nature and limited uptake of the HSRS. This prevents the realisation of the overarching objective of the HSRS to provide nutrition information on food

packages to assist consumers to make healthier choices. Indeed the review found that 65% of consumers want to see HSR on more products.⁵⁹

II. *Inconsistencies in the system are not addressed.*

The current HSRS results in inappropriately high ratings for some foods with relatively high levels of added sugar, sodium and saturated fat, all ingredients which are considered to increase the risk of chronic disease. A selection of nutrient poor, energy dense discretionary foods: cakes, biscuits, chips, jelly, and icy poles are scoring relatively high ratings of 3 to 5 stars. In contrast, the HSR Calculator rates some core foods, such as plain full fat dairy foods, at the lower end of the rating scale. This is contrary to the Australian Dietary Guidelines (ADG) and can mislead consumers as to the healthiness of foods when comparing between food categories – in particular between core foods and discretionary foods.

There are several problems with the algorithm which calculates the HSRS. In particular, the OPC is concerned with how the HSR Calculator treats added sugar. The current HSRS is based on total sugars in a product and makes no distinction between products with high levels of added sugar and those with intrinsic sugars – which are not considered dangerous to health, making it difficult to determine the relative healthiness of a product. It also does not appropriately score foods that are very high in added sugars but relatively low in the other negatively scored nutrients – saturated fat and sodium. The OPC would like to see the HSRS changed so that it is based on added sugars, not total sugars. Additional problems with the HSR Calculator and suggestions for modification are discussed in detail in the OPC's submission to the five year review.

III. *The 'as prepared' rules create confusion.*

The Guide for Industry to the HSR calculator (the Guide) provides guidance for the calculation of the HSR for products that are not intended to be consumed 'as sold' but must be prepared prior to consumption. The Guide allows products to display a HSR based on the product 'as prepared' according to the instructions on the packaging. This has created difficulties where products may be prepared in multiple ways. The OPC recommends that the current 'as prepared' rules be replaced by a new option whereby the HSR of products would be calculated on the basis of products 'as sold', apart from products that are required to be drained or reconstituted with water prior to consumption.

IV. *Consumers confused about the use of HSRS.*

The two year evaluation of the HSR campaign has revealed that there is confusion about some elements of the HSRS. In particular, the HSRS is perceived to promote processed foods, as opposed to promotion of a balanced, healthy diet consistent with the ADGs. One sixth of respondents thought that the HSR campaign conveyed the message that they should buy packaged instead of unpackaged food.⁶⁰ Many consumers believe that the HSRS should be used to compare foods in different categories, as 65% of respondents reported that they were using the system to compare products in different categories. Consumers had not received the information that the HSRs have been designed to be used to compare similar products within a category.

It is imperative to retain the HSRS as a front of pack labelling system, to assist consumers to make comparisons at a glance between similar products at the supermarket and to make healthier choices. However, the HSRS does have flaws that prevent its widespread implementation and contributes to diminishing consumer confidence and public credibility.

Recommendation: Make the following changes to the HSRS: -

- **Make the HSRS mandatory.**
- **Modify the HSRS calculator to correct inappropriately high ratings for some foods with relatively high levels of added sugar, sodium and saturated fat.**
- **Replace the current ‘as prepared’ rules with a new option whereby the HSR of products would be calculated on the basis of products ‘as sold’, apart from products that are required to be drained or reconstituted with water prior to consumption.**
- **Allocate significant funds to promote the key messages of the HSRS firmly in the context of a healthy diet across a wide range of media.**

5B Healthy Food Partnership

The Healthy Food Partnership (HFP) was introduced in 2016 as a mechanism for government, the public health sector and the food industry to cooperatively tackle obesity, encourage healthy eating and empower food manufacturers to make positive changes.⁶¹ Some action has been taken under the program, for instance stakeholders met in April 2018 to discuss the Healthy Food Partnership development and implementation of the voluntary pledge system for the food services sector. However, the program has a comprehensive logic model which presents specific outputs and impacts to be achieved within certain time frames which have not been met.⁶² A systematic analysis of the predecessor to the HFP, the Australian Food and Health Dialogue pointed to structural elements that would be crucial to the success of the new HFP. These elements included strong government leadership, independent monitoring and accountability and management of conflict of interest.⁶³ This advice would appear to remain relevant today. The OPC supports the Healthy Food Partnership but would like to see government set clear targets for food manufacturers, retailers and caterers with established time periods and regulation to assist compliance.

6. Evidence-based measures and interventions to prevent and reverse childhood obesity, including experiences from overseas jurisdictions;

The WHO Report of the Commission on Ending Childhood Obesity stated that obesity prevention and treatment requires a whole-of-government approach in which policies across all sectors systematically take health into account, avoid harmful health impacts, and thus improve population health and health equity.⁶⁴ The Commission developed a comprehensive, integrated package of recommendations to address childhood obesity, many of which are sought in this submission. The Commission also called for governments to take leadership and for all stakeholders to recognize their moral responsibility in acting on behalf of the child to reduce the risk of obesity and noted that the greatest obstacle to effective progress on reducing childhood obesity is a lack of political commitment and a

failure of governments and other actors to take ownership, leadership and necessary actions.⁶⁵

There is an urgent need for the federal government to demonstrate leadership in relation to overweight and obesity through the adoption of a whole-of-government obesity prevention strategy. There is also significant support for regulatory measures by the public. A recent report found that the majority of respondents (92.5%) considered overweight and obesity to be a somewhat or very serious problem in Australia, and almost 90% felt there should be at least some government regulation to protect the public.⁶⁶

Government leadership can be seen internationally, for example in the United Kingdom where the government has recently published *Childhood obesity: a plan for action*, Chapter 2,⁶⁷ a strategy outlining the steps it will take to address childhood obesity.

Recommendation: that the Federal Government introduces a whole-of-government obesity prevention strategy comprised of the measures outlined below

6A Set reformulation targets

Australians spend more than 58% of their food dollar on discretionary foods⁶⁸ and the average Australian household spends 27% of their weekly household budget on dining out and fast food, much of which is high in fat, salt and sugar.⁶⁹ The latest Australian Health Survey data shows that Australians are eating too much saturated fat, salt and sugar in the form of discretionary food, well exceeding WHO targets to improve population health.⁷⁰ Specifically Australians are consuming 31% of their daily energy (kilojoule) intake from fat, of which 12% is from saturated fats. They are consuming an average of 60g of added sugar per day, with 81% of this from discretionary foods and drinks.⁷¹ The main sources were sugar-sweetened beverages, muffins, cakes and confectionery.

Reformulating processed food products to make them healthier has the potential to impact palatability, profits and the consumer expectations of a product. Therefore, food manufacturers are likely to face a conflict of interest when encouraged to make these changes, which is an argument for regulation which would apply equally to all manufacturers and create a level playing field.

To ensure compliance with food reformulation goals, clear, specific nutrient reformulation targets must be set, with a fixed timeframe for each target to be met. Ideally, reformulation goals should be backed by government regulation or co-regulation, which will enable action to be taken where food manufacturers fail to meet the targets. It is important that reformulation targets are aligned with the Australian Dietary Guidelines and complement the Health Star Rating System, which has already been observed to generate reformulation of some packaged food products among major Australian manufacturers.

We note the recent reformulation targets set by the Australian Beverages Council, with a pledge to reduce sugar across the non-alcoholic beverage industry portfolio by 20% by 2025.⁷² This pledge clearly demonstrates the need for reformulation to be government-led and backed by government regulation. As with other forms of self-regulation, the Australian Beverages Council's pledge gives the appearance of a strong commitment, yet a closer look at the detail reveals that significant change is unlikely.

The pledge is voluntary, and will be measured based only on those companies who sign up. It is based on sales data and uses benchmark data from January 2016, 2.5 years ago. Importantly, the pledge does not require manufacturers to reduce the sugar levels in high-sugar drinks, or to reduce the sales of sugary drinks overall. As targets are sales-based, they can be met in various ways, for example by selling more low sugar drinks (with sales of high-sugar drinks potentially remaining unchanged). We consider that the beverages industry is capitalising on current market trends, which point to an increase in sales of low and no-sugar products, and is seeking to avoid the introduction of a health levy on sugary drinks, rather than making a genuine commitment to significantly reduce sales of sugary drinks or to reformulate its highest sugar products. Further, there will be no price signal to consumers to nudge them away from high sugar drinks under this proposal, unlike that imposed by a health levy.

International experience shows that when reformulation measures are strong and are government-led, real change can be achieved. In 2000, the United Kingdom Food Standards Agency implemented a salt reduction strategy, providing the food industry with voluntary targets for over 80 processed food categories and engaging in a simultaneous public awareness campaign. These targets were reset in consultation every two years, which enabled the Food Standards Agency to achieve a reduction in salt consumption by 0.9g per day between 2005 and 2014.⁷³ This is now being implemented in relation to other ingredients of concern, such as sugar in the UK. Public Health England is working to engage with all sectors of the food industry to reduce the amount of sugar in the foods that contribute most to children's intakes by 20% by 2020, with a 5% reduction in the first year.⁷⁴

Recommendation: Set clear, specific nutrient reformulation targets, with a fixed timeframe for each target to be met.

6B Labelling

Nutrition labelling

Increasingly, packaged foods and beverages have become readily available in virtually every community across all parts of Australia. Many packaged foods are processed with high levels of added sugars, sodium and saturated fats. Research has found these nutrients of concern are connected to increased obesity and chronic nutrition-related diseases.

It is difficult for consumers to make choices. They often shop in a hurry and most shoppers spend fewer than ten seconds selecting each item — not enough time to review current nutrition labels, which are complicated and ineffective. In essence, research has shown current back-of-the pack nutrition information panels do not work and simpler impactful options are needed.⁷⁵

Current research demonstrates the effectiveness of interpretive front of pack nutrition labelling.⁷⁶ Accordingly, the OPC continues to support the HSRS as evidence shows that interpretive front of pack nutrition labelling can play an important role in improving Australian diets.⁷⁷ In addition to the HSRS, the OPC recommends the introduction of advisory labels on foods where nutrients of concern exceed recommended levels as well as added sugar labelling.

Added sugar labelling

It is critical for Australian consumers to be aware of the amount of added sugar in food products, to allow them to make informed choices about the products they buy. The WHO's guideline recommends that the daily intake of added sugars for adults and children be reduced to 10% of their daily dietary intake, and 5% for the greatest health benefits.⁷⁸ For an average adult diet of 8700kj, the 10% goal amounts to 52g of added sugar, or 13 teaspoons. Similarly, the Australian Dietary Guidelines (ADGs) advise Australians to limit their intake of foods and drinks containing added sugars.

The WHO's recommendation was made for two reasons. First, eating too much food high in added sugar increases overall energy intake while reducing opportunities to eat more nutritious foods, leading to increased weight, an unhealthy diet and an increased risk of non-communicable diseases (NCDs). Second, increased intake of foods high in added sugar is a risk factor for tooth decay. Alarmingly, the latest Australian National Child Oral Health Study found that more than one third of Australian children have experienced tooth decay by the ages of 5 to 6 years, increasing to 46% of children by the ages of 9 to 10 years.⁷⁹

These concerning statistics reflect the fact that Australians, particularly children and teenagers, consume well over the recommended upper limit of added sugar in their daily diet. In 2011-12, Australians consumed on average 60g of added sugar per day (or 15 teaspoons).⁸⁰ Children and teenagers consume even larger amounts, with close to three-quarters of 9 to 13 and 14 to 18 year olds usually obtaining more than 10% of their dietary energy from added sugars and teenage males in particular consuming a huge amount – on average 92g (23 teaspoons) a day with the top 10% up to 160g (40 teaspoons) a day.⁸¹ Action is required to help Australians to lower their intake of added sugars. Consumer group Choice has shown that if consumers were able to identify added sugars on packaged foods, they could avoid 26 teaspoons of added sugar each day, or up to 38.3 kg a year.⁸² However, in Australia it is currently impossible to know how much added sugar is in the foods we buy and it is therefore very difficult to follow the WHO guideline or the ADGs in respect of added sugar.

While the ingredients list names sugar included in the product, added sugars can be called by over 40 different names,⁸³ a number of which consumers might not be familiar with, making it difficult to even identify what might be a sugar. Similarly, the nutrition information panel records the amount of total sugar in the product, but does not specify what amount is naturally occurring (for example, lactose in dairy which does not adversely impact on health) and what amount has been added by the manufacturer.⁸⁴ The Health Star Rating System, used on front of pack labelling, does not distinguish between added sugars and naturally occurring sugars when calculating Health Star Ratings and therefore limits consumers' ability to make healthier choices based on the added sugar content in food.

In 2016 the Food and Drug Authority (FDA) in the United States updated their nutrition information panel to require added sugars in grams and as a percent of Daily Value be included on the label. The FDA guidance states that the change was made on the basis of scientific data showing that it is difficult to comply with the 2015-2020 Dietary Guidelines and

meet nutrient needs while staying within calorie limits if you consume more than 10 percent of your total daily calories from added sugar.⁸⁵

We recommend that the Federal Government adopt recommendation 12 of the Labelling Logic Review of Food Labelling Law and Policy report. That is, where sugars are added as a separate ingredient to a food product, information must be provided on the label of that product to identify the added sugars.

Recommendation: Require manufacturers to identify added sugars on food labels, where sugars are added as a separate ingredient

Advisory labels regarding nutrients of concern

There is a growing body of research demonstrating that graphic health messages, similar to those used on cigarette packets, could be an effective way of helping people to make healthier food choices. Recent research has been conducted into the impact of graphic warning labels on the packaging of unhealthy foods. The results demonstrated that brief exposure to food product health warnings enhanced dietary self-control and this was substantiated by neurological imaging. The researchers found using negative images combined with negative messages were the most effective way of persuading people to avoid the unhealthy options and choose healthier foods.⁸⁶

Another Australian study evaluated the effectiveness of several different types of warning labels on sugary drinks, including graphic pictorial warnings, text warnings, information on the amount of sugar in the product, and Health Star Rating. It compared the impact on those in the intervention group to the control group who were not exposed to a label, and all the interventions significantly reduced selection of a sugary drink. However the magnitude of effect was greatest for the graphic pictorial warning label.⁸⁷ A recent American study also found graphic pictorial warnings to be most effective in reducing the sales of sugary drinks in a cafeteria.⁸⁸

Health advisory labels on food are beginning to be introduced internationally. For instance, new regulations in Chile require processed foods that exceed predetermined levels of key nutrients to include warning labels on the front of the package, identifying the food as being high in sugar, fat, salt, or total calories as applicable.

Figure 1: Chile warning labels on key ingredients



On the basis of these studies and international practice, the OPC recommends the introduction of health advisory statements where nutrients of concern exceed recommended levels, in particular for sugary drinks. There may be potential for such advisory statements, together with the HSR - which rates the healthiness of a product, to provide a more thorough nutritional profile of a product.

Recommendation: Introduce advisory labels on foods which are high in unhealthy ingredients, such as sugary drinks.

6C A 20% health levy on sugary beverages

A health levy on sugary drinks¹ to increase their retail price and reduce consumption is a powerful policy intervention to improve diets and reduce the burden of chronic disease in Australia. Revenue raised by such a levy could be used to support healthy eating initiatives and to fund subsidies on healthy foods, particularly for low socio-economic position households. A brief explanation of the case for a health levy is discussed below, but for a full examination of the arguments and evidence in support of a health levy on sugary drinks, please refer to [The case for a health levy on sugary drinks.](#)

Sugary drinks contribute to obesity

While overweight and obesity are complex conditions with multiple causes, there is evidence demonstrating that consumption of sugary drinks is associated with increased energy intake, weight gain and obesity, as well as other negative health impacts including metabolic syndrome and type 2 diabetes.⁸⁹ A clear link has also been established between sugary drink consumption and an increased risk of cancer.⁹⁰ Association between sugary drink consumption and BMI is not only shown in adults, but in children,⁹¹ including young children aged 2-5.⁹² Studies have also found a clear relationship between the amount and frequency of sugary drinks consumed and an increased risk of dental erosion.⁹³

¹ Includes all non-alcoholic water based beverages with added sugar, such as sugar-sweetened soft drinks, energy drinks, fruit drinks and cordials, excluding 100% fruit juices

Australians consume significant amounts of sugary drinks

Large numbers of Australian adults and children consume sugary drinks. Just looking at supermarket retail sales, Australians brought around 1.1 billion litres of sugary soft drinks in 2015 at a cost of 2.2 billion.⁹⁴ This doesn't include what is bought from fast-food outlets, cinemas, vending machines, hotels and convenience stores.

In 2011–12, Australians consumed an average of 60 grams of free sugar per day (around 14 teaspoons), with 52% of this free sugar coming from sugary drinks (including fruit juice and sugar free to alcoholic beverages).⁹⁵ A single can (375mL) of soft drink provides up to 40 grams (10 teaspoons) of added sugar.⁹⁶

A sugary drinks health levy is an effective tool to decrease consumption and reduce obesity

Price is one factor that can be highly effective in influencing consumption of sugary drinks.⁹⁷ There is evidence that taxes on sugary drinks (or sugar-sweetened soft drinks alone) could reduce consumption and improve population weight and health outcomes, if the tax is set at a sufficiently high level.⁹⁸ A recent Australian study found that increasing the price of sugary drinks by 20% through a levy could reduce consumption by 12.6%.⁹⁹ This reduction in consumption has the potential to generate a decline in the prevalence of obesity of 2.7% among men, and 1.2% among women, and could reduce the number of cases of type 2 diabetes by 800 per annum.¹⁰⁰ The study also estimated that the levy could raise revenue in excess of \$400 million per year, even when taking into account changes in consumption in response to the tax.¹⁰¹

There is strong support from the experts, the Australian public and global peak health bodies

The WHO has urged member states to consider economic policies and measures that discourage the consumption of less healthy food and drink options to reduce rates of obesity.¹⁰² The WHO has also recently recommended that governments tax sugary drinks to address type 2 diabetes, overweight and obesity and tooth decay. The measure is also acknowledged as cutting healthcare costs and increasing revenues to invest in health services.¹⁰³

A 2015 survey conducted by the OPC of 1,203 Australians found that 85% of people supported the revenue from a tax on sugary drinks being used for programs to reduce childhood obesity, with 84% support for the funding of initiatives to encourage children to play sport.¹⁰⁴

The tax has been introduced in many jurisdictions and is reducing consumption

More than thirty-five countries and jurisdictions around the world have introduced regulatory measures to reduce consumption of sugary drinks, In 2017 Portugal, Brunei, Saudi Arabia, United Arab Emirates, Thailand, the Catalan region of Spain and five US cities introduced a tax on sugary drinks, and the UK, the Republic of Ireland, South Africa, Estonia and the US city of Seattle, Washington introduced a tax on sugary drinks this year.¹⁰⁵

Data is still building around the impact of food taxes on health in other countries. Mexico's tax of approximately 10% on sugary drinks took effect on 1 January 2014. Evaluation data demonstrates that the tax was generally passed on through prices and that consumers have reduced their purchases of taxed beverages. Purchases of taxed beverages decreased 5.5% in 2014 and 9.7% in 2015, yielding an average reduction of 7.6 percent over 2 years.

There was also a 2.1% increase in the amount of untaxed beverages purchased.¹⁰⁶ The policy has had the most impact in lower socio-economic groups. The success of the Mexican experience demonstrates that even a relatively small levy on sugary drinks can result in a noticeable reduction in demand.

There are a number of different fiscal models that have been used internationally to increase the price of sugary drinks. The United Kingdom levy is imposed at the manufacturer or importer level to encourage companies to reformulate by reducing the amount of added sugar in the drinks that they sell.¹⁰⁷

A health levy on sugary drinks would reduce consumption to the greatest extent among groups most at risk of associated harms

Australians of low SEP are also disproportionately affected by high rates of diet-related illnesses and therefore stand to derive the greatest benefit from reduced consumption of unhealthy products such as sugary drinks.¹⁰⁸ Children from low SEP families also consume greater volumes of SSBs than their higher SEP counterparts and therefore stand to benefit from interventions to reduce purchasing and consumption.¹⁰⁹

A recent review on the impact by SEP of a sugary drink levy found that lower income households would pay a greater proportion of their income in additional tax. However the monetary burden across all households would be small, with relatively minor differences between higher and lower income households (less than \$5 USD per year).¹¹⁰ A sugary drinks levy would therefore be a pro-equity population policy to reduce consumption and improve weight and population health outcomes.

Use existing tax structures

In Australia, a health levy on sugary drinks could be relatively simply imposed through existing tax structures, keeping the costs of implementation and administration reasonably low.¹¹¹ Use of existing tax frameworks capable of accommodating a tax would mean implementation would not require the development of complex independent legislation and administrative structures.¹¹²

The fact that sugary drinks are readily identifiable would also facilitate the application of a health levy through existing structures. That is, applying a health levy to sugary drinks is not as difficult as applying a tax to foods, because unlike many foods which contain a mix of nutrients (so that a tax may decrease consumption of healthy nutrients as well as unhealthy), sugary drinks usually contain effectively no valuable nutrients.¹¹³

Recommendation: introduce a 20% levy on sugary drinks
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6D Regulate marketing of unhealthy food to children

Food companies and fast food chains target Australian children with unhealthy food marketing across their daily lives, including:

- On television and at the cinema – in advertisement breaks and product placement

- At the shops – on product packaging, in-store displays and promotions including free toy offers, product giveaways and competitions
- Online – on social media including Facebook, Instagram, Snapchat and YouTube, interactive games, websites and mobile applications
- On the street – on billboards and posters, on public transport
- At sport – sponsorship of children’s sporting competitions and sponsorship of major sporting events
- At school – fundraising drives

Constant marketing of unhealthy food undermines healthy eating messages from parents, schools, communities and governments who strive to support healthy diets and make the healthy choice the easy choice.

There is strong and robust evidence that marketing of unhealthy food not only influences children’s food attitudes and dietary preferences, it also influences what they eat and contributes to high rates of childhood overweight and obesity.¹¹⁴ Food marketing to children also raises serious ethical concerns, as children do not have the cognitive capacity to understand and resist the influence of this marketing.¹¹⁵

In light of the evidence, the WHO and numerous public health bodies have called for effective controls to protect children and limit their exposure to unhealthy food marketing and reduce their risk of a poor diet, weight gain and chronic disease.¹¹⁶

The failure of self-regulation

Control of unhealthy food marketing to children in Australia is largely left to a series of self-regulatory codes developed and administered by the food and advertising industries.¹¹⁷

The Australian Food and Grocery Council developed a code for fast food chains, the Quick Service Restaurant Initiative for Responsible Advertising and Marketing to Children (QSRI), and a code for food manufacturers, the Responsible Children’s Marketing Initiative (RCMI). The Australian Association of National Advertisers developed advertising codes, in particular the Code for Advertising and Marketing Communications to Children and the Food and Beverages Advertising and Marketing Communications Code,

These purport to set appropriate standards for the marketing of food to children, but in reality provide little protection. The self-regulatory codes do not adequately reduce the volume of unhealthy food marketing reaching children or effectively capture the broad range of marketing techniques used by food companies to target children.

The food industry has been given sufficient opportunity to demonstrate that it is able to protect children from the influence of unhealthy food marketing through self-regulation and has been shown to be incapable of doing so. Evidence shows that self-regulation is ineffective in reducing children’s exposure to unhealthy food marketing, both in Australia and around the world.¹¹⁸ Australian research shows there was no reduction in unhealthy food and drink advertisements on television during children’s peak viewing times between 2011 and 2015, despite further voluntary self-regulatory initiatives introduced by the food industry in 2009.¹¹⁹ On average an Australian child will still see around three advertisements per hour for unhealthy food during prime-time television and 44% of food advertisements will be for unhealthy food.¹²⁰ These figures are on television alone, and do not take into account

children's increasing focus on digital media, much of which is not adequately covered by the industry codes.

Evidence also shows that self-regulation does not reduce the amount of junk food sold. Recent research examining policies in 79 countries revealed that only countries that had enacted statutory policies showed a decrease in junk food sales over a period of time, compared to those with self-regulation which showed an increase in junk food sales.¹²¹

This failure of self-regulation is not surprising. There is an inherent conflict between the public health goal of improving diets and reducing overweight and obesity and a corporation's fundamental goal of increasing profits.

A new system of government regulation is needed

We call on the Government to regulate to reduce the volume and influence of unhealthy food marketing reaching children. A new scheme must have the following features:

It must be mandatory and apply equally to any organisation advertising food and beverage products, including manufacturers, retailers or restaurant chains.

The current self-regulatory scheme is largely voluntary and there are many instances of non-compliant advertising by organisations who are not signatories. The voluntary nature of the current scheme undermines its effectiveness as a significant amount of advertising is not covered.

Mandatory schemes are reflected in international practice and are in-place or in progress in the United Kingdom, South Korea, Taiwan, Chile, Mexico, Sweden and Canada.

It must be comprehensive and apply to all forms of marketing, media and promotion.

The scheme should cover marketing via free-to-air and subscription television, cinema, internet, radio, magazines, mobile applications, social media, billboards, websites, email and messaging, product placement, competitions, free toys and giveaways, product packaging, brand advertising and any new media and forms of communication that are developed in the future. It would also need to apply to children's sport sponsorship, all advertising and promotion in schools, public places, cinemas, and inside stores and supermarkets.

Comprehensive schemes have been enacted in other countries, for example in Chile where its broad rules apply to all forms of marketing, communication, recommendation, propaganda, information or action intended to promote consumption of a product.

We would like to highlight the following particular forms of marketing that are not adequately addressed by the current system:

Product packaging

The self-regulatory codes expressly exclude packaging and labelling of products. Children's food products often feature cartoon graphics or familiar characters to make them more attractive to children. Recent OPC research found that most products with cartoons or familiar characters on the packaging were unhealthy, containing high sugar levels of more than 15g of sugar per 100g. Common products displaying this child-targeted packaging include confectionary, sweet biscuits, chips/savoury, dairy snacks and ice-cream.¹²²

In-store promotions, competitions and giveaways

Children are also targeted with a range of promotions, including giveaways, free toy offers and competitions, as well as in-store displays. These promotional tools may be limited time offers or may be linked to a particular movie release, sporting event or other special event.

Sports sponsorship

Sponsorship of children's sporting teams is a common way that unhealthy food companies target children. Kids participating in weekend sport are exposed to unhealthy food marketing in various ways, from the food brand forming part of the competition's name, to the brand and logo being displayed on sporting equipment, uniforms and participant packs including free drink bottles, hats and other items.¹²³

Protecting children from exposure to unhealthy food marketing while playing sport is important as we know it influences children's perception of the advertised brands. Australian research shows children consider sponsors 'cool' and often like to 'return the favour' of sponsorship by buying the sponsor's products.¹²⁴ This research demonstrates the influence of sports sponsorship by unhealthy food companies on children and provides evidence for strong restrictions.

Brand and product line advertising

Brand and product line advertising occurs where companies use brands, logos or characters associated predominantly with unhealthy products to market to children without actually featuring any food or beverage products, or by featuring only healthy choice options..

Digital marketing

Digital media is playing an increasing role in children's lives, with Australian children spending an average of two hours online outside school hours on a typical weekday.¹²⁵ We know that children are accessing platforms that offer a wide range of content for all ages, not just child specific content.¹²⁶ Children use many forms of digital media, including social media platforms such as YouTube, Facebook and Instagram as well as mobile applications, interactive games and websites.

Digital marketing is of particular concern both because of its increasing presence in children's lives, and because of its ability to track and target users in ways different to traditional media. Digital media allows brands to creatively engage and immerse

children in a variety of interactive marketing techniques including themed game apps, paid partnerships with vloggers popular with children, social media content created by users, and peer-to-peer communication such as 'liking' and 'sharing' social media content.

Digital marketing is not adequately covered for two main reasons:

- the RCMI and QSRI do not expressly include all types of digital marketing, such as mobile applications, so coverage is unclear
- many types of digital media popular with children, such as social media platforms, are also popular with adults and have nominated age limits – they are found not to be 'directed primarily to children', a requirement of the self-regulatory codes.

It must restrict marketing that appeals to children in either its content or placement, including effective control of digital marketing.

A major problem with the current system is that it only applies to marketing that is 'directed primarily to children', and these words are defined and interpreted narrowly, with most marketing failing the test.

Placement

The current food industry codes include a placement test, finding an advertisement to be directed primarily to children if children represent 35 per cent or more of the audience of the medium. This captures some television programs designed specifically for young children, but does not capture the programs seen by the highest numbers of children, such as sporting events, family movies and reality TV programs. Those programs appeal to wider family audiences and would not have 35% of viewers under the age of 12 or 14. An analysis of Australian free-to-air TV viewing found no time in weekdays and only a short period at weekends when the proportion of the audience aged under 14 years exceeded 35%.¹²⁷

To address this flaw in the current system, we argue for time-based restrictions on free-to-air television at the times when the greatest numbers of children are likely to be watching – weekdays between 6.00am-9.00am and 4.00pm-9:00pm and on weekends between 6.00am-12.00pm and 4.00pm-9.00pm.

The 35% audience test is also inadequate when applied to digital marketing. The Advertising Standards Community Panel (the body that decides complaints – formerly known as the Advertising Standards Board) has considered a number of apps and websites popular with children, including YouTube, Facebook, Instagram and Snapchat, and on each occasion has said that the app or website is not a medium with an audience of more than 35% children.¹²⁸

The scheme must also effectively restrict marketing in other forms of media, in particular digital marketing.

Content

The restriction must apply to all unhealthy food advertising during these times and outside of these times to any advertisement that uses techniques that appeal to children. As well as a placement test, the current food industry codes include a content test, requiring a subjective assessment of whether the advertisement's themes, visuals and language are 'directed primarily to children'. This is interpreted narrowly by the Advertising Standards Community Panel. The Panel often finds that advertisements are not directed primarily to children, finding instead that marketing is directed at the parent or main grocery buyer, or directed at both parents and children. This means that a huge amount of marketing seen by, and appealing to children, is not restricted by the self-regulatory codes.

A new scheme must capture marketing that is seen by large numbers of children or appeals to children, regardless of whether it is also seen by or appealing to large numbers of adults.

It must clearly define 'unhealthy food' by reference to an appropriate nutrient profiling model.

A clear definition of what constitutes an unhealthy food is vital for effective regulation of unhealthy food marketing. The current food industry codes do not include a specific definition of unhealthy food, instead allowing food manufacturers to adopt their own definitions of 'healthier dietary choices'. This results in products including some high-sugar cereals, biscuits and ice-creams all being considered 'healthier dietary choices' that can be marketed to children.

Australia is falling behind a growing list of countries providing objective standards to determine which foods are considered healthy:

- In the United Kingdom and Ireland, the UK Food Standards Agency's nutrient profiling model is applied to determine which foods are considered high in sugar, salt or fat (HFSS) and those products may not be advertised to children.
- In New Zealand, the New Zealand Food and Beverage Classification System for Schools determines which foods are considered high in fat, salt or sugar and may not be advertised to children.
- In Canada a new scheme is being developed and proposes to include Government set nutrient threshold limits.

A recent survey of the policies in 79 countries found that those with standardised nutrition criteria underpinning their regulations showed a decrease in junk food sales over time while those that use only guidance criteria or no criteria showed an increase in junk food sales.¹²⁹

'Unhealthy food' should be defined as any food or beverage that fails to meet objectively determined 'nutrient profile criteria', which should be designed to disqualify energy-dense, nutrient poor foods from the types of foods that may be advertised to children.

It must apply to children under 16 years of age, at a minimum.

The self-regulatory codes currently define ‘children’ as either persons under 12 or 14 years. The OPC believes that the definition of ‘children’ should cover children younger than 16 years.

Teenagers are vulnerable to marketing because their decision making capacities are limited by their developing brain. Raising the age limit is particularly important in light of the teenagers’ increasing use of digital media, and its emphasis on peer-to-peer and viral marketing, techniques likely to be particularly influential on vulnerable teenagers.

Research supports the importance of protecting older children; recent research in the United Kingdom showed that teenagers who watch high levels of television with advertisements were more than twice as likely to have a high consumption of foods high in sugar, salt and fat. Teenagers were also more than twice as likely to be obese if they saw junk food advertisements regularly.¹³⁰

An age limit of 16 years is also supported by international bodies and has been implemented internationally. The WHO’s Regional Office for Europe released a 2016 report on digital food marketing to children, with a key recommendation that the age limit be set at a minimum of 16 years.¹³¹ The United Kingdom’s restrictions on non-broadcast marketing of unhealthy food to children apply to children younger than 16 years.¹³²

It must include strong governance, compliance and enforcement provisions. A new scheme must be administered and enforced by an independent agency and impose meaningful disincentives and sanctions for breach.

Compliance with the restrictions should be regularly monitored by a government department or a regulatory agency that is independent of the food and advertising industries. Complaints from the public should not be the only method to identify and investigate potential breaches. Where complaints are made, they should be investigated in a timely manner by an independent agency or department.

The scheme should impose meaningful disincentives and sanctions for breach to content creators, publishers and broadcasters. Penalties for breaches must go beyond removal of the advertisement and be significant enough to deter companies from publishing infringing advertisements in the future, even where a campaign is no longer running.

Recommendation: we call on the Government to regulate to reduce the volume and influence of unhealthy food marketing reaching children. A new scheme must have the following features-

- **It must be mandatory and apply equally to any organisation advertising food and beverage products, including manufacturers, retailers or restaurant chains**
- **It must be comprehensive and apply to all forms of marketing, media and promotion.**
- **It must restrict marketing that appeals to children in either its content or placement, including effective control of digital marketing.**
- **It must clearly define ‘unhealthy food’ by reference to an appropriate nutrient profiling model.**
- **It must apply to children under 16 years of age, at a minimum.**
- **It must include strong governance, compliance and enforcement provisions. A new scheme must be administered and enforced by an independent agency and impose meaningful disincentives and sanctions for breach.**

6E Update dietary guidelines

Dietary guidelines are tools that inform public health policies, but are also used by a wide range of organisations and individuals, including health professionals, food manufacturers, teachers and members of the community. Given that nutrition research is continuously evolving and new studies are published regularly, frequent revision of the Australian Dietary Guidelines (ADG) is required.

The 2013 ADG represent an evolution of the 2003 edition, with new key messages that are supported by a considerably stronger evidence base, following review of new data concerning associations between food, dietary patterns and health outcomes.¹³³ Frequent revision of nutrition guidelines will also take into account advances in methodology for generation of guidelines.¹³⁴ Given Australia’s poor compliance with the ADG,¹³⁵ it is essential that guidelines are accessible and useful to health professionals and the wider community.¹³⁶ Monitoring community compliance and attitudes, as well as advancements in scientific evidence, is necessary to ensure that dietary guidelines remain relevant.

Recommendation: Update the Australian Dietary Guidelines

6F Establish a comprehensive monitoring program of population diets and physical measurements

Monitoring population nutrition intakes are essential to setting accountable goals, understanding the impact of implemented policies and programs and to identify gaps. Regular monitoring was a recommendation of the National Preventative Health Taskforce in 2009. The most recent comprehensive population nutrition survey was conducted by the Australian Bureau of Statistics in 2011-12, the edition prior to this was almost two decades earlier in 1995. In a climate where food availability and choices are constantly evolving more

frequent monitoring of diets is essential to progressing relevant and effective interventions. Monitoring obesity prevalence in children and adults provides important population health data that can be used to track trends over time, identify areas at greatest risk of obesity, determine the effectiveness of interventions and policies, raise awareness and stimulate action.¹³⁷ Data on population weight status and children's weight status in particular is very limited in Australia. Evidence indicates the collection of weight and height data should be measured rather than self-reported¹³⁸ and for children it can be measured at school using an in an Opt-out rather than Opt in methodology to reduce the risk of under-reporting.¹³⁹

6G Fund mass media education campaigns to improve diets and prevent obesity:

Well-designed comprehensive mass media campaigns can be an effective tool for population behaviour change.¹⁴⁰ They can also be a useful tool for shifting social norms to preference healthy behaviours. Sustained investment and integration into the broader health promotion system is essential to ensure their effectiveness.¹⁴¹ The LiveLighter Victoria 'Sugary Drinks' campaign that highlighted the link between sugary drinks and toxic fat and encouraged Victorians to cut back on sugary drinks was broadcast on television and other supporting media from 11 October 2015 for a period of six weeks. The proportion of Victorians who consumed four or more cups of sugary drinks per week had declined from 31% prior to the campaign to 22% at the end of the campaign period.¹⁴²

A separate economic analysis estimated that if the same six-week campaign ran 12 times over three years in Victoria, at a cost of \$9.8 million, it would save \$51.3 million in healthcare costs, 1,085 new cases of type 2 diabetes and 153 new cases of heart disease.¹⁴³

7. The role of the food industry in contributing to poor diets and childhood obesity in Australia;

The legal obligation of large corporations, including those in the food and beverage industry, is to act in the interests of its shareholders and maximise sales and profits to the full extent permitted by law.¹⁴⁴ The food industry² therefore has an unavoidable conflict of interest when it comes to reducing consumption of its products, and cannot be relied upon to act in the interests of population health rather than profit. Industry uses a multiplicity of tactics to defeat proposed public health measures, delay or defeat policy and legislative action, and increase sales of their products.

Self-regulation is ineffective

The voluntary codes that purport to limit advertising to children discussed earlier in this submission were introduced by the food and beverage industry and the advertising industry after the Australian Government's Preventative Health Taskforce identified the need to reduce children's exposure to unhealthy food marketing. The codes were introduced as an alternative to government regulation.

The self-regulatory system protects the interests of the food industry by creating a façade of responsible conduct and avoiding the introduction of meaningful and effective government regulation. The analysis presented in this submission and elsewhere demonstrates the failure of self-regulation to reduce children's exposure to unhealthy food marketing. This is similar to the experience in other countries, where self-regulation has failed to have

² Reference to food industry includes the beverage industry where appropriate

meaningful impact in protecting children from exposure to unhealthy food marketing. Asking food manufacturers and fast food chains to voluntarily self-regulate to limit marketing and reduce sales of their unhealthy products is out of step with a corporation's fundamental goal of increasing profits. Nevertheless the food industry says it is '...committed to responsible advertising and marketing of food and/or beverages to Children.'¹⁴⁵ and describes its codes as a success, reporting compliance levels of over 99%.¹⁴⁶ The food industry's claims of compliance and success mean little in this context, as the bar set is so low. The food industry is effectively both setting its own homework and then giving itself top marks. The overall result is that children continue to be saturated with unhealthy food marketing which has been shown to contribute to poor diets and obesity.

The HSRS is another instance where a self-regulatory system has been stymied as industry campaigned to restrict the HSRS to a voluntary system which has resulted in piecemeal application and patchy coverage of products.

We also see a form of self-regulation demonstrated in the recent Australian Beverages Council pledge to reduce sugar in non-alcoholic beverages by 20% by 2025. Rather than representing a genuine commitment to reformulating high sugar drinks and reducing sales, we consider the pledge to be primarily aimed at avoiding the introduction of a sugary drinks levy and improving public perception of the industry. While we cannot yet assess the results of this pledge, its details mean that it is likely to be less effective than the government-led measures called for by public health experts: specific reformulation targets and a sugary drinks levy. This pledge cannot be allowed to take the place of these crucial government initiatives.

Fund research

The food industry is in a financial position to fund research that supports their products. Whether such organisations as Coca Cola are transparent about their investment in research has been the subject of much scrutiny both in Australia¹⁴⁷ and internationally. In August 2015, in response to a New York Times article reporting on the Coca-Cola Company's funding of the Global Energy Balance Network,¹⁴⁸ the company's CEO Muhtar Kent declared a commitment to act with more transparency.¹⁴⁹

Research was undertaken to evaluate whether the Coca-Cola Company complied with its undertaking and found that the Coca-Cola Company appears to have failed to declare a comprehensive list of its research activities. Further, several funded authors appear to have failed to declare receipt of funding. Most of Coca-Cola's research support is directed towards physical activity and disregards the role of diet in obesity.¹⁵⁰

Run disinformation campaigns to defeat public health measures

The food industry utilises public forums such as the media to actively critique public health campaigns. This has been particularly visible in recent months in the beverage industry's' attacks on the proposed sugary drinks levy. Despite the evidence and WHO recommendations, the proposition of a health levy on sugary drink has met with predictably vigorous opposition from the Australian beverage industry, which has vocally opposed such measures, employing a range of arguments relating to the evidence of harms, the efficacy of taxes and incursion on personal freedoms. Close examination, however, reveals the main arguments employed by industry to be flawed and often based on rhetoric, using evidence

selectively. Indeed, many of these arguments have been used in the campaigns against the introduction of health levies in other settings and disproved.

A recent World Cancer Research Fund report canvasses the tactics used by industry in depth.¹⁵¹ A potent example of such tactics was the claim by Beverage South Africa that the introduction of a levy on sugary drinks would cause job losses of 24,000. That estimate was contradicted by the National Treasury report on hearings to the Standing Committee on Finance and Select Committee on Finance about the impact of the sugary beverage tax. That report found that the potential employment losses would be between 5,000-7,000. Please refer to [Analysis of industry arguments against a health levy on sugary drinks in Australia](#) for a discussion of the arguments used by industry against a sugary drinks levy.

Coca Cola appears to be stepping up its campaign against sugary drinks taxes in the Pacific. Recent press reports have detailed a job advertisement which seeks an applicant, who will work from Auckland, to manage government relationships in the Pacific Islands to ensure sugar taxes don't negatively impact the business.¹⁵²

Influence the political agenda

There are obvious ways that the food industry endeavours to influence the political agenda. They may donate to political parties across the political spectrum. They also ensure that representatives from unhealthy industries are around the policy table as they did with the committees that were responsible for designing the HSRS.

They also engage in stealthier tactics as disclosed by the Beverage Council in their 2016 Annual report. The soft drink industry said its fight against a sugar tax was "consuming vast amounts of resources", but by lobbying politicians and bureaucrats it had managed to keep the policy off the table. The report stated that holding its annual board meeting at Parliament House in Canberra had allowed members to engage with key politicians and on reflection, the politicians' expressions of support last time the sugar tax debate flared up "was due in part to the positive outcomes from this meeting".¹⁵³

Seeks to influence stakeholders

The food industry seeks to be a voice in health professional's education¹⁵⁴ and engages nutritionists to provide testimonials for their products.¹⁵⁵ In addition they invite health professionals to events that promote their products and attend health professional education events such as conferences.¹⁵⁶

Industry also seeks to have an influence on dietary guidelines. Industry had made submissions which would support sales of their products. For instance, the Australian Beverages Council "The Australian Beverages Council (the Beverages Council) considers that the currently available scientific evidence does not support a specific focus on limiting sugar-sweetened beverages (SSB) as a means to combat obesity." The Meat Livestock Australia has made a submission supporting changing the recommendation on meat consumption from limit to 455g per week to consumption of trimmed red meat 3-4 times per week.¹⁵⁷

Distracts with corporate social responsibility programs

Corporate social responsibility programs have long been scrutinised as an example of an industry tactic aimed to distract the public's attention from the damage being done by food industry products. One particularly poignant program, given that results from the National Aboriginal and Torres Strait Islander Nutrition and Physical Activity Survey (NATSINPAS) showed that in 2012–13, half (50%) of Aboriginal and Torres Strait Islander people consumed sugary drinks compared with one-third of non-Indigenous people,¹⁵⁸ is Coca Cola Amatil's partnership with the indigenous community. The website states that "Our overarching commitment to Indigenous Australia focuses on partnering to make a difference."¹⁵⁹ Specifically Coca Cola Amatil is working with communities through Mai Wiru regional stores council to help them strengthen their businesses while delivering a low-kilojoule range to customers.¹⁶⁰

Recommendation- Only include those parties whose sole interest is in the promotion of public health in obesity prevention policy formulation. This would not include industry given that, whilst they may be interested in the promotion of public health, their primary responsibility is to their shareholders and to the profitability of their business.

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- ¹⁴⁷<https://www.smh.com.au/business/consumer-affairs/what-cocacola-isnt-telling-you-about-its-health-funding-in-australia-20160218-gmx3l3.html>
- ¹⁴⁸O'Connor A (2015) Coca-Cola funds scientists who shift blame for obesity away from bad diets. *The New York Times*, 9 August 2015. <https://well.blogs.nytimes.com/2015/08/09/coca-cola-funds-scientists-who-shift-blame-for-obesity-awayfrom-bad-diets/>
- ¹⁴⁹Kent M (2015) 'We'll Do Better': Coca-Cola Vows to Improve Transparency. <http://www.coca-colacompany.com/stories/welldo-better-coca-cola-vows-to-improve-transparency>
- ¹⁵⁰Seródio P M, McKeeM, and Stuckler D, Coca-Cola – a model of transparency in research partnerships? A network analysis of Coca-Cola's research funding (2008–2016)*Public Health Nutrition*: 21(9), 1594–1607
- ¹⁵¹World Cancer Research Fund International, Building momentum: lessons on implementing a robust sugar sweetened beverage tax, June 2018.
- ¹⁵²John Anthony, Coca-Cola recruiting lobbyist to fight sugar tax, despite new research revealing such taxes can save lives, 17 June 2018, <https://www.stuff.co.nz/business/industries/104744933/cocacola-recruiting-lobbyist-to-fight-sugar-tax-despite-new-research-revealing-such-taxes-can-save-lives>
- ¹⁵³Beverage Council Annual Report 2016, <https://www.smh.com.au/cqstatic/gz7s0g/annualreport.pdf>
- ¹⁵⁴Sugar research Advisory Service presented at RACGP General Practitioner annual conference in 2015 and provides sponsored online education through popular education and information providers such as Cirrus Media.
- ¹⁵⁵Nutritionists providing testimonial for unhealthy products eg Catherine Saxelby for The Beer Beautiful Truth <http://paidcontent.executivestyle.com.au/beer-the-beautiful-truth/beer/article/no-need-fear-beer/>
- ¹⁵⁶Nestle hosted a breakfast briefing for dietitians and nutritionists on 6 June 2018 at Cumulus Inc Melbourne where topics such as the place of flavoured milk in children's diets were presented.
- ¹⁵⁷https://consultations.nhmrc.gov.au/public_consultations/submissions/dietary_guidelines?page=2
- ¹⁵⁸Australian Bureau of Statistics. Australian Aboriginal and Torres Strait Islander Health Survey: Consumption of Food Groups from the Australian Dietary Guidelines, 2012-13,
- ¹⁵⁹<https://www.ccamatil.com/en/our-contribution/our-community/indigenous>
- ¹⁶⁰Ibid.