

The Health Select Committee Inquiry into
Obesity and Type Two Diabetes in New
Zealand: A back seat for physical activity

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Executive Summary

Over the past two years substantial attention has been paid by New Zealand politicians to the prevention of obesity and type 2 diabetes. The Health Select Committee of the House of Representatives has conducted and reported on a substantial Inquiry, and the Government has responded to the Select Committee's report.

This paper has two purposes: to describe what submitters told the Inquiry, and to consider how the politicians responded. It shows that what the submissions said about the role of physical activity in obesity prevention ("healthy action") received relatively little attention in either the Select Committee Report or the Government response. The emphasis in both is instead strongly focussed on the role of nutrition ("healthy eating"). It is argued that this is a mistake. It is crucial not to emphasise just one side of the energy equation, either in preventing obesity or non-communicable diseases in general. Both healthy eating and healthy action are essential.

The paper concludes by discussing some of the consequences of the failure to give equal prominence to healthy action and healthy eating, and what might be done to lessen the effect of these consequences.

PART I: THE CONTENT OF THE SUBMISSIONS

The Health Select Committee Inquiry

In May 2006 the Health Select Committee of the House of Representatives commenced an Inquiry into Obesity and type 2 Diabetes in New Zealand. Part I of this paper reports on what was said in submissions about the role of physical activity in obesity prevention.

Method

For the purposes of reporting on the submissions to the Inquiry, the 314 submissions were grouped into "sectors": health, physical activity, nutrition, breastfeeding, industry (food and advertising organisations) and "other". Health was the largest sector, with 143 submissions. The physical activity sector, with 35 submissions, was next in size apart from "other" (section 2.1).

The numerical analysis in this report is based on coding whether each submission contained specific 'propositions', which are general statements that indicate each submitter's position as expressed in their submission. Propositions are italicised in the text. It is important to note that failure to mention a proposition does not imply lack of support for it. For all or most propositions discussed, many more submitters would have agreed with them

than actually proposed them. Most submissions restricted themselves to a narrow range of issues (section 2.2).

Some general issues relating to obesity prevention

Two of the general issues regarding physical activity and obesity prevention that were raised in submissions are considered in this report. First is the need for obesity to be addressed at many levels, including measures to both increase physical activity and improve nutrition. This was expressed in 29 submissions through the proposition that *obesity prevention requires a 'whole of society' approach*. Of these 29 submissions, 16 went further by specifying that this needs to be a *'whole of society' approach that includes reducing socio-economic inequalities*. As one submitter noted, there is a need for policies “which influence the larger environment within which health and health inequalities are established” (section 3.1).

Second, three submissions, including that from internationally-recognised obesity expert Professor Boyd Swinburn, proposed that *interventions to decrease calorie intake are more likely to be effective in reducing obesity than interventions to increase physical activity*. On the other hand, four submissions, including that from the Public Health Advisory Committee (PHAC), proposed that *increasing physical activity is just as important as reducing calorie intake in addressing obesity*. Swinburn's argument appears to have been a persuasive one for the Select Committee (section 3.2).

Approaches to increasing physical activity

Ten submissions proposed that *addressing environmental barriers to physical activity is an effective means of increasing physical activity*. This would involve the creation of “activity friendly environments” (section 4.1).

It was also proposed in ten submissions that *the primary focus for increasing physical activity should be on facilitating it becoming more a part of everyday life*. The encouragement of active travel, including the promotion of active travel plans in workplaces, was seen as one means of achieving this (section 4.2).

Forty-three submissions proposed that *more resources need to be made available to encourage increased physical activity*. Of these 43, 26 proposed that *measures encouraging physical activity as part of everyday life need increased support*. There were also calls for more resources for Sport and Recreation New Zealand (SPARC), Regional Sports Trusts, green prescriptions, and community-based approaches to increasing physical activity (section 4.3).

Three submissions proposed that *employers should be given financial incentives to encourage employees to be more physically active*. Eight submissions believed that *subsidies should be provided to assist people in becoming more physically active* (section 4.4).

Several submissions noted that measures to increase physical activity would assist in the attainment of other socially desirable goals, including the reduction of carbon emissions (section 4.5).

The built environment and obesity prevention

The 'built environment' refers to the buildings, roads, parks and all other facilities that provide the physical setting for human activity.

The aspect of physical activity most mentioned in submissions as requiring encouragement was 'active transport' – primarily walking and cycling. Of the 314 submissions, 71 (23%) proposed that *more and safer routes for walking and/or cycling need to be provided*. Travel to school was frequently mentioned in this respect. Sixteen submissions supported expansion of public transport because of the walking typically involved at both ends of the trip (section 5.1).

Forty-one submissions proposed that *changes to the built environment to encourage active recreation are required*. On the whole these 41 submissions were concerned about the provision of recreation facilities (section 5.2).

The point was also made in many submissions that the built environment could affect healthy eating as well as healthy action. Thirty-six submissions proposed that *changes to the built environment to improve access to more healthy food are required*. There was also substantial support for changes to the built environment to decrease access to less healthy food, particularly through the zoning of fast food outlets (section 5.3).

Two central government initiatives, the Urban Design Protocol (2005) and the New Zealand Transport Strategy, received substantial support, with many calls that they be widely implemented (section 5.4).

Support for modification of the built environment to assist in obesity prevention was very widespread. Some form of change to the built environment to help prevent obesity (through greater physical activity and/or more healthy eating) was proposed in 115 (37%) of the 314 submissions (section 5.5).

Physical activity in schools

Twenty-six submissions proposed that *all school policies should promote and support physical activity* (section 6.1). This call for a 'whole of school' approach went beyond curricula, but it is noted that in 2005 changes were made to increase the prominence of physical activity in the curriculum (section 6.2). Forty submissions proposed that in order to address obesity, *school-based physical activity/physical education programmes should have an important place in the school curriculum* (section 6.3.1). This call, however, worried some physical educators who were concerned that health goals might supplant education goals in physical education programmes. But there seems to be no reason that the same programmes cannot serve both educational and health purposes (section 6.3.2).

PART II: OFFICIAL RESPONSES TO THE SUBMISSIONS

Given the balance of submissions, both the Health Select Committee Report and the Government response are surprising in the extent to which they place emphasis on interventions relating to healthy eating compared to healthy action (Chapter 7). Both effectively place healthy action second to healthy eating.

The Health Select Committee Report and physical activity

On 30 August 2007 the Health Select Committee released its report on the Inquiry. Healthy action interventions as part of obesity prevention are virtually ignored by the Committee. An analysis of the 55 recommendations made by the Committee illustrates this. There are 23 recommendations relating specifically to healthy eating, but none relating specifically to healthy action. In the 15 recommendations referring to both healthy eating and healthy action, physical activity is merely listed along with other areas for intervention, and always after nutrition (section 7.1.1).

In focussing on nutrition, the Select Committee Report relies on a theoretical argument rather than on evidence of what works (section 7.1.2).

The Report briefly covers issues relating to improving the built environment to encourage physical activity, but in only four paragraphs, and with no resulting recommendation. Yet the Committee received a number of well-argued submissions containing recommendations for substantial actions relating to the built environment.

The importance of making increased physical activity a part of everyday life, a point strongly made in many submissions, receives no mention in the Report.

The strong emphasis on nutrition rather than physical activity interventions in the Report does not reflect the balance of recommendations from submissions (section 7.1.3).

The Government Response to the Select Committee Report

In November 2007 the Government released its response to the Health Select Committee's report. The Government's response is to a large extent a recital of actions that the Government has taken, or plans to take, to combat obesity and type 2 diabetes. It contains no change of direction, and few new initiatives.

The Select Committee's emphasis on nutrition relative to physical activity in the prevention of obesity and type 2 diabetes continues in the Government's response. Of the 23 "new actions" that the Government announced in the response, 12 relate specifically to healthy eating, while none relate specifically to healthy action (section 7.2).

Healthy action as equal first with healthy eating

The relative lack of attention in the Health Select Committee Report and Government response given to physical activity is out of step with recent authoritative reports on obesity prevention. There is a clear consensus that both healthy action and healthy eating are important, and both must be addressed to reverse the trend towards higher rates of obesity (section 8.1).

The best available evidence also shows that healthy action and healthy eating should be considered equally important not just in preventing obesity, but in promoting health in general. This is particularly so for non-communicable diseases, including heart disease, cancer and diabetes (section 8.2).

Conclusion

The emphasis placed on nutrition at the expense of physical activity in the Health Select Committee Report, and in the Government's response, place our politicians out of step with the mainstream view of what needs to be done to prevent obesity and other non-communicable diseases. This matters, both in terms of resource allocation and the communication of consistent messages about public health.

The greater emphasis placed on nutrition than on physical activity by the Health Select Committee and Government is likely to be detrimental to finding the right balance in allocating resources between interventions to promote healthy eating and those to promote healthy action (section 9.1).

Arguments about whether healthy eating or healthy action deserves greater prominence in obesity prevention can cause confusion about effective intervention strategies for both the public and politicians. The public health message should never imply that nutrition interventions are more important than physical activity interventions in obesity prevention, or vice versa (section 9.2).

A major issue identified in submissions for increasing physical activity in the New Zealand population involves creating built environments that encourage people to engage in active transport (mainly walking and cycling) and active leisure. Some of the changes required will be expensive, and many cannot happen overnight. But this does not mean that we can neglect them.

Much too, can be done within existing environments. As an example, a number of suggestions are made in submissions about changes that could be implemented now to alter the balance on our roads between the needs of motorists on the one hand and those of cyclists and pedestrians on the other.

Such changes will undoubtedly be politically difficult. But the need to push hard for significant change is just as important for healthy action as it is for healthy eating. To achieve change in both areas, every opportunity must be taken to win public support for changing the environment to encourage more healthy lifestyles (section 9.3).

1 Introduction

Over the past two years substantial attention has been paid by New Zealand politicians to the prevention of obesity and type 2 diabetes. The Health Select Committee of the House of Representatives has conducted and reported on a substantial Inquiry, and the Government has responded to the Select Committee's report.

This paper has two purposes: to describe what submitters told the Inquiry, and to consider how the politicians responded. It concludes that what the submissions said with respect to the role of physical activity in obesity prevention ("healthy action") received relatively little attention in either the Select Committee report or the Government response. The emphasis in both was instead strongly focussed on the role of nutrition ("healthy eating"). It is argued that this was a mistake. It is crucial not to emphasise just one side of the energy equation, either in preventing obesity or non-communicable diseases in general. Both healthy eating and healthy action are essential.

The paper concludes by discussing some of the consequences of the failure to give equal prominence to healthy action and healthy eating, and what might be done to lessen the effect of these consequences.

1.1 *The Select Committee Inquiry*

On 22 February 2006 the Health Select Committee of the House of Representatives invited submissions to an Inquiry into Obesity and Type 2 Diabetes in New Zealand. The Terms of Reference were as follows:

1. To examine the causative factors likely to be driving increases in obesity and type 2 diabetes, including nutrition and physical activity.
2. To identify the effects of obesity and type 2 diabetes on the health of both children and adults and across ethnic and socio-economic groups and potential future costs.
3. To inquire into the effectiveness, particularly for children, of current obesity prevention approaches and interventions including primary prevention and screening, information provision, education, physical activity and voluntary steps taken by the food industry.
4. To inquire into whether additional interventions aimed at changing features of the environment that promote obesity are required.
5. To consider what policy or legislative mechanisms, if any, should be used to give effect to any findings of the inquiry.
6. To report the inquiry's findings and recommendations to the House of Representatives.

The Committee held a series of public hearings from 10 May 2006 to 8 November 2006. Two further hearings followed on 7 March 2007 (the Ministry

of Health) and 14 March 2007 (the New Zealand Food Safety Authority). Most hearings were in Wellington, but the Committee also travelled to Christchurch, Palmerston North, Auckland (twice) and Hamilton. The Committee heard oral presentations for a fraction over half of the submissions (159 of 314).

The Committee released its report on the Inquiry in August 2007. This was followed in November 2007 with the Government's response.

1.2 *The submissions to the Inquiry*

An earlier report focussed on recommendations from the submissions that would reduce the obesogenic effects of the food environment in New Zealand.¹ This report performs a similar role for physical activity. Together the two reports represent a comprehensive picture of most of the major themes pursued and recommendations made in the submissions to the Inquiry regarding the prevention of obesity and type 2 diabetes.

The other concerns of the Inquiry were the causes and effects of obesity and type 2 diabetes. A paper reporting what the submissions had to say on causes and effects is available on the Fight the Obesity Epidemic (FOE) website.²

¹ White, John (2007). The Health Select Committee Inquiry into Obesity and Type 2 Diabetes: An initial analysis of submissions. Available at www.foe.org.nz.

² See www.foe.org.nz.

Part 1: The Content of the Submissions

Chapters 3 through 6 report what submissions to the Inquiry had to say about the role that physical activity should play in the prevention of obesity and type 2 diabetes. This is preceded in Chapter 2 by a description of the methodology used in analysing the content of the submissions.

2 Method

2.1 Selection and classification of submissions

The Committee's records show that it received 313 submissions. Two further papers are treated as submissions for the purpose of this report. The first was a background paper provided to the Select Committee by the Ministry of Health. The second was a paper written as a submission by the Public Health Advisory Committee (PHAC)³, a subcommittee of the National Health Committee set up to provide independent advice to the Minister of Health. PHAC forwarded its submission via the Minister's Office with a recommendation that it be forwarded to the Select Committee, but it appears that the Select Committee did not receive or consider it. It is not listed among the submissions received in the Committee's report. It is treated as a submission in this paper because it is a public document written with the intent that it be considered as a submission by a group with substantial relevance to the Inquiry.

One submission was excluded from the analysis: submission 295 was a set of papers forwarded by an overseas academic, but without any covering discussion or recommendations. This left 314 submissions available for analysis.

The 314 submissions were classified into 28 categories (see Table 1).⁴ The purpose was to allow the submissions to be placed in groups that were of potential interest in terms of the propositions that they tended to support.

³ Public Health Advisory Committee. Advice on obesity inquiry. Retrieved 27 January 2008 from [http://www.phac.health.govt.nz/moh.nsf/pagescm/762/\\$File/health-report-11may06.pdf](http://www.phac.health.govt.nz/moh.nsf/pagescm/762/$File/health-report-11may06.pdf).

⁴ Where a submission could be classified as belonging to more than one category, the first descriptor mentioned was used to classify the submission. If, for example, a submitter described herself as a dietitian and parent she was classed as a dietitian. If she said she was a parent and a dietitian she was classed as a parent.

Table 1 also shows how the categories were then grouped into “sectors”: health, physical activity, nutrition, breastfeeding, industry (food and advertising organisations) and “other”. The physical activity sector, for example, comprised 35 submissions from seven categories:

- Central government 2 (SPARC⁵ and the Ministry of Transport⁶)
- Regional Sports Trusts 8
- Academic groups 2
- Academic individuals 3
- Professional association 1 (Physical Education New Zealand)
- Other groups 13
- Other workers 6

The health sector was by far the largest sector, contributing 143 (46%) of the 314 submissions.

The selection of sectors was partly dictated by the needs of the quantitative analysis, which considers differences across sectors in the clustering of support for particular propositions. It is acknowledged that many of those who wrote submissions classified as in the nutrition sector, for example, would regard themselves as part of the health sector. Similarly it could be said that breastfeeding is part of nutrition.

The submissions were not readily classifiable into those concerned with obesity and those concerned with type 2 diabetes. Many submissions addressed both, sometimes explicitly but more often implicitly. This was because of a widely-accepted assumption that obesity plays a very important role in the development of type 2 diabetes in individuals, and that measures to prevent obesity and type 2 diabetes are generally the same. As put by Pegasus Health:

The strategies for addressing obesity and diabetes are the same and are centred on improving nutrition and increased levels of physical activity... [This is because] reducing obesity is the only realistic way of having a significant impact on the trends in the prevalence of Type 2 Diabetes (s260, pp3,6).

⁵ SPARC (Sport and Recreation New Zealand) is a Crown Agency with a focus on encouraging physical activity.

⁶ The Ministry of Transport was placed in the physical activity sector for the purpose of this report as its submission was concerned with the promotion of walking and cycling.

Table 1 The 314 submissions by category and sector

Category	Health	Physical Activity	Nutrition	Breast-feeding	Industry	Other	Total
Academic group	8	2	2			1	13
Academic individual	8	3	2			1	14
Breastfeeding group				9			9
Broadcasting company					2		2
Central government agency	1	2	1			4	8
Church group						3	3
Company - food and beverages industry					5		5
Diabetes group	10						10
Dietitian			10				10
District Health Board	12						12
Industry group - advertising/broadcasting					6		6
Industry group - food and beverages					8		8
Local Cancer Society	5						5
Local Diabetes Society	7						7
Maori health provider/service	8						8
Medically-qualified health professional	11						11
National group - specific health condition	5						5
Obese or diabetic person, or formerly one						8	8
Other group	15	13	13			15	56
Other individual						30	30
Other worker	16	6					22
Parent						12	12
Primary Health Organisation	6						6
Professional association	14	1	2				17
Public health group	6						6
Regional group - nutrition/physical activity	11						11
Regional Sports Trust		8					8
School						2	2
Total	143	35	30	9	21	76	314

2.2 Propositions

The numerical analysis in this report is based on coding whether each submission contained specific 'propositions'. These are generalised statements that reflect common statements expressed in similar ways across a range of submissions. They are not quotations from particular submissions. Specific propositions are italicised when they occur in the text throughout this report.

There were two ways in which a submission was coded as *proposing* a proposition:

1. The submission included a statement that had the same or a very similar meaning to the proposition.
2. The proposition was clearly implied by statements made in the submission. For example, the statement "something needs to be done to make roads safer for cyclists" implies the proposition that *more and safer routes for walking and/or cycling need to be provided*, which in turn implies the higher-level proposition that *changing the built environment to encourage physical activity is required*.

It is important to note that failure to mention a proposition does not imply lack of support for it. For all or most propositions discussed, many more submitters would have agreed with them than actually proposed them. Most submissions restricted themselves to a narrow range of issues.

The report contains extensive quotations from submissions. This is central to the approach adopted, with the intent being to give an accurate picture and something of the flavour of what the submitters told the Inquiry.

3 General issues relating to physical activity and obesity prevention

A number of general principles relating to obesity prevention emerging from the submissions were reported in an earlier paper.⁷ There was very strong support, particularly from the health sector, for the propositions that:

- *to be effective, obesity prevention requires environmental changes that impact at a population level*
- *changing the environment to make healthy choices the easy choices is central to reducing obesity*
- *education and information provision without environmental changes will be ineffective in reducing obesity.*

These principles apply equally to interventions in support of both healthy action and healthy eating.

This chapter considers two further general issues raised in the submissions which relate to the role of physical activity in obesity prevention – the need for a ‘whole of society’ approach, and the relative importance of healthy eating compared to healthy action interventions.

3.1 The need for a ‘whole of society’ approach

A common thread in the submissions was that *obesity is a complex problem requiring an extensive set of solutions*⁸ (stated in 36 submissions). No submission proposed that there was a single solution. The complexity of the problem and the implications for solutions were expressed by former public health manager Paul Stephenson as follows:

Obesity appears to be the manifest result of a set of complex interactions between people and the changing environments and social norms that have resulted from our technological capability and the construction of modern society. We have created the problem through a myriad of decisions and actions... The problem is multifaceted and involves decisions by individuals, families, communities, businesses and government. The solution will require [that] all these groups make different decisions (s306⁹, p2).

⁷ White, John (2007). The Health Select Committee Inquiry into Obesity and Type 2 Diabetes: An initial analysis of submissions, Chapter 3. Available from www.foe.org.nz.

⁸ Statements in italics such as this are “propositions” as defined in section 2.2.

⁹ In this and other references to particular submissions, s306 means submission number 306 as recorded by the Select Committee clerk.

The need for the problem to be addressed at many levels was expressed in 29 submissions through the proposition that *obesity prevention requires a 'whole of society' approach*. Of these 29 submissions, 16 went further by specifying that this needs to be a *'whole of society' approach that includes reducing socio-economic inequalities*.

3.1.1 Addressing both physical activity and nutrition

Figure 1 has been included to show that submissions favouring a 'whole of society' approach to obesity prevention saw this as involving interventions directed at both increasing physical activity (healthy action) and improving nutrition (healthy eating). In order to derive the data in Figure 1, all submissions were classified into one of four groups:

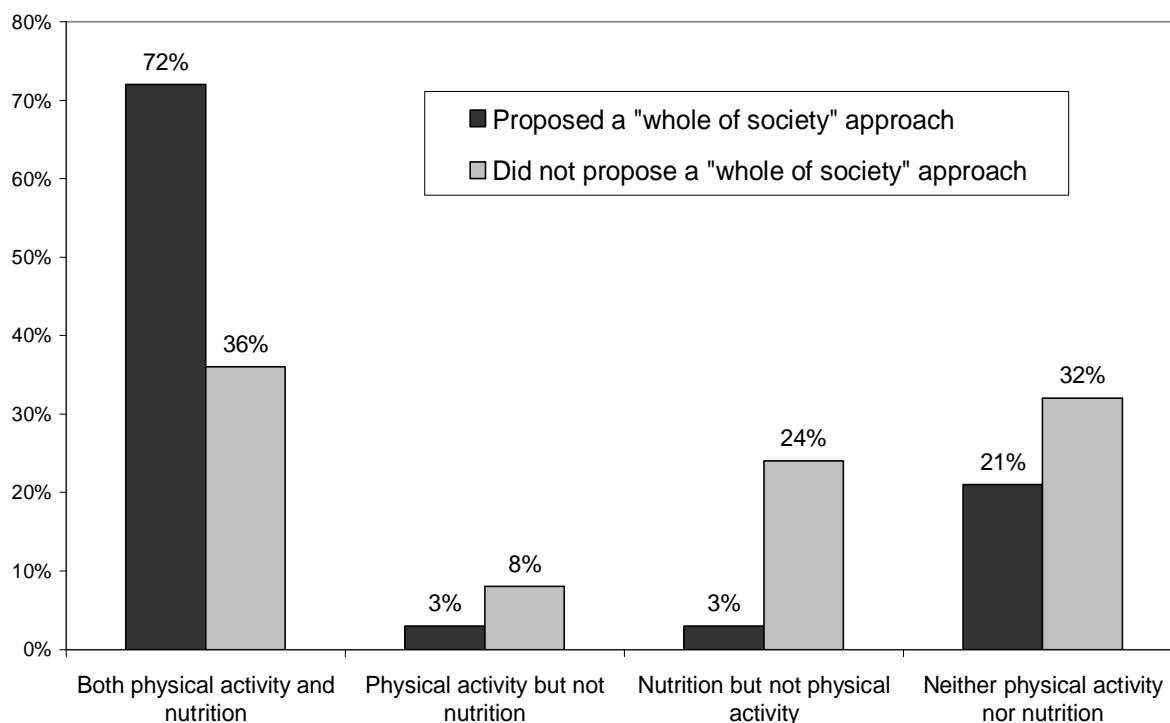
1. Proposed at least one measure to address obesity and/or type 2 diabetes through increased physical activity, and at least one measure through improved nutrition
2. Proposed at least one measure to address obesity and/or type 2 diabetes through increased physical activity, but no measures through improved nutrition
3. Proposed at least one measure to address obesity and/or type 2 diabetes through improved nutrition, but no measures through increased physical activity
4. Proposed no measures to address obesity and/or type 2 diabetes through either increased physical activity or improved nutrition.

Figure 1 shows a substantial difference in recommended interventions between the 29 submissions favouring a 'whole of society' approach, and the 285 who did not propose this.

Of the 29 submissions proposing a 'whole of society' approach, 21 (72%) recommended both physical activity and nutrition interventions. Only one submission (3%) recommended a physical activity intervention but not a nutrition intervention, and only one favoured a nutrition but not a physical activity intervention.

The remaining 285 submissions did not specifically propose a 'whole of society' approach. Only 36% of these 285 submissions recommended both physical activity and nutrition interventions. On the other hand, 24% proposed at least one nutrition intervention but no physical activity intervention, compared to just 3% of those proposing a 'whole of society' approach.

Figure 1 Comparison of the distribution of recommended interventions in those submissions proposing a ‘whole of society’ approach and those submissions that did not propose this



It is important to note that while 285 submissions that did not propose a ‘whole of society’ approach, this does not imply lack of support for this proposition. It is likely, from what is said elsewhere in their submissions, that a large majority of the 285 would have favoured a ‘whole of society’ approach if this was put to them in a questionnaire.

More detail relating to the distribution of recommendations about physical activity and nutrition across submissions is included in Appendix A.

3.1.2 Addressing socio-economic inequalities

The Public Health Advisory Committee (PHAC) noted the need for policies “which influence the larger environment within which health and health inequalities are established”. They continued:

Social, cultural, economic and historical inequalities develop and are perpetuated within the wider context. Policies which have to do with access to housing, education and the labour market, welfare, taxation, education, transport, and agricultural and trade policy all influence this

context. The health sector has a leadership role to play in brokering public health concepts with those who set these policies (s314¹⁰, p10).

The Cancer Society of New Zealand recommended that obesity be addressed through a focus on the broader determinants of health. The Society noted that health inequalities are the result of wider inequalities that are avoidable, including food supply, income inequalities, housing and transport options. They argued that the “Government must urgently look at strategies to improve health and wellbeing which improve the environmental and social determinants of health” (s72, p8).

The Child Poverty Action Group provided an extensive review of evidence linking obesity and low income. They concluded:

Dealing with food insecurity directly takes account of the reality of poor people’s lives, and is thus a first step to dealing with the underlying causes of obesity and ill-health that disproportionately affects low-income children and young people (s228, p8).

Catholic agency Caritas observed:

We believe that obesity and poor health associated with poor nutrition and low living standards are, to some extent, a transfer of liabilities from the Ministry of Social Development to the Ministry of Health (s253, p3).

3.2 *The relative importance of healthy eating compared to healthy action interventions*

Just seven submissions referred to the relative merits of healthy eating compared to healthy action interventions. However, at least one of these seven submissions (that from Professor Boyd Swinburn) appears to have a strong effect on the thinking of the Select Committee. Sections 3.2.1 and 3.2.2 report what the submissions said. The implications for the Select Committee’s report and the Government’s response to the Committee’s report are explored in Chapter 8.

3.2.1 The argument for emphasising healthy eating interventions

Three submissions proposed that *interventions to decrease calorie intake are more likely to be effective in reducing obesity (at least in the short term) than interventions to increase physical activity*. This point was emphasised by Professor Swinburn:

Action on food intake is more powerful than action on physical activity. A balanced portfolio must have both aspects and physical activity has many benefits in addition to helping maintain a healthy body weight. However, the energetics of the matter are inescapable. Physical activity makes up

¹⁰ This is the one exception to the rule for referring to submissions stated in the previous footnote. The writer of this report assigned the number (314) to this submission, as it was not forwarded to the Select Committee and included in their numbering.

only 20-30% of total energy expenditure. The part of that which is able to be influenced (mainly recreational activity and active transport) is only a fraction of that again. For a population of children to reduce their energy intake by 10% would mean a reduction of about 785kJ/d or about 450ml of soft drink. To achieve the same 10% energy balance deficit by increasing physical activity, it would require them to walk for an extra 2.5 hours a day to burn the 785kJ/d. Either of these behavioural changes would reduce their weight by about 4.5% or 1.4kg (s189, p6).

The New Zealand Branch of the Australasian Faculty of Public Health Medicine submitted that, as solutions to obesity in the short term, “reducing energy intake, especially reducing energy-dense food production, marketing and consumption, present the most practical strategies” (s159, p2). They also noted that while “debate will continue about the relative contribution of physical inactivity levels or excessive nutrition, it is clear that both are strong influences and taking action on both is needed” (p16).

The Ministry of Health reported that international obesity expert Professor Philip James “contends that price, availability and marketing of food are the key areas to consider for the prevention of obesity” (Ministry of Health background paper, p28).¹¹

Section 8.1 of this report shows that the view that healthy eating is more important than healthy action in obesity prevention is a minority one, and points to substantial evidence that this view is not sustainable.

3.2.2 The argument for equal prominence for healthy action interventions

Four submissions proposed that *increasing physical activity is just as important as reducing calorie intake in addressing obesity*. The Public Health Advisory Committee (PHAC) was the strongest advocate outside the physical activity sector for physical activity interventions to be given at least equal prominence to nutrition interventions.

Equal prominence for physical activity was central to the PHAC submission: its first recommendation was that “obesity control strategy be oriented as much toward increasing population physical activity as toward achieving healthier nutrition” (s314, p14).

PHAC proposed that two goals be adopted to reduce obesity:

- To create an environment where personal and community-wide physical activity is a supported and expected part of daily life
- To create an environment where healthful nutrition sources are available and affordable to all and energy-dense foods are not prominent (s314, p15).

¹¹ Because the Ministry was reporting a view rather than stating its own position, it was not categorised as supporting the proposition under discussion.

This reverses the usual order of referring first to healthy eating, then healthy action, as in the Government's Healthy Eating - Healthy Action (HEHA) strategy. The reversal is continued throughout the PHAC submission, where under a number of headings the sub-headings are "exercise" first and "nutrition" second.

PHAC does not present an argument as to why physical activity interventions are as effective as nutrition interventions. The closest PHAC goes to justifying its position is to refer to views in the literature on the relative roles of changes to physical activity and diet in explaining the current obesity epidemic (s314, p5).

Fitness New Zealand, the majority of whose members are organisations that operate fitness/exercise facilities, made an argument for the relative effectiveness of increased physical activity in addressing obesity and type 2 diabetes based on a limited citing of research evidence (s222, pp7-8). Further, the Fitness New Zealand submission provided an impressive list of other health benefits of physical activity based on World Health Organisation (WHO) information (s222, p9). Fitness New Zealand made a case that "any solutions with a greater emphasis on nutrition (as opposed to physical activity) will have substantially lower benefits" (s222, p8).

Sport and Recreation New Zealand (SPARC) also stressed health benefits of physical activity that went beyond weight reduction or weight maintenance:

There is a wealth of well founded and widely accepted evidence supporting the positive health effects that can be gained from physical activity. The benefits ...are brought about through a number of physiological mechanisms, e.g. improved glucose metabolism, increased insulin sensitivity, reduced body fat and lowered blood pressure. Physical activity also benefits hormonal metabolism and improves musculoskeletal health (s289, p1).

As is noted in section 3.2.1, Professor Swinburn himself acknowledges that "physical activity has many benefits in addition to helping maintain a healthy body weight". Even if granted, as Swinburn asserts, that nutrition interventions are more likely to be effective than physical activity interventions in reducing obesity, healthy action appears to be just as important as healthy eating for health in general. The evidence for this is presented in section 8.2.

4 Approaches to increasing physical activity

This chapter considers four approaches to increasing physical activity, as advocated in submissions:

- removing environmental barriers to physical activity
- making physical activity more a part of everyday life
- providing more resources to encourage physical activity
- providing financial incentives to encourage physical activity.

There is substantial overlap between the first two propositions above. Those concerned with removing environmental barriers to physical activity generally have in mind that this is to enable people to more easily incorporate physical activity as part of everyday life.

The chapter concludes with a point made in several submissions that increasing physical activity has synergies with other desirable outcomes, including helping to limit climate change by reducing carbon emissions.

4.1 Removing environmental barriers

Ten submissions proposed that *addressing environmental barriers to physical activity is an effective means of increasing physical activity*. As already noted, many more submitters are likely to have agreed with this proposition than the 10 who chose to include it in their submission.

The submission from He Kainga Oranga¹², which focused on children, noted that “being safely outdoors removes major barriers to physical activity” (s210, p2). They continued:

The barriers to physical activity for children include issues of security, the safety and quality of surroundings perceived by parents, the risks from crossing streets, the lack of cycleways, the quality and absence of footpaths, and distances to schools that encourage parents to provide transport. Urban neighbourhoods unfriendly to pedestrians and cyclists, and sprawling suburbs, limit the prospects for both children and adults to walk or cycle from homes to businesses and schools (s210, p2).

Active Hauraki, a group working to achieve “safe and activity friendly environments” in the Hauraki district, described what they believed would lead to greater levels of physical activity:

An activity-friendly environment enables people to, easily and safely, be active in their everyday life, and where:

¹² Housing and Health Research Programme, University of Otago

- Children have safe play areas
- Facilities for active leisure are accessible and affordable
- Community transport plans provide safe routes for active transport options ... and meet the needs of all road users including cyclists and mobility scooters (s204, p3).

The Canterbury West Coast Sports Trust also stressed the need to create “activity friendly environments which encourage more people to be more active” through increased accessibility and opportunities, and by ensuring safety (s98, p4).

4.2 Physical activity as part of everyday life

Ten submissions proposed that *the primary focus for increasing physical activity should be on facilitating it becoming more a part of everyday life*. In addition, 26 submissions wanted to see more resources applied to encouraging physical activity as part of everyday life (see section 4.3).

The submission from the Public Health Advisory Committee (PHAC) put particular emphasis on incidental physical activity, stressing “the importance of a comprehensive strategy that creates supportive environments for physical activity as a normal part of everyday life” (s314, p9). They continued:

At current, unsustainable rates of weight gain we need to build a society in which physical activity is an integral part of daily life rather than an exception or a costly diversion... physical activity must be an expected part of the daily routine in our society (s314, pp12-13).

From this perspective, PHAC proposed that the physical activity goal that should be adopted is to “create an environment where personal and community-wide physical activity is a supported and expected part of daily life” (s314, p15).

PHAC proposed that workplaces were one place where everyday physical activity could be encouraged and supported. Twenty-four submissions, influenced by material provided by the Obesity Action Coalition, proposed that *active travel plans should be promoted within workplaces*.

In other submissions, environments that encouraged active transport were seen as central to promoting everyday physical activity. Living Streets Aotearoa noted that transport choices are part of people’s daily lives, and focused their submission mainly on transport-related physical activity. They cited a substantial amount of research demonstrating that ‘active travel’ choices (walking and cycling) had large health benefits, including a reduction in overweight and obesity. They continued:

The critical primary health advantage of active travel (cycling and walking) is that it avoids the need to specifically undertake exercise separately from the daily routine of shopping, going to school, getting to work, and so on. This is potentially highly advantageous for those most

at risk from a lack of exercise: the 39 per cent or so of New Zealanders considered 'inactive' by the standard definition (s122, p11).

Living Streets Aotearoa noted that cycling involved risk, and that measures to promote cycling safety were a vital part of increasing the numbers of those prepared to cycle. As well, they noted that while risk exposure was not the issue with walking, there were "many actions that could increase the attractiveness of the walking environment and thus increase rates of walking" (s122, p14).

The New Zealand Branch of the Australasian Faculty of Public Health Medicine submitted that promoting active transport as part of everyday life was likely to be more effective than emphasising recreational activity. The Branch recommended that:

The promotion of physical activity should emphasis the inclusion of activity in everyday life... Promoting active transport (walking, cycling and public transport) is one good way to do this. Where strategies to promote physical activity require individuals to find extra time in their days to dedicate to physical activity, they are likely to compete with other time demands and be less effective (s159, p24).

The Ministry of Health also placed an emphasis on incidental physical activity. Future work in implementing HEHA, the Ministry stated, needs to particularly focus on actions that "impact on the price, availability and marketing of food, as well as increasing physical activity as a normal part of life" (Ministry of Health background paper, p28).

One submission took a different approach. Fitness New Zealand, representing organisations that operate fitness/exercise facilities, submitted that current physical activity messages "place far too much emphasis on low level incidental activity" (s222, p8). They argued that the '30 minutes a day' message had originated in response to concerns about coronary heart disease, and understated the level and duration of physical activity required to have a marked impact on obesity and type 2 diabetes. Fitness New Zealand submitted that 30 minutes a day was not enough for the management or prevention of obesity (s222, pp11-12). They also argued for greater focus on the use of exercise professionals in delivering programmes aimed at reducing obesity.

4.3 Resources for encouraging increased physical activity

Forty-three submissions proposed that *more resources need to be made available to encourage increased physical activity.*

At a general level, the Centre for Physical Activity and Nutrition Research at AUT University submitted that at present "the public health sector is grossly under-resourced to implement physical activity and nutrition programmes and evaluate the efficacy of such programmes" (s151, p3). The Centre argued that insufficient investment in preventive measures meant that large scale programme delivery was not feasible in most parts of the country.

Of the 43 submissions wanting more resources to encourage physical activity, 26 (60%) proposed that *measures encouraging physical activity as part of everyday life need increased support*.

Twenty-four of the 43 submissions proposed that *SPARC needs more resources for encouraging increased physical activity*. Six of the eight Regional Sports Trusts (RSTs) that made submissions included this proposition. And, unsurprisingly, RSTs comprised five of the six submissions proposing that *Regional Sports Trusts need more resources for promoting increased physical activity*. Harbour Sport (an RST) submitted that the funding received by SPARC and the Regional Sports Trust for programmes leading to increased participation in physical activity “is insufficient to do more than scratch the surface of the problem at the community level” (s140, p12). Sport Wellington Region (another RST) submitted that increased funding for SPARC should be linked to increased funding for regional delivery, so that RSTs were adequately funded to deliver quality programmes in their region (s277, p3).

Thirteen of the 43 submissions calling for more resources proposed that *more government support is needed for programmes for increasing physical activity such as Green Prescriptions*. Living Streets Aotearoa backed this call by providing a summary of research suggesting that Green Prescriptions were a cost-effective means of encouraging greater activity (s122, pp5-7). The Green Prescription scheme is outlined in the SPARC submission (s289, p6). Under the scheme, General Practitioners and practice nurses suggest a course of physical activity to patients rather than, or additional to, more traditional medical interventions such as drugs.

Finally, five submissions proposed that *community-based approaches to increase physical activity should be supported and strengthened*. One of these was from ZoomZone (Thames Sports and Community Education Trust). ZoomZone had spent five years in an unsuccessful attempt to establish a central facility where their community could meet and be active, whatever the weather. They noted that currently there is no provision for funding, or even seeking funding, for such projects and they requested that the Health Select Committee support establishment of “a small central fund that small communities could apply to, to assist them in helping themselves be active” (s244).

Push Play Southland pointed to the important role local government could play in promoting physical activity opportunities within their communities. They continued:

Local government’s responsibility for physical activity needs to be a component of the whole process, while nationally physical activity is promoted through authorities like SPARC there needs to be a flow down effect to local government. This process would require additional resource, and interventions would result in health promoting, active environments being established in areas of high need (s68, p3).

The Canterbury West Coast Sports Trust (CWCST) had as one of its recommendations:

Strengthen community action by encouraging a whole-community approach to physical activity to create an environment that is conducive to children participating in 60 minutes of physical activity and adults in at least 30 minutes every day (s98, p8).

The CWCST had adopted this as a strategic approach, but noted that there needed to be more resources available for communities to access so that they could “be empowered to take action and create sustainable Active Communities” (s98, p9).

4.4 Financial incentives to encourage increased physical activity

Three submissions proposed that *employers should be given financial incentives to encourage employees to be more physically active.*

The Cycling Advocates’ Network was keen that work places develop active travel plans for their employees. They gave examples including Nokia (Australia) where employees were reimbursed up to a limit for the cost of buying a cycle, and the New Zealand Police who rewarded their sworn staff for keeping themselves fit. Their submission noted that such measures involve a short term cost, with returns expected only in the medium to long term, through improved productivity. Incentives such as tax breaks for employers were suggested to cover initial costs (s45, pp4-5).

The Canterbury West Coast Sports Trust suggested reducing ACC levies as an incentive for employers to introduce activity friendly workplace policies (s98, p5).

Fitness New Zealand raised a point about Fringe Benefit Tax:

At present the current rules relating to Fringe Benefit Tax (FBT) are a barrier to businesses investing in their staff to address improve *[sic]* their health. If a business chooses to pay for a staff member to uptake physical activity for health reasons, this is regarded as a “personal benefit” from IRD, and hence subject to FBT of up to 64%. This is a major barrier to more businesses paying for staff to increase their physical activity levels, and for that reason we recommend that the government review FBT rules related to physical activity (s222, p17).

Eight submissions proposed that *subsidies should be provided to assist people in becoming more physically active.* A Massey University group¹³ drew attention to a Government initiative in the United Kingdom which promoted the purchase of bicycles (plus helmets and wet weather gear) through interest free loans and tax exemptions (s199, p5).

¹³ Nutrition and Human Health Cluster, Institute of Food, Nutrition and Human Health, Massey University.

Several submissions advocated subsidising subscriptions to facilities providing physical activity, or subsidising the facilities themselves so that they could provide cheaper services. The Active Schools facilitator working with Sport Auckland wanted to see a funding scheme established for lower income families to help meet costs of participation in children's sport such as fees, uniforms and equipment (s267, p2).

4.5 Synergies involving increased physical activity

Several submissions noted that measures to increase physical activity would assist in the attainment of other socially desirable goals. The staff at the School of Physical Education, University of Otago, noted:

Lack of physical activity, energy use, traffic congestion, pollution and greenhouse gas emissions are major issues facing our population. Incentives to increase physical activity, for example by promoting active transport, would act on all of these issues. Cross sectorial [*sic*] policies should be brought forward to achieve these synergies (s183, pp2-3).

Living Streets Aotearoa made the same point, noting "that where policy measures can work to promote physical activity, they often also promote environmental and social outcomes at the same time" (s122, p2).

5 The built environment and obesity prevention

The 'built environment' refers to the buildings, roads, parks and all other facilities that provide the physical setting for human activity.

This chapter considers what the submissions had to say on the potential for changes to the built environment to assist in obesity prevention. Three ways in which this can occur are discussed: changing the built environment to encourage active transport, to encourage active recreation, and to encourage healthy eating. This is followed by a discussion of two central government initiatives, the Urban Design Protocol (2005) and the New Zealand Transport Strategy. The chapter concludes with a summary of propositions indicating the widespread support in submissions for the importance of making changes to the built environment to help prevent obesity.

5.1 *Active transport and the built environment*

The aspect of physical activity most mentioned in submissions as requiring encouragement was active transport – primarily walking and cycling. The case for encouraging active transport as part of everyday life was made in section 4.2.

5.1.1 **Urban design and the encouragement of walking and cycling**

Encouraging active transport was usually framed by submitters as a built environment issue. Seventy-one submissions (23%) included the proposition that *more and safer routes for walking and/or cycling need to be provided*.

Living Streets Aotearoa noted that the relationship between urban design and walking and cycling (and hence health) was not entirely straightforward, but that scientific knowledge was increasing with the convergence of the two fields of public health and urban design (s122, p11). According to Living Streets Aotearoa, urban design features that encourage walking and cycling include street connectivity, mixed land use, and interlinked cycling and walking networks that might require coordination across local authorities. Features discouraging active transport include the separation of residential and commercial areas, suburban cul-de-sacs, and urban sprawl.

Living Streets Aotearoa argued that it is not just a matter of encouraging active transport:

[T]he most effective environmental interventions will increase the cost of sedentary transportation while reducing the costs of active forms of transportation. An example of one such strategy would be a host of traffic calming techniques that make it safer and more pleasant to walk by reducing the speed of cars, and thus the convenience and utility of this sedentary form of travel. Another obvious intervention would be raising

motor fuel taxes and allocating the proceeds to improvements in pedestrian, biking, and public transportation infrastructure and services (s122, p12).

Unsurprisingly, cycling groups were strong supporters of making roads more conducive to cycling. Cycle Action Auckland, for example, identified three things that cause cycling to be regarded as unsafe or unpleasant:

- too much traffic
- the traffic is too fast or intimidating
- there is a lack of space for cyclists (s227, p1).

Actions to reduce traffic volume suggested by Cycle Action Auckland included reallocation of road space (bus and bike lanes, removal of car parking spaces), financial disincentives for drivers (such as London's congestion tax), and raising the driving age. Traffic could be slowed by reducing speed limits and better enforcement of speed limits. Cycling could be made more pleasant by curbing vehicle modifications such as loud exhausts, and by compulsory vehicle emissions testing. And finally, measures are needed to give cyclists equal rights on our roads, including minimum design standards so that, for example, cycle lanes do not just peter out at intersections.

BikeNZ, an umbrella group for cycling organisations, stressed the need to complete networks for cyclists by removing design barriers which made otherwise usable networks under-used, or unused. These features ranged from poorly designed storm water drains to the Auckland Harbour Bridge. With such issues in mind, BikeNZ recommended that:

all road controlling authorities, including Transit, should be required to have auditable walking and cycling strategies with clear goals and mechanisms (including funding) for achieving these goals. Land Transport NZ funding should be predicated on all authorities having such plans. Support should also be provided for the funding of a 'level of service' walking and cycling audit process that assesses how well existing and planned land transport designs provide for active transport (s12, p5).

In a similar vein, the Cycling Advocates Network recommended that integrating the needs of cyclists be a mandatory part of all road design (s45, p4).

5.1.2 Travel to school

Of the 71 submissions wanting more and safer routes for walking and cycling, 33 specifically proposed that *more and safer routes for walking and/or cycling need to be provided, including to and from school.*

The Public Health Unit, MidCentral District Health Board submitted that new schools and early childhood centres "should be built off arterial routes in areas that are easily and safely reached by cyclists and pedestrians" (s273, p3).

Other measures to encourage safe walking and cycling to school that were commonly mentioned in submissions were school travel plans, walking school buses, traffic-calming measures around schools, and the provision of secure cycle racks. The Health Promotion Forum of New Zealand made a detailed case for greater use of walking school buses (s263, pp4-6).

5.1.3 Public transport

Sixteen submissions proposed that *public transport should be expanded to encourage greater use of active transport*. As noted by the Centre of Physical Activity and Nutrition Research at AUT University, public transport “supports the accumulation of physical activity as people have to walk/cycle to the public transport stop and/or final destination” (s151, p2).

The New Zealand Branch of the Australasian Faculty of Public Health Medicine argued that:

Priority should be given to transport- and planning-related interventions which target the physical, commercial and social environments, rather than interventions which target the individual. For instance, improvements to price and serviced availability for public transport should receive more emphasis than providing information encouraging public transport use, though both are worthwhile (s159, pp23-24).

5.1.4 Accessibility of facilities and active transport

It was proposed in nine submissions that *public services and facilities including shops should be accessible by walking/cycling/public transport*.

The Auckland Regional Public Health Service supported:

the adoption of land use policies and urban and regional developing plans to enable people to have easy access to settlements, housing and working areas, and shopping and leisure facilities by cycling, walking and public transport. Reducing the reliance on private vehicle transport as part of the development of “active living communities” is seen as an important step to improving the overall health and wellbeing of the population as it helps integrate physical activity into the population’s daily life (s82, p31).

The Heart Foundation sought to require “planning authorities to ensure that new or re-located public services, including schools and clinics, are sited where their clients and staff can reach them by walking, cycling and public transport” (s47, p11).

He Kainga Oranga¹⁴ argued that particular emphasis should be given to creating good active transport routes to important facilities, including schools and public transport connections. They noted that most walking occurs in the

¹⁴ Housing and Health Research Programme, Department of Public Health, Wellington School of Medicine and Health Sciences, University of Otago.

vicinity of people's homes. This means that the quality and safety of the immediate neighbourhood is crucial for walking. As well, encouraging more walking requires planning policies that promote high density, mixed-use, urban areas that keep distances short. Walking routes need to be safe, continuous, well-connected to key destinations, and well-signed. At major intersections pedestrians need to be given priority (s210, p3).

5.2 Active recreation and the built environment

Forty-one submissions proposed that *changes to the built environment to encourage active recreation are required*. On the whole these 41 submissions were concerned about the provision of recreation facilities.

A number of submissions called for the establishment of indoor facilities for active, community-based recreation.

Northland residents Robin and Jenny Hoare have for some time been researching and promoting the establishment of 'Healthy Life Centres' which would be funded by central government, and operated at first on an experimental basis. These centres would cater for a wide range of activities, but with a focus on non-competitive and fun physical activity, and would provide advice on healthy lifestyles. The Hoares make a strong case for such centres in their submission (s29), having observed the operation of similar centres in the United Kingdom. They have, however, had no success either with central or local government in attracting any funding for their proposal, even on an experimental basis.

As reported in section 4.3, ZoomZone (Thames Sports and Community Education Trust) has had a similar experience to the Hoares in failing to obtain funding for a facility where their community could meet and be active, whatever the weather (s244).

As part of addressing obesity in early childhood, the Central North Island Nutrition and Physical Activity Network Group called for "Indoor community play areas not linked to food (McDonald's and Lollipop Land) that are low cost or free, with flexible times" (s104, p2).

The Canterbury District Health Board, among others, suggested use of school facilities outside school hours by families and communities (s83, p18). This might go some way towards increasing the facilities available for active recreation.

On a different note, a submission from Dance Aotearoa New Zealand (DANZ) drew attention to dance as a healthy physical activity option for New Zealanders of all backgrounds and ages. DANZ urged organisations involved in the prevention and management of obesity and type 2 diabetes to "embrace and include dance, in all its diversity, as a recreation option" (s292).

Te Kainga Oranga suggested that the government should adopt a minimum overall aim in addressing the physical activity related causes of obesity and

type 2 diabetes: “To ensure that all children have safe and convenient places to walk, cycle, exercise and play outdoors; and that safe and attractive paths and cycleways connect their homes, schools and recreation areas” (s210, p4).

5.3 Healthy eating and the built environment

Two main ways in which the built environment has an impact on healthy eating were raised in submissions. First, there is concern about access to food purchase opportunities for some people, particularly for those on lower incomes living in poorly serviced locations. Second, a number of submissions called for some form of restriction on the location of fast food outlets.

While this topic is strictly outside the scope of this report, it is included here because some important points were made regarding it in submissions, it fits under the chapter heading of “the built environment and obesity prevention”, and it is useful to think about all health benefits, not just those relating to physical activity, when a broad view is taken on making the built environment more conducive to human health.

5.3.1 Access to more healthy food

Thirty-six submissions included the proposition that *changes to the built environment to improve access to more healthy food are required*.

As noted by national Māori health provider Te Hotu Manawa Māori, lack of access by a community to stores and restaurants with healthy kai is an important barrier to healthy eating. Te Hotu Manawa Māori saw a need to promote local markets, improve transport to food stores, and discourage the location of supermarkets away from where people lived (s100, p6). In a similar vein, Children’s Healthy Eating Healthy Action (Taranaki) noted that access to supermarkets and fruit shops is often limited in low socio-economic areas (s93, p6).

It was proposed in 19 submissions that *public transport should be expanded to help people access more healthy food*.

Seven submissions proposed that *public water drinking facilities should be freely available*. A retired person asked the Select Committee:

Please encourage local body Councils to install plenty of drinking water fountains in streets, parks, railway stations. Too often one must resort to the purchase of sugary fizz or “juice” ... simply because – unlike overseas towns & cities – NZ sports a dearth of drinking water fountains. Tourists often ask where they are, too (s217, p14).

5.3.2 Restricting access to less healthy food

Thirty-three submissions proposed that *changes to the built environment to decrease access to less healthy food are required*.

For 31 of these submissions, the concern was that *local authorities need to exercise some control, such as through zoning, on the location of fast food outlets.*

Of particular concern was the location of fast food outlets in close vicinity to schools.

5.4 Central government initiatives

5.4.1 The Urban Design Protocol (2005)

The Ministry for the Environment's Urban Design Protocol was launched in 2005. It is a voluntary commitment to specific urban design initiatives by signatory organisations, which include central and local government, the property sector, design professionals, professional institutes and other groups. The Protocol "aims to make our towns and cities more successful by using quality urban design" to help them, among other things, become

- liveable places that provide a choice of housing, work and lifestyle options
- a healthy environment that sustains people and nature.¹⁵

One submitter identified a number of ways addressed in the Protocol by which community design could contribute to improving physical activity opportunities, including:

- ensuring urban environments provide opportunities for all, especially the disadvantaged
- placing a high priority on walking, cycling and public transport, and
- providing environments that encourage people to become more physically active (s262, pp2-3).

Ten submissions agreed that *the Ministry for the Environment's Urban Design Protocol (2005) deserves support and/or needs to be implemented.*

In supporting the Protocol, the Taranaki District Health Board noted that:

Urban planning has an important role to play in reducing obesity by encouraging environments which support safe physical activity, such as safe footpaths and cycle ways, well designed and maintained playgrounds, green spaces & connecting walkways in new subdivisions (s92, p5).

A public health worker wanted to see incentives for central and local government bodies to sign up to the Protocol (s180, p3). Regional Public Health (Greater Wellington) went further, suggesting that the Protocol become

¹⁵ From the Ministry for the Environment website:
<http://www.mfe.govt.nz/issues/urban/design-protocol/index.html>.

mandatory for all local authorities. They believed that “regulations should be developed to prioritise walkers, cyclists and public transport users over other users in planning and development of towns and cities, including developing car-free areas with exceptions for disabled and elderly” (s135, p18).

5.4.2 The New Zealand Transport Strategy

The Ministry of Transport provided the Select Committee with a description of *Getting There – on foot, by cycle*, the Government’s strategy to advance walking and cycling (s299). *Getting There* sits under the New Zealand Transport Strategy (NZTS), which sets out the Government’s vision for transport. The NZTS includes the objective of “protecting and promoting public health”.

Getting There has three goals:

- community environments and transport systems that support walking and cycling
- more people choosing to walk and cycle, more often
- improved safety for pedestrians and cyclists.

The Ministry reported that new initiatives relating to *Getting There* “include the development of a research and evaluation programme, a review of transport sector alignment, the development of a walking and cycling information centre and a workforce development plan” (s299, p2).

Seven submissions proposed that *active transport components of the New Zealand Transport Strategy deserve support and/or need to be implemented*.

The submission from BikeNZ provided substantial detail as to what they wanted *Getting There* to achieve, and how this could be accomplished (s12). BikeNZ noted that a national implementation committee is identifying actions to realise the *Getting There* goals, and that in the interim some aspects of *Getting There* are being investigated or delivered by the existing *Bike Wise* programme managed by the Health Sponsorship Council.

BikeNZ had as its first recommendation:

that full financial and staffing support is provided to underpin the actions to be identified by the national implementation committee of the Walking and Cycling Strategy; and that in the meantime full support is given to the existing *Bike Wise* programme (s12, p2).

BikeNZ also supported other initiatives currently being implemented, including Land Transport New Zealand’s Safer Routes programme, travel planning in schools and workplaces, and SPARC’s Active Communities programme (s12, pp2-3).

The New Zealand Medical Council endorsed *Getting There*, but noted that “Councils in their District Plans often fail to take this into consideration” (s128, p21).

5.4.3 The role of Land Transport New Zealand

Land Transport New Zealand (LTNZ) is a Crown entity formed to promote land transport sustainability and safety, and allocate government funding for land transport.

The BikeNZ submission discussed at some length the role of LTNZ in promoting active transport.¹⁶ BikeNZ noted that while LTNZ supports “travel behaviour change”, this can easily come off second best in cost-benefit analyses (BCAs) compared to providing traditional roading that involves passive transport.

The BikeNZ recommendation relating to LTNZ was:

that greater investment is made into improving the technical abilities of Land Transport NZ staff to analyse the costs and benefits of active transport. The analysis needs to be done in terms of cross-sector goals in health, the environment (local and global), the economy and social equity. Land Transport NZ must also be required to fund ‘experimental’ projects more aggressively, and make better use of international data to justify such investment. Finally, the Government needs to support the continuing of, and expand the terms of reference for, the review of the BCA model currently used to allocate transport funding. The aim of the review should be to create a model that better reflects the policy goals of sustainable transport (s12, p4).

5.5 Summary: Support for changing the built environment

Support from submitters for some form of changing the existing built environment as part of obesity prevention was widespread.

- Some form of change to the built environment to encourage *active transport* was proposed in 79 submissions (25% of the 314 submissions)
- Some form of change to the built environment to encourage *active recreation* (such as the provision of recreation facilities) was proposed in 41 submissions (13%)
- Some form of change to the built environment to encourage *greater physical activity* (including active transport and active recreation) was proposed in 92 submissions (29%)
- Some form of change to the built environment to encourage *healthy eating* was proposed in 43 submissions (14%)
- Some form of change to the built environment to *help prevent obesity* (through greater physical activity and/or more healthy eating) was proposed in 115 submissions (37%).

¹⁶ The BikeNZ submission provides some excellent information and analysis, and should be consulted directly by those with an interest in the role of LTNZ in promoting active transport.

6 Physical activity in schools

This chapter focuses on school policies relating to physical activity. A number of submissions called for a ‘whole of school’ approach that goes wider than just school curricula. Recent government moves to strengthen the place of physical activity in the curriculum are discussed. There was general support for moves in this direction in many submissions. Finally, issues concerning the relationship between physical activity for health reasons and physical education for its own sake are considered.

6.1 *The need for a ‘whole of school’ approach*

Twenty-six submissions proposed that *all school policies should promote and support physical activity*.

The Ministry of Health recommended a “whole school community approach” engaging the entire school community in promoting consistent messages (MoH background paper, p21). Other submissions made the point that it was not just through the curriculum that schools influenced the behaviour and attitudes of their students, and that the whole school environment was important (s159, p25; s135, p16).

The Canterbury West Coast Sports Trust (CWCST) noted:

Schools ... need to create an environment and culture which supports and provides positive physical activity experiences for students. A whole of school approach to physical activity is important and would include: professional development for teachers in Physical Education and physical activity; additional funds for purchasing equipment or playground markings, and more Active Schools Facilitators (s98, p6).

Active Schools is a SPARC-led initiative which provides physical activity support to schools, and CWCST was concerned that over the next two-year period there were to be just 29 Active Schools Facilitators in Regional Sports Trusts nationally, servicing approximately 220 of the 2,400 schools in New Zealand (s98, p6).

The call for a ‘whole of school’ approach was often seen as including children’s travel to and from school. Twenty-one submissions, mostly influenced by material from the Obesity Action Coalition, proposed that *active travel plans should be promoted within educational institutions*.

6.2 *NEGs and NAGs*

The Government has taken some steps to strengthen school policies relating to physical activity. The National Education Goals (NEGs) administered by

the Ministry of Education were amended in December 2004 to include reference to physical activity in clause 5, which now reads:

A broad education through a balanced curriculum covering essential learning areas. Priority should be given to the development of high levels of competence (knowledge and skills) in literacy and numeracy, science and technology and physical activity.¹⁷

At the same time an additional clause was added to the National Administration Guidelines (NAGs). The addition, NAG (i) (c), requires the development and implementation of programmes that “give priority to regular quality physical activity that develops movement skills for all students, especially in years 1-6”. This requirement took effect from the beginning of 2006 (Ministry of Education website).

While many submissions made general statements about the need to strengthen school policies relating to physical activity (see section 7.2 above), in general they did not specifically discuss the adequacy of current government policies as expressed in the NEGs and NAGs. An exception was the submission from the Canterbury West Coast Sports Trust (CWCST), which welcomed the changes, but submitted that they did not go far enough.

The CWCST applauds the recent moves by the Government in developing National Education Goals (NEGs) and National Administration Guidelines (NAGs) around physical activity. More needs to be done now to ensure that ALL schools accept that their students need to be physically active on a daily basis. The current changes to NEGs and NAGs are still not sufficient to guarantee that schools will provide daily physical activity (curricular or co-curricular). *The Trust recommends that the current NEGs and NAGs are more prescriptive stating that physical activity needs to be compulsory, daily and of at least 30 minutes* (s98, p6).

6.3 Physical activity programmes in schools

6.3.1 The call for more physical activity and physical education

Forty submissions proposed that *school-based physical activity/physical education programmes should have an important place in the school curriculum*. This reflected the widespread view in submissions that children need to be more active for health reasons, and that schools provide an environment in which this could occur.

The Canterbury District Health Board mounted an evidence-based argument that physical activity “is declining in the school setting and this is contributing to the obesity epidemic” (s83, p22). The Board believed that physical education classes “play a role in addressing health inequalities by supporting children from low-income families to be active” (s83, p22).

¹⁷ Ministry of Education website, www.minedu.govt.nz.

The calls for more physical activity in schools were wide-ranging. The Heart Foundation, for example, suggested that schools offer a wide range of physical activity including, for example, dance, aerobics and self-defence (s047, p12). In a similar vein, Diabetes New Zealand suggested focusing physical education in schools “on aerobic sports that can be sustained throughout life, such as hill climbing, tennis, dancing, swimming and cycling” (s18, p7). Regional Public Health (Greater Wellington) wanted the New Zealand Health and Physical Education Curriculum extended as a compulsory programme from year 10, as at present, to year 13 (s135, p16).

6.3.2 Physical activity and physical education: concerns about goals

Many submissions, and particularly those outside the physical education sector, did not distinguish between physical activity programmes aimed at achieving physical fitness and control of weight, and programmes with an educational focus. This was understandable in that the Inquiry was concerned about health rather than education. Nevertheless, the interest of some health groups in school-based physical activity disturbed some physical education specialists who were concerned that their discipline was in danger of being hijacked to serve health rather than education purposes. They wanted emphasis to remain on what they regarded as the primary purpose of physical education – described in one submission as education in, through and about movement (s49, p4).

The submission from Physical Education New Zealand Te Ao Kori Aotearoa (PENZ), a professional organisation representing physical educators, argued that a focus on physical education as a way of achieving health goals is misguided and impoverishes education. PENZ wrote:

Schools are asked through the recent NEG and NAG changes to provide programmes that give greater focus on physical activity, both within and outside of curriculum. Many current initiatives do not sufficiently show that there is a clear understanding of the place, purpose and potential of physical education. Many schools themselves fail to recognise the way in which a quality and comprehensive physical education programme can meet the educational as well as physical activity needs of children and young people (s95, p5).

A retired physical educator documented how the time devoted to training teachers in physical education has been diminishing (s49).

There is no evidence from health sector submissions that they are dismissive of educational goals: they just do not discuss them. There seems to be no reason that the same programmes cannot serve both educational and health purposes. Both, it should be noted, are grouped together in the current Health and Physical Education curriculum, one of the aims of which is to “develop motor skills through movement, acquire knowledge and

understandings about movement, and develop positive attitudes towards physical activity".¹⁸

One of the goals of learning in, through and about movement is presumably an increase in skills, confidence and enjoyment. It might be expected that this increases the likelihood of greater participation in physical activity throughout life, with consequent health benefits.

¹⁸ Ministry of Education (1999). Health and Physical Education in the New Zealand Curriculum. Wellington, Learning Media Ltd, p7.

Part II: Official responses to the submissions

The main issues from submissions relating to the role of physical activity in preventing obesity identified in Part I include:

- the need for a ‘whole of society’ approach which includes addressing both physical activity and nutrition (Chapter 3)
- removing environmental barriers to physical activity and making physical activity more a part of everyday life (Chapter 4)
- providing more resources to help New Zealanders become more physically active (Chapter 4)
- modifying the built environment to encourage physical activity (Chapter 5), and
- encouraging more physical activity in schools (Chapter 6).

Part II examines the extent to which these issues were taken up by the Health Select Committee in its Report, and by the Government in its response to the Committee’s Report.

7 The Health Select Committee Report and Government Response: Healthy action comes second

Given the balance of submissions, both the Health Select Committee Report and the Government response are surprising in the extent to which they place emphasis on interventions relating to healthy eating compared to healthy action.

7.1 The Health Select Committee Report

7.1.1 The emphasis on healthy eating at the expense of healthy action

On 30 August 2007 the Health Select Committee released its report on the Inquiry (referred to below as “the Report”).¹⁹

¹⁹ *Inquiry into Obesity and Type 2 Diabetes in New Zealand: Report of the Health Committee*. Presented to the House of Representatives on 30 August 2007.

Healthy action interventions as part of obesity prevention are virtually ignored by the Committee. It is fair to say that little more than lip service is paid to physical activity. An analysis of the 55 recommendations²⁰ made by the Committee illustrates this. As Table 2 shows, there are 23 recommendations relating specifically to healthy eating, but none relating specifically to healthy action. In the 15 recommendations referring to both healthy eating and healthy action, physical activity is merely listed along with other areas for intervention, and always after nutrition.

Table 2 Summary of recommendations in the Select Committee Report

Recommendations relating to:	Both healthy eating and healthy action	Healthy eating alone	Healthy action alone	Neither healthy eating nor healthy action	Total
The Government	3	1		5	9
The food, drink, and marketing industries		15			15
The health sector and District Health Boards	2	1		5	8
Schools and early childhood education centres	3	3		1	7
Workplaces, communities, families and individuals	3			3	6
Breastfeeding		3			3
Media-related industries	2				2
Research funding agencies	2			3	5
Total	15	23		17	55

²⁰ The Select Committee did not number or present a count of its recommendations. The 55 recommendations used in producing Table 3 follow from the way in which the recommendations were counted in the Government's response.

7.1.2 The argument used in the Report to give priority to nutrition

The focus on healthy eating follows from the position taken in the Report that small but sustained increases in energy intake in individuals and the whole population are the main culprit in causing obesity and type 2 diabetes (p9). This statement is supported by reference to a Ministry of Health table showing that about three times as many deaths of New Zealanders in 1997 could be attributed to poor diet than to insufficient physical activity. Irrespective of the accuracy of this estimate, it does not imply that the focus for prevention should therefore be on diet. The more important question is not “what causes obesity?”, but “what can best be done to prevent obesity?”. Section 8.2 shows that the best available medical opinion gives equal weight to physical activity in preventing obesity.

In focussing on nutrition, the Select Committee Report relies on a theoretical argument rather than on evidence of what works. The Committee argues as follows:

Although it is important, promoting physical activity will not by itself reverse the trend [towards higher rates of obesity and type 2 diabetes]. Physical activity accounts for only 20 to 30 percent of total energy expenditure, only a small part of which can be influenced by increasing activity. Dietary changes to reduced energy intake are therefore critically important (p8).

This is the argument presented in the submission by Professor Boyd Swinburn (see section 3.2.1). As did Professor Swinburn, the Report acknowledges that physical activity contributes to obesity prevention, and has an important role in addressing other health issues:

There is agreement that physical inactivity is an important cause of obesity, especially in children. What is known of the physiology of activity and metabolism indicates that increasing activity can make only a relatively small contribution to achieving energy balance. However, physical activity confers many other important health benefits in addition to its contribution to obesity prevention, which justify efforts to promote physical activity at all ages (p23).

7.1.3 The failure of the Report to reflect the content of submissions

The Report briefly covers issues relating to improving the built environment to encourage physical activity (p24), but in only four paragraphs, and with no resulting recommendation. Yet, as is evident from Chapter 5, the Committee received a number of well-argued submissions containing recommendations for substantial actions relating to the built environment.

The importance of making increased physical activity a part of everyday life, a point strongly made in many submissions (section 4.2), receives no mention in the Report.

The strong emphasis on nutrition rather than physical activity interventions in the Report does not reflect the balance of recommendations from submissions. As is shown in Appendix A, 61% of the 314 submissions recommended at least one specific nutrition intervention, while 46% recommended at least one specific physical activity intervention. Of note is that 53% of submissions from the health sector and 37% from the nutrition sector recommended at least one physical activity intervention.

As was noted in section 2.1, the submission from the Public Health Advisory Committee (PHAC) was not forwarded to the Health Select Committee. The PHAC submission was very clear that both physical activity and nutrition interventions are required, and that the latter should not be regarded as pre-eminent (section 3.2.2). One might speculate that the Select Committee may have produced a different report if it had considered the PHAC submission, particularly if PHAC had made an oral presentation.

7.2 The Government Response to the Health Select Committee Report

In November 2007 the Government released its response to the Health Select Committee's report.²¹ The Government's response is to a large extent a recital of actions that the Government has taken, or plans to take, to combat obesity and type 2 diabetes. It contains no change of direction, and few new initiatives.

The Select Committee's emphasis on nutrition relative to physical activity in the prevention of obesity and type 2 diabetes continues in the Government's response. Appendix B lists the 23 "new actions" that the Government announced in the response. Of the 23, 12 relate specifically to healthy eating, while none relate specifically to healthy action.

Section 5 of the Government's response is titled "SPARC (Sport and Recreation New Zealand) and physical activity". This section contains no "new actions". It gives no indication that the Government has heard or heeded the strong message in many of the submissions to the Select Committee inquiry about the crucial need to make healthy action easier so that physical activity becomes more a part of everyday life.

²¹ Government response to the inquiry into obesity and type 2 diabetes 2007. Retrieved 30 December 2007, from http://www.parliament.nz/en-NZ/PB/Presented/Papers/1/4/a/48DBHOH_PAP16044_1-Government-Response-to-Report-of-the-Health-Committee.htm.

8 Why healthy action is equal first

Chapter 7 shows that both the Health Select Committee, and the Government in responding to the Committee's report, place much greater emphasis on healthy eating than on healthy action in preventing obesity. The present chapter shows how this emphasis is misplaced. Instead, both healthy eating and healthy action are shown to be essential, both for preventing obesity, and in preventing the major non-communicable diseases.

8.1 *Healthy action as equal first in obesity prevention*

The relative lack of attention in the Select Committee Report and Government response given to physical activity is out of step with recent authoritative reports on obesity prevention.

8.1.1 The 2007 Cancer Report

In late 2007 the World Cancer Research Fund and the American Institute for Cancer Research released one of the most thorough and scientifically-valid reports relating to public health ever produced (2007 Cancer Report)²².

Obesity was considered worthy of a major chapter in the Cancer Report on the grounds that “unless there is reason to think otherwise, anything that modifies the risk of weight gain, overweight, and obesity also modifies the risk of those cancers whose risk is increased by weight gain, overweight, and obesity” (p322).

Table 3 reproduces the table from the Report that summarises the findings of a systematic literature review on the effects of food, nutrition and physical activity on weight gain, overweight and obesity.

There is “convincing” evidence that physical activity decreases risk of overweight and obesity, and that sedentary living increases it. There is a lower level of evidence (“probable”) that low energy-dense foods decrease risk, and that energy-dense foods, sugary drinks, fast food and television viewing increase risk.

²² World Cancer Research fund / American Institute for Cancer Research. *Food, nutrition, physical activity, and the prevention of cancer: A global perspective*. Washington DC: AICR, 2007.

Table 3 Nutrition and physical activity risks identified in the 2007 Cancer Report

FOOD, NUTRITION, PHYSICAL ACTIVITY, AND WEIGHT GAIN, OVERWEIGHT, AND OBESITY		
<p>In the judgement of the Panel, the factors listed below modify the risk of weight gain, overweight, and obesity. Judgements are graded according to the strength of the evidence.</p> <p>Factors that decrease risk promote appropriate energy intake, and those that increase risk promote excess energy intake, relative to the level of energy expenditure.</p>		
	DECREASES RISK	INCREASES RISK
Convincing	Physical activity	Sedentary living ¹
Probable	Low energy-dense foods ² Being breastfed ⁴	Energy-dense foods ^{2,3} Sugary drinks ⁵ 'Fast foods' ⁶ Television viewing ⁷
Limited — suggestive		
Limited — no conclusion	Refined cereals (grains) and their products; starchy roots, tubers, and plantains; fruits; meat; fish; milk and dairy products; fruit juices; coffee; alcoholic drinks; sweeteners	
Substantial effect on risk unlikely	None identified	

- 1 Sedentary living comprises both high levels of physical inactivity and low levels of physical activity (in terms of intensity, frequency, and duration). Also see box 5.2.
- 2 The direct epidemiological evidence for low energy-dense foods is from wholegrain cereals (grains) and cereal products, non-starchy vegetables, and dietary fibre. The direct epidemiological evidence for energy-dense foods is from animal fat and fast foods. These are interpreted as markers of the energy density of diets, based on compelling physiological and mechanistic evidence (box 8.1).
- 3 Some relatively unprocessed energy-dense foods (which tend to be eaten sparingly), such as nuts, seeds, and some vegetable oils, are valuable sources of nutrients.
- 4 The evidence relates principally to obesity in childhood, but overweight and obesity in children tend to track into adult life: overweight children are liable to become overweight and obese adults.
- 5 The evidence relates to all drinks containing added caloric sweeteners, notably sucrose and high-fructose corn syrup. Fruit juices are also sugary drinks and could have similar effects, but the evidence is currently limited.
- 6 'Fast foods' characteristically are consumed often, in large portions, and are energy dense (box 8.2).
- 7 Television viewing (box 8.4) is here identified as a sedentary activity (box 5.2). It is also associated with consumption of energy-dense foods (box 8.1). The evidence relates specifically to childhood and adolescence, and is taken also to apply to adults.

For an explanation of all the terms used in the matrix, please see chapter 3.5.1, the text of this section, and the glossary.



The conclusions of the systematic literature review reported in Table 3 do not mean that physical activity is more important than nutrition in obesity prevention. The table reports how good the evidence is for a cause-effect relationship, but not how strong that relationship might be. It needs noting that the “convincing” vs. “probable” distinction might arise from differences in the feasibility of performing randomised controlled trials (the source of the highest level of evidence) in food and physical activity settings.

The point of including Table 3 here is not to support a claim that physical activity might be more important in obesity prevention than is nutrition. Rather, the table makes it difficult to sustain the case that nutrition is more important than physical activity, particularly given the authoritative nature of the Cancer Report.

8.1.2 The 2000 WHO report on obesity prevention

In addition to the 2007 Cancer Report, three other high quality reviews of the evidence on obesity prevention offer no support for the case that healthy eating is more important than healthy action in obesity prevention (see Appendix B).

One of these three is the report of a WHO consultation published in 2000.²³ This report states:

... two priority interventions important in preventing the development of obesity have been identified in this report, namely increasing levels of physical activity and improving the quality of the diet (p180).

The report then goes on to discuss physical activity interventions, followed by nutritional interventions.

8.1.3 Conclusion about obesity prevention

To repeat, it is not being suggested that there is a case that physical activity interventions are more important than changes to diet in preventing obesity. The point is they should not be considered less important, and deserve equal consideration by Government.

We can now have another look at the statement of the Health Select Committee reported in section 7.1.1:

- “Although it is important, promoting²⁴ physical activity will not by itself reverse the trend (towards higher rates of obesity and type 2 diabetes).”

²³ WHO Consultation. *Obesity: Preventing and managing the global epidemic*. Geneva: World Health Organization, 2000.

²⁴ “Promoting” is read here as meaning “addressing”, not as meaning advertising or marketing.

Following the evidence presented in section 8.1 we can now say that this statement is correct. But so too is the statement, not this time made or implied by the Committee, that:

- Although it is important, promoting improved nutrition will not by itself reverse the trend towards higher rates of obesity and type 2 diabetes.

What needs to be said is that:

- Both physical activity and improved nutrition are important, and both must be addressed to reverse the trend towards higher rates of obesity and type 2 diabetes.

8.2 *Healthy action as equal first for health in general*

The best available evidence also shows that healthy action and healthy eating should be considered equally important not just in preventing obesity, but in promoting health in general. This is particularly so when non-communicable diseases are considered.

Non-communicable diseases are distinguished from infectious diseases in that they are not transmitted between organisms. The major non-communicable diseases – heart disease, cancer and diabetes – are now acknowledged as a greater threat to the health of New Zealanders than are infectious diseases.²⁵ Lifestyle changes detrimental to health – both how we eat and how we move – are a major contributor to the growing prevalence of these diseases.

The 2007 Cancer Report identifies overweight and obesity as among the leading preventable causes of cancer. The first three recommendations are:

- 1 Be as lean as possible within the normal range of body weight
- 2 Be physically active as part of everyday life
- 3 Limit consumption of energy-dense foods and avoid sugary drinks.²⁶

This ordering of the recommendations does not suggest that physical activity should take second place behind nutrition in the prevention of cancer.

The case for equal prominence for healthy action and healthy eating is made in Appendix B. This appendix shows how recommendations from leading evidence-based reports and guidelines consistently treat both increased physical activity and improved nutrition as key areas of intervention for the primary prevention of non-communicable diseases, without suggesting or implying that one is more important than the other.

²⁵ The Public Health Bill currently before Parliament acknowledges this point, and goes on to address the prevention of non-communicable diseases as part of public health.

²⁶ The Cancer Report did not address cessation of smoking, which it took for granted as the first step in cancer prevention.

It is noted that Government's Healthy Eating - Healthy Action (HEHA) strategy focuses on reducing the impact of non-communicable diseases. Its three goals are to improve nutrition, to increase physical activity and to reduce obesity.²⁷ The key question regarding the balance of interventions from the Government's perspective is therefore not what is most effective in reducing obesity, but what works best in reducing the impact on health of all non-communicable diseases including obesity. This question cannot be adequately addressed from the submissions themselves, which understandably (given the Inquiry's Terms of Reference) focus on obesity.

²⁷ Ministry of Health. Healthy Eating - Healthy Action: A strategic framework 2003. Wellington, Ministry of Health, 2003.

9 Conclusion

This paper attempts to show that the mainstream view in the literature on the prevention of obesity, and major non-communicable diseases generally, is that both healthy eating and healthy action should be given equal prominence. The emphasis placed on nutrition at the expense of physical activity in the Health Select Committee Report, and in the Government's response, place our politicians out of step with this mainstream view. This matters, both in terms of resource allocation and the communication of consistent messages about public health.

9.1 The risk that resources will not be optimally allocated

The greater emphasis placed on nutrition than on physical activity by the Health Select Committee and Government is likely to be detrimental to finding the right balance in allocating resources between interventions to promote healthy eating and those to promote healthy action. In the last two years the Government has allocated substantial funding in support of healthy eating and healthy action. Failure to treat healthy action as equally important inevitably affects funding decisions. This applies not only to central government decisions, but to decision by, for example, District Health Boards, which will be influenced by perceptions of Government strategy.

Many submissions contained arguments that a 'whole of society' approach is needed to prevent obesity, including addressing socio-economic inequalities (section 3.1). At the highest level this is an argument for government policies that reduce economic inequalities and raise the capacity of those with fewer resources to participate more fully in activities and behaviours that benefit their health.

More direct economic incentives can also be used to increase physical activity rates. Some of these were outlined in submissions. Proposals from submissions for financial incentives to increase individual participation in healthy action are outlined in section 4.4. Other submissions made the case that financial assistance is required to assist communities in providing active recreation centres that meet local needs (section 5.2). None of these proposals received mention in the Select Committee Report.

9.2 The importance of a single public health voice

Arguments about whether healthy eating or healthy action deserves greater prominence in obesity prevention are of academic interest, but can cause confusion about effective intervention strategies for both the public and politicians. Statements that interventions relating to one are more important than those relating to the other are potentially harmful to establishing the public health case that both are essential.

Any statements or implications that healthy eating is more important than healthy action are likely to produce contrary statements from physical activity advocates, and vice versa. Such disputes within the obesity prevention community can provide ammunition for special interest groups pushing their own agendas. As an example, the food and advertising industries often promote arguments that interventions should focus on physical activity in order to divert attention from measures affecting food.

Further, arguments about the relative effectiveness of nutrition vs. physical activity interventions can feed the all-too-human tendency to hear what one wants to hear. As an example, a person who exercises regularly but loves junk food may well be persuaded by arguments that physical activity is more important, and so justify to themselves not changing their eating behaviour.

For all these reasons, the public health message should never imply that nutrition interventions are more important than physical activity interventions in obesity prevention, or vice versa.

Further confusion is created among the public if differing messages are promoted about lifestyle changes to prevent different non-communicable diseases. It is not useful, for example, if on the one hand the public health message is that moderate alcohol consumption may help prevent heart disease, while on the other hand the public is told that the less alcohol consumed the better to reduce the risk of cancer. The 2007 Cancer Report recognises this, and for this reason took the evidence on the prevention of other non-communicable diseases into account in framing its recommendations (2007 Cancer Report, p322).

9.3 *What can be done?*

A major issue identified in submissions for increasing physical activity in the New Zealand population involves creating built environments that encourage people to engage in active transport (mainly walking and cycling) and active leisure. Some of the changes required will be expensive, and many cannot happen overnight. But this does not mean that we can neglect them. The sooner new urban environments are designed with active transport and leisure in mind, the fewer the unsuitable environments in which New Zealanders will be forced to live over coming decades.

Much too can be done within existing environments. As an example, a number of suggestions are made in Chapter 5 about changes that could be implemented now to alter the balance on our roads between the needs of motorists on the one hand and those of cyclists and pedestrians on the other.

Such changes will undoubtedly be politically difficult. If we think that the food and advertising industries are powerful forces restricting improvements to nutrition, we should also contemplate the likely reaction of the motor vehicle and oil industries if some of the changes advocated in Chapter 5 are pushed hard. But the need to push hard is just as important for healthy action as it is for healthy eating.

One opportunity for change will come with the setting up of a Ministerial Committee with a supporting secretariat and advisory group to oversee Healthy Eating – Healthy Action (HEHA) initiatives (see “new action” Number 2 in Table C1). It is important that the advisory group includes members with a good grasp of the environmental changes needed to make physical activity easier, and the advocacy skills to make sure that their voice is heard.

Another important opportunity comes through the Public Health Bill currently before Parliament. Part 3 of the Bill allows the Director-General of Health to issue non-binding codes of practice or guidelines to a sector to reduce risk factors for non-communicable diseases such as heart disease, cancer and diabetes. But more important, it also contains a provision in Clause 374 for the Government to issue regulations to reduce risk factors for these diseases.

Regulations relating to non-communicable diseases made under Clause 374 might include requirements for facilitating greater levels of physical activity by, for example, territorial authorities or employers. However, it is not clear how workable Clause 374 would be, in part because it is not well supported by provisions and statements elsewhere in the Bill. As well, use of Clause 374 for non-communicable diseases is under attack on the grounds that it is an unwanted intrusion by the ‘nanny state’.

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

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

Having the ability within legislation to make significant changes is a key first step. But neither central government nor local authorities are likely to take bold actions which have significant opposition unless they have public opinion behind them. The long road of taking every opportunity to explain to the public the advantages of changing the environment to encourage more active lifestyles is the one that must be travelled.

Appendix A

Support in submissions for physical activity and nutrition interventions

The main purpose of this appendix is to explore the extent to which submissions from the physical activity sector supported nutrition in addition to physical activity interventions, and the reverse.

As outlined in section 3.1.2, all submissions were classified into one of four groups:

1. Proposed at least one measure to address obesity and/or type 2 diabetes through increased physical activity, and at least one measure through improved nutrition
2. Proposed at least one measure to address obesity and/or type 2 diabetes through increased physical activity, but no measures through improved nutrition
3. Proposed at least one measure to address obesity and/or type 2 diabetes through improved nutrition, but no measures through increased physical activity
4. Proposed no measures to address obesity and/or type 2 diabetes through either increased physical activity or improved nutrition.

The distribution of submissions falling into each of these four groups is shown in Table A1. This shows that 123 submissions (39%) fell into Group 1, 23 (7%) into Group 2, and 70 (22%) into Group 3.

In all, 216 (69%) of the 314 submissions recommended at least one intervention relating to physical activity and/or nutrition.

The most interesting feature of Table A1 is the difference in recommended interventions among the health, physical activity and nutrition sectors. This is illustrated in Figure A1.

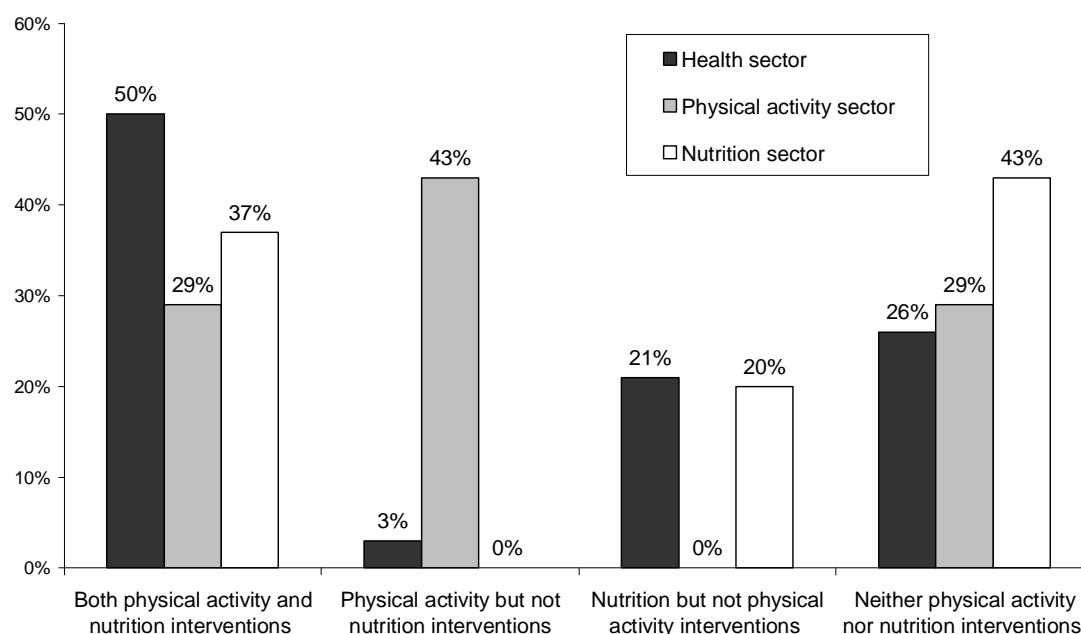
Half of the 143 health submissions proposed at least one physical activity and at least one nutrition intervention. A further 21% proposed at least one nutrition but no physical activity measure. No health submissions, however, proposed a physical activity but not a nutrition intervention.

The pattern is very different for the 35 submissions from the physical activity sector. More submissions (43%) proposed at least one physical activity intervention but no nutrition intervention than those that proposed both (37%). No physical activity submission proposed a nutrition intervention but not a physical activity intervention.

Table A1 The distribution of recommended interventions across sectors

Sector	Both physical activity and nutrition		Physical activity but not nutrition		Nutrition but not physical activity		Neither physical activity nor nutrition		Total	
Health	72	50%	4	3%	30	21%	37	26%	143	100%
Physical activity	10	29%	15	43%			10	29%	35	100%
Nutrition	11	37%			6	20%	13	43%	30	100%
Breastfeeding					9	100%			9	100%
Industry	4	19%	1	5%	1	5%	15	71%	21	100%
Other	26	34%	3	4%	24	32%	23	30%	76	100%
Total	123	39%	23	7%	70	22%	98	31%	314	100%

Figure A1 The distribution of recommended interventions across the health, physical activity and nutrition sectors



The 30 submissions from the nutrition sector showed the reverse pattern to the physical activity sector. One fifth (20%) proposed at least one nutrition intervention but no physical activity interventions. A further 21% proposed both nutrition and physical activity interventions, but none proposed physical activity interventions but not nutrition interventions.

To summarise, submissions from the physical activity sector tended to be more strongly focussed on just interventions related to their sector (43%) than

did nutrition submissions (20%). A possible reason for this is that many nutrition submissions were from people or groups working within the health sector, for example for District Health Boards. This might have led to a greater awareness on their part of interventions other than those relating to their speciality. Many physical activity submissions, on the one hand, were from Regional Sports Trusts (RSTs), or from people working for RSTs, organisations strongly focusing on physical activity.

It is only to be expected, of course, that submissions would focus on the areas of interest and expertise of those making them. The results outlined in the appendix in no way suggest that those working in the physical activity area do not believe that nutrition interventions are important, and vice versa.

Appendix B

Physical activity and nutrition recommendations for the primary prevention of non-communicable diseases

This appendix sets out to demonstrate that recommendations from leading evidence-based reports and guidelines consistently treat both increased physical activity and improved nutrition as key areas of intervention for the primary prevention of non-communicable diseases, without suggesting or implying that one is more important than the other.

The source of the reports considered here is Chapter 10 in the 2007 Cancer Report.²⁸ The Panel responsible for the recommendations in the Cancer Report decided that its recommendations should take into account the judgements and recommendations of authoritative reports on the prevention of other diseases. Among the reasons for this was the need for integrated and (where possible) consistent messages about nutrition and physical activity.

Chapter 10 reviews 111 reports published between 1990 and 2004. This provides an appropriate selection of high-quality reports that can be examined for what they have to say about both nutrition and physical activity in disease prevention.

Reports reviewed in Chapter 10 were selected for inclusion in the analysis for this appendix if they met the following criteria:

- published since 1 January 1998 (last 10 years)
- concerned with primary prevention of non-communicable diseases
- considered a broad range of preventive measures (for example, not just diet alone or physical activity alone).

Of the 111 reports, 25 met these criteria. One of the 25 was then excluded because it has since been withdrawn by the issuing body (Reference 90 in Chapter 10). Another was excluded because it was the earlier of two versions of the same report (Reference 23). This left the 23 reports listed in Table B1.

Table B1 therefore provides an appropriate sample of authoritative reports on the prevention of non-communicable diseases. All 23 of the reports in the table, covering nine non-communicable diseases, consider both increased physical activity and improved nutrition to be important facets of the

²⁸ World Cancer Research fund / American Institute for Cancer Research. *Food, nutrition, physical activity, and the prevention of cancer: A global perspective*. Washington DC: AICR, 2007.

prevention of the disease of concern. None of the 23 suggest or imply that nutrition is more important than physical activity, or vice versa.

Table B1 Recent authoritative reports on primary prevention of non-communicable diseases

Non-communicable disease	Reports
Obesity (three reports)	Krebs and Jacobson. (2003); National Institute for health and Clinical Excellence (2006); WHO Consultation (2000)
Cardiovascular disease (five reports)	De Backer et al. (2003); Kavey et al. (2003); Mosca et al. (2004); Pearson et al. (2002); Scottish Intercollegiate Guidelines Network (2007)
Stroke (two reports)	Goldstein et al. (2001); Pearson et al. (2002)
Dyslipidaemia (two reports)	National Heart Foundation of Australia (2001); South African Medical Association (2000)
Hypertension (two reports)	Touyz et al. (2004); Whelton et al. (2002)
Type 2 diabetes (four reports)	Australian Centre for Diabetes Strategies (2001); Canadian Diabetes Association (2003); Grundy et al. (1999); Sherwin et al. (2004)
Cancer (two reports)	Boyle et al. (2003); Kushi et al. (2006)
Osteoporosis (two reports)	Cheung et al. (2004); WHO Scientific Group (2003)
Constipation (one report)	Registered Nurses' Association of Ontario (2005)

References for Appendix B

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Appendix C

Analysis of the “new actions” in the Government Response to the Inquiry into Obesity and Type 2 Diabetes

The table below lists the 23 “new actions” identified in the Government’s response to the Health Select Committee Inquiry into Obesity and Type 2 Diabetes.²⁹ Each of the actions is categorised as being concerned with healthy eating alone, healthy action alone, or “other” (neither healthy eating alone nor healthy action alone, but may include both healthy eating and healthy action). The purpose of the table is to provide an objective indicator of the extent to which the Government’s response is focussed on nutrition relative to physical activity (see Section 8.2).

The wording of the actions is generally very close to the actual wording in the Government response. Some editing was undertaken, either to improve grammatical consistency or provide fuller information.

Of the 23 new actions, 12 focus on healthy eating alone, and none on healthy action alone.

Table C1 Analysis of “new actions” in the Government response to the Health Select Committee Report

No.	Action	Healthy eating alone	Healthy action alone	Other
1	Revise the HEHA implementation plan in 2008/09, with additional actions across the whole health continuum and the inclusion of process and outcome targets.			✓
2	Set up a Ministerial Committee with a supporting secretariat and implementation advisory group.			✓
3	Improve the Advertising Standards Authority self-regulatory system and set targets.	✓		

²⁹Government response to the inquiry into obesity and type 2 diabetes 2007. Retrieved 30 December 2007, from http://www.parliament.nz/en-NZ/PB/Presented/Papers/1/4/a/48DBHOH_PAP16044_1-Government-Response-to-Report-of-the-Health-Committee.htm.

No.	Action	Healthy eating alone	Healthy action alone	Other
4	Fund 50 scholarships with a focus on Māori and Pacific needs through the Clinical Training Agency to increase the number of dietitians in the health workforce.	✓		
5	The HEHA Community Action Programme is being established.			✓
6	Include health economic research in comprehensive research plan, and include economic analysis of evaluations where appropriate.			✓
7	Ministry of Health and DHBs to report annually on progress in implementation of HEHA, and practice management systems to be upgraded.			✓
8	Enhance the New Zealand Health Survey to enable additional questions on important dietary habits (e.g., consumption of energy-dense foods) and a physical activity module for children (not yet developed).			✓
9	Enhance the 2008 Adult Nutrition Survey by including measurement of fatty acids in bloods to provide a biochemical measure of change in dietary fat intake since 1997.	✓		
10	Collection of nutrition-related data available for young children is recommended in the Child Nutrition Survey.	✓		
11	A survey of infant feeding practices to add to the information available from the New Zealand Health Monitor is recommended.	✓		
12	Develop the Ministry of Health's own 24-hour recall dietary assessment data capture programme.	✓		
13	Increase the capacity of the Ministry of Health to undertake data integration and reporting to assist and inform policy programmes and services because those published to date have been very useful for informing government action.			✓

No.	Action	Healthy eating alone	Healthy action alone	Other
14	Develop and implement monitoring of food advertising, market and promotion.	✓		
15	Build up enrolments in Get Checked (programme for people with diagnosed diabetes), and evaluate of Get Checked.			✓
16	Increase in bariatric surgery is under consideration.			✓
17	Extend Fruit in Schools to decile two schools.	✓		
18	Provide additional funding for a social marketing campaign at national and district levels to promote breastfeeding in target audiences.	✓		
19	Establish of six new DHB regional food industry coordinator positions.	✓		
20	An increase in funding is required for additional Ministry of Health staff to work alongside the food industry to facilitate change in the food supply and facilitate the industry DHB positions.	✓		
21	It is suggested that one-off projects be funded to facilitate food industry-led activities to encourage the consumption of food and drinks low in fats, salt and sugar.	✓		
22	Develop a comprehensive obesity and diabetes research strategy and further resource for obesity and diabetes research, with joint (50/50) funding from the Ministry of Research, Science and Technology and the Ministry of Health.			✓
23	The Government will further fund the District Health Board Research Fund.			✓