



NATIONAL ADVISORY COMMITTEE  
ON HEALTH AND DISABILITY  
HUNGA KAITIJIRO | TE HAUORA O TE TĀRĀKA

## COMMITTEE REPORT

**Title: Public Health Advisory Committee (PHAC) Advice on Obesity Inquiry**

**Date: 11 May 2006**

**File Ref: HC50-06-6**

**Attention: Hon. Pete Hodgson (Minister of Health)**

### EXECUTIVE SUMMARY

An inquiry is currently underway into Obesity and Type 2 Diabetes by a Parliamentary Health Select Committee. The closing date for submissions was April 26, 2006. This report provides advice about obesity prevention and reversal from the Public Health Advisory Committee (PHAC), a subcommittee of the National Health Committee. PHAC's role is to provide independent advice to the Minister of Health. The PHAC is requesting you to pass on this advice to assist the Select Committee in their inquiry.

The incidence of obesity in New Zealand doubled over the past 25 years. It is creating a health crisis in New Zealand as overseas. The effects of this crisis are devastating for sufferers and their families, severely inequitable, and potentially crippling to the public health system.

The overweight population is an even larger group, within which successful intervention can bring the greatest gains by preventing some of New Zealand's top causes of mortality.

Weight gain is caused by excess energy intake (energy-dense foods) and, increasingly, lowered energy output (exercise). **Solutions to the problem of obesity should be oriented as much toward increasing population physical activity as toward achieving healthier nutrition.** To be effective, interventions must promote an environment that discourages unhealthy choices and encourages healthy choices. It should be an environment that supports and encourages daily exercise and healthy eating as an ordinary, expected part of life.


Health education campaigns alone are rarely successful. The PHAC recommends a comprehensive, whole-of-government, whole-society approach to obesity. **The evidence for the effectiveness of initiatives that focus on creating supportive environments for daily living is much stronger than the evidence for the effectiveness of initiatives that focus solely on the health education of individuals.** These changes require close intersectoral collaboration.

The PHAC is concerned that any policy to address obesity should focus as much on physical activity as nutrition and should address population and environmental factors rather than solely focus on the health education of individuals. The paper that follows should be read in light of these concerns.

## RECOMMENDATION

The recommendation is that you:

- (a) **forward** this Committee Report to the Parliamentary Health Select Committee inquiring into Obesity and Type 2 Diabetes Yes / No



Linda Holloway  
Chair

**MINISTER'S SIGNATURE:**

**DATE:**

## REPORT

### EXECUTIVE SUMMARY

An inquiry is currently underway into Obesity and Type 2 Diabetes by a Parliamentary Health Select Committee. The closing date for submissions was April 26, 2006. This report provides advice about obesity prevention and reversal from the Public Health Advisory Committee (PHAC), a subcommittee of the National Health Committee. PHAC's role is to provide independent advice to the Minister of Health. The PHAC is requesting you to pass on this advice to assist the Select Committee in their inquiry.

The incidence of obesity in New Zealand doubled over the past 25 years. It is creating a health crisis in New Zealand as overseas. The effects of this crisis are devastating for sufferers and their families, severely inequitable, and potentially crippling to the public health system.

The overweight population is an even larger group, within which successful intervention can bring the greatest gains by preventing some of New Zealand's top causes of mortality.

Weight gain is caused by excess energy intake (energy-dense foods) and, increasingly, lowered energy output (exercise). **Solutions to the problem of obesity should be oriented as much toward increasing population physical activity as toward achieving healthier nutrition.** To be effective, interventions must promote an environment that discourages unhealthy choices and encourages healthy choices. It should be an environment that supports and encourages daily exercise and healthy eating as an ordinary, expected part of life.

Health education campaigns alone are rarely successful. The PHAC recommends a comprehensive, whole-of-government, whole-society approach to obesity. **The evidence for the effectiveness of initiatives that focus on creating supportive environments for daily living is much stronger than the evidence for the effectiveness of initiatives that focus solely on the health education of individuals.** These changes require close intersectoral collaboration.

The PHAC is concerned that any policy to address obesity should focus as much on physical activity as nutrition and should address population and environmental factors rather than solely focus on the health education of individuals. The paper and recommendations that follow should be read in light of these concerns.

### RECOMMENDATIONS

PHAC recommends that:

- **obesity control strategy be oriented as much toward increasing population physical activity as toward achieving healthier nutrition**

- **a comprehensive, whole-of-government, whole-society approach to obesity prevention and reversal be established**
- **initiatives focus on supportive environments for daily living rather than solely on the health education of individuals**
- **Health Impact Assessment (HIA) be recognised as a useful tool to ensure urban design encourages physical activity as a supported and expected part of daily life.**

PHAC proposes the following goals be adopted:

- **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.**

## **PURPOSE**

1. The purpose of this document is to provide advice from the Public Health Advisory Committee (PHAC) on the prevention and reversal of obesity. It is in response to the comprehensive inquiry into Obesity and Type 2 Diabetes in New Zealand currently being conducted by Parliament's Health Select Committee.
2. The PHAC is a subcommittee of the National Health Committee (NHC). Its task is to provide independent advice to the Minister of Health on public health issues and the factors underlying the health of people and communities.

## **BACKGROUND INFORMATION**

3. Obesity is defined as a body mass index (*weight kg/height m<sup>2</sup>*) of 30 or more. Framed simply, overweight and obesity are a matter of chronically higher energy intake (food) than energy output (exercise).

### **Incidence**

4. Worldwide, diet and patterns of physical activity have shifted dramatically in the past 50 years. This has led to a rapid increase in preventable non-communicable diseases, including what many refer to as an 'epidemic' of obesity in developed and developing countries. New Zealand saw a dramatic rise in obesity from about 10 percent in 1977 to around 21 percent in 2003.<sup>1</sup>

---

1 Ministry of Health 2004, p xi.

## Costs

5. Obesity is one of the largest preventable causes of poor health in New Zealand. Obesity increases the risk of type 2 diabetes by as much as 40 times.<sup>2</sup> It is also a significant risk factor for cardiovascular disease and a range of chronic and acute conditions including osteoarthritis, respiratory disorders, gall bladder disease, non-alcoholic fatty liver, high blood pressure<sup>3</sup>, and a number of cancers.
6. Nutrition-related risk and physical inactivity have been shown to be the largest contributors to premature mortality. For example one New Zealand study estimated that 8000-9000 of deaths in 1997 were associated with diet and 2000-3000 reflected physical inactivity – together making up forty percent of all deaths.<sup>4</sup> This included more than 85 percent of ischaemic heart disease, 70 percent of stroke mortality, 80 percent of diabetes mortality and 6 percent of all cancer mortality. Other analyses have placed more emphasis on the role of physical inactivity than diet in explaining the current epidemic.<sup>5</sup>
7. Obesity poses huge costs to society in addition to premature mortality. In 1997, direct costs to the health care system were conservatively estimated at \$135 million per year.<sup>6</sup> Additional indirect costs include impaired quality of life, workdays lost, physical and emotional pain, toll on family/whānau and carers, physician visits, and life opportunity costs.
8. The risk of type 2 diabetes, coronary heart disease, congestive heart failure, hyperlipidaemia and hypertension rise continuously with increasing body weight from a BMI between 20 and 25.<sup>7</sup> Overweight, defined as a BMI of 25 or more, affects 42 percent of male and 28 percent of female New Zealanders<sup>8</sup>. This group comprises not only the entire group of those at risk of developing obesity but contains most preventable cases of diabetes/cardiovascular disease as well. The benefits of interventions that address overweight, particularly the benefits of increased physical activity, extend beyond prevention of obesity to prevention of some of the nation's main causes of mortality.

## Causes

9. Sedentary lifestyles and high intake of energy-dense foods promote obesity while regular physical activity and high intake of dietary fibre protect against it.<sup>9</sup> Obesity is also partially determined by an individual's genetic inheritance.
10. A widely accepted model of the determinants of health (*Dahlgren and Whitehead 1991*) outlines a hierarchy of modifiable and unmodifiable factors affecting health status. Genetic, sex and age factors are unmodifiable. Moving 'upstream,' the next four tiers are individual lifestyle, social and community

---

2 Frumkin et al 2004, p 97.

3 Caballero et al 2006.

4 Ministry of Health and University of Auckland 2003.

5 Prentice et al 1995, Frumkin 2004, p 90.

6 Swinburn et al 1997.

7 New Zealand Guidelines Group 2003, p 49.

8 Ministry of Health 2004, p 14.

9 WHO 2003a, p 46. The totality of the evidence was taken into account.

influences, living and working conditions, and socio-economic, environmental and cultural environment. The further 'upstream' interventions are made, the better they are able to make an impact at a population level.<sup>10</sup>

11. Overweight and obesity are generated by behaviours that are heavily influenced by the environment within which people live.<sup>11</sup> For this reason the environment is often referred to as 'obesogenic'- and obesity itself described as 'a normal response to an abnormal environment.'<sup>12</sup> Strong evidence has been found associating home and school environments that support healthy food choices with a decreased risk of obesity.<sup>13</sup>
12. Dietary strategies for weight loss are not effective in the long term across populations. The World Health Organization asserts that "changes at a public health level require an environment supportive of healthy food choices and an active life."<sup>14</sup> Concerted public health intervention will be required to change the environmental pressures that promote obesity in the population at large.<sup>15</sup>

### Health inequalities

13. In more affluent countries obesity is becoming more common among younger adults and children, and is particularly associated with lower socioeconomic status, especially in women.<sup>16</sup> This pattern of distribution is reflected in New Zealand, where socioeconomic inequality in the distribution of BMI is 'marked' among females and emerging among males.<sup>17</sup> WHO reports that this relationship may be bi-directional: obese people may be more likely to end up in groups with low socioeconomic status.<sup>18</sup>
14. Obesity and overweight are conditions whose consequences are severely inequitable for Maori and Pacific peoples.<sup>19</sup> For instance, disproportionately large numbers of Maori are diagnosed with cardiovascular disease, New Zealand's top killer. Maori and Pacific peoples also have significantly higher rates of diagnosed type-2 diabetes. This disease causes up to 20 percent of all deaths among Maori compared with four percent for non-Maori non-Pacific people.<sup>20</sup>

---

10 Dahlgren and Whitehead (1991) *Model of the social and economic determinants of health* in Public Health Advisory Committee 2004, p 6.

11 Kim et al 2006, Egger et al 1997.

12 Swinburn et al 1997.

13 WHO 2003a, p 46. The totality of the evidence was taken into account. The World Cancer Research Fund schema was modified to give randomized controlled trials the highest ranking, and associated evidence and expert opinion was taken into account in relation to environmental determinants, where direct trials were often not available.

14 WHO 2003a p 47.

15 Foreyt et al 2003 p 226.

16 WHO 2003a p 45. People with low socioeconomic status may be more at the mercy of the obesogenic environment. The evidence for this effect is consistent in higher income countries.

17 Ministry of Health 2004 p xii.

18 WHO 2003a p 48.

19 Wilson et al 2006.

20 New Zealand Guidelines Group 2003.

## **Obesity is a priority for Government and the Ministry of Health**

15. The Minister of Health has named chronic conditions, and obesity (as a risk factor) in particular, as New Zealand's top health priority. Among the population health objectives highlighted in the *New Zealand Health Strategy 2000* for short to medium term action, items two, three and four are: improve nutrition, reduce obesity, and increase the level of physical activity.
16. There is a comprehensive strategy to improve New Zealanders' nutrition and physical activity: *Healthy Eating – Healthy Action (HEHA) Strategy and Implementation Plan*. Successful implementation will rely upon collaboration across government and with industry. Virtually every ministry or department is able to take some action or policy steps that will assist.

## **Effectiveness, evidence and the need for research**

17. In spite of the growing awareness of the importance of measuring the effectiveness of interventions, there is little hard evidence available on the effectiveness of obesity control and reversal interventions across populations.<sup>21</sup> This is partly a result of the relative youth of the obesity epidemic and study of its causes and cures. It is also a product of the difficulties inherent in any evaluation of large-scale public health measures and the delay between intervention and effect.
18. The purpose of all health interventions is to achieve positive health outcomes. Without evidence to this effect we must act on best examples, but ongoing monitoring and evaluation is crucial to the development of effective and cost-effective solutions.
19. Funding for initiatives should, where possible, incorporate opportunities for a meaningful evaluation component in order to build a foundation of evidence.
20. We must continue to conduct such research to fill gaps in existing knowledge of the incidence of obesity by demographic group. Data trends needed to build effective policy must be specific for sex, ethnicity, age, social group and socioeconomic status and to track changes over time.<sup>22</sup>
21. At the same time, the health crisis leaves us no time to wait for more evidence. In some countries, obesity related mortality and health care costs are soon expected to exceed those from tobacco.<sup>23</sup> We must take advantage of international experience and lessons from tobacco control, building appropriate monitoring and evaluation into interventions where possible, but we must act.

---

21 See for example HTA-20020926, a search of fourteen databases drawn from INAHTA.

22 WHO 2003a p 101.

23 Daynard, 2004 p 292.

## DISCUSSION

### Change the (im)balance by changing the environment

22. Interventions at the individual level alone have not made significant cross-population gains. Weight and energy intake/expenditure is influenced by nearly every aspect of our daily lives. Without a supportive context, the potential for change is greatly reduced.<sup>24</sup>
23. The World Health Organization outlines the scope of an enabling environment broadly: school, workplace, community, transport, urban design, and availability of healthy food and safe opportunities for physical activity. It requires supportive legislative, regulatory and fiscal policies.<sup>25</sup>

### Public health education and health inequalities

24. An informed public is better able to influence policy-makers and society alike. Community leadership for change and community support for policy-level change are an important part of the environmental shifts demanded by the obesity epidemic.
25. At the same time, experience has shown that health education alone is relatively ineffective in population terms, failing to reach any but the better educated and more affluent. This is a powerful argument against limited campaigns which prioritise health education. Some health education has been shown to have no effect or even a negative effect.<sup>26</sup>
26. Existing data monitoring New Zealand's body mass index (BMI) distribution shift suggests an approach which pairs general strategies that aim to improve the environmental support for healthy behaviour (what some call 'health protection') with targeting of hard-to-reach and high-risk groups.<sup>27</sup> Health education can be a useful supplement, but should not be the centrepiece.

### Obesity demands a comprehensive approach

27. Any serious move to control obesity demands a comprehensive approach. The *Ottawa Charter for Health Promotion* asserts the need for public health action to simultaneously address multiple aspects: to build healthy public policy, to create supportive environments, to strengthen community action, to support development of personal skills, and to reorient health services in the direction of population health approaches. This thinking reflects the complex and interrelated nature of population health and wellbeing.
28. The need for such a range of initiatives has been borne out by the success of comprehensive tobacco control strategies. With the exception of price regulation, no single component of the range of interventions put in place for

---

<sup>24</sup> Ministry of Health 2004, p 80 endorses this view: 'It remains likely that any sustainable change will require policy intervention to reduce the obesogenicity of the environment.'

<sup>25</sup> WHO 2003a p 99.

<sup>26</sup> Ebrahim 2001.

<sup>27</sup> Ministry of Health 2004 p xi.

tobacco control can account for the reduced consumption observed. Some argue that collectively, the variety of initiatives employed produced an emergent effect.

29. Obesity is frequently referred to as an 'epidemic'. Recent fears of the spread of bird influenza have spurred a comprehensive strategy across government to prepare for a possible epidemic. Though obesity is not a communicable disease, its implications are serious enough to warrant borrowing prevention and mitigation principles from pandemic planning strategy. The plan is based on intersectoral collaboration at both central and regional levels. The strategy combines a population education and communication plan with an acute and emergency response component. Monitoring and surveillance are integral.
30. The success of staged, integrated tobacco control measures and a series of failures<sup>28</sup> of international community-based and health promotion initiatives to reduce cardiovascular risk factors demonstrate that a combined approach: policies to produce a healthy *environment* and a *comprehensive* strategy of integrated and concurrent initiatives with *regulatory support*, is critical to success.<sup>29</sup>
31. While the use of regulation is readily transferable to the area of nutrition, it may not have as much relevance for supporting physical activity. What does have relevance is the importance of a comprehensive strategy that creates supportive environments for physical activity as a normal part of everyday life.

### **The Health Intervention Framework to improve health and reduce inequalities**

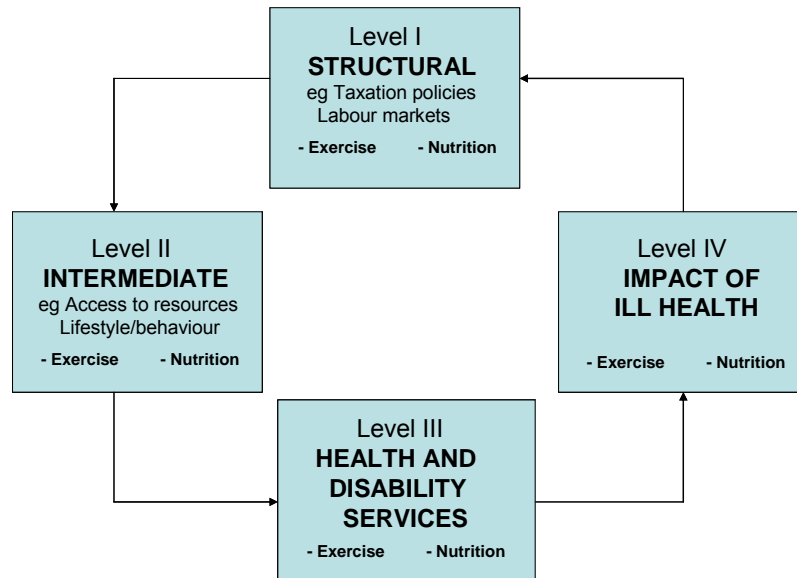
32. The PHAC recommends the Health Intervention Framework<sup>30</sup> outlined below to policy-makers for evaluating interventions for preventing and reversing obesity. The framework has several advantages: it places health inequalities at the centre rather than treating them incidentally; it is a simple model for setting out interventions at multiple levels; and it allows gaps in comprehensiveness and coordination to be quickly spotted.
33. A population approach can, and should, be taken in interventions at every level. Within each of the four levels, interventions can be divided into those that promote physical activity and those that improve nutrition.

---

28 Ebrahim 2001

29 See Sharpe, 2006

30 J. Mackenbach's 'Points of Intervention' model, highlighted in the National Health Committee's 1998 *Social, Cultural and Economic Determinants of Health in New Zealand* and developed in *Reducing Inequalities in Health* 2002 (Ministry of Health) and *The Health of People and Communities* 2004 (Public Health Advisory Committee).



34. Some examples of interventions the PHAC believes show promise are placed within the following discussion according to this framework. These are intended to serve as examples only; there is much room for innovation.
35. Interventions at the structural level to reduce social and economic inequalities will have the greatest and most sustained effect on health outcomes throughout the population. It is here that the PHAC recommends focusing most effort.

**I. STRUCTURAL** level of intervention: Policies which influence the larger environment within which health and health inequalities are established. 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. Examples of collaborative relationships for health gains are between Health and Transport, Health and Education, and Health and local planners.

#### **Exercise and Nutrition**

- a. Government's strategic framework *Healthy Eating - Healthy Action Oranga Kai – Oranga Pumau* acknowledges and addresses the need for collaboration across sectors. Implementation will require active ongoing commitment and adequate resources from each relevant Ministry and providers.<sup>31</sup>
- b. Provide active government support for an international framework for obesity control, the World Health Organization's *Global Strategy on Diet, Physical Activity and Health*, 2004. (Support for the *Framework*

<sup>31</sup> Sharpe 2006.

*Convention on Tobacco Control* was a successful aspect of the global battle for tobacco control.<sup>32)</sup>

### Exercise

- c. Land use patterns, design characteristics and transportation systems each play a distinct role within the built environment in shaping the form of activity.<sup>33</sup> There are strong relationships between the land-use mix, footpath presentation, and pleasing aesthetics, for instance, and levels of walking in a neighbourhood.<sup>34</sup> Research also suggests that physical activity in a natural setting offers extra benefits, including increased mental and emotional health and a sense of connection with and concern for the natural world.<sup>35</sup>

Health Impact Assessment (HIA) is a critical intervention at this level to ensure healthy design of built environments. Recently a partnership between Counties Manukau District Health Board and Auckland Regional Public Health Service has agreed to conduct an HIA to evaluate the Mangere Growth Centre Plan. The HIA will focus specifically on how urban design can contribute to a reduction in obesity.

### Nutrition

- d. Make the healthy choice the easy choice by improving access to healthy foods and discouraging access to unhealthy foods. The long term objectives of the food industry- maximising profit - and the health sector - improved health outcomes - are not the same. Putting in place a regulatory framework to reduce the cost of healthy foods will create an environment supportive of healthy outcomes within which cooperative moves can be negotiated.<sup>36</sup> Regulatory measures should also control food marketing and sponsorship, particularly those forms directed at children.<sup>37</sup>

**II. INTERMEDIATE PATHWAYS** level of intervention: Social, economic, cultural and historical determinants are mediated by the physical, social and psychosocial environment, access to material resources, and lifestyle. Intermediate Pathways are programmes that reduce barriers to healthy working and living environments and increase feelings of control by enabling community development. Examples of interventions at this level include settings-based programmes such as WHO's *Healthy Cities*, community development programmes and health education.

---

32 WHO 2003b.

33 Frumkin et al 2004, p 99.

34 Frumkin et al 2004, p 100.

35 Pretty et al 2003.

36 Daynard 2004, p 294.

37 Wilson et al 2006. Wilson et al set out six key priorities for upstream public policy to create a healthy food environment in New Zealand: Controls on food marketing and sponsorship, a nationally coordinated communications strategy, consideration of pricing controls to promote healthy food choices, support for an international legal framework for obesity control, improved research and monitoring of food marketing, and a 'well-funded, comprehensive equitable and coordinated effort to implement *Healthy Eating – Healthy Action: Oranga Kai – Oranga Pumau*.'

### **Exercise**

- a. Encouragement for workplaces to actively make exercise an expected and enjoyable part of daily life. 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. Workplaces can encourage cycling, climbing stairs and walking. For example, after three years of a comprehensive workplace programme directed at prevention, detection and rehabilitation support, a Health & Wellness programme in the US showed significant improvement in eight of thirteen risk categories.<sup>38</sup>

### **Nutrition**

- b. Instigate programmes that take multi-pronged approaches within schools to minimise risk factors, particularly for children in lower socio-economic groups. The US-based *Child and Adolescent Trial for Cardiovascular Health (CATCH)* incorporated changes to food services in schools, health and physical education, family/whānau participation and smoke-free policies. Lower consumption of fat and higher energy expenditure levels were maintained by students for a minimum of three years without further interventions.<sup>39</sup>

### **III. HEALTH AND DISABILITY SERVICES level of intervention:**

Policies which improve the affordability, appropriateness, quality, availability, and distribution of health and disability services, as well as community participation in health care decisions can all reduce obesity at this level of the framework. Policies which help identify and match population health needs to services and improve pathways through care for all groups, particularly those most at-risk and hard to reach, also fall into this category.

### **Exercise**

- a. Primary care can be an effective locus for physical activity counselling with telephone follow-up. For sedentary people this has been shown to be effective, particularly when done in association with exercise specialists. For instance, in the Waikato region, the Hillary Commission's *Green Prescription* program was effective in increasing subjects' physical activity levels and quality of life over a 12 month period.<sup>40</sup>

### **Nutrition**

- b. Recognise the role of primary care in reaching at-risk populations, including the overweight. For example, detect cardiovascular disease early using multivariate screening in general practice and treat or prevent by providing follow-up nutritional counselling.

---

38 WHO 2005, p 103.

39 WHO 2005, p 102.

40 Elley et al 2004, Dalziel et al 2006

**IV. IMPACT OF ILL-HEALTH** level of intervention: Chronic illness and poor health, including obesity, present a higher risk of downward socio-economic mobility through lower fitness, motivation, educational and occupational achievement. Interventions at this level seek to prevent or reduce the negative impacts of ill-health and provide relief from pressures, deprivations and inequalities that arise as a result of poor health and obesity.

**Exercise**

- a. The most important principle for interventions to address exercise at this level is the principle that physical activity must be an expected part of the daily routine in our society. Because obesity itself makes accessing exercise facilities, parks and even footpaths more difficult and less likely, the significance of the environment for the obese is arguably even greater than it is for healthy or at-risk populations.

**Nutrition**

- b. In British Columbia, hospitals and the Public Health Service Association have partnered to create a prototype assessment and treatment program for families with obese children to nurture healthy eating and active living. This program includes a provincially supported resource centre and regionally supported program teams.<sup>41</sup>

**CONCLUSION**

**Comprehensive approach**

36. “If existing interventions are used together as part of a comprehensive, integrated approach, the global goal for preventing chronic diseases can be achieved. The only question is how governments, the private sector and civil society can work together to put such approaches into practice.”  
- WHO 2005. *Preventing Chronic Diseases – A Vital Investment*
37. A comprehensive approach to preventing and reversing obesity in New Zealand needs to be pursued in multiple arenas:
  - collaboration within single Ministries in which all directorates are working to a common end
  - whole of government health-related policy development, meaning cross-Ministry collaboration
  - a whole-society perspective on obesity prevention, incorporating government and non-government organisations, the private sector and community-based activity
  - life-course strategies for prevention and reversal of risk factors (from maternal and neo-natal care to elder care and including health, school, work and community settings)
  - cross-population strategies that view interventions – both public health and clinical – on a continuum of populations from the well, to the at-risk (both clinically and socio-economically), to the symptomatic

---

<sup>41</sup> ActNow British Columbia

- integration of public health and clinical interventions, emphases and messages
- integration of policies to promote personal skills development and policies designed to change the social environment
- strategies that promote multiple behaviour changes – six or seven - rather than just one or two.

38. The PHAC endorses the following resolutions adopted by the World Health Organization at the 53rd World Health Assembly.

Member countries should:

- develop a national policy framework taking into account healthy public policies creating a conducive environment for healthy lifestyles;
- develop fiscal and taxation policies towards healthy and unhealthy goods and services;
- establish programmes for the prevention and control of non-communicable diseases; and
- assess and monitor mortality and morbidity attributable to non-communicable disease.

39. The PHAC notes that creating an environment conducive to healthy lifestyles and supportive fiscal and taxation policies are the more difficult and controversial of the goals above. Nevertheless they are the more important ones. The importance of the association of poverty (and the affordability of healthy choices) with increased incidence of communicable and non-communicable diseases and risk factors is well-recognised. In the United Kingdom, for instance, a health strategy aims to halve the proportion of people in poverty as its primary goal. “The failure of governments to make often difficult decisions about tobacco, alcohol and food pricing and its availability is a more powerful determinant of cardiovascular disease risk than the failure of individuals to heed health education messages.”<sup>42</sup>

## RECOMMENDATIONS

40. PHAC recommends that:

- **obesity control strategy be oriented as much toward increasing population physical activity as toward achieving healthier nutrition**
- **a comprehensive, whole-of-government, whole-society approach to obesity prevention and reversal be established**
- **initiatives focus on supportive environments for daily living rather than solely on the health education of individuals**
- **Health Impact Assessment (HIA) be recognised as a useful tool to ensure urban design encourages physical activity as a supported and expected part of daily life.**

---

42 Ebrahim et al 2001 p 203.

41. PHAC proposes the following goals be adopted:

- **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.**

**Contact for telephone discussion (if required)**

Name	Position	Telephone		Suggested First Contact
		Direct Line	After Hours	
Margaret Earle	Manager, NHC Secretariat	(04) 496-2082	(04) 934-2313	yes
Liza Wilcox	Senior Policy Analyst	(04) 816-2520	(04) 938-8740	

## References

- Bauman A, MClean G, Hurdle D, Walker S, Boyd J, van Aalst I, Carr H. 2003. Evaluation of the National 'Push Play' campaign in New Zealand. *Journal of the New Zealand Medical Association* 116(1179).
- Breslow L. 2006. Commentary: On 'public health aspects of weight control'. *International Journal of Epidemiology* 35: 12-14.
- Breslow L. 2006. Public health aspects of weight control. *International Journal of Epidemiology* 35: 10-12.
- Caballero B, Wang Y. 2006. Commentary: Obesity and mortality – light at the end but still a long tunnel. *International Journal of Epidemiology* 35: 21-22.
- Dalziel K, Segal L, Elley C.R. 2006. Cost utility analysis of physical activity counselling in general practice. *Australian and New Zealand Journal of Public Health* 30(1): 57-63.
- Daynard R.A. 2004. Lessons from tobacco control for the obesity control movement. *Journal of Public Health Policy* 24(3/4): 291-5.
- Ebrahim S, Smith GD. 2001. Exporting Failure? Coronary heart disease and stroke in developing countries. *International Epidemiological Association* 30:201-205.
- Egger G, Swinburn B. 1997. An “ecological” approach to the obesity pandemic. *British Medical Journal* 315: 477-480.
- Elley R, Kerse N, Arroll B, Swinburn B, Ashton T, Robinson E. 2004. Cost-effectiveness of physical activity counselling in general practice. *The New Zealand Medical Journal* 117(1207).
- Foreyt J, Walker S, Poston II C, McInnis KJ, Rippe JM. 2003. *Lifestyle Obesity Management*. Malden MA: Blackwell Publishing Inc.
- Frumkin H, Frank L, Jackson R. 2004. *Urban Sprawl and Public Health: Designing, planning, and building for healthy communities*. Washington: Island Press.
- Hider P N. 2001. *Environmental interventions to reduce energy intake or density: A critical appraisal of the literature*. NZHTA Report. 4(2).
- Hohepa M, Schofield G, Kolt G. 2004. Adolescent obesity and physical inactivity. *The New Zealand Medical Journal* 117(1207).
- Jain A. 2005. Treating obesity in individuals and populations. *British Medical Journal* 331: 1387-90.
- Kim S, Popkin B. 2006. Commentary: Understanding the epidemiology of overweight and obesity – a real global public health concern. *International Journal of Epidemiology* 35: 60-67.

Ministry of Health and the University of Auckland. 2003. *Nutrition and the Burden of Disease: New Zealand 1997-2011*. Wellington: Ministry of Health.

Ministry of Health. 2000. *The New Zealand Health Strategy*. Wellington: Ministry of Health.

Ministry of Health. 2004. *Tracking the Obesity Epidemic: New Zealand 1977-2003*. Wellington: Ministry of Health.

New Zealand Guidelines Group. 2003. *The Assessment and Management of Cardiovascular Risk*. Wellington: New Zealand Guidelines Group.

NHS Centre for Reviews and Dissemination. 2006. *The prevention and treatment of childhood obesity*. Health Technology Assessment Database Issue 2. York: Centre for Reviews and Dissemination. Ref No: HTA-20020926.  
<http://www.york.ac.uk/inst/crd/ehcb.htm>

Pretty J, Griffin M, Sellens M, Pretty C. 2003. *Green Exercise: Complementary Roles of Nature, Exercise and Diet in Physical and Emotional Well-Being and Implications for Public Health Policy*. Essex: University of Essex  
<http://www2.essex.ac.uk/ces/ResearchProgrammes/CESOccasionalPapers/GreenExercise.pdf>

Prentice AM, Jebb SA. 1995. Obesity in Britain: Gluttony or sloth? *British Medical Journal*. 311: 437-439

Public Health Advisory Committee. 2004. *The Health of People and Communities: A Way Forward: Public policy and the economic determinants of health*. Wellington: Public Health Advisory Committee.

Sharpe N. 2006. Heart health has an adverse future forecast in New Zealand: and alarm call to action across the continuum. *The New Zealand Medical Journal* 119(1232).

Swinburn B, Ashton T, Gillespie J, et al. 1997. The healthcare costs of obesity in New Zealand. *International Journal of Obesity*. 21:891-6.

Wilson N, Watts C, Signal L, Thomson G. 2006. Acting upstream to control the obesity epidemic in New Zealand. *The New Zealand Medical Journal* 119(1231).

World Health Organization. 2003a. *Diet, Nutrition and the Prevention of Chronic Diseases*. Technical report series 916.

World Health Organization. 2003b. *Framework Convention for Tobacco Control*. Geneva: WHO Press. <http://www.who.int/tobacco/en/> Accessed April 2006.

World Health Organization. 2005. *Preventing Chronic Disease: A vital investment*. Geneva: WHO Press. [http://www.who.int/chp/chronic\\_disease\\_report/en/](http://www.who.int/chp/chronic_disease_report/en/)