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Generating political priority for regulatory interventions targeting obesity prevention: an Australian case study

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Abstract

Effective obesity prevention requires a synergistic mix of population-level interventions including a strong role for government and the regulation of the marketing, labelling, content and pricing of energy-dense foods and beverages. In this paper we adopt the agenda of the Australian Federal Government (AFG) as a case study to understand the factors generating or hindering political priority for such 'regulatory interventions' between 1990 and 2011. Using a theoretically-guided process tracing method we undertook documentary analysis and conducted 27 interviews with a diversity of actors involved in obesity politics. The analysis was structured by a theoretical framework comprising four dimensions: the power of actors involved; the ideas the actors deploy to interpret and portray the issue; the institutional and political context; and issue characteristics. Despite two periods of sustained political attention, political priority for regulatory interventions did not emerge and was hindered by factors from all four dimensions. Within the public health community, limited cohesion among experts and advocacy groups hampered technical responses and collective action efforts. An initial focus on children (child obesity), framing the determinants of obesity as 'obesogenic environments', and the deployment of 'protecting kids', 'industry demonization' and 'economic costs' frames generated political attention. Institutional norms within government effectively selected out regulatory interventions from consideration. The 'productive power' and activities of the food and advertising industries presented formidable barriers, buttressed by a libertarian/neolibertarian rhetoric emphasizing individual responsibility, a negative view of freedom (as free from 'nanny-state' intervention) and the idea that regulation imposes an unacceptable cost on business. Issue complexity, the absence of a supportive evidence base and a strict 'evidence-based' policy-making approach were used as rationales to defer political priority. Overcoming these challenges may be important to future collective action efforts attempting to generate and sustain political priority for regulatory interventions targeting obesity.

Key words: agenda-setting; Australia; governance; health policy; nutrition; obesity; political priority; regulation

Introduction

Since the turn of the century obesity has emerged onto the agendas of multiple governments (Kurzer & Cooper, 2011; Oliver, 2006), in parallel with a surge of attention from researchers, the media and business (Saguy & Riley, 2005). It is now common to hear of the 'obesity epidemic' with broad recognition that tackling the problem *should be* a political priority. Obesity is, however, a formidable political challenge. It has been referred to as 'a test case for 21st century health policy' and as a 'wicked policy problem' with many interconnected determinants, and coordinated action required 'at all levels of government and in many sectors of society' (Kickbusch & Buckett, 2010, p13).

A cost-effective and equitable approach to obesity prevention requires a mix of population-level interventions, including a strong role for government and the use of law and regulation (Gortmaker et al., 2011; Swinburn et al., 2011). This includes *inter alia* the regulation of the marketing, labelling, content, and pricing of energy-dense foods and beverages (referred to hereon as 'regulatory interventions'). Experts argue that without addressing these determinants of 'obesogenic environments' policy responses are likely to be ineffective (Sassi, Devaux, & Cecchini, 2012; Swinburn et al., 2011).

Despite widespread attention to the issue, however, political priority for action to tackle obesogenic environments is low in many countries. Responses have favoured programme and education-based interventions (Lachat et al., 2013), despite evidence that such interventions *in isolation* have limited efficacy and cost-effectiveness (Lemmens, Oenema, Klepp, Henriksen, & Brug, 2008; Summerbell et al., 2005). Indeed, obesity experts assert that '[t]he degree of political difficulty for implementation of…regulatory interventions is typically much higher than that for program-based and education-based interventions' (Swinburn et al., 2011, p810).

Recognizing such challenges, a small number of studies elaborate on the political dimensions of obesity in Australia (Crammond et al., 2013; Shill et al., 2012). Crammond *et al.*, for example, investigated the barriers to the adoption of regulatory interventions by the Executive Branch of the Australian Government. Yet, in focusing only on government actors these studies do not account for the broader network of non-state actors,

including civil society, experts, and business groups, that also shape political responses to obesity. Thus, we conceptualise obesity as 'governed' by a plurality of actors in society rather than through the machinations of 'government' alone (Baldwin, Cave, & Lodge, 2012).

In this paper we bring key questions into play: Why are regulatory interventions politically difficult to achieve? Under what conditions do regulatory interventions receive political priority? Such questions concern the 'agenda-setting' phase of the policy cycle, when some problems rise to the attention of policy-makers while others receive minimal attention, or none at all (Kingdon, 2003). Political attention is a necessary but insufficient condition for political action. Hence, we view this concept as related to but distinct from 'political priority', the extent to which political leaders respond to the issue by mobilising official institutions and wider political systems into providing resources and enacting interventions commensurable with the severity of the issue (Shiffman & Smith, 2007).

Although obesity and poor diet are the leading causes of death and disability in Australia (Australian Institute of Health and Welfare, 2014), political priority for regulatory interventions has been notably absent. This paper adopts the agenda of the Australian Federal Government (AFG) as a case study and determines the factors generating or hindering political priority for regulatory interventions targeting obesity prevention, thereby helping to understand how future political priority might come about.

Materials and methods

Scope and setting of the case study design

A qualitative within case-study design was adopted because the temporally dynamic and multi-variable nature of the topic made an experimental design impossible (George & Bennett, 2005). The Australian Federal Government (AFG) was selected as a case study of national agenda-setting, beginning with the year prior to the establishment of the Australia New Zealand Obesity Society in 1991, and ending in November 2011 with the final statement by the AFG on its response to obesity.

Australia has a liberal-democratic federal system of government comprising the AFG, state/territory, and local, governments, as well as linkages to the international system. The AFG is elected on a three-year term and includes a bicameral Parliamentary legislature (House of Representatives and Senate) and an Executive led by the Prime Minister and Cabinet. Two political parties dominate Australian politics: the libertarian conservative Liberal Party of Australia (LPA) which usually governs in coalition with the conservative National Party, and the democratic socialist Australian Labor Party (ALP). From hereon the residing Government will be referred to as AFG (LPA) or (ALP). The Australian Public Service (APS) administers AFG policy with responsibilities for making, monitoring, and enforcing regulation (Parkin, Summers, & Woodward, 2002).

With regards to obesity prevention, Parliament legislates exclusively in the areas of advertising standards with implementing regulation established by the Australian Communications and Media Authority, and general taxation with tax policy the responsibility of the Commonwealth Treasury. Other areas are governed jointly with state governments through the Council of Australian Governments (COAG) and various inter-ministerial councils. For example, food standards (including labelling) policy is made by the Australia and New Zealand Ministerial Forum on Food Regulation, standards are set by the statutory authority Food Standards Australia New Zealand, and state and territory governments enact the standards into legislation.

Method

A theoretically guided process-tracing method was adopted because it is well suited to the study of complex political phenomena and partly addresses limitations of the within-case study design (George & Bennett, 2005). To minimise bias multiple data sources were used. Semi-structured interviews were conducted by the principal investigator (XX) between September 2010 and April 2011 with 27 informants spanning a diversity of sectors (Table 1), recruited using a purposive snowball sampling strategy (Goodman, 1961). Interviews lasted between 40 and 75 minutes. 23 were conducted face-to-face and four by phone. Interviews were recorded and transcribed verbatim. Given the sensitive nature of the topic informants were de-identified.

Documents were sourced from government websites including media releases, speeches and Hansard transcripts of the House of Representatives, the Senate, and Parliamentary Committees available from the ParlInfo database. Other grey literature was sourced from the websites of relevant non-government organizations (NGOs). Media articles were sourced from Factiva and journal articles from the Scopus and Pubmed databases using a combination of obesity and policy related search terms.

<Insert Table 1 about here>

Theoretical framework

We adopted a social constructionist view of agenda-setting whereby political priority is determined less by the material importance of the issue (e.g. attributable mortality and morbidity) and more by how effective political actors are at interpreting and communicating (i.e. framing) the issue in ways that mobilize supporters and demobilize opponents . Certain framing combinations – for example those attributing causality, responsibility, severity, neglect, tractability and benefit to an issue – will resonate with the values and worldviews of political leaders, whereas others will barely register, if at all (Shiffman, 2009; Shiffman & Smith, 2007).

Ideas were not considered powerful in isolation; they are amplified through, for example, the centrality of actors in policy networks (e.g. access to elite decision-makers) (Lewis, 2006), the possession and control of material resources (e.g. as large employers or providers of government revenue), the capacity to shape informal or formal rules and institutional arrangements in ways that implicitly select (or select out) alternative courses of action (Beland, 2005), or through an authoritative claim to policy relevant expertise and knowledge (e.g. experts and epistemic communities) (Haas, 1992).

A theoretical framework (the 'framework') grounded in social constructionism and developed to explain political priority for health initiatives was adapted to guide the analysis, including the development of an interview protocol (Shiffman & Smith, 2007). The theoretically pluralistic nature of the Framework was considered a strength because it enabled us to test the data against multiple theories rather than one alone

(George & Bennett, 2005), including Kingdon's well known multiple streams framework and Sabatier's advocacy coalition approach. The Framework hypothesises eleven determinants of political priority categorised into four dimensions (Table 2). Given a recognized role of industry groups in obesity politics we hypothesised an additional factor 'industry mobilisation'. No single factor was viewed as sufficient or necessary to generate political priority, but increased its likelihood (Shiffman & Smith, 2007).

<Insert Table 2 about here>

Analysis

Interview transcripts and documents were coded using Atlas.ti software by XX. A coding schema was developed from the theoretical Framework and additional emergent themes captured using open coding. The coding schema was refined using constant comparative thematic analysis. The final interpretation of events was clarified through discussion among authors (XX, XY, XZ) and cross-checked with several key informants. Key informants were presented in the results of the analysis using a general descriptor (e.g. Health advocate). Public statements by influential individuals identified in documents were also presented in the results by name and position (e.g. Hon. Nicola Roxon, ALP Health Minister).

Ethics and funding

This study was approved by the Australian National University Human Research Ethics Committee. The principal investigator was funded by an Australian Postgraduate Award scholarship, provided by the AFG. The AFG was not involved in the conduct of this study..

Results

Evidence of political attention and priority

Three distinct periods of political attention were evident;

1. In 1990-2001 there was low political attention to the issue with policy processes bifurcated into 'diet' and 'physical activity' rather than a single 'obesity' category. Later in the period, attention to obesity emerged in parallel to the issue's rising social salience.
2. In 2002 the issue of childhood obesity ascended onto multiple state government agendas. This momentum generated national attention to the issue and triggered its ascendance onto the AFG (LPA) agenda.
3. Attention to the issue intensified with the election of a new AFG (ALP) in 2006-07 and the launch of that Government's preventative health agenda before declining.

Despite this attention informants noted that obesity was an emerged issue at an early stage of achieving political priority. Policy responses initiated by the AFG (ALP) were viewed as 'just a start' and the public health community faced a decade or more of advocacy ahead. Some were sceptical of AFG responses describing them as 'paying lip service' and as 'a long history, effectively, of inaction'. No regulatory interventions were evident, with policy responses largely focused on social marketing and settings-based interventions, and the endorsement of industry self-regulation.

Power of actors

In the first dimension of the Framework actor power is described as 'the strength of individuals and organizations concerned with an issue'. Further, 'A…policy community is more likely to generate political support for its concern if it is cohesive, well-led, guided by strong institutions, and backed by mobilised civil societies' (Shiffman & Smith, 2007, p 1372).

The policy community was comprised of health advocates, public servants, parliamentarians, industry executives and lobbyists, and academics. Some individuals were seen as 'champions' for obesity prevention, for example LPA Senator Guy Barnett and ALP Health Minister Nicola Roxon. However, their voices were seen to have been 'drowned out' by opponents and no individual had united the policy community. Although cohesion of the policy community was seen to be growing it was fragmented as a result of tensions within and between the various actor groups.

Academics played a role in disseminating research, informing policy consultations, and in advocacy efforts, with cohesion enhanced through shared membership in technical committees and the Australia New Zealand Obesity Society (ANZOS). Established in 1991, ANZOS was a member organization of the International Association for the Study of Obesity (IASO; now the World Obesity Federation). In 1998 IASO members initiated the first World Health Organization (WHO) consultation on obesity (Technical Report Series 894), which was seen to have 'launched' obesity onto multiple government agendas. Pharmaceutical companies (Servier, Roche, and Abbot) were major seed funders of ANZOS and IASO and through this sponsorship were therefore important in generating initial political attention to obesity globally.

However, in addition to 'obesity experts' a diverse set of others were involved, spanning the fields of nutrition, physical activity, the built environment, and clinical medicine. This diversity was seen to have resulted in a limited consensus on the most significant causes and solutions to obesity and hampered efforts to inform policy. As informants described it;

> The biggest problem we have with obesity politics in Australia is that there are too many people who are fanatical about one aspect…they get so obsessed with their own area that they don't see the big picture (Academic)

> It's a less evolved field and there are so many competing interests. You've got physical activity, food, diabetes, urban environment, a whole range of different players. That caused a lot of extra work for people developing policy (Health advocate)

> [With] tobacco we had strong evidence, we knew really who the key people would be to put around the table…[With] obesity we felt that we wanted to engage a much broader group of people, and it was quite hard (Policy-maker)

Civil society mobilization was led by disease-orientated NGOs including the Cancer Council, Diabetes Australia and the National Heat Foundation. These (with others) established the Australian Chronic Disease Prevention Alliance to agree on a consistent approach to 'how we might talk about physical activity and

nutrition issues'. The Australian Medical Association, Public Health Association of Australia and Obesity Policy Coalition were also considered influential. However, no overarching coalition of aligned organizations had emerged, to the detriment of collective action efforts;

> We should be trying to work more closely together with aligning priorities…[We] do this well in tobacco when all the groups get together and decide on the priorities and work cohesively to do it. It's much less so around the obesity agenda (Health advocate)

Civil society cohesion was seen as hindered in two ways. The receipt of industry funding by some NGOs was seen by some as a serious 'conflict of interest' that had generated divergent advocacy positions;

> We've conflicts within the public health community, there are those who take funding [and] play with industry. So the people who should be our natural allies are our opponents and it's very frustrating. Some of the biggest changes in tobacco came when we [took] a tough line (Health advocate)

Positions on the labelling issue were also divergent. Although most advocated for an interpretive scheme (multi-traffic light labelling), one NGO had a 'more conservative stance', possibly due to potential competition with its own scheme. Some advocates were critical of the latter, that it did not consider added sugar, encouraged more and not less food consumption, and applied to products constituting a 'healthier choice' within the same category rather than 'healthier overall'.

The food and advertising industries were viewed by advocates and some academic informants as the most important actors inhibiting political priority. The Australian Association of National Advertisers (AANA) and Australian Food and Grocery Council (AFGC), both private-interest NGOs, were the primary vehicles of industry power. Industry was viewed by a diversity of informants as cohesive and 'singing the same tune', with considerable access to policy elites within the AFG and associations with international business associations and public relations networks;

> There's generally a fairly high level of agreement as to the way in which to go about addressing issues. Many…are involved in the same international associations. So people have common language, understanding at an international level, common causes, and therefore line up to be supportive (Anonymous)

The AFGC and the AANA initiated self-regulatory codes on marketing and labelling, an industry labelling scheme and a food reformulation initiative. The latter resulted in the Food and Health Dialogue, a 'non-regulatory' partnership between the AFG, food industry and public health groups to encourage voluntary food reformulation. Self-regulatory codes on marketing were implemented proactively, just prior to or during AFG and state government developments on the same issues, and co-evolved with international-level industry initiatives. Self-regulatory codes were seen by some advocates and academics as an effective strategy to delay the adoption of AFG-led regulatory interventions.

The AFGC was established in 1995 by 16 corporations of which 13 were transnational food and beverage corporations. Only one of the top-20 corporations (as ranked by turnover of parent) signatory to obesity-related self-regulatory codes was a wholly-owned Australian company (Table 2). Thus the AFGC largely represented the interests and drew upon the political power of international capital. It also represented ~150 companies with 80% of the gross dollar value of the Australian sector. This 'reach' into the food system was seen to make implementation of labelling and reformulation initiatives difficult if industry was not 'on-board'.

<Insert Table 3 about here>

Power of ideas

The Framework theorises that political priority is also influenced by the 'ideas' deployed by actors, with 'framing' defined as 'the way in which an issue is understood and portrayed publically'. 'Internal frames' are those that '…unify policy communities by providing a common understanding of the…problem'.

'External frames' are those 'that resonate externally...[and] move essential individuals and organisations to action' (Shiffman & Smith, 2007, pg1372).

Before 2000 obesity was seen by advocates and academics as a non-issue from a population-health perspective. Attention was described as then escalating alongside a shift in rhetoric, particularly the emergence of an 'obesogenic environment' frame emphasising the social, economic, and commercial determinants of obesity (i.e. those outside of individual control). The term first appeared in the 1997 National Health & Medical Research Council report *Acting on Australia's Weight*. This 'aetiological broadening' was seen to have resulted in the entry of more actors into the research and policy spaces;

> In the early '90s people thought [prevention] was a very odd subject to study...The recognition of it as a population health issue has gone through the roof, particularly in the last 5 to 7 years. There's been a movement away from a focus only on clinical management to prevention, at least in terms of rhetoric. And therefore there's a lot more players in the area...people in a research sense, in a policy and practice sense, and of course industry (Academic)

In parallel addressing the problem was increasingly seen to be the responsibility of a wider set of actors beyond the individual alone;

> It's been a massive change in terms of public perception of obesity...Ten years ago it was pretty much accepted that it was individual responsibility and that was it. Whereas now it's pretty much accepted that it's a whole-of-community and whole-of-government responsibility in addition to [the] individual (Health advocate)

However, aetiological broadening was also problematic. The established evidence that energy intake is more important in the aetiology of obesity than energy expenditure was seen to have led to the envelopment of physical activity within the obesity category rather than as a stand-alone risk factor. The food industry was also seen as emphasising physical activity to sideline attention to nutrition issues, resulting in less support for physical activity by nutrition advocates.

A powerful idea triggering initial issue attention was 'child vulnerability'. In 2002, new studies demonstrating a two- to three-fold increase in child obesity rates were widely reported in the media and used by the New South Wales Government (ALP) to justify a Summit and initial policy responses. Premier Bob Carr framed the poor diets of some children 'as an instance of child cruelty'. Subsequently the Victorian, Tasmanian and South Australian governments initiated similar responses. This state-level momentum launched the issue onto the AFG agenda, when later that year the Australian Health Minister's Conference established the National Obesity Taskforce, resulting in the first significant national level policy on obesity, focused on children.

'Industry demonization', 'junk food' (i.e. comparing unhealthy foods to 'junk') and 'protecting kids' frames were deployed consistently by advocates to generate support for regulatory interventions. This was most evident in 2004 Parliamentary debates initiated by ALP parliamentarians on child obesity and the marketing issue, and by the 2006 *Protecting Children from Junk Food Advertising Bill* proposed (unsuccessfully) by the Green Party. LPA parliamentarians typically deployed counter-frames emphasising parental rather than industry or government responsibility. For example;

> Prime Minister, given the influence advertising can have on children, and the importance of this issue, will the government now [support] a ban on junk food advertising during children's television programs? (Mark Latham, Leader of the ALP)

> The question of what children eat is ultimately the responsibility of their parents, and it is about time the [ALP] stood up for parental responsibility instead of trying to throw everything over to the Government. We will never build a nation of independent, proud, self-reliant people until we reinforce, indeed revive, the notion of parental responsibility for their children (John Howard, LPA Prime Minister)

Industry groups also deployed several counter-frames. The self-regulatory codes described earlier were seen as part of wider corporate social responsibility initiatives targeting obesity prevention, acting to favourably

portray food companies as 'good corporate citizens'. 'Slippery-slope' arguments were used to frame industry as vulnerable, that regulation was a 'risk' that would reduce revenue and cost jobs, for example;

> There is a case for consideration of the risk of well-meaning but ill-conceived recommendations...the cost of potential impairment of the social and economic benefits flowing from a $30 billion advertising, marketing & media industry, particularly at a time when the nation is threatened by a global financial crisis (AANA, submission to the Preventative Health Taskforce)

With regards to the food industry, slippery-slope frames were seen to be particularly powerful given that half of the food manufacturing workforce was located in rural Australia, a disproportionally powerful voting-bloc under the Australian electoral system. The argument of protecting farmers and blue-collar workers was also seen to resonate with politicians with these constituencies.

A 'nanny-state' metaphor was deployed by several LPA parliamentarians against government intervention, symbolically conveying an image of Government as a 'coddling nanny'. This was seen as highly influential by informants from all sectors, for example;

> A genuine attempt to get say an advertising restriction policy in, and get some public sympathy for it, can easily be derailed by a nanny state article [in] the media (Heath advocate)

A typical instance of this frame is given below;

> What we do need is to equip families with the information and support to make positive health and lifestyle choices. That is a far better long-term solution…than just pursuing…a nanny state approach to the issue (Mathias Cormann, LPA Senator)

The economic burden of obesity was regularly cited to justify political priority. Attributable costs reported in policy and technical documents escalated from $0.84 billion in 1995 to $58.2 billion in 2008; a 69-fold increase far in excess of any real increase in obesity prevalence. This 'economic rationale' received wide

attention in 2006 and 2008 when figures from modelling reports commissioned by Diabetes Australia were used by ALP parliamentarians to challenge the AFG (LPA) on its inaction.

In 2005-06 primary preventive health in general had low political priority, with only 1.7% ($1.5 billion) of Australian total health spending ($86.9 billion) going to public health initiatives. Some priority emerged in 2007 when the ALP linked obesity prevention to economic productivity in order to justify its new 'preventative health agenda';

> If we fail to deal with chronic illnesses, many linked to obesity, then we won't have the healthy, working community we need to carry us into the next century...So tackling obesity will not only help our kids – it will add to Australia's economic productivity (Nicola Roxon, ALP Minister for Health)

Some advocates and academics also employed an economic rationale, framing childhood obesity as an 'economic success but market failure' warranting government intervention. In contrast powerful AFG actors, including the Productivity Commission, stated that the economic externalities from obesity were complex, difficult to assess, and probably minor. Fiscal interventions were considered difficult to design, non-discriminatory (affecting both the obese and non-obese) and regressive (affecting poorer consumers), and were therefore unjustified.

The political context

The third category of the Framework refers to the broader political and institutional environment. First, policy windows are 'moments in time when…conditions align favourably for an issue, presenting advocates with especially strong opportunities to reach…political leaders'. Second, the governance structure or the extent to which 'the set of norms…and the institutions that negotiate and enforce these norms' provide a platform for effective collective action (Shiffman & Smith, 2007, pg 1372).

Two notable policy windows opened. First, as described earlier, attention to the issue by the NSW State Government in 2002 generated further attention to the issue by other state governments, and subsequently triggered its ascendance onto the AFG agenda. Momentum was also building at the international level during

this period, with the *Global Strategy on Diet, Physical Activity and Health*, ratified by WHO member states in 2004.

Second, under the AFG (LPA) led by John Howard there appeared to be low priority for regulatory interventions, with responses largely focused on social marketing and school programmes. In 2007, the election of a new AFG (ALP) led by Kevin Rudd presented an opportunity for advocates with the initiation of policy and technical reviews on obesity within a broader 'preventative health agenda'. This included the establishment of a National Partnership Agreement on Preventive Health (through COAG, a commitment of $872 million over six years), a Standing Committee on Health and Ageing Inquiry into Obesity (SCHAIO), and a National Preventative Health Taskforce (NPHT). However, although Health Minister Nicola Roxon was described as 'supportive' and as someone 'who gets prevention' support for regulatory interventions did not eventuate.

Norms within the Department of Health and Ageing (DOHA) were seen to have impeded political priority for regulatory interventions. Although viewed as highly effective at initiating public health responses on some public health issues (e.g. tobacco, HIV/AIDS), obesity was seen as a highly complex issue that conflicted with powerful industries and industry-orientated AFG portfolios. The views of elites within DOHA were described as 'very clear' and 'very influential' and had cultivated an institutional culture that selected out regulatory interventions from consideration. As one informant described it;

> [They were]…absolutely aware that as you start getting into some of the territories that we might like to see some changes in, in terms of the food supply, or in terms of advertising, that you start to tangle with some very big and important political and economic players. So [they were]...in the epicentre in terms of translating those political realities…into what was defined as acceptable or less than acceptable within the Department. It was certainly a cultural view that came down the line that this was dangerous territory and [policy-makers] should tread with caution (I18, anonymous)

Thus, given limited support from DOHA there was no single institutional venue for advocating regulatory interventions within the APS. Instead, multiple institutional venues were to shape the AFG's responses. For

example, in response to the SCHAIO and NPHT reports, the AFG (ALP) deferred decisions to recommendations made by non-health policy reviews including the Labelling Logic Review, the Henry Tax Review, and the Children's Television Standards review. Of these only the first, led by former Health Minister Neal Blewett, had a favourable outcome for public health advocates.

However, a new institutional venue, the Australian National Preventive Health Agency, was proposed by the AFG (ALP) in 2008, with establishing legislation passed in 2010. Although described by Health Minister Nicola Roxon as a 'key weapon in the Government's fight against obesity', the establishment of the agency was strongly contested. Some LPA parliamentarians opposed the establishment of the agency, framing it as 'the nation's nanny-in-chief'. How the Agency would be established was of particular interest to public health advocates and industry informants alike, who noted that its 'distance' from government would have an important bearing on its functions and effectiveness. The Consumers Health Forum of Australia was to advocate, for example;

> If the Agency is to fall within the Health and Ageing portfolio and be answerable to Health Ministers, it is extremely unlikely to be truly independent and able to provide frank and possibly uncomfortable advice (CHFA, submission to the National Health and Hospitals Reform Commission)

In contrast the AFGC advocated;

> [S]uch functions should remain within [DOHA] as a dedicated 'division', rather than in a separate agency. There is no argument for an "independent" agency, particularly if it has input, and substantial influence, on government policy (AFGC, submission to the National Preventative Health Taskforce)

Issue characteristics

The complexity of obesity was seen to have presented several difficulties. Although the body mass index was used as an established obesity measure with some population survey data available, a lack of

longitudinal nutrition data was problematic. The absence of an established nutritional profiling system was a noted impediment to the design of regulatory interventions (i.e. in defining what constitutes an 'unhealthy food'). Thus, unlike with tobacco, there were no clear products for regulators to target. Issue complexity also enabled opponents to label specific policy interventions, in particular marketing restrictions, as 'silver bullets' and 'magic cures' to vilify their suitability as solutions to a complex problem;

> We do take the issue of child health very seriously. However, we do not believe that simply banning junk food advertising is the silver bullet that some people want us to believe it is (Mathias Cormann, LPA Senator)

Aside from modelling studies there was a limited evidence-base demonstrating the efficacy and cost-effectiveness of regulatory interventions. There was also a noted 'settings-bias' with most evidence focused on behavioural interventions in schools. This was viewed as an impediment to framing the issue as tractable;

> It's our job to make policies more evidence-informed…but there's not vast amounts of evidence around what does and doesn't work in a true empirical sense, particularly for high level policies. You just don't get randomised control trials on junk food marketing bans (I7, academic)

In response, actors attempted to strategically manage the interface between complexity, evidence and approaches to policy-making. For example, some academics and advocates used a 'food is like tobacco' metaphor to call for 'comprehensive' and 'learning by doing' policy approaches akin to that taken with tobacco;

> We can't wait for all the evidence of an intervention before trying it...As long as we evaluate interventions we will learn and policy will evolve. We can also adopt policy that's worked in other areas…the first thing that had an impact on tobacco usage was restrictions on advertising (I14, health advocate)

In contrast, industry actors called for a strict 'evidence-based' approach. Political decision-makers deployed an 'absence of evidence' rationale for the successive deferment of politically contentious regulatory

decisions. For example, in 2010 the AFG (ALP) announced that in their 'hierarchy in our approach in prevention' obesity was in third place behind tobacco and alcohol, because 'the evidence is still pretty unclear about which interventions are going to be successful' (Hon. Nicola Roxon, Minister for Health).

Discussion

This research demonstrates that although there were periods of significant political attention to obesity, political priority for regulatory interventions did not emerge. The theoretical Framework used to guide this analysis offers several insights into understanding the determinants of political priority in this case, and how it might be generated in future.

First, it is clear that obesity emerged as a social and political issue in Australia (as distinct from a material one) in the early 2000's, facilitated by an emergent expert community at global and national levels. However, the resulting consolidation of physical activity, nutrition and other stand-alone issues into a single obesity category was problematic, bringing a diversity of experts into competition. This supports the view that with complex issues like obesity the sources of credible expertise can be diverse (Saguy & Riley, 2005). In this case such diversity hindered the development of expert consensus. Although cohesion of civil society organizations mobilized around the issue was building no over-arching coalition had emerged, with divergent positions on industry funding and labelling hampering collectively driven action. Thus, a lack of cohesion among experts and advocates likely hindered the building of influential advocacy coalitions often described in the agenda-setting literature (Shiffman & Smith, 2007).

Nonetheless, experts and advocates deployed powerful frames to generate political priority, resonating with communitarian notions of social justice and protecting vulnerable groups from harm. An initial emphasis on child (vs. adult) obesity and a 'protecting kids' frame helped push the issue on to state and subsequently Federal government agendas. This is consistent with studies demonstrating a concern with protecting children has wide trans-cultural resonance and mobilizing potential (Keck & Sikkink, 1998). An 'industry demonization' frame was also important, particularly in this case the marketing of 'junk food' to children.

The assignment of blame to industry is a powerful framing strategy, acting to create a visible enemy and spurring collective action (Kersh & Morone, 2002).

An obesogenic environment frame, which emerged initially from within the expert community, was also important. In this view, differences in the prevalence of obesity are systemically rather than individually produced, resulting from the political, economic and social determinants of toxic food and physical activity environments. This locates responsibility with the 'causes of the causes' of obesity and thus with a wider diversity of actors including industry and government. As others have noted, this framing strategy shifts responsibility from the 'personal to the political' sphere, thereby motivating collective action as demonstrated previously in tobacco, alcohol and gun control (Dorfman, Wilbur, Lingas, Woodruff, & Wallack, 2004; Kersh & Morone, 2002).

The food, beverage and advertising industries appear to have powerfully shaped political priority. This power stems from their economic importance as large industries and employers (so-called 'productive power'), good access to policy-elites, their reach into food systems, and their pre-emptive adoption of self-regulation. This is consistent with observations that the power of business to influence social policy has grown substantially in recent decades, alongside expanding government preferences for less punitive forms of regulation and hybrid (i.e. public-private) approaches to governance (Fuchs, 2007). Industry power was buttressed by a libertarian/neolibertarian political rhetoric emphasising individual and parental responsibility, a negative view of freedom (i.e. as free from 'nanny-state' intervention), and the idea that regulating free enterprise will incur significant harms on business and the broader economy. Others have demonstrated the dominance of such frames in reporting of obesity by the Australian news media, which in turn acts to reinforce the power of such groups (Henderson, Coveney, Ward, & Taylor, 2009).

To generate political priority advocates also deployed an economic-utilitarian rhetoric, that obesity is a market failure, incurs a heavy economic and social cost, and thereby warrants government intervention. At times this generated significant political attention to the issue, consistent with the view that economic arguments can be influential in contemporary policy-making. However this was neutralised by a counter-

rhetoric deployed by powerful economic actors within Government, that the harms (or in economic terms 'externalities') were minor and located mostly with the individual.

Fourth, the political and institutional context also powerfully shaped political priority. The election of a new Government, in this case Labor governing with the Greens, focused further attention onto preventive health and obesity. Consistent with the idea of 'policy-transfer' the results demonstrate how actions by one state government were quickly adopted by others and subsequently pushed the AFG to action. This suggests that when confronted by AFG power barriers, advocates might best target state governments, who may then compel the AFG to action.

Institutional norms cultivated by public service elites within the DOHA likely constitutes one such power barrier, having effectively selected out regulatory interventions from consideration. Bachrach and Baratz conceptualize this as a 'mobilization of bias', as 'the practice of limiting the scope of actual decision making to safe issues by manipulating the dominant community values,…political institutions and procedures' (Bachrach & Baratz, 1963, p 632). A mobilization against upstream regulatory interventions is also consistent with the concept of 'lifestyle-drift' where, in this case, political commitments to address obesogenic environments are narrowed to lifestyle interventions targeting individuals (Popay, Whitehead, & Hunter, 2010).

The APS has become increasingly politicized in recent decades (Aucoin, 2012). In this context the Department's support for regulatory interventions may be strongly influenced by the partisan nature of Australian politics. The establishment of a new institution with a mandate to address the issue would create an alternative platform to support collective action. Since this analysis was conducted an Australian National Preventive Health Agency was established in January 2011 by the AFG (ALP) and abolished by the AFG (LPA) in June 2014. The results demonstrate that the establishment and mandate of any future agency (i.e. institutional design) is likely to be highly contested, particularly its 'distance' from Government.

Finally, a weak evidence-base to support regulatory interventions was a significant barrier. A 'settings-bias' in existing obesity research may reflect the priorities of research funding agencies in Australia and

elsewhere. In the United States, for example, biomedical research has been prioritised with '[r]elatively little work...funded on economic and other social drivers of the obesity problem' (Brescoll, Kersh, & Brownell, 2008). Despite the portrayal of objectivity this 'mode' of knowledge-production is not apolitical but rather acts to reinforce power-relations because it 'facilitates political decisions that disregard…the most powerful channels for intervention' (Stuckler, Basu, & McKee, 2010).

The observed 'absence of evidence' rationale consistently used to defer decisions on regulatory interventions suggests that political priority is more likely to emerge when an 'evidence-informed and practice-based' rather than strictly 'evidence-based' approach to policy is adopted (i.e. active policy experimentation and evaluation over inaction) (Swinburn, Gill, & Kumanyika, 2005). Such an approach has been called for by the UK Government's Foresight investigation on obesity and Australia's National Preventative Health Taskforce and could include large-scale demonstration projects, population-level interventions, and the evaluation of natural experiments. In the absence of supporting evidence, the use of metaphor in political discourse can be used strategically to imply a similar causal story and a 'prescription for action' (Stone, 2002, pg 148). In this analysis advocates deployed a 'food is like tobacco' metaphor to achieve this.

Conclusion

Generating and sustaining future political priority will likely require overcoming key challenges. First, is to achieve cohesion among experts and advocates, making for more powerful technical and collective action responses. Establishing a unified coalition of civil society organizations may be an important step forward. Second, is overcoming an unsupportive institutional environment within Government. Although the re-establishment of a National Preventive Health Agency is likely to be highly contested, this may provide an important institutional platform for advocates. Third, overcoming industry opposition presents a formidable challenge. Lessons from other public health movements, particularly tobacco control, suggests that ongoing 'demonization' efforts alongside calls for regulatory intervention may be effective (Dorfman et al., 2004). The lack of a clear regulatory target identified as a challenge may be overcome by more specific targeting of product categories with a strong evidence-base (e.g. sugar-sweetened beverages). A further option is to

advocate for a responsive regulatory model with more punitive measures adopted if industry self-regulation proves unsuccessful.

There are several limitations of this analysis. The single case study design makes generalizations from the research difficult. The factors that most affected political priority are also under-determined. These are general limitations of the within-case study design and this analysis should be interpreted with this in mind (George & Bennett, 2005). Comparative case-study designs, ideally contrasting multiple jurisdictions and/or issues (e.g. alcohol, tobacco) may address such limitations in future. This analysis supports the utility of the Shiffman and Smith Framework for explaining political priority for health issues. This analysis suggests that the list of factors included in the Framework might also include 'industry mobilization'.

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Tables

Table 1. Characteristics of key informants

Position / sector	No.	Non-respondents
Politicians	1	2
Federal public servants	3	3
Health advocates	9	0
Industry lobbyists	3	2
Industry executives	2	1
Academics	9	1
Total	27	9

Table 2. Framework on determinants of political priority

Dimension	Description	Factors shaping political priority
Actor power	Strength of individuals and organisations concerned with the issue	Policy community cohesion: degree of coalescence among the network of individuals and organisations centrally involved with the issue
		Leadership: the presence of individuals capable of uniting the policy community and particularly strong champions for the cause
		Guiding institutions: effectiveness of organisations or coordinating mechanisms with a mandate to lead the initiative
		Civil society mobilisation: extent to which grassroots organisations mobilise to press political authorities to address the issue
		Industry mobilisation: extent to which corporations mobilise to press political authorities to address the issue
Ideas	How actors understand and portray the issue	Internal frame: degree to which the policy community agrees on the issues definition, causes, and solutions
		External frame: public portrayals of the issue in ways that resonate with external audiences, especially political leaders
Political contexts	Political and institutional environments in which actors operate	Policy windows: political moments when conditions align favourably, presenting opportunities for advocates to influence decision makers
		Governance structure: the degree to which norms and institutions

		operating in a sector provide a platform for effective collective action
Issue characteristics	Features of the problem	Credible indicators: clear measures that show the severity of the problem and that can be used to monitor progress
		Severity: the size of the burden relative to other problems, as indicated by objective measures such as mortality levels
		Effective interventions: extent to which proposed solutions are clearly explained, cost effective, backed by scientific evidence, simple to implement, and inexpensive

Footnotes: Adapted from (Shiffman & Smith, 2007).

Table 3. Top-20 AFGC member companies signatory to industry self-regulatory initiatives, ranked by annual turnover of parent company

Company	Parent	Headquarters	Signatory codes	Parent's annual revenue AU$ million (2010-11)
Nestle Australia*	Nestle SA†	Switzerland	RCMI,	$136,051
Unilever Australasia*	Unilever†	UK/Netherlands	RCMI,	$59,349
PepsiCo Australia	PepsiCo†	USA	RCMI,	$58,614
Kraft Food Australia/New Zealand*	Kraft Foods†	USA	RCMI,	$50,207
Coca-Cola South Pacific*	Coca-Cola†	USA	RCMI	$35,590
Mars Snackfood Australia	Mars†	USA	RCMI,	$30,403
National Foods*	Kirin Holdings	Japan	RCMI	$27,008
McDonald's Australia	McDonalds	USA	QSR	$24,398
George Weston Foods*	Associated British Foods	UK	RCMI,	$17,627
Subway	Doctor's Associates	USA	QSR	$16,417
Fonterra Australia New Zealand*	Fonterra Co-operative	New Zealand	RCMI	$15,368
General Mills Australia	General Mills†	USA	RCMI	$14,996
Kelloggs (Aust)*	Kelloggs†	USA	RCMI	$12,563
Yum! Restaurants (KFC/Pizza Hut)	Yum Brands	USA	QSR	$11,495
Ferrero Australia	Ferrero†	Italy	RCMI	$9,196
Campbell Arnott's*	Campbell Soup	USA	RCMI	$7,779
Simplot Australia	J R Simplot Company	USA	RCMI	$4,560
Hungry Jack's	Burger King Holdings	USA	QSR	$2,361
Cereal Partners Worldwide	General Mills/Nestle	Switzerland	RCMI	$1,773
QSR Holdings (Red Rooster/Oporto)	QSR Holdings	Australia	QSR	$236

Footnotes: RCMI = Responsible Children's Marketing Initiative; QSR = Australian Quick Service Restaurant Industry Initiative for Responsible Advertising and Marketing to Children; FLP = Code of Practice for Food Labelling and Promotion; † = International Food & Beverage Alliance member; * = Founding member of the AFGC. Sources: http://forbes.com; company websites, accessed 10th March, 2012.

Highlights

- Obesity prevention requires food marketing, labelling, pricing & content regulation
- We identify factors enabling & constraining political priority for such regulation
- Enablers: rising obesity prevalence, state government attention, issue framing
- Constraints: non-cohesive advocates, industry power, institutional norms, evidence
- Overcoming these challenges will be important to future obesity prevention efforts