Health Research Council Summer Ethics Research Scholarship

Research Report:

Applying the Nuffield Council on Bioethics Stewardship Model to New Zealand Public Health Policy: A case study

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Abstract

Public health is political and value driven. Ethics can provide guidance through debates and help examine value claims. Ethical frameworks for public health though are still being developed and often fail to give practical assistance. The aim of this research therefore was to test the applicability of the UK Nuffield Council on Bioethics public health ethics framework, through the case study of food marketing to children in New Zealand. The approach taken was to develop a set of questions to test the principles when applied to the particular case. The results of the case study suggest that implementing restrictions on food marketing to children would be ethically justifiable. The framework was helpful in reviewing the evidence and for considering the appropriateness of the proposed actions, because it provided a clear set of questions that brought an ethical lens to reviewing the evidence around a proposed public health intervention. In particular the framework added a lens regarding questions of proportionality, intrusiveness, and impact on equity. The framework appears a useful starting point for more explicit consideration of ‘downstream ethics’ in development of public health policy, however for the application in New Zealand an additional Treaty lens must be added to the framework.
**Introduction**

While there is considerable debate about the philosophical virtue of ethics in public health these discussions do not easily facilitate practitioners and policy makers to actually make any decisions.

There is much debate about the justified intrusiveness of health promotion interventions on individual freedom, often represented as claims and counter-claims about ‘nanny state’ interventions in media and political discourse (Calman, 2009). To assess whether or not state action is justified, benefits and constraints must be weighed against each other, guided by a set of ethical principles.

In public health policy making there are diverse interests and values. How far the state restricts personal freedom to promote population health depends on the political philosophy influencing the inherent values in public health (Cribb, 2010). Within liberal western societies there is a strong tendency to emphasize the individual’s right to self-determination, but this goal must coincide with the virtue of public health to take measures to improve collective wellbeing (Peckham & Hann, 2010). Public health interventions are often debated between interventionists and libertarians, where the latter argue that state intervention in people’s health unnecessarily intrudes into people’s lives. On the other hand, interventionists believe that the state should have the mandate to maximise collective utility reflected by the joint will of the community. Here, ethics can help to guide through value-driven debates by exposing and examining value claims.

In 2007 the Nuffield Council on Bioethics published a framework *Public health: Ethical issues* (referred to hereafter as the Nuffield framework) offering guidance on ethical decision-making in public health interventions (Nuffield Council on Bioethics, 2007). So far the report has been welcomed by the UK Public Health Association (Baldwin, Brownswor, & Schmidt, 2009), and adopted by UK National Institute for Clinical Excellence (NICE) to justify interventions for mental health promotion in workplaces (Killeran & White, 2010). The framework comprises two analytical tools to consider arising ethical issues in population health: The ‘stewardship model’ and the ‘intervention ladder’.

The stewardship model is based upon a liberal framework, but recognises a role for state action to achieve collective goods when the need justifies collective action. In these cases individual autonomy may, justifiably, be reduced. The Nuffield framework attempts to provide guidance on when such collective (at the expense of individual autonomy) action is justified. Overall, the aim is to achieve the desired health outcomes while preserving individual freedom. The stewardship model describes acceptable goals and constraints for public health policy. Under the framework the duties of the state are to enable people to lead healthy lives while giving special attention to reducing health inequalities. The framework is presented in Table 1.
Table 1. Nuffield on Bioethics Framework

<table>
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<tr>
<th>Public health interventions should</th>
<th>Public health interventions should not:</th>
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<tr>
<td>Reduce the risks and causes of ill health</td>
<td>Coerce adults to lead healthy lives</td>
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<td>Reduce causes of ill health by regulations that ensure environmental conditions that sustain good health</td>
<td>Introduce interventions without individual consent of those affected, or with procedural justice arrangements</td>
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<tr>
<td>Pay special attention to the health of children and other vulnerable people</td>
<td>Implement interventions that are perceived as unduly intrusive and in conflict with important personal values</td>
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<tr>
<td>Promote health not only by providing information and advice, but also by programmes to help people overcome addictions and other unhealthy behaviours</td>
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<tr>
<td>Ensure that it is easy for people to lead a healthy life</td>
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<tr>
<td>Ensure that people have appropriate access to medical services</td>
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<td>Reduce health inequalities</td>
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The Nuffield framework is informed by a precautionary approach, and principles of reducing inequalities, recognizing vulnerable groups, creating healthy environments, and procedural justice. Scientific risk assessment, fairness and consistency, consideration of costs and benefits of actions, transparency, and proportionality guide the precautionary approach and are implicit in the Nuffield framework.

The intervention ladder (Table 2) presents different levels of intrusiveness of public health policies, from 'doing nothing' to 'eliminating choice', which is assessed based upon the proportion of people affected and urgency of intervention. For instance, an intervention that restricts personal freedom and choice through legislation must be backed up with strong evidence to justify action. ‘No action’ is also a value statement and requires some justification. Together both tools aim to ensure that public health interventions are based on ethical values and principles.

Table 2. Intervention ladder by Nuffield Council on Bioethics

- Eliminate choice
- Restrict choice
- Guide choice through disincentives
- Guide choice through incentives
- Guide choices through changing the default policy
- Enable choice
- Provide information
- Do nothing or simply monitor the current situation

There has been little discussion of the Nuffield framework in the academic literature. While the purpose of this report is not to evaluate the theoretical underpinnings of the Nuffield framework, we note that two published critiques have questioned the concepts of stewardship and paternalism (Coggan, 2008; Dawson & Verweij, 2008). Critiques included that there was lack of clarity as to what the stewardship model would add over the normal liberal position; that there is confusion about the concept of paternalism; and that the common good is not the foundation of the framework (Dawson & Verweij, 2008). Nuffield Report authors have recently answered these critiques (Baldwin, et al., 2009).

The Nuffield framework is not the only public health ethics framework available. Ten Have et al. (ten Have, de Beaufort, Mackenbach, & van der Heide, 2010), identified six ethical frameworks that could be used to inform obesity interventions. All frameworks included common principles of public health ethics, such as reducing inequalities, personal freedom, or public consent. They note that practical guidance on applying the framework to inform interventions was lacking, such as who should use the frameworks and when. The authors concluded that the use of questions rather than naming guiding principles encouraged greater consideration of the ethical aspects raised in the proposed interventions.

This report seeks to evaluate the usefulness of the Nuffield framework for considering public health interventions. To achieve this, the stewardship model and intervention ladder are applied to a case study of regulating food and beverage advertising to children. The report concludes by reflecting on the usefulness of the framework for guiding public health interventions in New Zealand.

**Case Study**

To test the application of the Nuffield framework, we have chosen to consider the application of the ‘Sydney Principles’ (Table 3) to reduce the promotion of foods and beverages to children (IOTF, 2008). Using the Sydney Principles, we defined the actions to be tested as including: Statutory regulations; inclusion of all types of marketing (e.g. television advertising, print, sponsorships, competitions, loyalty schemes, product placements, relationship marketing, Internet); taking actions to create commercial-free education facilities, such as early childhood centres and schools; and have an independent agency to monitor, evaluate, and enforce regulations.

Table 3. The Sydney Principles

<table>
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<th>Actions to reduce commercial promotions to children should:</th>
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<td>1. Support the rights of children.</td>
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<td>2. Afford substantial protection to children.</td>
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<td>3. Be statutory in nature.</td>
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<td>4. Take a wide definition of commercial promotions.</td>
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<tr>
<td>5. Guarantee commercial-free childhood settings.</td>
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<td>6. Include cross-border media.</td>
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<td>7. Be evaluated, monitored and enforced.</td>
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It should be noted that the Nuffield Report itself uses obesity as a case study considering different policy options more broadly. However, while the report includes a brief discussion of ethics in obesity prevention, the examination of specific measures within a defined context is lacking and does not present how the framework may be applied in practice. Additionally, the present project is investigating the proposed actions for the New Zealand context, which further distinguish the present research from the Nuffield case study.

**Childhood obesity and food marketing in New Zealand**

In New Zealand approximately 30 percent of 5-14 year olds are overweight or obese (Ministry of Health, 2008). The distribution is not even between ethnicities with Māori and Pacific children experiencing more obesity. Reducing these inequalities in health through effective policies is a priority in the New Zealand Health Strategy (Ministry of Health, 2000).

In New Zealand there are currently no statutory regulations that restrict food marketing to children; decisions are guided by an industry code of conduct (Shaw, 2009). A comparison of 13 countries showed that in 1999 New Zealand had the third-highest rate of food advertising, the highest rate of confectionery and beverage advertising, and the second-highest rate of restaurant advertising including fast food outlets (Hammond, Wyllie, & Casswell, 1999).

**Method**

Currently, it is unclear how the principles contained within the Nuffield framework should be applied practically (Peckham & Hann, 2010). The approach taken here is to develop a set of questions to test the principles when applied to a particular case. Developing questions to guide consideration of a proposed intervention is similar to the approach used in guiding health impact assessment of programmes and policies (Ministry of Health, 2007; Public Health Advisory Committee, 2005). First, general questions were formulated from the Nuffield framework (Table 4), which were then adapted accordingly to the present case study (Table 5).

**Table 4. General questions to apply the Nuffield framework to a public health issue**

1. Will the action reduce the risks of ill health?
   a. Is the issue sufficiently important to warrant the proposed action?
   b. What is the quality and certainty of the evidence for the cause?
   c. Is there evidence that shows the effectiveness of the proposed action?
   d. Is this action the least intrusive and costly whilst still achieving the aims?
2. Will the action create environmental conditions that sustain good health?
3. Will the action affect children and other vulnerable people?
4. Will the action: (a) do more than provide information; and (b) help people overcome addictions and unhealthy behaviour, and live healthier lives?
5. Are there inequalities in health outcomes and/or opportunities/access on this issue? If yes, will the action potentially reduce inequalities?
6. Will the action attempt to coerce adults to lead healthy lives and reduce individual freedom/choice?
7. Do the actions require a democratic decision-making process and/or public consultation/deliberation? If yes, are any viewpoints known to date?

Table 5. Questions applied to case study: Regulating food marketing to prevent childhood obesity

1. Will regulating food marketing to children decrease the risks for developing childhood obesity?
   a. Is reducing childhood obesity sufficiently important to warrant regulations on food marketing?
   b. What is the quality and certainty of the evidence that food marketing affects childhood obesity?
   c. Is there evidence that shows effectiveness on children's diets and/or weight through regulating food marketing?
   d. Is regulating food marketing the least intrusive and costly whilst still achieving the aims?

2. Will regulating food marketing create environmental conditions that can reduce childhood obesity?

3. Will regulating food marketing affect children and other vulnerable groups?

4. Will regulating food marketing (a) help people overcome unhealthy dietary behaviour and (b) enable them to live healthier lives?

5. Are there inequalities in the burden of childhood obesity? Would regulations on food marketing reduce health inequalities?

6. Will regulating food marketing coerce adults to lead healthy lives and reduce the foods available for consumption?

7. Does regulating food marketing to children require a democratic decision-making process and/or public consultation? If yes, are any viewpoints known to date? Will food marketing regulations be subject to further democratic processes?

To answer these questions (Table 5) a literature review was undertaken. The literature review is not comprehensive, as the exercise is for purposes of testing and illustration. Three types of literature have been accessed for each question: (i) international review articles; (ii) recent international peer reviewed articles; and (iii) New Zealand peer reviewed and grey literature. The search was conducted between November 2010 and January 2011, and included Google for grey literature and the databases Pubmed, CINAHL, Web of Science, and ERIC.
Results

1. Will regulating food marketing to children reduce the risks for developing childhood obesity?

The first question to be answered is whether childhood obesity is a sufficient problem to warrant preventative actions, such as marketing restrictions (question 1a). Before any specific public health action is taken though, the level of the risk must be determined. The Nuffield framework takes the ‘statistical approach’ to risk assessment and states that policy should be based on the best available scientific evidence. Under the Nuffield framework two types of evidence are deemed important. First, the evidence for the causes of ill health must be examined (question 1b), and secondly there should be some evidence concerning the effectiveness of the proposed actions to improve public health (question 1c). Thereby, it must also be considered whether the proposed action is cost-effective and the least intrusive action available (question 1d).

a. Is reducing childhood obesity sufficiently important to warrant regulations on food marketing?

There is an exhaustive amount of evidence about the prevalence and severity of childhood obesity, which can be demonstrated through five overarching arguments. First, the prevalence of childhood obesity is increasing in most industrialised (Wang & Lobstein, 2006) and many developing (Kelishadi, 2007) countries. In New Zealand approximately 30 percent of 5-14 year olds are overweight or obese (Ministry of Health, 2008). Second, the burden of overweight and obesity amongst New Zealand children is disproportionately located with Pacific, Māori and children from lower socioeconomic status households (Ministry of Health, 2008). Third, there is a wide range of short and long term health and education impacts that can result from childhood obesity; including emotional, behavioural, and physical health issues (Reilly, 2005; Sattar & Lean, 2007). Fourth, there is a high financial cost of overweight and obesity amongst the New Zealand population. In 2004 the direct cost of health care for excess weight related treatment was estimated from $400 to $500 million in 2004. Productivity losses for the same year were approximately $370 million (0.25 percent of GDP) (New Zealand Government, 2007). Finally, reducing childhood obesity has been a priority on the Government’s health agenda since 2004 (Ministry of Health, 2004) and is therefore already identified as a legitimate target for public health policy in New Zealand.

b. What is the quality and certainty of the evidence that food marketing affects childhood obesity?

Robust evidence shows that food marketing to children contributes to childhood obesity. This evidence stems from independent systematic reviews that have established a relationship between marketing and adverse effects on children’s dietary choices and beliefs (Hastings, McDermott, & Angus, 2006; Hastings, et al., 2003; Hawkes, 2004). Hastings et al. (2003) found that food marketing has an independent effect on children’s purchase behaviour, food preferences and consumption at a brand and category level. As desired under the Nuffield framework the Hastings report was subject to a rigorous peer-review process (Ambler, 2004; Food Standards Agency, 2003; Livingstone, 2004) and has informed policy changes in the UK.
New Zealand research suggests that most the food advertised during children’s television viewing hours is high in fat, salt, and sugar (HFSS) (Wilson, Quigley, & Mansoor, 1999; Wilson, Signal, Nicholls, & Thomson, 2006). Jenkin, Wilson, and Hermanson (2008) used a nutrient profiling model to categorize advertised food during children’s viewing hours and found that 66% of the foods could be classified as HFSS foods and 53% of the foods were from major fast-food franchises. The resulting connection that longer television viewing times are associated with unhealthy food consumption is also supported empirically (Utter, Scragg, & Schaaf, 2006). The link between food marketing and childhood obesity in New Zealand is therefore supported by international and national research.

c. Is there evidence that shows effectiveness on children’s diets and/or weight through regulating food marketing?

In New Zealand food marketing is currently controlled through industry self-regulation. To provide an argument for government intervention the current self-regulatory system must be proven ineffective. International research on effectiveness of self-regulation has shown that the food industry commonly fails to adequately profile nutrient composition of foods in advertisements (Hebden, et al., 2010) and presents a high prevalence of non-compliance (Romero-Fernández, Royo-Bordonada, & Rodríguez-Artalejo, 2010). Analysis of a selection of Advertising Standards Authority (ASA) complaints, concluded that the current self-regulation by the ASA is reactive rather than proactive, lacks independent monitoring, and shows inconsistent decision-making (Thornley, Signal, & Thomson, 2010). Applied in a specific case study Hoek and King (2008) tested the New Zealand self-regulatory system and found that it did not meet the level of openness, independence or transparency that are necessary for an effective self-regulation system. The authors conclude that a government-led regulatory system would provide better protection (Hoek & King, 2008).

Overall, most countries rely on self-regulatory measures, therefore evidence for effectiveness of government interventions is still scarce. For instance evidence from the UK on restricting certain foods being advertised on television is not convincing, which may be due to diversion of marketing budgets into non-broadcast TV channels (Matthews, 2008); providing an argument for a comprehensive approach as proposed under the ‘Sydney Principles’ (e.g. cross-border media, commercial-free schools, wide definition of commercial promotions).

Creating commercial free education settings holds promise for positive dietary impact. Reducing the availability of competitive foods in schools promises to be beneficial for children’s nutrition (Fox, Meinen, Pesik, Landis, & Remington, 2005; Jaime & Lock, 2009). It has been shown that removing vending machines and restricting exposure to competitive foods in schools can positively affect children’s overall calorie intake and weight (Neumark-Sztainer, French, Hannan, Story, & Fulkerson, 2005).

There have been various modelling approaches to estimate potential effects of regulating TV advertising to children (Kelly, King, Bauman, Smith, & Flood, 2007; Magnus, Haby, Carter, & Swinburn, 2009; Veerman, Van Beeck, Barendregt, & Mackenbach, 2009). In a mathematical simulation model Veerman and colleagues (2009) approximated the possible effects on obesity rates (measured on BMI) through reducing children’s exposure to TV food advertising. Their findings suggest that up to one in three children in the US may not be obese today if they had had no exposure to TV advertising for unhealthy food; and it is proposed marketing restriction to be an effective component of a broader approach to reduce childhood obesity. Further research on direct effects on
obesity levels after restricting food marketing to children is not yet available. Under the Nuffield framework though it is still desirable to consider promising policies even if the evidence for effectiveness is incomplete (Nuffield Council on Bioethics, 2007).

d. Is regulating food marketing the least intrusive and costly whilst still achieving the aims?

The Nuffield framework makes note of precaution and proportion when designing public health policy. There is substantial evidence that obesity is a serious health threat meaning that lack of full scientific certainty is no reason to defer cost-effective public health measures. Indications that there may be potential health gains therefore justify government regulation of food marketing to children. Within the Nuffield intervention ladder, the regulation of food marketing practices can be placed somewhere between ‘enabling choice’ (for instance enabling children to change their dietary behaviour if unhealthy food is less salient) and ‘guiding choices through changing the default policy’ (for instance policies on product placements in supermarkets). The intervention is intrusive on company marketing practices, however, it does not intrude on the choices available to individuals.

As stated earlier the financial burden of obesity is high for the New Zealand government and cost-effective measures are sought for. Restricting advertising can be cost-effective, for instance a comparison of intervention costs for restricting television advertising to children found that the intervention was promising, because it resulted in a health gain compared to current practice (Magnus, et al., 2009). In Australia a modelling approach developed to assess cost-effectiveness in youth obesity showed that among 13 potential obesity interventions one of the greatest health benefits, as measured by disability-adjusted life years (DALYs), could be achieved through the reduction of television advertising of unhealthy food and beverages (Haby, et al., 2006). Hence, regulating food marketing to children seem likely to be cost-effective where small effects on the mean BMI would translate into significant population gains.

2. Will regulating food marketing create environmental conditions that can reduce childhood obesity?

The Nuffield framework recognises the role of environments for shaping people’s behaviour and choices. In relation to obesity, this equates to an ecological perspective, which considers environmental, biological and behavioural influences on energy intake and expenditure, as the causes of obesity (Swinburn, Egger, & Raza, 1999). Relevant to the debate on food marketing are ‘obesogenic’ environments, which can be defined as “the sum of influences that the surroundings, opportunities, or conditions of life have on promoting obesity in individuals or populations” (Swinburn, et al., 1999, p. 564). Creating health promoting environments is more inclusive and will less likely stigmatize individuals than targeted intervening (ten Have, et al., 2010). It is important that public health actions ‘do no harm’ and not further stigmatize obese children (Latner & Stunkard, 2003; O’Dea, 2005). Weight stigma not only threatens psychological and physical health of obese individuals, but also counters effective public health actions and increases health inequalities (Puhl & Heuer, 2010). Universal measures, as suggested under the Nuffield framework, aim to create conditions in which all individuals collectively benefit. Regulations on food marketing to children would create ‘optimal defaults’ that avoid individual focused approaches and stigmatization; and make the healthier choices the ‘easier ones’, for instance through less persuasion to consume unhealthy foods (Brownell, Schwartz, Puhl, Henderson, & Harris, 2009).
That the environments in New Zealand are ‘obesogenic’ has been shown in several studies. The high level of food and beverage advertising has already been discussed. Furthermore, it has been shown that school food environments are not conducive to healthy food guidelines in New Zealand, and commonly have more unhealthy food options available (Carter & Swinburn, 2004). Implementing statutory regulations is likely to have a direct effect on creating more health promoting environments for New Zealand children.

3. **Will regulating food marketing affect children and other vulnerable groups?**

Under the Nuffield framework vulnerability is defined as the lack of autonomy or being constrained in freely determining choices. Under this definition the framework deems children, the elderly, socially disadvantaged, and those who lack healthcare-related knowledge as vulnerable (Nuffield Council on Bioethics, 2007).

In New Zealand there is an unequal distribution of childhood obesity by socioeconomic status and ethnic grouping (Ministry of Health, 2008; Parnell, Scragg, Wilson, Schaaf, & Fitzgerald, 2003). Aspects of children’s diets and related behaviour also appear to vary between ethnic groups. Māori and Pacific households are overrepresented in socioeconomically deprived areas (Utter et al., 2007). A series of secondary analyses of the 2002 New Zealand Children’s Nutrition Survey, by Utter and colleagues, show a number of differences in nutrition practices between children of Māori, Pacific and other ethnic groups (Utter, Schaaf, Mhurchu et al., 2007a; Utter, Scragg, Mhurchu et al., 2007b; Utter et al., 2007c). For example, Māori and Pacific children are more likely to watch two or more hours of television a day, compared with other ethnicities. Māori and Pacific children are also more likely to consume the commonly advertised food products (Utter, Scragg, & Schaaf, 2006a). Children of Māori and Pacific ethnicities were more likely than children of other ethnicities to purchase breakfast, or food to eat at school, from food outlets on the way to school or the school canteen/tuck-shop (Utter, Schaaf, Mhurchu, & Scragg, 2007; Utter, Scragg, Schaaf, & Fitzgerald, 2006). A positive association between BMI and purchasing food from the school canteen was shown for all ethnic groups, but the effects were largest for Pacific students (Utter, Scragg, Schaaf, Fitzgerald, & Wilson, 2007). Food marketing practices therefore affect vulnerable groups and Māori and Pacific children are affected worse since they potentially carry a ‘double burden of vulnerability’ and would highly benefit from the proposed public health actions.

4. **Will regulating food marketing help people (a) overcome unhealthy dietary behaviour and (b) enable them to live healthy lives?**

From a stewardship perspective public health policies need to do more than simply provide information and should actively help people to easily lead healthy lives (Nuffield Council on Bioethics, 2007). Regulating food marketing would decrease children’s exposure to the promotion of unhealthy foods, which make it less likely that children will favour unhealthy foods over healthier options. By creating environments where unhealthy food is less salient, there is less persuasion and temptation to consume the marketed foods. Under the Nuffield framework it is recognized that choices result from habitual behaviour and are not voluntary. The notion of first and second-order desires helps to justify that, while children may prefer to consume certain foods, higher order desires to loose weight may be stronger yet harder to achieve since immediate pleasure satisfaction through consumption of available and familiar foods is the most salient option (Brownell, et al., 2009)
5. Are there inequalities in the burden of childhood obesity? Would regulations on food marketing reduce health inequalities?

The burden of overweight and obesity amongst New Zealand children is disproportionately located with Pacific, Māori and children from lower socioeconomic status households (Ministry of Health, 2008). Nutrition behaviours, such as purchasing commonly advertised food at school or not having breakfast, are associated with obesity, and are unequally distributed by ethnic group in New Zealand (Utter, Scragg, et al., 2007). If ethnic and socioeconomic differences are not considered through intervention design, the risk of increasing health inequalities between groups will likely be increased (Whitehead, 2007). Regulating food marketing is seen as a universal approach in the Nuffield framework because it provides conditions for health that are not reliant on an individual’s education or access. Most obesity prevention strategies lack the recognition that obesity—and its unequal distribution—is the result of a complex system that is shaped by how society is organised (Friel, Chopra, & Satcher, 2007). Traditional interventions focus on behaviour change through promoting the development of personal skills and enhancing the local environment (Flynn, et al., 2006). Their uptake is often greater in higher social status groups, increasing the social gradient in obesity (Lahelema, 2006). Public health actions must tackle the inequities in this system through aiming to create living conditions with more equally distributed material and psychosocial resources, and design environments that offer easy access and uptake of healthier options by all. The proposed actions to restrict food marketing to children therefore have the potential to reduce health inequalities; first because food marketing contributes to obesity, which has shown to be unevenly associated with dietary behaviour across population groups; and second by being inclusive in that the effectiveness is not reliant on individual uptake.

6. Will regulating food marketing coerce adults to lead healthy lives and reduce the foods available for consumption?

Regulating food marketing to children is not coercive to adults. While the extreme libertarian position considers any state intervention coercive and paternalistic, away from such an extreme position, reducing exposure to marketing is unlikely to be seen as coercion. The reasons for the proposed actions are discussed in the previous questions, with the overall aim to increase autonomy through decreasing the degree to which children’s food preferences are shaped by marketing practices.

Action to implement the Sydney Principles would not necessarily limit availability or increase price, therefore would not restrict the choice available to consumers. Marketing food to children contrarily restricts choice, since they are persuaded to consume particular foods.

7. Does regulating food marketing to children require a democratic decision-making process and/or public consultation? If yes, are any viewpoints known to date? Will food marketing regulations be subject to further democratic processes?

Within the Nuffield framework it is recognized that not all individuals can consent to a public health action. Therefore, the framework relies on democratic practices to offer the public an opinion and voice. Available public opinions on the food marketing debate in New Zealand include a parliamentary select committee report which considered different policy responses to type 2 diabetes and obesity (Health Select Committee, 2007); as well as a survey on public acceptance (ISSP) (Massey University Department of Marketing,
and parents' attitudes (Phoenix Research, 2007), and a NGO position statement (National Heart Foundation, 2005).

A review of 312 submissions to the Obesity and Type 2 diabetes select committee, concluded that overall there was strong support for Government regulation for all forms of food marketing (White, 2007). Even though food marketing was not stated in the terms of reference, close to half of the submissions proposed some form of marketing regulation. The greatest support was for Government to ban or strongly regulate television advertising, but also to forbid sponsorship that associated brands of less healthy food with schools or children’s sport. There were also propositions that food marketing across all media types should be banned or strongly regulated by Government. In sum, the health sector position advocated for government regulations and not industry self-regulation. Opponents of regulatory restrictions on food marketing included leading groups from the food and advertising industries (e.g. the Food Industry Group, the Food and Grocery Council, and the Association of New Zealand Advertisers). The Government response to this inquiry agreed that there is a need to take action on the current food marketing practices in New Zealand. It was recommended that independent monitoring positions are established and further restrictions on television advertising are implemented (New Zealand Government, 2007).

Phoenix Research (2007) conducted a telephone survey where 401 parents and grandparents of children up to the age of 13 were asked for their opinion on food marketing to children. The majority (82%) agreed or strongly agreed that advertising unhealthy products to children should be stopped. A position statement by the National Heart Foundation expresses the need to implement evidence-based strategies, such as restricting food advertising on TV, in New Zealand as an essential action against childhood obesity. The representative International Social Survey Programme (ISSP) showed strong support for state intervention to reduce obesity. Eighty percent of New Zealanders support stricter regulations on food advertising to children, 60% think the use of famous sports people in marketing should be banned, and most (70%) believe the Ministry of Health should be responsible for regulations.

Discussion

Overall the application of the Nuffield framework has provided arguments for taking government action on regulating food marketing to children in New Zealand. Through systematically answering the questions, important ethical issues in public health interventions are considered. A precautionary approach is achieved through the scientific assessment of risk, acknowledging uncertainties and new evidence; fairness and consistency; consideration of costs and benefits of actions; transparency; and proportionality. Regulating food marketing to children is justified under the Nuffield framework because childhood obesity is a serious health threat in New Zealand (1a); because there is ample evidence for a link between unhealthy dietary practices and food marketing (1b); because there is evidence that such an approach promises to be effective (1c); because it is minimally intrusive to people’s lives and is likely to be cost-effective (1d); because it helps create health promoting environments (2); because it affects vulnerable groups (3); because it will likely help children overcome unhealthy dietary behaviour (4); because it can potentially contribute to reducing health inequalities through universal measures (5); because it is not coercive and does not reduce the foods available (6); and because a recent democratic process showed a stronger vote for, compared to
against, regulation of food marketing to children in New Zealand (7).

The framework was helpful in reviewing the evidence and for considering the appropriateness of the proposed actions, because it provided a clear set of questions that brought an ethical lens to reviewing the evidence around a proposed public health intervention. This added in particular questions of proportionality, intrusiveness, and impact on equity.

Application in New Zealand

The Nuffield framework was developed in and for the UK. Public health policy and practice in New Zealand requires the unique consideration of indigenous Māori health and Treaty of Waitangi obligations (Durie, 1998; Martin, 2002; Ministry of Health, 2002). The Treaty of Waitangi is a contract between the Crown and Māori signed in 1840. The document comprises three articles. Article One (Governance/ Kawanatanga) outlines the Crown’s obligations and responsibilities to govern and to protect Māori interests. Article Two (self-determination/ tino rangatiratanga) provides for Māori to exercise control, authority and responsibility over their affairs, including health. Article Three (equity/ orietanga) addresses issues of equity and equality (Reid, 1999). Such obligations include, but go beyond, the existing focus on inequalities within the Nuffield framework. For New Zealand application, additional questions designed to test actions against the Treaty of Waitangi are needed, which could be achieved through adopting an articles-based approach. Tentative questions for illustrative purposes are provided below (Table 6) - these need further thought and development. Furthermore, the process of engagement with Māori to define and answer these questions may be as important as the question matter.

Table 6. Tentative questions

- Do Māori support the proposed action and does it match Māori health strategies?
- Will the action compromise Māori autonomy over their lives? Is the action agreed with by iwi, hapu, and whānau?
- Will the proposed action promote equity between Māori and other New Zealanders?

Intervention ladder and the ‘nanny state’

By adopting the Nuffield framework, any claims of ‘nanny state’ or stewardship can be explicitly tested to examine the foundation of such claims, and the value positions of those making such claims. The intervention ladder and principles of effectiveness, proportionality and least coercive option available, lay bare any ‘nanny state’ claims of interventions. Indeed such claims may be justified – where a proposed intervention is high on the ladder, yet claims of issue significance or intervention effectiveness cannot be adequately supported. In the case presented here, however, any claims of ‘nanny state’ in the regulation of marketing of food and beverages to children would seem unjustified. The level of coercion has been shown to be minimal; individual’s choices in products to purchase are unaffected; a strong argument is presented that childhood obesity is a significant issue; and food marketing is both a cause and plausible intervention area.
Limitations of the Nuffield Framework

The Nuffield framework has been critiqued that it is not clear how it goes 'beyond' the Millian paradigm (Dawson & Verweij, 2008). In his critique of the theoretical foundation of the Nuffield framework, Coggan (2008) points to the work by Raz (1994); who suggests that valuing individual freedom in a society contributes to a common liberal culture, which serves the whole community. Thus, from his point of view ensuring a certain amount of personal freedom itself contributes to the common good, meaning that it is important to consider intrusiveness in public health interventions to further nourish the common good towards a society where individualism and collective goods are complementary (Raz, 1994).

Another criticism is that overall the Nuffield framework lacks concern for the common good, leading to an individualistic framing of public health issues (Dawson & Verweij, 2008). We agree that a limitation of the framework is that individual freedom is predefined as a key value in the intervention ladder, which emphasizes individual over community wellbeing. The report itself also acknowledges this limitation by stating that 'critics may feel that despite the acknowledgement here of the importance of public goods and services, this framework remains too strongly committed to individual autonomy' (p.18). Unfortunately the report fails to strongly support this claim. However, building on an argument by Coggan (2008) we suggest it is the theory used to justify the framework that is weak, rather than the framework itself. As Coggan (2008) states:

"After all, if we are to be persuaded that the Nuffield Report's framework should be adopted because the ends it seeks to protect are 'good', we do not need to worry about a Millian, or any other, framework. We just need a means of assessing the goodness of any policies, based on the matters presented in the Report as important (such as reducing health inequalities, protecting vulnerable groups)" (p.800).

We found that although there is a focus on individual freedom, common goods, such as healthy environments and health inequalities, were considered through the application of our questions. Using the intervention ladder did not automatically lead to dismissing any intervention for its intrusiveness, but enabled us to consider whether the severity of childhood obesity warrants impingements on personal freedom.

The Nuffield framework does not address broader 'external' questions, such as framing the problem or whether the overall benefits are actually desirable in the given society, what Cribb describes as 'downstream ethics' (Cribb, 2010). Within the policy sciences it is recognised that the framing of a policy issue impact upon the range of identified solutions (Bastian, 2011; Fischer, 1998; Midgley, 2000). The Nuffield framework appears useful for 'downstream ethics', but is likely to have limited use in 'upstream ethics' and examination of issue definition.

How to use the Framework?

The Nuffield Report does not suggest how the framework should be used (Peckham & Hann, 2010). In this paper we have developed a set of questions that can be used to guide application of the framework when considering the ethical merits of a proposed public health intervention. This set of questions could be used in a stand-alone fashion as another
input into the policy process. Another option is to use the questions as an additional step within an impact assessment process of competing policy options. In fact a health impact assessment would likely cover some similar areas, such as consideration of impacts on health inequalities – and so would appear complimentary.

However, we suggest that the real strength of the framework lies in the ability to assess evidence claims alongside ethical principals in a way that exposes the values of those applying the framework. If two or more differing sets of stakeholders, with varying value sets, were to present their analysis and conclusions from applying the framework, this would likely constitute a useful form of issue guide within a deliberative forum. Deliberative forums (such as citizen juries) involve citizens evaluating competing moral and evidence claims to identify a collective view of a way forward (Fisher, 2009; Innes & Booher, 2003; Paul, Nicholls, Priest, & McGee, 2008). The outcomes of deliberative forums can be new policy options, that may avoid political deadlock or reversal following a change in government (Raisio, 2010). Using the Nuffield framework to insert public health ethics considerations into a citizen deliberative process is likely a practical way to inform political decisions in a contested terrain. Political decision makers still decide the final course of action, but these decisions can be informed by the deliberation results.

Conclusion
In summary, the application of the Nuffield framework was useful in evaluating the proposed intervention of child focussed food and beverage marketing restrictions, for the purpose of improving diets and preventing obesity. Applying the framework required an analysis of evidence against criteria, including proportionality of the action in relation to the public health problem; likely effect on health inequalities; and impacts on autonomy. These principles are seldom evaluated in an explicit way within literature considering policy interventions. While further work is required to translate the framework to the New Zealand policy context, particularly around Treaty of Waitangi considerations, it appears a useful starting point for more explicit consideration of ‘downstream ethics’ in development of public health policy.
References


