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Obesity and Diabetes: the Enemies Within

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So you're telling me that your family
Has a history of obesity,
You got a polycystic ovary,
You say, 'It's just the way God made me.'

It's unlikely, statistically,
To be a physical thing.
But either way it don't explain why you
Are in the queue at Burger King!

- Tim Minchin, 'Do Not Feed Doughnuts to Your Obese Children'

McDonald's signature cookies have an energy density comparable to hydrazine. Hydrazine is a rocket fuel used to manoeuvre spacecraft in orbit. It was astonishing, then, to watch a short, very pudgy child consume two boxes of the desiccated biscuits in one sitting. Unsated, he washed them down with fries and a Big Mac (energy densities equivalent to coal, or dry cow dung) before his family concluded their dinnertime outing and drove home.[2] All told, the boy grazed his way through a male adult's average daily energy intake.

Besides their colossal meal, it was an otherwise unremarkable encounter with one overweight boy and his incipiently obese parents. By all accounts, obesity-proper is far more confronting. Rotting flesh, abraded joints, specially-adapted ambulances, invasive surgeries, and the attendant humiliation all await sufferers in the short term. Cancers, type 2 diabetes and fatal cardiovascular disease lie ahead in the long term, with premature death just beyond that.[3] As such, significant scholarly attention has been devoted to studying the physiological causes of overweight and obesity. The simplest formulation says that obesity results when a person's energy intake exceeds their energy expenditure. Genetic anomalies, diet, physical activity, and sedentary lifestyles are contributory and proximal causes.[4]

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[1] BA/LLB III, The University of Sydney. Submitted 2013 under the pseudonym Victoria Maybury.
[2] Data taken from McDonald's Australia nutritional information.
[3] For a particularly graphic account of treating the morbidly obese, see Karen Kasmauski, 'Fat City', *The Monthly*, Vol. 87, (March 2013). Michael Lean, 'Health consequences of overweight and obesity in adults', in *Obesity Epidemiology: From Aetiology to Public Health,* David Crawford *et al.* eds, (New York: Oxford University Press, 2010), 43.
[4] Aviva Must and E. Whitney Evans, 'The Epidemiology of Obesity', in *The Oxford Handbook of the Social Science of Obesity,* John Cawley ed, (New York: Oxford University Press), 20-1.

Yet caught up in the distracting and largely academic quarrel over genetic versus social causes, diet versus exercise, policymakers have neglected their preventative public health functions. They have invested in the exhausted, glib explanation that maintaining nutritional health is a matter of personal and parental responsibility – a corporate defence strategy adapted from the tobacco and alcohol industries. By implication, obesity is the result of individual *ir*responsibility: poor dietary choices, idle lifestyles, questionable parenting, or inadequate resolve – behavioural 'enemies within'.

This interpretation of the obesity epidemic lazily defers some crucial questions. Is liability for obesity properly attributable to the sufferers alone? Is government intervention necessary, and to what extent? Should industry play a role? This essay hopes to reconcile medical, economic, and industry interests by arguing that intervention is justified, and that the food and beverage industry has an inevitable role to play in addressing that fundamental nutritional imbalance.

Asserting Personal Responsibility

Governments in Australia and overseas are reluctant to support strident preventative health measures to combat obesity. Implicit in their inaction is a belief that irresponsible personal choices are to blame. This derives from a simplistic understanding of the effect of social and economic factors on vulnerable people and, in some cases, a misrepresentation of the role of genetics.[5] As the federal Minister for Health in the Howard government, for instance, Tony Abbott rejected the prospect of junk food advertisement bans on children's television, declaring that:

> The only person responsible for what goes into my mouth is me, and the only people who are responsible for what goes into kids' mouths are the parents… What we really need is more responsible dietary behaviour from parents, from individuals and school canteens.[6]

Labor governments have also resisted legislative intervention. The Gillard government ignored the recommendations of its own National Preventative Health Taskforce established in 2009 to tax unhealthy food groups and phase out junk food advertising directed at children. The

[5] Christina A. Roberto and Kelly D. Brownell, 'The Imperative of Changing Public Policy to Address Obesity', in *The Oxford Handbook of the Social Science of Obesity*, John Cawley ed, (New York: Oxford University Press), 588.
[6] Belinda Kontominas and Mark Metherell, 'Junk food ban run off road', 12 April 2006, *Sydney Morning Herald*, http://www.smh.com.au/news/national/junk-food-ban-run-off-road/2006/04/11/1144521342394.html, accessed 5 August 2013.

government's response, *Taking Preventative Action,* was ambivalent and unambitious, cataloguing instead a handful of populist initiatives to develop sporting facilities and promote anti-obesity campaigns via social media.[7]

Intuitively, it is easy to understand the political appeal of the personal responsibility doctrine. It conforms to established cultural stereotypes, that 'fat people' are slothful and indolent. These stereotypes fuel interest in television programming like *The Biggest Loser*: shows which fetishise obesity, and generate their appeal from the spectacle of 'fat people' working hard to correct their dietary transgressions. Moreover, assuming collective responsibility for obesity and diabetes prevention would likely require highly invasive disincentives like sugar or beverage taxes. Policymakers are naturally eager to avoid the political liability associated with these proposals.

But our endorsement of personal responsibility paradigms highlights a more basic gap in popular understanding of the links between unhealthy lifestyles and the development of severe chronic disease. Anti-smoking campaigns have aired in Australia since the 1970s, and for 2009-14, more than $170 million in public funds has been set aside for national social marketing.[8] The duration, intensity, and visual impact of these alarming campaigns mean that Australians remain acutely aware of the causal links between smoking and lung cancer or emphysema (80-90 percent of lung cancer deaths are attributable to smoking).[9] It is more difficult to illustrate the same direct links between obesity and its corollaries. First, the ongoing *Measure Up* campaign – emphasising the correlation between waist girth and risk of chronic disease – received public funding equivalent to a third of that given to anti-smoking marketing.[10] Anti-obesity efforts are substantially lower as a federal preventative health priority, and there is no indication that this will change soon.[11]

Second, it is difficult to convey the immediacy of the obesity epidemic, and the causal link between obesity and non-communicable diseases. Overweight and obesity is highly prevalent in Australia with some 35.0 percent of adults overweight and 28.3 percent obese. The 63.4 percent of overweight or obese adults has risen from 56.3 percent in 1995.[12] 20-25 percent of the global overweight and obese population will likely acquire type 2 diabetes, which is the sixth

[7] Nicola Roxon, *Taking Preventative Action,* 11 May 2010, 34-60.
[8] Nicola Roxon, *Taking Preventative Action*, 11 May 2010, 64; Tom Carroll, 'Tobacco-control campaigns in Australia: experience', August 2007, Tobacco in Australia, http://www.tobaccoinaustralia.org.au/chapter-14-social-marketing/14-3-tobacco-control-campaigns-in-australia-experi, accessed 5 August 2013.
[9] *The health consequences of smoking: a report of the Surgeon General*, 2004, Center for Disease Control and Prevention, 39
[10] Nicola Roxon, *Taking Preventative Action*, 11 May 2010, 44-5.
[11] S. MacKay, 'Legislative solutions to unhealthy eating and obesity in Australia', *Public Health,* Vol. 125, (2011), 858.
[12] Australian Bureau of Statistics, 'Australian Health Survey: First Results, 2011-12: Overwight and Obesity', 2012, http://www.abs.gov.au/ausstats/abs@.nsf/0/034947E844F25207CA257AA30014BDC7?opendocument, accessed 5 August 2013.

leading cause of death in Australia.[13] Alarmingly, diabetes and pre-diabetes sufferers account for 65 percent of total cardiovascular disease-related deaths.[14] And globally, abnormal body mass index accounts for 23 percent of disability-adjusted life-years.[15]

But the conditions under which overweight progresses to obesity and then to diabetes are multifaceted and poorly understood by the general public. Indeed, some commentators argue that the medical community should focus less on trying to untangle the precise web of associations between obesity and secondary diseases.[16] While it appears, for example, that acquiring type 2 diabetes requires some genetic predisposition, this conclusion is not particularly insightful when up to 40 percent of people have that predisposition.[17] Moreover, the attention given to diabetes – the effects of which scarce few laypersons can describe with any accuracy or appreciate with any gravity – stands in contrast with the minimal attention given to the role of obesity in that most emotive health concern: cancer development.[18] In the United States, as many as 15-20 percent of all cancer deaths are attributable to overweight and obesity.

So to the cookie fiend and his family in McDonald's Bathurst, the obesity epidemic seems neither urgent nor particularly comprehensible. Onlookers might twitter about their poor food choices, or stare maliciously at their folds of skin, but the prevailing attitude is one of indifference: '*laissez faire,* and let them eat cake!'

Questioning the Personal Responsibility Paradigm

We defer to the personal responsibility paradigm because it minimises our collective exposure to invasive public health policies, and because we have not yet appreciated the extent of the epidemic. Both obesity and type 2 diabetes are deeply human tragedies, but that is yet to register among the public and policymakers. They are tragedies that happen to other people, after a seemingly predictable descent into sedentary living and poor eating. Neither disease has the terrifying arbitrariness of cancer, nor the abruptness of a sudden heart attack – neither seems to warrant the same degree of concern, or commitment to prevention.

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[13] Must and Evans, 'The Epidemiology of Obesity', 13; Lean, 'Health consequences of overweight and obesity in adults', 44; Australian Bureau of Statistics, 'Causes of Death, Australia, 2011: Overview', 2013, http://www.abs.gov.au/ausstats/abs@.nsf/Lookup/3303.0Chapter42011, accessed 5 August 2013.

[14] *Diabetes: the silent pandemic and its impact on Australia*, 2012, Baker IDI, http://www.diabetesaustralia.com.au/Documents/DA/What's%20New/12.03.14%20Diabetes%20management%20booklet%20FINAL.pdf, accessed 5 August 2013, 21.

[15] Stephen Lim *et al.*, 'A comparative risk assessment of burden of disease and injury attributable to 67 risk factors and risk factor clusters in 21 regions, 1990-2010: a systematic analysis for the Global Burden of Disease Study 2010', *Lancet,* Vol. 380, No. 9859, (2012), 2229.

[16] Lean, 'Health consequences of overweight and obesity in adults', 56.

[17] Lean, 'Health consequences of overweight and obesity in adults',44.

[18] Must and Evans, 'The Epidemiology of Obesity', 23.

If they proceed unchecked, however, obesity and diabetes will devastate global populations. There are strong medical and ethical justifications for intervention to positively influence patterns of consumption and lifestyles. An oft-cited prediction holds that if the number of sufferers continues to grow, children born today will enjoy shorter life expectancies than both their parents and grandparents.[19] As if to emphasise the urgency of this grim prophecy, the Australian Bureau of Statistics recently published its landmark survey into chronic disease. For every four diagnosed cases of diabetes among the respondents, the blood and urine tests uncovered one undiagnosed case.[20]

These health imperatives are buttressed by economic arguments for more vigorous intervention. In 2005, Australia spent $21 billion on annual direct costs for overweight and obesity.[21] In real terms, expenditure on type 2 diabetes management totals $6 billion annually.[22] Elsewhere, these costs are more pronounced, and foreshadow the sort of burdens Australia can expect to shoulder in the near future. The US, for instance, spent USD$147 billion in 2008 treating obesity-related illness, which accounted for 10 percent of all medical expenditure.[23] And placing a dollar value on non-tangible factors like wellbeing and satisfaction, the *Herald*-Lateral Economic Index suggests that obesity costs Australia the equivalent of $120 billion per year in lost productivity and overall happiness.[24]

These social and economic costs mount in spite of efforts to emphasise personal responsibility. That approach is clearly ineffective: changes in individual behaviour and discipline cannot explain the rapid, global rise in obesity. Nor, for that matter, can genetics. The chronic disease epidemics have exploded despite relatively stable genetic characteristics among the human population.[25] Adult and school education programs have also failed to reverse the overconsumption of high-energy, unhealthy foods and sedentary living.[26]

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[19] Rogan Kersh and James Morone, 'Obesity Politics and Policy', in *The Oxford Handbook of the Social Science of Obesity,* John Cawley ed, (New York: Oxford University Press), 159; *Diabetes: the silent pandemic and its impact on Australia*, 40.
[20] Australian Bureau of Statistics, 'Australian Health Survey: Biomedical Results for Chronic Diseases, 2011-12: Key Findings', 2013, http://www.abs.gov.au/ausstats/abs@.nsf/Lookup/4364.0.55.005Chapter1002011-12, accessed 5 August 2013.
[21] Stephen Colagiuri *et al.,* 'The cost of overweight and obesity in Australia', *Medical Journal of Australia*, Vol. 192, No. 5, (March 2010), 26.
[22] *Diabetes: the silent pandemic and its impact on Australia*, 29.
[23] John Cawley, 'The Economics of Obesity', in *The Oxford Handbook of the Social Science of Obesity,* John Cawley ed, (New York: Oxford University Press), 127.
[24] Matt Wade, 'Obesity costs drag down national good', 9 March 2013, *Sydney Morning Herald*, http://www.smh.com.au/national/health/obesity-costs-drag-down-national-good-20130308-2fr0b.html, accessed 5 August 2013.
[25] Must and Evans, 'The Epidemiology of Obesity', 21.
[26] Marlene B. Schwartz and Kelly D. Brownell, 'The need for courageous action to prevent obesity', in *Obesity Epidemiology: From Aetiology to Public Health,* David Crawford *et al.* eds, (New York: Oxford University Press, 2010), 426-7.

Yet there is a more pernicious side effect of the personal responsibility doctrine. It has ushered into practice the 'holistic approach' to combating obesity: that is, a set of guidelines which encourage consumers to address both sides of the energy imbalance (consumption and exercise). This is, in theory, a very sensible and comprehensive approach to prevention. In practice, it relies on empty exhortation, and serves as a rhetorical conceit which allows industry stakeholders to parry responsibility. Eager to prove their ethical credentials, most fast food and beverage manufacturers have developed responsible consumption principles which – nominally – promote a holistic attitude to food. Take the Coca-Cola motto, for example, buried in the depths of its corporate FAQ webpage: 'Think, Drink, Move'. Likewise, Cadbury's Be Treatwise program describes its mission as: 'to educate and remind people that confectionary is... designed to be enjoyed as part of a balanced diet and active lifestyle'. The emphasis in each case is not on moderation or abstinence. Instead, they encourage consumers to increase their energy expenditure, thereby accommodating the tablespoon of sugar ingested with the product.

These observations confirm what is clear from the US and Europe: central to the food industry's corporate responsibility mission is a selective emphasis on physical activity over diet, insistence on personal responsibility, and a denial of the good food/bad food dichotomy.[27] The CEO of Coca-Cola, Muhtar Kent, provided a typical illustration of this faux-conscientious marketing in an article for the *Wall Street Journal*: 'Obesity is a serious problem. We know that. And we agree that Americans need to be more active and take greater responsibility for their diets.'[28] Reducing weight necessarily entails a reduction in energy consumption or an increase in energy expenditure. Commercial interests are best served by preserving the rate of consumption, and instead making appeals to exercise and physical activity.

As the Gillard government's *Taking Preventative Action* report suggests, this deflection routine has contaminated policymaking. Governments across the world – with the exception of the occasional Mayor Bloomberg – avoid antagonising the food industry with taxes or onerous licensing regimes. Like industry, the Gillard government committed to sporting initiatives whilst rejecting many of the recommendations touching on food packaging and taxation.

In part, this attests to the weight of commercial advocacy bodies. The Australian Food and Grocery Council has been particularly resistant to the introduction of highly effective, colour-coded 'traffic light labelling'. The current daily intake guide was indeed implemented to delay the development of such a labelling system. In Europe, the food industry spent €1 billion

[27] Schwartz and Brownell, 'The need for courageous action to prevent obesity', 430; MacKay, 'Legislative solutions to unhealthy eating and obesity in Australia', 898.

[28] Muhtar Kent, 'Coke Didn't Make America Fat', 7 October 2009, *Wall Street Journal*, http://online.wsj.com/article/SB10001424052748703298004574455464120581696.html, accessed 5 August 2013.

opposing the same proposal.[29] Political representations are particularly virulent in the US where PepsiCo alone spent USD$9 million in 2009 to lobby Congress. More perversely, the US Sugar Association threatened the World Health Organisation that it would lobby the US government to withhold funding because the WHO had reported strong links between sugar and chronic disease.[30]

So policymakers are stuck in a trap of industry's design. Through the personal responsibility conceit, and the 'holistic' Think. Drink. Move. discourse, the debate over tackling obesity has been reduced to a simplistic binary: consumption and substance control versus the promotion of physical exercise. It is a neat and digestible expression of the basic obesity problem – energy-in > energy-out – but it is a one dimensional caricature of the complex factors behind obesity control.

Towards a Truly Holistic Approach

A truly holistic approach to obesity prevention will take into account the social, economic, and marketing factors influencing consumption beyond mere personal choice. Naturally, this requires aggressive scrutiny of advertising and pricing practices. But importantly, obesity control will also require government collaboration with the food and beverage industry. These public-private partnerships form an important part of the anti-obesity strategies of international organisations like the European Union and WHO. In 2006 the EU public health commissioner said: 'You cannot legislate on what people eat. You have to form public-private partnerships. We are all... part of the problems and are all part of the solution.'[31]

After the foregoing discussion, there seems to be few compelling reasons to include corporate stakeholders as partners in any preventative healthcare model. Across tobacco, alcohol and fast food, industry researchers tend to distort science in favour of their commercial interests; their lobbyists obstruct public health initiatives; and they seem incapable of reconciling their overconsumption-oriented business models with affirmations of corporate responsibility.[32] Any overtures made by industry to government are seen as a 'delaying tactic' (recall the daily intake

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[29] MacKay, 'Legislative solutions to unhealthy eating and obesity in Australia', 900.
[30] Rob Moodie *et al.*, 'Profits and pandemics: prevention of harmful effects of tobacco, alcohol, and ultra-processed food and drink industries', *Lancet,* Vol. 381, (February 2013), 674.
[31] Corinna Hawkes, 'Public health sector and food industry interaction', *European Journal of Public Health,* Vol. 21, No. 4, (2011), 400.
[32] This argument is elaborated upon in Rob Moodie *et al.*, 'Profits and pandemics: prevention of harmful effects of tobacco, alcohol, and ultra-processed food and drink industries', 670-5.

guide) and self-imposed initiatives like product reformulation are merely 'damage-limitation exercise[s]'.[33] It would seem more appropriate to engage the law. Legislation can be used to:

> counter, alter or remove deleterious environmental influences on food choices… to create incentives and disincentives that indirectly shape consumer behaviour through tools such as taxes and subsidies.[34]

Research from the Cancer Council in Victoria suggests that despite perceptions of obesity as a problem of individual responsibility, the public are increasingly supportive of nutritional and labelling regulation, for example.[35] Proponents of unilateral regulation envisage that obesity prevention will follow the path of tobacco control.[36] Restricting advertising, sales, packaging and smoking in public has proven relatively effective in arresting rising cigarette user rates, and in drawing attention to the health consequences of smoking.

Analogising obesity control with tobacco control overlooks a number of important distinctions between the two, however. Combating smoking and lung cancer requires total abstinence from cigarette use, and the progressive extinction of the tobacco industry. Combating obesity requires a small change in a person's overall energy balance: one study has found that weight gain in 90 percent of the US population could be prevented by reducing the positive energy imbalance by as little as 100kcal/day.[37] Whether or not responsibility is attributed to individual or corporate behaviour, the necessary change in consumption and activity patterns is minimal – a question of degrees.

The flexible nature of obesity control contributes to the problems discussed above, namely, that stakeholders can apportion and redistribute blame to other stakeholders. But treating obesity control like tobacco control would be more problematic. The tobacco industry exerted tremendous effort in lobbying and litigating against regulation, because smoking and cancer control was an existential threat to the industry. Governments could avoid much of the same resistance to food and beverage control if they adopted a more conciliatory approach. There is the grain of an uncomfortable truth in Muhtar Kent's complaint that governments and public health advocates are unhelpfully 'demonising' food and beverage industries. The more

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33 Moodie *et al.*, 'Profits and pandemics: prevention of harmful effects of tobacco, alcohol, and ultra-processed food and drink industries', 675.

34 MacKay, 'Legislative solutions to unhealthy eating and obesity in Australia', 897.

35 MacKay, 'Legislative solutions to unhealthy eating and obesity in Australia', 898.

36 Shawna L. Mercer *et al.*, 'Drawing possible lessons from obesity prevention and control from the tobacco-control experience', in *Obesity Epidemiology: From Aetiology to Public Health,* David Crawford *et al.* eds, (New York: Oxford University Press, 2010), 271.

37 James Hill, 'Physical activity and obesity', *Lancet*, Vol. 363, (January 2004), 182. See also: Must and Evans, 'The Epidemiology of Obesity', 26.

they do so, the greater the resistance. Governments can negotiate this resistance on favourable terms – they need not inflame it.

Much of the criticism of public-private partnerships turns on the submissiveness and deference of government to their more dominant commercial 'partners'. That power imbalance must be corrected for collaboration to work, and government must articulate a 'coherent and agreed-upon framework for interaction'.[38] At times, restoring the dominance of government will necessitate legislating in the face of commercial interests, and the *failure* to legislate for more effective labelling, for instance, has only made the imbalance more pronounced. But policymakers should remember that they do not need to alienate industry to achieve public health objectives and that, in any case, they do not possess the political fortitude to fight industry over every regulatory initiative. Self-regulation will remain a fixture in obesity control.

In time, governments will find it easier to work productively with industry. The emergence of anti-obesity industries like organic food, sportswear, and fitness is particularly interesting. Last year, Bank of America Merrill Lynch released a report detailing investment opportunities in that space.[39] It was lambasted by obesity control advocates as an example of industry cynicism toward public health, but it illustrates how economic interests stack up on both sides of the public health spectrum. Moreover, as unhealthy foods become increasingly vilified and out-regulated, large food corporations have shown themselves capable of accommodating by directing resources into other healthier areas of their product line. Solely fast food corporations like McDonald's have a greater investment in maintaining the status quo, but they too have shown themselves eager to comply with most self-regulation commitments over labelling, advertising, and product reformulation. Fast food companies in particular cannot afford more negative publicity.

Conclusion

The personal responsibility paradigm has resulted in a lacuna of public health policies addressing the structural causes of obesity. Governments have been caught up in the food politics of 'energy-in-energy-out' without asking *why* almost 10 percent of the Australian population visits McDonald's every day, *why* Indigenous communities suffer disproportionately high rates of obesity and diabetes, *why* ultra-processed, highly palatable foods are cheaper than

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[38] Moodie *et al.*, 'Profits and pandemics: prevention of harmful effects of tobacco, alcohol, and ultra-processed food and drink industries', 670.

[39] 'Globesity – the global fight against obesity', 21 June 2012, Bank of America Merrill Lynch, http://www.foodpolitics.com/wp-content/uploads/Globesity-Report_12.pdf, accessed 5 August 2013.

healthy alternatives, or *why* a small boy still ploughs through burgers and biscuits for dinner despite school curriculums saturated in healthy eating education.

Food access, for instance, has not been sufficiently addressed. There are strong correlations between the cost of foods and overconsumption of that food. Unhealthy foods are typically cheaper than healthy varieties, and consumption of those foods is higher in low income Australian families.[40] Moreover, the price of unhealthy foods are decreasing and that of healthy food increasing: between 1990 and 2007, the real price of a 2L bottle of Coca-Cola fell 34.9 percent whilst between 1997 and 2003, the real price of fruits and vegetables rose 17 percent.[41] In Australia, the cost of food generally increased by 34 percent between 2003 and 2004.[42] Globally, food systems are geared towards high calorie production and in many OECD nations, farm subsidies indirectly subsidise fast food production.[43]

The unambitious *National Food Plan* white paper devotes two pages to the question of food access. The Australian Government pledges to promote awareness among Australians about food choices, but it provides no material policies to subsidise healthy food consumption or incentivise healthy food production.[44] Instead, it makes vague references to industry self-regulation, and even then, on industry's terms.

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Clearly, understandings of personal responsibility will play an important role in any obesity control regime. Eliminating it entirely is unhelpful. The cliché that genetics absolve individuals of any liability for obesity is exactly that: a cliché. Moreover, it 'medicalises' the obesity epidemic, placing emphasis on cure rather than prevention. The recent US Federal Drug Administration approval of two new weight loss pills in the US – after a 13 year hiatus – is some indication that that paradigm is gaining traction. But attending to the medical factors contributing to obesity should not detract from education and awareness initiatives. At a fundamental level, education relies on the premise that informed people will at least try to behave more healthily.

Yet people do not get fat for want of 'personal responsibility'. That explanation cannot explain the scope or severity of the obesity-diabetes epidemics. It is an exaggerated caricature of

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[40] Deanne Condon-Paoloni, 'Food costs, diet quality and risk of disease', *Nutrition and Dietetics*, Vol. 68, (2011), 244.
[41] US prices reported. John Cawley, 'The Economics of Obesity', 124-5.
[42] Claire Palermo, 'The cost of nutritious food: a determinant of health', *Nutrition and Dietetics*, Vol. 68, 246.
[43] Olivier De Schutter, 'Report submitted by the Special Rapporteur on the right to food', 26 December 2011, United Nations General Assembly, A/HRC/19/59, 20.
[44] *National Food Plan*, 2013, Australian Government, http://www.daff.gov.au/__data/assets/pdf_file/0011/2293328/national-food-plan-white-paper.pdf, 62-3.

the myriad factors which influence consumption and lifestyle patterns of individuals. It allows government and industry to play pass-the-parcel with obesity, without meaningfully addressing the structural roots of overconsumption: cost of living, manipulative marketing, nutritional misinformation and – often overlooked – simple palatability.

But consumption is the half of the obesity equation which has the greatest effect, and over which we have the most control. Governments must work constructively with the food industry to manage it. This public health crisis is not perfectly analogous to the tobacco wars, and heavy, unilateral regulation is not warranted. Public health advocates reach too readily for the gun: industry can be a partner in the solution, albeit a subordinate one. But governments must also cooperate firmly. Commercial interests tend towards inaction. Policymakers must set measurable objectives, and drive industry toward their fulfilment. In any case, the status quo is unsustainable. Australia is already the muffin top of Asia, and it is killing our citizens. 'The enemy within' is a lazy, outdated political attitude to obesity control.

Bibliography

Australian Bureau of Statistics, 'Australian Health Survey: First Results, 2011-12: Overwight and Obesity', 2012, http://www.abs.gov.au/ausstats/abs@.nsf/0/034947E844F25207CA257AA30014BDC7?opendocument, accessed 5 August 2013

Australian Bureau of Statistics, 'Australian Health Survey: Biomedical Results for Chronic Diseases, 2011-12: Key Findings', 2013, http://www.abs.gov.au/ausstats/abs@.nsf/Lookup/4364.0.55.005Chapter1002011-12, accessed 5 August 2013

Australian Bureau of Statistics, 'Causes of Death, Australia, 2011: Overview', 2013, http://www.abs.gov.au/ausstats/abs@.nsf/Lookup/3303.0Chapter42011, accessed 5 August 2013

Carroll, T., 'Tobacco-control campaigns in Australia: experience', August 2007, Tobacco in Australia, http://www.tobaccoinaustralia.org.au/chapter-14-social-marketing/14-3-tobacco-control-campaigns-in-australia-experi, accessed 5 August 2013

Cawley, J., 'The Economics of Obesity', in *The Oxford Handbook of the Social Science of Obesity,* Cawley, J. ed, (New York: Oxford University Press)

Colagiuri, S. *et al.,* 'The cost of overweight and obesity in Australia', *Medical Journal of Australia*, Vol. 192, No. 5, (March 2010)

Condon-Paoloni, D., 'Food costs, diet quality and risk of disease', *Nutrition and Dietetics*, Vol. 68, (2011)

De Schutter, O., 'Report submitted by the Special Rapporteur on the right to food', 26 December 2011, United Nations General Assembly, A/HRC/19/59

Diabetes: the silent pandemic and its impact on Australia, 2012, Baker IDI, http://www.diabetesaustralia.com.au/Documents/DA/What's%20New/12.03.14%20Diabetes%20management%20booklet%20FINAL.pdf, accessed 5 August 2013

'Globesity – the global fight against obesity', 21 June 2012, Bank of America Merrill Lynch, http://www.foodpolitics.com/wp-content/uploads/Globesity-Report_12.pdf, accessed 5 August 2013

Hawkes, C., 'Public health sector and food industry interaction', *European Journal of Public Health,* Vol. 21, No. 4, (2011)

Hill, J. 'Physical activity and obesity', *Lancet*, Vol. 363, (January 2004)

Kasmauski, K., 'Fat City', *The Monthly*, Vol. 87, (March 2013)

Kent, M., 'Coke Didn't Make America Fat', 7 October 2009, *Wall Street Journal*, http://online.wsj.com/article/SB10001424052748703298004574455464120581696.html, accessed 5 August 2013

Kersh, R. and Morone, J., 'Obesity Politics and Policy', in *The Oxford Handbook of the Social Science of Obesity,* Cawley, J. ed, (New York: Oxford University Press)

Kontominas, B. and Metherell, M., 'Junk food ban run off road', 12 April 2006, *Sydney Morning Herald*, http://www.smh.com.au/news/national/junk-food-ban-run-off-road/2006/04/11/1144521342394.html, accessed 5 August 2013

Lean, M., 'Health consequences of overweight and obesity in adults', in *Obesity Epidemiology: From Aetiology to Public Health,* Crawford, D. *et al.* eds, (New York: Oxford University Press, 2010)

Lim, S. *et al.*, 'A comparative risk assessment of burden of disease and injury attributable to 67 risk factors and risk factor clusters in 21 regions, 1990-2010: a systematic analysis for the Global Burden of Disease Study 2010', *Lancet,* Vol. 380, No. 9859, (2012)

MacKay, S., 'Legislative solutions to unhealthy eating and obesity in Australia', *Public Health,* Vol. 125, (2011)

Mercer, S.L. *et al.*, 'Drawing possible lessons from obesity prevention and control from the tobacco-control experience', in Obesity Epidemiology: From Aetiology to Public Health, Crawford, D. *et al.* eds, (New York: Oxford University Press, 2010)

Moodie, R. *et al.,* 'Profits and pandemics: prevention of harmful effects of tobacco, alcohol, and ultra-processed food and drink industries', *Lancet,* Vol. 381, (February 2013)

Must, A. and Evans, E.W., 'The Epidemiology of Obesity', in *The Oxford Handbook of the Social Science of Obesity,* Cawley, J. ed, (New York: Oxford University Press)

National Food Plan, 2013, Australian Government, http://www.daff.gov.au/__data/assets/pdf_file/0011/2293328/national-food-plan-white-paper.pdf, accessed 5 August 2013

Palermo, C., 'The cost of nutritious food: a determinant of health', *Nutrition and Dietetics*, Vol. 68, (2011)

Roberto, C.A. and Brownell, K.D., 'The Imperative of Changing Public Policy to Address Obesity', in *The Oxford Handbook of the Social Science of Obesity,* John Cawley ed, (New York: Oxford University Press)

Roxon, N., *Taking Preventative Action,* 11 May 2010

Schwartz, M.B. and Brownell, K.D., 'The need for courageous action to prevent obesity', in *Obesity Epidemiology: From Aetiology to Public Health,* Crawford, D. *et al.* eds, (New York: Oxford University Press, 2010)

The health consequences of smoking: a report of the Surgeon General, 2004, Center for Disease Control and Prevention

Wade, M., 'Obesity costs drag down national good', 9 March 2013, *Sydney Morning Herald*, http://www.smh.com.au/national/health/obesity-costs-drag-down-national-good-20130308-2fr0b.html, accessed 5 August 2013