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Obesity framing for health policy development in Australia, France and Switzerland

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Abstract
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Keywords
development, policy, health, australia, framing, france, obesity, switzerland

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Obesity Framing for Health Policy Development in Australia, France, Switzerland

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Abstract

The obesity epidemic is a consequence of the interaction of cultural, environmental, genetic and behavioural factors; framing the issue is central to determining appropriate solutions. This study used content and thematic framing analysis to explore portrayal of responsibility for obesity in policy documents in Australia, France and Switzerland. For Australia and France, obesity causality was a combination of individual and environmental factors, but for Switzerland it was predominantly individual. The primary solutions for all countries were health promotion strategies and children's education. Industry groups proposed more school education while health advocates advised government intervention. Where France emphasized cultural attitudes towards taste, Australia focused on sport. The French were most keen on legislating against unhealthy foods, compared with Switzerland where there was opposition towards regulation of individual's choices. To curb the increasing prevalence of obesity, allocation of responsibility needs to be considered and initiatives enacted accordingly.

Introduction

Obesity levels have been increasing consistently over the past three decades across many developed countries. With rates expected to continue rising, the impact on health services is significant (OECD, 2010). The obesity epidemic is a consequence of the interaction of cultural, environmental, genetic and behavioural factors. Economic, social and physical living environments are linked to this increase, which has been termed an 'obesogenic environment' (OECD, 2010; Branca et al., 2007). With such varied aetiology, determining strategies to combat obesity is difficult. Ascribing causation and assigning responsibility alters how the public perceives issues and the type of government 'response' that is deemed appropriate (Kersh and Morone, 2002; Lawrence, 2004; Stone, 1989). If health issues are defined or 'framed' as 'individualized' then people are held personally accountable for their health behaviour, but where the cause is 'environmental', government policy or regulation is expected (Lawrence, 2004). Issue framing is, therefore, central to determining the range and type of interventions considered relevant to tackling the obesity epidemic.

The aim of this research was to examine public health documents in three western nations using framing theory, and to explore how issue framing is reflected in public health policies, strategies and programmes to combat obesity. Specific objectives were to explore the framing of obesity in terms of individual or systemic causality and responsibility, and to identify common themes within countries regarding attitudes to diet and activity

Causal Theory, Framing and Health Policy

Framing theory uses conceptual constructs to link to people's core values and beliefs (Entman, 1993). To commence policy-making, public health issues are framed in terms of cause and perceived risk (Talley and Crews, 2007). Stone (1989) proposes that political actors deliberately compose stories to determine cause, link risk with an identifiable agent and influence audience perception to gain support. Individualized frames indicate personal responsibility, compared with systemic frames where industry or environment/society are blamed and government is accountable (Lawrence, 2004).

This research study is based on Entman's (1993) theory of communication, and Stone's (1989) causal theory. Stone's (1989) methods involve determining causality in an attempt to allocate responsibility for the problems and their solutions. Entman (1993) states that frames are created from four areas of the communication process: 'Communicator', 'Message', 'Receiver', and 'Culture'. In this research this process identifies how politicians and advocates (the 'communicators') portray the obesity problem and solutions ('message' or key words) to their audience (the 'receivers' whose opinion may be shaped by this message). 'Culture' represents common themes within countries regarding attitudes towards diet and activity.

Case countries

The three countries chosen for the study were Australia, France and Switzerland as they have distinctive national cultures in terms of political and health structures, regulation and policy. Furthermore, rates of obesity differ between the countries with Australian levels much higher

than Europe (table 1). In adults, obesity levels are increasing - a Swiss study showed that adult levels of overweight and obesity in 2011 had reached 45.4% and 13.4% respectively (Chappuis et al., 2011). However current studies confirm that obesity levels in French and Australian children have stabilized and even reduced slightly, although rates remain high (ABS, 2011; DREES, 2011).

Australia is a parliamentary democracy with a universal healthcare system where health policy reflects a collaboration between the Federal Department of Health and Ageing, State departments, statutory authorities and advocacy groups (Hilless and Healy, 2001). France is a unitary state with a pluralistic healthcare system and universal medical coverage funded by Statutory Health Insurance. The Ministry of Health is principally responsible for health policy and funding with planning at the regional level (Sandier et al., 2004; Steffen, 2010). Switzerland has a Federal Parliament under a collegial system and comprehensive health coverage financed via obligatory insurance with twenty-six cantons, each with separate constitution, legislation and financing (OECD, 2006).

Hofstede et al (2010), in their analysis of national cultures, compared nations on the five dimensions of power distance, individualism, masculinity, uncertainty avoidance and long-term orientation. They describe Australia, France and Switzerland as individualistic nations, where people care for themselves and their family. According to Hofstede et al (2010), Australians are a relaxed society but individualistic, competitive and self-reliant. The French expect inequalities, centralize power and are more interested in quality of life, solidarity and caring for others. In Switzerland, while there is some difference between the German and

French-speaking parts, overall the Swiss believe in ideologies and rules, minimizing inequalities, and are intolerant of unconventional behaviour.

Methods

A content and thematic framing analysis was conducted on government documents, and non-government organisations' (NGO) submissions to government, related to obesity within each country. Grey literature was included. Relevant documents included press releases, policy statements, obesity-reduction programmes, White Papers, professional conference proceedings and research reports prepared for government or NGOs. The period of investigation covered the years 2000-2011 inclusive, as analysis commenced in 2012 and earlier scoping searches found no documents dated prior to 2000.

Sampling Frame

An internet search was conducted to find all government and NGOs' submissions which contained the words 'obesity', 'obese' or 'overweight' (or the French variants). Documents were limited to those at the federal/national level, as inclusion of regional or state documentation was considered beyond the scope of this study. The primary search included all government and ministry health departments, followed by medical, dietetic and health organisations. Documents from industry and stakeholder groups were included if they were submitted to government. Document inclusion was based on the criteria that obesity and overweight were the primary topics for the report, and where the following were discussed: obesity causes, e.g. marketing, environmental or genetic; obesity problems, e.g. chronic disease risks, increased health expenditure; and/or solutions e.g. school physical activity,

banning of specific advertisements.

The exclusion criteria included regional programmes, newspaper and journal articles, and discussion of diseases where obesity was part of the cause and not the primary topic. For example where a document reviewed diabetes and mentioned obesity as a cause. Articles exclusively describing obesity prevalence were excluded if they did not specify causation or describe solutions. In total, 152 documents were considered eligible for this review (Table 2).

Once the publications were retrieved, each document was read prior to coding, to enable the analyst to become familiar with the data and note any recurring topics. Any particular interpretation or association between these topics/themes and specific advocacy groups was also recorded. The researcher read all the documents in their original language of English or French.

Coding

Both traditional and interpretive content analyses were used (Ahuvia 2001). Coding consisted of three stages where texts were read, coded and the results interpreted. Traditional content analysis was conducted for the more straightforward analyses, such as identifying the communicators. Interpretive content analysis enabled a more holistic approach, improving the researcher's ability to derive complex interpretations and context from the whole text, for example, common themes and references to culture (Ahuvia 2001).

Documents were coded for content relating to the following questions:

Q1. Who are the advisors, coalitions and advocates involved *(The Communicators*)?

Q2. Who are the policies and strategies aimed at (*The Receivers*)?

Q3. How is causality of obesity portrayed?

Q4. Are there similar primary objectives and themes throughout (*Text*)?

Q5. Are any common frames portrayed between countries (*Culture*)?

Several sub-themes were identified: Causality was separated into individual or environmental responsibility. Solutions were assigned according to: individual, government, industry, social/environmental or other. Text was further analysed by strategies to reduce obesity, prompts to government or industry and whether the underlying theme was related to responsibility for solutions, for example, schools, parents, government or industry, or describing the causative problem for example, sedentary lifestyle or urbanisation.

Coding sheets were developed *a priori* to facilitate coding decisions, with definitions and instructions for use. These were then refined during initial analyses as ambiguities in coding arose. The same coding sheets were used throughout to ensure continuity. Standardized prompts, for example, 'individual' or 'environmental' responsibility, were used on the coding sheets, to enable the coders to consistently identify the framing process. These were developed in accordance with the research questions and sub-themes. Each prompt had a box to write further comment or copy relevant text. Documents were analysed by reading each one thoroughly to identify common themes, whilst making notes on the coding sheets with reference to page numbers. Manual coding was determined to be more appropriate as the sub-themes were varied and computer analysis required predefined frames, limiting further exploration. Relevant text was selected from the documents to illustrate the researchers'

findings and interpretations regarding the communicator's approach towards obesity and to determine any common themes or references to 'culture'. A random selection of five English language documents was double-coded by a second researcher (KJ) and the responses were compared. The inter-reliability rating (Cohen's Kappa) was 0.8. This was a high rating, however differences were noted in the assessment of culture, a more 'interpretative' element of the analysis. Therefore coding sheets were revised with instructions for searching for specific terms, in order to make decision-making more standardised and transparent.

Analysis

This study incorporates qualitative analyses to capture the content and context within the documents with a focus on examining the differences, or similarities, between countries regarding the communicators, receivers, culture and how responsibility was interpreted. Themes, or messages, were established from text relating to proposed solutions and who should implement them. Recurrent patterns or words emerging from the text were highlighted. An excel spreadsheet with all data from the coding sheets was compiled and further analysis was conducted on this document. The relative proportion of whether documents from each country accorded more individual or environmental responsibility was recorded, together with the proffered solution. This was examined in conjunction with the document source and the communicators to determine whether there were commonly-shared frames and institutional influences within and/or between countries. Data were analysed across timelines for each country to identify any similarities in policy development.

Whilst reading the reports, repeated references to cultural attitudes were discovered and specific search terms were developed to capture these issues. In longer reports, text was searched directly using specific terms, e.g. 'Australian' or 'way of life', 'français', 'goût', 'vie', 'Suisse'.

Results

The results are shown under subheadings according to the research questions asked. The number of documents retrieved each year increased until 2009 for Australia (AUS) and until 2010 for France (FR). The number of Swiss (CH) documents were similar each year from when they commenced in 2003 (see Figure 1).

Communicators

Twenty seven organisations were the originators of the communications in Australia, including various government departments. The earliest file dated from 2001. The reports were primarily from the government and government-funded organisations (54/87; 62%) but also included submissions from various advocacy groups, particularly health and medical organizations (see Table 2), including the Australian Medical Association and the Preventative Health Taskforce. Other documents included government-produced media releases, strategy papers and clinical guidelines. There were a higher number of files from Australian medical and health organisations compared to France and Switzerland.

The French documents included 20 different communicator organisations, primarily government or government-associated groups (33/39; 85%), with a few government-

produced media releases. The earliest document was from 2000. The Programme National Nutrition Santé produced 11 reports.

The earliest Swiss document was released in 2003. The communicators were predominantly government-associated organisations (20/26; 77%), with the major contributors being Promotion Santé Suisse (9/26, 35%) and Suisse Balance (4/26, 15%).

Receivers

Within the Australian documents, there was a wide range of receivers – groups primarily aimed at supporting population health, spread between government, health professionals, advocacy groups, industry, media, workplaces, schools, community groups, and parents. The French documents were predominantly directed toward government along with health professionals and schools. The Swiss documents were largely aimed at the role of Federal government to establish national frameworks and standards between cantons.

Causality

Statements relating to the factors surrounding obesity causation were made in 95% of the Australian, 89% of the Swiss and 87% of the French documents. The causative factors included environmental, i.e. industry advertising, urbanisation, economics and genetics; and individual, i.e. diet and sedentary lifestyles. In Australia, responsibility was divided between environmental (68% of documents) and individual (58%) with greater emphasis on environmental causes. There was no apparent change across the decade studied. The government described several socio-economic factors, but their primary focus (mentioned in 62% of documents) was on lifestyle choices and lack of exercise:

‘Our lifestyles have changed, kids don’t walk to school enough…they play too many video games instead of being out playing sport’. *(Abbott, 2006)*.

The government-associated organisations emphasized a combination of individual (57%) and environmental (59%) factors with slightly more focus on environmental causes. Health associations discussed predominantly environmental, obesogenic and industry-related causes (84%) including unhealthy foods, marketing, urban development and lack of school physical activity:

‘..those sections of the food industry that market and profit from energy dense and nutrient poor food products, are not bearing the full costs of their activity, but are shifting costs onto the public sector and general community’. (*Australian Medical Association, 2009)*.

The industry documents supported an individual’s ability for self-regulation, although Nestlé (2008) discussed ‘shared responsibility’ whilst recommending ‘ending the blame-game’.

Causality in Switzerland was framed as a combination of individual and environmental factors with slightly more emphasis on individual (72%) than environmental (68%) responsibility:

‘The primary risk factors are modifiable – excessive or unbalanced food intake – poor dietary behaviour; sedentary lifestyle’. (*Observatoire Suisse de la Santé, 2007).*

The medical professionals emphasized both factors, specifically lack of physical activity, excess dietary intake and societal changes such as increased multimedia, migration,

marketing and working parents. Health insurance companies were split between health behaviours, genetics and environmental causes. The reports from Swiss Balance suggested more individual and family responsibility. Promotion Santé Suisse suggested high-energy diet, urbanisation and genetics. There was no change across the decade studied.

Over two-thirds of the French documents, including the majority of government departments, suggested environmental and economic factors were responsible, with <25% indicating both individual and environmental causes. Individual factors were discussed alongside environmental and social perspectives and a destructuring of family life. Environmental responsibility was referred to more frequently after 2005. The few documents from non-government health organisations framed the causations of obesity across the range of the individual's sedentary behaviour, excessive consumption and environmental factors.

Message

Common themes were noted regarding the objectives and proposed solutions to obesity. This comprised medical or educational strategies, along with environmental considerations and policy development, including increased industry regulation. All the countries made frequent reference to the increased problems of low socio-economic groups, such as access to healthy, affordable food, and recognized the need for health promotion strategies that employed multiple actors:

'The struggle against excess weight involves the participation of numerous actors: government, health authorities, medical professionals, schools, parents, food industry and the

media. Its success depends upon the mobilization and collaboration of all actors concerned'. (*Office Fédéral de la Statistique Suisse, 2007*)

There were many proposals, particularly from government departments, for parental involvement. School and family education programmes were considered the primary targets for most government and NGOs within each country. French and Australian communicators recognised that an exclusively individual approach would have no lasting benefit, instead opting for a more environmental, community-based approach with national coordination.

Australian recommendations, particularly government departments, while still focussed on schools, were more directed towards physical activity.

In Switzerland, solutions remained largely portrayed as individual responsibility by both government and NGOs. Health insurance groups advocated individual or family approaches to weight loss. According to one health insurance group:

'a healthy diet, associated with regular physical activity, constitutes the best form of prevention'. (*Groupe Mutuel Assurance, 2008).*

Approximately half of the Australian and French documents recommended that solutions should come from collaboration with businesses, such as the food industry. In Australia, this was primarily suggested by health professionals, such as the Australian Medical Association, in contrast with France, where government made the proposals. In Switzerland, this view occurred in under 20% of the documents, generally from health advocacy groups rather than government.

Legislation was one area where frames diverged. The French perspective was to initiate policy regarding the food industry and media (Ministère de la Santé, 2008). In Australia, alongside current industry self-regulation, there were proposals by advocacy groups to: '..prohibit the broadcast advertising of energy-dense and nutrient-poor food products and beverages to children'. (*Australian Medical Association, 2010*).

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In contrast, both government and non-government documents suggested that the Swiss people do not support legislating on individual behaviour but encourage self-regulation, particularly on an issue not yet considered a major health concern.

'Until now, child obesity has not been recognized as a disease by the Federal government and no treatment has been financed by the health funds, which goes against international opinion'. (*Farpour-Lambert et al.,* 2007).

Common Frames and Culture

Almost half of the French documents contained numerous comments defining the French attitude towards food. These included the importance placed on the social role of food and eating, family meal-times and the pleasure of eating, whilst appreciating the taste and origins of numerous, fresh foods:

'To eat is not only a functional act; it is a daily, shared pleasure that obeys certain principles: conviviality, variety of foods, regular meal-times and a meal structure based around three fundamental courses. These rules define the French culture of eating'. (*Programme National pour l'Alimentation, 2011).*

In 15 Australian documents (17%), culture was discussed, primarily related to physical activity. The Australian comments tended to display a more negative outlook, with people perceiving overweight as ‘normal’ and how current lifestyles foster sedentary behaviours. Eight (31%) Swiss documents discussed cultural attitudes, describing the overall Swiss view of obesity, health and sport as individual responsibility.

Discussion

The communicators in all countries included primarily government, industry, and health professionals but the balance of these groups varied. The French had a mix of government and government-funded departments with selected advocacy groups and one major government project (Programme National Nutrition Santé). France uses a system of Health Technology Assessment which has increased regulation and negotiation between key stakeholders, such as medical professionals and government. This leads to more effective lobbying from experts, alongside political involvement, partly as healthcare is funded by the public budget (Weill and Banta, 2009). With few documents directly from government, three national Swiss health groups proposed the majority of strategies. Swiss healthcare provision is not harmonized, lacking national coordination. Instead, it is predominantly driven by health insurance companies, potentially leading to conflicts of interest which challenge and influence healthcare priorities (Koch et al., 2009).

In Australia, the factors surrounding obesity were described at length within various documents. Responsibility was assigned differently depending on the communicators involved. Similarly, Olsen et al (2009) found various communicators assigned responsibilities differently, for example health advocacy groups suggested obesity was predominantly industry-related compared with government, who incorporated lifestyle choices alongside environmental factors. In Switzerland, responsibility for obesity ascribed by health groups was split between either individual and family, or urbanization and genetics. In France, many reports emphasised solutions, with little association with blame or causality.

Such portrayal was similar to the work of Saguy et al (2010) who found obesity was portrayed as a social-structural problem with finding solutions a state priority.

For all three countries the importance of the government developing health promotion strategies was consistent with contemporary academic literature (Swinburn, 2008). Nonetheless, the documents in each country noted there were many factors to consider (Branca et al., 2007) and the solutions proposed were diverse, varying between countries. All countries acknowledged a need for national coordination and collaboration between key stakeholders.

All the countries considered that children were the most important group in which to encourage behaviour change and comprehensive strategies targeting school programmes were the primary objectives, with programmes aimed additionally at families. However, the issue of school health education has been considered to be a more 'downstream' strategy promoting self-management (Millstone and Lobstein, 2007). Such a focus indirectly suggested that children were responsible for their lifestyle choices rather than incorporating an enabling role for legislation (Henderson et al., 2009). 'Upstream' measures, such as banning advertisements and junk food sales in schools, were not as frequently mentioned in the documents. This may be because such strategies have been identified as not readily acceptable to industry stakeholders (Millstone and Lobstein, 2007).

Although the WHO (Branca et al., 2007) has recognized the necessity to develop policy in collaboration with stakeholder groups to address the issue of obesity, policy strategies were

not consistently mentioned in the three countries. In Australia and France, about half of the documents recommended industry regulation as a strategy to address obesity, in contrast with under 20% of Swiss documents. This lower priority of policy strategies may be due to the federal government in Switzerland having limitations on its structural capacity to instigate such policy and it must rely instead on cantonal and voluntary participation as such powers are devolved to this level (Macri and Battino, 2012).

Policy approaches may also reflect wider socio-political factors. In Australia, neoliberal policies were adopted under the notion that private markets were more economical and efficient than government. This has impacted healthcare provision in Australia, leading to a more decentralized system, industry self-regulation and individualized approach to health (Henderson et al., 2009, Townend, 2009). In contrast, the universal, socialist healthcare system was introduced in France in 1945, with the most recent reform the 2004 Public Health Bill. Centralized governance has increased the government's ability to intervene and legislate (Steffen, 2010). These results suggest similarities to Hofstede et al's (2010) cultural dimensions model with Australia being more autonomous, France's principles of equality and solidarity, and Switzerland's more conventional beliefs. Socio-political factors need to be taken into consideration when exploring and advocating policy options to address public health issues.

The media has been identified as a politically important area for legislative consideration, as increased television viewing times and industry food advertising are associated with rises in obesity, particularly in children (Harris et al., 2009). The French have already committed to

government regulations on media, for example obligatory health messages on certain food advertisements (Hercberg et al., 2008). In Australia, there have been proposals for government to prohibit food advertising directed at children and to improve food labelling (MacKay, 2011). However, clarity of purpose of such regulations is hampered by a confusing array of voluntary codes and a system that relies on self-regulation (King et al., 2011). Similarly, regulations on media in Switzerland had not significantly progressed, as the Swiss did not view obesity as a major health concern needing government intervention or health insurance funding. However the Swiss government has commenced development of food labelling policy (PSS, 2010).

Recurring themes throughout the documents involved cultural attitudes to food or lifestyle. Many reports characterized the French culture as taking pleasure in eating and the primary solution was portrayed as redefining the attitude to food using taste. Similar French attitudes to food have been shown to shape media reporting and impact policy development (Saguy et al., 2010). In Australia, there was discussion of culture with sport playing an important role. The Swiss recognized the challenge to change family lifestyles and associated obesity with the influx of foreign junk foods ('Americanization') which correlates with other findings (Saguy et al., 2010).

Limitations

The researchers followed a systematic and transparent process, however some limitations to the study are acknowledged. Only internet-based documents were used. However sampling documents from the year 2000 via the internet should include most, if not all, relevant

documentation on obesity. Due to the different countries involved, accessing non-internet based documents was considered out of this study's scope.

This study analysed published documents according to specific criteria. No documents from regional or state government were included, which may have provided further insights into how obesity is framed at the local level within each nation. Therefore some documents from other sources may not have been identified or others excluded. However the expansive searching and spread of the sample reduces the likelihood that documents were omitted.

Subjective bias may have occurred during familiarization and reading of the documents, coding and interpretation. Specific coding questions limited this effect by ensuring all possible data were collected and, secondly, another analyst double-coded several documents to validate the coding sheets.

By just examining published documents, it was not possible to differentiate the extent to which the wording of the documents reflected individual authors or institutional positions. The communicators may be influenced by associated institutions. Any such potential influence is outside the scope of this study and the authors limited the analysis to the perspectives outlined within the documents according to the primary communicators.

Another potential limitation was that only Swiss documents in French were used. However many of these documents would have been officially translated into French from German, and thus it was considered that the study would have included most documents available.

However, the original official translation from German to French (and then by the primary researcher into English) could alter the original meaning slightly. For the purposes of this paper, the researcher translated any relevant text into English using the whole text as a guide for the appropriate context.

Conclusion

This research focussed on the framing of causation and responsibility for action to address obesity within policy documents in Australia, France and Switzerland. Policy recommendations were found to reflect both government structures and socio-political perspectives. Despite differences being found in the framing of responsibility for tackling overweight and obesity in the policies of the three countries, the prevalence of the conditions rose in all the countries during the study period (2000 – 2011). This could be for a number of reasons. The allocation of responsibility within policy documents may not have been appropriate, proposed implementation of initiatives to tackle overweight and obesity were not undertaken by those assigned responsibility and/or enacted initiatives were not effective. Future research should focus on what governments do, as well as what they say should be done, if the increasing prevalence of overweight and obesity is to be curbed. This could include evaluating effectiveness of national and regional programmes such as school nutrition education or social marketing initiatives to improve individuals' food choices.

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Table 1: Change in obesity rates in Australia (AUS), France (FR) and Switzerland (CH)

Country / Year	**Adults**	**Adults**	**Children[1]**	**Children[1]**
	Overweight (inc. obese)	**Obese**	**Overweight (inc. obese)**	**Obese**
AUS 2007-8	61 %[a]	24 %[a]	25%[a]	8%[a]
AUS 1995	57 %[a]	19 %[a]	21%[a]	5%[a]
AUS 1989	38 %[a]	9 %[a]		
FR 2008	38.2%[b]	11.2%[b]	17.8%[b]	3.5%[b]
FR 2002/2000	37.5 %[b]	9.4 %[b]	18%[c]	4%[c]
FR 1990	29.7%[b]	5.8%[b]	12%[c]	3%[c]
CH 2009	-	-	17.9%[d]	5.2%[d]
CH 2007	37.3%[b]	8.1%[b]	14.9%[d]	4.3%[d]
CH 2002	37.1%[b]	7.7%[b]	19.4%[d]	6.5%[d]
CH 1992	30.3%[b]	5.4%[b]		

References: a) ABS, 2011; b) OECD, 2011; c); IASO, 2004; d) Aeberli et al., 2010

Note 1: The age range of the children involved in the studies of overweight and obesity for Australia was 5-17 years; France was 3-17 years; Switzerland was 6-12 years.

Table 2: Number of documents retrieved and their source: Australia (AUS), France (FR), Switzerland (CH)

Number of documents	AUS	FR	CH
– found using initial search terms	1538	1628	416
– retained after exclusion	87	39	26
Document Source			
Government Health Department	37	16	1
Government created and/or funded organisations	17	17	19
Medical organisations	12	2	4
Industry submissions	3	2	2
Health organisations	12	1	0
Research Institutes	6	1	0

Figure 1: The number of documents retrieved per year for Australia (AUS), France (FR) and Switzerland (CH)