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How do different stakeholder groups influence public health policy? Thematic content analysis of responses to a public consultation on the regulation of television food advertising to children in the UK

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3 1 TITLE PAGE
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6 2 Article Title: How do different stakeholder groups influence public health
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8 3 policy? Thematic content analysis of responses to a public consultation on the
9
10 4 regulation of television food advertising to children in the UK
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30 **Abstract**

31 *Objectives:* We explore one aspect of the decision-making process - public consultation on
32 policy proposals by a national regulatory body - aiming to understand how public health
33 policy development is influenced by different stakeholders.

34 *Design:* We use thematic content analysis to explore responses to a national consultation on
35 the regulation of television advertising of foods high in fat, salt and sugar aimed at children.

36 *Setting:* United Kingdom.

37 *Results:* 139 responses from key stakeholder groups were analysed to determine how they
38 influenced the regulator's initial proposals for advertising restrictions. The regulator's
39 priorities were questioned throughout the consultation process by public health
40 stakeholders. The eventual restrictions implemented were less strict in many ways than
41 those originally proposed. These changes appeared to be influenced most by commercial,
42 rather than public health, stakeholders.

43 *Conclusions:* Public health policy-making may prioritise commercial over public health
44 interests. Tactics such as the questioning and reframing of scientific evidence may be used.
45 In this example exploring the development of policy regulating television food advertising to
46 children, commercial considerations appear to have led to a watering down of initial
47 regulatory proposals. This seems likely to have compromised the ultimate public health
48 effectiveness of the regulations eventually implemented.

49

50 **Article Summary – Strengths and limitations of this study**

- 51 • We explore one aspect of the policy making process, namely an Ofcom stakeholder
52 consultation over television advertising restrictions on high fat, salt and sugar foods.
- 53 • Established qualitative methodology was used to evaluate all stakeholder responses
54 to this consultation allowing us to identify arguments used in making both pro- and
55 anti-restriction arguments.
- 56 • Policy-making can be influenced through other non-public means. Therefore, we are
57 unable to comment on how other methods of influencing policy-making may have
58 affected this consultation's outcome.

59
60

60 **Background**

61 The commercialisation of food has led to changes in our dietary habits.¹ This, combined with
62 more sedentary lifestyles has resulted in a large increase in the burden of obesity and non-
63 communicable diseases.² Foods high in fat, salt and sugar (HFSS) are a contributing factor to
64 increasing rates of non-communicable disease³ and have therefore become a target for
65 public health action.⁴ The World Health Organization (WHO) has encouraged member states
66 to take action on non-communicable diseases, including through regulation of the
67 advertising of HFSS foods.⁵ However, a 2016 study found that no member states had
68 implemented comprehensive legislation or enforced mandatory regulations regarding
69 marketing of unhealthy food and beverages to young people,⁶ despite multiple systematic
70 reviews and journal articles demonstrating how food marketing contributes to childhood
71 obesity.⁷⁻⁹ Industry groups often seek to influence public health policy.¹⁰ For example, in
72 2003 a WHO recommendation suggested people should reduce their sugar intake. This
73 resulted in the Sugar Association (a sugar industry information group) pressing the US
74 Congress to cut WHO funding.¹¹

75 Influences on public health policy regarding food are not limited to the food industry. Health
76 professionals, charities, politicians and members of the public have all attempted to
77 influence public health policy making through directly lobbying policy makers and running
78 publicity campaigns in order to influence public opinion. Evidence of the impact of these
79 activities is hard to find in peer-reviewed literature.

80 Systematic reviews^{12,13,14} have demonstrated how the alcohol and tobacco industries focus
81 on lobbying efforts and promoting self-regulation as means to minimise the impact of public
82 health policy on commercial activities. A recent South African study exploring how the policy
83 around alcohol marketing was formulated demonstrated the strategic use of evidence and
84 how commercial and financial interests use influence to avoid regulations.¹⁵ These tactics
85 have also been seen in relation to food where, in one case study, government opinion
86 reflected industry rather than public health opinion.¹⁶ However, at present, we have limited
87 insight into how stakeholders other than those representing industry interests attempt to
88 influence public health policy in general or dietary public health policy in particular.
89 Identifying strategies and arguments used by these interested parties in a public setting may

90 help inform how public health policy is determined and how it might more effectively be
91 developed in the future.

92

93 ***Policy context***

94 In December 2003, the UK Government asked Ofcom (the UK communications industry
95 regulator) to consider proposals for strengthening rules on television advertising of food
96 aimed at children. (Fig 1). Ofcom decided to use the Food Standards Agency's Nutrient
97 Profiling Model to determine which foods were classified as HFSS. Ofcom originally put
98 three proposed 'packages' of regulations to public consultation in March 2006 (Packages 1-3
99 in Table 1). Following this, Ofcom produced an alternative package of restrictions (Modified
100 Package 1 in Table 1) in November 2006, on which Ofcom again consulted.

101 Figure 1: A timeline of the Ofcom process on developing new recommendations for limiting
102 television food advertising to children.

103 Table 1: Packages of regulations proposed by Ofcom in the initial consultation (March 2006)

Options	Detail
Package 1	<ul style="list-style-type: none"> • No HFSS* food advertising during programmes specifically made for children • No HFSS food advertising during programmes of particular appeal to children+ aged 4-9 years
Package 2	<ul style="list-style-type: none"> • No food or drink advertising during programmes made specifically for children or of particular appeal to children aged up to 9 years
Package 3	<ul style="list-style-type: none"> • Volume of food and drink advertising to be limited at times when children are most likely to be watching
Modified Package 1	<ul style="list-style-type: none"> • As per package 1 except restrictions on HFSS food advertising to be extended to programmes of particular appeal to children aged 4-15 years

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2
3 104 * 'Interested parties' are stakeholder groups who may have been affected by the proposed changes, including
4 105 advertising agencies, advocacy groups, broadcasters, charities, healthcare associations, politicians, the food
5 106 industry and the general public.
6
7

8 107 Following the second consultation (November 2006), modified package 1 was
9 108 recommended by Ofcom and was implemented from January 2009. A comparison of the
10 109 final regulations implemented to the initial packages proposed suggests that the
11 110 consultations had substantial impacts on policy decisions. The only independent evaluation
12 111 of the regulations eventually implemented found no change in the proportion of
13 112 advertisements seen by children that were for HFSS foods from before to after
14 113 implementation.^{17,18} A '9pm watershed' (i.e. no advertising of HFSS foods before 21.00hr) is
15 114 now the preferred option of many civil society organisations¹⁹ as well as Public Health
16 115 England²⁰ and was a manifesto pledge by the Labour party for the 2017 general election.²¹
17 116 The recently released Childhood Obesity Plan Chapter 2 also proposes a 9pm watershed.²²
18 117 The consultations on the Ofcom regulations on the restriction of television food advertising
19 118 to children offers an opportunity to analyse responses from a range of stakeholder groups
20 119 to a consultation on an important policy that aims to promote dietary public health through
21 120 regulation of the food industry. We aimed to identify which arguments, and from whom,
22 121 appeared to be most influential in shaping the changes in Ofcom's position from the initial
23 122 consultation to the final recommendations.
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41 124 **Methods**

42
43 125 We followed the Standards for Reporting Qualitative Research²³ in reporting our findings.
44

45 126 ***Patient and Public Involvement***

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47
48 127 This study did not involve use of patient identifiable data and only used publicly-available
49 128 responses from stakeholder groups.
50

51 129 ***Data Sources***

52
53
54 130 We qualitatively analysed all written responses from stakeholder groups to the 2006-7
55 131 Ofcom public consultation on the regulation of television advertising of food and drink to
56 132 children. Responses were freely available on the Ofcom website²⁴ and responses to both the
57 133 first and second consultations were included. Responses from individual members of the
58
59
60

1
2
3 134 public were not included as they tended to be very brief and non-specific. We therefore
4
5 135 focused our analysis on key stakeholder organisations representing key constituencies.
6
7 136 Where needed, Optical Character Recognition software was used to transcribe the
8
9 137 responses. The consultation questions can be seen in Table A in the Appendix.
10

11 138

13 139 **Data Analysis**

14
15 140 Conventional thematic content analysis²⁵ was used to analyse the data and the Framework
16
17 141 method²⁶ used to organise and chart data. This method involves creating coding categories
18
19 142 directly from the data and organising coding within a flexible matrix, which can then be
20
21 143 adjusted as more codes emerge from the text. As existing literature on the topic of
22
23 144 stakeholder influence on public health policy is limited, rather than using preconceived
24
25 145 categories with which to code the data, a new framework for analysis was developed, based
26
27 146 on no *a priori* assumptions. After familiarisation with the data, coding was performed line by
28
29 147 line for each of the responses from interested parties in NVivo (software developed by QSR
30
31 148 International for qualitative research).

32
33 149 Each response was assigned to a category based on the organisation from which it
34
35 150 originated to stratify responses between the various types of interested parties (Table 2).

36
37 151 The longest and second longest submissions from each category were then coded to
38
39 152 develop the initial framework.

40
41 153 Table 2: The categories into which stakeholder groups were classified. A list of each group
42
43 154 classified by category can be found in the Appendix.

Category	Definition
Advertising stakeholders	Advertising companies and representative bodies
Broadcast stakeholders	Broadcasting companies and representative bodies
Civil society groups	Groups that represent the interests of all or some of the general population. This does not include groups that may have

	affiliations with industry who would be included in one of the 'stakeholders' groups.
Food manufacturers	Companies that produce and sell food to retailers
Food retailers	A company that sells food to the general population
Food industry representative groups	Bodies that represent the interests of groups of food manufacturers and retailers
Politicians	Persons professionally involved in politics
Public health stakeholders	Groups that focus on promoting the health of the population

155

156 Following coding of the first two longest responses by in each category by AR, a set of codes
 157 to apply to further responses was agreed between all authors. Codes were also grouped
 158 into themes at this stage to provide the most meaningful thematic coding of the data. The
 159 remaining responses were all coded using this analytical framework by AR with additional
 160 codes being created when needed. Once each of the responses was coded, a 10% sample of
 161 the data were independently duplicate-coded by one of the other authors (JA or MW) in
 162 order to ensure appropriate categorisation of the various codes and code hierarchy, and to
 163 improve internal validity. Using a matrix, the data were charted resulting in a summary of
 164 the data by category from each transcript. Illustrative quotations were highlighted at this
 165 point.

166 The resulting charted data were then interpreted and analysed to determine recurrent
 167 themes or topics. These were explored further using quotations to demonstrate the range
 168 of opinions in relation to each theme or topic. The positions taken by the interested parties
 169 were then compared to Ofcom's starting position and final statement, to identify which
 170 positions from which stakeholders appeared to have held the most influence on Ofcom's
 171 final position.

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3 172
45 173 **Ethics**

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8 174 Ethical permission was not sought for this study. The consultation responses used have
9
10 175 been made freely available on the Ofcom website with the full knowledge of their authors.
11
12 176 We, therefore, treat this as publically available data which does not require ethical
13
14 177 permission for analysis. As we did not seek informed consent from the authors of
15
16 178 consultation responses, we do not name them here – although names were provided on the
17
18 179 Ofcom website. Instead, we have used only the categories described in Table 2 to identify
19
20 180 quotations in our results. This also avoided the study from becoming too focused on specific
21
22 181 stakeholder groups rather than building a general picture of arguments used by different
23
24 182 stakeholder groups.
25

26 183

27 184 **Results**

28
29 185 Of 1136 responses received to both rounds of consultation, 997 were from individual
30
31 186 members of the public (and thus excluded from the analysis); 139 were from stakeholder
32
33 187 groups and were included in the analysis; 114 were responses to the initial consultation and
34
35 188 25 responses to the second consultation. The vast majority of responses from individuals
36
37 189 were one-line statements of support for some form of restrictions without directly
38
39 190 addressing specific issues concerning implementation. As such it was determined that there
40
41 191 was not sufficient detail to determine arguments used, or positions taken. Therefore, these
42
43 192 responses are unlikely to have influenced Ofcom other than to reaffirm that there was
44
45 193 public support for some form of restriction.
46

47 194

48
49 195 The stakeholder responses varied in length from a few lines to double-digit numbers of
50
51 196 pages. Most took the form of an initial broad statement outlining a policy position with
52
53 197 supporting evidence, followed by shorter responses directed at addressing the specific
54
55 198 questions in the consultation as outlined by Ofcom (shown in Table A, Appendix).

56 199
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60

200 The organisations in the stakeholder groups outlined in Table 2 broadly fell into two
 201 separate categories. Civil society groups, politicians and public health stakeholders were
 202 encouraging of restrictions in order to reduce the exposure of children to advertising of
 203 HFSS foods. Advertising stakeholders, broadcast stakeholders, food manufacturers, food
 204 retailers and food industry stakeholders argued that restrictions would minimally impact
 205 childhood obesity whilst having a substantial impact on businesses. Though there were
 206 subtleties within each group with regards to what level of restrictions would be ideal, there
 207 were not sufficient differences in order to further analyse the differences in responses of
 208 the various stakeholder groups beyond these two broad categories.

209 The key changes from the initial Ofcom position to the final recommendations are
 210 summarised in Table 3. Arguments relating to each of the principles below, as outlined in
 211 the recommendations, were captured from the framework and are described in detail.

212 Table 3: The changes in Ofcom's position during the course of the consultation

Initial options presented by Ofcom	Consultation responses and Ofcom's reaction	Ofcom's final position	Reference in consultation
<i>Ofcom's packages 1-3 varied on 3 key principles:</i>			
1. Restrictions on advertising of all foods versus just HFSS foods	Following the first consultation it was clear that the majority of responses preferred restricting advertising of only HFSS foods.	The eventual package of restrictions enacted was specific to HFSS foods.	Ofcom Executive Summary 1.12
2. Total ban on food advertising versus volume-based restrictions	Almost all stakeholders did not consider volume based restrictions as being effective at reducing exposure to advertising and this option was dismissed following the first consultation.	There was a total ban enacted on HFSS food advertising in programming 'of particular interest to' children.	Ofcom Executive Summary 1.12

<p>3. Restrictions only on children's channels versus all programmes 'of particular interest' to children, irrespective of channel</p>	<p>Some responses highlighted that children may watch adult TV and a ban on all less healthy food advertising before a 9pm watershed may be more effective than focusing specifically on children's programming. Other responses worried that this would disproportionately impact advertising revenues.</p>	<p>Ofcom rejected the idea of a pre-9pm ban due to concerns about the effect it would have on broadcasters, programming and advertising revenues.</p>	<p>Ofcom Executive Summary 1.12</p>
<p><i>Further changes that were made:</i></p>			
<p>Restrictions should apply to children aged 4-9 years</p>	<p>Many responses pointed out that children are legally defined as under 16 years.</p>	<p>The restrictions applied to children aged 4-15 years.</p>	<p>Ofcom Final Statement 4.9</p>
<p>All restrictions should start in April 2007</p>	<p>Children's channels argued that they should be allowed a transitional period as they would be affected financially.</p>	<p>Children's channels were allowed a phased implementation of restrictions, with final implementation by January 2009.</p>	<p>Ofcom Final Statement 5.3/5.4</p>

213

214 ***To which foods should restrictions apply?***

215 There was non-partisan agreement that having a blanket ban on all television food
 216 advertising was counter-productive and had the possibility of inadvertently reducing
 217 exposure of children to advertisements for healthier products.

218

219 Quotes: Should restrictions apply to all foods?

220 *“We do not support any options which would restrict advertising of all foods, including foods*
221 *such as fruit and vegetables, milk and dairy products. These foods can play an important*
222 *part in children consuming a balanced diet, and we consider that advertising can play a*
223 *useful role in educating both parents and children in the ways to achieve this.”* (Food
224 industry stakeholder)

225 *“[Public health stakeholder] believes that it is desirable to distinguish between healthy and*
226 *unhealthy foods. We do not believe it would be useful to restrict the advertising of all foods*
227 *because this would mean manufacturers and retailers would be unable to promote healthy*
228 *foods, such as fresh fruit and vegetables.”* (Public health stakeholder)

229

230 As the underlying aim of the restrictions was to protect health, preventing the advertising of
231 healthy products would be counter-productive. Stakeholder groups agreed that banning
232 advertisements of all foods would be deleterious to efforts to promote healthy eating and
233 promoting a balanced diet.

234

235 **Total ban or volume based ban?**

236 The idea of a broad volume based restriction rather than a total ban targeting children’s
237 programming was proposed in Package 3 and was nearly universally disliked. Broadcasters,
238 advertisers and food industry stakeholders argued that a volume-based restriction would
239 have a very large effect on commercial revenues, whereas public health stakeholders and
240 civil society groups cited how little a volume-based restriction would actually reduce the
241 exposure of children to HFSS food advertising.

242

243 Quotes: Would a volume-based restriction be effective?

244 *“The least acceptable option would be Package 3, which would have a devastating effect on*
245 *our overall revenues - several times greater than Ofcom has estimated – while delivering a*

1
2
3 246 *smaller reduction in the number of times children see food and drink adverts.” (Broadcast*
4 stakeholder)
5 247

6
7 248 *“Package 3 not only restricts the option to promote healthy foods to children, but also fails*
8 *to restrict HFSS adverts during periods of viewing when many children are still watching i.e.*
9 *up to 9pm.” (Public health stakeholder)*
10 249
11 250

12
13 251

14
15 252 Many responses argued that Package 3 would result in very little change in exposure of
16 children to television advertising of HFSS foods but would substantially impact broadcasters
17 and advertisers financially. Arguments concerning commercial impacts were used
18 throughout the responses of industry groups, with emphasis on the fact that as a broadcast
19 regulator, Ofcom has a duty to minimise impact on revenues for broadcasters.
20 254
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24 258 ***Restrictions on children’s programming or a pre-9pm watershed ban?***

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28
29 259 Although not included in any of Ofcom’s proposals, civil society groups and public health
30 stakeholders called for restricting all HFSS food advertising before a 9pm ‘watershed’ (Box
31 3). Advertisers, broadcasters and the food industry claimed such restrictions would impinge
32 upon adult viewing. All three groups highlighted the trade-off between protecting children
33 and the loss of advertising exposure to adults. Advertisers, broadcasters and food industry
34 groups cited the negative commercial impacts of a pre-9pm watershed ban as outweighing
35 any ‘marginal’ public health benefits; whereas civil society groups and public health groups
36 saw the public health benefit of a pre-9pm watershed ban as outweighing commercial
37 impacts.
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49 269 Quotes: Arguments pertaining to the pre-9pm watershed ban on HFSS food advertising

50
51 270 *“[Food industry stakeholder organisation] welcomes Ofcom’s rejection of the pre-9pm*
52 *watershed, as this would have been tantamount to a complete ban on the advertising of*
53 *food and soft drink products on television, and would have impacted on adult airtime.”*
54 271
55 272

56
57 273 (Food industry stakeholder)
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2
3 274 *“We believe that the most suitable option is the pre 9pm ban of HFSS advertising, for the*
4
5 275 *following reasons:*
6
7 276 *• achieves one of the key regulatory objectives, that of significantly reducing the impact of*
8
9 277 *HFSS advertising on younger children*
10
11 278 *• removes 82% of the recorded HFSS advertising impacts on all children (aged 4-15)*
12
13
14 279 *• contributes substantially to enhancing protection for older children by reducing their*
15
16 280 *exposure to HFSS advertising*
17
18 281 *• offers the greatest social and health benefits of all options – in the ranges of £50 million -*
19
20 282 *£200 million per year or £250million - £990 million per year (depending on the value of life*
21
22 283 *measure)”. (Civil society group)*
23
24 284 *“The avoidance of intrusive regulation of advertising during adult airtime is only justifiable*
25
26 285 *once full account has been taken to address the over-riding priority to protect children’s*
27
28 286 *health. At times when adults and children are watching, the need to protect children must*
29
30 287 *take priority.” (Public health stakeholder)*
31
32 288
33
34 289 Ofcom rejected banning HFSS food advertising before a 9pm watershed due to the effect
35
36 290 this was expected to have on adult viewing times and commercial revenues, suggesting that
37
38 291 industry arguments were more persuasive on this topic. Industry groups successfully argued
39
40 292 that adult viewing should be unaffected despite the possibility that both children and adults
41
42 293 may be watching television together. The need to protect the right of adults to see
43
44 294 whatever they wish was a common argument against restricting advertising on television
45
46 295 channels that were not explicitly targeted at children. The individual freedom of an adult
47
48 296 therefore appeared to be given precedence over exposing children to HFSS food advertising.
49
50 297 Ofcom’s research showed that 48% of parents supported restricting HFSS food advertising
51
52 298 before 9pm, which was often cited by industry responses as evidence of a lack of public
53
54 299 support. Some responses highlighted the fact that the complete figures were 48% in support
55
56 300 of a pre-9pm watershed ban, 24% against the ban, with the remainder undecided. An
57
58 301 apparently valid complaint made by public health groups regarding this issue was that
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60

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3 302 Ofcom did not ever consult on a pre-9pm watershed ban despite its own research showing
4
5 303 this would reduce the exposure of children to HFSS advertising by 82%.

6
7 304 We are also able to see here the use of evidence-based arguments by the civil society group
8
9 305 in making their case. Often civil society groups and public health stakeholders would cite
10
11 306 evidence to support their argument. Food industry representative groups on the other hand
12
13 307 tended to cite a lack of evidence and sought to downplay the existing evidence.

14
15 308

16
17 309 ***To what ages of children should the restrictions apply?***

18
19
20 310 Ofcom initially planned to restrict advertisements targeted at children aged 4-9 years.
21
22 311 Under 4s were thought to have little influence over what foods and drinks were given to
23
24 312 them and therefore not considered as part of the restrictions. Throughout the consultation
25
26 313 food industry representative groups and food manufacturers argued that restricting
27
28 314 advertisements to children aged 4-9 was appropriate, whereas as public health stakeholders
29
30 315 argued that this should be expanded to cover children aged 4-15 years (Box 4).

31
32 316

33
34 317 Quotes: Arguments pertaining to the age of children to which restrictions should apply

35
36 318 *“It is neither logical nor is there any explanation as to why Ofcom should propose to limit the*
37
38 319 *focus of regulation to children aged under 10. The government asked Ofcom to consider*
39
40 320 *proposals for strengthening its rules on television advertising of food to children. It did not*
41
42 321 *ask Ofcom to limit its focus to any particular age group. Ofcom should logically apply*
43
44 322 *restrictions according to its own definition of children (aged 15 [or under]).”* (Public health
45
46 323 stakeholder)

47
48 324

49
50 325 *“Children develop and refine their ability to interpret advertising messages as they get older.*
51
52 326 *Existing studies suggest that by 10 years old (indeed, most studies suggest an even earlier*
53
54 327 *age) they are considered to have sufficient cognitive development to understand the*
55
56 328 *implications of television advertising.”* (Food manufacturer)

57
58 329

59
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1
2
3 330 *“We are alarmed by the decision to extend volume and scheduling restrictions of food and*
4
5 331 *drink advertising to children under 16. The intention of Ofcom and the government has*
6
7 332 *always been to protect younger children and industry responded on this basis. Ofcom has*
8
9 333 *previously stated that it wished to find a proportionate solution and we question the*
10
11 334 *evidence base on which this decision was made. A review of Ofcom’s own literature would*
12
13 335 *seem to contradict the question put to consultation and support the conclusion that young*
14
15 336 *people are capable of differentiating between programming and advertising.” (Food*
16
17 337 *industry representative group)*

18 338
19
20 339 The logic of defining children as aged 4-9 years was questioned by many stakeholders as,
21
22 340 according to Ofcom and in the UK, children are legally defined as those under the age of 16
23
24 341 years. A number of food manufacturers stated that they already did not advertise their
25
26 342 products to children under 8-12 years. They argued that during adolescence children
27
28 343 become ‘media literate’ and are able to understand advertising and should therefore not be
29
30 344 a target of the restrictions.

31
32 345 Industry arguments appeared to suggest that media ‘illiterate’ children need protecting
33
34 346 from HFSS food advertising whereas public health groups suggested all children needed
35
36 347 protecting regardless of how ‘media literate’ they are. Public health groups argued that
37
38 348 adolescents are still susceptible to advertising, have more purchasing power and greater
39
40 349 pester power than younger children, and may not appreciate the health implications of a
41
42 350 poor diet. Ofcom concluded that expanding restrictions to include children aged 4-15 was
43
44 351 appropriate.

45 352

46
47
48 353 ***When should the restrictions start?***

49
50 354 The need for a transitional period was also hotly debated (Box 5). Public health stakeholders
51
52 355 and civil society groups suggested that as companies were already aware that restrictions
53
54 356 were due to be enforced any transitional period should be minimal. Industry groups argued
55
56 357 that a transition period was necessary to allow adjustments to be made.

57
58 358

1
2
3 359 Quotes: Arguments pertaining to the need for a transitional period
4

5 360 *"We do not believe [a] transitional period is appropriate. The arguments for "phasing in"*
6
7 361 *restrictions appear to be of a commercial nature and not supportive of the policy's public*
8
9 362 *health objectives."* (Public health stakeholder)
10

11 363 *"We would ask for a transitional period of at least three years. This would allow production*
12
13 364 *companies to adjust, and the growing number of public companies to issue profit warnings*
14
15 365 *where necessary."* (Broadcast stakeholder)
16

17 366
18

19
20 367 Instead of starting restrictions soon after announcement of the final policy statement
21
22 368 (February 2007), a phased transition over 1-2 years was implemented (varying for different
23
24 369 channel types), suggesting industry arguments held more weight on this point. Despite the
25
26 370 stated objective of minimising the exposure of children to HFSS food advertising, it appears
27
28 371 that Ofcom was more concerned about the potential commercial impact of advertising
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30 372 restrictions and delayed enforcement of the restrictions as a result.
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3 375 **Discussion**
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5 376 ***Summary of principal findings***
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8 377 This study presents a unique opportunity for a detailed analysis of responses to a public
9 378 consultation on a public health policy in the UK. Such data is often not in the public domain
10 379 and these data therefore offer a rare opportunity for scientific scrutiny. For example,
11 380 responses to the 2016 consultation on the UK Soft Drinks Industry Levy, have not been
12 381 released. Our paper highlights how, despite the relative transparency of the 2006-7
13 382 consultation, policy appeared to be substantially influenced, most importantly by
14 383 commercial stakeholders.
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23 385 As far as we are aware, this is the first analysis to examine how a range of stakeholder
24 386 groups influenced the development of a public health policy aiming to regulate food
25 387 industry advertising. Ofcom's decision to implement Modified Package 1 contained
26 388 concessions to commercial as well as civil society and public health stakeholders. However,
27 389 ultimately industry arguments appeared to hold more sway, with the main concession to
28 390 public health groups being expanding restrictions to children aged 4-15. For the most part,
29 391 Ofcom appeared to make concessions to industry arguments. Ofcom appeared to believe
30 392 that the commercial impact of the regulation of advertising should carry greatest weight,
31 393 even when the aim of the regulation was to protect children's health. As such, Ofcom
32 394 rejected a pre-9pm ban, as proposed by public health and civil society stakeholders, instead
33 395 approving a two year transition period and emphasising the need for 'proportionate action'.
34 396 Some public health advocates argued that Ofcom, being a broadcast regulator rather than a
35 397 public health stakeholder, felt an obligation to protect industry interests. The case for
36 398 restricting advertising was made in a Department of Health 'white paper' (NHS Strategy
37 399 documents are known as 'white papers'). However, Ofcom was tasked with how to
38 400 implement these restrictions. Under the Communications Act 2003, Ofcom retains direct
39 401 responsibility for advertising scheduling policy. This then begs the question of whether a
40 402 governmental body with a duty to protect broadcasting interests should be leading on
41 403 public health legislation.
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3 405 This conflict between Ofcom's duties to the public and to broadcasters, may have resulted
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5 406 in eventual restrictions that did not appear to alter the level of exposure of children to HFSS
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7 407 food advertising.^{17,18} Ofcom appeared to balance arguments related to commercial and
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9 408 public interests, in terms of jobs and the wider economy, with those relating to public
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11 409 health. Being proportionate in their restrictions was frequently cited by Ofcom in their
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13 410 decision making. Ofcom did not, however, appear to consider the cost to the economy of
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15 411 poor health that could stem from a lack of appropriate restrictions. Ofcom also appeared to
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17 412 give greater priority to allowing advertisers access to adults than to restricting exposure to
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19 413 HFSS food advertising among children, who may be viewing the same programming .
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21 414 Industry representative groups tended to highlight commercial arguments whilst citing
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23 415 evidence that appeared to downplay the role of television advertising in childhood obesity.
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25 416 Self-regulation was also touted as an effective measure to address childhood obesity
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27 417 instead of government-mandated regulations. A recent Canadian study showed how self-
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29 418 regulation had limited impact on how much children are exposed to unhealthy food
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31 419 advertising, concluding mandatory regulations were necessary.²⁷ Public health groups
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33 420 emphasised that the health of children should outweigh any financial concerns and pointed
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35 421 out that even small changes to advertising at an individual level would affect large numbers
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37 422 of children and so accrue to large population level benefits.
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424 ***Strengths and Limitations***

41 425 Using established qualitative methods allowed us to identify key themes in the consultation
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43 426 responses according to stakeholder interests. The creation of a *de novo* framework
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45 427 minimised bias that might have been imposed by using a pre-existing framework. Instead,
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47 428 we allowed categories to emerge from the data. The classification of the responses also
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49 429 enabled us to see what positions were taken by the various stakeholders and which type of
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51 430 responses carried the most influence. Measures were taken to maximise the reliability of
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53 431 our coding, such as duplicate coding a sample of consultation responses. The use of publicly
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55 432 available data was resource efficient. Additionally, the use of all the available data ensured
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57 433 that no perspectives were omitted, adding to internally validity. The omission of responses
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59 434 from individual members of the public was because most public responses lacked detail and
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435 were no more than a sentence long. Commercial influences on public health policy are

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3 436 unlikely to have changed over the past decade with no changes in lobbying rules or policy
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5 437 making procedures, making it highly likely that our findings from the 2007 consultation are
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7 438 applicable today.
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11 440 There may be alternative methods by which the public influences policy making, such as by
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13 441 writing to their Member of Parliament. This is a study of only one case of public health
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15 442 policy making and our specific findings may not be generalisable to other aspects of dietary
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17 443 public health policy specifically or public health policy more generally. In this consultation,
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19 444 all members of a stakeholder category were treated as one, though there was some inter-
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21 445 category variation on position. There are also other ways by which interested parties could
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23 446 influence Ofcom, which we were unable to examine in this study. For example, Ofcom gave
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25 447 the option of providing confidential responses which were not available for us to
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27 448 incorporate into our dataset. Other informal lobbying may have occurred. Whether such
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29 449 channels of influence were used or whether similar arguments will have been used privately
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31 450 as were used publicly is unclear.

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34 452 ***Relationship to existing knowledge***

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37 453 Some literature exists on the methods by which public health advocates influence policy. In
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39 454 2006, the New Zealand government held an 'Inquiry into Obesity' in order to determine
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41 455 what could be done to limit increasing obesity rates.¹⁶ Jenkin *et al* found that in three out of
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43 456 four domains examined, the governmental position aligned with that of industry groups,
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45 457 with the exception being nutritional policy in schools. In the other three domains, national
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47 458 obesity strategy, food industry policy, and advertising and marketing policy, the analysis
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49 459 determined that the governmental position allied with industry groups. Much like our study,
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51 460 public health groups were shown to have a limited impact on the eventual policies, with
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53 461 industry arguments proving more influential. An explanation suggested for this was the
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55 462 significance of the food industry to New Zealand's economy, highlighting how
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57 463 considerations outside of public health may importantly shape public health policy. It may
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59 464 be the case that similar factors shaped the eventual restrictions in our case study, despite
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465 the appearance of Ofcom wanting to develop 'proportionate restrictions', balancing

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3 466 commercial and public health interests. The question of what is proportionate appears to be
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5 467 determined by ideology and how much one feels government's role is to protect health
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7 468 even if it impacts on industry. If this is the case, we must question whether commercial
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9 469 companies can ever be truly motivated to improve health at the possible detriment to their
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11 470 short-term profits. A thematic analysis of alcohol industry documents in Australia²⁸
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13 471 concluded that the industry attempted to create an impression of social responsibility whilst
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15 472 promoting interventions that did not affect their profits and campaigning against effective
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17 473 interventions that might affect profits. The *de facto* exemption of commercial stakeholders
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19 474 from bearing the negative external costs of their profitable endeavours (e.g. environmental,
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21 475 social or health impacts) has been widely questioned.²⁹
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23 476

24 477 ***Interpretation and implications of the study***

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26 478 Much of the research undertaken to date on stakeholder influences on public health policy
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28 479 has focused on industry behaviours and practices, whereas in this study we have treated
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30 480 both pro-industry and pro-public health groups equally in our analysis. Our findings suggest
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32 481 that, in the case of the Ofcom consultation on the regulation of TV advertising of foods to
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34 482 children, civil society and public health stakeholders carried less weight than their industry
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36 483 counterparts. Industry groups were apparently successfully able to argue that extensive
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38 484 restrictions would impact upon their commercial revenues, suggesting that their economic
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40 485 arguments importantly influenced the thinking of policy-makers. However, the future
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42 486 (external) costs of treating the potential health implications of HFSS food consumption did
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44 487 not appear to influence policy-making. This may be because any potential cost-savings are
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46 488 long-term and would apply to the health sector, for which Ofcom has no governmental
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48 489 responsibility, whereas the short-term costs would apply to the broadcast sector for which
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50 490 Ofcom is the regulatory body.

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52
53 492 Public health advocacy is an activity in which many public health professionals are keen to
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55 493 improve to ensure evidence is translated into policy.^{30,31} This study highlights that
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57 494 responding to public health policy consultations alone may not result in policy making
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59 495 favourable to public health and other avenues of influence may also need to be explored.
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3 496 Conversely, the change in the definition of children from 4-9 years to 4-15 years
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5 497 demonstrates that there is scope for public health advocates to shape policy should an issue
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7 498 be sufficiently clear and difficult to oppose. A more Machiavellian interpretation would be
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9 499 that to define children as aged 4-9 years at the outset may have been a cynical ploy aimed
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11 500 at ensuring that there was at least some ground to concede to public health stakeholders
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13 501 and distract from the more contentious issues. This is supported by the fact that the
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15 502 definition of children as aged 4-9 years was inherently questionable, given Ofcom's own
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17 503 definition of children as under 16 years, in line with the legal and medical definitions used in
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19 504 the UK. A few companies pointed to their media literacy campaigns as evidence that
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21 505 adolescents can understand advertising as an argument against redefining the scope of
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23 506 these restrictions to children aged 4-15 years. Evidence shows that advertisers simply use
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25 507 different ways to target adolescents,³² rendering media literacy moot,³³ and suggesting that
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27 508 restrictions are still needed to protect adolescents.

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30 510 The issue of TV advertising of less healthy foods remains highly politically sensitive and at
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32 511 the top of the public health strategy agenda for obesity.²² Many UK public health
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34 512 organisations have recently campaigned to ban television advertising of less healthy foods
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36 513 before 9pm (the so-called 9pm watershed).^{20,21,34-37} Our analysis of the 2006-7 consultation
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38 514 offers specific insights that could be influential in this ongoing national debate, in the same
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40 515 way as such analyses of historical documents have influenced tobacco control efforts in
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42 516 recent years.^{13,38} The Ofcom regulation of television advertising of less healthy foods to
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44 517 children is one of few national public health policies of this sort to have been independently
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46 518 evaluated.^{18,39} The independent evaluation found that the introduction of the regulations
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48 519 were not associated with a decrease in children's exposure to less healthy food
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50 520 advertising.³⁹ Our analysis sheds further light on why and how a regulatory policy that
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52 521 appears to have been ineffective in reducing children's exposure to less healthy food
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54 522 advertising came about. Publishing responses to public consultations in full is a key
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56 523 component of transparent policy making. The UK Treasury's reluctance to make available
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58 524 responses to the Soft Drinks Industry Levy consultation is contrary to this principle.

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526 ***Further questions and future research***

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3 527 How policy making is influenced through means other than public consultations should be
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5 528 further studied. Other means of applying political pressure such as political lobbying and
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7 529 having indirect relationships with positions of power are much more opaque and difficult to
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9 530 monitor. Parliamentary records of lobbying activity, copies of internal or leaked documents
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11 531 and registers of MPs interests may all be potential sources of data to explore these issues
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13 532 further. Interviews with former or current employees of policy forming bodies such as
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15 533 Ofcom, as well as other stakeholder groups could also be fruitful. Claims made during this
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17 534 consultation, such as industry claims of needing to issue profit warnings as a consequence of
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19 535 lost revenue from these restrictions, could be analysed. Thematic analysis of further
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21 536 documents such as the responses analysed in this study could provide valuable insight into
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23 537 whether a similar combination of commercial arguments and questioning scientific data is
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25 538 used across different public health policy consultations.

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27 28 540 **Conclusion**

29
30 541 This analysis increases our understanding of how influential some stakeholders are in policy
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32 542 making and provides a framework from which further understanding of the influences on
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34 543 public health policy can be determined. From this case study, we can see that commercial
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36 544 influences on dietary public health policy-making appear to be somewhat greater than the
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38 545 influence of public health stakeholders and may have resulted in compromised legislation.
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40 546 In this case, the potential for commercial impacts of legislation promoting public health
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42 547 appeared to outweigh the anticipated population health benefits in policy decision making.

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44 549

45 550 **Authors' contributions** - The authors declare that they have no competing interests.

46
47 551 Responses were coded by AR with a sub-sample duplicate coded by JA or MW. AR, JA and

48
49 552 MW contributed to the manuscript in terms of both writing and editing.

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555 **References**

- 556 1. Fleuret P, Fleuret A. Nutrition, Consumption, and Agricultural Change. *Hum Organ*.
557 1980;39(3):250-260. doi:10.17730/humo.39.3.53332403k1461480.
- 558 2. Jebb SA, Moore MS. Contribution of a sedentary lifestyle and inactivity to the etiology
559 of overweight and obesity: current evidence and research issues. *Med Sci Sports*
560 *Exerc*. 1999;31(11 Suppl):S534-41. doi:10.1097/00005768-199911001-00008.
- 561 3. Global Health Observatory. WHO | Obesity. WHO.
- 562 4. WHO global co-ordination mechanism on the prevention and control of
563 noncommunicable diseases (GCM/NCD) POLICY BRIEF: REDUCING THE USE OF SALT
564 IN THE FOOD INDUSTRY TO LOWER SODIUM CONSUMPTION. 2014.
565 <http://www.who.int/nmh/ncd-coordination-mechanism/Policybrief34.pdf>. Accessed
566 June 28, 2017.
- 567 5. WHO | Reducing the impact of marketing of foods and non-alcoholic beverages on
568 children. WHO. 2014.
569 http://www.who.int/elena/titles/guidance_summaries/food_marketing_children/en/
570 . Accessed August 8, 2017.
- 571 6. Kraak VI, Vandevijvere S, Sacks G, et al. Policy & practice Progress achieved in
572 restricting the marketing of high-fat, sugary and salty food and beverage products to
573 children. *Bull World Heal Organ*. 2016;94:540-548. doi:10.2471/BLT.15.158667.
- 574 7. Raine KD, Lobstein T, Landon J, et al. Restricting marketing to children: Consensus on
575 policy interventions to address obesity. *J Public Health Policy*. 2013;34(2):239-253.
576 doi:10.1057/jphp.2013.9.
- 577 8. Harris JL, Pomeranz JL, Lobstein T, Brownell KD. A Crisis in the Marketplace: How
578 Food Marketing Contributes to Childhood Obesity and What Can Be Done. *Annu Rev*
579 *Public Health*. 2009;30(1):211-225. doi:10.1146/annurev.publhealth.031308.100304.
- 580 9. Cairns G, Angus K, Hastings G, Caraher M. Systematic reviews of the evidence on the
581 nature, extent and effects of food marketing to children. A retrospective summary.
582 *Appetite*. 2013;62:209-215. doi:10.1016/j.appet.2012.04.017.
- 583 10. WHO | Protecting children from the harmful effects of food and drink marketing.

- 1
2
3 584 WHO. 2014. <http://www.who.int/features/2014/uk-food-drink-marketing/en/>.
4
5 585 Accessed June 28, 2017.
6
7 586 11. Sibbald B. Sugar industry sour on WHO report. *CMAJ*. 2003;168(12):1585.
8
9 587 <http://www.pubmedcentral.nih.gov/articlerender.fcgi?artid=156706&tool=pmcentrez&rendertype=abstract>. Accessed December 23, 2015.
10
11 588
12
13 589 12. Savell E, Fooks G, Gilmore AB. How does the alcohol industry attempt to influence
14
15 590 marketing regulations? A systematic review. *Addiction*. 2016;111(1):18-32.
16
17 591 doi:10.1111/add.13048.
18
19 592 13. Savell E, Gilmore AB, Fooks G, Weishaar H, Gilmore A. How Does the Tobacco
20
21 593 Industry Attempt to Influence Marketing Regulations? A Systematic Review. Derrick
22
23 594 GE, ed. *PLoS One*. 2014;9(2):e87389. doi:10.1371/journal.pone.0087389.
24
25 595 14. Grüning T, Gilmore AB, McKee M. Tobacco industry influence on science and
26
27 596 scientists in Germany. *Am J Public Health*. 2006;96(1):20-32.
28
29 597 doi:10.2105/AJPH.2004.061507.
30
31 598 15. Bertscher A, London L, Orgill M. Unpacking policy formulation and industry influence:
32
33 599 the case of the draft control of marketing of alcoholic beverages bill in South Africa.
34
35 600 *Health Policy Plan*. June 2018. doi:10.1093/heapol/czy049.
36
37 601 16. Jenkin G, Signal L, Thomson G. Nutrition policy in whose interests? A New Zealand
38
39 602 case study. *Public Health Nutr*. 2012;15(8):1483-1488.
40
41 603 doi:10.1017/S1368980011003028.
42
43 604 17. Adams J, Tyrrell R, Adamson AJ, White M. Effect of restrictions on television food
44
45 605 advertising to children on exposure to advertisements for “less healthy” foods: repeat
46
47 606 cross-sectional study. *PLoS One*. 2012;7(2):e31578.
48
49 607 doi:10.1371/journal.pone.0031578.
50
51 608 18. Adams J, Hennessy-Priest K, Ingimarsdóttir S, Sheeshka J, Ostbye T, White M. Food
52
53 609 advertising during children’s television in Canada and the UK. *Arch Dis Child*.
54
55 610 2009;94(9):658-662. doi:10.1136/adc.2008.151019.
56
57 611 19. Children’s Food Campaign. *Through the Looking Glass: A Review of Topsy-Turvy Junk*
58
59 612 *Food Marketing Regulations.*; 2013.
60

- 1
2
3 613 https://www.sustainweb.org/publications/through_the_looking_glass/. Accessed
4
5 614 October 10, 2017.
6
7 615 20. Sugar Reduction The evidence for action. 2015. www.gov.uk/phe. Accessed October
8
9 616 10, 2017.
10
11 617 21. The Labour Party. Labour Manifesto.
12
13 618 <http://www.labour.org.uk/index.php/manifesto2017>. Published 2017. Accessed June
14
15 619 28, 2017.
16
17 620 22. *Childhood Obesity: A Plan for Action Chapter 2 2 DH ID Box Title: Childhood Obesity: A*
18
19 621 *Plan for Action, Chapter 2.*; 2018. [www.nationalarchives.gov.uk/doc/open-](http://www.nationalarchives.gov.uk/doc/open-government-licence/)
20
21 622 [government-licence/](http://www.nationalarchives.gov.uk/doc/open-government-licence/). Accessed November 27, 2018.
22
23 623 23. O'Brien BC, Harris IB, Beckman TJ, Reed DA, Cook DA. Standards for reporting
24
25 624 qualitative research: a synthesis of recommendations. *Acad Med*. 2014;89(9):1245-
26
27 625 1251. doi:10.1097/ACM.0000000000000388.
28
29 626 24. Ofcom. *Television Advertising of Food and Drink Products to Children: Final*
30
31 627 *Statement*.
32
33 628 25. Hsieh H-F, Shannon SE. Three approaches to qualitative content analysis. *Qual Health*
34
35 629 *Res*. 2005;15(9):1277-1288. doi:10.1177/1049732305276687.
36
37
38 630 26. Gale NK, Heath G, Cameron E, Rashid S, Redwood S. Using the framework method for
39
40 631 the analysis of qualitative data in multi-disciplinary health research. *BMC Med Res*
41
42 632 *Methodol*. 2013;13:117. doi:10.1186/1471-2288-13-117.
43
44 633 27. Potvin Kent M, Wanless A. The influence of the Children's Food and Beverage
45
46 634 Advertising Initiative: change in children's exposure to food advertising on television
47
48 635 in Canada between 2006-2009. *Int J Obes (Lond)*. 2014;38(4):558-562.
49
50 636 doi:10.1038/ijo.2014.4.
51
52 637 28. Miller PG, de Groot F, McKenzie S, Droste N. Vested interests in addiction research
53
54 638 and policy. Alcohol industry use of social aspect public relations organizations against
55
56 639 preventative health measures. *Addiction*. 2011;106(9):1560-1567.
57
58 640 doi:10.1111/j.1360-0443.2011.03499.x.
59
60 641 29. Stuckler D, Nestle M. Big food, food systems, and global health. *PLoS Med*.

- 1
2
3 642 2012;9(6):e1001242. doi:10.1371/journal.pmed.1001242.
4
5 643 30. Dorfman L, Krasnow ID. Public Health and Media Advocacy. *Annu Rev Public Health*.
6 644 2014;35(1):293-306. doi:10.1146/annurev-publhealth-032013-182503.
7
8 645 31. Herrick C. The post-2015 landscape: vested interests, corporate social responsibility
9 646 and public health advocacy. *Sociol Health Illn*. 2016;38(7):1026-1042.
10 647 doi:10.1111/1467-9566.12424.
11
12 648 32. Livingstone S, Helsper EJ. Does Advertising Literacy Mediate the Effects of Advertising
13 649 on Children? A Critical Examination of Two Linked Research Literatures in Relation to
14 650 Obesity and Food Choice. *J Commun*. 2006;56(3):560-584. doi:10.1111/j.1460-
15 651 2466.2006.00301.x.
16
17 652 33. Montgomery KC, Chester J. Interactive Food and Beverage Marketing: Targeting
18 653 Adolescents in the Digital Age. *J Adolesc Heal*. 2009;45(3):S18-S29.
19 654 doi:10.1016/j.jadohealth.2009.04.006.
20
21 655 34. Sustain / Children's Food Campaign. Junk Food Marketing.
22 656 https://www.sustainweb.org/childrensfoodcampaign/junk_food_marketing/.
23 657 Accessed November 1, 2017.
24
25 658 35. Cancer Research UK. Being overweight or obese could cause around 700,000 new UK
26 659 cancers by 2035 | Cancer Research UK. [http://www.cancerresearchuk.org/about-](http://www.cancerresearchuk.org/about-us/cancer-news/press-release/2016-01-07-being-overweight-or-obese-could-cause-around-700000-new-uk-cancers-by-2035)
27 660 [us/cancer-news/press-release/2016-01-07-being-overweight-or-obese-could-cause-](http://www.cancerresearchuk.org/about-us/cancer-news/press-release/2016-01-07-being-overweight-or-obese-could-cause-around-700000-new-uk-cancers-by-2035)
28 661 [around-700000-new-uk-cancers-by-2035](http://www.cancerresearchuk.org/about-us/cancer-news/press-release/2016-01-07-being-overweight-or-obese-could-cause-around-700000-new-uk-cancers-by-2035). Accessed November 1, 2017.
29
30 662 36. Obesity Health Alliance. Tackling Childhood Obesity - 2017 Election Manifesto.
31 663 <http://obesityhealthalliance.org.uk/policy/>. Accessed November 1, 2017.
32
33 664 37. Faculty of Public Health. Start Well, Live Better.
34 665 http://www.fph.org.uk/start_well%2C_live_better_-_a_manifesto. Accessed
35 666 November 1, 2017.
36
37 667 38. Fooks GJ, Gilmore AB. Corporate philanthropy, political influence, and health policy.
38 668 *PLoS One*. 2013;8(11):e80864. doi:10.1371/journal.pone.0080864.
39
40 669 39. Adams J, Tyrrell R, Adamson AJ, White M. Effect of restrictions on television food
41 670 advertising to children on exposure to advertisements for "less healthy" foods: repeat

- 1
2
3 671 cross-sectional study. *PLoS One*. 2012;7(2):e31578.
4
5 672 doi:10.1371/journal.pone.0031578.
6
7 673 40. Ofcom. Television Advertising of Food and Drink Products to Children - Ofcom.
8
9 674 https://www.ofcom.org.uk/consultations-and-statements/category-2/foodads_new.
10
11 675 Accessed August 8, 2017.
12

13 676

14 677

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16
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18
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For peer review only

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3 678 **Figure titles and legends**
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5 679 Figure 1: A timeline of the Ofcom process on developing new recommendations for limiting
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7 680 television food advertising to children.
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9 681 *Figure 1 legend:*

10 682 * 'Interested parties' are stakeholder groups who may have been affected by the proposed
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12 683 changes, including advertising agencies, advocacy groups, broadcasters, charities,
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14 684 healthcare associations, politicians, the food industry and the general public.
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19
20 686 Table 1: Packages of regulations proposed by Ofcom in the initial consultation (March 2006)
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22 687 *Table 1 legend:*

23
24 688 * HFSS food = High, Fat, Sugar and Salt foods

25
26 689 + 'of particular appeal to children' = when the proportion of people watching who are
27
28 690 children is more than 120% of the proportion of children in the UK population⁴⁰
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31 691

32
33 692 Table 2: The categories into which stakeholder groups were classified. A list of each group
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35 693 classified by category can be found in the Appendix.
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38 694

39
40 695 Table 3: The changes in Ofcom's position during the course of the consultation
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45 697 **Appendix**
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47 698 Table A: The questions Ofcom asked as part of the consultation
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49 699

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51 700 Table B1: The classification of the responses by organisational category
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56 702 Table B2: The classification of the responses by organisational category (continued)
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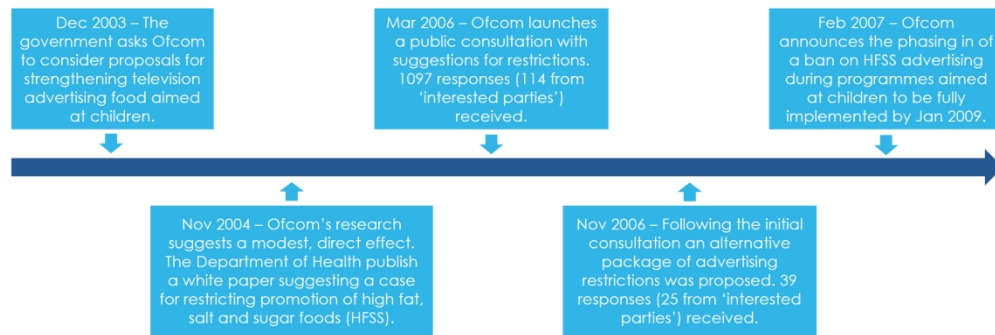


Figure 1: A timeline of the Ofcom process on developing new recommendations for limiting television food advertising to children.

Legend: * 'Interested parties' are stakeholder groups who may have been affected by the proposed changes, including advertising agencies, advocacy groups, broadcasters, charities, healthcare associations, politicians, the food industry and the general public.

Options	Detail
Package 1	<ul style="list-style-type: none"> • No HFSS* food advertising in programmes specifically made for children • No HFSS food advertising in programmes of particular appeal to children+ aged 4-9 years
Package 2	<ul style="list-style-type: none"> • No food or drink advertising in programmes made specifically for children or of particular appeal to children aged up to 9 years
Package 3	<ul style="list-style-type: none"> • Volume of food and drink advertising to be limited at times when children are most likely to be watching
Modified Package 1	<ul style="list-style-type: none"> • As per package 1 except restrictions on HFSS food advertising to be extended to programmes of particular appeal to children aged 4-15 years

Table 1: Packages of regulations proposed by Ofcom in the initial consultation (March 2006)

Legend: * HFSS food = High, Fat, Sugar and Salt foods
 + 'of particular appeal to children' = when the proportion of people watching who are children is more than 120% of the proportion of children in the UK population³⁹

Category	Definition
Advertising interests	Advertising companies and representative bodies
Broadcast interests	Broadcasting companies and representative bodies
Civil society groups	Groups that represent the interests of all or some of the general population
Food manufacturers	Companies that produce and sell food to retailers
Food retailers	A company that sells food to the general population
Food industry interests	Bodies that represent the interests of groups of food manufacturers and retailers
Politicians	Persons professionally involved in politics
Public health interests	Groups that focus on promoting the health of the population

Table 2: The categories into which stakeholder groups were classified. A list of each group classified by category can be found in the Appendix.

Initial options presented by Ofcom	Consultation responses and Ofcom's reaction	Ofcom's final position	Reference in consultation
<i>Ofcom's packages 1-3 varied on 3 key principles:</i>			
1. Restrictions on advertising of all foods versus just HFSS foods	Following the first consultation it was clear that the majority of responses preferred restricting advertising of only HFSS foods.	The eventual package of restrictions enacted was specific to HFSS foods.	Ofcom Executive Summary 1.12
2. Total ban on food advertising versus volume-based restrictions	Almost all stakeholders did not consider volume based restrictions as being effective at reducing exposure to advertising and this option was dismissed following the first consultation.	There was a total ban enacted on HFSS food advertising in programming 'of particular interest to' children.	Ofcom Executive Summary 1.12
3. Restrictions only on children's channels versus all programmes 'of particular interest' to children irrespective of channel	Some responses highlighted that children may watch adult TV and a ban on all less healthy food advertising before the 9pm watershed may be more effective than focusing specifically on children's programming. Other responses worried that this would disproportionately impact advertising revenues.	Ofcom rejected the idea of a pre-9pm ban due to concerns about the effect it would have on broadcasters, programming and advertising revenues.	Ofcom Executive Summary 1.12
<i>Further changes that were made:</i>			
Restrictions should apply to children aged 4-9 years	Many responses pointed out that children are legally defined as under 16 years.	The restrictions applied to children aged 4-15 years.	Ofcom Final Statement 4.9
All restrictions should start in April 2007	Children's channels argued that they should be allowed a transitional period as they would be affected financially.	Children's channels were allowed a phased implementation of restrictions, with final implementation by January 2009.	Ofcom Final Statement 5.3/5.4

Table 3: The changes in Ofcom's position during the course of the consultation

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- Question 1 Do you agree that the regulatory objectives set out in paragraph 5.2 above are appropriate?
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- Question 2 Do you consider that it is desirable to distinguish between foods that are high in fat, salt or sugar and those that are healthier in order to achieve the regulatory objectives, or could an undifferentiated approach provide a reasonable alternative?
-
- Question 3 If so, do you consider the FSA's nutrient profiling scheme to be a practical and reasonable basis for doing so? If not, what alternative would you propose? (Note: The nutrient profiling scheme was developed by the FSA and handed to Ofcom following extensive consultation (see FSA web site). This being the case, and given the scheme itself and the science upon which it is based fall outside Ofcom's area of responsibility and expertise, it is not appropriate in this consultation to seek responses on those matters)
-
- Question 4 Do you agree that voluntary self-regulation would not be likely to meet Ofcom's regulatory objectives or the public policy objectives?
-
- Question 5 Do you agree that the exclusion of all HFSS advertising before 9.00pm would be disproportionate?
-
- Question 6 Do you agree that all food and drink advertising and sponsorship should be excluded from programmes aimed at pre-school children?
-
- Question 7 Do you agree that revised content standards should apply to the advertising or sponsorship of all food and drink advertisements?
-
- Question 8 Do you consider that the proposed age bands used in those rules aimed at preventing targeting of specific groups of children are appropriate?
-
- Question 9 Do you consider the proposed content standards including their proposed wording to be appropriate, and if not, what changes would you propose, and why?
-
- Question 10 Do you consider a transitional period would be appropriate for children's channels in the context of the scheduling restrictions, and if so, what measure of the 'amount' of advertising should be used?
-
- Question 11 Do you consider there is a case for exempting low child audience satellite and cable channels from the provisions of Package 3?
-
- Question 12 Do you agree that there should not be a phase-in period for children's channels under Package 3?
-
- Question 13 Which of the three policy packages would you prefer to be incorporated into the advertising code and for what reasons?
-
- Question 14 Alternatively, do you consider that a combination of different elements of the three packages would be suitable? If so, which elements would you favour within an alternative package? (You should note that the analysis in the Impact Assessment has focused on estimating the costs of restricting scheduling, volume, and content separately and would therefore allow consideration of other combinations of the same elements).
-
- Question 15 Where you favour either Package 1 or 2, do you agree that it would be appropriate to allow children's channels a transitional period to phase in restrictions on HFSS / food advertising, on the lines proposed?
-
- Question 16 Do you consider that the packages should include restrictions on brand advertising and sponsorship? If so, what criteria would be most appropriate to define a relevant brand? If not, do you see any issue with the prospect of food manufacturers substituting brand advertising and sponsorship for product promotion?
-
- Question 17 Ofcom invites comments on the implementation approach set out in paragraph 5.45 and 5.46.

Advertising stakeholders	Broadcast stakeholders	Lawyers	Politicians	Retailers
Institute of Practitioners in Advertising	Producer's Alliance for Cinema and Television 1	Baker and McKenzie LLP	Mary Creagh MP	Sainsbury
Advertising Association	Five		Welsh Assembly	The Co-operative
Incorporated Society of British Advertisers 1	Channel 4		All Party Parliamentary group on Heart Disease	British Retail Consortium 1
Mediavest Manchester	Flextech television		David Amess MP	British Retail Consortium 2
Zenith Optimedia	ITV			
Mindshare	GMTV			
Incorporated Society of British Advertisers 2	Jetix, Nickelodeon and Turner			
	Producer's Alliance for Cinema and Television 2			

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	Broadcast Advertising Clearance Centre			
	British Academy of Film and Television Arts			
	Broadcast Committee of Advertising Practice			

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Food companies	Food industry representative groups	Civil society groups	Public health stakeholders
Kellogg 1	Food Advertising Unit 1	Kids Inc	National Heart Forum 1
Kraft 1	Food and Drink Federation 2	Consumer Council of Northern Ireland	Northern Ireland Chest Heart and Stroke 2
Pepsico	Snack Nut and Crisp Manufacturers Association 1	Children's Food Bill Coalition	UK Public Health Association
GlaxoSmithKline 1	Food Advertising Unit 2	National Consumer Council 1	Royal Society of Health
United Biscuits	Food and Drink Federation 1	Which 1	Consensus Action on Salt and Health
Nestle	Dairy Council	Officer of the Children's Commissioner	Nutrition Society
Cadbury	Snack Nut and Crisp Manufacturers Association 2	School Food Trust 1	Diabetes UK
Ferrero 1	Provision Trade Federation	Trading Standards Institute	Association for the Study of Obesity

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3	Masterfoods 2	British Cheese Board	Which 2	Heart of Mersey 2
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9	Coca-cola 1	Chocolate	Welsh Consumer	National Oral Health
10		Confectionery	Council	Promotion Group
11		Association 1		
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18		Biscuit Cake		
19	McDonalds 2	Chocolate	Food Aware	Scientific Advisory
20		Confectionery		Committee on Nutrition
21		Association 2		
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27	Vimto	Dairy UK	Safefood Ireland	British Psychological
28				Society
29				
30				
31				
32				
33	Wrigley		The Caroline Walker	British Dietetic
34			Trust	Association
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38	Wiltshire farm foods		Advisory Committee for	National Heart Forum 2
39			England	
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43	Unilever		Voice of the Listener	British Heart
44			and Viewer 2	Foundation
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49	GlaxoSmithKline 2		Advertising Advisory	British Medical
50			Committess	Association 1
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57	Coca-cola 2		British Nutrition	Cheshire and
58			Foundation	Merseyside Public
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4	Masterfoods 2	Food Ethics Council	Health Protection Agency Northern Ireland
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21	RHM Group	National Family and Parenting Institute	National Heart Alliance Ireland 2
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30	Kellogg 2	National Union of Teachers	International Association for the Study of Obesity 1
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37	Ferrero 2	The Nutrition Society	British Medical Association 2
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42		Children's Food Campaign	Heart of Mersey 1
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49		Consumer Council	Northern Ireland Chest Heart and Stroke 1
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55		Barnardos	Irish Heart Foundation 2
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59		National Children's Bureau	NHS Borders
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6		School Food Trust	British Heart Foundation 2
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11		Scotland's Commissioner for Young People	Cancer Research UK
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21		Food Standards Agency	Northern Ireland Chest Heart and Stroke 3
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29		National Youth Agency	International Association for the Study of Obesity 2
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37		Advisory Committee for Northern Ireland	Royal College of Physicians
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42		Food Commission 1	Weight Concern
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46		Women's Institute 1	British Dental Association
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51		The Food Commission	Medical Research Council 2
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		The Obesity Awareness and Solutions Trust	Joint statement by the British Heart Foundation, Cancer Research UK and Diabetes UK
		National Federation of Women’s Institutes 1	Royal College of Nursing
		National Federation of Women’s Institutes 2	

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Reporting checklist for qualitative study.

Based on the SRQR guidelines.

Instructions to authors

Complete this checklist by entering the page numbers from your manuscript where readers will find each of the items listed below.

Your article may not currently address all the items on the checklist. Please modify your text to include the missing information. If you are certain that an item does not apply, please write "n/a" and provide a short explanation.

Upload your completed checklist as an extra file when you submit to a journal.

In your methods section, say that you used the SRQR reporting guidelines, and cite them as:

O'Brien BC, Harris IB, Beckman TJ, Reed DA, Cook DA. Standards for reporting qualitative research: a synthesis of recommendations. *Acad Med.* 2014;89(9):1245-1251.

	Reporting Item	Page Number
#1	Concise description of the nature and topic of the study identifying the study as qualitative or indicating the approach (e.g. ethnography, grounded theory) or data collection methods (e.g. interview, focus group) is recommended	5
#2	Summary of the key elements of the study using the abstract format of the intended publication; typically	2

1			includes background, purpose, methods, results and	
2				
3			conclusions	
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5				
6	Problem formulation	#3	Description and significance of the problem /	4
7				
8			phenomenon studied: review of relevant theory and	
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10			empirical work; problem statement	
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13	Purpose or research	#4	Purpose of the study and specific objectives or questions	5
14	question			
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19	Qualitative approach and	#5	Qualitative approach (e.g. ethnography, grounded theory,	5
20	research paradigm		case study, phenomenology, narrative research) and	
21			guiding theory if appropriate; identifying the research	
22			paradigm (e.g. postpositivist, constructivist / interpretivist)	
23				
24			is also recommended; rationale. The rationale should	
25			briefly discuss the justification for choosing that theory,	
26			approach, method or technique rather than other options	
27			available; the assumptions and limitations implicit in	
28			those choices and how those choices influence study	
29			conclusions and transferability. As appropriate the	
30			rationale for several items might be discussed together.	
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44	Researcher	#6	Researchers' characteristics that may influence the	1
45	characteristics and		research, including personal attributes, qualifications /	
46	reflexivity		experience, relationship with participants, assumptions	
47			and / or presuppositions; potential or actual interaction	
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49			between researchers' characteristics and the research	
50			questions, approach, methods, results and / or	
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52			transferability	
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1	Context	#7	Setting / site and salient contextual factors; rationale	4
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4	Sampling strategy	#8	How and why research participants, documents, or	5
5			events were selected; criteria for deciding when no	
6			further sampling was necessary (e.g. sampling	
7			saturation); rationale	
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14	Ethical issues pertaining	#9	Documentation of approval by an appropriate ethics	8
15	to human subjects		review board and participant consent, or explanation for	
16			lack thereof; other confidentiality and data security issues	
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22	Data collection methods	#10	Types of data collected; details of data collection	5
23			procedures including (as appropriate) start and stop	
24			dates of data collection and analysis, iterative process,	
25			triangulation of sources / methods, and modification of	
26			procedures in response to evolving study findings;	
27			rationale	
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36	Data collection	#11	Description of instruments (e.g. interview guides,	6
37	instruments and		questionnaires) and devices (e.g. audio recorders) used	
38	technologies		for data collection; if / how the instruments(s) changed	
39			over the course of the study	
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46	Units of study	#12	Number and relevant characteristics of participants,	8
47			documents, or events included in the study; level of	
48			participation (could be reported in results)	
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54	Data processing	#13	Methods for processing data prior to and during analysis,	6
55			including transcription, data entry, data management and	
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1		security, verification of data integrity, data coding, and	
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3		anonymisation / deidentification of excerpts	
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6	Data analysis	#14 Process by which inferences, themes, etc. were identified	6
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8		and developed, including the researchers involved in	
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10		data analysis; usually references a specific paradigm or	
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12		approach; rationale	
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16	Techniques to enhance	#15 Techniques to enhance trustworthiness and credibility of	7
17	trustworthiness	data analysis (e.g. member checking, audit trail,	
18		triangulation); rationale	
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23	Syntheses and	#16 Main findings (e.g. interpretations, inferences, and	8
24	interpretation	themes); might include development of a theory or	
25			
26		model, or integration with prior research or theory	
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31	Links to empirical data	#17 Evidence (e.g. quotes, field notes, text excerpts,	11
32		photographs) to substantiate analytic findings	
33			
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35			
36	Intergration with prior	#18 Short summary of main findings; explanation of how	17
37	work, implications,	findings and conclusions connect to, support, elaborate	
38			
39	transferability and	on, or challenge conclusions of earlier scholarship;	
40			
41	contribution(s) to the field	discussion of scope of application / generalizability;	
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43		identification of unique contributions(s) to scholarship in a	
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48		discipline or field	
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51	Limitations	#19 Trustworthiness and limitations of findings	18
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53			
54	Conflicts of interest	#20 Potential sources of influence of perceived influence on	1
55			
56		study conduct and conclusions; how these were	
57			
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managed

Funding

#21 Sources of funding and other support; role of funders in data collection, interpretation and reporting

1

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BMJ Open

How do different stakeholder groups influence public health policy? Thematic content analysis of responses to a public consultation on the regulation of television food advertising to children in the UK

Journal:	<i>BMJ Open</i>
Manuscript ID	bmjopen-2018-028221.R1
Article Type:	Research
Date Submitted by the Author:	22-Mar-2019
Complete List of Authors:	Razavi, Ahmed; MRC Epidemiology Unit Adams, J; University of Cambridge, Centre for Diet & Activity Research White, Martin; Newcastle University, Institute of Health and Society; University of Cambridge, Centre for Diet & Activity Research
Primary Subject Heading:	Public health
Secondary Subject Heading:	Health policy, Public health, Qualitative research
Keywords:	PUBLIC HEALTH, QUALITATIVE RESEARCH, Health policy < HEALTH SERVICES ADMINISTRATION & MANAGEMENT

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Manuscripts

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3 1 TITLE PAGE
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6 2 Article Title: How do different stakeholder groups influence public health
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8 3 policy? Thematic content analysis of responses to a public consultation on the
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10 4 regulation of television food advertising to children in the UK
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13 5
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31 14 Corresponding author: Ahmed Razavi – ahmed.razavi@nhs.net
32

33 15 Key words: public health; health policy; diet; qualitative research; influence
34

35 16 4570 words
36

37 17 Competing interests - None
38

39 18 Funding - This work was undertaken by the Centre for Diet and Activity Research (CEDAR), a
40
41 19 UKCRC Public Health Research Centre of Excellence. Funding from Cancer Research UK, the
42
43 20 British Heart Foundation, the Economic and Social Research Council, the Medical Research
44
45 21 Council, the National Institute for Health Research, and the Wellcome Trust, under the
46
47 22 auspices of the UK Clinical Research Collaboration, is gratefully acknowledged. The funders
48
49 23 had no role in the study design, data collection, analysis, interpretation, or writing, nor in
50
51 24 the decision to submit the article for publication.

52 25 There was no patient or public involvement in the study design or conduct of the study.
53

54 26 Data availability - Data used was freely available from the Ofcom website until a recent
55
56 27 update to the website following which data was removed from the website. Ofcom may be
57
58 28 able to provide access to the responses on request.
59
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30 **Abstract**

31 *Objectives:* We explore one aspect of the decision-making process - public consultation on
32 policy proposals by a national regulatory body - aiming to understand how public health
33 policy development is influenced by different stakeholders.

34 *Design:* We use thematic content analysis to explore responses to a national consultation on
35 the regulation of television advertising of foods high in fat, salt and sugar aimed at children.

36 *Setting:* United Kingdom.

37 *Results:* 139 responses from key stakeholder groups were analysed to determine how they
38 influenced the regulator's initial proposals for advertising restrictions. The regulator's
39 priorities were questioned throughout the consultation process by public health
40 stakeholders. The eventual restrictions implemented were less strict in many ways than
41 those originally proposed. These changes appeared to be influenced most by commercial,
42 rather than public health, stakeholders.

43 *Conclusions:* Public health policy-making may prioritise commercial over public health
44 interests. Tactics such as the questioning and reframing of scientific evidence may be used.
45 In this example exploring the development of policy regulating television food advertising to
46 children, commercial considerations appear to have led to a watering down of initial
47 regulatory proposals. This seems likely to have compromised the ultimate public health
48 effectiveness of the regulations eventually implemented.

49

50 **Article Summary – Strengths and limitations of this study**

- 51 • Established qualitative methodology (thematic content analysis) was used to
52 evaluate all stakeholder responses.
- 53 • A *de novo* analytical framework was created, minimising bias that may have occurred
54 from using a pre-existing framework.
- 55 • Stakeholder groups were sorted into eight broad categories allowing us to compare
56 and contrast responses by category.
- 57 • Policy-making can be influenced through other non-public means (e.g. direct
58 lobbying), making us unable to comment on how other methods of influencing
59 policy-making may have affected this consultation's outcome.
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- 60 • This is one case study of influencing policy and our findings may not be generalisable
61 to other cases.

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63 **Background**

64 Foods high in fat, salt and sugar (HFSS) are a contributing factor to increasing rates of non-
65 communicable disease worldwide¹ and the World Health Organization (WHO) has
66 encouraged member states to take action on non-communicable diseases, including
67 through regulation of the advertising of HFSS foods.² However, a 2016 study found that no
68 member states had implemented comprehensive legislation restricting marketing of
69 unhealthy food and beverages to young people,³ despite multiple systematic reviews
70 demonstrating the importance of food marketing as a driver of childhood obesity.⁴⁻⁶

71 Industry groups often seek to influence public health policy.⁷ For example, in 2003 a WHO
72 recommendation suggesting reduction in population sugar intake resulted in the Sugar
73 Association (a sugar industry information group) pressing the US Congress to cut WHO
74 funding.⁸ However, influences on dietary public health policy are not limited to the food
75 industry. Health professionals, charities, politicians and members of the public have all
76 attempted to influence policy making. Evidence of the impact of these activities is hard to
77 find in peer-reviewed literature.

78 Systematic reviews^{9,10,11} have demonstrated how the alcohol and tobacco industries focus
79 on lobbying efforts and promote self-regulation as means to minimise the impact of public
80 health policy on commercial activities. These tactics have also been seen in relation to food
81 where, in one case study, government opinion reflected industry rather than public health
82 opinion.¹² However, at present, we have limited insight into how stakeholders other than
83 those representing industry interests attempt to influence public health policy in general or
84 dietary public health policy in particular. Identifying strategies and arguments used by these
85 interested parties in a public setting may help inform how public health policy is determined
86 and how it might more effectively be developed in the future.

87

88 **Policy context**

89 In December 2003, the UK Government asked Ofcom (the UK communications industry
90 regulator) to consider proposals for strengthening rules on television advertising of food
91 aimed at children (Fig 1). Ofcom decided to use the Food Standards Agency's Nutrient
92 Profiling Model to determine which foods were classified as HFSS. Ofcom originally put

93 three proposed 'packages' of regulations to public consultation in March 2006 (Packages 1-3
 94 in Table 1). Following this, Ofcom produced an alternative package of restrictions (Modified
 95 Package 1 in Table 1) in November 2006, on which Ofcom again consulted.

96 Figure 1: A timeline of the Ofcom process on developing new recommendations for limiting
 97 television food advertising to children.

98 Table 1: Packages of regulations proposed by Ofcom in the initial consultation (March 2006)

Options	Detail
Package 1	<ul style="list-style-type: none"> No HFSS* food advertising during programmes specifically made for children No HFSS food advertising during programmes of particular appeal to children+ aged 4-9 years
Package 2	<ul style="list-style-type: none"> No food or drink advertising during programmes made specifically for children or of particular appeal to children aged up to 9 years
Package 3	<ul style="list-style-type: none"> Volume of food and drink advertising to be limited at times when children are most likely to be watching
Modified Package 1	<ul style="list-style-type: none"> As per package 1 except restrictions on HFSS food advertising to be extended to programmes of particular appeal to children aged 4-15 years

99 * 'Interested parties' are stakeholder groups who may have been affected by the proposed changes, including
 100 advertising agencies, advocacy groups, broadcasters, charities, healthcare associations, politicians, the food
 101 industry and the general public.

102 Following the second consultation (November 2006), modified package 1 was
 103 recommended by Ofcom and was implemented from January 2009. A comparison of the
 104 final regulations implemented to the initial packages proposed suggests that the
 105 consultations had substantial impacts on policy decisions. The only independent evaluation
 106 of the regulations eventually implemented found no change in the proportion of
 107 advertisements seen by children that were for HFSS foods from before to after

1
2
3 108 implementation and an increase exposure of HFSS advertising among adults.^{13,14} A '9pm
4
5 109 watershed' (i.e. no advertising of HFSS foods before 21.00hr) is now the preferred option of
6
7 110 many civil society and public sector organisation to reduce exposure of children to HFSS
8
9 111 food advertisings^{15 16 17 18}

112 ***Study aims***

113 The consultations on the Ofcom regulations on the restriction of television food advertising
114 to children offers an opportunity to analyse responses from a range of stakeholder groups
115 to a consultation on an important policy that aims to promote dietary public health through
116 regulation of the food industry. We aimed to identify which arguments, and from which
117 stakeholder groups, appeared to be most influential in shaping the changes in Ofcom's
118 position from the initial consultation to the final recommendations.

120 ***Methods***

121 We followed the Standards for Reporting Qualitative Research¹⁹ in reporting our findings.

122 ***Patient and Public Involvement***

123 This study did not involve use of patient identifiable data and only used publicly-available
124 responses from stakeholder groups. We did not consult the public on the methods.

125 ***Data Sources***

126 We qualitatively analysed all written responses from stakeholder groups to the 2006-7
127 Ofcom public consultation on the regulation of television advertising of food and drink to
128 children. The consultation asked for responses to a series of questions regarding the various
129 policy packages outlined by Ofcom. Options such as having a 9pm watershed before which
130 HFSS foods could not be advertised, self-regulation, having a transitional period and
131 exemptions to the regulations were asked about. Responses were freely available on the
132 Ofcom website²⁰ and responses to both the first and second consultations were included.
133 Responses from individual members of the public were not included as they tended to be
134 very brief and non-specific. We therefore focused our analysis on key stakeholder
135 organisations representing key constituencies. Where needed, Optical Character

1
2
3 136 Recognition software was used to transcribe the responses. The consultation questions can
4
5 137 be seen in Table A in the Appendix.
6

7 138
8

9
10 139 **Data Analysis**

11
12 140 Conventional thematic content analysis²¹ was used to analyse the data and the Framework
13
14 141 method²² used to organise and chart data. This method involves creating coding categories
15
16 142 directly from the data and organising coding within a flexible matrix, which can then be
17
18 143 adjusted as more codes emerge from the text. As existing literature on the topic of
19
20 144 stakeholder influence on public health policy is limited, rather than using preconceived
21
22 145 categories with which to code the data, a new framework for analysis was developed, based
23
24 146 on no *a priori* assumptions. After familiarisation with the data, coding was performed line by
25
26 147 line for each of the responses from interested parties in NVivo (software developed by QSR
27
28 148 International for qualitative research).

29 149 Each response was assigned to a category based on the person or organisation from which it
30
31 150 originated to stratify responses between the various types of interested parties (Table 2).
32
33 151 These categories were initially determined by assigning labels to each response and then
34
35 152 subsequently refined by the reviewers. A list of each group classified by category can be
36
37 153 found in the Appendix Tables B1 and B2. The longest and second longest submissions from
38
39 154 each category were then coded to develop the initial framework.

40
41 155 Table 2: The categories into which stakeholder groups were classified.
42

Category	Definition
Advertising stakeholders	Advertising companies and representative bodies
Broadcast stakeholders	Broadcasting companies and representative bodies
Civil society groups	Groups that represent the interests of all or some of the general population. This does not include groups that may have

	affiliations with industry who would be included in one of the 'stakeholders' groups.
Food manufacturers	Companies that produce and sell food to retailers
Food retailers	A company that sells food to the general population
Food industry representative groups	Bodies that represent the interests of groups of food manufacturers and retailers
Politicians	Persons professionally involved in politics
Public health stakeholders	Groups that focus on promoting the health of the population

156

157 Following coding of the first two longest responses in each category by AR, a set of codes to
 158 apply to further responses was agreed between all authors. Codes were also grouped into
 159 themes at this stage to provide the most meaningful thematic coding of the data. The
 160 remaining responses were all coded using this analytical framework by AR with additional
 161 codes being created when needed. Once each of the responses was coded, a 10% sample of
 162 the data were independently duplicate-coded by one of the other authors (JA or MW) in
 163 order to ensure appropriate categorisation of the various codes and code hierarchy, and to
 164 improve internal validity. Using a matrix, the data were charted resulting in a summary of
 165 the data by category from each transcript. Illustrative quotations were highlighted at this
 166 point.

167 The resulting charted data were then interpreted and analysed to determine recurrent
 168 themes or topics. These were explored further using quotations to demonstrate the range
 169 of opinions in relation to each theme or topic. The positions taken by the interested parties
 170 were then compared to Ofcom's starting position and final statement, to identify which
 171 positions from which stakeholders appeared to have held the most influence on Ofcom's
 172 final position.

1
2
3 173
45 174 **Ethics**

6
7
8 175 Ethical permission was not sought for this study. The consultation responses used have
9
10 176 been made freely available on the Ofcom website with the full knowledge of their authors.
11 177 We, therefore, treat this as publically available data which does not require ethical
12
13 178 permission for analysis. As we did not seek informed consent from the authors of
14
15 179 consultation responses, we do not name them here – although names were provided on the
16
17 180 Ofcom website. Instead, we have used only the categories described in Table 2 to identify
18
19 181 quotations in our results. This also avoided the study from becoming too focused on specific
20
21 182 stakeholders rather than building a general picture of arguments used by different
22
23 183 stakeholder groups.
24

25 184

26
27 185 **Results**

28
29 186 Of 1136 responses received to both rounds of consultation, 997 were from individual
30
31 187 members of the public (and thus excluded from the analysis); 139 were from stakeholder
32
33 188 groups and were included in the analysis; 114 were responses to the initial consultation and
34
35 189 25 responses to the second consultation. The vast majority of responses from individuals
36
37 190 were one-line statements of support for some form of restrictions without directly
38
39 191 addressing specific issues concerning implementation. As such it was determined that there
40
41 192 was not sufficient detail to determine arguments used, or positions taken. Therefore, these
42
43 193 responses are unlikely to have influenced Ofcom other than to reaffirm that there was
44
45 194 public support for some form of restriction.
46

47 195

48
49 196 The stakeholder responses varied in length from a few lines to double-digit numbers of
50
51 197 pages. Most took the form of an initial broad statement outlining a policy position with
52
53 198 supporting evidence, followed by shorter responses directed at addressing the specific
54
55 199 questions in the consultation as outlined by Ofcom (shown in Table A, Appendix).

56
57 200
58
59
60

201 The organisations in the stakeholder groups outlined in Table 2 broadly fell into two
 202 separate categories. Civil society groups, politicians and public health stakeholders were
 203 encouraging of restrictions in order to reduce the exposure of children to advertising of
 204 HFSS foods. Advertising stakeholders, broadcast stakeholders, food manufacturers, food
 205 retailers and food industry stakeholders argued that restrictions would minimally impact
 206 childhood obesity whilst having a substantial impact on businesses. Though there were
 207 subtleties within each group with regards to what level of restrictions would be ideal, there
 208 were not sufficient differences in order to further analyse the differences in responses of
 209 the various stakeholder groups beyond these two broad categories.

210 The key changes from the initial Ofcom position to the final recommendations are
 211 summarised in Table 3. Arguments relating to each of the principles below, as outlined in
 212 the recommendations, were captured from the framework and are described in detail.

213 Table 3: The changes in Ofcom's position during the course of the consultation

Initial options presented by Ofcom	Consultation responses and Ofcom's reaction	Ofcom's final position	Reference in consultation
<i>Ofcom's packages 1-3 varied on 3 key principles:</i>			
1. Restrictions on advertising of all foods versus just HFSS foods	Following the first consultation it was clear that the majority of responses preferred restricting advertising of only HFSS foods.	The eventual package of restrictions enacted was specific to HFSS foods.	Ofcom Executive Summary 1.12
2. Total ban on food advertising versus volume-based restrictions	Almost all stakeholders did not consider volume-based restrictions as being effective at reducing exposure to advertising and this option	There was a total ban enacted on HFSS food advertising in programming 'of	Ofcom Executive Summary 1.12

	was dismissed following the first consultation.	particular interest to' children.	
3. Restrictions only on children's channels versus all programmes 'of particular interest' to children, irrespective of channel	Some responses highlighted that children may watch adult TV and a ban on all less healthy food advertising before a 9pm watershed may be more effective than focusing specifically on children's programming. Other responses worried that this would disproportionately impact advertising revenues.	Ofcom rejected the idea of a pre-9pm ban due to concerns about the effect it would have on broadcasters, programming and advertising revenues.	Ofcom Executive Summary 1.12
<i>Further changes that were made:</i>			
Restrictions should apply to children aged 4-9 years	Many responses pointed out that children are legally defined as under 16 years.	The restrictions applied to children aged 4-15 years.	Ofcom Final Statement 4.9
All restrictions should start in April 2007	Children's channels argued that they should be allowed a transitional period as they would be affected financially.	Children's channels were allowed a phased implementation of restrictions, with final implementation by January 2009.	Ofcom Final Statement 5.3/5.4

214

215 ***To which foods should restrictions apply?***

1
2
3 216 There was non-partisan agreement that having a blanket ban on all television food
4
5 217 advertising was counter-productive and had the possibility of inadvertently reducing
6
7 218 exposure of children to advertisements for healthier products.
8

9 219

10
11 220 Quotes: Should restrictions apply to all foods?

12
13
14 221 *“We do not support any options which would restrict advertising of all foods, including foods*
15
16 222 *such as fruit and vegetables, milk and dairy products. These foods can play an important*
17
18 223 *part in children consuming a balanced diet, and we consider that advertising can play a*
19
20 224 *useful role in educating both parents and children in the ways to achieve this.”* (Food
21
22 225 industry stakeholder)

23
24 226 *“[Public health stakeholder] believes that it is desirable to distinguish between healthy and*
25
26 227 *unhealthy foods. We do not believe it would be useful to restrict the advertising of all foods*
27
28 228 *because this would mean manufacturers and retailers would be unable to promote healthy*
29
30 229 *foods, such as fresh fruit and vegetables.”* (Public health stakeholder)

31 230

32
33
34 231 As the underlying aim of the restrictions was to protect health, preventing the advertising of
35
36 232 healthy products would be counter-productive. Stakeholder groups agreed that banning
37
38 233 advertisements of all foods would be deleterious to efforts to promote healthy eating and
39
40 234 promoting a balanced diet.

41 235

42
43
44 236 **Total ban or volume-based ban?**

45
46 237 The idea of a broad volume-based restriction rather than a total ban targeting children’s
47
48 238 programming was proposed in Package 3 and was nearly universally disliked. Broadcasters,
49
50 239 advertisers and food industry stakeholders argued that a volume-based restriction would
51
52 240 have a very large effect on commercial revenues, whereas public health stakeholders and
53
54 241 civil society groups cited how little a volume-based restriction would actually reduce the
55
56 242 exposure of children to HFSS food advertising.

57 243

58
59
60 244 Quotes: Would a volume-based restriction be effective?

1
2
3 245 *“The least acceptable option would be Package 3, which would have a devastating effect on*
4
5 246 *our overall revenues - several times greater than Ofcom has estimated – while delivering a*
6
7 247 *smaller reduction in the number of times children see food and drink adverts.” (Broadcast*
8
9 248 *stakeholder)*

10
11 249 *“Package 3 not only restricts the option to promote healthy foods to children, but also fails*
12
13 250 *to restrict HFSS adverts during periods of viewing when many children are still watching i.e.*
14
15 251 *up to 9pm.” (Public health stakeholder)*

16
17 252

18
19 253 Many responses argued that Package 3 would result in very little change in exposure of
20
21 254 children to television advertising of HFSS foods but would substantially impact broadcasters
22
23 255 and advertisers financially. Arguments concerning commercial impacts were used
24
25 256 throughout the responses of industry groups, with emphasis on the fact that as a broadcast
26
27 257 regulator, Ofcom has a duty to minimise impact on revenues for broadcasters.

28
29 258

30
31 259 ***Restrictions on children’s programming or a pre-9pm watershed ban?***

32
33 260 Although not included in any of Ofcom’s proposals, one of the consultation questions asked
34
35 261 about whether restricting advertising before 9pm would be a suitable measure. In response,
36
37 262 civil society groups and public health stakeholders called for restricting all HFSS food
38
39 263 advertising before a 9pm ‘watershed’. Advertisers, broadcasters and the food industry
40
41 264 claimed such restrictions would impinge upon adult viewing. All three groups highlighted
42
43 265 the trade-off between protecting children and the loss of advertising exposure to adults.
44
45 266 Advertisers, broadcasters and food industry groups cited the negative commercial impacts
46
47 267 of a pre-9pm watershed ban as outweighing any ‘marginal’ public health benefits; whereas
48
49 268 civil society groups and public health groups saw the public health benefit of a pre-9pm
50
51 269 watershed ban as outweighing commercial impacts.

52
53 270

54
55 271 Quotes: Arguments pertaining to the pre-9pm watershed ban on HFSS food advertising

56
57 272 *“[Food industry stakeholder organisation] welcomes Ofcom’s rejection of the pre-9pm*
58
59 273 *watershed, as this would have been tantamount to a complete ban on the advertising of*

1
2
3 274 *food and soft drink products on television, and would have impacted on adult airtime.”*

4
5 275 (Food industry stakeholder)

6
7 276 *“We believe that the most suitable option is the pre 9pm ban of HFSS advertising, for the*
8
9 277 *following reasons:*

- 10
11 278 • *achieves one of the key regulatory objectives, that of significantly reducing the*
12
13 279 *impact of HFSS advertising on younger children*
14
15 280 • *removes 82% of the recorded HFSS advertising impacts on all children (aged 4-15)*
16
17 281 • *contributes substantially to enhancing protection for older children by reducing their*
18
19 282 *exposure to HFSS advertising*
20
21 283 • *offers the greatest social and health benefits of all options – in the ranges of £50*
22
23 284 *million - £200 million per year or £250million - £990 million per year (depending on*
24
25 285 *the value of life measure)”. (Civil society group)*

26
27 286 *“The avoidance of intrusive regulation of advertising during adult airtime is only justifiable*
28
29 287 *once full account has been taken to address the over-riding priority to protect children’s*
30
31 288 *health. At times when adults and children are watching, the need to protect children must*
32
33 289 *take priority.” (Public health stakeholder)*

34
35 290

36
37 291 In their final statement following the consultation,²³ Ofcom explained why they had rejected
38
39 292 banning HFSS food advertising before a 9pm watershed due to the effect this was expected
40
41 293 to have on adult viewing times and commercial revenues. Industry groups appeared to be
42
43 294 successful in arguing that adult viewing should be unaffected despite the possibility that
44
45 295 both children and adults may be watching television together. The need to protect the right
46
47 296 of adults to see whatever they wish was a common argument against restricting advertising
48
49 297 on television channels that were not explicitly targeted at children. The individual freedom
50
51 298 of an adult therefore appeared to be given precedence over exposing children to HFSS food
52
53 299 advertising.

54 300 Ofcom’s research²³ showed that 48% of parents supported restricting HFSS food advertising
55
56 301 before 9pm, which was often cited by industry responses as evidence of a lack of public
57
58 302 support. Some responses highlighted the fact that the complete figures were 48% in support
59
60 303 of a pre-9pm watershed ban, 24% against the ban, with the remainder undecided. An

1
2
3 304 apparently valid complaint made by public health groups regarding this issue was that
4
5 305 Ofcom did not ever consult on a pre-9pm watershed ban despite its own research showing
6
7 306 this would reduce the exposure of children to HFSS advertising by 82%.

8
9 307 We are also able to see here the use of evidence-based arguments by the civil society group
10
11 308 in making their case. Some civil society groups and public health stakeholders would cite
12
13 309 evidence to support their argument. The quotes above illustrate an example of how a civil
14
15 310 society group used data and evidence to support their arguments by, for instance,
16
17 311 suggesting that banning advertising prior to 9pm could reduce advertising exposure of
18
19 312 children by 82%. This figure was taken from Ofcom's own analysis of the effects of the
20
21 313 various policy options, which can now be found included in Ofcom's final report on the
22
23 314 consultation.²³ Food industry representative groups on the other hand tended to cite a lack
24
25 315 of evidence or only used evidence that appeared to support their arguments..

26 316 Quotes: Arguments regarding available evidence and its interpretation

27
28 317 *"As Ofcom has found from its own research, television advertising has only a "modest direct*
29
30 318 *effect" on children's food preferences, consumption and behaviour, and that other factors –*
31
32 319 *including taste, price familiarity, peer pressure and convenience - all have a higher effect.*
33
34 320 *Hastings, in his report for the Food Standards Agency, found that advertising had only a 2%*
35
36 321 *direct effect on children's choice." (Food company)*

37
38 322 *"Ofcom quotes an estimate that advertising/television accounts for some 2% of variation in*
39
40 323 *food choice/obesity. This is not a small figure considering that calculations by the Institute of*
41
42 324 *Medicine show that this would mean an estimated additional 1.5 million young people in the*
43
44 325 *US falling into the obese category." (Public health interests)*

45
46 326 *"The evidence that television has anything but an extremely small impact on the HFSS*
47
48 327 *element of the diet of children is unconvincing and accordingly it is difficult to support*
49
50 328 *proposals that appear disproportionate." (Broadcast interests)*

51
52 329

53
54 330 ***To what ages of children should the restrictions apply?***

55
56 331 Ofcom initially planned to restrict advertisements targeted at children aged 4-9 years,
57
58 332 although this was subsequently expanded to cover children ages 4-15 years in the final
59
60

1
2
3 333 regulations. Children under 4 years were thought to have little influence over what foods
4
5 334 and drinks were given to them and therefore not considered as part of the restrictions.
6
7 335 Throughout the consultation food industry representative groups and food manufacturers
8
9 336 argued that restricting advertisements to children aged 4-9 years was appropriate, whereas
10
11 337 as public health stakeholders argued that this should be expanded to cover children aged 4-
12
13 338 15 years.

14
15 339

16
17 340 Quotes: Arguments pertaining to the age of children to which restrictions should apply

18
19 341 *"It is neither logical nor is there any explanation as to why Ofcom should propose to limit the*
20
21 342 *focus of regulation to children aged under 10. The government asked Ofcom to consider*
22
23 343 *proposals for strengthening its rules on television advertising of food to children. It did not*
24
25 344 *ask Ofcom to limit its focus to any particular age group. Ofcom should logically apply*
26
27 345 *restrictions according to its own definition of children (aged 15 [or under])."* (Public health
28
29 346 stakeholder)

30
31 347

32
33 348 *"Children develop and refine their ability to interpret advertising messages as they get older.*
34
35 349 *Existing studies suggest that by 10 years old (indeed, most studies suggest an even earlier*
36
37 350 *age) they are considered to have sufficient cognitive development to understand the*
38
39 351 *implications of television advertising."* (Food manufacturer)

40
41 352

42
43 353 *"We are alarmed by the decision to extend volume and scheduling restrictions of food and*
44
45 354 *drink advertising to children under 16. The intention of Ofcom and the government has*
46
47 355 *always been to protect younger children and industry responded on this basis. Ofcom has*
48
49 356 *previously stated that it wished to find a proportionate solution and we question the*
50
51 357 *evidence base on which this decision was made. A review of Ofcom's own literature would*
52
53 358 *seem to contradict the question put to consultation and support the conclusion that young*
54
55 359 *people are capable of differentiating between programming and advertising."* (Food
56
57 360 industry representative group)

58
59 361
60

1
2
3 362 The logic of defining children as aged 4-9 years was questioned by many stakeholders as,
4
5 363 according to Ofcom and in the UK, children are legally defined as those under the age of 16
6
7 364 years. A number of food manufacturers stated that they already did not advertise their
8
9 365 products to children under 8-12 years. They argued that during adolescence children
10
11 366 become 'media literate' and are able to understand advertising and should therefore not be
12
13 367 a target of the restrictions.

14
15 368 Industry arguments appeared to suggest that media 'illiterate' children need protecting
16
17 369 from HFSS food advertising whereas public health groups suggested all children needed
18
19 370 protecting regardless of how 'media literate' they are. Public health groups argued that
20
21 371 adolescents are still susceptible to advertising, have more purchasing power and greater
22
23 372 pester power than younger children, and may not appreciate the health implications of a
24
25 373 poor diet. Ofcom concluded that expanding restrictions to include children aged 4-15 years
26
27 374 was appropriate, suggesting the arguments of public health groups held more weight over
28
29 375 this issue.

30 376

31
32 377 ***When should the restrictions start?***

33
34 378 The need for a transitional period was also hotly debated. Public health stakeholders and
35
36 379 civil society groups suggested that as companies were already aware that restrictions were
37
38 380 due to be enforced any transitional period should be minimal. Industry groups argued that a
39
40 381 transition period was necessary to allow adjustments to be made.

41
42 382

43
44
45 383 Quotes: Arguments pertaining to the need for a transitional period

46
47 384 *"We do not believe [a] transitional period is appropriate. The arguments for "phasing in"*
48
49 385 *restrictions appear to be of a commercial nature and not supportive of the policy's public*
50
51 386 *health objectives."* (Public health stakeholder)

52
53 387 *"We would ask for a transitional period of at least three years. This would allow production*
54
55 388 *companies to adjust, and the growing number of public companies to issue profit warnings*
56
57 389 *where necessary."* (Broadcast stakeholder)

58
59 390
60

1
2
3 391 Instead of starting restrictions soon after announcement of the final policy statement
4
5 392 (February 2007), a phased transition over 1-2 years was implemented (varying for different
6
7 393 channel types), suggesting industry arguments held more weight on this point. Despite the
8
9 394 stated objective of minimising the exposure of children to HFSS food advertising, it appears
10
11 395 that Ofcom was more concerned about the potential commercial impact of advertising
12
13 396 restrictions and delayed enforcement of the restrictions as a result.

14 397

15 398

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For peer review only

1
2
3 399 **Discussion**

4
5 400 ***Summary of principal findings***

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7
8 401 This study presented a unique opportunity for a detailed analysis of responses to a public
9
10 402 consultation on a public health policy in the UK. Such data is often not in the public domain
11
12 403 and these data therefore offered a rare opportunity for scientific scrutiny. For example,
13
14 404 verbatim responses to the 2016 consultation on the UK Soft Drinks Industry Levy, have not
15
16 405 been released. Our paper highlights how, despite the relative transparency of the 2006-7
17
18 406 consultation, the final policy appeared to be substantially influenced by stakeholders.
19
20 407 Commercial and public health interests aligned with regards to whether restrictions should
21
22 408 apply to all foods or just HFSS foods as neither wished to ban advertising of healthy foods.
23
24 409 Likewise, common ground was found when considering a volume-based ban, with it having
25
26 410 large commercial impact but little public health impact as per Ofcom's own findings.²³

27 411
28
29 412 As far as we are aware, this is the first analysis to examine how a range of stakeholder
30
31 413 groups influenced the development of a public health policy aiming to regulate food
32
33 414 industry advertising. Ofcom's decision to implement Modified Package 1 contained
34
35 415 concessions to commercial as well as civil society and public health stakeholders. However,
36
37 416 ultimately industry arguments appeared to hold more sway, with the main concession to
38
39 417 public health groups being expanding restrictions from children aged 4-9 years to those
40
41 418 aged 4 to 15 years. For the most part, Ofcom appeared to make concessions to industry
42
43 419 arguments. Ofcom appeared to believe that the commercial impact of the regulation of
44
45 420 advertising should carry greatest weight, even when the aim of the regulation was to
46
47 421 protect children's health. As such, Ofcom did not formally consider a pre-9pm ban as part of
48
49 422 any of its packages, as had been proposed by public health and civil society stakeholders,
50
51 423 although one of the consultation questions did refer to a pre-9pm ban. Instead, Ofcom
52
53 424 approved a two-year transition period and emphasised the need for 'proportionate action'.
54
55 425 Some responses to the consultation from public health advocates argued that Ofcom, being
56
57 426 a broadcast regulator rather than a public health stakeholder, felt an obligation to protect
58
59 427 industry interests. The case for restricting advertising was made in a Department of Health
60
428 'white paper'²⁴ (NHS Strategy documents are known as 'white papers'). However, Ofcom
429 was tasked with determining how to implement these restrictions. Under the

1
2
3 430 Communications Act 2003, Ofcom retains direct responsibility for advertising scheduling
4
5 431 policy. This then begs the question of whether a governmental body with a duty to protect
6
7 432 broadcasting interests should be leading on public health legislation.
8

9 433

10
11 434 This conflict between Ofcom's duties to the public and to broadcasters, may have resulted
12
13 435 in eventual restrictions that did not appear to alter the level of exposure of children to HFSS
14
15 436 food advertising.^{13,14} Ofcom appeared to balance arguments related to commercial and
16
17 437 public interests, in terms of jobs and the wider economy, with those relating to public
18
19 438 health. Being proportionate in their restrictions was frequently cited by Ofcom in their
20
21 439 decision making. Ofcom did not, however, appear to consider the cost to the economy of
22
23 440 poor health that could stem from a lack of appropriate restrictions. Although this was cited
24
25 441 by some public health groups (see quotes pertaining to a pre-9pm ban) this does not appear
26
27 442 to have been considered by Ofcom in their final report, with no mention of wider societal
28
29 443 costs. Ofcom also appeared to give greater priority to allowing advertisers access to adults
30
31 444 than to restricting exposure to HFSS food advertising among children, who may be viewing
32
33 445 the same programming. Industry representative groups tended to highlight commercial
34
35 446 arguments whilst citing evidence that appeared to downplay the role of television
36
37 447 advertising in childhood obesity. Public health groups emphasised that the health of
38
39 448 children should outweigh any financial concerns and pointed out that even small changes to
40
41 449 advertising at an individual level would affect large numbers of children and so accrue to
42
43 450 large population level benefits.

44 451

45 452 ***Strengths and Limitations***

46
47
48 453 Using established qualitative methods allowed us to identify key themes in the consultation
49
50 454 responses according to stakeholder interests. The creation of a *de novo* framework
51
52 455 minimised bias that might have been imposed by using a pre-existing framework. Instead,
53
54 456 we allowed categories to emerge from the data. The classification of the responses also
55
56 457 enabled us to see what positions were taken by the various stakeholders and which type of
57
58 458 responses carried the most influence. Measures were taken to maximise the reliability of
59
60 459 our coding, such as duplicate coding a sample of consultation responses. The use of publicly

1
2
3 460 available data was resource efficient. Additionally, the use of all the available data ensured
4
5 461 that no perspectives were omitted, adding to internally validity. The omission of responses
6
7 462 from individual members of the public was because most public responses lacked detail and
8
9 463 were no more than a sentence long. Commercial influences on public health policy are
10
11 464 unlikely to have changed over the past decade with no changes in lobbying rules or policy
12
13 465 making procedures, making it highly likely that our findings from the 2007 consultation are
14
15 466 applicable today.

16
17 467

18
19 468 There may be alternative methods by which the public influences policy making, such as by
20
21 469 writing to their Member of Parliament. This is a study of only one case of public health
22
23 470 policy making and our specific findings may not be generalisable to other aspects of dietary
24
25 471 public health policy specifically or public health policy more generally. In this consultation,
26
27 472 all members of a stakeholder category were treated as one, though there was some inter-
28
29 473 category variation on position. There are also other ways by which interested parties could
30
31 474 influence Ofcom, which we were unable to examine in this study. For example, Ofcom gave
32
33 475 the option of providing confidential responses which were not available for us to
34
35 476 incorporate into our dataset. Other informal lobbying may have occurred. Whether such
36
37 477 channels of influence were used or whether similar arguments will have been used privately
38
39 478 as were used publicly is unclear.

40
41 479

42 480 ***Relationship to existing knowledge***

43
44 481 Some literature exists on the methods by which public health advocates influence policy. In
45
46 482 2006, the New Zealand government held an 'Inquiry into Obesity' in order to determine
47
48 483 what could be done to limit increasing obesity rates.¹² Jenkin *et al* found that in three out of
49
50 484 four domains examined, the governmental position aligned with that of industry groups,
51
52 485 with the exception being nutritional policy in schools. In the other three domains, national
53
54 486 obesity strategy, food industry policy, and advertising and marketing policy, the analysis
55
56 487 determined that the governmental position allied with industry groups. Much like our study,
57
58 488 public health groups were shown to have a limited impact on the eventual policies, with
59
60 489 industry arguments proving more influential. An explanation suggested for this was the

1
2
3 490 significance of the food industry to New Zealand's economy, highlighting how
4
5 491 considerations outside of public health may importantly shape public health policy. It may
6
7 492 be the case that similar factors shaped the eventual restrictions in our case study, despite
8
9 493 the appearance of Ofcom wanting to develop 'proportionate restrictions', balancing
10
11 494 commercial and public health interests. The question of what is proportionate appears to be
12
13 495 determined by ideology and how much one feels government's role is to protect health
14
15 496 even if it impacts on industry. If this is the case, we must question whether commercial
16
17 497 companies can ever be truly motivated to improve health at the possible detriment to their
18
19 498 short-term profits. A thematic analysis of alcohol industry documents in Australia²⁵
20
21 499 concluded that the industry attempted to create an impression of social responsibility whilst
22
23 500 promoting interventions that did not affect their profits and campaigning against effective
24
25 501 interventions that might affect profits. The *de facto* exemption of commercial stakeholders
26
27 502 from bearing the negative external costs of their profitable endeavours (e.g. environmental,
28
29 503 social or health impacts) has been widely questioned.²⁶

30 504

31 505 ***Interpretation and implications of the study***

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33
34 506 Much of the research undertaken to date on stakeholder influences on public health policy
35
36 507 has focused on industry behaviours and practices, whereas in this study we have treated
37
38 508 both pro-industry and pro-public health groups equally in our analysis. Our findings suggest
39
40 509 that, in the case of the Ofcom consultation on the regulation of TV advertising of foods to
41
42 510 children, civil society and public health stakeholders carried less weight than their industry
43
44 511 counterparts. Industry groups were apparently successfully able to argue that extensive
45
46 512 restrictions would impact upon their commercial revenues, suggesting that their economic
47
48 513 arguments importantly influenced the thinking of policy-makers. However, the future
49
50 514 (external) costs of treating the potential health implications of HFSS food consumption did
51
52 515 not appear to influence policy-making. This may be because any potential cost-savings are
53
54 516 long-term and would apply to the health sector, for which Ofcom has no governmental
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56 517 responsibility, whereas the short-term costs would apply to the broadcast sector for which
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58 518 Ofcom is the regulatory body.

59 519
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1
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3 520 Public health advocacy is an activity in which many public health professionals are keen to
4
5 521 become more effective to better ensure that evidence is translated into policy.^{27,28} This
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7 522 study highlights that responding to public health policy consultations alone may not result in
8
9 523 policy making favourable to public health and other avenues of influence may also need to
10
11 524 be explored. Conversely, the change in the definition of children from 4-9 years to 4-15
12
13 525 years demonstrates that there is scope for public health advocates to shape policy should
14
15 526 an issue be sufficiently clear and difficult to oppose. A more Machiavellian interpretation
16
17 527 would be that to define children as aged 4-9 years at the outset may have been a cynical
18
19 528 ploy aimed at ensuring that there was at least some ground to concede to public health
20
21 529 stakeholders and distract from the more contentious issues. This is supported by the fact
22
23 530 that the definition of children as aged 4-9 years was inherently questionable, given Ofcom's
24
25 531 own definition of children as under 16 years, in line with the legal and medical definitions
26
27 532 used in the UK. A few companies pointed to their media literacy campaigns as evidence that
28
29 533 adolescents can understand advertising as an argument against redefining the scope of
30
31 534 these restrictions to children aged 4-15 years. Evidence shows that advertisers simply use
32
33 535 different ways to target adolescents,²⁹ rendering media literacy moot,³⁰ and suggesting that
34
35 536 restrictions are still needed to protect adolescents.

36
37 537

38
39 538 The issue of TV advertising of less healthy foods remains highly politically sensitive and at
40
41 539 the top of the public health strategy agenda for obesity.¹⁸ Many UK public health
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43 540 organisations have recently campaigned to ban television advertising of less healthy foods
44
45 541 before 9pm (the so-called 9pm watershed).^{16,17,31-34} Our analysis of the 2006-7 consultation
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47 542 offers specific insights that could be influential in this ongoing national debate, in the same
48
49 543 way as such analyses of historical documents have influenced tobacco control efforts in
50
51 544 recent years.^{10,35} The Ofcom regulation of television advertising of less healthy foods to
52
53 545 children is one of few national public health policies of this sort to have been independently
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55 546 evaluated.^{14,36} The independent evaluation found that the introduction of the regulations
56
57 547 were not associated with a decrease in children's exposure to less healthy food
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59 548 advertising.³⁶ Our analysis sheds further light on why and how a regulatory policy that
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549 appears to have been ineffective in reducing children's exposure to less healthy food
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551 550 advertising came about. Publishing responses to public consultations in full is a key

1
2
3 551 component of transparent policy making. The UK Treasury's reluctance to make available
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5 552 responses to the Soft Drinks Industry Levy consultation is contrary to this principle.
6

7 553
8

9 554 ***Further questions and future research***

11 555 How policy making is influenced through means other than public consultations should be
12
13 556 further studied. Other means of applying political pressure such as political lobbying and
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15 557 having indirect relationships with positions of power are much more opaque and difficult to
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17 558 monitor. Parliamentary records of lobbying activity, copies of internal or leaked documents
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19 559 and registers of MPs interests may all be potential sources of data to explore these issues
20
21 560 further. Interviews with former or current employees of policy forming bodies such as
22
23 561 Ofcom, as well as other stakeholder groups could also be fruitful. Claims made during this
24
25 562 consultation, such as industry claims of needing to issue profit warnings as a consequence of
26
27 563 lost revenue from these restrictions, could be analysed. Thematic analysis of further
28
29 564 documents such as the responses analysed in this study could provide valuable insight into
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31 565 whether a similar combination of commercial arguments and questioning scientific data is
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33 566 used across different public health policy consultations.
34

35 567

36 568 **Conclusion**

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38
39 569 This analysis increases our understanding of how influential some stakeholders are in policy
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41 570 making and provides a framework from which further understanding of the influences on
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43 571 public health policy can be determined. From this case study, we can see that commercial
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45 572 influences on dietary public health policy-making appear to be somewhat greater than the
46
47 573 influence of public health stakeholders and this imbalance may have contributed to the
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49 574 ultimately compromised legislation. In this case, the potential for commercial impacts of
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51 575 legislation promoting public health appeared to outweigh the anticipated population health
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53 576 benefits in policy decision making.
54

55 577

56 578 **Authors' contributions** – The authors declare that they have no competing interests.

57 579 Responses were coded by AR with a sub-sample independently duplicate coded by JA or

58
59 580 MW. AR, JA and MW contributed to the manuscript in terms of both writing and editing.
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52
53
54
55
56
57
58
59
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602 **References**

- 603 1. Global Health Observatory. WHO | Obesity. WHO.
- 604 2. WHO | Reducing the impact of marketing of foods and non-alcoholic beverages on
605 children. WHO. 2014.
606 http://www.who.int/elena/titles/guidance_summaries/food_marketing_children/en/
607 . Accessed August 8, 2017.
- 608 3. Kraak VI, Vandevijvere S, Sacks G, et al. Policy & practice Progress achieved in
609 restricting the marketing of high-fat, sugary and salty food and beverage products to
610 children. *Bull World Heal Organ*. 2016;94:540-548. doi:10.2471/BLT.15.158667.
- 611 4. Raine KD, Lobstein T, Landon J, et al. Restricting marketing to children: Consensus on
612 policy interventions to address obesity. *J Public Health Policy*. 2013;34(2):239-253.
613 doi:10.1057/jphp.2013.9.
- 614 5. Harris JL, Pomeranz JL, Lobstein T, Brownell KD. A Crisis in the Marketplace: How
615 Food Marketing Contributes to Childhood Obesity and What Can Be Done. *Annu Rev*
616 *Public Health*. 2009;30(1):211-225. doi:10.1146/annurev.publhealth.031308.100304.
- 617 6. Cairns G, Angus K, Hastings G, Caraher M. Systematic reviews of the evidence on the
618 nature, extent and effects of food marketing to children. A retrospective summary.
619 *Appetite*. 2013;62:209-215. doi:10.1016/j.appet.2012.04.017.
- 620 7. WHO | Protecting children from the harmful effects of food and drink marketing.
621 WHO. 2014. <http://www.who.int/features/2014/uk-food-drink-marketing/en/>.
622 Accessed June 28, 2017.
- 623 8. Sibbald B. Sugar industry sour on WHO report. *CMAJ*. 2003;168(12):1585.
624 [http://www.pubmedcentral.nih.gov/articlerender.fcgi?artid=156706&tool=pmcentre](http://www.pubmedcentral.nih.gov/articlerender.fcgi?artid=156706&tool=pmcentrez&rendertype=abstract)
625 [z&rendertype=abstract](http://www.pubmedcentral.nih.gov/articlerender.fcgi?artid=156706&tool=pmcentrez&rendertype=abstract). Accessed December 23, 2015.
- 626 9. Savell E, Fooks G, Gilmore AB. How does the alcohol industry attempt to influence
627 marketing regulations? A systematic review. *Addiction*. 2016;111(1):18-32.
628 doi:10.1111/add.13048.
- 629 10. Savell E, Gilmore AB, Fooks G, Weishaar H, Gilmore A. How Does the Tobacco
630 Industry Attempt to Influence Marketing Regulations? A Systematic Review. Derrick

- 1
2
3 631 GE, ed. *PLoS One*. 2014;9(2):e87389. doi:10.1371/journal.pone.0087389.
4
5 632 11. Grüning T, Gilmore AB, McKee M. Tobacco industry influence on science and
6
7 633 scientists in Germany. *Am J Public Health*. 2006;96(1):20-32.
8
9 634 doi:10.2105/AJPH.2004.061507.
10
11 635 12. Jenkin G, Signal L, Thomson G. Nutrition policy in whose interests? A New Zealand
12
13 636 case study. *Public Health Nutr*. 2012;15(8):1483-1488.
14
15 637 doi:10.1017/S1368980011003028.
16
17 638 13. Adams J, Tyrrell R, Adamson AJ, White M. Effect of restrictions on television food
18
19 639 advertising to children on exposure to advertisements for “less healthy” foods: repeat
20
21 640 cross-sectional study. *PLoS One*. 2012;7(2):e31578.
22
23 641 doi:10.1371/journal.pone.0031578.
24
25 642 14. Adams J, Hennessy-Priest K, Ingimarsdóttir S, Sheeshka J, Ostbye T, White M. Food
26
27 643 advertising during children’s television in Canada and the UK. *Arch Dis Child*.
28
29 644 2009;94(9):658-662. doi:10.1136/adc.2008.151019.
30
31 645 15. Children’s Food Campaign. *Through the Looking Glass: A Review of Topsy-Turvy Junk*
32
33 646 *Food Marketing Regulations.*; 2013.
34
35 647 https://www.sustainweb.org/publications/through_the_looking_glass/. Accessed
36
37 648 October 10, 2017.
38
39 649 16. Sugar Reduction The evidence for action. 2015. www.gov.uk/phe. Accessed October
40
41 650 10, 2017.
42
43 651 17. The Labour Party. Labour Manifesto.
44
45 652 <http://www.labour.org.uk/index.php/manifesto2017>. Published 2017. Accessed June
46
47 653 28, 2017.
48
49 654 18. *Childhood Obesity: A Plan for Action Chapter 2 2 DH ID Box Title: Childhood Obesity: A*
50
51 655 *Plan for Action, Chapter 2.*; 2018. [www.nationalarchives.gov.uk/doc/open-](http://www.nationalarchives.gov.uk/doc/open-government-licence/)
52
53 656 [government-licence/](http://www.nationalarchives.gov.uk/doc/open-government-licence/). Accessed November 27, 2018.
54
55 657 19. O’Brien BC, Harris IB, Beckman TJ, Reed DA, Cook DA. Standards for reporting
56
57 658 qualitative research: a synthesis of recommendations. *Acad Med*. 2014;89(9):1245-
58
59 659 1251. doi:10.1097/ACM.0000000000000388.
60

- 1
2
3 660 20. Ofcom. *Television Advertising of Food and Drink Products to Children: Final*
4
5 661 *Statement*.
6
7 662 21. Hsieh H-F, Shannon SE. Three approaches to qualitative content analysis. *Qual Health*
8
9 663 *Res*. 2005;15(9):1277-1288. doi:10.1177/1049732305276687.
10
11 664 22. Gale NK, Heath G, Cameron E, Rashid S, Redwood S. Using the framework method for
12
13 665 the analysis of qualitative data in multi-disciplinary health research. *BMC Med Res*
14
15 666 *Methodol*. 2013;13:117. doi:10.1186/1471-2288-13-117.
16
17 667 23. Ofcom. Television Advertising of Food and Drink Products to Children - Ofcom.
18
19 668 https://www.ofcom.org.uk/consultations-and-statements/category-2/foodads_new.
20
21 669 Accessed August 8, 2017.
22
23 670 24. Department of Health. *Choosing Health: Making Healthy Choices Easier.*; 2004.
24
25 671 [https://webarchive.nationalarchives.gov.uk/20120509221645/http://www.dh.gov.uk](https://webarchive.nationalarchives.gov.uk/20120509221645/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_133489.pdf)
26
27 672 [/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/](https://webarchive.nationalarchives.gov.uk/20120509221645/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_133489.pdf)
28
29 673 [dh_133489.pdf](https://webarchive.nationalarchives.gov.uk/20120509221645/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_133489.pdf). Accessed March 12, 2019.
30
31 674 25. Miller PG, de Groot F, McKenzie S, Droste N. Vested interests in addiction research
32
33 675 and policy. Alcohol industry use of social aspect public relations organizations against
34
35 676 preventative health measures. *Addiction*. 2011;106(9):1560-1567.
36
37 677 doi:10.1111/j.1360-0443.2011.03499.x.
38
39 678 26. Stuckler D, Nestle M. Big food, food systems, and global health. *PLoS Med*.
40
41 679 2012;9(6):e1001242. doi:10.1371/journal.pmed.1001242.
42
43 680 27. Dorfman L, Krasnow ID. Public Health and Media Advocacy. *Annu Rev Public Health*.
44
45 681 2014;35(1):293-306. doi:10.1146/annurev-publhealth-032013-182503.
46
47 682 28. Herrick C. The post-2015 landscape: vested interests, corporate social responsibility
48
49 683 and public health advocacy. *Sociol Health Illn*. 2016;38(7):1026-1042.
50
51 684 doi:10.1111/1467-9566.12424.
52
53 685 29. Livingstone S, Helsper EJ. Does Advertising Literacy Mediate the Effects of Advertising
54
55 686 on Children? A Critical Examination of Two Linked Research Literatures in Relation to
56
57 687 Obesity and Food Choice. *J Commun*. 2006;56(3):560-584. doi:10.1111/j.1460-
58
59 688 2466.2006.00301.x.
60

- 1
2
3 689 30. Montgomery KC, Chester J. Interactive Food and Beverage Marketing: Targeting
4
5 690 Adolescents in the Digital Age. *J Adolesc Heal*. 2009;45(3):S18-S29.
6
7 691 doi:10.1016/j.jadohealth.2009.04.006.
8
9 692 31. Sustain / Children's Food Campaign. Junk Food Marketing.
10
11 693 https://www.sustainweb.org/childrensfoodcampaign/junk_food_marketing/.
12
13 694 Accessed November 1, 2017.
14
15 695 32. Cancer Research UK. Being overweight or obese could cause around 700,000 new UK
16
17 696 cancers by 2035 | Cancer Research UK. [http://www.cancerresearchuk.org/about-](http://www.cancerresearchuk.org/about-us/cancer-news/press-release/2016-01-07-being-overweight-or-obese-could-cause-around-700000-new-uk-cancers-by-2035)
18
19 697 [us/cancer-news/press-release/2016-01-07-being-overweight-or-obese-could-cause-](http://www.cancerresearchuk.org/about-us/cancer-news/press-release/2016-01-07-being-overweight-or-obese-could-cause-around-700000-new-uk-cancers-by-2035)
20
21 698 [around-700000-new-uk-cancers-by-2035](http://www.cancerresearchuk.org/about-us/cancer-news/press-release/2016-01-07-being-overweight-or-obese-could-cause-around-700000-new-uk-cancers-by-2035). Accessed November 1, 2017.
22
23 699 33. Obesity Health Alliance. Tackling Childhood Obesity - 2017 Election Manifesto.
24
25 700 <http://obesityhealthalliance.org.uk/policy/>. Accessed November 1, 2017.
26
27 701 34. Faculty of Public Health. Start Well, Live Better.
28
29 702 http://www.fph.org.uk/start_well%2C_live_better_-_a_manifesto. Accessed
30
31 703 November 1, 2017.
32
33 704 35. Fooks GJ, Gilmore AB. Corporate philanthropy, political influence, and health policy.
34
35 705 *PLoS One*. 2013;8(11):e80864. doi:10.1371/journal.pone.0080864.
36
37 706 36. Adams J, Tyrrell R, Adamson AJ, White M. Effect of restrictions on television food
38
39 707 advertising to children on exposure to advertisements for "less healthy" foods: repeat
40
41 708 cross-sectional study. *PLoS One*. 2012;7(2):e31578.
42
43 709 doi:10.1371/journal.pone.0031578.
44
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3 712 **Figure titles and legends**
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5 713 Figure 1: A timeline of the Ofcom process on developing new recommendations for limiting
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7 714 television food advertising to children.
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9
10 715 *Figure 1 legend:*
11

12 716 * 'Interested parties' are stakeholder groups who may have been affected by the proposed
13
14 717 changes, including advertising agencies, advocacy groups, broadcasters, charities,
15
16 718 healthcare associations, politicians, the food industry and the general public.
17

18 719

19
20 720 Table 1: Packages of regulations proposed by Ofcom in the initial consultation (March 2006)
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22
23 721 *Table 1 legend:*
24

25 722 * HFSS food = High, Fat, Sugar and Salt foods
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27 723 + 'of particular appeal to children' = when the proportion of people watching who are
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29 724 children is more than 120% of the proportion of children in the UK population²³
30

31 725
32

33
34 726 Table 2: The categories into which stakeholder groups were classified. A list of each group
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36 727 classified by category can be found in the Appendix.
37

38 728

39
40 729 Table 3: The changes in Ofcom's position during the course of the consultation
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45 731 **Appendix**
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47 732 Table A: The questions Ofcom asked as part of the consultation
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52 734 Table B1: The classification of the responses by organisational category
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56 736 Table B2: The classification of the responses by organisational category (continued)
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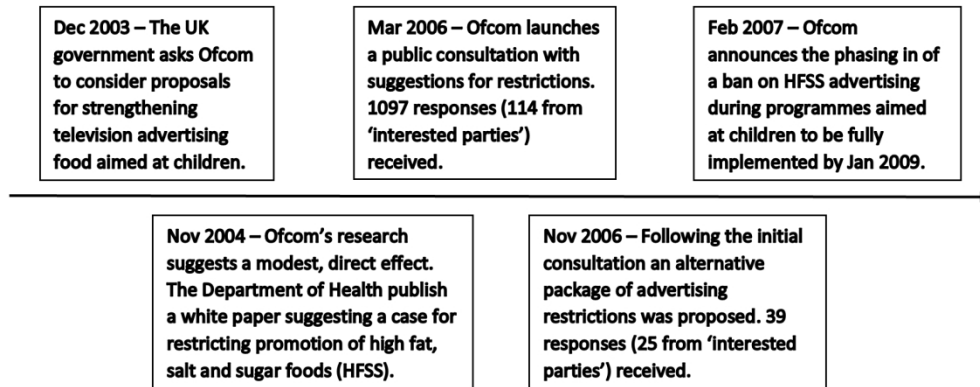


Figure 1: A timeline of the Ofcom process on developing new recommendations for limiting television food advertising to children.

Legend: * 'Interested parties' are stakeholder groups who may have been affected by the proposed changes, including advertising agencies, advocacy groups, broadcasters, charities, healthcare associations, politicians, the food industry and the general public.

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- Question 1 Do you agree that the regulatory objectives set out in paragraph 5.2 above are appropriate?
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- Question 2 Do you consider that it is desirable to distinguish between foods that are high in fat, salt or sugar and those that are healthier in order to achieve the regulatory objectives, or could an undifferentiated approach provide a reasonable alternative?
-
- Question 3 If so, do you consider the FSA's nutrient profiling scheme to be a practical and reasonable basis for doing so? If not, what alternative would you propose? (Note: The nutrient profiling scheme was developed by the FSA and handed to Ofcom following extensive consultation (see FSA web site). This being the case, and given the scheme itself and the science upon which it is based fall outside Ofcom's area of responsibility and expertise, it is not appropriate in this consultation to seek responses on those matters)
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- Question 4 Do you agree that voluntary self-regulation would not be likely to meet Ofcom's regulatory objectives or the public policy objectives?
-
- Question 5 Do you agree that the exclusion of all HFSS advertising before 9.00pm would be disproportionate?
-
- Question 6 Do you agree that all food and drink advertising and sponsorship should be excluded from programmes aimed at pre-school children?
-
- Question 7 Do you agree that revised content standards should apply to the advertising or sponsorship of all food and drink advertisements?
-
- Question 8 Do you consider that the proposed age bands used in those rules aimed at preventing targeting of specific groups of children are appropriate?
-
- Question 9 Do you consider the proposed content standards including their proposed wording to be appropriate, and if not, what changes would you propose, and why?
-
- Question 10 Do you consider a transitional period would be appropriate for children's channels in the context of the scheduling restrictions, and if so, what measure of the 'amount' of advertising should be used?
-
- Question 11 Do you consider there is a case for exempting low child audience satellite and cable channels from the provisions of Package 3?
-
- Question 12 Do you agree that there should not be a phase-in period for children's channels under Package 3?
-
- Question 13 Which of the three policy packages would you prefer to be incorporated into the advertising code and for what reasons?
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- Question 14 Alternatively, do you consider that a combination of different elements of the three packages would be suitable? If so, which elements would you favour within an alternative package? (You should note that the analysis in the Impact Assessment has focused on estimating the costs of restricting scheduling, volume, and content separately and would therefore allow consideration of other combinations of the same elements).
-
- Question 15 Where you favour either Package 1 or 2, do you agree that it would be appropriate to allow children's channels a transitional period to phase in restrictions on HFSS / food advertising, on the lines proposed?
-
- Question 16 Do you consider that the packages should include restrictions on brand advertising and sponsorship? If so, what criteria would be most appropriate to define a relevant brand? If not, do you see any issue with the prospect of food manufacturers substituting brand advertising and sponsorship for product promotion?
-
- Question 17 Ofcom invites comments on the implementation approach set out in paragraph 5.45 and 5.46.

Advertising stakeholders	Broadcast stakeholders	Lawyers	Politicians	Retailers
Institute of Practitioners in Advertising	Producer's Alliance for Cinema and Television 1	Baker and McKenzie LLP	Mary Creagh MP	Sainsbury
Advertising Association	Five		Welsh Assembly	The Co-operative
Incorporated Society of British Advertisers 1	Channel 4		All Party Parliamentary group on Heart Disease	British Retail Consortium 1
Mediavest Manchester	Flextech television		David Amess MP	British Retail Consortium 2
Zenith Optimedia	ITV			
Mindshare	GMTV			
Incorporated Society of British Advertisers 2	Jetix, Nickelodeon and Turner			
	Producer's Alliance for Cinema and Television 2			
	Broadcast Advertising Clearance Centre			
	British Academy of Film and Television Arts			
	Broadcast Committee of Advertising Practice			

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Food companies	Food industry representative groups	Civil society groups	Public health stakeholders
Kellogg 1	Food Advertising Unit 1	Kids Inc	National Heart Forum 1
Kraft 1	Food and Drink Federation 2	Consumer Council of Northern Ireland	Northern Ireland Chest Heart and Stroke 2
Pepsico	Snack Nut and Crisp Manufacturers Association 1	Children's Food Bill Coalition	UK Public Health Association
GlaxoSmithKline 1	Food Advertising Unit 2	National Consumer Council 1	Royal Society of Health
United Biscuits	Food and Drink Federation 1	Which 1	Consensus Action on Salt and Health
Nestle	Dairy Council	Officer of the Children's Commissioner	Nutrition Society
Cadbury	Snack Nut and Crisp Manufacturers Association 2	School Food Trust 1	Diabetes UK
Ferrero 1	Provision Trade Federation	Trading Standards Institute	Association for the Study of Obesity
Masterfoods 2	British Cheese Board	Which 2	Heart of Mersey 2
Coca-cola 1	Biscuit Cake Chocolate Confectionary Association 1	Welsh Consumer Council	National Oral Health Promotion Group
McDonalds 2	Biscuit Cake Chocolate Confectionary Association 2	Food Aware	Scientific Advisory Committee on Nutrition
Vimto	Dairy UK	SafeFood Ireland	British Psychological Society
Wrigley		The Caroline Walker Trust	British Dietetic Association
Wiltshire farm foods		Advisory Committee for England	National Heart Forum 2
Unilever		Voice of the Listener and Viewer 2	British Heart Foundation 2
GlaxoSmithKline 2		Advertising Advisory Committee	British Medical Association 1
Coca-cola 2		British Nutrition Foundation	Cheshire and Merseyside Public Health Network
Masterfoods 2		Food Ethics Council	Health Protection Agency Northern Ireland
Kraft 2		Voice of the Listener and the Viewer 1	Irish Heart Foundation 1
McDonalds 1		National Consumer Council 2	National Heart Alliance Ireland 1
RHM Group		National Family and Parenting Institute	National Heart Alliance Ireland 2
Kellogg 2		National Union of Teachers	International Association for the Study of Obesity 1
Ferrero 2		The Nutrition Society	British Medical Association 2
		Children's Food Campaign	Heart of Mersey 1
		Consumer Council	Northern Ireland Chest Heart and Stroke 1
		Barnardos	Irish Heart Foundation 2
		National Children's Bureau	NHS Borders
		Public Voice	Medical Research Council 1
		School Food Trust	British Heart Foundation 2
		Scotland's Commissioner for Young People	Cancer Research UK
		Food Standards Agency	Northern Ireland Chest Heart and Stroke 3
		National Youth Agency	International Association for the Study of Obesity 2
		Advisory Committee for Northern Ireland	Royal College of Physicians
		Food Commission 1	Weight Concern
		Women's Institute 1	British Dental Association
		The Food Commission	Medical Research Council 2
		The Obesity Awareness and Solutions Trust	Joint statement by the British Heart Foundation, Cancer Research UK and Diabetes UK
		National Federation of Women's Institutes 1	Royal College of Nursing
		National Federation of Women's Institutes 2	

Reporting checklist for qualitative study.

Based on the SRQR guidelines.

Instructions to authors

Complete this checklist by entering the page numbers from your manuscript where readers will find each of the items listed below.

Your article may not currently address all the items on the checklist. Please modify your text to include the missing information. If you are certain that an item does not apply, please write "n/a" and provide a short explanation.

Upload your completed checklist as an extra file when you submit to a journal.

In your methods section, say that you used the SRQR reporting guidelines, and cite them as:

O'Brien BC, Harris IB, Beckman TJ, Reed DA, Cook DA. Standards for reporting qualitative research: a synthesis of recommendations. *Acad Med.* 2014;89(9):1245-1251.

	Reporting Item	Page Number
	#1 Concise description of the nature and topic of the study identifying the study as qualitative or indicating the approach (e.g. ethnography, grounded theory) or data collection methods (e.g. interview, focus group) is recommended	5
	#2 Summary of the key elements of the study using the abstract format of the intended publication; typically includes background, purpose, methods, results and conclusions	2
Problem formulation	#3 Description and significance of the problem / phenomenon studied: review of relevant theory and empirical work; problem statement	4
Purpose or research question	#4 Purpose of the study and specific objectives or questions	5
Qualitative approach and research paradigm	#5 Qualitative approach (e.g. ethnography, grounded theory, case study, phenomenology, narrative research) and	5

guiding theory if appropriate; identifying the research paradigm (e.g. postpositivist, constructivist / interpretivist) is also recommended; rationale. The rationale should briefly discuss the justification for choosing that theory, approach, method or technique rather than other options available; the assumptions and limitations implicit in those choices and how those choices influence study conclusions and transferability. As appropriate the rationale for several items might be discussed together.

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14	Researcher	#6	Researchers' characteristics that may influence the	1
15	characteristics and		research, including personal attributes, qualifications /	
16	reflexivity		experience, relationship with participants, assumptions	
17			and / or presuppositions; potential or actual interaction	
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19			questions, approach, methods, results and / or	
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25	Context	#7	Setting / site and salient contextual factors; rationale	4
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28	Sampling strategy	#8	How and why research participants, documents, or	5
29			events were selected; criteria for deciding when no	
30			further sampling was necessary (e.g. sampling	
31			saturation); rationale	
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35	Ethical issues pertaining	#9	Documentation of approval by an appropriate ethics	8
36	to human subjects		review board and participant consent, or explanation for	
37			lack thereof; other confidentiality and data security issues	
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40	Data collection methods	#10	Types of data collected; details of data collection	5
41			procedures including (as appropriate) start and stop	
42			dates of data collection and analysis, iterative process,	
43			triangulation of sources / methods, and modification of	
44			procedures in response to evolving study findings;	
45			rationale	
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50	Data collection	#11	Description of instruments (e.g. interview guides,	6
51	instruments and		questionnaires) and devices (e.g. audio recorders) used	
52	technologies		for data collection; if / how the instruments(s) changed	
53			over the course of the study	
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57	Units of study	#12	Number and relevant characteristics of participants,	8
58			documents, or events included in the study; level of	
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		participation (could be reported in results)	
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3	Data processing	#13 Methods for processing data prior to and during analysis, including transcription, data entry, data management and security, verification of data integrity, data coding, and anonymisation / deidentification of excerpts	6
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9	Data analysis	#14 Process by which inferences, themes, etc. were identified and developed, including the researchers involved in data analysis; usually references a specific paradigm or approach; rationale	6
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16	Techniques to enhance trustworthiness	#15 Techniques to enhance trustworthiness and credibility of data analysis (e.g. member checking, audit trail, triangulation); rationale	7
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21	Syntheses and interpretation	#16 Main findings (e.g. interpretations, inferences, and themes); might include development of a theory or model, or integration with prior research or theory	8
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27	Links to empirical data	#17 Evidence (e.g. quotes, field notes, text excerpts, photographs) to substantiate analytic findings	11
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31	Intergration with prior work, implications, transferability and contribution(s) to the field	#18 Short summary of main findings; explanation of how findings and conclusions connect to, support, elaborate on, or challenge conclusions of earlier scholarship; discussion of scope of application / generalizability; identification of unique contributions(s) to scholarship in a discipline or field	17
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40	Limitations	#19 Trustworthiness and limitations of findings	18
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43	Conflicts of interest	#20 Potential sources of influence of perceived influence on study conduct and conclusions; how these were managed	1
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48	Funding	#21 Sources of funding and other support; role of funders in data collection, interpretation and reporting	1
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BMJ Open

What arguments and from whom are most influential in shaping public health policy: Thematic content analysis of responses to a public consultation on the regulation of television food advertising to children in the UK

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Primary Subject Heading:	Public health
Secondary Subject Heading:	Health policy, Public health, Qualitative research
Keywords:	PUBLIC HEALTH, QUALITATIVE RESEARCH, Health policy < HEALTH SERVICES ADMINISTRATION & MANAGEMENT

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3 1 TITLE PAGE
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6 2 Article Title: What arguments and from whom are most influential in shaping
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8 3 public health policy: Thematic content analysis of responses to a public
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10 4 consultation on the regulation of television food advertising to children in the
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12 5 UK
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35
36 16 Key words: public health; health policy; diet; qualitative research; influence

37
38 17 4570 words

39
40 18 Competing interests - None

41
42 19 Funding - This work was undertaken by the Centre for Diet and Activity Research (CEDAR), a
43
44 20 UKCRC Public Health Research Centre of Excellence. Funding from Cancer Research UK, the
45
46 21 British Heart Foundation, the Economic and Social Research Council, the Medical Research
47
48 22 Council, the National Institute for Health Research, and the Wellcome Trust, under the
49
50 23 auspices of the UK Clinical Research Collaboration, is gratefully acknowledged. The funders
51
52 24 had no role in the study design, data collection, analysis, interpretation, or writing, nor in
53
54 25 the decision to submit the article for publication.

55
56 26 There was no patient or public involvement in the study design or conduct of the study.

57
58 27 Data availability - Data used was freely available from the Ofcom website until a recent
59
60 28 update to the website following which data was removed from the website. Ofcom may be
29
30 29 able to provide access to the responses on request.

1
2
3 30
45 31 **Abstract**

6
7 32 *Objectives:* We explore one aspect of the decision-making process - public consultation on
8
9 33 policy proposals by a national regulatory body - aiming to understand how public health
10
11 34 policy development is influenced by different stakeholders.

12
13 35 *Design:* We use thematic content analysis to explore responses to a national consultation on
14
15 36 the regulation of television advertising of foods high in fat, salt and sugar aimed at children.

16
17 37 *Setting:* United Kingdom.

18
19
20 38 *Results:* 139 responses from key stakeholder groups were analysed to determine how they
21
22 39 influenced the regulator's initial proposals for advertising restrictions. The regulator's
23
24 40 priorities were questioned throughout the consultation process by public health
25
26 41 stakeholders. The eventual restrictions implemented were less strict in many ways than
27
28 42 those originally proposed. These changes appeared to be influenced most by commercial,
29
30 43 rather than public health, stakeholders.

31
32 44 *Conclusions:* Public health policy-making appears to be considered as a balance between
33
34 45 commercial and public health interests. Tactics such as the questioning and reframing of
35
36 46 scientific evidence may be used. In this example exploring the development of policy
37
38 47 regulating television food advertising to children, commercial considerations appear to have
39
40 48 led to a watering down of initial regulatory proposals, with proposed packages not including
41
42 49 the measure public health advocates considered to be the most effective. This seems likely
43
44 50 to have compromised the ultimate public health effectiveness of the regulations eventually
45
46 51 implemented.

47 52

48 53 **Article Summary – Strengths and limitations of this study**

- 49
50 54
- 51 • Established qualitative methodology (thematic content analysis) was used to
52 evaluate all stakeholder responses.
 - 53 • A *de novo* analytical framework was created, minimising bias that may have occurred
54 from using a pre-existing framework.
 - 55 • Stakeholder groups were sorted into eight broad categories allowing us to compare
56 and contrast responses by category.
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- 60 • Policy-making can be influenced through other non-public means (e.g. direct
61 lobbying), making us unable to comment on how other methods of influencing
62 policy-making may have affected this consultation’s outcome.
- 63 • This is one case study of influencing policy and our findings may not be generalisable
64 to other cases.

For peer review only

66 **Background**

67 Foods high in fat, salt and sugar (HFSS) are a contributing factor to increasing rates of non-
68 communicable disease worldwide¹ and the World Health Organization (WHO) has
69 encouraged member states to take action on non-communicable diseases, including
70 through regulation of the advertising of HFSS foods.² However, a 2016 study found that no
71 member states had implemented comprehensive legislation restricting marketing of
72 unhealthy food and beverages to young people,³ despite multiple systematic reviews
73 demonstrating the importance of food marketing as a driver of childhood obesity.⁴⁻⁶

74 Industry groups often seek to influence public health policy.⁷ For example, in 2003 a WHO
75 recommendation suggesting reduction in population sugar intake resulted in the Sugar
76 Association (a sugar industry information group) pressing the US Congress to cut WHO
77 funding.⁸ However, influences on dietary public health policy are not limited to the food
78 industry. Health professionals, charities, politicians and members of the public have all
79 attempted to influence policy making. Evidence of the impact of these activities is hard to
80 find in peer-reviewed literature.

81 Systematic reviews^{9,10,11} have demonstrated how the alcohol and tobacco industries focus
82 on lobbying efforts and promote self-regulation as means to minimise the impact of public
83 health policy on commercial activities. These tactics have also been seen in relation to food
84 where, in one case study, government opinion reflected industry rather than public health
85 opinion.¹² However, at present, we have limited insight into how stakeholders other than
86 those representing industry interests attempt to influence public health policy in general or
87 dietary public health policy in particular. Identifying strategies and arguments used by these
88 interested parties in a public setting may help inform how public health policy is determined
89 and how it might more effectively be developed in the future.

90

91 ***Policy context***

92 In December 2003, the UK Government asked Ofcom (the UK communications industry
93 regulator) to consider proposals for strengthening rules on television advertising of food
94 aimed at children (Fig 1). Ofcom decided to use the Food Standards Agency's Nutrient
95 Profiling Model to determine which foods were classified as HFSS. Ofcom originally put

96 three proposed 'packages' of regulations to public consultation in March 2006 (Packages 1-3
 97 in Table 1). Following this, Ofcom produced an alternative package of restrictions (Modified
 98 Package 1 in Table 1) in November 2006, on which Ofcom again consulted.

99 Figure 1: A timeline of the Ofcom process on developing new recommendations for limiting
 100 television food advertising to children.

101 Table 1: Packages of regulations proposed by Ofcom in the initial consultation (March 2006)

Options	Detail
Package 1	<ul style="list-style-type: none"> • No HFSS* food advertising during programmes specifically made for children • No HFSS food advertising during programmes of particular appeal to children+ aged 4-9 years
Package 2	<ul style="list-style-type: none"> • No food or drink advertising during programmes made specifically for children or of particular appeal to children aged up to 9 years
Package 3	<ul style="list-style-type: none"> • Volume of food and drink advertising to be limited at times when children are most likely to be watching
Modified Package 1	<ul style="list-style-type: none"> • As per package 1 except restrictions on HFSS food advertising to be extended to programmes of particular appeal to children aged 4-15 years

102 * 'Interested parties' are stakeholder groups who may have been affected by the proposed changes, including
 103 advertising agencies, advocacy groups, broadcasters, charities, healthcare associations, politicians, the food
 104 industry and the general public.

105 Following the second consultation (November 2006), modified package 1 was
 106 recommended by Ofcom and was implemented from January 2009. A comparison of the
 107 final regulations implemented to the initial packages proposed suggests that the
 108 consultations had substantial impacts on policy decisions. The only independent evaluation
 109 of the regulations eventually implemented found no change in the proportion of
 110 advertisements seen by children that were for HFSS foods from before to after

1
2
3 111 implementation and an increase exposure of HFSS advertising among adults.^{13,14} A '9pm
4
5 112 watershed' (i.e. no advertising of HFSS foods before 21.00hr) is now the preferred option of
6
7 113 many civil society and public sector organisation to reduce exposure of children to HFSS
8
9 114 food advertisings^{15 16 17 18}

11 115 **Study aims**

12
13 116 The consultations on the Ofcom regulations on the restriction of television food advertising
14
15 117 to children offers an opportunity to analyse responses from a range of stakeholder groups
16
17 118 to a consultation on an important policy that aims to promote dietary public health through
18
19 119 regulation of the food industry. We aimed to identify which arguments, and from which
20
21 120 stakeholder groups, appeared to be most influential in shaping the changes in Ofcom's
22
23 121 position from the initial consultation to the final recommendations.
24

25 122

27 123 **Methods**

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29 124 We followed the Standards for Reporting Qualitative Research¹⁹ in reporting our findings.
30

31 125 **Patient and Public Involvement**

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33
34 126 This study did not involve use of patient identifiable data and only used publicly-available
35
36 127 responses from stakeholder groups. We did not consult the public on the methods.
37

38 128 **Data Sources**

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41 129 We qualitatively analysed all written responses from stakeholder groups to the 2006-7
42
43 130 Ofcom public consultation on the regulation of television advertising of food and drink to
44
45 131 children. The consultation asked for responses to a series of questions regarding the various
46
47 132 policy packages outlined by Ofcom. Options such as having a 9pm watershed before which
48
49 133 HFSS foods could not be advertised, self-regulation, having a transitional period and
50
51 134 exemptions to the regulations were asked about. Responses were freely available on the
52
53 135 Ofcom website²⁰ and responses to both the first and second consultations were included.
54
55 136 Responses from individual members of the public were not included as they tended to be
56
57 137 very brief and non-specific. We therefore focused our analysis on key stakeholder
58
59 138 organisations representing key constituencies. Where needed, Optical Character
60

1
2
3 139 Recognition software was used to transcribe the responses. The consultation questions can
4 be seen in Table A in the Appendix.
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10 142 **Data Analysis**

11
12 143 Conventional thematic content analysis²¹ was used to analyse the data and the Framework
13 method²² used to organise and chart data. This method involves creating coding categories
14 144 directly from the data and organising coding within a flexible matrix, which can then be
15 145 adjusted as more codes emerge from the text. As existing literature on the topic of
16 146 stakeholder influence on public health policy is limited, rather than using preconceived
17 147 categories with which to code the data, a new framework for analysis was developed, based
18 148 on no *a priori* assumptions. After familiarisation with the data, coding was performed line by
19 149 line for each of the responses from interested parties in NVivo (software developed by QSR
20 150 International for qualitative research).
21 151

22
23 152 Each response was assigned to a category based on the person or organisation from which it
24 153 originated to stratify responses between the various types of interested parties (Table 2).
25 154 These categories were initially determined by assigning labels to each response and then
26 155 subsequently refined by the reviewers. A list of each group classified by category can be
27 156 found in the Appendix Tables B1 and B2. The longest and second longest submissions from
28 157 each category were then coded to develop the initial framework.
29

30
31 158 Table 2: The categories into which stakeholder groups were classified.
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Category	Definition
Advertising stakeholders	Advertising companies and representative bodies
Broadcast stakeholders	Broadcasting companies and representative bodies
Civil society groups	Groups that represent the interests of all or some of the general population. This does not include groups that may have

	affiliations with industry who would be included in one of the 'stakeholders' groups.
Food manufacturers	Companies that produce and sell food to retailers
Food retailers	A company that sells food to the general population
Food industry representative groups	Bodies that represent the interests of groups of food manufacturers and retailers
Politicians	Persons professionally involved in politics
Public health stakeholders	Groups that focus on promoting the health of the population

159

160 Following coding of the first two longest responses in each category by AR, a set of codes to
 161 apply to further responses was agreed between all authors. Codes were also grouped into
 162 themes at this stage to provide the most meaningful thematic coding of the data. The
 163 remaining responses were all coded using this analytical framework by AR with additional
 164 codes being created when needed. Once each of the responses was coded, a 10% sample of
 165 the data were independently duplicate-coded by one of the other authors (JA or MW) in
 166 order to ensure appropriate categorisation of the various codes and code hierarchy, and to
 167 improve internal validity. Using a matrix, the data were charted resulting in a summary of
 168 the data by category from each transcript. Illustrative quotations were highlighted at this
 169 point.

170 The resulting charted data were then interpreted and analysed to determine recurrent
 171 themes or topics. These were explored further using quotations to demonstrate the range
 172 of opinions in relation to each theme or topic. The positions taken by the interested parties
 173 were then compared to Ofcom's starting position and final statement, to identify which
 174 positions from which stakeholders appeared to have held the most influence on Ofcom's
 175 final position.

176

177 Ethics

178 Ethical permission was not sought for this study. The consultation responses used have
179 been made freely available on the Ofcom website with the full knowledge of their authors.
180 We, therefore, treat this as publically available data which does not require ethical
181 permission for analysis. As we did not seek informed consent from the authors of
182 consultation responses, we do not name them here – although names were provided on the
183 Ofcom website. Instead, we have used only the categories described in Table 2 to identify
184 quotations in our results. This also avoided the study from becoming too focused on specific
185 stakeholders rather than building a general picture of arguments used by different
186 stakeholder groups.

187

188 Results

189 Of 1136 responses received to both rounds of consultation, 997 were from individual
190 members of the public (and thus excluded from the analysis); 139 were from stakeholder
191 groups and were included in the analysis; 114 were responses to the initial consultation and
192 25 responses to the second consultation. The vast majority of responses from individuals
193 were one-line statements of support for some form of restrictions without directly
194 addressing specific issues concerning implementation. As such it was determined that there
195 was not sufficient detail to determine arguments used, or positions taken. Therefore, these
196 responses are unlikely to have influenced Ofcom other than to reaffirm that there was
197 public support for some form of restriction.

198

199 The stakeholder responses varied in length from a few lines to double-digit numbers of
200 pages. Most took the form of an initial broad statement outlining a policy position with
201 supporting evidence, followed by shorter responses directed at addressing the specific
202 questions in the consultation as outlined by Ofcom (shown in Table A, Appendix).

203

204 The organisations in the stakeholder groups outlined in Table 2 broadly fell into two
 205 separate categories. Civil society groups, politicians and public health stakeholders were
 206 encouraging of restrictions in order to reduce the exposure of children to advertising of
 207 HFSS foods. Advertising stakeholders, broadcast stakeholders, food manufacturers, food
 208 retailers and food industry stakeholders argued that restrictions would minimally impact
 209 childhood obesity whilst having a substantial impact on businesses. Though there were
 210 subtleties within each group with regards to what level of restrictions would be ideal, there
 211 were not sufficient differences in order to further analyse the differences in responses of
 212 the various stakeholder groups beyond these two broad categories.

213 The key changes from the initial Ofcom position to the final recommendations are
 214 summarised in Table 3. Arguments relating to each of the principles below, as outlined in
 215 the recommendations, were captured from the framework and are described in detail.

216 Table 3: The changes in Ofcom's position during the course of the consultation

Initial options presented by Ofcom	Consultation responses and Ofcom's reaction	Ofcom's final position	Reference in consultation
<i>Ofcom's packages 1-3 varied on 3 key principles:</i>			
1. Restrictions on advertising of all foods versus just HFSS foods	Following the first consultation it was clear that the majority of responses preferred restricting advertising of only HFSS foods.	The eventual package of restrictions enacted was specific to HFSS foods.	Ofcom Executive Summary 1.12
2. Total ban on food advertising versus volume-based restrictions	Almost all stakeholders did not consider volume-based restrictions as being effective at reducing exposure to advertising and this option was	There was a total ban enacted on HFSS food advertising in programming 'of particular interest to' children.	Ofcom Executive Summary 1.12

	dismissed following the first consultation.		
3. Restrictions only on children's channels versus all programmes 'of particular interest' to children, irrespective of channel	Public health and civil society responses highlighted that children may watch adult TV and a ban on all less healthy food advertising before a 9pm watershed may be more effective than focusing specifically on children's programming. Television and advertising industry responses worried that this would disproportionately impact advertising revenues.	Ofcom rejected the idea of a pre-9pm ban due to concerns about the effect it would have on broadcasters, programming and advertising revenues.	Ofcom Executive Summary 1.12
<i>Further changes that were made:</i>			
Restrictions should apply to children aged 4-9 years	Many public health and civil society responses pointed out that children are legally defined as under 16 years.	The restrictions applied to children aged 4-15 years.	Ofcom Final Statement 4.9
All restrictions should start in April 2007	Children's channels argued that they should be allowed a transitional period as they would be affected financially.	Children's channels were allowed a phased implementation of restrictions, with final implementation by January 2009.	Ofcom Final Statement 5.3/5.4

217

218 ***To which foods should restrictions apply?***

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3 219 There was non-partisan agreement that having a blanket ban on all television food
4
5 220 advertising was counter-productive and had the possibility of inadvertently reducing
6
7 221 exposure of children to advertisements for healthier products.
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9 222

10
11 223 Quotes: Should restrictions apply to all foods?

12
13
14 224 *“We do not support any options which would restrict advertising of all foods, including foods*
15
16 225 *such as fruit and vegetables, milk and dairy products. These foods can play an important*
17
18 226 *part in children consuming a balanced diet, and we consider that advertising can play a*
19
20 227 *useful role in educating both parents and children in the ways to achieve this.”* (Food
21
22 228 industry stakeholder)

23
24 229 *“[Public health stakeholder] believes that it is desirable to distinguish between healthy and*
25
26 230 *unhealthy foods. We do not believe it would be useful to restrict the advertising of all foods*
27
28 231 *because this would mean manufacturers and retailers would be unable to promote healthy*
29
30 232 *foods, such as fresh fruit and vegetables.”* (Public health stakeholder)

31 233

32
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34 234 As the underlying aim of the restrictions was to protect health, preventing the advertising of
35
36 235 healthy products would be counter-productive. Stakeholder groups agreed that banning
37
38 236 advertisements of all foods would be deleterious to efforts to promote healthy eating and
39
40 237 promoting a balanced diet.

41 238

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43
44 239 **Total ban or volume-based ban?**

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46 240 The idea of a broad volume-based restriction rather than a total ban targeting children’s
47
48 241 programming was proposed in Package 3 and was nearly universally disliked. Broadcasters,
49
50 242 advertisers and food industry stakeholders argued that a volume-based restriction would
51
52 243 have a very large effect on commercial revenues, whereas public health stakeholders and
53
54 244 civil society groups cited how little a volume-based restriction would actually reduce the
55
56 245 exposure of children to HFSS food advertising.

57 246

58
59
60 247 Quotes: Would a volume-based restriction be effective?

1
2
3 248 *“The least acceptable option would be Package 3, which would have a devastating effect on*
4
5 249 *our overall revenues - several times greater than Ofcom has estimated – while delivering a*
6
7 250 *smaller reduction in the number of times children see food and drink adverts.” (Broadcast*
8
9 251 *stakeholder)*

10
11 252 *“Package 3 not only restricts the option to promote healthy foods to children, but also fails*
12
13 253 *to restrict HFSS adverts during periods of viewing when many children are still watching i.e.*
14
15 254 *up to 9pm.” (Public health stakeholder)*

16
17 255

18
19 256 Many responses argued that Package 3 would result in very little change in exposure of
20
21 257 children to television advertising of HFSS foods but would substantially impact broadcasters
22
23 258 and advertisers financially. Arguments concerning commercial impacts were used
24
25 259 throughout the responses of industry groups, with emphasis on the fact that as a broadcast
26
27 260 regulator, Ofcom has a duty to minimise impact on revenues for broadcasters.

28
29 261

30
31 262 ***Restrictions on children’s programming or a pre-9pm watershed ban?***

32
33 263 Although not included in any of Ofcom’s proposals, one of the consultation questions asked
34
35 264 about whether restricting advertising before 9pm would be a suitable measure. In response,
36
37 265 civil society groups and public health stakeholders called for restricting all HFSS food
38
39 266 advertising before a 9pm ‘watershed’. Advertisers, broadcasters and the food industry
40
41 267 claimed such restrictions would impinge upon adult viewing. All three groups highlighted
42
43 268 the trade-off between protecting children and the loss of advertising exposure to adults.
44
45 269 Advertisers, broadcasters and food industry groups cited the negative commercial impacts
46
47 270 of a pre-9pm watershed ban as outweighing any ‘marginal’ public health benefits; whereas
48
49 271 civil society groups and public health groups saw the public health benefit of a pre-9pm
50
51 272 watershed ban as outweighing commercial impacts.

52
53 273

54
55 274 Quotes: Arguments pertaining to the pre-9pm watershed ban on HFSS food advertising

56
57 275 *“[Food industry stakeholder organisation] welcomes Ofcom’s rejection of the pre-9pm*
58
59 276 *watershed, as this would have been tantamount to a complete ban on the advertising of*

1
2
3 277 *food and soft drink products on television, and would have impacted on adult airtime.”*

4
5 278 (Food industry stakeholder)

6
7 279 *“We believe that the most suitable option is the pre 9pm ban of HFSS advertising, for the*
8
9 280 *following reasons:*

- 10
11 281 • *achieves one of the key regulatory objectives, that of significantly reducing the*
12
13 282 *impact of HFSS advertising on younger children*
14
15 283 • *removes 82% of the recorded HFSS advertising impacts on all children (aged 4-15)*
16
17 284 • *contributes substantially to enhancing protection for older children by reducing their*
18
19 285 *exposure to HFSS advertising*
20
21 286 • *offers the greatest social and health benefits of all options – in the ranges of £50*
22
23 287 *million - £200 million per year or £250million - £990 million per year (depending on*
24
25 288 *the value of life measure)”. (Civil society group)*

26
27 289 *“The avoidance of intrusive regulation of advertising during adult airtime is only justifiable*
28
29 290 *once full account has been taken to address the over-riding priority to protect children’s*
30
31 291 *health. At times when adults and children are watching, the need to protect children must*
32
33 292 *take priority.” (Public health stakeholder)*

34
35 293

36
37 294 In their final statement following the consultation,²³ Ofcom explained why they had rejected
38
39 295 banning HFSS food advertising before a 9pm watershed due to the effect this was expected
40
41 296 to have on adult viewing times and commercial revenues. Industry groups appeared to be
42
43 297 successful in arguing that adult viewing should be unaffected despite the possibility that
44
45 298 both children and adults may be watching television together. The need to protect the right
46
47 299 of adults to see whatever they wish was a common argument against restricting advertising
48
49 300 on television channels that were not explicitly targeted at children. The individual freedom
50
51 301 of an adult therefore appeared to be given precedence over exposing children to HFSS food
52
53 302 advertising.

54 303 Ofcom’s research²³ showed that 48% of parents supported restricting HFSS food advertising
55
56 304 before 9pm, which was often cited by industry responses as evidence of a lack of public
57
58 305 support. Some responses highlighted the fact that the complete figures were 48% in support
59
60 306 of a pre-9pm watershed ban, 24% against the ban, with the remainder undecided. An

1
2
3 307 apparently valid complaint made by public health groups regarding this issue was that
4
5 308 Ofcom did not ever consult on a pre-9pm watershed ban despite its own research showing
6
7 309 this would reduce the exposure of children to HFSS advertising by 82%.

8
9 310 We are also able to see here the use of evidence-based arguments by the civil society group
10
11 311 in making their case. Some civil society groups and public health stakeholders would cite
12
13 312 evidence to support their argument. The quotes above illustrate an example of how a civil
14
15 313 society group used data and evidence to support their arguments by, for instance,
16
17 314 suggesting that banning advertising prior to 9pm could reduce advertising exposure of
18
19 315 children by 82%. This figure was taken from Ofcom's own analysis of the effects of the
20
21 316 various policy options, which can now be found included in Ofcom's final report on the
22
23 317 consultation.²³ Food industry representative groups on the other hand tended to cite a lack
24
25 318 of evidence or only used evidence that appeared to support their arguments..

26 319 Quotes: Arguments regarding available evidence and its interpretation

27
28 320 *"As Ofcom has found from its own research, television advertising has only a "modest direct*
29
30 321 *effect" on children's food preferences, consumption and behaviour, and that other factors –*
31
32 322 *including taste, price familiarity, peer pressure and convenience - all have a higher effect.*
33
34 323 *Hastings, in his report for the Food Standards Agency, found that advertising had only a 2%*
35
36 324 *direct effect on children's choice." (Food company)*

37
38 325 *"Ofcom quotes an estimate that advertising/television accounts for some 2% of variation in*
39
40 326 *food choice/obesity. This is not a small figure considering that calculations by the Institute of*
41
42 327 *Medicine show that this would mean an estimated additional 1.5 million young people in the*
43
44 328 *US falling into the obese category." (Public health interests)*

45
46 329 *"The evidence that television has anything but an extremely small impact on the HFSS*
47
48 330 *element of the diet of children is unconvincing and accordingly it is difficult to support*
49
50 331 *proposals that appear disproportionate." (Broadcast interests)*

51
52 332

53
54 333 ***To what ages of children should the restrictions apply?***

55
56 334 Ofcom initially planned to restrict advertisements targeted at children aged 4-9 years,
57
58 335 although this was subsequently expanded to cover children ages 4-15 years in the final
59
60

1
2
3 336 regulations. Children under 4 years were thought to have little influence over what foods
4
5 337 and drinks were given to them and therefore not considered as part of the restrictions.
6
7 338 Throughout the consultation food industry representative groups and food manufacturers
8
9 339 argued that restricting advertisements to children aged 4-9 years was appropriate, whereas
10
11 340 as public health stakeholders argued that this should be expanded to cover children aged 4-
12
13 341 15 years.

14
15 342

16
17 343 Quotes: Arguments pertaining to the age of children to which restrictions should apply

18
19 344 *"It is neither logical nor is there any explanation as to why Ofcom should propose to limit the*
20
21 345 *focus of regulation to children aged under 10. The government asked Ofcom to consider*
22
23 346 *proposals for strengthening its rules on television advertising of food to children. It did not*
24
25 347 *ask Ofcom to limit its focus to any particular age group. Ofcom should logically apply*
26
27 348 *restrictions according to its own definition of children (aged 15 [or under])."* (Public health
28
29 349 stakeholder)

30
31 350

32
33 351 *"Children develop and refine their ability to interpret advertising messages as they get older.*
34
35 352 *Existing studies suggest that by 10 years old (indeed, most studies suggest an even earlier*
36
37 353 *age) they are considered to have sufficient cognitive development to understand the*
38
39 354 *implications of television advertising."* (Food manufacturer)

40
41 355

42
43 356 *"We are alarmed by the decision to extend volume and scheduling restrictions of food and*
44
45 357 *drink advertising to children under 16. The intention of Ofcom and the government has*
46
47 358 *always been to protect younger children and industry responded on this basis. Ofcom has*
48
49 359 *previously stated that it wished to find a proportionate solution and we question the*
50
51 360 *evidence base on which this decision was made. A review of Ofcom's own literature would*
52
53 361 *seem to contradict the question put to consultation and support the conclusion that young*
54
55 362 *people are capable of differentiating between programming and advertising."* (Food
56
57 363 industry representative group)

58
59 364
60

1
2
3 365 The logic of defining children as aged 4-9 years was questioned by many stakeholders as,
4
5 366 according to Ofcom and in the UK, children are legally defined as those under the age of 16
6
7 367 years. A number of food manufacturers stated that they already did not advertise their
8
9 368 products to children under 8-12 years. They argued that during adolescence children
10
11 369 become 'media literate' and are able to understand advertising and should therefore not be
12
13 370 a target of the restrictions.

14
15 371 Industry arguments appeared to suggest that media 'illiterate' children need protecting
16
17 372 from HFSS food advertising whereas public health groups suggested all children needed
18
19 373 protecting regardless of how 'media literate' they are. Public health groups argued that
20
21 374 adolescents are still susceptible to advertising, have more purchasing power and greater
22
23 375 pester power than younger children, and may not appreciate the health implications of a
24
25 376 poor diet. Ofcom concluded that expanding restrictions to include children aged 4-15 years
26
27 377 was appropriate, suggesting the arguments of public health groups held more weight over
28
29 378 this issue.

30 379

31
32 380 ***When should the restrictions start?***

33
34 381 The need for a transitional period was also hotly debated. Public health stakeholders and
35
36 382 civil society groups suggested that as companies were already aware that restrictions were
37
38 383 due to be enforced any transitional period should be minimal. Industry groups argued that a
39
40 384 transition period was necessary to allow adjustments to be made.

41
42 385

43
44
45 386 Quotes: Arguments pertaining to the need for a transitional period

46
47 387 *"We do not believe [a] transitional period is appropriate. The arguments for "phasing in"*
48
49 388 *restrictions appear to be of a commercial nature and not supportive of the policy's public*
50
51 389 *health objectives."* (Public health stakeholder)

52
53 390 *"We would ask for a transitional period of at least three years. This would allow production*
54
55 391 *companies to adjust, and the growing number of public companies to issue profit warnings*
56
57 392 *where necessary."* (Broadcast stakeholder)

58
59 393
60

1
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3 394 Instead of starting restrictions soon after announcement of the final policy statement
4
5 395 (February 2007), a phased transition over 1-2 years was implemented (varying for different
6
7 396 channel types), suggesting industry arguments held more weight on this point. Despite the
8
9 397 stated objective of minimising the exposure of children to HFSS food advertising, it appears
10
11 398 that Ofcom was more concerned about the potential commercial impact of advertising
12
13 399 restrictions and delayed enforcement of the restrictions as a result.

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402 Discussion

403 *Summary of principal findings*

404 This study presented a unique opportunity for a detailed analysis of responses to a public
405 consultation on a public health policy in the UK. Such data is often not in the public domain
406 and these data therefore offered a rare opportunity for scientific scrutiny. For example,
407 verbatim responses to the 2016 consultation on the UK Soft Drinks Industry Levy, have not
408 been released. Our paper highlights how, despite the relative transparency of the 2006-7
409 consultation, the final policy appeared to be substantially influenced by stakeholders.
410 Commercial and public health interests aligned with regards to whether restrictions should
411 apply to all foods or just HFSS foods as neither wished to ban advertising of healthy foods.
412 Likewise, common ground was found when considering a volume-based ban, with it having
413 large commercial impact but little public health impact as per Ofcom's own findings.²³

414
415 As far as we are aware, this is the first analysis to examine how a range of stakeholder
416 groups influenced the development of a public health policy aiming to regulate food
417 industry advertising. Ofcom's decision to implement Modified Package 1 contained
418 concessions to commercial as well as civil society and public health stakeholders. However,
419 ultimately industry arguments appeared to hold more sway, with the main concession to
420 public health groups being expanding restrictions from children aged 4-9 years to those
421 aged 4 to 15 years. Ofcom appeared to believe that the commercial impact of the regulation
422 of advertising should carry greatest weight, even when the aim of the regulation was to
423 protect children's health. As such, Ofcom did not formally consider a pre-9pm ban as part of
424 any of its packages, as had been proposed by public health and civil society stakeholders,
425 although one of the consultation questions did refer to a pre-9pm ban. Instead, Ofcom
426 approved a two-year transition period and emphasised the need for 'proportionate action'.
427 Some responses to the consultation from public health advocates argued that Ofcom, being
428 a broadcast regulator rather than a public health stakeholder, felt an obligation to protect
429 industry interests. The case for restricting advertising was made in a Department of Health
430 'white paper'²⁴ (NHS Strategy documents are known as 'white papers'). However, Ofcom
431 was tasked with determining how to implement these restrictions. Under the
432 Communications Act 2003, Ofcom retains direct responsibility for advertising scheduling

1
2
3 433 policy. This then begs the question of whether a governmental body with a duty to protect
4
5 434 broadcasting interests should be leading on public health legislation.
6

7 435
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9
10 436 This conflict between Ofcom's duties to the public and to broadcasters, may have resulted
11
12 437 in eventual restrictions that did not appear to alter the level of exposure of children to HFSS
13
14 438 food advertising.^{13,14} Ofcom appeared to balance arguments related to commercial and
15
16 439 public interests, in terms of jobs and the wider economy, with those relating to public
17
18 440 health. Being proportionate in their restrictions was frequently cited by Ofcom in their
19
20 441 decision making. Ofcom did not, however, appear to consider the cost to the economy of
21
22 442 poor health that could stem from a lack of appropriate restrictions. Although this was cited
23
24 443 by some public health groups (see quotes pertaining to a pre-9pm ban) this does not appear
25
26 444 to have been considered by Ofcom in their final report, with no mention of wider societal
27
28 445 costs. Ofcom also appeared to give greater priority to allowing advertisers access to adults
29
30 446 than to restricting exposure to HFSS food advertising among children, who may be viewing
31
32 447 the same programming. Industry representative groups tended to highlight commercial
33
34 448 arguments whilst citing evidence that appeared to downplay the role of television
35
36 449 advertising in childhood obesity. Public health groups emphasised that the health of
37
38 450 children should outweigh any financial concerns and pointed out that even small changes to
39
40 451 advertising at an individual level would affect large numbers of children and so accrue to
41
42 452 large population level benefits.
43

44 453

454 ***Strengths and Limitations***

45
46 455 Using established qualitative methods allowed us to identify key themes in the consultation
47
48 456 responses according to stakeholder interests. The creation of a *de novo* framework
49
50 457 minimised bias that might have been imposed by using a pre-existing framework. Instead,
51
52 458 we allowed categories to emerge from the data. The classification of the responses also
53
54 459 enabled us to see what positions were taken by the various stakeholders and which type of
55
56 460 responses carried the most influence. Measures were taken to maximise the reliability of
57
58 461 our coding, such as duplicate coding a sample of consultation responses. The use of publicly
59
60 462 available data was resource efficient. Additionally, the use of all the available data ensured

1
2
3 463 that no perspectives were omitted, adding to internally validity. The omission of responses
4
5 464 from individual members of the public was because most public responses lacked detail and
6
7 465 were no more than a sentence long. Commercial influences on public health policy are
8
9 466 unlikely to have changed over the past decade with no changes in lobbying rules or policy
10
11 467 making procedures, making it highly likely that our findings from the 2007 consultation are
12
13 468 applicable today.

14
15 469

16
17 470 There may be alternative methods by which the public influences policy making, such as by
18
19 471 writing to their Member of Parliament. This is a study of only one case of public health
20
21 472 policy making and our specific findings may not be generalisable to other aspects of dietary
22
23 473 public health policy specifically or public health policy more generally. In this consultation,
24
25 474 all members of a stakeholder category were treated as one, though there was some inter-
26
27 475 category variation on position. A cross-question analysis could have been performed
28
29 476 analysing responses by each question posed, although many of the responses were free text
30
31 477 and did not address each question directly. In this study, we have only addressed what
32
33 478 arguments and from whom are most influential in shaping public health policy, not
34
35 479 specifically the various methods by which different stakeholders influence policy. There are
36
37 480 also other ways by which interested parties could influence Ofcom, which we were unable
38
39 481 to examine in this study. For example, Ofcom gave the option of providing confidential
40
41 482 responses which were not available for us to incorporate into our dataset. Other informal
42
43 483 lobbying may have occurred. Whether such channels of influence were used or whether
44
45 484 similar arguments will have been used privately as were used publicly is unclear. Further
46
47 485 work could explore other means of influence in due course.

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49 486

49 487 ***Relationship to existing knowledge***

50
51 488 Some literature exists on the methods by which public health advocates influence policy. In
52
53 489 2006, the New Zealand government held an 'Inquiry into Obesity' in order to determine
54
55 490 what could be done to limit increasing obesity rates.¹² Jenkin *et al* found that in three out of
56
57 491 four domains examined, the governmental position aligned with that of industry groups,
58
59 492 with the exception being nutritional policy in schools. In the other three domains, national
60

1
2
3 493 obesity strategy, food industry policy, and advertising and marketing policy, the analysis
4
5 494 determined that the governmental position allied with industry groups. Much like our study,
6
7 495 public health groups were shown to have a limited impact on the eventual policies, with
8
9 496 industry arguments proving more influential. An explanation suggested for this was the
10
11 497 significance of the food industry to New Zealand's economy, highlighting how
12
13 498 considerations outside of public health may importantly shape public health policy. It may
14
15 499 be the case that similar factors shaped the eventual restrictions in our case study, despite
16
17 500 the appearance of Ofcom wanting to develop 'proportionate restrictions', balancing
18
19 501 commercial and public health interests. The question of what is proportionate appears to be
20
21 502 determined by ideology and how much one feels government's role is to protect health
22
23 503 even if it impacts on industry. If this is the case, we must question whether commercial
24
25 504 companies can ever be truly motivated to improve health at the possible detriment to their
26
27 505 short-term profits. A thematic analysis of alcohol industry documents in Australia²⁵
28
29 506 concluded that the industry attempted to create an impression of social responsibility whilst
30
31 507 promoting interventions that did not affect their profits and campaigning against effective
32
33 508 interventions that might affect profits. The *de facto* exemption of commercial stakeholders
34
35 509 from bearing the negative external costs of their profitable endeavours (e.g. environmental,
36
37 510 social or health impacts) has been widely questioned.²⁶

511

512 ***Interpretation and implications of the study***

513 Much of the research undertaken to date on stakeholder influences on public health policy
514 has focused on industry behaviours and practices, whereas in this study we have treated
515 both pro-industry and pro-public health groups equally in our analysis. Industry groups were
516 apparently successfully able to argue that extensive restrictions would impact upon their
517 commercial revenues, suggesting that their economic arguments importantly influenced the
518 thinking of policy-makers. However, the future (external) costs of treating the potential
519 health implications of HFSS food consumption did not appear to influence policy-making.
520 This may be because any potential cost-savings are long-term and would apply to the health
521 sector, for which Ofcom has no governmental responsibility, whereas the short-term costs
522 would apply to the broadcast sector for which Ofcom is the regulatory body.

523

1
2
3 524 Public health advocacy is an activity in which many public health professionals are keen to
4
5 525 become more effective to better ensure that evidence is translated into policy.^{27,28} This
6
7 526 study highlights that responding to public health policy consultations alone may not result in
8
9 527 policy making favourable to public health and other avenues of influence may also need to
10
11 528 be explored. Conversely, the change in the definition of children from 4-9 years to 4-15
12
13 529 years demonstrates that there is scope for public health advocates to shape policy should
14
15 530 an issue be sufficiently clear and difficult to oppose. A more Machiavellian interpretation
16
17 531 would be that to define children as aged 4-9 years at the outset may have been a cynical
18
19 532 ploy aimed at ensuring that there was at least some ground to concede to public health
20
21 533 stakeholders and distract from the more contentious issues. This is supported by the fact
22
23 534 that the definition of children as aged 4-9 years was inherently questionable, given Ofcom's
24
25 535 own definition of children as under 16 years, in line with the legal and medical definitions
26
27 536 used in the UK. A few companies pointed to their media literacy campaigns as evidence that
28
29 537 adolescents can understand advertising as an argument against redefining the scope of
30
31 538 these restrictions to children aged 4-15 years. Evidence shows that advertisers simply use
32
33 539 different ways to target adolescents,²⁹ rendering media literacy moot,³⁰ and suggesting that
34
35 540 restrictions are still needed to protect adolescents.

36
37 541

38
39 542 The issue of TV advertising of less healthy foods remains highly politically sensitive and at
40
41 543 the top of the public health strategy agenda for obesity.¹⁸ Many UK public health
42
43 544 organisations have recently campaigned to ban television advertising of less healthy foods
44
45 545 before 9pm (the so-called 9pm watershed).^{16,17,31-34} Our analysis of the 2006-7 consultation
46
47 546 offers specific insights that could be influential in this ongoing national debate, in the same
48
49 547 way as such analyses of historical documents have influenced tobacco control efforts in
50
51 548 recent years.^{10,35} The Ofcom regulation of television advertising of less healthy foods to
52
53 549 children is one of few national public health policies of this sort to have been independently
54
55 550 evaluated.^{14,36} The independent evaluation found that the introduction of the regulations
56
57 551 were not associated with a decrease in children's exposure to less healthy food
58
59 552 advertising.³⁶ Our analysis sheds further light on why and how a regulatory policy that
60
553 appears to have been ineffective in reducing children's exposure to less healthy food
554
555 advertising came about. Publishing responses to public consultations in full is a key

1
2
3 555 component of transparent policy making. The UK Treasury's reluctance to make available
4
5 556 responses to the Soft Drinks Industry Levy consultation is contrary to this principle.
6

7 557
8

9 558 ***Further questions and future research***

11 559 How policy making is influenced through means other than public consultations should be
12
13 560 further studied. Other means of applying political pressure such as political lobbying and
14
15 561 having indirect relationships with positions of power are much more opaque and difficult to
16
17 562 monitor. Parliamentary records of lobbying activity, copies of internal or leaked documents
18
19 563 and registers of MPs interests may all be potential sources of data to explore these issues
20
21 564 further. Interviews with former or current employees of policy forming bodies such as
22
23 565 Ofcom, as well as other stakeholder groups could also be fruitful. Claims made during this
24
25 566 consultation, such as industry claims of needing to issue profit warnings as a consequence of
26
27 567 lost revenue from these restrictions, could be analysed. Thematic analysis of further
28
29 568 documents such as the responses analysed in this study could provide valuable insight into
30
31 569 whether a similar combination of commercial arguments and questioning scientific data is
32
33 570 used across different public health policy consultations.
34

35 571

36
37 572 **Conclusion**

38
39 573 This analysis increases our understanding of how influential some stakeholders are in policy
40
41 574 making and provides a framework from which further understanding of the influences on
42
43 575 public health policy can be determined. From this case study, we can see that commercial
44
45 576 influences on dietary public health policy-making appear to be somewhat greater than the
46
47 577 influence of public health stakeholders in the initial framing of the consultation and this
48
49 578 imbalance may have contributed to the ultimately compromised legislation. In this case, the
50
51 579 potential for commercial impacts of legislation promoting public health appeared to
52
53 580 outweigh the anticipated population health benefits in policy decision making.
54

55 581

56 582 **Authors' contributions** – The authors declare that they have no competing interests.

57 583 Responses were coded by AR with a sub-sample independently duplicate coded by JA or

58 584 MW. AR, JA and MW contributed to the manuscript in terms of both writing and editing.
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59
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606 **References**

- 607 1. Global Health Observatory. WHO | Obesity. WHO.
- 608 2. WHO | Reducing the impact of marketing of foods and non-alcoholic beverages on
609 children. WHO. 2014.
610 http://www.who.int/elena/titles/guidance_summaries/food_marketing_children/en/
611 . Accessed August 8, 2017.
- 612 3. Kraak VI, Vandevijvere S, Sacks G, et al. Policy & practice Progress achieved in
613 restricting the marketing of high-fat, sugary and salty food and beverage products to
614 children. *Bull World Heal Organ*. 2016;94:540-548. doi:10.2471/BLT.15.158667.
- 615 4. Raine KD, Lobstein T, Landon J, et al. Restricting marketing to children: Consensus on
616 policy interventions to address obesity. *J Public Health Policy*. 2013;34(2):239-253.
617 doi:10.1057/jphp.2013.9.
- 618 5. Harris JL, Pomeranz JL, Lobstein T, Brownell KD. A Crisis in the Marketplace: How
619 Food Marketing Contributes to Childhood Obesity and What Can Be Done. *Annu Rev*
620 *Public Health*. 2009;30(1):211-225. doi:10.1146/annurev.publhealth.031308.100304.
- 621 6. Cairns G, Angus K, Hastings G, Caraher M. Systematic reviews of the evidence on the
622 nature, extent and effects of food marketing to children. A retrospective summary.
623 *Appetite*. 2013;62:209-215. doi:10.1016/j.appet.2012.04.017.
- 624 7. WHO | Protecting children from the harmful effects of food and drink marketing.
625 WHO. 2014. <http://www.who.int/features/2014/uk-food-drink-marketing/en/>.
626 Accessed June 28, 2017.
- 627 8. Sibbald B. Sugar industry sour on WHO report. *CMAJ*. 2003;168(12):1585.
628 [http://www.pubmedcentral.nih.gov/articlerender.fcgi?artid=156706&tool=pmcentre](http://www.pubmedcentral.nih.gov/articlerender.fcgi?artid=156706&tool=pmcentrez&rendertype=abstract)
629 [z&rendertype=abstract](http://www.pubmedcentral.nih.gov/articlerender.fcgi?artid=156706&tool=pmcentrez&rendertype=abstract). Accessed December 23, 2015.
- 630 9. Savell E, Fooks G, Gilmore AB. How does the alcohol industry attempt to influence
631 marketing regulations? A systematic review. *Addiction*. 2016;111(1):18-32.
632 doi:10.1111/add.13048.
- 633 10. Savell E, Gilmore AB, Fooks G, Weishaar H, Gilmore A. How Does the Tobacco
634 Industry Attempt to Influence Marketing Regulations? A Systematic Review. Derrick

- 1
2
3 635 GE, ed. *PLoS One*. 2014;9(2):e87389. doi:10.1371/journal.pone.0087389.
4
5 636 11. Grüning T, Gilmore AB, McKee M. Tobacco industry influence on science and
6
7 637 scientists in Germany. *Am J Public Health*. 2006;96(1):20-32.
8
9 638 doi:10.2105/AJPH.2004.061507.
10
11 639 12. Jenkin G, Signal L, Thomson G. Nutrition policy in whose interests? A New Zealand
12
13 640 case study. *Public Health Nutr*. 2012;15(8):1483-1488.
14
15 641 doi:10.1017/S1368980011003028.
16
17 642 13. Adams J, Tyrrell R, Adamson AJ, White M. Effect of restrictions on television food
18
19 643 advertising to children on exposure to advertisements for “less healthy” foods: repeat
20
21 644 cross-sectional study. *PLoS One*. 2012;7(2):e31578.
22
23 645 doi:10.1371/journal.pone.0031578.
24
25 646 14. Adams J, Hennessy-Priest K, Ingimarsdóttir S, Sheeshka J, Ostbye T, White M. Food
26
27 647 advertising during children’s television in Canada and the UK. *Arch Dis Child*.
28
29 648 2009;94(9):658-662. doi:10.1136/adc.2008.151019.
30
31 649 15. Children’s Food Campaign. *Through the Looking Glass: A Review of Topsy-Turvy Junk*
32
33 650 *Food Marketing Regulations.*; 2013.
34
35 651 https://www.sustainweb.org/publications/through_the_looking_glass/. Accessed
36
37 652 October 10, 2017.
38
39 653 16. Sugar Reduction The evidence for action. 2015. www.gov.uk/phe. Accessed October
40
41 654 10, 2017.
42
43 655 17. The Labour Party. Labour Manifesto.
44
45 656 <http://www.labour.org.uk/index.php/manifesto2017>. Published 2017. Accessed June
46
47 657 28, 2017.
48
49 658 18. *Childhood Obesity: A Plan for Action Chapter 2 2 DH ID Box Title: Childhood Obesity: A*
50
51 659 *Plan for Action, Chapter 2.*; 2018. [www.nationalarchives.gov.uk/doc/open-](http://www.nationalarchives.gov.uk/doc/open-government-licence/)
52
53 660 [government-licence/](http://www.nationalarchives.gov.uk/doc/open-government-licence/). Accessed November 27, 2018.
54
55 661 19. O’Brien BC, Harris IB, Beckman TJ, Reed DA, Cook DA. Standards for reporting
56
57 662 qualitative research: a synthesis of recommendations. *Acad Med*. 2014;89(9):1245-
58
59 663 1251. doi:10.1097/ACM.0000000000000388.
60

- 1
2
3 664 20. Ofcom. *Television Advertising of Food and Drink Products to Children: Final*
4
5 665 *Statement*.
6
7 666 21. Hsieh H-F, Shannon SE. Three approaches to qualitative content analysis. *Qual Health*
8
9 667 *Res*. 2005;15(9):1277-1288. doi:10.1177/1049732305276687.
10
11 668 22. Gale NK, Heath G, Cameron E, Rashid S, Redwood S. Using the framework method for
12
13 669 the analysis of qualitative data in multi-disciplinary health research. *BMC Med Res*
14
15 670 *Methodol*. 2013;13:117. doi:10.1186/1471-2288-13-117.
16
17 671 23. Ofcom. Television Advertising of Food and Drink Products to Children - Ofcom.
18
19 672 https://www.ofcom.org.uk/consultations-and-statements/category-2/foodads_new.
20
21 673 Accessed August 8, 2017.
22
23 674 24. Department of Health. *Choosing Health: Making Healthy Choices Easier.*; 2004.
24
25 675 [https://webarchive.nationalarchives.gov.uk/20120509221645/http://www.dh.gov.uk](https://webarchive.nationalarchives.gov.uk/20120509221645/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_133489.pdf)
26
27 676 [/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/](https://webarchive.nationalarchives.gov.uk/20120509221645/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_133489.pdf)
28
29 677 [dh_133489.pdf](https://webarchive.nationalarchives.gov.uk/20120509221645/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_133489.pdf). Accessed March 12, 2019.
30
31 678 25. Miller PG, de Groot F, McKenzie S, Droste N. Vested interests in addiction research
32
33 679 and policy. Alcohol industry use of social aspect public relations organizations against
34
35 680 preventative health measures. *Addiction*. 2011;106(9):1560-1567.
36
37 681 doi:10.1111/j.1360-0443.2011.03499.x.
38
39 682 26. Stuckler D, Nestle M. Big food, food systems, and global health. *PLoS Med*.
40
41 683 2012;9(6):e1001242. doi:10.1371/journal.pmed.1001242.
42
43 684 27. Dorfman L, Krasnow ID. Public Health and Media Advocacy. *Annu Rev Public Health*.
44
45 685 2014;35(1):293-306. doi:10.1146/annurev-publhealth-032013-182503.
46
47 686 28. Herrick C. The post-2015 landscape: vested interests, corporate social responsibility
48
49 687 and public health advocacy. *Sociol Health Illn*. 2016;38(7):1026-1042.
50
51 688 doi:10.1111/1467-9566.12424.
52
53 689 29. Livingstone S, Helsper EJ. Does Advertising Literacy Mediate the Effects of Advertising
54
55 690 on Children? A Critical Examination of Two Linked Research Literatures in Relation to
56
57 691 Obesity and Food Choice. *J Commun*. 2006;56(3):560-584. doi:10.1111/j.1460-
58
59 692 2466.2006.00301.x.
60

- 1
2
3 693 30. Montgomery KC, Chester J. Interactive Food and Beverage Marketing: Targeting
4 694 Adolescents in the Digital Age. *J Adolesc Heal.* 2009;45(3):S18-S29.
5 695 doi:10.1016/j.jadohealth.2009.04.006.
6
7
8
9 696 31. Sustain / Children's Food Campaign. Junk Food Marketing.
10 697 https://www.sustainweb.org/childrensfoodcampaign/junk_food_marketing/.
11 698 Accessed November 1, 2017.
12
13
14
15 699 32. Cancer Research UK. Being overweight or obese could cause around 700,000 new UK
16 700 cancers by 2035 | Cancer Research UK. [http://www.cancerresearchuk.org/about-](http://www.cancerresearchuk.org/about-us/cancer-news/press-release/2016-01-07-being-overweight-or-obese-could-cause-around-700000-new-uk-cancers-by-2035)
17 701 [us/cancer-news/press-release/2016-01-07-being-overweight-or-obese-could-cause-](http://www.cancerresearchuk.org/about-us/cancer-news/press-release/2016-01-07-being-overweight-or-obese-could-cause-around-700000-new-uk-cancers-by-2035)
18 702 [around-700000-new-uk-cancers-by-2035](http://www.cancerresearchuk.org/about-us/cancer-news/press-release/2016-01-07-being-overweight-or-obese-could-cause-around-700000-new-uk-cancers-by-2035). Accessed November 1, 2017.
19
20
21
22
23 703 33. Obesity Health Alliance. Tackling Childhood Obesity - 2017 Election Manifesto.
24 704 <http://obesityhealthalliance.org.uk/policy/>. Accessed November 1, 2017.
25
26
27 705 34. Faculty of Public Health. Start Well, Live Better.
28 706 http://www.fph.org.uk/start_well%2C_live_better_-_a_manifesto. Accessed
29 707 November 1, 2017.
30
31
32
33 708 35. Fooks GJ, Gilmore AB. Corporate philanthropy, political influence, and health policy.
34 709 *PLoS One.* 2013;8(11):e80864. doi:10.1371/journal.pone.0080864.
35
36
37 710 36. Adams J, Tyrrell R, Adamson AJ, White M. Effect of restrictions on television food
38 711 advertising to children on exposure to advertisements for "less healthy" foods: repeat
39 712 cross-sectional study. *PLoS One.* 2012;7(2):e31578.
40 713 doi:10.1371/journal.pone.0031578.
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3 716 **Figure titles and legends**
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5 717 Figure 1: A timeline of the Ofcom process on developing new recommendations for limiting
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7 718 television food advertising to children.
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10 719 *Figure 1 legend:*
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12 720 * 'Interested parties' are stakeholder groups who may have been affected by the proposed
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14 721 changes, including advertising agencies, advocacy groups, broadcasters, charities,
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16 722 healthcare associations, politicians, the food industry and the general public.
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20 724 Table 1: Packages of regulations proposed by Ofcom in the initial consultation (March 2006)
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22
23 725 *Table 1 legend:*
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25 726 * HFSS food = High, Fat, Sugar and Salt foods
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27 727 + 'of particular appeal to children' = when the proportion of people watching who are
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29 728 children is more than 120% of the proportion of children in the UK population²³
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34 730 Table 2: The categories into which stakeholder groups were classified. A list of each group
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36 731 classified by category can be found in the Appendix.
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40 733 Table 3: The changes in Ofcom's position during the course of the consultation
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45 735 **Appendix**
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47 736 Table A: The questions Ofcom asked as part of the consultation
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52 738 Table B1: The classification of the responses by organisational category
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56 740 Table B2: The classification of the responses by organisational category (continued)
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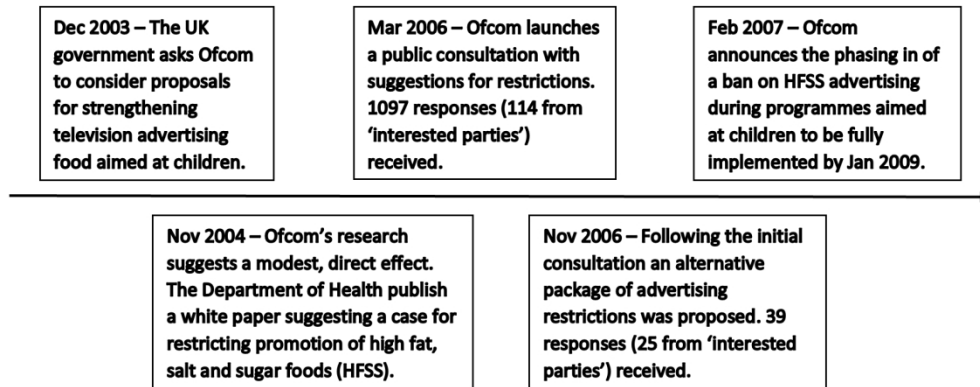


Figure 1: A timeline of the Ofcom process on developing new recommendations for limiting television food advertising to children.

Legend: * 'Interested parties' are stakeholder groups who may have been affected by the proposed changes, including advertising agencies, advocacy groups, broadcasters, charities, healthcare associations, politicians, the food industry and the general public.

Question 1	Do you agree that the regulatory objectives set out in paragraph 5.2 above are appropriate?
Question 2	Do you consider that it is desirable to distinguish between foods that are high in fat, salt or sugar and those that are healthier in order to achieve the regulatory objectives, or could an undifferentiated approach provide a reasonable alternative?
Question 3	If so, do you consider the FSA's nutrient profiling scheme to be a practical and reasonable basis for doing so? If not, what alternative would you propose? (Note: The nutrient profiling scheme was developed by the FSA and handed to Ofcom following extensive consultation (see FSA web site). This being the case, and given the scheme itself and the science upon which it is based fall outside Ofcom's area of responsibility and expertise, it is not appropriate in this consultation to seek responses on those matters)
Question 4	Do you agree that voluntary self-regulation would not be likely to meet Ofcom's regulatory objectives or the public policy objectives?
Question 5	Do you agree that the exclusion of all HFSS advertising before 9.00pm would be disproportionate?
Question 6	Do you agree that all food and drink advertising and sponsorship should be excluded from programmes aimed at pre-school children?
Question 7	Do you agree that revised content standards should apply to the advertising or sponsorship of all food and drink advertisements?
Question 8	Do you consider that the proposed age bands used in those rules aimed at preventing targeting of specific groups of children are appropriate?
Question 9	Do you consider the proposed content standards including their proposed wording to be appropriate, and if not, what changes would you propose, and why?
Question 10	Do you consider a transitional period would be appropriate for children's channels in the context of the scheduling restrictions, and if so, what measure of the 'amount' of advertising should be used?
Question 11	Do you consider there is a case for exempting low child audience satellite and cable channels from the provisions of Package 3?
Question 12	Do you agree that there should not be a phase-in period for children's channels under Package 3?
Question 13	Which of the three policy packages would you prefer to be incorporated into the advertising code and for what reasons?
Question 14	Alternatively, do you consider that a combination of different elements of the three packages would be suitable? If so, which elements would you favour within an alternative package? (You should note that the analysis in the Impact Assessment has focused on estimating the costs of restricting scheduling, volume, and content separately and would therefore allow consideration of other combinations of the same elements).
Question 15	Where you favour either Package 1 or 2, do you agree that it would be appropriate to allow children's channels a transitional period to phase in restrictions on HFSS / food advertising, on the lines proposed?
Question 16	Do you consider that the packages should include restrictions on brand advertising and sponsorship? If so, what criteria would be most appropriate to define a relevant brand? If not, do you see any issue with the prospect of food manufacturers substituting brand advertising and sponsorship for product promotion?
Question 17	Ofcom invites comments on the implementation approach set out in paragraph 5.45 and 5.46.

Page 33 of 37 Advertising stakeholders	Broadcast stakeholders	BMJ Open Lawyers	Politicians	Retailers
1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35	Institute of Practitioners in Advertising Advertisers 1 Channel 4 Flextech television ITV GMTV Jetix, Nickelodeon and Turner Producer's Alliance for Cinema and Television 2 Broadcast Advertising Clearance Centre British Academy of Film and Television Arts Broadcast Committee of Advertising Practice	Baker and McKenzie LLP	Mary Creagh MP Welsh Assembly All Party Parliamentary group on Heart Disease David Amess MP	Sainsbury The Co-operative British Retail Consortium 1 British Retail Consortium 2

Food companies	Food industry representative groups	Civil society groups	Public health stakeholders
		BMJ Open	Page 34 of 37
Kellogg 1	Food Advertising Unit 1	Kids Inc	National Heart Forum 1
Kraft 1	Food and Drink Federation 2	Consumer Council of Northern Ireland	Northern Ireland Chest Heart and Stroke 2
1 2 PepsiCo	Snack Nut and Crisp Manufacturers Association 1	Children's Food Bill Coalition	UK Public Health Association
3 GlaxoSmithKline 1	Food Advertising Unit 2	National Consumer Council 1	Royal Society of Health
4 United Biscuits	Food and Drink Federation 1	Which 1	Consensus Action on Salt and Health
5 Nestle	Dairy Council	Officer of the Children's Commissioner	Nutrition Society
6 Cadbury	Snack Nut and Crisp Manufacturers Association 2	School Food Trust 1	Diabetes UK
7 Ferrero 1	Provision Trade Federation	Trading Standards Institute	Association for the Study of Obesity
8 Masterfoods 2	British Cheese Board	Which 2	Heart of Mersey 2
9 Coca-cola 1	Biscuit Cake Chocolate Confectionary Association 1	Welsh Consumer Council	National Oral Health Promotion Group
10 McDonalds 2	Biscuit Cake Chocolate Confectionary Association 2	Food Aware	Scientific Advisory Committee on Nutrition
11 Vimto	Dairy UK	Safefood Ireland	British Psychological Society
12 Wrigley		The Caroline Walker Trust	British Dietetic Association
13 WiltsHife farm foods		Advisory Committee for England	National Heart Forum 2
14 Unilever		Voice of the Listener and Viewer 2	British Heart Foundation
15 GlaxoSmithKline 2		Advertising Advisory Committee	British Medical Association 1
16 Coca-cola 2		British Nutrition Foundation	Cheshire and Merseyside Public Health Network
17 Masterfoods 2		Food Ethics Council	Health Protection Agency Northern Ireland
18 Kraft 2		Voice of the Listener and the Viewer 1	Irish Heart Foundation 1
19 McDonalds 1		National Consumer Council 2	National Heart Alliance Ireland 1
20 RHM Group		National Family and Parenting Institute	National Heart Alliance Ireland 2
21 Kellogg 2		National Union of Teachers	International Association for the Study of Obesity 1
22 Ferrero 2		The Nutrition Society	British Medical Association 2
23		Children's Food Campaign	Heart of Mersey 1
24		Consumer Council	Northern Ireland Chest Heart and Stroke 1
25		Barnardos	Irish Heart Foundation 2
26		National Children's Bureau	NHS Borders
27		Public Voice	Medical Research Council 1
28		School Food Trust	British Heart Foundation 2
29		Scotland's Commissioner for Young People	Cancer Research UK
30		Food Standards Agency	Northern Ireland Chest Heart and Stroke 3
31		National Youth Agency	International Association for the Study of Obesity 2
32		Advisory Committee for Northern Ireland	Royal College of Physicians
33		Food Commission 1	Weight Concern
34		Women's Institute 1	British Dental Association
35		The Obesity Awareness and Solutions Trust	Medical Research Council 2
36		The Obesity Awareness and Solutions Trust	Joint statement by the British Heart Foundation, Cancer Research UK and Diabetes UK
37		National Federation of Women's Institutes 1	Royal College of Nursing
38		National Federation of Women's Institutes 2	

Reporting checklist for qualitative study.

Based on the SRQR guidelines.

Instructions to authors

Complete this checklist by entering the page numbers from your manuscript where readers will find each of the items listed below.

Your article may not currently address all the items on the checklist. Please modify your text to include the missing information. If you are certain that an item does not apply, please write "n/a" and provide a short explanation.

Upload your completed checklist as an extra file when you submit to a journal.

In your methods section, say that you used the SRQR reporting guidelines, and cite them as:

O'Brien BC, Harris IB, Beckman TJ, Reed DA, Cook DA. Standards for reporting qualitative research: a synthesis of recommendations. *Acad Med.* 2014;89(9):1245-1251.

	Reporting Item	Page Number
	#1 Concise description of the nature and topic of the study identifying the study as qualitative or indicating the approach (e.g. ethnography, grounded theory) or data collection methods (e.g. interview, focus group) is recommended	5
	#2 Summary of the key elements of the study using the abstract format of the intended publication; typically includes background, purpose, methods, results and conclusions	2
Problem formulation	#3 Description and significance of the problem / phenomenon studied: review of relevant theory and empirical work; problem statement	4
Purpose or research question	#4 Purpose of the study and specific objectives or questions	5
Qualitative approach and research paradigm	#5 Qualitative approach (e.g. ethnography, grounded theory, case study, phenomenology, narrative research) and	5

guiding theory if appropriate; identifying the research paradigm (e.g. postpositivist, constructivist / interpretivist) is also recommended; rationale. The rationale should briefly discuss the justification for choosing that theory, approach, method or technique rather than other options available; the assumptions and limitations implicit in those choices and how those choices influence study conclusions and transferability. As appropriate the rationale for several items might be discussed together.

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14	Researcher	#6	Researchers' characteristics that may influence the	1
15	characteristics and		research, including personal attributes, qualifications /	
16	reflexivity		experience, relationship with participants, assumptions	
17			and / or presuppositions; potential or actual interaction	
18			between researchers' characteristics and the research	
19			questions, approach, methods, results and / or	
20			transferability	
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25	Context	#7	Setting / site and salient contextual factors; rationale	4
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28	Sampling strategy	#8	How and why research participants, documents, or	5
29			events were selected; criteria for deciding when no	
30			further sampling was necessary (e.g. sampling	
31			saturation); rationale	
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35	Ethical issues pertaining	#9	Documentation of approval by an appropriate ethics	8
36	to human subjects		review board and participant consent, or explanation for	
37			lack thereof; other confidentiality and data security issues	
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40	Data collection methods	#10	Types of data collected; details of data collection	5
41			procedures including (as appropriate) start and stop	
42			dates of data collection and analysis, iterative process,	
43			triangulation of sources / methods, and modification of	
44			procedures in response to evolving study findings;	
45			rationale	
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50	Data collection	#11	Description of instruments (e.g. interview guides,	6
51	instruments and		questionnaires) and devices (e.g. audio recorders) used	
52	technologies		for data collection; if / how the instruments(s) changed	
53			over the course of the study	
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57	Units of study	#12	Number and relevant characteristics of participants,	8
58			documents, or events included in the study; level of	
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		participation (could be reported in results)	
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3	Data processing	#13 Methods for processing data prior to and during analysis, including transcription, data entry, data management and security, verification of data integrity, data coding, and anonymisation / deidentification of excerpts	6
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9	Data analysis	#14 Process by which inferences, themes, etc. were identified and developed, including the researchers involved in data analysis; usually references a specific paradigm or approach; rationale	6
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16	Techniques to enhance trustworthiness	#15 Techniques to enhance trustworthiness and credibility of data analysis (e.g. member checking, audit trail, triangulation); rationale	7
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21	Syntheses and interpretation	#16 Main findings (e.g. interpretations, inferences, and themes); might include development of a theory or model, or integration with prior research or theory	8
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27	Links to empirical data	#17 Evidence (e.g. quotes, field notes, text excerpts, photographs) to substantiate analytic findings	11
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31	Intergration with prior work, implications, transferability and contribution(s) to the field	#18 Short summary of main findings; explanation of how findings and conclusions connect to, support, elaborate on, or challenge conclusions of earlier scholarship; discussion of scope of application / generalizability; identification of unique contributions(s) to scholarship in a discipline or field	17
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40	Limitations	#19 Trustworthiness and limitations of findings	18
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43	Conflicts of interest	#20 Potential sources of influence of perceived influence on study conduct and conclusions; how these were managed	1
44			
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48	Funding	#21 Sources of funding and other support; role of funders in data collection, interpretation and reporting	1
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