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# An inconvenient truth: why evidence-based policies on obesity are failing Māori, Pasifika and the Anglo working class

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**ABSTRACT**

Public health initiatives around obesity have generally worked well for middle class Australians and New Zealanders. This message has not had the same impact in Anglo working class areas and certain CALD communities, especially Māori and Pasifika,[1] where obesity rates remain highest. This paper employs qualitative data from interviews with eighty-five Māori and Pasifika migrants to Australia to explore attitudes to food purchasing and consumption behaviours and associated health risks. It is evident the individual, medicalised approach to improving obesity rates has not been effective and there needs to be a new culturally responsive structural approach. This would require governments to prioritise population health over existing relationships with commercial food manufacturers – especially in relation to spatial domination of commercialised fast food outlets in low socio-economic status districts and in the areas of sports and education sponsorship. We also explore the assumptions of evidence-based health policy more generally, providing a critique of who is represented and served by the commercial solicitation and management of health research. This includes what constitutes 'evidence', who is conducting and funding the research, who appraises and compares the data and how is it interpreted and employed.

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## Introduction

The demonstrable correlations between lifestyle and health have been extensively examined in the public domain for decades and have formed the basis for governments to adopt evidence-based health policies. Awareness of the importance of reducing the intake of salts and fats, to eat nutritious foods in modest amounts and the need for regular exercise has translated into relatively good health and longevity for baby boomers. However, for Māori, Pasifika, indigenous Aboriginal people[2] and Anglo working class Australians and New Zealanders, this model of moderation and abstinence has been less successful. Indeed, obesity statistics are moving away from designated targets at an accelerating rate.

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The apparent reluctance of 'high risk' groups to adopt the top-down messaging around food practices has perplexed and frustrated health professionals committed to the individual model of health. In the context of this paper, we are not disputing the correlations described above; we are arguing that there is a range of complex sociological factors (class/cultural/structural) impacting on people's food and lifestyle choices. High concentrations of obesity in 'minority' populations and the working class poor indicate that socio-economic positioning is significant. However, the interaction of other forms of social marginalisation and cultural practices also contribute to higher rates of obesity and related illness in Māori, Pasifika and Aboriginal communities.

International studies indicate that socio-economic positioning and ethnicity are powerful indicators of the trajectory and outcomes of obesity-related illness (Ajwani et al. 2003; Swinburn 2008; Friel 2009). The extremely high rates of *preventable* chronic disease, disability and premature mortality are impacting on community well-being and on already over-stretched health systems (Bedford et al. 2009; Rodriguez 2012). There are considerable financial implications of continuing with present policies. The 'moderation' message of personal responsibility and 'lifestyle choice' has been successful in certain population groups; arguably those groups with high enough disposable incomes and the health literacy to understand these issues and have incorporated the recommendations into their lives. For other groups, 'more of the same' messaging is not going have the same impact if it has not done so already. Consequently, more 'evidence' that eating fatty food, drinking soft drinks and having a sedentary lifestyle is damaging to your health is not going to make inroads in population groups with growing obesity rates.

## What are the component parts of evidence-based policy?

To be clear, the authors of this paper are in no way opposed to policy being based on evidence. Essentially this is the most responsible approach that should lead to better bipartisan policy-making. It would be difficult to find a government institution, department or agency that does not advocate the benefits of evidence-based policy. Our questions and concerns circulate around the way the evidence is collected, who is served by the results of this evidence, the cost/benefit ratio of implementing the proposed policy and increasingly, the rushed way in which evaluations of research are being conducted. We are mindful that what constitutes good research and who determines the value of this evidence is a critical process and are concerned that there are not enough resources allocated to adequately undertake systematic reviews of the literature regarding particular policies. In other words: are the current evaluative processes up to the task of giving us evidence-based policy?

This paper argues that the term itself – evidence-based policy – benefits from a public trust in the scientific/medical tradition of impartial gathering and interpretation of data. It brings reassurance that the evidence has been arrived at in an ethical and systematic fashion and the associated policies are driven by non-partisan application of the results. These assumptions, as summed up by Jensen (2013, p. 3), have come to be regarded as an improvement in the social condition itself:

> The ultimate objective of 'evidence based' policy is to use actual evidence on what works – rather than rely on ideology – to promote good public policies. That way, good policies

survive and bad policies are killed off. Using an incremental approach like this, we can continue to make the world a better place.

As a buzz term, 'evidence-based policy' has been widely used with little critique of processes, methodologies and interpretation. Specifically, this paper raises questions in relation to obesity and related illness: who conducts the research, who pays for it, what methodologies are employed, what are the skills of those who compare the data and who decides what 'evidence' prevails if the data are contradictory. Due to the limited scope of this paper, these issues will be dealt with very briefly and hopefully form part of a larger discussion of commercialised research in relation to health. This issue has implications for health budgets on both sides of the Tasman.

The qualitative data discussed in this paper provide context and meaning as to why repeated government initiatives to arrest the obesity 'epidemic' are ineffective. In turn, this raises the question of why successive governments continue to spend significant amounts of money on unsuccessful policies. Given the constraints on health resources it appears perplexing that governments continue to outlay monies on various campaigns promoting 'healthy eating', while refusing to challenge the fast food industry and its disproportionate commercial exposure in low-income districts. We argue a more effective model would be public health initiatives that reflect what is relevant to affected population groups: policy as discourse.

It is clear that clusters of obesity cannot be redressed without a wide-ranging series of structural reforms such as those introduced around smoking. These would include radically limiting children's exposure to relentless advertising of fast food and beverages and the banning of alcohol and fast food sponsorship in sport. In Australia, when tobacco companies were finally barred from sponsoring sports, there was intense scare-mongering about the end of certain sports events. This did not happen. Indeed, as this paper suggests, the various state and federal governments would be financially better off transferring funds currently earmarked for anti-obesity campaigns directly into the sponsorship of sports at all levels.

We briefly examine how large corporations influence public health research globally and explore how 'big business' frequently disguises this influence in a process known as 'astro turfing'. This paper argues that there needs to be a new direction – an intersectoral approach to address existing health disparities and to act in the broader public health interest in relation to the fast food and beverage giants.

## Methods and methodology

This paper utilises the results of two qualitative studies with Māori and Pasifika in Australia. Sixty-seven interviews were conducted by the first author incorporating the views and experience of families in relation to their food practices and perceptions of health. Three key respondents (one Māori and two Pasifika nurses) played a significant role. A smaller study of 18 respondents was undertaken by the second author in relation to these and other broader social issues. Interviews were conducted over several hours and sometimes over several sessions. The data were manually themed and coded. All three authors have on-going substantial ties with the extended communities in Australia. A *Kaupapa Māori/Fa'a Pasifika* methodology was employed at all stages.[3] Interviewees are quoted using self-identified descriptors.

## Results

In Australia very little qualitative work has been done with Māori/Pasifika peoples in relation to health. One significant exception has been Bedford et al. (2009) where Tongan respondents were interviewed as part of a project by Queensland health professionals and the Ethnic Communities Council of Queensland (ECCQ). The findings in this paper reflect and expand on these data. The results also support a range of studies conducted in New Zealand that are referenced in this paper. Clearly the individual health approach to this issue fails to resonate with those most at risk. The majority of respondents identified both economic and cultural factors as instrumental in their food purchasing and consumption behaviours. It was frequently acknowledged that it is difficult for one person to change their eating patterns within the context of extended family. This would support the idea that food and exercise recommendations would be better targeted in a *whanau* and/or community context. Also in the majority of households both men and women are working and facing time constraints that have led to a higher uptake of commercialised food.[4]

## Middle class solutions to a working class problem

'Evidence based' policy recommendations rely heavily on people having high health literacy and an almost civic responsibility to control their weight and that of their children (Petersen and Lupton 1997). The prevailing discourse around obesity operates by assuming that the individual chooses to eat too much poor quality food and declines adequate exercise. The problem is therefore seen as 'information deficit': if only more people had access to the healthy lifestyle message they would rationally adopt a healthier lifestyle in their own best interests. This is the individual approach to health. This model has led to the development of public health messages that appear reasonable: buy good quality foods, calculate their caloric value, consume them in reasonable quantities and exercise in proportion to energy consumed. The individual is expected to take this information 'on-board' and radically change their lifestyles, or risk being labelled obstinate, lazy, undisciplined and recalcitrant. However, this is essentially a middle-class position which does not take into account the socio-economic requirements of having to feed a large family cheaply, or poor awareness of labelling 'double speak'; nor does it address the cultural practices around food in working class, Māori, Pasifika and Aboriginal communities (Rodriguez and George 2014; Rodriguez 2012).

The cyclical nature of socio-economic disadvantage compounds this issue. Obesity is demonstrably greater in low socio-economic groups, and in turn, obesity contributes to further social disadvantage in terms of reduced employment opportunities and increased likelihood of disability and poor health. With this understanding, obesity and related long-term debilitating illness and premature mortality are not simply health problems. As pointed out by Blakley et al. (2011) and other commentators on public health policy, technical and medical solutions while necessary for health, are radically insufficient to address the broader social determinants underlying current health disparities. In other words, because of the failure of governments to address social inequality 'upstream' – where people live and work – we all pay the price 'downstream'.

The cost of *not* addressing this issue is considerable. In New Zealand, Signal (2011) estimated that the cost of obesity-related illness has risen from approximately 2% of the New

Zealand health budget to 7%. The Australian government has been repeatedly advised that correlations between socio-economic status and poor health underlie the budget 'blow outs' in the hospital system, yet there is resistance to shifting focus towards prevention (see Belcher 2014; Duckett 2014). As health economist Paul Gross explained a decade ago: 'It's part of the benign neglect that masquerades for health policy' (Pirani 2007, p. 21).

## Foodscapes – purchasing behaviours and attitudes

International studies in the United States and United Kingdom have found that consumers on low incomes are the least likely group to adopt dietary change (Turrell and Kavanagh 2006; Drewnowski and Darmon 2008). According to these and other authors, strategies that recommend high-cost foods to those in low-income households are ineffective. However, food purchasing and eating behaviours have a complex aetiology and should not be automatically regarded as synonymous with low incomes. Consumption behaviours reflect a number of issues including the actual and perceived high cost of fresh food, availability, motivation and entrenched class and cultural factors.

The ubiquitous presence of fast food outlets in low-income neighbourhoods has accelerated. In the last decade the term 'food deserts' has been employed to describe geographical localities of working class and low-income urban and regional districts. Combined with poor fresh food options, there is a marked spatial domination of particular types of fast food outlets that reinforces food 'poverty' (Smoyer-Tomic et al. 2006). This increases families' exposure to fast food advertising and arguably encourages children to exercise their 'pester power'.

There is also the scale of consumption to consider, particularly in relation to large Māori, Pasifika and Aboriginal families. The economic power of commercial food manufacturers, in conjunction with the monopoly of supermarket chains, acts to reduce the retail options available in a given geographic location. Their appeal is enhanced by offering deals on large-scale purchases both of the ready-to-eat meal and other supermarket items. The need to feed large numbers of people affordably results in an increase of bulk buying of 'no name' products, many of which are of poor quality. There were many examples of the socio-economic rationale applied to food purchases amongst participants:

> It's a shame really. Māori and Islanders are the very ones who should be looking after their health, but you can't pay $6 for a box of 'good' cereal that's going to last one breakfast, if that. Most times we would go through two boxes a day, so we buy the cheapest. (Cook Island mother, mid 50s)

The nutritional preoccupation with portion size and labelling also fails to resonate. As pointed out by a Niuean nurse: 'There's no point telling an Islander that they should have two "serves" of this and that. What does that mean? They aren't going to look for the "tick" on the cereal – they buy in bulk. It's all another world'.

## Class and cultural preferences as distinction – it is not always about the money

Programmes such as the Healthy and Active Australia Initiative (DHA 2015) continue to rely heavily on the nutritional science perspective. This regards the sociocultural factors around food as relevant only in how they operate as a barrier or enhancement to

people achieving the 'correct' diet. Like previous campaigns designed to address the issue of obesity via restraint, it has failed. While low household incomes can be directly correlated to poor food choices, there are other examples where household income is not the sole driver of food consumption habits (Higginbotham et al. 2010; Rodriguez 2012).

These class and cultural factors need to be explored as to *why* certain population groups are defying the dire health warnings and refusing to take up the 'good food/diet/exercise' mantra. The work of Gray et al. (2014) and others indicate middle class health values and goals are unlikely to make an impact in a community that perceives itself as outside the mainstream in the first place. For Māori and Pasifika, notions of cultural identity and well-being are entwined with the preparation and consumption of food. As a key respondent pointed out: 'Polynesians are happy when they're eating. That's it. If you feel happy you don't feel sick. They don't associate what we eat with getting sick. The more food the better'.

The patterns around food and dietary behaviour are deeply embedded in cultural practices of social exchange, obligation and cohesion that inform household, family and community life. Food brings the family together. It is regarded both as a reward for hard work and a source of comfort and pleasure. In the migrant context, food rituals have largely been preserved as a form of social solidarity and act to strengthen the bonds of kinship and culture in the wider Māori/Pasifika community. Food and food practices, therefore, represent togetherness, tradition and identity. Consequently, what health professionals see as problematic may be the very things that bring families and community together: 'We go to church, then we eat. When the family gets together it is always around food – lots and lots of food. It's how Polynesians see life' (Samoan female, 35).

Other respondents offered similar ideas:

> To a Māori, food is where it's at. Food is better than sex. We work hard. There's nothing beats sitting down with your *whanau* [family] and having a gigantic feed – then you have a nap. (Māori male, mid 40s)

> Tongans are big eaters and that's the truth. An ordinary meal, compared to an Australian meal is *so* much. With Tongans we have a tendency to eat as much as you can – its pleasure … . (Tongan female, 46)

In this way, 'traditions' of class combine with cultural traditions to establish certain eating patterns that may, when observed as part of the middle class discourse around good health, appear to be detrimental but persist because of emotional and cultural gratifications they afford.

## Globalisation, nutrition transitions and the role of governments

International food corporations and franchised fast food outlets have invested vast sums of money cultivating a taste for their products. Inevitably, there have been shifts in the 'global palette' that are reflected in changes to the foods that are available, and/or desirable. These mega-corporations are extremely aggressive in their marketing practices and arguably have come to dominate global and local foodscapes.[5]

Many Aboriginal, Māori and Pasifika families have both a larger number of children than their Anglo counterparts, and an established cultural practice of housing relatives for extended periods of time. Not surprisingly, these communities will tend to congregate

in the more affordable regions that comprise this low socio-economic cluster, in particular, outer urban and regional areas. These are the same areas that have disproportionate concentrations of fast food outlets per capita.

There is not only government inertia in regard to the structural issues of food poverty, but it also appears that the 'hand of health' is not on speaking terms with the 'hand of trade'. In regard to the sale of mutton flaps to Pacific Island nations, repeated reports commissioned by the New Zealand government have advocated for legislative interventions (see Swinburn 2004; Clarke and McKenzie 2007). However, vested interests in the meat industry and trade commissions continue to dissuade both the Australian and New Zealand governments from supporting bans on the export of flaps. This dynamic is summed up by public health advocate Professor Nick Wilson (Cumming 2010, p. 1):

> The people who carry political sway are the people who are getting economic benefit from selling mutton flaps, not the people that are having to pay for renal dialysis. I think they need to build some public health into their trade policies.

The globalised franchises of fast food giants continue to have unfettered access to children. Unlike the Netherlands, Canada and other countries, the Australian federal government refuses to restrict junk food advertising in early television timeslots. When cleverly designed fast food ads are combined with growing up in a geographical area saturated with fast food outlets, it becomes harder to make the 'right' choices. This message is reinforced – we would argue in a reckless and callous manner – by companies such as McDonalds sponsoring children's hospital facilities, Coca Cola sponsoring educational programmes and the current sponsorship arrangements in Australian sport.

## Rugby League – brought to you by alcohol, fast food and gambling

The working class sport of rugby league in Australia is sponsored by Kentucky Fried Chicken – alongside VB (beer), Wild Turkey (Bourbon) and gambling agencies. The Obesity Policy Coalition and other organisations have been unsuccessful in appeals to state and federal governments to intervene. This bizarre and destructive triad of fast food, alcohol and gambling is defended by the somewhat circular logic that rugby league could not afford to lose these sponsors, and sponsors give us sport, and sport is healthy, right?

There appears to be no cohesive national policy that prioritises the health of young people that embraces effective strategies for better eating practices and engaging young people in physical activities including organised sport. Given the financial implications for New Zealand and Australian governments, the cost of obesity-related illness itself should act as an impulse to address the issue. Arguably both countries could save a considerable amount of money in health spending by investing directly in sports. In Australia the user-pays principle in grassroots sports is prohibitive for many parents:

> People of lower socio economic situations are doing less sport, less physical activity and that is flowing through to children which is worrying considering childhood obesity in Australia. (Rolfe 2016, p. 1)

This is a clear illustration of how evidence utilised in one domain ignores contradictory findings – or recommendations for more complex solutions – in another domain. For

example, there is evidence that sport improves physical fitness, improves mental health and has other positive social outcomes. However, there is also evidence that the rising costs of sport are limiting the participation rates of those children most at risk of obesity. This leads to policies operating in isolation and frequently against each other.

## The risks and limitations of evidence-based policy

As described above, we have the various organs of government (health/housing/sport/education) all allegedly using 'evidence-based policy' yet the results continue to be poor for those who are socially marginalised. It also highlights the lack of intersectionality in response to health and other broader social issues. There is a sense that the phrase 'evidence-based policy' has become a catch-all term rather than a well-informed outcome of research.

Evidence-based policy sounds responsible and proactive. It is reliant on a principle that by acquiring more data (usually in the form of numbers, not qualitative enquiry) we will be closer to envisioning a successful intervention. It manages to appear value-neutral, scientifically based and therefore rational. Its perceived neutrality means it is construed by policy-makers, many health researchers and certainly the public, as beyond politics; meaning not susceptible to ideological vagaries of particular parties. This is misleading in many ways. Arguably health research benefits from a deeply ingrained public perception that it is 'pure' research. However, given the trend to sponsored research and the degree of outsourcing of research to pharmaceutical corporations and private companies, it can no longer be reliably regarded as conducted by truly independent researchers.

The protected status of policy resulting from 'evidence based' research infers that scientists are not subject to political influence. Kaplan (2004) gives the example of the Bush administration in the United States which set about appointing not only federal advisory bodies but also peer-review committees with researchers known to be matched to the conservative agenda of the President. Cannella and Lincoln (2004, p. 165) refer to this as 'methodological fundamentalism'. They argue that the current conservatism in certain research discourses fails to incorporate 'critical theory, race/ethnic studies, feminist theories and silenced the voices and life conditions of the traditionally marginalized'.

This fundamentalism (or deep conservatism) does not allow for localised knowledge and understandings, context or a range of multi-variant and interactionist factors. By ignoring specificities and messy complexities it assumes that 'good data' is standardised and can be readily shared by the wider research community. This makes sense in what Denzin (2009) and others refer to as the audit culture of research funding: if more researchers can access and re-work existing data this represents more value for money. Policy development also works in conjunction with cost/benefit analyses: how to achieve health improvements for the least outlay – in other words, more 'bang for your buck'. This means that policy-making is a constant process of attempting to reconcile what is actually needed with what can be provided in the way of resources. Shaw (2010) and Russell et al. (2008) remain critical of attempts by political rationalists to improve outcomes without engaging in the densely layered and complex interactions of various policy environments.

As these and other authors point out, policy innovation, particularly in relation to health challenges such as obesity, should not just be a rolled-out response from a single

source of 'evidence'. It should also consider appropriate models of understanding social behaviours and include context, including inter-departmental and intersectoral responses to an issue (see also Williams 2002; Bacchi 2008). This would involve a move towards a mixed method approach: quantitative and qualitative inputs including interviewing stakeholders.

Current directives emerging from the conventional evidence-based model still centre around the individual's responsibility for their own health. It is constituted in the belief that human behaviour is, in the words of 'constant, uniform and predictable'. This helps explain why this model continues to fail. In an attempt to include the social experience, many health services have moved from the strictly biomedical approach to the bio-psycho-social approach – people in society. The problem with this model is that it is still preoccupied with the individual *in* society, and does not reflect the problematic nature of inequities of life chances and access in the broader society itself.

## The quantitative vs. qualitative debate: how the status quo serves the political class

Using medical/scientific research as the gold standard, quantitative findings are considered to be universally applicable. Researchers dissect elements of a problem and produce discrete outcomes. For example, a short-term intervention can have successful outcomes such as losing weight and better health for some. Comparing results with baseline data from participants is measurable. The implicit understanding is that it worked for the test population so if everyone did this, they too would be slimmer and fitter. The perception that these success stories emanate from government policy or health initiative allows bureaucrats and politicians to be seen to be decisive and effective.

By contrast, qualitative studies are considered 'soft', of questionable validity, not replicable and consequently do not offer an acceptable contribution to 'true' research (see Morse 2006). Historically, the idea that social problems such as household over-crowding and poor sanitation led to health problems was met with practical and rational solutions, for example, ensuring the public had access to a clean water supply. Such rationalist and positivist perspectives relied on natural science methods to define the problem and direct the solution. However, as pointed out by Bonner (2003) and others, when applied to other social and health problems, this model falls short.

As the statistics around obesity continue to frustrate and mystify health workers and politicians, policy-makers appear determined to continue down this same path. The resistance to funding qualitative engagement and listening to those most affected by this issue is summed up by Shaw (2010, p. 197; Rodriguez 2013):

> As a result, comprehensive and political rationalism have developed analytic and conceptual sophistication within the field of health-related policy with limited attention paid to conceptualising policy-as-discourse and to the practicable means by which it can be analysed and utilised.

Some authors go further. According to Hammersley (2005, p. 3) the uncritical adoption of evidence-based policy may actually constitute a threat to good research. This is particularly relevant when private or corporate funding is used to commission and fund research. Some academics who have been critical of the influence of private companies in health

research have expressed concern that they are being monitored. In Australia, Lisa Bero of the Charles Perkins Centre has been targeted for questioning the integrity of industry-sponsored research by tobacco companies. Michael Spence, University of Sydney, has also been targeted. His work exposed Coca Cola as a large contributor to research that 'proves' that it is exercise not diet that leads to a reduction in obesity. The *New York Times* describes this process as 'astro turfing', namely: 'the covert development of opinion supporting a position in a way to make it appear to be unsolicited research' (Strom 2016, p. 3)

## Discussion and conclusions

There is a clear need for transparency of funding, improved evaluation and integrated policy. Jensen (2013) argues for more rigorous social evaluation processes to be applied to the policy arena. For example, a policy that encourages women back into the workplace after having a baby will inevitably have a knock-on effect on the demand for childcare. This raises issues around how policies are assessed as being 'good' or 'bad'. It is actually very difficult to make the call unless very detailed analysis is undertaken of comparative studies in other places both with and without the policies and ensuring researchers are well skilled in how to extract and describe 'evidence' in a social science context. If researchers are not adequately trained across a mixed methods platform, combined with the pressures of modern political expediency, it would appear to be a recipe for a quick fix. With not enough time and resources to do a systematic review of a subject area, there is a risk that inadequate research may form the basis of the next 'evidence based' policy.

It is evident that there is need for wider policy interventions that resonate with class and cultural populations who are not responding to the individualistic 'healthy eating/healthy lifestyle' model of restraint. It is well understood that there are entrenched cultural patterns around the consumption and exchange of foods in the extended Māori/Pasifika community. There are also consumption behaviours – considered problematic by health professionals – that are shared with working class communities in Australia and New Zealand. The capacity of individuals and their families to adopt lifestyle changes that may be beneficial to health is affected by a mix of socio-economic circumstances, class positioning and cultural behaviours.

Health researchers and policy-makers need to understand why the most at-risk groups resist these well-intentioned campaigns. This requires engagement in qualitative research with these population groups to understand what *they* feel are the factors contributing to their own obesity and that of their families. However, more complex time-consuming social exploration is not an easy sell. Long-term support and interventions for chronic 'lifestyle' conditions are expensive, rendering them unpopular in political terms (Duckett 2008). There is a marked political preference for continuing to centre policy around the biomedical/individual approach to obesity.

In order for health policy to prioritise culturally appropriate services that engage working class and culturally diverse populations, it requires the building of strategic alliances within and between sectors. This represents a commitment towards public health being regarded as a social issue. Currently there is a lack of cohesion, appropriate mechanisms and political will to facilitate cooperation in the interest of achieving the best possible outcomes for health consumers, and the allied workers who care for them.

A radical re-think is required. The discourse around public health needs to encourage and authorise governments to work across narrow sectoral boundaries. As Friel (2009) points out in relation to obesity, alcohol and tobacco, operationalising these recommendations requires a combination of coherent policy, strong leadership by the health sector and community level action. It also involves bipartisan economic commitment over the long haul. Investment in education, transitional employment and urban development will be off-set by savings in the health sector for the next generation and beyond. There is also substantial 'evidence' that other social and economic benefits from such input have considerable and lasting impact.

In regard to the responsibilities of leadership, the short-term interests of globalised fast food giants and trade representations should not be allowed to sabotage the health of vulnerable populations. Australia and New Zealand should not fear restriction of junk food advertising during children's television hours. This is not a moral argument. It is about the economic cost of the next generation of children having higher rates of chronic conditions than their parents. It is no longer economically viable for governments to tinker about with the 'traffic light system' on foods at the supermarket while allowing corporate sponsorship of sport or educational programmes by fast food chains, alcohol and gambling outlets. This requires regulation of the spatial monopolisation of fast food dynasties in certain urban and regional areas. It also needs to harness the power of neighbourhood to affect well-being.

The silos of individual government portfolios, health research and community development are at present not on speaking terms. Academia is not immune to these processes of rationalisation. While most universities suggest they are interested in transdisciplinary research and other notional collaborations, in real life it is very difficult to have an authentic scholarly exchange across disciplines. This lack of vision in political, academic and public life means we may all pay a very high price for ignoring these issues.

## Notes

1. In this paper Pasifika and Pasifika peoples refer to Pacific Islanders of Tongan, Samoan, Niuean and Cook Island descent. Interview respondents are quoted using their self-identified ethnicity.
2. For this paper Aboriginal refers to the Indigenous people of Australia.
3. This included participants to be able to choose the venue for the interviews, usually their own home. Other family members who were not technically part of the interview process were able to sit in and participants could choose whether or not to disclose any relevant health information.
4. For a more detailed understanding of cultural health perspectives in relation to obesity, please see Rodriguez (2012) and Rodriguez and George (2014).
5. For more on the subject of foodscapes in relation to Māori, see Panelli and Tipa (2009).

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