The Australian Prevention Partnership Centre

Policy Development Handbook

Developing codes of practice as a means of activating new non-communicable disease (NCD)-prevention provisions embedded within the South Australian Public Health Act 2011

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Policy Development Handbook: Developing codes of practice as a means of activating new non-communicable disease (NCD)-prevention provisions embedded within the South Australian Public Health Act 2011

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Disclaimer: This evidence review is not necessarily a comprehensive review of all literature relating to the topic area. It was current at the time of production (but not necessarily at the time of publication) and is based on sources believed to be reliable.

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2. Executive summary

In 2011, South Australia became the first jurisdiction in Australia to modernise its public health legislation by including non-communicable disease (NCD) prevention provisions in the *South Australian Public Health Act 2011* (the Act). The NCD-prevention provisions empower the Minister to introduce codes of practice (Codes; a set of written rules) specific to an NCD which regulate the marketing, manufacturing, supply or accessibility of goods, substances or services that may contribute to that NCD. The operationalisation or 'activation' of the provisions requires the Minister to voluntarily issue one or more Codes.

This project, in collaboration with Wellbeing SA, an attached office to South Australia's Department of Health and Wellbeing, aimed to inform new policy and co-design codes of practice through a Technical Advisory Group (TAG). This group consisted of policy makers from Wellbeing SA, public health lawyers, and experts in health economics, systems thinking, implementation science, food and alcohol policy, population nutrition and obesity. The TAG will guide the design and implementation of these Codes.

This policy handbook has been designed to support the TAG throughout the process of policy development and contains an:

- Overview of the project and its objectives
- Outline of the South Australian health and wellbeing landscape
- Summary of existing regulatory interventions in South Australia
- Legal brief of the key features of the South Australian Public Health Act, and the key opportunities it contains to develop regulatory interventions to support Wellbeing SA's NCD-prevention agenda.

This process of co-production has the potential to directly benefit Wellbeing SA by accommodating stakeholder priorities at the outset and facilitating the incorporation of consumer and community involvement, and research evidence into policy in real-time. This work could also benefit the South Australian population by enhancing the public value of existing 'inactive' legislation and delivering positive, equitable and sustainable changes to population health and wellbeing.

3. Project overview

3.1 What is the issue?

In 2011, South Australia became the first state in Australia to include non-communicable disease (NCD) prevention provisions in its Public Health Act.[1] This means South Australia's Minister for Health and Wellbeing is empowered to declare an NCD and issue a code of practice to prevent or reduce impact. However, these provisions have not yet been activated.

This project, in collaboration with Wellbeing SA, an attached office to South Australia's Department of Health and Wellbeing, will co-design codes of practice to inform new policy. The NCD-prevention provisions are the first attempt to transform a core piece of public health law in response to Australia's chronic disease epidemic. This is significant in stemming lifestyle-related chronic disease such as type 2 diabetes, stroke, cardiovascular disease and some cancers.

South Australia's Public Health Act 2011 (the Act) is an example of infrastructural public health law. These laws provide legal frameworks that empower or force public health agencies to act. Public health concerns contained in infrastructural public health law, such as core public health acts, have traditionally focused on sanitation and communicable disease. This is the first public health Act in Australia to include NCD prevention provisions. The Minister's powers may be used to regulate how specific goods (for example sugar-sweetened beverages), substances or services are advertised, sponsored, promoted or marketed, manufactured, distributed, supplied, sold or accessed by the public. Yet, a code of practice for NCD prevention has not been created before.

3.2 How is the project addressing the issue?

This project will attempt to design and support future implementation of the first code of practice for NCD prevention under the Act. It is also the first to attempt co-designing this aspect of the law and is therefore significant in exploring the contribution law can make to emerging public health issues.

A collaboration involving policy makers and a group of multidisciplinary public health experts was established to form a technical advisory group (TAG) consisting of policy makers from Wellbeing SA, public health lawyers, and experts in health economics, systems thinking, implementation science, food and alcohol policy, population nutrition and obesity.

This research collaboration will play an instrumental role in realising the full potential of SA's NCD-prevention provisions by co-producing codes of practice and other resources to support implementation aligned with Wellbeing SA's strategic priorities.

Data collection methods included workshops, legal and policy analyses, a stakeholder consultation, and process evaluation. The project's design and methodology will be published as a study protocol to ensure rigour and transparency in public health law research and makes a valuable contribution to the literature.

3.3 Relevance for practice

The project will inform the activation of the NCD-prevention provisions by co-producing model codes of practice reflecting strong public health evidence. It will also provide a framework for embedding NCD-prevention provisions within existing public health law.

The research findings will form a useful case study for other states and territories about the declaration of an NCD and the development of associated codes of practice. In the long term, the project will help reduce chronic disease through effective public health law and regulation, contributing to the creation of healthy environments.

3.4 What are the expected outcomes?

The project will help show how to undertake productive research collaborations with public health researchers, from establishing rules of engagement to priority setting and formulating a research plan that meets the needs of policy makers and researchers. These insights will have cross-jurisdictional relevance for researchers and governments and will enable future policy partnerships.

The research will also increase collective knowledge about applied public health law research and how it can be used to investigate the potential of existing and future public health laws. It is hoped that this work will empower policy makers and researchers to work together to generate rigorous public health law research evidence needed to make policy decisions quickly and take effective action to improve the public's health.

This policy handbook has been designed to support the TAG throughout the process of policy development and includes:

- The South Australia context
    - Sociodemographic and socioeconomic analysis
    - South Australian population health risk factors
- Summary of existing regulatory interventions in South Australia
- Legal brief of the key features of the South Australian Public Health Act, and the key opportunities it contains to develop regulatory interventions to support Wellbeing SA's NCD-prevention agenda.

4. The South Australian context

4.1 Sociodemographic and socioeconomic analysis

Understanding South Australia's sociodemographic profile is an important step in designing codes of practice that may improve the health of its population. The majority of South Australians benefit from a high standard of living, live in safe neighbourhoods and have secure housing, a stable income, and can access quality essential services; health and social services, education and transport.[2] However, this is not the case for all South Australians. The descriptive statistics below are based on Australian Bureau of Statistics data[3].

Population

- South Australia is Australia's fifth most populous state or territory with a population of 1,676,653.
- The state's rate of population growth is distinctly slower than the national average. Between 2011 and 2016 South Australia's population grew by 5.0%, in contrast to the national growth rate of 8.8%.
- South Australia also has a distinctly older population distribution than wider Australia with a median age of 40 compared to an overall median age of 37.

Ethnicity

- The proportion of South Australians born in Australia (71.1%) is consistent with the national average (71.5%).
- South Australia's top five countries of birth outside Australia are England (5.8%), India (1.6%), China (1.5%), Italy (1.1%), and Vietnam (0.9%).

Income and housing

- The income of personal and family households in South Australia is less than the national median ($46,937, second lowest of all states and territories).

Education

- The proportion of South Australian (43.5%) residents having a tertiary qualification is marginally lower than the national average (46.6%).
- The types of tertiary qualifications attained by South Australians is changing — certificate level qualifications are declining in enrolments while high-level tertiary studies are becoming increasingly popular.

Rural and remote population

- Rural and remote communities comprise 22.7% of the South Australian population.
- A lower proportion of the rural and remote population (11.2%) were born overseas, compared with Greater Adelaide (26.3%).
- The rural and remote population is distinctly older (median 44.3 years) than their counterparts in Adelaide (median 38.6 years).

- South Australians living in rural and remote areas, have higher rates of chronic health conditions and have poorer physical and mental health status than those living in metropolitan Adelaide. Rates of risk factors for disease are higher and access to services poorer[2].

Aboriginal and Torres Strait Islander population

- South Australia has an Aboriginal and Torres Strait Islander population of 42,265 people.
- Just over half (51.9%) of the state's Aboriginal and Torres Strait Islander population live in Greater Adelaide, while 32.7% and 14.6% live in regional and remote areas respectively.
- The median age for Aboriginal and Torres Strait Islanders population in South Australia is 23 years, compared with 41 years for non-Indigenous South Australians.
- On every measure of social determinants, Aboriginal people have lower levels of health. They also experience higher rates of the risk factors that contribute to chronic diseases and poorer access to health services.[2]

4.2 South Australian population health risk factors

In the 2017–18 National Health Survey, more than half (55.8%) of South Australians aged 15 years and over considered themselves to be in excellent or very good health.[3] Data presented below presents health statistics for the state regarding the health risk factors from this survey.

Smoking

- The rate of South Australian adults reported as daily smokers marginally decreased from 13.8% in 2014–15 to 13.1% in 2017–18, just below the national average of 13.8%.
- Rates of smoking were higher in areas of most disadvantage with 18.4% of adults smoking daily, compared with 6.8% in the least disadvantaged areas.[4*]
- Rates of smoking were lower in Greater Adelaide (12.0%) compared with regional and remote communities (16.7%).

Overweight and obesity

- Nearly 70% of South Australian adults were overweight or obese. This figure is slightly higher than the national average of 67%.
- Worth noting is that South Australia was one of three states and territories that saw increases in the proportion of overweight or obese adults from 2014–15.
- Adults living in regional and remote Australia were more likely to be overweight or obese than those living in Greater Adelaide (75.6% and 68.5% respectively).

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*The ABS measure Socio-Economic Indexes for Areas (SEIFA), the Index of Relative Socio-Economic Advantage and Disadvantage (IRSAD) by considering the income, education, occupation and housing characteristics of a population to categorise a population's socio-economic advantage and disadvantage into quintiles.

Alcohol consumption

- 16% of adults in South Australia exceeded the lifetime risk guideline of more than two standard drinks per day on average. This rate of consumption is similar to 2014–15 (16.8%) and on par with the national average (16.1%).
- Men were more than twice as likely to exceed the lifetime risk guideline as women (23.6% compared with 9.5%). Similarly, Australian born adults were almost twice as likely as those born overseas to drink in excess of the lifetime risk guideline.

Physical activity

- More than half (51.5%) of South Australians aged 18–64 undertook 150 minutes or more of exercise in the last week of the survey being conducted. This was the lowest rate of physical activity for states and territories alongside Queensland.

High blood pressure

- A quarter (25.4%) of South Australian adults had a measured high blood pressure reading. This rate is trending upwards from 2011–12 (23.3%) and 2014–15 (24.5%).
- This rate is also distinctly higher than the Australian average (22.8%) but can be attributed to the state's older age distribution.

Fruit and vegetable consumption

- Almost half of South Australian adults (48.2%) met the Australian Dietary Guidelines for recommended daily serves of fruit, while just 6.7% met the guidelines for daily serves of vegetables.
- More than two-thirds of South Australian children (70.5%) met the Australian Dietary Guidelines for recommended daily serves of fruit, while only 3.7% met the guidelines for recommended daily serves of vegetables. This is distinctly lower than the Australian average for children meeting the guidelines (6.3%).

Sugar-sweetened and diet drink consumption

- Just over half (51.8%) of South Australian adults consume either sugar sweetened drinks or diet drinks at least once per week. This is higher than the national average (48.0%).
- Consumption of sugar sweetened drinks peaks among young adults (18–24 years), with 72.3% consuming at least one per week.
- The highest rate of children who consume either sugar sweetened drinks or diet drinks at least once per week, across Australia was South Australia (48.3%).

4.3 Stakeholder perspectives on wellbeing

The Fay Fuller Foundation supports organisations and communities' work towards achieving healthier outcomes for South Australians. In 2018, the Foundation released the report Health Needs and Priorities in South Australia in conjunction with The Australian Centre for Social Innovation and the South Australian Health and Medical Research Institute.[2]

In the report, The Australian Centre for Social Innovation conducted semi-structured interviews and activities with 18 health consumers from both metropolitan Adelaide and a semi-rural location. These sites were

identified as regions with high prevalence of disease burden and risk factors. The following details the report's analysis of the respondents' perspective on health and wellbeing in South Australia.

Stakeholders interviewed overwhelmingly agreed that wellbeing was important to maintaining health. To maintain health the respondents identified taking personal responsibility, having support from family and friends, giving back to people, participating in activities that enabled them to connect, and having a relationship with their clinician as the five key elements. Stakeholders also believed that the health system considers health (illness) and wellbeing (prevention) as mutually exclusive terms, rather than being markers along a health continuum.

The report highlights three key opportunities, extracted from the stakeholder interviews, for the South Australian Government to promote wellbeing:

1. Translating policy shifts to focus upon wellbeing within service delivery
2. Developing a health system that values a wholesome, patient centred understanding of health consumers
3. Emphasising the importance of building positive relationships with clinicians within the health system.

4.4 Health strategies and plans in South Australia

South Australia has three primary plans or strategies targeting health and wellbeing:

- *State Public Health Plan 2019 – 2024*[5]
- South Australian Health and Wellbeing Strategy 2020–2025[6]
- Wellbeing SA Strategic Plan 2020–2025.[7]

State Public Health Plan 2019–2024

The State Public Health Plan, developed under Section 50 of the *South Australian Public Health Act 2011 (the Act)*, provides a framework for working together to take early action to protect health, prevent illness and promote physical and mental health and wellbeing for all South Australians. The purpose of the Plan is to guide coordinated action in partnership with local government, Public Health Partner Authorities, State Government departments, the non-government sector and other public health partners. The vision of the Plan is for South Australians to benefit from "a healthy, liveable and connected community". The Plan is the first update of the inaugural South Australian Public Health Plan (2013), which has maintained the principles of the *Act* at its core.

The *State Public Health Plan* recognises there are multiple factors – social, economic and environmental – that influence a person's health. As a guide the Plan identifies four priority areas which build upon the framework established by the 2013 Plan:

1. Promote – build stronger communities and healthier environments.
2. Protect against public and environmental health risks and respond to climate change.
3. Prevent chronic disease, communicable disease, and injury.
4. Progress – strengthen the systems that support public health and wellbeing.

Action combining these four key areas are key to the *State Public Health Plan's* work on progressing ongoing and essential services as well as new work to manage identified public health risks and take advantage of identified opportunities. See Appendix item A for the Plan's monitoring and reporting model.

South Australian Health and Wellbeing Strategy 2020–2025

The vision for the South Australian Health and Wellbeing Strategy 2020–2025 is to ensure "South Australians experience the best health in Australia". The Strategy was developed alongside the establishment of 10 Local Health Network (LHN) Governing Boards to deliver services tailored to their local communities, and the creation of Wellbeing SA to lead community-based health and prevention services.

The SA Government have set several key goals, including:

- Preventing chronic disease and injury and prevent the exacerbation of established chronic disease
- Partnering with individuals, families and communities to enhance their health and wellbeing
- Creating healthier neighbourhoods and communities
- Protecting against public and environmental health risks and adapt to climate change.

Five strategic themes provide the framework for the strategy. The overarching theme is 'Together' and indicates the SA Government's commitment to partnering with community to protect and improve the health and wellbeing of the population. The remaining four strategic themes are:

- Trusted – SA Health is trusted to provide safe, reliable and high-quality treatment and care
- Targeted – SA Health targets priority health needs and disparities with the right evidence, motivation and interventions
- Tailored – SA Health tailors services to meet the diverse and complex needs of individuals
- Timely – SA Health optimises health and wellness outcomes delivering timely and appropriate health care.

The Strategy also outlines South Australia's future health needs:

- Population growth in SA is slower than the national average, however in the next few years there are expected increases in population numbers particularly in the outer northern metropolitan area and continued growth in the peri-urban areas and the thoroughfare between the city and Port Adelaide.
- It is expected that the number of children (0–14 years) and working adults (15–64 years) will increase, although the growth in age groups is much smaller.
- The development of a Women's, Child and Youth Health Plan 2021–2023, which has since been published.
- The age profile of the SA Aboriginal population differs significantly from the non-Aboriginal population with more than 33% of the SA Aboriginal population aged 15 years and under compared to 17.8% of the non-Aboriginal population for the same age group. Aboriginal people under the age of 25 make up 53% of the SA Aboriginal population.

4.5 Summary of existing food policy interventions in South Australia

In August 2018, The Australian Prevention Partnership Centre, Deakin University and the International Network for Food and Obesity/NCDs Research, Monitoring and Action Support (INFORMAS) undertook a study into progress the South Australian Government has made towards the recommended policy actions identified in the Health Food Environment Policy Index (Food-EPI).[8] The Food-EPI assesses all the government

food and diet-related policies that are in place and identifies gaps that impact population diet, obesity and infrastructure support.

A progress update was undertaken, describing action taken by the South Australian Government against the top five policy recommendations made in the Food-EPI .[9,10] South Australia has taken 'Limited action' and in some cases 'Some action' against the policy recommendations, refer to Appendix C.

Leadership: Develop a comprehensive strategy and implementation plan for addressing population nutrition needs in South Australia

- As of March 2022, South Australia has a new Labor Government. A Liberal government was in power at the initiation of this project.
- SA Health established a new Prevention and Population Health Branch (PPHB) in July 2017. PPHB has focused on prevention, health promotion and population health, working across the SA Government and branches within South Australia Health;
  - The PPHB Strategic Plan 2018–2020 has committed to focusing on healthy eating and promoting physical activity. A key component of the Plan identifies expanding the capacity to progress public health nutrition priorities in South Australia and recruiting two public health nutritionists.
- South Australia Health implemented two of their own strategic plans;
  - South Australia Health Strategic Plan (2017–2020)[11]
  - Public Health and Clinical Systems Strategic Plan (2018–2020).

The plans were at the time of the Food EPI data collection and have since been updated or replaced.

School food: Mandate implementation of healthy school food guidelines in all schools, and actively monitor compliance

- The Department for Education have mandated schools, pre-schools and online teaching to help implement the '*Right Bite*' policy.[12] Compliance with the '*Right Bite*' policy is a condition of each education facility's funding.
- Limiting the impact of unhealthy food and drink on children within the school setting is one of five obesity prevention strategies being progressed by the Council of Australian Government Health Council (CHC) to improve children's diets and prevent child obesity. Other action areas focus on health care settings, children's sport and recreation, restricting unhealthy food environments in government owned facilities and regulating the food system.

Food promotion: Implement policies to restrict the promotion of unhealthy foods in settings controlled or managed by the South Australian Government

South Australia Health is represented on the CHC Obesity Working Group and has contributed to the development of a national interim guide to define unhealthy food and drinks to try and reduce their presence in government facilities.

The CHC endorsed the National Interim Guide to Reduce Children's Exposure to Unhealthy Food and Drink Promotion for use in South Australia.

Monitoring: Actively monitor food environments, including marketing of unhealthy foods to children, and food in schools and public sector settings

- The Department of Education has provided funding to the South Australia Schools Canteen Network to provide support and guidance to school canteens on healthy food and drinks, in accordance with 'Right Bite'.
- The PPHB has commenced internal planning to review the Healthy Food and Drink Choices for Staff and Visitors in South Australian Health Facilities policy and will develop a strategy to improve healthy food provisions in government settings.[13]

Leadership: Support local governments to develop and implement plans to create healthy food environments and improve population nutrition

- The implementation of the State's Public Health Plan encourages local councils to consider implementing the four principles for healthy eating environments; Connected environments, Healthy eating environments, Safe environments and Sustainable environments (CHESS).
- The Department for Health and Wellbeing has supported Councils with the implementation of Regional Public Health Plans, some of which support food access, food security and sustainability through use and preservation of arable and designated horticultural land. Some of these Plans also aim to make food availability healthy and affordable while also focusing on food literacy.
- The State Public Health Plan (2019–2024) encourages local councils to consider healthy food environments and population nutrition through; promotion by building stronger communities and healthier environment, and prevention through the prevention of chronic disease, communicable disease and injury.
- The Department for Health and Wellbeing has also developed the Creating Healthier Local Food Environments Guide for Local Government.[14] This guide supports local councils in assessing their own policies, plans and practices around healthy eating.

5. Legal brief: Getting to know South Australia's Public Health Act 2011

5.1 Background

Why public health law?

Law is a highly effective, though sometimes undervalued and under-recognised, tool in the prevention of disease and the promotion of healthy lifestyles and environments. Of the ten biggest public health achievements of the twentieth century, all have been supported by legal interventions. These include laws commonly thought of as public health laws, such as those relating to vaccination, communicable disease or tobacco control.

It also includes laws that operate in contexts not typically seen as having a public health focus, for example: motor vehicle safety, (laws mandating safer road and motor vehicle designs; mandatory seatbelt use; and drink driving laws); general product safety (through the consumer laws and the work of the ACCC); workplace safety; land use planning and environment protection. Following this strong tradition, the field of public health law has gained traction within the last two decades amongst public health and legal scholars as an under-utilised, though potentially highly effective public health tool to address the global epidemic of non-communicable disease.

How does the South Australian Public Health Act compare to other public health laws?

A useful way to think about the similarities and differences between the South Australian Public Health Act and other types of public health law is through Burris et al.'[15] widely recognised typology of public health law, which comprises three major categories:

- Incidental
- Interventional
- Infrastructural public health law.

Incidental laws

These are enacted for purposes other than promoting public health but have led to health consequences for populations. A key challenge is that these laws are implemented by agencies without a clear primary public health mandate. For example, the primary purpose of planning and environmental law may be to establish a framework for planning the use, development and protection of land. This means the key questions such planning laws are concerned with include whether: land is being used the way it was intended; a new development is properly located in the correct zone (for example, commercial, mixed use, industrial or residential); and, if it has any adverse amenity impacts (such as increasing traffic flow).

On the other hand, planning laws often lack public health imperatives that acknowledge the health impacts of proposed developments, for example that the density of stores selling potentially harmful or addictive products such as alcohol can subsequently influence patterns of consumption. An additional challenge is that some public health impacts, for example, the potential impact of a new alcohol outlet on consumption patterns, can be deemed too conjectural and open to dispute. Alternatively, arguments for better planning that incorporate open space and walkability is well accepted and generally regarded as a relevant criterion in land use decision making.

Interventional public health laws

These have been implemented with the explicit purpose of improving public health. As an example, Australia's *Tobacco Plain Packaging Act 2011* was enacted to improve public health by discouraging individuals from consuming tobacco products and to reduce second-hand exposure to tobacco smoke.[16] This Act was implemented as a means of reducing the appeal of tobacco, making health warnings more visible, and reducing the ability of retail packaging to mislead consumers about the carcinogenic nature of tobacco products such as cigarettes.

Other examples, which have been transplanted into a variety of low, middle and high-income countries include sugar taxes, controls on the supply of alcohol and laws mandating the use of seatbelts and child restraints in motor vehicles.

Currently interventional laws are ranked amongst the World Health Organization's 'best buy' interventions for NCD prevention.[17] Further, this class of laws feature most prominently in NCD-prevention research and public health advocacy initiatives. However, it is not always possible (particularly in politically conservative environments) or appropriate (they can be regressive, or harmful without adequate partner health and social programs) to implement such laws. As such, a variety of legal tools are needed to address the NCD epidemic.

Infrastructural laws

The third category, infrastructural laws are those that establish the powers, duties and features of public health agencies, and have been severely neglected in the global health and public health literatures. Public health Acts have historically played an instrumental role in proactively creating conditions for people to live healthier lives – particularly regarding sanitation and infectious disease control.

5.2 Historical overview

Australia's public health Acts were modelled on the English *Public Health Act 1848*.[18] That Act is considered a major milestone in the history of public health and signalled a move from reactive responses to epidemics (smallpox, cholera and other diarrhoeal diseases) to a more proactive approach to disease prevention. It was the first time the state became the guarantor of standards of health and environmental quality and provided resources to local units of government to achieve those standards. The Act established a General Board of Health empowered to create local boards of health. Local boards had authority to deal with water supplies, sewerage, and other sanitary matters.

Australia's modern public health system began with pre-Federation colonial governments adopting the *Public Health Act 1848*, enabling local governments to establish basic standards of sanitation for residential dwellings. Australia's adoption of the English Act allowed for public health responsibilities to be shared amongst pre-Federation colonial governments. It was this system infrastructure, refined and modernised by Australia's states, territories, and the Commonwealth after Federation, that later facilitated the implementation and enforcement of laws to prevent the spread of infectious disease. These first *Acts* split public health responsibilities between the central (colonial administrations) and the local (local councils and shires), and this has been an enduring feature of public health administration. These efforts, in addition to increased standards of living, the extension of social welfare, better levels of education, improved medical care contributed to marked improvements in the health of the Australian population by the first decade of the 20th century. By the 1960s, many infectious diseases were controlled, life expectancy rose significantly, and infant mortality rates dropped dramatically.

Infrastructural law can potentially facilitate a whole-of-government and whole-of-society approach because it outlines the rights and responsibilities of a range of actors – all levels of government, industry and community. These responsibilities have been expressed more directly via explicit links such as the requirement for health impact assessment or 'health in all' policies. Such infrastructural law has likely been

neglected because Public Health Acts, in many cases, have failed to keep up with the changing burden of disease and the change in understanding in public health management.

5.3 Overview of South Australia's Public Health Act 2011

State and local governments have often been laboratories of innovation and a testing ground for innovative policies and shifting social norms. The *South Australian Public Health Act 2011* (the Act) is an example of adopting a forward thinking outcomes based, rather than a prescriptive, approach to law making.[1] The Act was approved by Parliament in June 2011 with certain sections put into effect immediately. The remaining sections of the *Act* were implemented in a staggered process over two years. It operated concurrently with the *Public and Environmental Health Act 1987* over that period before replacing it altogether.[19] The Act is evaluated by a parliamentary committee at least every five years. The first evaluation started in late 2018, with the final report and government response published in late 2020.[20,21]

The Act is positioned within a comprehensive package of public health legislation including the *Food Act 2011, Safe Drinking Water Act 2011, Controlled Substances Act 1984,* and the *Tobacco Products Regulation Act 1997*.[22-25]

The 2011 Act includes many advances on its predecessor including:

- The inclusion of objects and principles
- Definition of public health, including a new approach to public health risks
- A redesign of the minister's functions
- A new statutory position for the Chief Public Health Officer (CPHO)
- The establishment of the South Australian Public Health Council (SAPHC)
- New functions of councils
- The concept of state and regional public health planning
- NCD-prevention provisions and codes of practice.

The inclusion of objects and principles

Objects of the Act outline the key objectives, what the Act seeks to achieve and are a new development. The objects promote the provision of information to individuals and communities about risks to public health, encourage individuals and communities to plan for, create and maintain a healthy environment, and seek to ensure a healthy environment for all South Australians (particularly those who live within disadvantaged communities).

A range of principles have been introduced to guide regulation (see Table 1). Section 4(2) places obligations on decision makers and administrators to take these objects and principles into account, and in the case of objects, seek to further them. This gives the provisions a real operational significance. The **precautionary principle** allows for measures to be taken to prevent public health risks, even where scientific certainty is lacking. The principle of prevention and population focus emphasises the actions necessary to protect and improve the health and wellbeing of the community.

The **participation principle** emphasises the importance of individuals and communities participating in decisions on how to protect and promote their own health and the health of communities. The **partnership principle** highlights the important role of partnership and collaboration, and joint action across various sectors and levels of government. The **equity principle** highlights that decisions and actions should not unduly or unfairly disadvantage individuals or communities and consideration should be given to the health disparities between population groups and to strategies that can minimise or alleviate such disparities.

What this means for our study

- Provides guidance for using the Act.
- Assists in the justification for decision making.
- Serves as a communication tool in engaging with various sectors of government.

Definition of public health and a new approach to public health risks

As a general concept, public health is defined as the health of individuals within the context of the wider health of the community. As a field of practice, it is defined as the combination of policies, programs and safeguards designed to protect, maintain or promote the health of the community at large, and to prevent or reduce the incidence of disease, injury or disability within the community.

The concept of harm is broad – including long term or immediate impact or effect, and potential harm includes risk of harm and future harm. Most importantly, the Act adopted a risk-based approach, reflected in the creation of a general duty to avoid any action that might cause 'harm to public health.' This replaced the traditional prescriptive approaches found in the definitions of 'insanitary condition' or 'public health nuisance', which in many respects continued to include 19th century concerns about miasmas and their accompanying dangers.

What this means for our study

- Provides justification for community-based policies that promote prevention.
- Provides basis for codes of practice to be framed as risk-mitigating and harm minimising.
- Provides a way of distinguishing between a public health issue and an issue of private health. This can be important when confronting arguments of the 'nanny state' libertarian critics insofar as it delineates the boundaries of the public health jurisdiction.

A redesign of the Minister's functions

The Minister is required to take action to preserve, protect or promote public health, and to promote standards of public and environmental health within the state by ensuring adequate measures are taken to give effect to, and ensure compliance with the Act. The Minister can develop policies or codes of practice identifying risks to public health and setting standards in connection with any activity, material, substance or equipment relevant to public health. The Minister is a primary source of advice to government about health preservation, protection and promotion.

What this means for our study

- Codes can be framed as a tool to enable the Minister to perform their responsibilities to set standards which preserve, protect and promote public health.
- Establishing buy-in with the Minister will be essential to the acceptability and potential implementation of the codes.

The creation of a new statutory position of Chief Public Health Officer (CPHO) with a range of powers under the Act

The creation of this new role means that the CPHO has the power to develop and implement strategies to protect or promote public health. The CPHO must ensure the Act is complied with and advise the Minister and the Chief Executive of the Department about proposed legislative or administrative changes related to public health, and other matters relevant to public health. The CPHO is to establish and maintain a network of health practitioners and agencies designed to foster collaboration and coordination to promote public health. After advising the Minister and the Chief Executive, the CPHO can make public statements on matters relevant to public health.

What this means for our study

- CPHO may be able to support the effectiveness and sustainability of the codes of practice by developing and implementing supplementary public health strategies.
- The CPHO may make public statements which help to garner public and government support for codes of practice.

The establishment of the South Australian Public Health Council

The role of the South Australian Public Health Council (SAPHC) is to assist and advise the CPHO in relation to the protection and promotion of public health, developing and maintaining a system of strategic planning for public health at local, regional and state levels.

The SAPHC is tasked with developing health plans and strategies to ensure that a sufficiently trained and skilled workforce is in place for the purposes of the Act. The SAPHC also assists with the preparation of the CPHO's biennial report (required under Division 2).

What this means for our study

- Establishing buy-in within the SAPHC is potentially an important component of our engagement strategy, as a conduit between the TAG and the CPHO.
- SAPHC may be able to develop a system of strategic planning that ensures the effectiveness and longevity of our codes of practice.
- SAPHC may assist in outlining the roles and responsibilities of each level of government under the codes of practice.
- Our codes of practice may be most effective and acceptable to government if they align with SAPHC's health plans.

New functions of local councils

Councils are now seen as public health authorities for the area. They are to take action to preserve, protect and promote public health within its area, to cooperate with other authorities in the administration of the Act, identify risks to public health, assess activities and development (existing or proposed) to determine and respond to public health impacts (or potential public health impacts). Councils are also to provide or support the provision of educational information about public health and provide support activities within its area to preserve, protect or promote public health.

What this means for our study

- The risks to public health identified by councils can be worked into our codes of practice.
- Councils' assessment of development activities (for example, proposed development of alcohol or fast-food outlets in residential areas) may inform the content of codes of practice.
- Councils may cooperate with other authorities to maximise the impact of the codes of practice
- Councils may raise awareness about, or supplement codes of practice by providing educational information about public health.
- There may be opportunities for the TAG to develop guidance and tools for local governments to administer sections of the Act, such as prescribed templates, guidance documents, and/or information circulars.
- The TAG may be able to support the SA Government in providing high quality training tailored for different skill levels and varying circumstances (for example, those with and without a public health background, those living in rural or remote environments vs those located in metropolitan councils with strong peer support).

The concept of state and regional public health planning

Public health planning has been a valuable tool to raise the awareness of councils' roles, the determinants of health and the realisation that many of the factors that influence public health lay outside the health sector. There has been an increase in understanding 'wellbeing' and 'public health', which provides an opportunity to work together to deliver ongoing central support to increase the organisational capabilities of councils, particularly in developing the workforce capacity of local government public health planners to implement this work and advance the four priority areas defined in the current state plan to:

1. **PROMOTE**
   Build stronger communities and healthier environments
2. **PROTECT**
   Protect against public and environmental health risks and respond to climate change
3. **PREVENT**
   Prevent chronic disease, communicable disease and injury
4. **PROGRESS**
   Strengthen the systems that support public health and wellbeing.

The Minister can also declare an 'entity' a public health partner authority. These authorities can take responsibility for implementing any strategy or attaining any priority or goal within the public health plan. These authorities need to have regard to public health plans in undertaking their functions. There are currently 10 partnership agreements in place in South Australia.

What this means for our study

- Public health plans can supplement codes of practice – either by improving the informational environment or outlining roles and responsibilities for regional authorities for executing the codes of practice.
- This project could work with councils to develop workforce capacity of local government public health planners to integrate research evidence into their plans.

NCDs and Codes of Practice (Part 8)

NCDs and Codes of Practice enable the Minister to develop voluntary codes of practice for industry, business and other parts of the community, with the aim of preventing non-communicable conditions. This will give guidance on how to best prevent the spread of noncommunicable conditions (such as heart disease, diabetes, obesity and some forms of cancer). These conditions are major causes of mortality in the community, and as such, major public health threats.

What this means for our study

- We now have the capacity to inform the design of NCD-prevention codes of practice and develop a process for evaluating them, so they remain fit for purpose, and reflective of current public health evidence (see Chapter 6).

5.4 What might we achieve with Part 8 of the Act?

Part 8 of the Act facilitates the design and implementation of the codes of practice including who the codes might impact and what the codes contain:

Who might the codes impact?

An industry or sector, a section or part of the community, an activity, undertaking or circumstance.

What directives can the codes contain?

Directives relating to:

- How goods, substances or services are advertised, sponsored, promoted or marketed (including through the provision of certain information to consumers of certain goods, substances, or services).
- How goods or substances are manufactured, distributed, supplied or sold (including the composition, contents, additives and design or specified goods or substances).
- The way buildings infrastructure or other works are designed, constructed or maintained; and how the public are able to access specified goods, substances or services.

5.5 What are the limitations on the regulatory interventions Part 8 can support?

There may be limitations on some types of interventions the codes of practice can support such as interventions requiring the involvement of other statutory authorities. For example, banning the use of industrial trans-fats in the food chain must be implemented through the Food Standards Australia New Zealand (FSANZ) process and become part of the Food Standards Code.[26] The Code is then enforced by state and territory departments, agencies, and local councils.

Interventions that require the application of other categories of public health law (interventional or incidental) is another example. Enacting and enforcing restrictions on the physical availability of retailed alcohol (via reduced hours of sale) requires the application of state and territory government liquor licensing and planning laws. This may be an area where other sections of the Act can be used to support our public health agenda. Similarly, while providing convenient and safe access to quality public open space and

adequate infrastructure to support walking and cycling would require planning controls and decisions, other sections of the *Act* could be used to support these measures.

Where these barriers exist or are identified, a code of practice may not be used to implement a regulatory intervention, but instead codes can play a supporting role. For example, in the case of enacting and enforcing an appropriate minimum age for purchase or consumption of alcoholic beverages, while this must be prescribed by licensing laws, a code of practice could be designed to support its enforcement.

There may also be areas where an intervention may be inappropriate or has wider consequences outside the code's objective. For example, interventions which result in the effective taxation on sugar-sweetened beverages or increasing excise taxes on alcoholic beverages.

In addition, some regulatory interventions will need to be excluded because they require specific public health legislation to be introduced (for example, in the case of establishing minimum prices for alcohol).

5.6 Are codes of practice enforceable?

In instances of non-compliance with codes of practice, the Minister may publish a report on the performance of an industry, sector or person in relation to a code, essentially 'naming and shaming' them.

In addition, a compliance notice can be issued and failure to comply with a notice may lead to prosecution. However, it is likely that we would use the enforceability component cautiously and view Part 8 primarily as a collaborative exercise where industry is expected to comply with the resulting code.

Beyond this, there are important questions regarding who would take responsibility for enforcing the Act. Is there a need to establish a dedicated agency, or would Wellbeing SA or another agency take responsibility? This is important to clarify to avoid creating an 'enforcement vacuum'.

5.7 What remains unknown? How can we start to fill those gaps?

Contextual opportunities and constraints to policy change

How do we identify and analyse these opportunities and constraints? For example, conditions that are unique in setting and time may limit policy change, including situational, structural, cultural and other exogenous factors.

Formal and informal processes

Similarly, how do we identify the formal and informal processes through which decisions are made, such as agenda setting, formulation, adoption, implementation and sustaining reforms), over the life-course of a policy in specific arenas?

Stakeholder mapping

Who are the players affected by the proposed interventions that is, what is the anticipated impact on different stakeholders from the consequences of policy change? What are the potential gains and losses for different stakeholders?

Questions of power

How do we analyse the power, that is, the political resources, of stakeholder groups, their underlying interests, their positions and the level of commitment towards the specific issue? This is important to

ascertain, for while public health has a disparate array of supporters and advocates, it is unclear whether a concerted lobby for public health exists, other than the Public Health Association of Australia.

One effective lobby was formed temporarily in South Australia in 1987 through the combined efforts of the Anti-Cancer Council and the National Heart Foundation that worked well supporting the Minister's efforts to push the first prohibitions on tobacco advertising and sponsorship through parliament. However, the most effective and well-resourced lobbyists (such as the Food and Grocery Council) tend to act in the interests of industry and may present challenges for the implementation of the codes of practice, or other public health policies we design and advocate.

6. Designing and implementing codes of practice

Key points

- A suite of codes can be implemented under Part 8 of the Act addressing specific NCD areas
- There is no clear legal definition of a code of practice and terminology is often used interchangeably with standards, procedures or guidelines
- Codes can be mandatory or voluntary with the overall aim to provide a practical guide for meeting obligations (mandatory) or recommendations (voluntary)
- Effectiveness of codes can be limited by narrowly worded provisions and a lack of clear, measurable objectives
- Voluntary codes can be undermined by a lack of uptake and should be regularly reviewed.
- Independent compliance monitoring improves the effective operations of codes of practice and promotes transparency
- Mechanisms should be in place to promote responsive regulation and move up the regulatory pyramid (Figure 2) of voluntary measures and self-regulation are not effective
- Self-regulation must be considered within the context of conflicts of interest
- Clear, enforceable, and evidence-based guidance is critical to the effectiveness of such public health law.

6.1 Definitions and use of codes of practice

There is no clear legal definition of a code of practice. However, based on explanatory statements within existing codes of practice supporting Australia legislation, they are commonly thought to be practical guides for meeting requirements under the Regulations or Act. This is universal in workplace health and safety regulation where codes of practice sit subordinate to higher pieces of legislation (Figure 1).

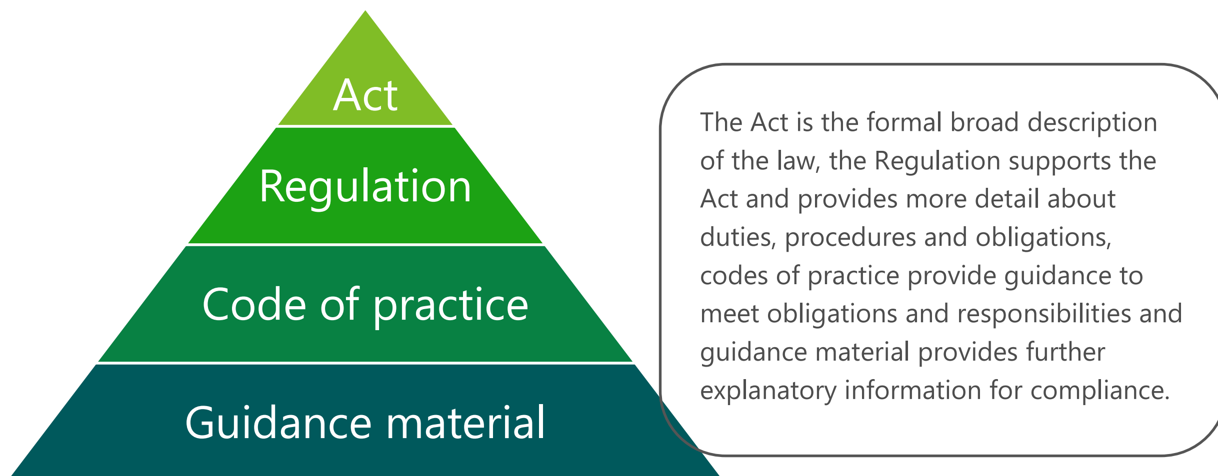


Figure 1: Pyramid of workplace health and safety policy layers.

Codes of practice can be issued by governments and by an industry or profession. They can be voluntary or mandatory and issued as a mechanism of self-regulation, quasi-regulation, co-regulation or explicit government regulation. Some codes are very prescriptive while others are more open to interpretation. They also vary in length and are occasionally presented as a guide or handbook rather than legal text. This may be due to different operational governance and regulatory frameworks.

6.2 Regulatory frameworks

There are a range of regulatory responses that can be used to achieve a policy objective, including rules-based, compliance-based, and responsive regulation.[27] Rules-based regulation is either principle based or prescriptive. Compliance based regulation is an outcomes-based approach where rule making, monitoring and enforcement are designed concurrently to achieve a policy objective. Responsive regulation evolved from compliance-regulation theory and is bespoke regulation, where the regulators listen and observe the area they are regulating and choose a course of action up or down the pyramid to correct the deficiency that they are observing (Figure 2).[28] Codes of practice appear to be used in a variety of different regulatory approaches as shown in the case studies section of this report.

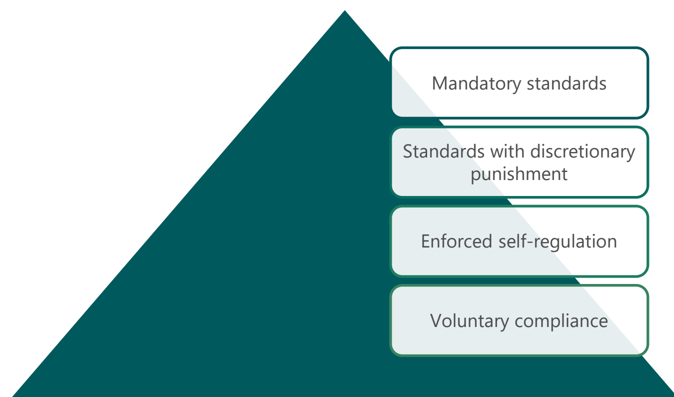


Figure 2: Responsive regulation pyramid

6.3 Legal typology

The way that codes of practice are used varies by jurisdiction and industry, including inconsistent use of terminology. A standard, procedure, guideline or scheme are sometimes used in place of a code of practice. However, the intent of codes of practice (or similar) is the same – to provide a practical guide for meeting obligations (mandatory) or recommendations (voluntary).

It is possible that a code of practice could be a combination of a standard and procedure, outlining mandatory rules to support a policy objective (standard), while also setting out the operational processes to implement and enforce the standard or policy (procedure).

Guidelines are thought to be less prescriptive than codes of practice and voluntary in nature. As indicated by the name, guidelines are a guide. However, this does not always appear to be the case, as guidelines are sometimes used interchangeably with codes of practice in some jurisdictions and can sit under legislation. For example, the Liquor Promotion Guidelines that sit under the Liquor Regulations are explained in more detail below in the case studies.

Table 1: Typology of legal instruments used for regulation

Policy	• Identifies the issue and scope • Statement of intent
Standard	• Assigns quantifiable measures • Sets a level of quality or attainment • Rules to support policy objective
Procedure	• Instructions • Establishes proper steps to take • Operational process to implement or enforce a standard or policy
Guideline	• A piece of advice • Recommended action • Contributes to the overall state of knowledge
Code of practice	• Provides guidance for meeting obligations • Detailed instructions and requirements
Code of conduct	• Sets expectations • Norms, rules or responsibilities for a business, profession or individual
Scheme	• Detailed plan • Implements an idea or meets an objective
Practice note	• Details how procedures should be handled • Extra practical guidance

6.4 Case studies

The following case studies provide more detail as to how codes of practice (or similar regulatory instruments) are being used in different regulatory environments. Table 1 provides a summary of case studies 1, 2 and 3, which are examples of codes of practices administered under government legislation. The case studies illustrate that:

- Effectiveness of codes can be limited by narrowly worded provisions and a lack of clear, measurable objectives
- Voluntary codes can be undermined by a lack of uptake and should be regularly reviewed.
- Independent compliance monitoring improves the effective operations of codes of practice and promotes transparency
- Self-regulation must be considered within the context of conflicts of interest
- Clear, enforceable and evidence-based guidance is critical to the enactment of public health law.

Table 1: Summary of case studies one, two and three

	Case study one	Case study two	Case study three
	Late Night Trading Code of Practice	*Managing work environment and facilities Code of Practice*	*Food and Grocery Code of Conduct*
Is it voluntary or mandatory?	Mandatory	Mandatory & Voluntary	Voluntary
Who monitors compliance?	Government	Industry & Government	Industry
Who enforces compliance?	Government	Government	Industry & Government
What does it do?	Outlines specific rules	Rules & guidance	Provides guidance
Is it effective?	Yes	Yes	Unclear

Case study 1 – SA general and late night codes of practice

Type of regulation:	Explicit government regulation
Format:	Prescriptive legal text
Administered by:	Government
Enforcement:	Mandatory
Monitoring:	Proactive and reactive
Penalties:	Pecuniary
Compliance:	High
Reviewed:	After one year then as needed

The SA *Liquor Licensing Act 1997*, like the *Public Health Act*, empowers the Minister to issue codes of practice (Section 11A).[29] Two codes of practice have been issued that restrict the way liquor is promoted, sold and made available to the public.

The general code sets out general requirements for training and practices (for example, Responsible Service of Alcohol training, bans on certain liquor promotions, managing intoxicated patrons) as well as required measures to promote compliance (for example, risk assessment and management plan).[30]

The Late-Night Code sets out additional requirements for high-risk venues – those trading past 3am – such as restrictions on rapid consumption beverages (shots), the use of CCTV and entry restrictions.[31]

The general code applies to the entire industry (all liquor licences) whereas the *Late Night Code* is targeted, applying only to on-premise licences that trade past 2am (in addition to the general code). Both are mandatory.

There are also guidelines and other specifications providing further detail under the Codes of Practice. Penalties for non-compliance range from $10,000 – $20,000 per offence. The codes were required to be reviewed 12 months after implementation. There are no requirements for follow up reviews.

A government review of the codes in 2015 was conducted in consultation with researchers, stakeholders, industry, and community.[32] It found that they met their objectives and received high levels of support. Implementation and compliance with the Late-Night Code is particularly good. There was less evidence and feedback provided on the general code.

The specific, prescriptive, and targeted nature of the Late-Night Code meant that knowledge and understanding regarding compliance was high. The Late-Night Code was effective at reducing late night alcohol-related offences, violence, and harm; it improved local amenity and created safer and healthier environments; and it achieved its objectives in minimising harm from alcohol and ensuring the sale and supply of alcohol is safe and within community expectations.

Case study 2 – SA Managing the work environment and facilities code of practice

Type of regulation:	Co-regulation
Responsiveness:	Standard with discretionary punishment
Format:	Instructive handbook
Administered by:	Government (Worksafe SA)
Enforcement:	Mandatory and voluntary
Monitoring:	Proactive and reactive
Penalties:	Notices
Compliance:	High
Reviewed:	Adhoc

South Australia's *Managing the work environment and facilities Code of Practice (March 2019)* is one of over 20 codes of practice issued under the *Work Health and Safety Act 2012* (Section 274).[33,34] It aims to provide safe and healthy environments for employees by providing guidance to businesses on their responsibilities under the *Act*. It is an example of a code of practice that specifies how workplaces are designed, constructed and maintained. It is a standard with discretionary punishment and is a state code developed off the model code by Safe Work Australia.

The code is presented as a handbook with instructions regarding mandatory requirements as well as recommended courses of action for risk management, specifics regarding work environments and facilities (such as floors, ventilation, toilets and eat facilities), preparing emergency plans and additional guidance for specific types of work.

The code itself is not legally enforceable and has no penalties for non-compliance, compared to the Late Night Code which sets out specific penalties. However, the code is admissible in court meaning it can be used as evidence for non-compliance with the Regulation or Act. Notices can also be issued by inspectors to encourage businesses to improve, change or stop a risky activity.

All states and territories have adopted codes of practice based off the model code therefore providing a reasonable degree of consistency in content, implementation, and enforcement across the country. The code has been developed in consultation with industry, unions, and the public. Support for the code is high and compliance is high.

Case study 3 – ACCC Food and Grocery Code of Conduct

Type of regulation:	Co-regulation
Responsiveness:	Enforced self-regulation/ discretionary punishment
Format:	Prescriptive legal text
Administered by:	Government and industry
Enforcement:	Voluntary
Monitoring:	Reactive, complaints based
Penalties:	No
Compliance:	Unclear
Reviewed:	Adhoc

The Food and Grocery Code of Conduct is a voluntary industry standard prescribed under the *Competition and Consumer Commission Act 2010* (CC Act).[35,36] It is an example of a code that applies to an entire business sector –the food and grocery sector – and provides a framework for dealings between retailers, wholesalers and suppliers. The Food and Grocery Code provides a standard for the food and grocery supply chain. However, there are currently only four signatories and the Food and Grocery Code focuses entirely on business agreements with no direct considerations for the consumer. Yet, there is clearly scope under the CC Act to focus on consumers and on public health.

The Food and Grocery Code is administered by the Australian Competition and Consumer Commission (ACCC). However, the ACCC only handles systemic compliance issues. One-off disputes are managed internally using mediation and arbitration at the cost of the business. It is a combination of a standard with discretionary punishment and enforced self-regulation and is the only voluntary standard under the *Act*. There is scope under the *Act* for the code to issue penalties. However, currently none exist due to the code being a voluntary, industry-led model. Comparatively, the *Franchising Code of Conduct* (also issued under the CC Act) has pecuniary penalties and infringement notices for breaches of civil penalties.

A government review of the code found it was difficult to determine if the code was effective as there are only four signatories, all retailers, no wholesalers or suppliers have signed.[37] But the review also suggested that the voluntary nature was sufficient as the signatories made up 75% of the market share and therefore are capturing a large part of the industry. However, it could be argued that these large retailers (Coles, Woolworths and Aldi) are signing because they have market power and the financial resources to handle internal disputes. There are few mechanisms in place to support smaller retailers or suppliers. In the review of the code smaller businesses and farming groups called for financial penalties to be added to deter misconduct.

The code is developed with and led by industry. Support for the code is mixed and the level of compliance is unclear.

Case study 4 – AFGC Responsible marketing to children initiative

Type of regulation:	Self-regulation
Responsiveness:	Self-regulation
Format:	Principles-based
Administered by:	Industry
Enforcement:	Voluntary
Monitoring:	Reactive, complaints based
Penalties:	No
Compliance:	Low

The *Responsible Marketing to Children Initiative* is a self-regulatory code developed by the Australian Food and Grocery Council (AFGC), which is the peak body for Australia's food, drink and grocery manufacturing industry.[38] The initiative aims to "reduce advertising and marketing communications to children for food and beverage products that do not represent healthier choices".

It is principle based and voluntary. Signatories to the code are required to develop action plans.[39] The Initiative Administration Committee, comprised of three industry members and two external stakeholders, administer the initiative. There is no active monitoring and enforcement. Compliance is managed through consumer complaints that are submitted through AdStandards, the advertising industry self-regulator. Members of the AFGC are major funders of AdStandards and sit on the AdStandards board.

The initiative is developed with industry and reviewed internally. The AFGC publish annual reports which suggest that compliance with the initiative is high. However, the voluntary nature and lack of proactive monitoring and enforcement makes it difficult to know the true level of compliance. Evaluations of the initiative found it ineffective due to:[40-43]

- Inadequate definitions for when and where food marketing to children can occur
- Permissive definitions of foods considered appropriate for advertising
- Excluding persuasive marketing techniques that appeal and are targeted at children.

The initiative is a source of market failure as it allows industry to draft the ground rules and there is no incentive for them to remove any loopholes and be stringent while drafting the regulation. The system enables businesses to comply without necessarily promoting the social or public health intention of the code. There is a clear conflict of interest in this form of self-regulation as the business imperative – selling more products – is at direct odds with the public health benefit from controlled marketing.

Case study 5 – NSW Liquor Promotion Guidelines

Type of regulation:	Explicit government regulation
Responsiveness:	Standard with discretionary punishment
Format:	Principles-based
Administered by:	Government
Enforcement:	Mandatory
Monitoring:	Proactive and reactive
Penalties:	Notices and pecuniary
Compliance:	Low
Reviewed:	Adhoc

The NSW Liquor Promotion Guidelines are issued under Section 102(4) of the *Liquor Act 2007*.[44,45] Following the publication of guidelines, the Department Secretary has the power to ban or restrict 'undesirable' liquor promotions run by licensed venues in NSW by issuing a notice under Section 102 of the *Act*.

The Liquor Promotion Guidelines document is principle based. It provides guidance to all liquor licensees in NSW regarding their obligations under the *Act* to ensure promotional activities are not 'undesirable'. They help set standards by providing explanations for the principles, examples of previous promotions found to be in breach of the guidelines, and list steps for minimising risk and harm.

The Liquor Promotion Guidelines are administered by Liquor & Gaming NSW. There is some proactive monitoring but investigations are mainly instigated following complaints from community members. Enforcement of the guidelines is conducted using a staged approach through conversations and variations or removal of promotions, followed by notices and penalties of up to $5,500.

The Liquor Promotion Guidelines are developed by government in consultation with industry, stakeholders and the community.

Case study 6 – VIC Code of Practice for music festivals and events

Type of regulation:	Co-regulation
Responsiveness:	Standard with discretionary punishment
Format:	Instructive handbook
Administered by:	Government and industry
Enforcement:	N/A
Monitoring:	N/A
Penalties:	N/A
Compliance:	Unclear
Reviewed:	Annually

The Victorian Code of Practice for Music Festivals and Events is issued by the Department of Health to assist event providers in planning and managing safe events, and in meeting the relevant legal requirements, government standards and safety obligations. It sets the standard of practice for music festivals and events in Victoria.[46]

The code is long and in a handbook format. The code includes instructions regarding mandatory requirements as well as recommended courses of action. It does not appear to have been issued under a specific piece of legislation but rather out of a need from the industry and community.

There is no specific monitoring and enforcement of the code, instead the code sets out all the requirements of operators under various pieces of existing legislation and government standards including the occupational health and safety, building, and liquor Acts and other public health duties and requirements.

It was developed by a working group of government, industry and health organisations with wider stakeholders and the community also consulted. Support for the code is high.

Case study 7 – SA Code of Practice for the provision of sanitation and personal hygiene

Type of regulation:	Explicit government regulation
Format:	Mandatory standard
Administered by:	Government
Enforcement:	Mandatory
Monitoring:	Proactive
Penalties:	Notices
Compliance:	High
Reviewed:	Adhoc

The SA Code of Practice for the provision of sanitation and personal hygiene is a prescribed code under the South Australian Public Health (General) Regulations 2013 and supports the administration of the *South Australian Public Health Act 2011* by local public health authorities.[47] It provides information to building owners to ensure appropriate sanitation and personal hygiene is met in public facilities.

It is written as a handbook. Specific responsibilities within the code include sharps disposal facilities, disposal of waste, lighting and ventilation requirements and infant care facilities. Requirements under the code are in addition to obligations and general duties required under the Act. Public health officers routinely inspect buildings to ensure compliance. A notice can be issued in the event of non-compliance and therefore hold the building owner liable. Pecuniary penalties are not issued under the code.

7. Conclusions

Australia is experiencing a high burden of lifestyle-related chronic disease such as type 2 diabetes, stroke and cardiovascular disease. The COVID-19 pandemic has exacerbated this burden, and there is an urgent need for clear, enforceable and evidence-based policy responses. Using the South Australian context as a case study, this Policy Development Handbook provides a blueprint for developing sustainable solutions to this prevention policy issue.

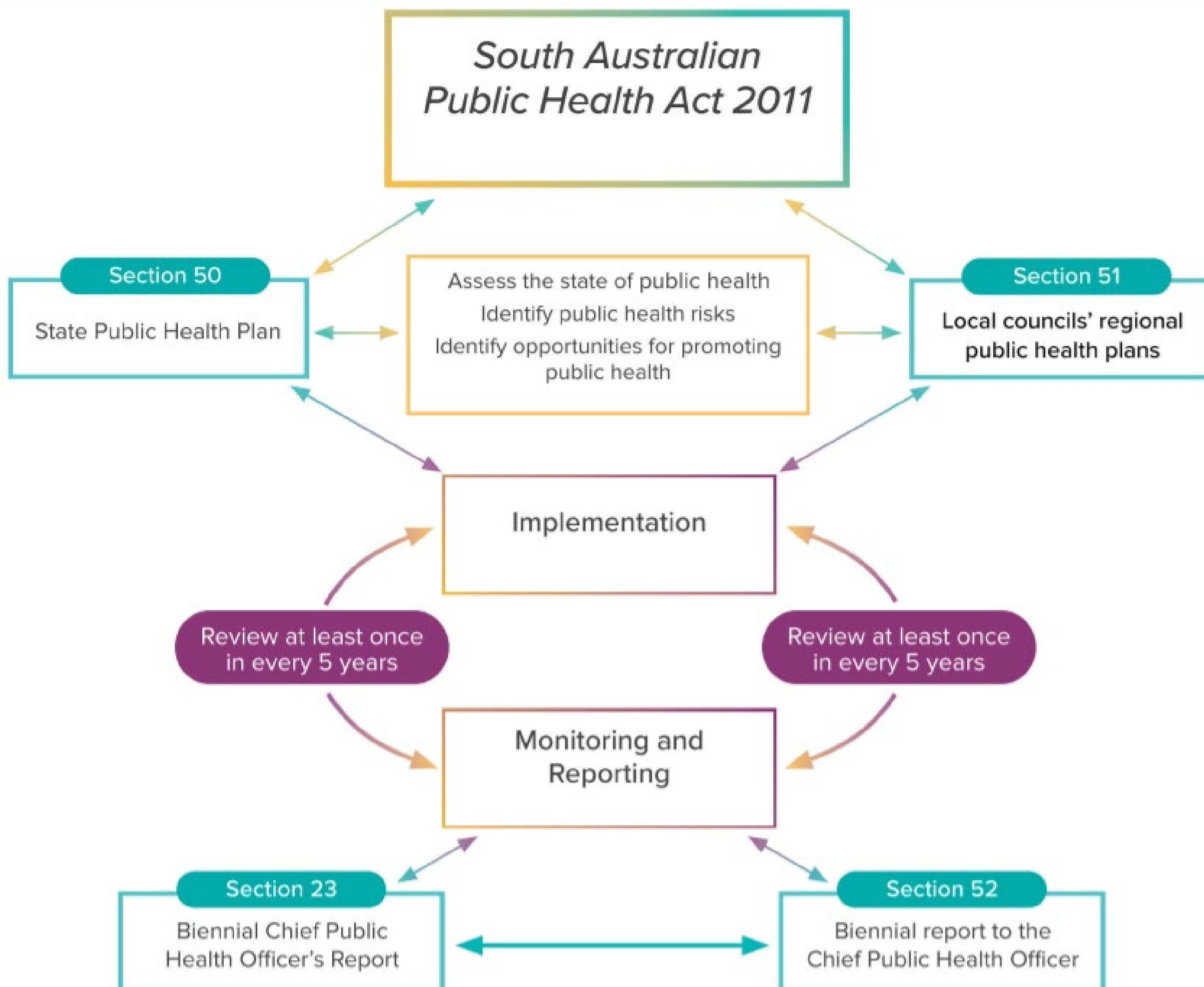
As this Handbook demonstrates, law is a highly effective, though has been historically undervalued and under-recognised tool in the prevention of disease. South Australia (SA) is unique in its inclusion of non-communicable disease (NCD) prevention provisions in core legislation to regulate marketing, manufacturing, supplying or accessibility of goods, substances or services that may contribute to NCDs.

This is particularly significant given the traditional focus of public health acts on sanitation and infectious disease control, and is just one example of SA's long history of using policy innovation to shift social norms. Our analysis of the SA Public Health Act outlines how substantive features of state legislation can empower a range of stakeholders – from community to local government to the Minister – to act collectively to prevent NCDs. The Handbook also unpacks several areas including contextual opportunities and constraints to policy change, regulatory models, and questions of power that will either present opportunities or act as barriers to the Act success in directing NCD-prevention efforts.

We hope this work will assist the SA government in fully realising the potential of the Act and encourage other jurisdictions around the world to implement similar provisions. Ultimately, our goal is to use public health law to effect positive, equitable and sustainable changes to population health and wellbeing.

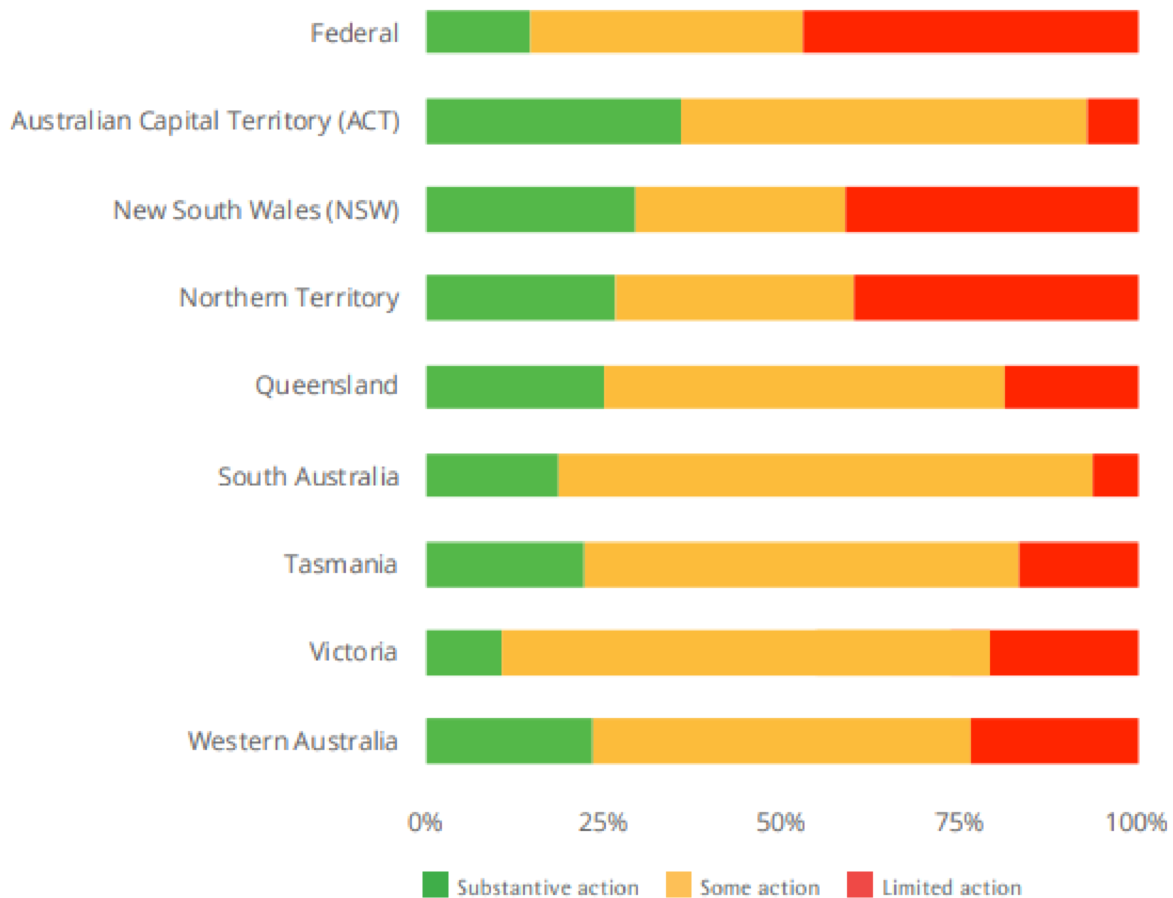
8. Appendices

Appendix A: State Public Health Plan implementation monitoring and reporting model



Source: SA Health, State Public Health Plan 2019-2024. 2018, Government of South Australia: Adelaide.

Appendix B: Action taken (July 2016 – December 2018) by Australian governments regarding the recommended policies from the 2017 Food Policy Index Report



Source: Sacks G, Robinson E for the Food-EPI Australia project team. Policies for tackling obesity and creating healthier food environments: 2019 Progress update, Australian governments. Melbourne: Deakin University, 2019.

9. References

1. SA Health. South Australian Public Health Act 2011. Government of South Australia. 2011. Available from: https://www.sahealth.sa.gov.au/wps/wcm/connect/public+content/sa+health+internet/about+us/legislation/public+health+act/public+health+act

2. Fay Fuller Foundation, Health Needs and Priorities in South Australia - Gathering a stakeholder-informed evidence base. 2018;114. Available from: https://www.tacsi.org.au/our-work/project/health-needs-priorities-sa

3. Australian Bureau of Statistics. ABS Census - South Australia. 2018 [cited 2020 May 1]; Available from: https://www.abs.gov.au/websitedbs/D3310114.nsf/Home/census.

4. Australian Bureau of Statistics. Census of Population and Housing - Socio-Economic Advantage and Disadvantage. 2018 [cited 2020 April 20]. Available from: https://www.abs.gov.au/ausstats/abs@.nsf/Lookup/by%20Subject/2071.0~2016~Main%20Features~Socio-Economic%20Advantage%20and%20Disadvantage~123.

5. SA Health. State Public Health Plan 2019–2024. Government of South Australia: Adelaide. 2018.

6. SA Health. South Australian Health and Wellbeing Strategy. Government of South Australia: Adelaide. 2020.

7. Wellbeing SA. Wellbeing SA Strategic Plan 2020–2025. Government of South Australia: Adelaide. 2020. Available from: https://www.sahealth.sa.gov.au/wps/wcm/connect/337cc838-658a-48c2-b171-a6e05c2aeaad/20090.1+WellbeingSA-StrategicPlan-2020update-WEB.PDF?MOD=AJPERES&CACHEID=ROOTWORKSPACE-337cc838-658a-48c2-b171-a6e05c2aeaad-nKQKPUL

8. Food-EPI Australia Project. Australian Federal government: summary of current government policy action to 8 May 2016. Melbourne: Deakin University, 2017. Available from: https://www.opc.org.au/downloads/food-policy-index/food-epi-australia-2016-federal-govt-policy-details.pdf

9. Sacks G. Healthy Food Environment Policy Index (Food-EPI) – Australia, in South Australia Government: Progress Update (1 July 2016 – 30 June 2018). The Australian Prevention Partnership Centre. 2018.

10. Policies for tackling obesity and creating healthier food environments: 2019 progress update, South Australian Government. 2019 Mar. Available from: https://preventioncentre.org.au/wp-content/uploads/2021/10/Food-Policy-Index-Progress-Update-2019-SA-FINAL-002.pdf

11. SA Health. SA Health Strategic Plan 2017 to 2020. Government of South Australia: Adelaide. 2017.

12. South Australia Department of Education and Childrens Service and SA Health, Right Bite: healthy food and drink supply strategy for South Australian schools and preschools. 2008, Government of South Australia: Adelaide.

13. SA Health, Healthy Food and Drink Choices for Staff and Visitors in SA Health Facilities. 2011, Government of South Australia: Adelaide.

14. Local Government Relations and Policy Team, Creating Healthier Local Food Environments Guide for Local Government, S. Health, Editor. 2017, Government of South Australia: Adelaide.

15. Burris, S., Wagenaar, AC., Swanson, J., Ibrahim JK., Wood, J., Mello, MM, Making the case for laws that improve health: a framework for public health law research. Millbank Quarterly, 2010. **88**(2):145–281.

16. Tobacco Plain Packaging Act 2011 in C2011A00148. 2011: Australia.

17. World Health Organization, Tackling NCDs: 'best buys' and other recommended interventions for the prevention and control of noncommunicable diseases. 2017, World Health Organization: Geneva.

18. Public Health Act 1848. United Kingdom.

19. Public and Environmental Health Act 1987. South Australia. 1987.

20. Social Development Committee, Review of the South Australian Public Health Act 2011, Part 1: Forty-third report of the Social Development Committee L. Council. South Australia Parliament: Adelaide. 2020.

21. Government of South Australia. Responses to recommentations: 43rd report of the SA Parliament Social Development Commitee, Review of the South Australian Public Health Act 2011, Department of Health and Wellbeing. South Australia Parliament: Adelaide. 2020.

22. Food Act 2011. South Australia. 2011.

23. Safe Drinking Water Act 2011. South Australia. 2011.

24. Controlled Substances Act 1984. South Australia. 1984.

25. Tobacco Products Regulation Act 1997. South Australia. 1997.

26. Food Standards Australia New Zealand. Food Standards Code 2021 [cited 2022 June 20]. Available from: https://www.foodstandards.gov.au/code/Pages/default.aspx.

27. Drahos P. Regulatory Theory: Foundations and Applications. ANU Press. 2017.

28. Ayres I and Braithwaite J. Responsive Regulation: Transcending the Deregulation Debate. Oxford University Press. 1992.

29. Government of South Australia. Liquor Licensing Act 1997. South Australia. Government of South Australia; 1997.

30. Consumer and Business Services, Liquor Licensing Act 1997 General Code of Practice. Government of South Australia: Adelaide. 2019.

31. Consumer and Business Services, Liquor Licensing Act 1997 Late Night Trading Code of Practice. Government of South Australia: Adelaide. 2019.

32. Internal Consultancy Services Group, Review of codes established under the Liquor Licensing Act 1997 - Late Night Trading Code of Practice, General Code of Practice, O.o.P.E.a. Review, Editor. Government of South Australia: Adelaide. 2015.

33. Government of South Australia SafeWork SA. Managing the work environment and facilities Code of Practice. Government of South Australia: Adelaide. 2019.

34. Work Health and Safety Act 2012. South Australia. 2012.

35. Competition and Consumer Act 2010. Commonwealth of Australia. 2010.

36. Competition and Consumer (Industry Codes—Food and Grocery) Regulation 2015. Commonwealth of Australia. 2015.

37. The Australian Government the Treasury. Independent Review of the Food and Grocery Code of Conduct Final Report. Australian Government: Canberra. 2018 Sep.

38. Australian Food and Grocery Council, Responsible Children's Marketing Initiative. Australian Food and Grocery Council (AFGC): Barton. 2018.

39. AANA. Australian Food and Grocery Council Initiatives. Self-regulation 2020 [cited 2022 June]; Available from: https://aana.com.au/self-regulation/codes-guidelines/australian-food-and-grocery-council-initiatives/.

40. Watson WL, Pagotto A, Richmond K, Hughes C. Monitoring complaints about food marketing to children under the Australian industry Codes 2015–20: a qualitative analysis. Australian and New Zealand Journal of Public Health. 2021 Dec;45(6):562–67.

41. Reeve B. Self-regulation of food advertising to children: an effective tool for improving the food marketing environment?. Monash University Law Review. 2016 Jan;42(2):419–57.

42. King L, Hebden L, Grunseit A, Kelly B, Chapman K, Venugopal K. Industry self regulation of television food advertising: responsible or responsive?. International Journal of Pediatric Obesity. 2011 Jun;6(2Part2):e390–98.

43. Watson WL, Lau V, Wellard L, Hughes C, Chapman K. Advertising to children initiatives have not reduced unhealthy food advertising on Australian television. Journal of Public Health, 2017 Dec 1;39(4):787–92.

44. Liquor Act 2007, in No. 90. NSW. https://legislation.nsw.gov.au/view/whole/html/inforce/current/act-2007-090

45. NSW, Liquor and Gaming. Liquor Promotion Guidelines. NSW Government: Sydney. 2019. Available from: https://www.liquorandgaming.nsw.gov.au/working-in-the-industry/serving-alcohol-responsibly/liquor-promotions

46. Mental Health and Drugs Division, Code of practice for running safer music festivals and events. Department of Health. 2013, State Government of Victoria: Melbourne. https://content.health.vic.gov.au/sites/default/files/migrated/files/collections/research-and-reports/m/mfe-guidelines---pdf.pdf

47. SA Health, Code of Practice for the provision of sanitation and personal hygiene. Government of South Australia: Adelaide. 2018.

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