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Official Committee Hansard

**HOUSE OF
REPRESENTATIVES**

STANDING COMMITTEE ON HEALTH AND AGEING

Reference: Obesity in Australia

WEDNESDAY, 4 FEBRUARY 2009

CANBERRA

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HOUSE OF REPRESENTATIVES
STANDING COMMITTEE ON HEALTH AND AGEING

Wednesday, 4 February 2009

Members: Mr Georganas (*Chair*), Mr Irons (*Deputy Chair*), Mr Bidgood, Mr Briggs, Mr Coulton, Ms Hall, Mrs Irwin, Ms King, Mrs May and Ms Rishworth

Members in attendance: Mr Bidgood, Mr Georganas, Ms Hall, Mrs Irwin and Ms King

Terms of reference for the inquiry:

To inquire into and report on:

The increasing prevalence of obesity in the Australian population, focusing on future implications for Australia's health system.

The Committee will recommend what governments, industry, individuals and the broader community can do to prevent and manage the obesity epidemic in children, youth and adults.

WITNESSES

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Committee met at 8.45 am

CHAIR (Mr Georganas)—Welcome. I declare open the health and ageing committee's public hearing in Canberra inquiring into obesity in Australia. This is the 13th and final public hearing for this inquiry being conducted by the House of Representatives Standing Committee on Health and Ageing. The committee has spent the last year travelling around Australia—that is, capital cities and regional and remote areas—taking evidence for this inquiry. We have visited hospitals, schools and communities and looked at community initiatives to learn about the increasing prevalence of overweight and obesity in Australia and the future implications for Australia's health system. We have consulted governments, industry, individuals and the broader community about what more all of us can do to prevent and manage the obesity epidemic better.

The committee notes that Australian health ministers agreed to obesity becoming a national health priority area at their April 2008 meeting. One of the first tasks of the newly created Preventative Health Taskforce will be to provide advice on a comprehensive national health strategy to address obesity, diet and physical activity. In recognition of the need to tackle obesity rates, last year we received an informative briefing from Dr Lyn Roberts, a member of the Preventative Health Taskforce, which provided us with an overview of where the national health strategy is headed. Today we look forward to hearing further from the Department of Health and Ageing, the lead agency in this process. The hearing is open to the public and a transcript of what is said will be placed on the committee's website. If you would like further details about the inquiry or the transcripts, please ask any of the committee staff that are here.

[8.47 am]

BRYANT, Ms Jennifer, First Assistant Secretary, Population Health Division, Department of Health and Ageing

MORRIS, Mr Peter Thomas, Assistant Secretary, Population Health Strategy Unit, Department of Health and Ageing

PEACHEY, Ms Catherine, Acting Assistant Secretary, Healthy Living Branch, Department of Health and Ageing

SINDALL, Mr Colin Alexander, Senior Adviser, Population Health Strategy Unit, Department of Health and Ageing

CHAIR—Good morning and welcome. Would you like to make an opening statement?

Ms Bryant—I will not make an opening statement. We have made a submission and hopefully we have made a contribution in setting out some of the key data which has informed our thinking, some of what we are seeing in the international context and what we see to be some of the impacts down the track on the health system. Perhaps I can maximise the committee's time to ask us questions.

CHAIR—The preventative task force has been going for approximately 12 months.

Ms Bryant—I think the minister announced it in April last year, so about nine months.

CHAIR—Nine months. Are there any recommendations or anything solid that has come out of it at this point that you could explain to us?

Ms Bryant—Late last year the task force released a discussion paper and three supporting technical papers, one of which dealt specifically with obesity. It is due to report in June 2009 and I think that will be its next formal product.

CHAIR—That will be just after our recommendations come out.

Ms HALL—What sort of recommendations do you have in the area of research and what sort of information is coming out relating to psychosocial factors relating obesity? Has the department been working towards some sort of a recommendation in that area?

Ms Bryant—In terms of behavioural research?

Ms HALL—Yes, in relation to the whole issue of obesity. The more I hear, the more I talk to people, the more I realise that it is about not only what you eat and how you exercise; there are a number of other factors involved. Many people are very aware of those particular issues, but there are also the psychosocial, or psychological, should I say, issues that impinge on a person's weight. I said 'psychosocial'; are you looking at some recommendation that deals with the fact

that people from lower socioeconomic groups tend to have more of a problem with obesity? I think it starts even at birth, where it can be linked to breastfeeding rates, which also links into another inquiry this committee did. I am sorry; I did not mean to talk that long.

Ms Bryant—If I can pick up several dimensions of that and then let my colleagues come in as well. In terms of breastfeeding research—just to pick up that minor dimension of your question—following the committee’s inquiry and the government’s response, we are doing some research. We have commissioned some research into factors that influence people both initiating breastfeeding and continuing it—just what the enablers and the barriers are. So we have some research in train already on that. In terms of research more generally, there is a growing recognition, I think, of the issues you raised, such as the contribution of psychosocial factors. Certainly, the National Health and Medical Research Council is giving increased recognition to the importance of research in that area in setting its research priorities and so on for the coming period. So, yes, there is a recognition of it. The task force made comments in this area, but I think it is a bit too early to know what the shape of their final thinking will be. Departmentally we are attempting to follow the National Health and Medical Research Council and we have contact with CSIRO on this—they do a lot of work in these types of areas—and it is an area that we recognise as being of increasing importance. Do you want to add anything to that, Peter?

Mr Morris—I would, briefly. Certainly, the NHMRC is the major funding body of all public health research. The ARC also has a significant role. I think there is widespread concern that we achieve a better balance between biology based research and behavioural research. Professor Don Nutbeam has just conducted a review of the public health research program of the NHMRC. I think this issue was canvassed within that context. And the task force is certainly quite seized with the issue of that balance between biological research and behavioural research. There is a very small amount of money in the new national partnership agreement on preventive health for what is called translational research, which will go to the matter of behavioural research at the sharp end of policy. Within the NHMRC, its new national partnerships program, a research grants program, offers the opportunity for a much clearer policy direction to research, and we would hope that would yield a better focus on behavioural research.

I think it is important to note that both domains matter in the long run; it is an issue of balance. Some of the most potentially important levers one could exercise on diet, for example, could come through the nutrition chain and the way it interacts with the human metabolism and human satiation and the human accumulation of calories. You only have to look at what happened with the switch in fats from saturates to monounsaturates and polyunsaturates to see the power of that sort of switch within the food supply. When you can carry the consumer with you, you can achieve a dramatic change in nutritional outcomes. But at the moment there is no doubt that our capacity in behavioural research severely lags behind our capacity in biological research, and that needs to be rectified.

Ms HALL—I will ask a follow-on question. Would you, as a player or a member of the task force be pushing for that to be included in the recommendations?

Mr Morris—The department is not a member of the task force. The task force is—

Ms HALL—I am sorry, I was not listening.

Mr Morris—We provide the secretariat. The task force is fully independent.

Ms HALL—Fair enough.

Mrs IRWIN—On page 34 of your submission, part 2, Australia's policy and program response, you stated that Australia released the world's first strategic plan for obesity prevention in 1997. That is over a decade ago. You have also stated in your submission that there has been 'successful implementation of a number of national programs and activities'.

CHAIR—Because of the lack of a quorum we need to form a subcommittee.

Ms HALL—I move that a subcommittee be formed.

CHAIR—Thank you.

Mrs IRWIN—I apologise about that. I go back to my question. The strategic plan was over a decade ago and then your submission mentions 'the successful implementation of a number of national programs and activities'. Can you identify the more successful programs?

Ms Bryant—Can you point me to your second quote?

Mrs IRWIN—It is in the fifth paragraph down. It says:

Associated with the release of these various plans and initiatives, has been the successful implementation of a number of national programs and activities.

I just wonder whether you could identify the more successful programs.

Ms Bryant—I think those go primarily to the Healthy and Active task force initiatives and so on, a number of which I think are detailed in the following text—the Healthy and Active Australia Community and School Grants Program; the active after school programs, which I think were expanded; and there have been initial social marketing campaigns and so on, there. Are there others we should particularly highlight, Colin?

Mr Sindall—Going way back—post the NHMRC strategic plan—one initiative that flowed from the strategic plan developed by the NHMRC was a recommendation about the development of obesity management guidelines for general practitioners, for children and adults. That was a project that was seen through and completed. I think it is currently being revised but I understand it was considered a fairly valuable resource for the primary care sector in terms of addressing the issues. I think it was probably somewhere around the time of the NHMRC plan that the active Australia campaign was launched, and we saw some social marketing around encouraging people to be more physically active. I recall that that tracked fairly well.

At a state level we saw a number of campaigns in terms of promoting fruit and vegetable consumption and Western Australia's find 30 minutes of exercise a day. I think that statement partly refers to a range of activities, all of which have not been listed here, but in terms of more recent times many of the programs that were implemented in the last few years are documented.

Mrs IRWIN—Were there any campaigns that were not successful?

Mr Sindall—Probably most of the things that were done have made a contribution and showed some success in terms of their immediate implementation, but clearly they have not been of sufficient power or scale or been sustained sufficiently to really have affected the problem, because it still continues to be one.

CHAIR—The recent campaign—*Measure Up*—which we have all seen on TV, I think visually brings the message home. I think it is great. I know it is early days, but has there been any chance to monitor or see the effectiveness at this point? Has there been any research? I understand that it is very, very early—it has only been three months or something—but it is a very visual campaign.

Ms Bryant—Yes. It has attracted a great deal of interest. We have some stats here about hits on the website which we can give you.

Ms Peachey—An evaluation will commence shortly. The next phase of activity is happening in March, so it will be back on the TV screens again then. But I can give you some facts and figures on what sort of interest it has generated that we can measure. It is evidenced by about 6,819,217 hits on our website in the period from October to January.

Mrs IRWIN—That is a great amount.

CHAIR—Those hits have obviously been generated by the ads on TV and in the newspapers.

Ms Peachey—That is right, and there is a whole range of supporting material underneath that that hits particular population groups. It is an average of 3,529 visits a day between 17 October and 17 January. Also, 330 healthy tips have been posted on the website by members of the public, 139,233 copies of the 12-week healthy eating planner have been downloaded and 143,858 tape measures have been distributed. We need to undertake some research to benchmark and evaluate the effectiveness of the campaign, but we have been very encouraged by the early interaction.

CHAIR—Is there any mechanism in place to get back to the people who have made those hits? In other words, is there can any mechanism on there where you ask them to contact you again in two or three months to see how they are going? For example, with the Quit campaign for smoking, if you call in they will ring you on a regular basis to see how you are going. Therefore they can evaluate individuals.

Ms Peachey—No, not for hits, but some people are emailing and asking for particular advice or that type of thing. In that case, I understand that there is a process in place to respond to those inquiries.

CHAIR—Excellent.

Ms Bryant—One individual has actually started their own blog on the website, where they are telling their story. The amount of attention it has attracted is very interesting.

CHAIR—How would this campaign compare to other campaigns? For example, if we go right back to the eighties and look at the Norm campaign, ‘Life. Be in it.’ it was very similar, in a way. It had a cartoon character. In this case we have real-life characters, which I think is more realistic. Were campaigns like Norm successful back in those days? Are you monitoring this one against other campaigns that have been run?

Ms Bryant—I think one of the differences with this campaign is that the focus group research that we did for the development of the campaign showed that people knew they had to do something but they did not understand the why and the how of it. With this campaign we were seeking to give people some of those explanations and encourage them to think that small steps were feasible and productive to take. We were seeking to give them some of the rationale for taking those steps and then point them at the beginning steps. The Norm campaign showed massive recall. In testing, people had a strong memory of it after having seen it, and we all do years later. It is a bit like the Grim Reaper campaign. Some are standout ones that you remember. However, it did not deal with those dimensions so well. That was where we were seeking to take this particular campaign.

Mr BIDGOOD—I used to run two medical centres, managing 10 GPs. I am not a doctor myself. One thing which I was always concerned about was the management of obesity. I would like to hear from you concerning Medicare numbers to do with healthcare plans. On page 35 of your submission you talk about Medicare reforms. The doctors that I have spoken to have said they would really like to see a healthcare plan specifically for obesity. Could you elaborate on your thinking on that.

Mr Morris—Prevention is a major concern of two current reviews that will affect primary care. One is the development of the National Primary Health Care Strategy and the other is development of the Preventative Health Taskforce strategy. Both have an interest in this issue of the role of primary care in prevention, in relation specifically to obesity but also to tobacco and excessive alcohol consumption. I think there is widespread recognition that the system could be better configured than it is at the moment. But there are complex policy issues at stake there, and I think it is probably better for us not to comment on that. You will appreciate that. What we can do is take on notice your first question. If I heard it correctly it was: what has been the uptake of the 45-year-old health check under the Australian Better Health Initiative? We can supply you with that data if you like.

Ms Bryant—And what the particular Medicare item numbers involved are.

Mr BIDGOOD—I am more particularly concerned with Medicare numbers and provision of numbers. That obviously has a funding implication and things like that. The doctors I have spoken to said that, just as there is an asthma management plan, a mental health plan, an aged care plan and a diabetes plan, there should be an obesity plan for really acute obesity where people need real help. That would include management for them to go to dieticians, perhaps to get help with their exercise regime and things like that. That is what I have picked up from the GPs I have spoken to.

Mr Morris—Anyone who has what is referred to as a ‘chronic and complex’ condition already has access to a care plan and referral to a number of allied health professional services, which I think would address your concern. A ‘chronic and complex’ condition implies a

minimum of two chronic conditions, I think, to qualify for access to that item. But I think the best thing we can do is take your question on notice and return to the committee with a written answer.

Mr BIDGOOD—It is just that the call I have heard from GPs is that they would like a specific obesity management plan in the same fashion as those for asthma, diabetes, mental health and aged care.

CHAIR—I know that you are only halfway through your consultations with the task force, but can you perhaps elaborate bit. When the recommendations do come out, how technical or broad will they be? Do you envisage any specific areas that it will be looking at in terms of recommendations?

Mr Morris—The task force has given a very clear indication of its strategic directions in the discussion paper and the technical papers. I think it has revealed its hand very well there. You are correct: we are about two-thirds of the way through the consultations. They are occurring in 35 different locations around the country. The task force has received nearly 400 submissions, so it is actually swamped at the moment.

CHAIR—A bit like us!

Mr Morris—There is a massive analytical exercise going on as we speak. It would not be for me to foreshadow their brief specifically as to the recommendations; the task force is wrestling with that very issue at the moment.

CHAIR—What about the actual consultations? Could you give us an overview of some of the consultations that have taken place and what types of groups they are speaking to?

Mr Morris—The consultations have been run in two tranches. One tranche has been what we call local or regional consultations, which are by invitation but seek a broad spectrum of local stakeholders in public health and interested agencies, industry et cetera. They have been general consultations. They have occurred in each capital city and at least one regional centre—in some cases in two regional centres—in each jurisdiction and we have sometimes married specific Indigenous consultations to those regional consultations.

The second tranche has been what we have called thematic national roundtables. With those, we have identified about 10 key themes—for example, alcohol, the fitness and recreation sector and primary care. We have invited the peak national organisations who have a vital interest in those themes to those roundtables, which involve a much more focused sort of discussion. We are combining those two plus a third tranche, which, as I should have mentioned, is with state officials in each jurisdiction. The chair is seeking bilateral meetings with each individual state health minister. Excluding the ministerial consultations, there will be about 35 consultations all up.

The issues raised are vast. They vary between people affirming the direction of the task force and, in some cases, challenging it. There are clearly stakeholders who have a vital interest in the status quo, and you would expect some contention around their concerns. So you get in-principle comments and then you get very specific ones—for example, from someone who runs a mobile

health assessment service out of a van in the Central West of New South Wales and travels from workplace to workplace running health assessments for men. It is innovative and interesting but it is far too detailed to find its way into a recommendation for the task force, yet it illustrates on an anecdotal level the sorts of things that can be done if you unleash the creative potential within the stakeholders.

I do not think there are any surprises in the comments that have been made in the public consultations. Broadly, there has been, with the exception of particular industry interests, very positive affirmation of the direction of the task force. I think there has been a very obvious welcome and, indeed, building of expectation, which your committee may have experienced too, around the hope that, at long last, we will get an obesity strategy out of this. But there have been no surprises. There is nothing which I think would steer the task force from the directions it has aired in its papers.

Ms HALL—Where are those consultations at? Are they completed?

Mr Morris—No, we are halfway. We have two weeks left.

Ms HALL—And how are the roundtables et cetera advertised?

Mr Morris—They are not advertised. It is all done by invitation. Our process was by invitation in order to manage the volume and the pace at which we had to move but also in recognition of the fact that there is something of submission and consultation fatigue in the constituency with your inquiry, with the 2020 Summit—

Ms Bryant—Health and Hospitals Reform Commission, primary care.

Ms HALL—From my perspective as a member, it is really good if we know those things are happening in our area. I suspect that the regional area I come from is one that would have had input into the roundtables and consultations because there are some significant programs there. It is very good for us to know that they are happening. Please just be mindful of that in the future. Thanks.

Mrs IRWIN—I just want to go back to page 21 of your submission, when you were mentioning results of international modelling and telling us about the Foresight study in the United Kingdom. You gave us considerable detail on that. You stated:

it is likely that the Australian situation would be broadly comparable with UK scenarios

and:

This needs to be tested using Australian data.

Does the department intend to commission modelling here similar to the Foresight study in the UK? If so, when? If not, why not?

Mr Morris—The department at this stage is not commissioning modelling of that kind. That is an issue for the task force. The task force is considering at this very moment what sort of modelling it will require and how to go about doing that.

Ms HALL—Two of the issues that we have probably received more evidence on than anything have been advertising and labelling. What are the thoughts of the department in those areas and are you getting any feedback from the task force on either of those issues?

Ms Bryant—They are both interesting and, as you would appreciate, controversial. I will tackle advertising first, and I will let my colleagues also make some comments. Advertising is clearly a significant policy issue for government to think about in light of the advice that it has commissioned from the Preventive Health Taskforce and so on. It is not one that we can give you any pointers on as to the advice that we might give government—we are a sort of step back from that—but it is useful to think about a number of the issues that flow from thinking about advertising and so on. So perhaps we can go through some of those with you. Cath, do you want to comment.

Ms Peachey—I guess one of the difficulties, which you will have already identified through processes, is that causation is really difficult to isolate and quantify. While there is an emerging body of evidence that advertising influences children's preferences, there is not a lot of evidence around how that impacts on their behavioural outcomes—that it changes their behaviour. When you are thinking about the policy considerations, the sorts of things we would be thinking about, if you were to consider bans of that sort, would be: whether it is evidenced based, whether it is going to impose unjustifiable regulatory burdens and costs, whether it is capable of being enforced, whether it is proportionate, and whether it will really give you the outcome you are seeking to achieve, which is less consumption of high fat/salt/sugar foods by children? They are the sorts of things we would think about. As you know, there is a process in place. The Australian Communication and Media Authority is finalising its review of the Children's Television Standards and, like many stakeholders, we are interested in the outcome of that review. The Preventive Health Taskforce is equally looking at this vexed issue and we will consider that advice is well.

Ms Bryant—In the UK Ofcom has now got the main findings of its initial review phase and certainly it appears to show a significant reduction in exposure to the advertising. The regulatory framework that they have created has reduced the amount of high fat, salt and sugar advertising on television seen by children four to 15 fell by an estimated 34 per cent. There are other stats that we could give you that go to the issue of exposure. But their analysis has not gone—and is not going, as I understand it in the future—to behavioural outcomes. It only points us to the fact that you can only make an impact on the amount of advertising seen and not what that does in terms of subsequent outcomes.

The industry itself is taking a number of steps, as you are aware, in terms of self-regulation and are trying to put on a voluntary basis constraints around advertising. In the Australian context I think it will be interesting to watch the outcome of that process. Clearly the industry wants to avoid heavy-handed regulation down the track and there is self-interest in it, but it is also a recognition I think on their part of the community concern.

Ms HALL—And labelling?

Ms Bryant—There is already quite a lot work in train on labelling.

Ms HALL—There are traffic lights and all the other different forms of labelling, daily intake, calories, kilojoules or whatever. Is there any thought from the department as to which is the most effective way to designate the amount of fat, sugar or whatever is in the food?

Ms Bryant—As consumers and individuals I think this is one area where we all have views and preferences. We all go into the supermarket. If you have a look at the tins, you need to put on your magnifying spectacles—

Ms HALL—But we also have traffic lights and the other types of issues.

Ms Bryant—This again is a complex area and it is driven by individual choice and so on. I think most of the schemes are good at one thing or another. As I understand it, traffic light type labelling is good at assisting you to make a choice within a category of products. If you are choosing between sandwiches, it tells you which of the sandwiches in the range is best. It does not help you choose between sandwiches and breakfast cereal.

CHAIR—And it still does not prevent you from having five sandwiches in one go!

Ms Bryant—Quite. It is helpful for choosing within a category. There are other forms of labelling and so on. There is the recommended daily intake. As you would appreciate as consumers you look at products and you think, ‘This is great on the salt and sugar but it is bad on the fat.’ It tells you those things but it is still an exercise in thought for individuals to say, ‘I kept my salt and my sugar down in that meal but it was higher than desirable and for the rest of the day I have to balance it in other ways.’ There is no perfect, ideal, single model with food labelling. Combinations serve people’s needs in different ways. A number of products now on the market are moving to have at least two of labelling systems on them concurrently.

Ms Peachey—The tick program has been very successful in that regard as well. It is another model you could adopt.

CHAIR—I do not want to call it misleading advertising but there are cases where things are claimed to be nutritional when their sugar content is extreme—we see this in a lot of cereals—yet they claim to be nutritional, healthy, dietary, light, a whole range of words that conjure up the thought that this is not fattening. I think it was at Westmead Hospital that a woman told us about her problems with her weight all these years. She thought she was doing the right thing by buying these particular products. It was not until she developed diabetes when someone sat down with her and told her that she should not be eating these products that she realised. I think that is an area where the labelling is misleading in terms of calling it nutritional et cetera.

Ms HALL—There was an issue recently with the Coles label looking like the tick.

Ms Bryant—The industry itself would tell you that the issues in this area are very complex. I think a lot of their marketing shows for example that if they label some foods as ‘light’ that appeals to a certain market. If they label them as ‘low salt’ often people deliberately choose the alternative normal or higher salt products. There are some things that consumers, although it might be better for them, actually find unattractive as choices when they are purchasing

products. It is very complex and even if you label things to try to give people some guidance and some choice, their reaction as consumers to the products is often not what you would anticipate.

I think you are right. Nutrition education is a complex area. We often wonder how we could assist best. We have the Go for 2&5, the fruit and vegetable campaign. I think there is a lot of headway to be made with ideas such as eating smaller serves and drinking more water, and keeping the message as simple and straightforward as possible. The more complex the calculation, the less people can compute it in a constructive way in the course of their daily lives. I do not think labelling is a panacea for all of these things. It is guidance for some purposes. I do not think any one model embodies all of the information that is useful to consumers. I think some sort of composite is probably a useful space to be thinking in, but we also ought to be thinking about simpler and more straightforward messages that in fact assist people: portion size and drinking water. There is a strong view that drinking fruit juice is a great thing for children. It is in one sense but the sugar content is another issue. Provided their fruit and vegetable intake is adequate in other respects then water may be a better choice.

Mr BIDGOOD—I take on board what you are saying about the traffic light idea and all the other things we can do. One fundamental thing for me is that when I go into a supermarket I want to save money when I purchase my food. The Americans are talking about taxing fat. I would like to know if you have seen any international research where that approach has been taken and whether it has been affective. A comparison can be made with leaded and unleaded fuel. It is cheaper to buy unleaded fuel, so people tend to make that conscious choice. When families are struggling, their health choices are constrained by what they can afford. Often I go into the supermarket and I buy the basic brands just to save money. It is as simple as that. What is your view on that? Is there any international evidence and do you think that is a way Australia should go?

Ms Bryant—I think this is something the task force has looked at and perhaps we can tell you some of their thinking.

Mr Morris—The task force has a view on tax as a potential lever for altering dietary habits. The evidence around this is extremely thin internationally, I think. Colin, would you mind commenting on that?

Ms HALL—What does Sweden do as far as tax is concerned? I notice Sweden has a low rate of obesity.

Mr Sindall—I am afraid I do not know the answer to that.

Ms HALL—That is a country you would expect would probably tax.

Ms Bryant—As Mr Morris has said, there is very limited evidence around taxing salts, fats or sugars. That is the case internationally, I think. The task force has certainly looked at the issue and given it some thought, but again it is one of those areas, like advertising, in which there are significant public policy issues that need to be considered. It can be regressive in nature, so it can have effects on those on whom you do not want it to have an impact. Taken together with the cost of healthier alternatives or other products, you would have to be confident that you were in fact producing a better overall dietary outcome.

Mr BIDGOOD—That point is taken. I have seen the debate on American TV. It is taking place now under the Obama administration. They are suggesting that the tax gathered on high-sugar, high-fat and high-salt products is put directly into the medical health service. Just through economic constraints of what they can and cannot afford, if it is cheaper to buy healthy food I am sure they are going to do that. That is my personal view. I personally think that is the way to go. If we do not want people to pollute the atmosphere, we say unleaded is cheaper than leaded; you have an incentive to buy the good stuff. We need an incentive in this country to buy good, healthy food. I think that is a way to go. I would like you to take that on notice and consider the international evidence, because obviously we are not sure. I would like to see something come back on that, Chair, if it is possible.

Ms Bryant—We can perhaps tell you what international models exist.

CHAIR—That would be great. I have one last question, a very broad one. We have had reports from Access Economics in which they estimated that the financial cost of obesity to Australia was \$3.7 billion in 2005. They reported also that the figure rose to \$8 billion in 2008—that is, it has more than doubled. The net cost of lost wellbeing has increased from \$21 billion in 2006 to \$58 billion in 2008. I am sure the department has seen those figures. Do you agree with those figures? I can never work out how they get to these figures, but they seem astronomical. If the cost has doubled in the last couple of years, the cost on governments is going to completely blow out. I am sure you are looking at figures.

Mr Morris—The significance of the Access revisions is not so much that the real cost has doubled; it is rather that their capacity to estimate what the real cost is has changed. It has changed principally on account of two developments. One is that AIHW, as I understand it, has revised what it calls its ‘attribution factors’, which are the factors by which it says, ‘The contribution of obesity to diseases A, B, C and D will be X per cent, Y per cent, Z per cent.’ That all has to be estimated using epidemiological modelling, and AIHW has revised upwards.

CHAIR—When you say ‘A, B, C disease,’ we are talking about diseases such as cardiovascular diseases, diabetes or hypertension?

Mr Morris—Cardiovascular, diabetes et cetera, yes. AIHW revised upwards its attribution factors for the significance of obesity in causing chronic disease. The second methodological revision was to do with the valuation of life. That resulted from Access—

CHAIR—That would be the wellbeing study?

Mr Morris—Yes. It did a major study for the—

Mr Sindall—It was the Office of the Australian Safety and Compensation Council.

Mr Morris—Yes. It was a very major literature review of life estimates. This caused them to revalue the cost of a life foregone or disability in life. So it was principally a methodological revision driven by two major components. The best way to think of the 2008 estimate is that they had underestimated in their previous exercise.

Ms HALL—You were saying that they use A, B and C disease to calculate, but wouldn't they have compared that to previous data, so that the increase would have been not just because of a change in methodology but rather because the methodology was refined so that what was in the past could be looked at—that is, it still would be a valid reassessment and upward movement because they would surely be comparing A, B, C, D in 1990 to A, B, C, D in 2000 or A, B, C, D in 1996 to A, B, C, D in 2006?

Ms Bryant—Are you asking if they took steps to keep price constant and go back and adjust the earlier work by applying the new method? I think the answer to that question is no.

Mr Morris—They did not do a revision on the basis of obesity prevalence as it stood in 2005 and compare that with the estimate for 2008, applying the same methodologies. What they did is say: 'We did this exercise once in 2005. We are doing it again in 2008 with different methodologies.'

Ms HALL—So they are not comparing—

Ms Bryant—They are not directly comparable.

Mr Morris—It is not an apples with apples comparison.

Ms HALL—the diabetes rate in 2000 to the diabetes rate in 2006, or whatever it was?

Ms Bryant—No.

Ms HALL—Oh well, then it is not a valid study.

Mr Morris—Sorry?

Ms Bryant—They are not comparing apples and apples.

Mr Morris—They have changed the methodology.

Ms Bryant—Yes, there is a change in methodology. Inside the study, if you went back to the raw data, you could probably look at the crude rates of diabetes or the crude rates of different things at points in time. But they are commenting on what the cost impact of those things is. Because of the different methodology, they are saying, 'We've calculated costs in a different way in the 2008 study to the way we did it in the 2005 study.'

Ms HALL—But you could still make a valid comparison. You could go back—

Ms Bryant—You could go back to the crude data but within the raw data segment.

CHAIR—So when we are talking about the costs of obesity to the nation, as they have stated, we are talking about not just the cost of obesity on the health agencies.

Mr Morris—They parse that out. Colin, can you assist here?

Mr Sindall—They distinguish between the direct financial costs and the costs of lost wellbeing or lost lives. Then, in terms of the financial costs, they parse that out. In terms of their new estimate of \$8.2 billion or \$8.3 billion they suggest that about \$3.6 billion of that is probably lost productivity or effects on productivity. The actual health system cost is close to \$2 billion.

CHAIR—That is the 2008 figure?

Mr Sindall—Yes, the 2008 figure, which is an increase of \$800 million or so. I cannot remember what their 2005 health system cost estimate was. Then there are a further \$1.9 billion in carer costs, which they also include in their estimates. And the \$2 billion, based on the methodological revisions, is actually reasonably consistent with what they had estimated before taking account of the new methodology. It certainly does affect the direct financial costs, partly because of the AIHW shift in the population attributable risk associated with obesity and partly because of a slight adjustment of prevalence based on another study that they used, the BEACH survey. But the big shift, obviously, is in their estimations of the value of life, where the estimate shifted from \$163,000 to \$266,000. It is a big jump.

Ms Bryant—In fact, another way of looking at it is that they said in 2005, ‘We estimate the impact to be this,’ and they are now saying, ‘We have a more accurate handle on what we think the impact is,’ and that is reflected in the changed methodology. It is a growth in understanding.

Mr Morris—They are very transparent about that.

CHAIR—I have seen some other figures somewhere during this inquiry—I cannot recall exactly where I have seen them—

Ms HALL—It was the Baker study.

CHAIR—which say that if we lost five kilos across the board in Australia these figures would go down to less than half. Has the department looked at any of those figures? How correct would they be? Are they just estimates? For very little loss in weight, they are huge savings. We are talking in billions.

Ms Bryant—At a population level it is undoubtedly true. If everybody lost a kilo or something, at a population level, taken across all those millions of people—

CHAIR—Some people might lose 10 kilos and others less.

Ms Bryant—Yes, but you would have a significant impact at a population level. The impact at an individual level is obviously more a product of what the individual does. But at a population level it is undoubtedly true that there would be a significant impact.

Mr Sindall—There were some methodological debates and issues around the Baker work, and that happens with most studies. I do not think anyone would swear that those figures were the ones but I think they give us a sense of the sort of impact that could be achieved. The foresight modelling tells a similar story. If you could get that across-the-board relatively small reduction, a long way downstream there would be significant savings. But if that is not achieved,

the evidence from around the world suggests that, yes, the healthcare costs are going to be pretty substantial.

Ms HALL—The commonsense approach.

Ms Bryant—There are others that say if you eat one less biscuit every day or every week then at the end of a year you will have lost two kilos or some number of kilos. It is useful in illustrating to individuals that even quite small steps result in some quite—

CHAIR—Which goes back to our campaign.

Ms Bryant—Yes.

CHAIR—Thank you very much for giving evidence before the committee; we really appreciate it. I am sure that we will speak again at some stage before our report is out and before your report is out, I suspect. I now declare this meeting closed. I thank you all for attendance and thank Hansard.

Resolved (on motion by **Ms Hall**):

That this committee authorises publication, including publication on the parliamentary database, of the transcript of the evidence given before it at public hearing this day.

Subcommittee adjourned at 9.40 am