Addressing the Obesity Epidemic in Australia

TO: Chair, Committee on Obesity, Department of the Senate, Parliament House, Canberra ACT 2600. E: obesitycommittee.sen@aph.gov.au

FROM: Jennifer F Thompson BSc,

Focus of this submission

I welcome the opportunity to provide information for the *Select Committee into the Obesity Epidemic in Australia*[1], and will address the below listed Terms of Reference sections, with professional and supporting data overview, followed by personal reflections, in the hopes that the information I provide may be of use to the Committee:

c. The short and long-term harm to health associated with obesity, particularly in children in Australia;
d. The short and long-term economic burden of obesity, particularly related to obesity in children in Australia;
e. The effectiveness of existing policies and programs introduced by Australian governments to improve diets and prevent childhood obesity;
f. Evidence-based measures and interventions to prevent and reverse childhood obesity, including experiences from overseas jurisdictions;
g. The role of the food industry in contributing to poor diets and childhood obesity in Australia

About the Submitter

With my below listed experience in managing research aimed at increasing bodies of evidence, I am passionate about evidence-based research being able to inform real improvements in health and healthcare for Australians. However, I have not only a professional interest in childhood obesity, but I am also a person who has experienced being of average weight, overweight, or obesity during my life, both during and since adolescence. Therefore, I have a personal interest in not only obesity's short-term effects on children and adolescents, but also the long-term effects on the person, health system, and economic system. It is from my personal perspective that this submission is made.

In the interest of full disclosure; I am the manager of a national collaborative research centre based at a higher education institute in Australia where I oversee the operational aspects of research and reporting as well as the strategies that we have for informing evidence-based research outcomes into practice and policy. I have a BSc (Human Biology) and am currently completing a Master's degree in Health Policy (MHPol). I have experience working in and managing pharmaceutical clinical trials, collaborative group research, and academic research. My position prior to my current one was managing a Clinical Research Centre at a large paediatric teaching hospital here in Australia where academic and clinical experts in the field of child and adolescent obesity are based.

c. The short and long-term harm to health associated with obesity, particularly in children in Australia

Professional overview/supporting data: With the prevalence of being overweight for Australian children (5-19yrs) being estimated by the World Health Organisation (WHO) at greater than 30% by 2016 (Table 1[2]), Australia is one of the WHO member nations facing the greatest challenge to our population health.

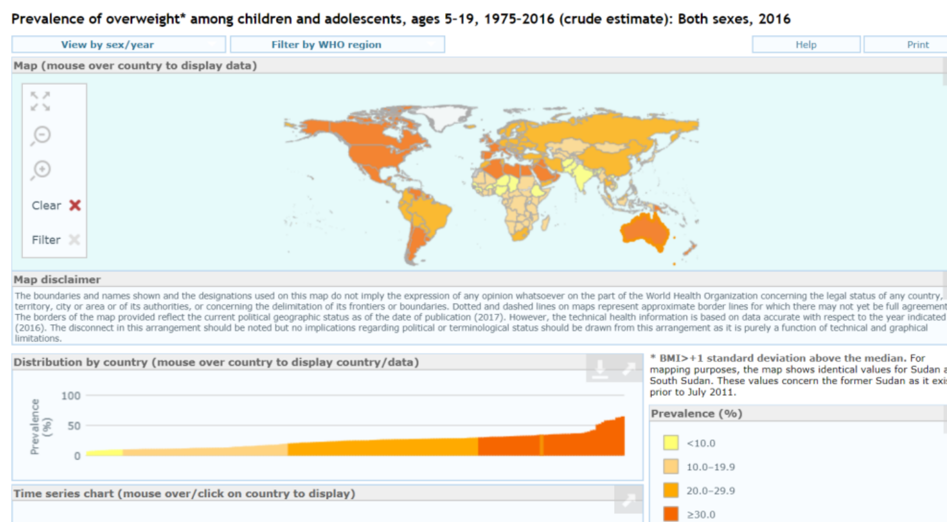
The evidence on obesity being a short and long-term driver for adverse health outcomes for young people still in childhood and adolescence, and for their health potential as adults, is significant. The European Association for the Study of Obesity (EASO) Childhood Obesity Task Force (COTF) position statement released in 2015[3] confirms childhood obesity as "one of the greatest health challenges of the 21st century" and agreed to that childhood obesity can be classified as a chronic disease.

In 2017, Australian writer Bianca Nogrady, told in Nature[4], the sad story of how young people are developing the life-changing liver complications fibrosis and cirrhosis; some by the age of 8.

Nicole Black and other researchers at Monash University (Melbourne) have identified that Australian boys with obesity and a higher BMI seem to have significantly lower levels of cognitive achievement than their peers[5].

In 2017 Kovesdy et al (on behalf of the World Kidney Day Steering Committee) published *Obesity and Kidney Disease: Hidden Consequences of the Epidemic*[6] giving evidence that obesity can damage the kidneys and is a significant risk factor for diabetes, cardiovascular disease, and kidney disease and cancer.

Figure 1: Prevalence of overweight among children and adolescents, ages 5-19, 1975-2016 (crude estimate): Both sexes, 2016[2]



Personal reflection: The weight of evidence links childhood obesity with some significant adverse health outcomes that can have short-term health effects e.g. developing liver diseases in childhood, and long-term health impacts e.g. males with lower levels of academic achievement will likely move into lower paying unskilled jobs as adults. This information provides drivers for the Australian Government to continue its prioritisation of funding in the areas of prevention. There should be continued support for research on prevention through funding of The Australian Prevention Partnership Centre and grants to early-career, mid-career, and experienced researchers in this field.

d. The short and long-term economic burden of obesity, particularly related to obesity in children in Australia

Professional overview/supporting data:

The Australian Story: To get a true picture of the economic burden of childhood obesity in Australia requires recognition that the economic costs will not be solely direct healthcare costs; indirect costs will also come into play. The Australian Institute of Health and Welfare (AIHW) 2017 report *A picture of overweight and obesity in Australia 2017*[7] can provide your Committee useful information on the direct and indirect costs associated with childhood obesity.

Our Australian experts in the childhood obesity field, including Alison Hayes and Louise Baur, wrote *Early Childhood Obesity: Association with Healthcare Expenditure* in Australia in 2016[8]. Their data shows you that the direct healthcare costs of obese 2-year old's (2011-2014) were more than 1.5 times greater than toddlers of the same age who were within their healthy weight-range.

While the AIHW[7] report and Alison Hayes et al's paper can give you information about significant direct health costs e.g. 124,600 weight-loss surgeries performed in 2014-15 (section 5, page 31); the impact of indirect costs on the Australian economy should not be discounted. These indirect costs are significant and include loss of productivity and tax revenue, increased welfare payments, and the cost of government programs aimed at reducing obesity in Australia e.g. development and maintenance costs of Department of Health websites like the Welcome to the Obesity Guidelines Website[9]
http://www.health.gov.au/internet/main/publishing.nsf/content/obesityguidelines-index.htm.

The International Story: While Australia has the AIHW report[7], globally there seems to be a paucity of short-term or longitudinal evidence on the economic impacts of childhood obesity. A comprehensive review paper *The lifetime costs of overweight and obesity in childhood and adolescence: a systematic review*[10] published in April 2018 by researchers in Ireland identified this lack of evidence. That team looked at the available international literature evidence for lifetime healthcare and productivity costs caused by childhood obesity, and of the just 13 evidence-based papers identified, all were from the USA (n=8) or Europe (n=5) and none were from Australia or New Zealand.

Personal reflection: I believe the lack of international evidence on the impacts of obesity, in particular childhood obesity, needs to be addressed through coordinated federal and State Government policy initiatives, including prioritised creation of a National Obesity Strategy. It is not acceptable that despite the challenge of obesity being openly recognised in both social and policy contexts in Australia, the Australian Government has not moved forward with strong economic and health policy and initiatives to address this national and international challenge. The impact of obesity on the economy in Australia, is however still not fully understood, and this highlights the great opportunity for funding to be prioritised for development of Australian specific research evidence on the economic impacts of childhood obesity.

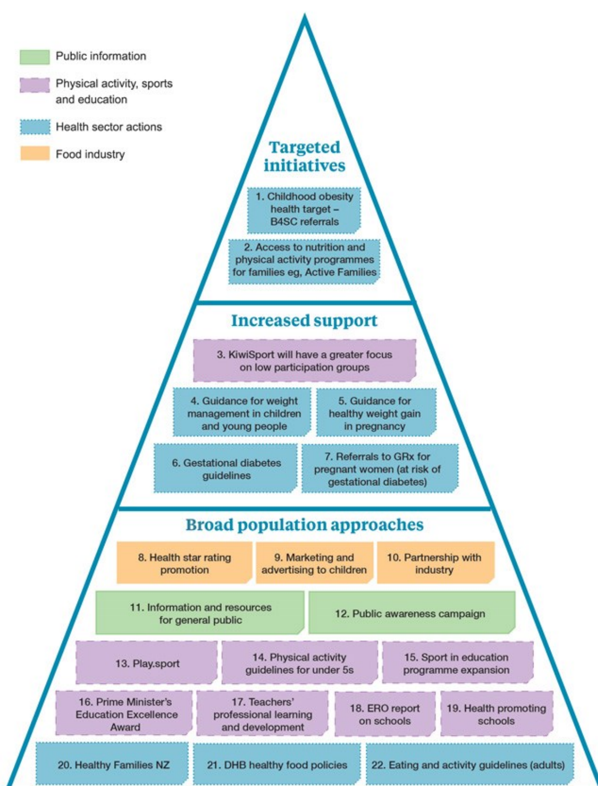
e. The effectiveness of existing policies and programs introduced by Australian governments to improve diets and prevent childhood obesity, and

f. Evidence-based measures and interventions to prevent and reverse childhood obesity, including experiences from overseas jurisdictions

Professional overview/supporting data:

The Australian Government has already addressed a national health and economic challenge in the form of tobacco use through the *National Tobacco Strategy 2012-2018*[11] so we have evidence that government can implement strong policy instruments to effect positive change in policy and practice.

There is currently no National Obesity Strategy in Australia. In 2017, Professor Talley (Chair of the Council of Presidents of Medical Colleges (CPMC) reported in the Medical Journal of Australia on a National Health Summit on Obesity call for government action: *National Health Summit on Obesity calls for Australia to take action to stem the pandemic*[12]. In that article Professor Talley not only noted that "it is urgent to put measures in place for the benefit of future generations" and notably referenced obesity as a pandemic.



New Zealand through its Ministry of Health (Manatu Hauora) launched its *Childhood Obesity Plan*[13] in 2015. The comprehensive plan is a collaborative plan supported by a number of national bodies including the Ministry of Education, Health Promotion Agency, and the Ministry for Primary Industries and Sport NZ. The plan comprises targeted initiatives, increased support, and broad population approaches (Figure 2), which in combination, it is hoped, will reduce prevalence of childhood obesity.

Canada through its Public Health Agency published their national framework *Curbing Childhood Obesity: A Federal, Provincial and Territorial Framework for Action to Promote Healthy Weights*[14] in 2011. The Canadian framework gives the Canadian Government and people three prioritised strategies:

1. Childhood obesity is to be a collective priority for action;
2. efforts to reduce childhood obesity will be coordinated; and
3. there will be measurement of progress and reporting of progress on the initiatives.

Figure 2: The childhood obesity plan (New Zealand Ministry of Health)[15]

Personal reflection: The Australian Government has, in the past 20 years driven change and regulation for the tobacco industry through the introduction of the National Tobacco Strategy[11]. This has reduced the prevalence of smoking in Australia and will have long-lasting positive health consequences. However there is no National Obesity Strategy.

The lack of an Australian National Obesity Strategy has not gone un-noticed. Natasha Robinson's ABC News' 2017 article *Australia 'running behind' in obesity prevention policy, health specialists say*[16] highlighted not only Renee and Zoe Gilbert's story of obesity from childhood and their perception that:

> "You can't get any help from the Government or the community, there needs to be more facilities and more support" *Renee Gilbert* (ABC News, 2017[16])

That story also highlighted the lack of coordinated national policy. Indeed the lack of national policy was labelled as "unacceptable". And I agree with that statement.

With other countries implementing national policies like the 2015 *New Zealand Ministry of Health's Childhood Obesity Plan*[13] and the 2011 *Canadian Framework for Action*[14], an Australian National Obesity Strategy is long overdue.

I don't think it would be inappropriate for these plans and frameworks, from our traditional closely allied partner Commonwealth countries, to be utilised as models for an Australian National Strategy on Obesity, or at least a strategy for childhood obesity.

With citizens like myself, and media and health experts calling for more to be done, it is time for the Australian Government to step up and help Australians move towards health and reduced adverse health and economic outcomes. If Professor Nicholas Talley and other leaders in obesity knowledge, research, and treatment in Australia are referencing our challenge as a PANDEMIC rather than an epidemic, then government should be paying attention (see *National Health Summit on Obesity calls for Australia to take action to stem the pandemic*[12]), and creation of a National Obesity Strategy should be more than a hope. It should be an inevitability, and I hope the members of the Select Committee into the Obesity Epidemic in Australia will, after reviewing the evidence provided to you in this inquiry, move forward with establishment of our Australian strategy.

g. The role of the food industry in contributing to poor diets and childhood obesity in Australia

Professional overview/supporting data:

Phillip Baker in his 2017 piece *Fat nation: the rise and fall of obesity on the political agenda* [17] acknowledged obesity as a challenge for Australian politicians. And, that major challenge was in the lobbying strength of industry groups who, like tobacco companies before them, have an inherent economic interest in maintaining the status quo.

The fragmented responsibility for public health; shared between local and federal government certainly does not facilitate cohesiveness to address the role of the food industry, however some local governments are concerned as evidenced by SUSTAIN the Australian Food Network and the Victorian Local Governance Association's guidance document *Food Systems and the Role of Local Government*[18] which identifies fast food outlets in low income districts in Melbourne as contributing to a rising incidence of diabetes in those areas.

The Australian Government, through the NHMRC provides clear guidelines for Australians on recommended daily intakes (RDIs), and this does include RDIs for children (Table 1[19]), however you will see in my personal reflection above, that the food industry advertisers may not be choosing to show these to their customers, and currently they are not required to. The *2011 Labelling Logic, Review of Food Labelling Law and Policy (2011)*[20] recommended that food labelling changes should be driven by consumers in the first place (section 2.2, page 32). It then went on to acknowledge that the food industry "demands to be as autonomous as practicable" (section 2.12, page 34). And finally, the role of government was identified as being critical, however the focus of the government's role was identified as being food SAFETY rather than nutrition (section 2.22, page 37).

Table 1: Nutrient Reference Values for Australia and New Zealand (NHMRC)[19]

Recommendations by life stage and gender

Infants and children

Table 1 - Estimated Energy Requirements (EER) of infants and young children

Age (months)	Reference weight (kg)		EER (kJ/day)	
	Boys	Girls	Boys	Girls
1	4.4	4.2	2,000	1,800
2	5.3	4.9	2,400	2,100
3	6.0	5.5	2,400	2,200
4	6.7	6.1	2,400	2,200
5	7.3	6.7	2,500	2,300
6	7.9	7.2	2,700	2,500
7	8.4	7.7	2,800	2,500
8	8.9	8.1	3,000	2,700
9	9.3	8.5	3,100	2,800
10	9.7	8.9	3,300	3,000
11	10.0	9.2	3,400	3,100
12	10.3	9.5	3,500	3,200
15	11.1	10.3	3,800	3,500
18	11.7	11.0	4,000	3,800

Personal reflection: The food industry in Australia is a strong market force with significant lobbying strength in Canberra. In order to maintain their relatively self-regulated industry, executives and marketers from that industry

continue to frame their industry as being threatened by any strong changes to food policy like a sugar tax. I believe that obesity, and childhood obesity in particular, is as significant a challenge for Australia as smoking was. It will require strong and measured government regulation on the food industry to curb the fast food industry's:

- Advertising to children,
- large portion sizes, and
- lack of clear nutritional labelling…

I believe that requiring food industry providers to publish the correct RDI range for the age-range they are advertising to would be a good step for government to take.

While some fast food chains do provide some nutritional value information on their signage already, it is mostly information that doesn't provide a total picture for the community. For example, below you can see a screen shot of the current advertising Boost Juice has on its website at June 2018[21] (Figure 3). This brightly coloured flyer has kilojoule counts for each drink and each size. However, the daily intake provided is the one for adults. The company could more appropriately have used a range for children 6 year to 12 years (low 2500 to high 3500kilojoules/day from the National Health and Medical Research Council (NHMRC) website here: https://www.nrv.gov.au/dietary-energy)[19]. The portion sizes at this chain are not insignificant and one shake could have the kilojoule count equivalent to an entire meal, particularly if the parent purchases their child an adult drink option, many of which exceed 1000kjs per portion served. I believe that requiring food industry providers to publish the correct RDI range for the age-range they are advertising to would be a good step for government.

Figure 3: BOOST Juice Kids' Menu – The nitty-gritty details https://www.boostjuice.com.au/wp-content/uploads/2017/06/kids_menu_nips.pdf (accessed 02 June 2018)[21]

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