

Submission No. 134  
(Inq into Obesity)

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**NSW Government Submission**

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To the  
**Parliament of Australia**  
**House of Representatives Standing Committee on Health and Ageing**

**Inquiry into Obesity in Australia**

## **CONTENTS**

<b>1. Introduction</b> .....	<b>3</b>
1.1 Terms of Reference of Inquiry.....	3
1.2 The NSW Government's Commitment to Overcoming Obesity .....	3
<b>2. Defining Overweight and Obesity</b> .....	<b>5</b>
<b>3. The increasing Prevalence of People who are Overweight/Obese</b> .....	<b>6</b>
<b>4. Implications of the Increasing Prevalence of Overweight &amp; Obesity</b> ..	<b>7</b>
4.1 Consequences of Overweight and Obesity on Australia's Health .....	7
4.2 Consequences of Overweight and Obesity on Australia's Health System .....	7
<b>5. Factors Contributing to Overweight and Obesity</b> .....	<b>9</b>
5.1 Individual Factors.....	9
5.2 Family Factors .....	9
5.3 Environmental Factors .....	9
5.4 Societal Factors .....	10
<b>6. Strategies to Address Obesity</b> .....	<b>12</b>
6.1 Disease Prevention and Health Promotion.....	13
6.2 Whole of Population and Targeted Approaches .....	13
6.3 High Risk Groups.....	15
6.4 Addressing Lifestyle Behaviours .....	15
6.5 Multiple Points of Intervention .....	16
6.6 Multi-Sectoral Collaboration, Investment and Leadership.....	19
6.7 Research, Evaluation, Monitoring, Training and Professional Development.....	23
<b>7. Recommendations</b> .....	<b>25</b>
<b>8. References</b> .....	<b>27</b>

## **1. INTRODUCTION**

### **1.1 Terms of Reference of Inquiry**

The Committee will 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.

### **1.2 The NSW Government's Commitment to Overcoming Obesity**

The NSW Government is committed to reducing current rates of adult and childhood obesity.

The NSW State Plan target, S3: Improved health through reduced obesity, smoking, illicit drug use and risk drinking, seeks to stop the growth in childhood obesity by holding childhood obesity at the 2004 level of 25% by 2010, then reduce levels to 22% by 2016.

For adulthood obesity, the NSW State Health Plan target, improve health through reduced obesity, smoking, illicit drug use and risk drinking, seeks to prevent the further increases in levels of adult obesity which are currently at 50%.

These are ambitious targets that require a comprehensive, inter-sectoral and collaborative approach if they are to be achieved. The NSW Government has several intersectoral mechanisms in place to facilitate achieving these targets. These include partnerships with a number of NSW agencies representing human services (Department of Health, Department of Community Services, Department of Education and Training, Department of Housing, and the NSW Cancer Institute) and infrastructure agencies including the Ministry of Transport, Department of Planning, and the Roads and Traffic Authority. The NSW Department of Premier and Cabinet, NSW Department of Local Government, NSW Department of the Arts, Sport and Recreation and Commission for Children and Young People are also represented.

The NSW Government was the first government in Australia to identify and respond to the need for a coordinated approach to obesity prevention. The NSW Childhood Obesity Summit held in 2002 and subsequent Government Action Plan on Obesity (2003 – 2007) provided the initial mechanism for raising community awareness and developing the platform for a coordinated cross-agency commitment to implementation of obesity prevention strategies. The summit identified 34 actions that a variety of NSW Government agencies agreed to implement to address the issue of obesity in children and young people.

A range of initiatives were developed as part of the NSW Government's Action Plan. These included the establishment of considerable research infrastructure at the University of Sydney (known as the NSW Centre for Overweight & Obesity); a mandatory healthy school canteen policy; increased financial support for key non government organisations such as the Healthy Kids School Canteen Association and the Australian Breastfeeding Association; a grants program for Local Government; and dissemination of information to the community, including the establishment of the website: [www.healthykids.nsw.gov.au](http://www.healthykids.nsw.gov.au).

In more recent years, the NSW Government has further increased its commitment to, and investment in, overweight and obesity prevention strategies. Within the Australian Better Health Initiative (ABHI) the NSW Government has committed \$20.1 million over a four-year period to the health promotion priorities 1 & 3. This commitment is linked to the NSW State Plan and NSW State Health Plan.

A key program under the auspices of the ABHI is the development, implementation and evaluation of a Diabetes Prevention Program. The purpose of this program is to develop, implement and evaluate community based diabetes prevention strategies including intensive lifestyle interventions for those at high risk. It is envisaged that this new program will reorient the way diabetes prevention is dealt with in NSW. The program will support and empower participants to make positive changes to their diet and increase their amount of exercise.

The NSW Government has developed the initiative 'Live Life Well'. It is a call to action that embraces many of NSW Health's activities that seek to promote healthier lifestyles and avoid ill health, rather than treating symptoms as they occur. 'Live Life Well' is about ensuring that people are able to access the right information at the right time, supporting their needs and assisting healthy informed choices about nutrition, physical activity, alcohol consumption, smoking, healthy weight and stress. These modifiable risk factors are the major causes of ill health in the NSW community, and hence are a priority for the NSW Government.

Within the 'Live Life Well' initiative, NSW Health has major commitments to implement programs to promote nutrition and physical activity and prevent obesity. Some of the programs include:

- The Good for Kids, Good for Life Program - Australia's largest ever childhood obesity prevention trial. It aims to prevent overweight and obesity in children from 0-15 years of age in the Hunter New England area and to build evidence for policy and practice related to the prevention of childhood obesity in NSW. The program brings together a variety of agencies, community groups and industry, including work with the Alliance of General Practitioners, to provide practical information, new programs and systems to help children, parents, carers and the wider community, know more about healthy weight, nutrition and physical activity.
- The Live Life Well@School initiative, which is a whole of schools approach to physical activity, healthy eating and sedentary activity program in NSW government primary schools targeting students 5 to 12 years of age. Live Life Well@School is a joint initiative between the Department of Health and the Department of Education and Training Curriculum K-12 Directorate.

This is only a snapshot of the work being done in NSW. The NSW Government is currently finalising an action plan for 2008 – 2011 which will provide a framework for integrated strategic action across government in partnership with other stakeholders, communities and individuals to prevent and reduce the prevalence of obesity, and ensure that people within NSW 'Live Life Well'. To build upon the considerable focus of activities within overweight and obesity prevention, the NSW Government is now also increasing its focus on the treatment and management of obesity, with a rollout of medical and surgical services planned over the next few years.

It must be recognised, however, that overweight and obesity prevention initiatives in NSW will always be influenced, and potentially limited, by national activity. To-date, there has been little coordinated national action, and consideration of very powerful levers for intervention including legislation, taxation and policy change.

The NSW Government welcomes the opportunity to work with the Australian Government to achieve the required change together.

## **2. DEFINING OVERWEIGHT AND OBESITY**

Overweight and obesity are defined as excessive body adiposity that is fat, to the extent to which it impacts on one's wellbeing (Caballero, 2007). For practical reasons, body weight has been used to indicate whether someone is overweight or obese, and is commonly calculated by Body Mass Index (BMI). Body Mass Index is calculated using height and weight measurement.

A BMI of between 18.5 and 25kg/ m<sup>2</sup> is considered to be in a 'healthy weight range'; a BMI of 25 to 29 overweight; and a BMI over 30 considered to indicate obesity (NSW Centre for Public Health Nutrition & NSW Department of Health, 2003).

Another method for identifying adults who are overweight or obese is a waist circumference measurement. This measurement gives an indication of the excessive body fat around the abdomen (central obesity), which is an indication of a greater risk of ill-health associated with obesity (Kumanyika, Jeffery, Morabia, Ritenbaugh, & Antipatisa, 2002). A waist circumference measurement for females of greater than or equal to 88cm, and a circumference of equal to or greater than 102 cm for males is considered at very high risk of poor health (NHMRC, 2001).

For children, calculating healthy weight is complicated by their development, as their height and weight are changing. Commonly a BMI-for-age is calculated by the 85th percentile being the cut off point for overweight and above the 5th percentile being the cut off point for being underweight (Gill, King, & Webb, 2005).

### **3. THE INCREASING PREVALENCE OF PEOPLE WHO ARE OVERWEIGHT/OBESE**

Overweight and obesity is recognised nationally and internationally as a serious rapidly increasing public health problem (Gill et al., 2005). In Australia, the life threatening non-communicable disease has reached epidemic proportions and is a major contributor to the burden of illness, disease and disability. Compared with other causes of chronic diseases, obesity now equals tobacco use and environmental tobacco smoke exposure as the most important and avoidable cause of ill-health in Australia (Commonwealth of Australia, 2003).

In 2005, 3.24 million Australians were estimated to be obese (Access Economics, 2006). In NSW in 2005, 49.9% of the population were classified as overweight or obese with more males (57.5%) than females (42.3%), (Population Health Survey, 2006).

Current rates of childhood obesity are also increasing sharply. This is a major concern. Across three Australian states - Victoria, NSW and South Australia between 1985 and 1997, there was evidence of a doubling of the prevalence of overweight and obesity for those aged 7 to 15, with the prevalence of overweight alone having increased approximately 60 to 70% and obesity rates having trebled (Booth et al., 2003). In NSW, almost a quarter of school students aged 5 to 16 are overweight or obese, with 25% of boys and 23.3% of girls being either overweight or obese (Booth et al. 2006).

The rapidly rising prevalence of obesity in children, young people and adults is a challenge. If rates of obesity continue to increase at historical rates, there may be as many as 7.2 million obese Australians by 2025 (Access Economics, 2006). This would pose a significant threat to Australian health systems.

Although obesity is affecting the whole community, the incidence of overweight and obesity is disproportionate among socially and economically disadvantaged groups, some culturally and linguistically diverse groups, Aboriginal people and isolated individuals (Gill et al., 2005).

Also, some studies (De, Small, & Baur, in press; Patradoon-Ho, Scheinberg, & Baur, 2005) have shown that children and young people with acquired brain injuries or developmental disabilities are more likely to be overweight and obese than the general population of children. This poses increased challenges for these children and their families as they learn to live with their disabilities.

## **4. IMPLICATIONS OF THE INCREASING PREVALENCE OF OVERWEIGHT AND OBESITY**

### **4.1 Consequences of Overweight and Obesity on Australian's Health**

Being overweight or obese substantially reduces one's quality of life and increases risk of both acute health problems and the chronic diseases that account for a high proportion of illness, disability and premature death (Gill et al., 2005). The risk of developing health problems is not limited to adults. Children and young people who are overweight have a high risk of developing similar physical and psychosocial problems. For example, being overweight is a primary risk factor for Type 2 diabetes. The prevalence of Type 2 diabetes is growing rapidly. It is estimated that nearly one in four Australian adults have impaired glucose metabolism or diabetes (Bellew, 2005). Disappointingly, once unrecognisable in young people, the prevalence of Type 2 diabetes in adolescents is also growing (Ebbeling, Pawiak & Ludwig, 2002).

Excessive body fat, particularly around the abdomen, increases the risk of developing physical as well as psychosocial health problems such as:

- Raised blood pressure;
- High cholesterol;
- Elevated blood sugar;
- Clinical depression;
- Lowered self-esteem; and
- Job discrimination and other forms of social stigmatisation and stereotypes.

These can subsequently lead to a variety of conditions such as:

- Cardiovascular disease / Stroke;
- Type 2 diabetes;
- Orthopaedic problems due to excess weight bearing on joints;
- Sleep apnoea;
- Asthma and other respiratory difficulties;
- Fatty liver disease;
- Hyper tension;
- Some cancers;
- Gall bladder disease;
- Infertility; and
- Skin conditions. (Ebbeling et al., 2002; Kumanyika et al., 2002).

An additional concern is that people who are obese can take longer to recover from illness or surgery due to poor health.

The high risk of persistence of childhood obesity and its associated health risks into adulthood are a cause for concern. Young people who are overweight or obese have a 25 to 50% chance of progressing to be overweight adults. This rate may increase to as much as 78% in older obese adolescents (Must, & Strauss, 1999).

### **4.2 Consequences of Overweight and Obesity on Australia's Health System**

Overweight and its associated illnesses is a huge financial burden for Government. These include direct costs to the Australian health system, through increased health care costs and increased demand on health care services, and other financial costs including productivity losses, carer costs, foregone taxation revenue, welfare payments, and other costs such as aids and equipment (Access Economics, 2006; Gill et al., 2005).

Taking into account the financial costs alone, Access Economics (2006) estimates that the cost of obesity in 2005 was \$3.767 billion. If non-financial cost such as lost wellbeing are added, an additional \$17.2 billion, the total cost of obesity in 2005 was \$21.0 billion.

Health services are finding the need to provide appropriate hospital accommodation for bariatric patients - for example a larger wheelchair, a designated bariatric room fitted with a larger bed and a hoist for assistance with transfers and personal care. These services will be required to cope with the increase in overweight and obese patients. This may also place staff at risk of injury when transferring or lifting patients.

As discussed by Bellew (2005), ambulatory care sensitive conditions, those for which hospitalisation is considered potentially avoidable through prevention, accounted for more than half (51%) of all ambulatory care sensitive hospitalisations in NSW for the period 2001/02 to 2003/04. The ambulatory care sensitive conditions include diabetes complications, angina, and asthma; conditions which overweight / obesity can increase the risk of their development. Diabetes complications alone accounted for the largest total number of bed days among all ambulatory care sensitive conditions (99,336 hospital separations between 2000/01 to 2002/03 combined and a prevalence rate of 487 per 100,000 population).

If a cultural change across Australia does not occur emphasising the benefits of preventing chronic diseases, it is projected that treatment costs alone for people with diabetes, cardiovascular disease, cancers and musculoskeletal conditions will increase from approximately \$3.3 billion in 2000/01 to \$6.1 billion by 2020/21 (Bellew, 2005).



## **5. FACTORS CONTRIBUTING TO OVERWEIGHT AND OBESITY**

Obesity is reflective of a number of social determinants of health that warrant consideration. Obesity should be properly addressed, but not in isolation from other factors. Overweight and obesity are caused by numerous social and environmental factors which influence people's energy intake and energy expenditure. Once an individual is overweight or obese, reversing the energy balance to restore a healthy weight is a significant challenge. Four key areas which contribute to the development overweight and obesity include:

1. individual factors;
2. family factors;
3. the built environment; and
4. societal factors.

### **5.1 Individual Factors**

#### *Energy intake and expenditure*

Weight gain and obesity develops from a sustained period of energy imbalance where energy intake from drink and food exceeds energy expenditure from physical activity and other metabolic processes. The community norm is more energy taken in than expended. The cumulative effects of lifestyle changes have promoted greater intake of energy dense nutrient poor (EDNP) foods and a decrease in energy from an increased in sedentary pastimes and a decrease in physical activity.

People are including in their diets more foods and drinks that are high in fat, sugar and energy. For example, the average energy intake increased for Australian young people aged 10 to 15 by over 10% between 1985 and 1995 (Cook, Rutishauser & Seeling, 2001 cited in NSW Department of Health, 2003).

Reasons which have been attributed to an increase in sedentary pastimes and a decrease in physical activity include a decrease in physically demanding work; an increase in technology and appliances in the home; increase in reliance on car transportation; and an increase in passive leisure activities such as watching television or playing computer games (Kumanyika et al., 2002). It has been thought that many of these activities have displaced physical activity.

### **5.2 Family Factors**

The family environment is a primary source of influence on children and young people. Children and young people have little direct control over food and activity choices until they get older. In order to address weight gain behaviours and obesity in young people, the needs of young people as well as parents / carers and the family's needs must be supported. The most salient features of the family environment that impact and increase the risk of young person gaining weight include the increased trend of eating out; greater access to passive activities such as television watching and playing games, particularly during meal times; and neglect (Ebbeling et al., 2002).

### **5.3 Environmental Factors**

A range of settings such as the home, educational institutions, workplaces, the built environment (encompassing all buildings, spaces and products modified by people (Srinivasan, 2003)), and social and cultural structures such as legislation, policy, and advertising all play critical roles in shaping people's lives. These settings subsequently impact on health and

behaviours, either hindering or supporting healthy dietary and activity behaviours (Gill et al., 2005). Each of these factors contribute to the creation of 'obesogenic environments' defined as, "the sum of influences that the surroundings, opportunities, or conditions of life have on promoting obesity in individuals or populations" (Swinburn, Egger, & Raza, 1999, p.563). Obesogenic environments make unhealthy choices the easier and/or more affordable choice.

#### *Settings and the Built Environment*

Modifying places in which people live can influence their choices. For example, workplace policies that support people walking, cycling or using public transport can support physical activity. In the built environment, factors such as the neighbourhood layout, how safe people view their neighbourhood to be, access to public open space, public transport and food outlets, can encourage or discourage people from being active and making appropriate food choices (Gill et al., 2005). For example, adults who perceive their neighbourhood as unsafe are less likely to engage in physical activity than other people (Jackson & Kocktiitsky, 2001). Therefore, parents living in areas perceived as unsafe may limit their children's physical activity by not allowing them to play outside or, walk/cycle to school. Lower physical activity levels in young people aged 11 to 16 were found in neighbourhoods with lower levels of perceived safety (Oliver & Hayes, 2005).

Another determinant of physical activity is whether community infrastructure and public spaces facilitate activity. Infrastructure can include sports grounds, playgrounds, skate parks, bike paths and public open space. When suitable infrastructure does not exist, is poorly maintained, or is perceived to be unsafe, people are less likely to be physically active, particularly young people and women (Transportation Research Board, 2005). Even when infrastructure is available, it can be inaccessible for those without private transport or participation fees may be too expensive.

#### **5.4 Societal Factors**

Social and cultural structures such as legislation and policy across many sectors, advertising and access to appropriate food choices and dietary information can influence food selection. In Australia, industry, supported by large profits, is able to advertise products that promote and reinforce 'obesogenic' behaviours (Gill et al., 2005). Competing against industry to motivate healthy choices is challenging.

The International Obesity Taskforce (IOTF) developed the following diagram [Figure 1], to demonstrate the level of complexity and wide range of societal causal factors giving rise to obesogenic environments and the population outcomes in terms of overweight and obesity that can result.

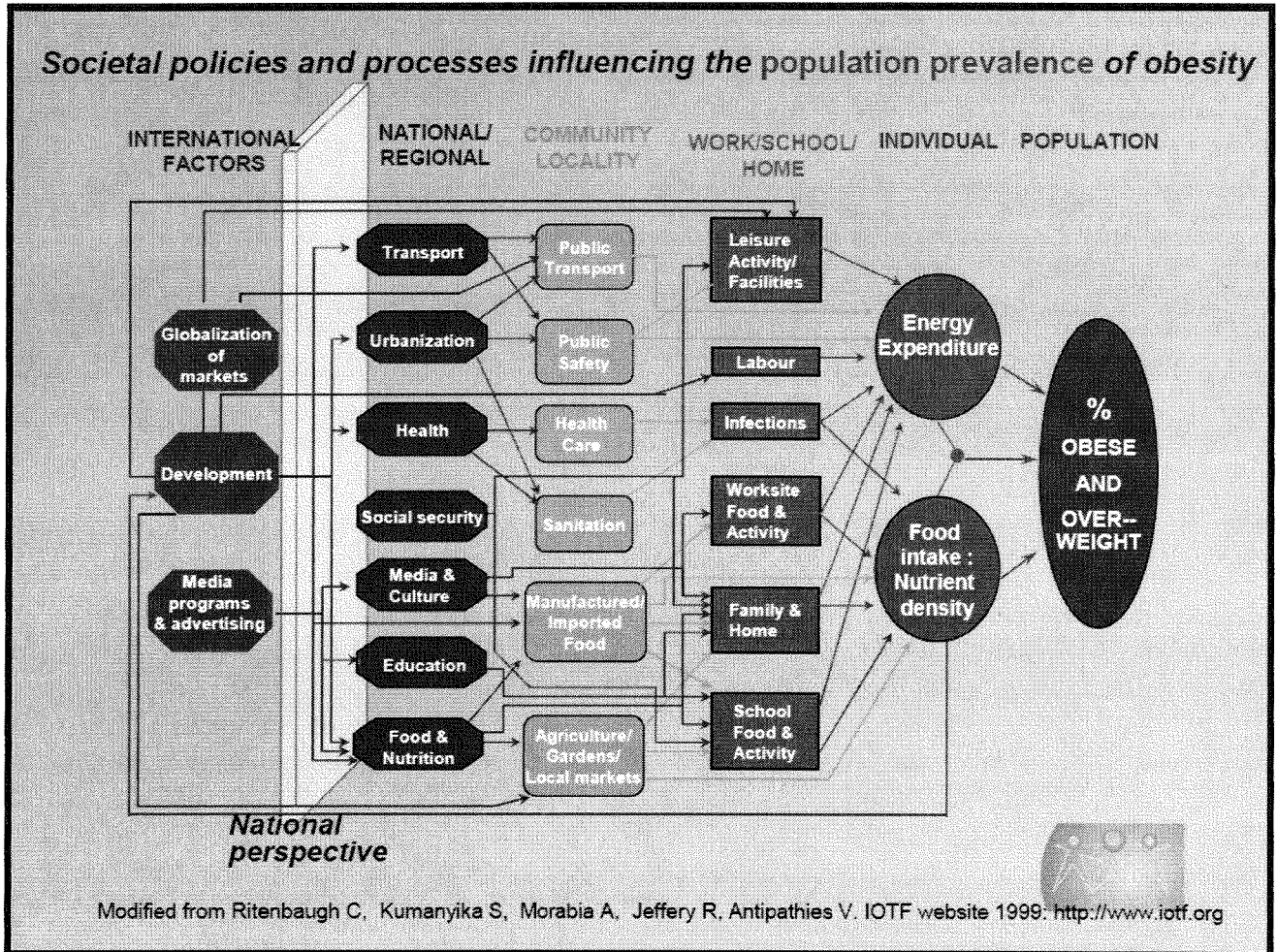


Figure 1: Factors that directly and indirectly influence the prevalence of overweight and obesity (James, 1999)

## 6. STRATEGIES TO ADDRESS OBESITY

Any approach to addressing obesity must be underpinned by action based principles.

The following principles draw on evidence and recommendations from the IOTF and the Ottawa Charter of Health Promotion (WHO, 1986).

- ***Disease Prevention and Health Promotion***

Primarily, policies, programs and projects must be prevention focused. Any approach should be sustainable and, where possible, build on existing theory, evidence and existing initiatives. Untried yet promising innovative strategies should be given due consideration.

A priority must be placed on the prevention and management of overweight and obesity in children and young people.

- ***Whole of Population and Targeted Approaches***

All parts of the community must be reached, not just individuals who are already motivated to be healthy. Targeted approaches will need to be used to support populations who may have additional needs.

- ***Address Lifestyle Behaviours***

Changes to dietary and activity habits must both be addressed to influence energy imbalance.

- ***Multiple Points of Intervention***

Education alone is not sufficient to change behaviours. Strategies must be comprehensive including individual, environmental and societal interventions to promote and support behaviour change.

- ***Inter-sectoral collaboration, investment and leadership***

Political support, whole of government collaboration, whole of community participation are essential for success. Policies and programs must be resourced. Acting locally in national initiatives, allows programmes to be tailored to meet local needs, expectations and opportunities.

- ***Research, Evaluation, Monitoring and Organisational Change***

Programs should be properly monitored, evaluated and documented. This is important for dissemination and transfer of experiences.

## 6.1 Disease Prevention and Health Promotion

The NSW Government recognises the need to ensure the health of all members of our population is achieved by making prevention everybody's business. As outlined in the NSW State Plan (2006), there is sound evidence to support the need for greater investment in disease prevention and health promotion. Wellbeing is influenced by a complex interplay of individual, environmental and socioeconomic factors, and the best outcomes are often achieved when such determinants are actively managed at an early stage.

Widespread investment in effective and affordable prevention programs can bring benefits in financial terms such as reduced medical care costs, greater sustainability of health care systems, but more importantly in non-financial benefits such as saving lives and improved health outcomes, providing value for money (Bellew, 2005). Applied Economics (2003) evaluated the returns from prevention strategies for tobacco consumption, coronary heart disease, immunisation programs, HIV/AIDS, and road trauma programs. The studies showed high rates of return to these prevention programs.

There are several important reasons to address the prevention of obesity, rather than a sole focus on treatment and/or management. Weight gain and subsequent obesity develops over time and once established it is difficult to treat. With approximately 50% of the population overweight or obese, treatment would be quite expensive. Maintaining a healthy weight or preventing weight gain is likely to be less expensive, and potentially a more effective means of controlling obesity since the cumulative effect of health consequences associated with being overweight may not be completely reversible through weight loss (Gill et al. 2005).

With these reasons in mind, the focus of public expenditure and policy initiatives should be primarily on the prevention of overweight and obesity in children and young people and the maintenance of weight (or prevention of further weight gain) in adults. Significant investment in whole-of-government prevention and early intervention strategies, such as Families NSW, is based on the premise that the first few years of a child's development are crucial for setting the foundation for lifelong learning, behaviours and health outcomes. A primary focus on preventing weight gain in adults is a simple message of relevance to all adults in NSW, regardless of current weight status.

Obesity prevention is a process of social change. Australia has the opportunity to lead efforts on addressing overweight/obesity. Any target will only be achieved through full implementation and full resourcing.

Currently, low levels of investment are devoted to prevention and health promotion. For example, in 2005-2006 total public health expenditure in Australia was \$1,467.9 million accounting for only 1.8% of the total recurrent health expenditure (AIHW, 2007).

## 6.2 Whole of Population and Targeted Approaches

Public health obesity prevention effort should focus on the entire population. All parts of the community must be reached – not just the motivated healthy.

Energy must be focused on specific target groups such as families and children or individuals at increased risk of overweight or obesity as they might require additional supports or have additional needs to the general population. Health gains realised over the past several decades have not been equally shared across the entire population. There remains a health 'gap' between those people with the best and poorest health. This gap has profound implications for health outcomes for some of the most vulnerable groups in the community, including children and young people.

Strategies should be tailored to address vulnerable populations' specific needs. This will require skills in working with different population groups and also greater investment into targeted approaches. Working collaboratively with 'health influencing' agencies such as the Department of Education will promote a greater consideration of the factors that lie outside the health sectors control, that is, the social determinants of health and health inequities.

Strategies must be equitable, acknowledging and accommodating diversity and ensuring due consideration to the different needs of particular groups. Targeted approaches should include the following populations:

### **6.2.1 Children and Young People in the Context of their Families and Communities**

Children and young people must be the focus of any obesity strategy. A population health approach requires that strategies target children and young people in the context of their families and communities. Current evidence shows that in children and young people, dietary and physical activity behaviours can be changed in a positive manner, with prevention strategies having a greater chance of success (Gill et al., 2005).

#### *Children 0-5 years*

The importance of supporting development and learning during the early years of a child's life has become a fundamental prevention and early intervention strategy within health and community service settings. The development of movement skills and requirements for good nutrition to enable growth and development make the pre-school years an important target group. The pre-school years are also a significant focus for food marketing and promotion because of the effectiveness of 'pester-power' and exposure to TV.

#### *Children 5-12 years*

Children aged 5-7 years are at particular risk of weight gain as during this age body mass index begins to rise rapidly after lower rates during early childhood. Research indicates that early and rapid weight rebound often precedes the development of obesity (Gill et al., 2005). Children of primary school age may be exposed to peer-group preferences and independent eating situations. The impacts of marketing and promotion of food is of particular concern for this age group.

#### *Young people 13 -18 years*

Adolescence brings challenges of many kinds, not least a risk of overweight and obesity which stems in part from increased autonomy in relation to food purchases and consumption, ad-hoc meal times and changes in leisure activities, particularly the type and amount of organised physical activity (Gill et al., 2005). Young women tend to lay down fat deposits during this time as a result of puberty and hormonal changes. Evidence also suggests that young women are more likely to drop out of physical activities and sport as they enter adolescence, particularly if they lack proficiency in fundamental movement skills. The latest research has found rates of obesity among young men were increasing while rates for young women were stable (Booth et al., 2006). Further research identifies the concerning trend that rates of disordered eating behaviours and eating disorders had increased among adolescent girls. Healthy weight messages need to sensitively target this age group.

### 6.3 High Risk Groups

In addition to children, young people and families, a number of groups have been identified which warrant special consideration due to their higher risk of developing overweight and obesity (NSW Centre for Public Health Nutrition, 2003).

#### *Aboriginal and Torres Strait Islander People*

The 2004-2005 National Aboriginal and Torres Strait Islander Health Survey (NATSIHS) found that obesity is an increasing problem in the Indigenous population with levels of overweight and obesity increasing among Indigenous peoples living in non-remote areas from 48% in 1995 to 58% in 2004-2005 (ABS, 2006). Strategies responding to overweight and obesity in Indigenous communities have highlighted the importance of working with Indigenous leaders and providing education to parents and children.

#### *Pregnant women and lactating women*

While still in utero, children are at risk of overweight and obesity. Emerging research indicates that in-utero development has permanent effects on later growth and energy regulation. Pregnant women who stop breastfeeding early, and do not regain a pre-pregnancy healthy weight are likely to continue the trend of weight gain with each new pregnancy (Gill et al., 2005).

#### *Socially or economically disadvantaged and isolated communities*

Research indicates that rates of obesity are higher in communities experiencing isolation, social or economic disadvantage (AIHW: O'Brien, & Webbie, 2003). In a recent study by the Cancer Council NSW (2007), people in isolated communities and from lower socioeconomic populations had fewer fruit and vegetable varieties available, suggesting an impact on consumption levels. Similarly, studies across Australia, as cited by The Cancer Council NSW (2007), have demonstrated that the cost of healthy food is significantly higher in rural areas than metropolitan areas and with the increase in distance from metropolitan regions parallels the decline in quality and variety of fruit and vegetables.

#### *Specific cultural groups*

Particular cultural groups have been found to be at additional risk of overweight and obesity. For example, recent migrants from the Middle East and southern Mediterranean countries are more likely to be obese, with their children more likely to develop a more severe form of obesity (Gill et al., 2005). Another group of particular concern is the newly arrived refugee population. Information and education for this group is essential. Little access to health services, no nutritional advice and cultural factors put these communities at greater risk of obesity and related health affects. Therefore, obesity prevention responses must accommodate individual and cultural difference and diversity.

### 6.4 Addressing Lifestyle Behaviours

Obesity is the outcome of an energy imbalance. As individuals are consuming more energy through food and drink than expending, strategies need to be put in place to allow people to make healthy choices and restore a balance in energy consumption and expenditure.

There is convincing evidence to support that the maintenance of healthy weight can be facilitated through individual preferences for 'healthy choices' across six key behavioural areas:

- 1) *Reducing the intake of high energy dense nutrient poor foods (ie foods high in fat/sugar)*

- 2) *Increasing the intake of fresh vegetables and fruits.* Linked to the previous behaviours, increasing intake of fruit and vegetables is identified in the literature as a 'protective' factor, particularly if this becomes a part of a child's diet from an early age (0-5 years).
- 3) *Reducing the consumption of sugar-sweetened beverages.* The increased consumption of sugar-sweetened beverages (soft drinks, cordials and flavoured milks and fruit juices) as an alternative to water has a clear link with high daily energy intake.
- 4) *Increasing incidental activity.* Changes in the way we work as well as increased reliance on the car as the key transport mode cumulatively have a negative impact on our energy expenditure. While most effective in helping to restore the energy balance, rather than reverse it (for weight loss) increasing the amount we walk and engaging in incidental activity is essential if population weight gain is to be managed in the future.
- 5) *Increase regular physical activity, in particular, moderate to vigorous physical activity.* Engaging in moderate to vigorous physical activity provides a range of benefits which include increased levels of fitness, mental wellbeing and opportunities to participate in the community, as well as providing a prime opportunity for energy expenditure.
- 6) *Reduced sedentary behaviours such as television and small screen time.* Children and young people spend a large amount of time in front of the TV, computer or using other small screen devices (Booth et al., 2006), limiting their involvement in organised or other incidental activity.

However, to facilitate behaviour change across these areas, environmental obstacles need to be significantly reduced.

## **6.5 Multiple Points of Intervention**

There is no single strategy that stands out against all others as the key to turning back the obesity epidemic. Reducing rates will require multiple sustainable strategies across multiple agencies. Since wellbeing is influenced by many factors, focusing on people's behaviour within the context of the settings, the built environment and the social and cultural norms in which they live, will be necessary to improve the health of a population. In addition, because of the large number of affected people, provision of affordable and effective treatment services is also required.

### **6.5.1 Settings based approach**

Obesity prevention strategies need to appeal to individuals in the context of the environments they live. A setting based approach develops strategies around the contexts in which people live. It is a mechanism which can reach specific target populations, influencing individual's choices (Gill et al., 2005). For example, if one's workplace or schools has a policy which supports active transport, then this can influence one's commitment to regular physical activity.

Research has indicated that engaging with particular settings will have the greatest impact on obesity. These settings include: Homes and Communities; Healthcare Environment; Schools; Childcare and Children's Services; and the Urban Environment.

#### *Home and Communities*

Families and communities are key target groups, but also provide a setting to target obesity prevention strategies. While families can not directly protect children against an obesogenic



environment, they can moderate it, through monitoring sedentary small screen behaviours, providing healthy meal choices and opportunities for physical activity (Gill et al., 2005). As recognised by the United Nations, for full development, young people should be able to grow up in a family environment of happiness, love and understanding (Office of the High Commissioner for Human Rights, 1989).

Support needs to be provided to those within the young person's environment to ensure this occurs. Particularly for addressing childhood obesity, interventions that have shown success have required significant parental involvement (Ebbeling et al., 2002).

There are a number of key behaviours that can be targeted within a family setting that influence obesity. For example families who are supportive of their children participating in physical activity are more active (Sallis, Prochaska, Taylor, Hill, & Geraci, 1999); and parental/carer attitudes, beliefs and behaviours are amongst some of the strongest influences on children and young people's dietary and activity behaviour.

Using role modelling as an example, research has shown that parental health status and their behaviours can have a direct influence on the current and future lifestyle patterns of their child. For example parental obesity can increase the risk of adult obesity among their children (Whitaker et al. 1997); and young people may not be inclined to participate in physical activity if their parents are not modelling healthy lifestyle behaviours themselves (AIHW, 2005). Therefore, developing parent/carer skills is necessary to assist in modelling healthy behaviour.

#### *Healthcare Settings, Early Childhood Health Services, General Practitioners (GPs) and Allied Health Services*

Healthcare settings such as early childhood services, GPs and allied health services have a role in supporting obesity prevention through education, screening and treatment. These services have a wide distribution across communities and extensive existing networks and can provide an ideal setting for "opportunistic" screening of individuals for obesity risks.

The numbers and distribution of GPs throughout communities provides a potentially large and effective resource for targeting intervention strategies. Prevention and early intervention can include 'brief interventions' – a preventative strategy compatible with short consultations as already used effectively in smoking prevention. This can include a referral to specific weight control or weight management programs.

GP and the hospital setting also provide a good setting to identify and manage young people's weight issues. In the 2002-2006 Australia wide survey of over 42,000 children aged 2-17 years attending general practice, only 0.5% of children were managed for overweight or obesity, even though 30% overall were affected (Cretikos, Valento, Britt, & Baur, 2008).

However, within the hospital setting, a recently completed audit of tertiary paediatric health care institutions within Australia has shown that only three states have specific tertiary level services for obese paediatric patients, with an average waiting time of 5 months for an appointment (Spilchak, Denney-Wilson, King & Baur (2007). There seems to be unmet demand in every state for tertiary level obesity services.

Allied health services which include dieticians, psychologists and exercise physiologists are also important stakeholders to engage.

Early childhood health services and child and family health services can offer clinical, group and community programs targeted at childhood and parental weight issues. It has been demonstrated consistently that individuals who receive a healthy start in life, enjoy significant long-term physical, mental and emotional health benefits. The Healthy Kids Check, a family

policy initiative of the Australian Government, demonstrates a significant step towards investing in children's wellbeing and subsequently their future adult health.

This is a new initiative to provide all four year olds with a health check comprising height, weight, eyesight and hearing tests. The check will be linked to the immunisation schedule for four year olds and be conducted by GPs, practice nurses and immunisation providers. The Healthy Kids Check is expected to benefit 250,000 four year olds each year, prior to commencing school. NSW Health understands that the Healthy Kids Check will be provided through a Medicare rebate.

To ensure this initiative is effective, parents and carers will need to be supported as part of the Healthy Kids Checks. It is understood that when a child is assessed under the Healthy Kids Checks, parents or carers will receive a Healthy Habits for Life Guide to provide information about establishing healthy patterns. However, the provision of a "Guide" may not be sufficient, and hence consideration needs to be given to the provision of more intensive support.

It is recognised that while identification is an important step, resources must be provided, particularly to General Practitioners, to support the treatment of individual children who are identified. Likewise, health problems such as obesity are as much a societal concern as an individuals concern. Therefore, the Healthy Kids Checks need to be complemented with changes to people's communities to provide opportunities for enable children and parents to make behavioural changes and live life well.

### *Schools*

Available evidence strongly supports school settings as one focus for obesity prevention initiatives. Through the curriculum, schools can educate and raise awareness around the causes of obesity as well as prevention strategies. This setting is often a source of information for families through the schools regular communication with parents via newsletters and teacher contact. School canteens are also a source of food, hence ensuring nutritious food is available is essential. Sport and physical education are mandatory in NSW public schools and this provides an opportunity to develop skills and establish positive physical activity behaviours.

### *Childcare and Children's Services*

A significant number of children and young people spend time in early childhood and prior-to-school settings on a regular basis. In Australia 40% of children aged 0-5 years attend formal non-familial care each week with average attendances ranging from approximately 9 to 18 hours per week (SCRGSP, 2007). Early childhood settings have been identified for their value as a health promotion setting for a range of prevention and early intervention initiatives. This setting is critical because of the evidence that obesity during childhood is likely to be maintained through to adulthood. Early childhood settings offer opportunities to provide education to parents, share nutritional recipes and role model activities that help manage the 'energy balance'.

### *Urban Environment*

Urban environments include the neighbourhoods and communities in which we live. They provide a range of opportunities to influence behaviours that align with obesity prevention objectives, for instance integrating urban development and public transport planning which can promote incidental exercise, thereby making healthy choices 'easier' and more appealing. There are many urban environment factors which seem to contribute to activity levels in the community including street design, density of housing and facilities, public transport accessibility, aesthetics of the surrounds, safety, cycling and walking facilities (Bauman, Bellew, Vita, Brown, & Owen, 2002).

### *Commercial and retail food outlets*

Even dietary intake can be impacted upon by the built environment. Commercial and food outlets are key obesity prevention settings because they can influence the food choices. They are also sites for food promotion and advertising. Commercial and retail outlets are being frequented more often as shopping increasingly becomes a social activity. The type, density and the location of food outlets available within a neighbourhood, in addition to the level of access, influence purchasing behaviour (Gill et al., 2005).

### *Sport and Recreation Organisations and Programs*

The NSW Government supports a range of sport and recreation facilities including camps, programs and parks. These settings already provide valuable opportunities for physical activity but may provide further opportunity for raising awareness and achieving change around other obesity related behaviours. This may involve working with community-based sporting clubs and parents who volunteer as coaches for sporting activities across the state. Ensuring that these facilities are accessible will also be necessary to increase activity levels (Gill et al., 2005).

### *Community organisations and facilities*

Community organisations provide a range of services to target groups identified at risk of overweight and obesity. Organisations and the facilities in which they deliver services can be used to reinforce obesity prevention messages and promote activity and nutrition.

#### *Workplaces*

Workplaces are useful target areas for implementing obesity prevention programs. Workplaces strongly support occupational health and safety procedures but can also support healthy workplace policies; recruitment of staff into health programs; effectively communicate information; and provide social support and facilities for behavioural changes such as healthy eating and increased exercise. Like schools, workplaces can encourage travel to work by public transport, walking and cycling by providing the necessary information on available travel choices to employees and visitors and providing end-of-trip facilities, such as showers, change rooms and bicycle parking.

#### *Information and Communication Technology*

There is growing evidence that information and communication technology can be effective in changing behaviour (Kroeze, Werkman, & Brug, 2006). The process of computer tailoring has been likened to personal counselling in that participants are assessed, the results of which are then used to generate feedback and advice that is individualised (Brug, Oenema, Kroeze, & Raat, 2005).

Computer tailored interventions can be delivered in many ways, for example, through interactive technology or desktop applications such as websites, email and CD-ROM programs, or mobile devices such as mobile phones and handheld computers (Norman et al, 2007).

Computer tailoring is a promising health education strategy. There are a number of benefits in the application of this technology, particularly in the promotion of physical activity and nutrition. Firstly, it enables the health information received by the participant to be personalised, without the high cost of interpersonal counselling. The feedback and advice received by the participant is individualised and relevant to their performance levels, awareness, motivation, goals, expectations and self-efficacy. Perceived personal relevance, feedback, interactivity and the tailoring of strategies to explicit goals, all of which are possible in computer tailored health interventions, have been shown to contribute to the effectiveness of nutrition and physical activity education (Kroeze et al, 2006). Secondly, it has potential for wide distribution at low cost due to its application to both print (Marcus et al, 1998) and electronic non-print media such as

the World Wide Web. Thirdly, self-assessment is easy and valid in computer tailoring and the participant's performance can be compared to recommendations and the performance of anonymous peers (Kroeze et al, 2006; Marcus et al, 1998).

### *Media*

The media is a key setting for reducing the promotion of energy dense and nutrient poor foods and beverages. Obesity is receiving increasing media coverage and this provides an opportunity to initiate well targeted social marketing campaigns through visual, print and online media. It is clear that advertising influences children's food preferences, diet and health. Children are vulnerable to commercial promotion because they generally do not understand the difference between information and advertising. The restriction of television advertising of energy dense and nutritionally poor products to children is a key element of any approach to addressing childhood obesity.

A substantial body of research indicates that the current 'broadcast diet' promotes the consumption of energy dense, nutrient poor foods and drink and contributes to childhood obesity. A study (Kelly, Smith, King, & Bauman, 2007) which assessed advertising on the three commercial television stations in Sydney over a one week period, based on a very conservative estimate on one hour television per day, found that children were exposed to 96 food advertisements per week including 63 for energy dense nutrient poor foods.

The study also showed that advertisements for energy dense nutrient poor food are broadcast more frequently during children's scheduled viewing hours (as defined by the current children's television standards) than at other times: 49% of all food advertising broadcast during children's viewing periods was for energy dense nutrient poor foods, compared to 39% during adult viewing times (CFAC, 2007). Only 4.6% of total food advertisements during children's viewing periods were for fruit and vegetables. According to the overall body of research in Australia, energy dense nutrient poor foods are the subject of between 55-81% of food advertisements broadcast during children's viewing hours (CFAC, 2006).

The restriction of television advertising is seen at an international level as a necessary obesity strategy. The 60<sup>th</sup> World Health Assembly on 23 May 2008 adopted resolution WHA60.23 (WHO, 2007) urging member states to promote the responsible marketing of foods and non-alcoholic beverages to children, to reduce the impact of foods high in saturated fats, trans-fatty acids, free sugars and salt.

A majority of parents also support this strategy with the Coalition on Food Advertising to Children (CFAC) releasing results of a community attitudes survey, which found that almost 90% of the 400 parents surveyed supported a ban on junk-food advertising at times when children watch TV (CFAC, 2007).

## **6.6 Multi-Sectoral Collaboration, Investment and Leadership**

The causes of obesity are complex, inter-related and pervasive, hence an integrated approach to developing strategies must be taken. There is a need for leadership in actioning the principle 'prevention is better than cure'.

Many factors that affect people's health lie outside the control of the health sector. If strategies are contained within the health system only, there will be limited impact. While changes in health care delivery, health promotion campaigns, and school education programs are all important strategies for addressing the situation, there is clear evidence that they are not addressing the core issue. For example, if it is important for people's wellbeing that they are

more active in all areas of their lives, behavioural change across all areas of their lives is needed. What is needed is the creation of built environments and the implementation of social policies that enable all community members to live healthy active lives. To achieve this objective, policies from agencies other than Health need to be influenced.

Reducing rates of obesity nationally therefore, requires leadership, shared responsibility and commitment, investment and collaboration across all three levels of government, as well as with corporate industry sector, the non-government sector, and community groups.

### **6.6.1 Government**

Challengingly, there are mixed views across all levels of government as to the extent to which obesity prevention should be a priority for all agencies. A whole of government approach will only be able to drive change around obesity through partnership and collaboration. This will require a significant reprioritisation, investment and improved partnerships at all levels.

#### *Australian Government*

The Australian Government holds significant levers in relation to preventing obesity, such as food labelling; taxation (including the potential for taxing energy dense nutrient poor foods, and providing a tax deduction on sport participation and/or sporting equipment); engaging with GPs; and regulating the promotion and marketing of energy dense nutrient poor foods and beverages to children.

For example the Chronic Disease Medicare items on the Medicare Benefits Schedule enable GPs to manage the health care of patients with chronic medical conditions, including patients who need multidisciplinary care. This approach provides funding for two levels of care planning: GP managed care via GP Management Plans and Team based care via Team Care Arrangements for chronic and complex conditions. These approaches, whilst supportive of most chronic diseases, do not regard obesity as a chronic medical condition in its own right under the schedule. Neither a GP Management Plans nor Team Care Arrangements Medicare Benefits Schedule item can be claimed for a patient suffering with obesity alone. An additional challenge with the existing system is that the Medical Benefits Schedule items that could be used to subsidise treatment of people with obesity are available to GPs, Practice Nurses, and Allied Health Professionals. Non-private practitioners would also need to be able to access this to ensure the greatest availability of services to the community. The Australian Government should explore the inclusion of obesity management in the existing Medical Benefits Schedule items and examine the opportunity for increasing clinicians' access to the Medical Benefits Schedule items.

National Health agencies must also develop strong strategic partnerships with those agencies for which the creation of environments is core business. Each member of the partnership will need to work closely with others to plan and create such environments. Partnerships with agencies such as Treasury, Education, Employment and Workplace Relations; Infrastructure, Transport, Regional Development and Local Government; Families, Housing, Community Services, and Indigenous Affairs; Human Services; and Environment, Water, Heritage and Arts, will need to operate automatically, with a coordinated planning approach to take place at the commencement of any new obesity initiative.

The NSW Government commends the Preventative Healthcare Taskforce for stating that one of its first tasks will be to develop a National Obesity Strategy.

A national strategic framework would provide a mechanism to align the diverse array of agencies needed to coordinate any obesity initiatives. An appropriate governance structure

should be established to ensure the delivery of targets around specific obesity prevention strategies that together make up a comprehensive prevention strategy.

Before a strategy is developed, a process must be established to negotiate and develop the framework so that all agencies are committed. It is critical that any strategies generated from the framework are supported by infrastructure and funding. Agency ownership of obesity prevention efforts may be achieved by linking funding directly to agency based initiatives, rather than through a lead agency.

#### *State and Territory Governments*

State and Territory Governments have the ability to influence key laws and policies in areas such as education, health and the environment. Although Health should be the lead agency for preventing obesity, all strategies require a coordinated, inter-sectoral response. It will be essential for the Australian Government to collaborate with State and Territory Governments to ensure a consistent approach to obesity prevention is promoted.

#### *Local Government*

Local Government also plays a critical role in supporting communities and influencing urban environments through planning controls and delivery of community services. Local Government is a key setting for health initiatives (World Health Organisation, 1997) for two key reasons. Firstly, the Local Government Sector is mandated to improve the environment in which people live. The environment includes the aspects of one's neighbourhood, as well as the social and economic context (Harris & Wills, 1997). Many of these issues have a direct impact on people's health. Secondly, local councils have a close connection with their community. They are in the ultimate position to provide local community knowledge, and have a greater understanding of what is required to improve the health and well being of people in their area. It is this broad spectrum of areas of influence and councils' connection to the community that they serve that provides a strong rationale to ensure that Local Governments are partners in addressing obesity.

There is significant scope for local councils to be involved in obesity prevention initiatives if appropriately supported. In addition to the significant impact that can be provided through planning controls, access to parks and design of streetscapes, councils also provide a range of community services and work in partnership with the community to plan strategically for the future.

### **6.6.2 Other Key Partners**

#### *Industry*

Partnership and collaboration with industry/corporate bodies, such as the Australian Food and Grocery Council, the agri-food industry, the Australian Association of National Advertisers, Advertising Federation of Australia and the Federation of Commercial Television Stations, will be required to ensure industry is consulted, barriers to change are identified and strategies to support the change process can be put into effect. Facilitating dialogue between consumers such as parents and the food industry may support the change process and increase healthy food options available.

#### *Non-government Organisations and Community Groups*

Community groups, non-government organisations and service providers are key settings for obesity prevention. Engagement and involvement of partners in strategy development and

implementation at the local level will ensure strategies have the widest possible reach; are appropriate to the community; and obesity prevention messages are meaningful to local communities and can be reinforced across a range of settings. Identifying and working with local champions who can work on the ground to support the change process will be critical in shifting community attitudes and behaviours.

Change agents who could be targeted across all partners include:

- Volunteers, particularly parents as coaches in organised sporting activities;
- Early childhood, primary and high school teachers;
- Councillors and officers;
- Leaders in regional agency offices who drive the process of collaboration between agencies and sectors;
- Non-government organisations and service delivery partners in the human services sector; and
- Health workers and GPs.

## **6.7 Research, Evaluation, Monitoring, Training and Professional Development**

Strategies to tackle obesity will need to be underpinned by a dynamic change process. The key elements of the process should include research, evaluation, monitoring, training and professional development.

### **6.7.1 Research, Evaluation and Monitoring**

The NSW Government has made significant contributions to the research and evaluation field through partnerships with a number of research centres.

The NSW Centre for Overweight and Obesity (COO) is a collaboration between public health research groups, funded by the NSW Department of Health, to address the growing and serious problem of overweight and obesity, with particular emphasis on children and young people.

Reviewing the evidence relating to obesity prevention reveals that there is still much work to be done. Building evidence about the effectiveness of health promotion and disease prevention is key to tackling obesity. Continuing to develop the knowledge base around what obesity prevention strategies work and why, is critical to ensuring effective, value-for-money interventions.

As worldwide interest in tackling obesity increases, the evidence base for obesity prevention steadily grows. However, building Australian expertise in this area, specifically as it relates to the Australian context is a fundamental component of this obesity prevention framework. In tackling the obesity epidemic, research approaches into the specific causes, consequences, treatment and prevention of obesity should be supported. Areas of research identified by the Australasian Child & Adolescent Obesity Research Network (ACAORN) as under-invested include addressing the complex up-stream drivers of the obesity epidemic; the implementation of solution based interventions aimed at treating or preventing obesity; and the translation of study findings into established and sustainable practice and policy.

Continuing to invest in research and research centres and develop the evidence base around the strategies that return the best outcomes as well as identifying new approaches to harder to reach behaviours such as small screen sedentary activities will be an ongoing part of halting and reversing the obesity epidemic.

There is, however, a significant body of literature relating to public health strategies such as tobacco control and the prevention of heart disease which can provide an indication of the types

of population level prevention strategies that provide 'promise', that is a level of confidence based on the evidence that the intervention will produce a benefit under ideal conditions.

Investing in the evaluation and monitoring of strategies is also extremely important. Evaluation and monitoring cannot only provide information about the effectiveness of a strategy but can document the experience to share with others (Kumanyika et al., 2002).

### **6.7.2 Training and Professional Development**

Training and professional development is important to support obesity prevention strategies and is a fundamental requirement in the change process. Agency training, collaboration with professional associations and tertiary education institutions will support the building of government and industry capacity to prevent obesity through policies, programs and service delivery. For example, there are few clinical training opportunities for health professionals in weight management medicine. The only post in Australia where paediatricians in training (Registrars) can be trained in paediatric weight management is at The Children's Hospital at Westmead (shared Adolescent Medicine /Weight Management 6-month training post). Likewise, to our knowledge there are very few, if any, paediatric weight management training positions for nurses, many allied health professionals such as clinical psychologists, physiotherapists, exercise scientists or GPs. Investigations into different types of training and development will be required as the needs of agencies will differ significantly.



## **7. RECOMMENDATIONS**

**1. That the Australian Government develop a National Strategic Framework for addressing Overweight/Obesity.**

The NSW Government commends the Preventative Healthcare Taskforce for stating that one of its first tasks will be to develop a National Obesity Strategy.

A national strategic framework would provide a mechanism to align the diverse array of agencies needed to coordinate any obesity initiatives. An appropriate governance structure should be established to ensure the delivery of targets around specific obesity prevention strategies that together make up a comprehensive prevention strategy.

Before a strategy is developed, a process must be established to negotiate and develop the framework so that all agencies are committed. It is critical that any strategies generated from the framework are supported by infrastructure and funding. Agency ownership of obesity prevention efforts may be achieved by linking funding directly to agency based initiatives, rather than through a lead agency.

**2. That the Australian Government and industry collaborate to address obesity, particularly regarding the restriction of advertising of energy dense nutrient poor foods and beverages to children and young people.**

The Australian Government should act to ban or otherwise restrict advertisements of energy dense, nutrient poor foods and drinks, as classified through an agreed nutrient classification system, during peak viewing times for children. It is recommended that the bans or restrictions exist when children actually watch television not just during children's program schedules. The Food and Drink Advertising and Marketing Practices State and Territory Jurisdictional Working Party also support this stance..

Other areas that the Federal government and industry should collaborate on include: the development of regulatory requirements for clear food labelling, including fast food; and guidelines for the fast food industry on providing healthy food choices and appropriate portion sizes.

**3. That the Australian Government in collaboration with State/Territory Governments, Local Government and agencies whose core business is to create urban environments, promote and implement healthy urban planning.**

Healthy urban planning is vital for addressing obesity. At a national level, agencies for which the creation of environments is core business must be key partners in addressing obesity. Encouraging active transport planning and healthy urban design will support changes to both dietary and activity behaviours. Identifying opportunities for conducting Health Impact Assessments in approval processes for major projects will contribute to ensuring the creation of healthy living environments.

**4. That the Australian Government further invest in national social marketing campaigns promoting healthy weight and the development of campaign supportive resources.**

Enabling communities to make healthy choices by ensuring they are well informed is a fundamental strategy that supports all other obesity prevention initiatives in this framework. Key messages focusing on dietary and activity behaviour should be developed in consultation with young people, diverse communities and other stakeholders to ensure the campaign addresses the challenges of obesity, while acknowledging diversity, cultural difference and individual sensitivity around the issue of obesity.

Investigations into the effectiveness of the development of promotional material for households, similar to the National Drug Strategy that focus on obesity risks, obesity prevention strategies and treatment options, would be useful.

**5. That the Australian Government invest in the growth of prevention focused research in the field of obesity.**

There is a need to support Australian research to develop, implement and evaluate solutions for the obesity epidemic, especially as it affects children and young people. An ongoing commitment to research and evaluation primarily in the field of prevention is needed.

Research should focus on funding inter-sectoral research that focuses on reducing obesity from interventions that are delivered within and beyond the health system, with particular attention to the built environment, public transport, food availability, manufacturing, marketing and costs, work practices, education, and occupational health and media policies.

**6. That the Australian Government consider a range of strategies to build the capacity of agencies to respond to obesity.**

Underpinning any strategic framework must be a commitment to building the capacity of agencies to respond to obesity. This will require a significant investment in training and professional development to support the effective implementation of obesity prevention strategies. This should be aimed at all relevant clinicians for example nursing staff, dietitians, clinical psychologists, physiotherapists, exercise scientists and doctors (GPs, junior medical staff, paediatricians) as well as health promotion professionals.

**7. That the Australian Government consider financial incentives to promote healthy lifestyle behaviours among the community.**

The Australian Government should consider levy options or other measures applying market mechanisms to capture the externality costs of consumption of energy dense nutrient poor foods and review foods currently categorised as GST free. Further consideration should be given to the provision of financial incentives for parents/carers such as a Back to Sport allowance, similar to the Back to School allowance, or to working with the health insurance industry to provide rebates for sporting club membership.

**8. That the Australian Government facilitate the development of a coordinated model of care for overweight/obesity, particularly for children and young people.**

Treatment is a critical part of the prevention and early intervention continuum. Reducing current rates of childhood overweight and obesity requires a range of treatment services for children and adults that include a spectrum from generalist weight management and physical activity programs to specialist treatment with pharmaceutical and surgical interventions. A coordinated model of care for overweight and obesity, across each state and territory is needed. Individuals at risk of overweight and obesity have the right to appropriate medical care through access to appropriate affordable treatment services. However, currently there are no well-established models of care for adult weight management, let alone for paediatric weight management.

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## Minister for Health

P08/476

Mr Steve Georganas MP  
Chairman  
Standing Committee on Health and Ageing  
Parliament House  
CANBERRA ACT 2600

Dear Mr Georganas

### **Commonwealth Parliamentary Inquiry into Obesity in Australia**

I refer to your letter of 25 March 2008 inviting submissions to the Commonwealth Parliamentary Inquiry into Obesity in Australia being undertaken by the Standing Committee on Health and Ageing.

The attached NSW Government submission has been prepared for the Committee's consideration. The submission addresses the general Terms of Reference of the Inquiry and highlights the NSW Government's commitment to reducing adult and childhood obesity.

Should you require further information in relation to the attached submission, please contact Matthew Monahan, NSW Department of Health, Parliament and Cabinet Unit, on telephone (02) 9391 9328.

Yours faithfully

Reba Meagher MP  
**Minister for Health**

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