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Individuals

5.1 This chapter will examine the role that individuals can play in preventing and managing the obesity epidemic, and cover:

- individual responsibility for body weight;
- other factors that influence individual body weight;
- family responsibility; and
- examples of individual achievement.

Individual responsibility

5.2 Throughout the course of the inquiry, the Committee repeatedly heard that ultimately individuals must take responsibility for their own health, including their weight. Obesity is caused by an imbalance in energy intake (from diet) and expenditure (from activity). Individually we make the decisions as to how much we eat and how much activity we undertake.

5.3 Evidence to the Committee indicated that a small, seemingly insignificant energy imbalance results in weight gain over time, implying that each of us can control our own weight by controlling what we eat and how much we exercise. In their submission, the Department of Health and Ageing (DoHA) told the Committee that over the past 20 years the average weight of Australian adults has increased by 0.5-1kg. This gain is caused by a daily extra energy intake of as little as 100 kcal, equivalent to:

> … one slice of bread, a soft drink or 30 minutes of sitting instead of brisk walking.[1]

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1 Department of Health and Ageing, Submission No. 154, p iii.

5.4 To correct the energy imbalance, individuals need to develop a healthy lifestyle by making changes to correct their dietary habits and increase their activity levels. The Committee was advised that the best way for individuals to achieve success in changing their lifestyle is to undertake small, incremental changes. Professor Stewart from the Baker Heart Research Institute advocated the 'five in five' approach where people are encouraged to lose a kilo a month for five months by eating less and exercising more.[2]

5.5 However, even small lifestyle changes require behavioural change and a large amount of evidence to the inquiry stressed how difficult this type of change can be. The Committee noted that changing our behaviour is possible but that individuals require motivation and ongoing support from a variety of sources to succeed. Professor Littlefield from the Australian Psychological Society identified the elements for success:

> This needs very carefully constructed programs, where people monitor their food intake and their activity levels, and construct rewards for small steps in changing them, which sounds really easy to do but it is not easy, and it is certainly not easy to sustain.[3]

Other factors

5.6 Oral and written evidence to the inquiry showed that self discipline is not always, or indeed the only, answer. A number of other important factors influence the ability of individuals to control their body weight. These include:

- biological reasons;
- the obesogenic environment; [4]
- psychological factors;
- socio-economic levels; and
- knowledge/education.

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2 Professor S Stewart, Baker Heart Research Institute, Official Transcript of Evidence, 20 June 2008, p 3.

3 Professor L Littlefield, Australian Psychological Society, Official Transcript of Evidence, 24 October 2008, p 32.

4 An obesogenic environment can be defined as one which causes obesity: tends to encourage excessive weight gain. Source: Encarta World English Dictionary, <http://encarta.msn.com/dictionary_701708213/obesogenic.html> accessed 17 April 2009.

Biological reasons

5.7 Expert witnesses to the Committee advised that there are biological reasons why some people have difficulty controlling their weight. The Committee was provided with scientific evidence showing that this may occur for three reasons:

- human evolution;
- some people carry a gene or genes that pre-dispose them to obesity; and
- homeostatic regulation which can cause the body to maintain or increase its weight in response to changes in diet or activity levels.

5.8 A number of witnesses referred to our evolutionary background telling the Committee that because our ancestors were hunter gatherers living in a feast or famine environment, our bodies naturally store fat during times of plenty. One witness explained:

> The body is designed to store fat as an energy reserve for lean times – a feature we developed during the thousands of years when a regular meal could not be guaranteed. It explains why weight is relatively easy to put on – but hard to get off.[5]

5.9 In their submission to the inquiry, the University of Melbourne Obesity Consortium (the Consortium) explained that there are two genetic reasons for obesity: genes mutating or some genes being either over or under active. These genetic conditions upset the balance between the hormones that regulate our appetite and make us feel hungry or full, making it difficult to lose weight by lifestyle changes alone.[6] The Consortium quoted studies on twins and adopted children to show that genetic predisposition has a strong influence on an individual's ability to control their weight. Studies of twins indicate that '70percent of the influence on body weight is genetic while 30percent is environmental', while studies of adopted children show that the children resemble their biological parents rather than their adoptive parents.[7] The Consortium is calling for more research to understand these genetic conditions and to help develop evidence based strategies for prevention and treatment.[8]

5.10 The Committee heard that a related biological factor that influences a person's ability to lose weight is the body's homeostatic regulation. Dr Lawrence from the Telethon Institute for Child Health Research explained

5 National Association of Retail Grocers of Australia, Submission No. 121, Attachment p 15.
6 The University of Melbourne Obesity Consortium, Submission No. 13, npn.
7 The University of Melbourne Obesity Consortium, Submission No. 13, npn.
8 The University of Melbourne Obesity Consortium, Submission No. 13, npn.

that the body regulates the amount of energy it consumes by adjusting our basal metabolism rate. Our basal metabolism is the amount of energy we use to maintain our bodily functions, like breathing, when we are at rest. Dr Lawrence told the Committee that when we change our dietary or activity habits, the body may react to maintain or increase its current weight by adjusting the basal metabolism. This response is linked to our survival mechanisms, allowing the body to protect itself from starvation. If you eat less, your body will use less energy. If you exercise more, your body will stimulate your appetite so that you eat more:

> … the body can really fight to maintain its weight. The body can make big changes to the basic metabolism that you cannot consciously control that can undermine your efforts.[9]

The obesogenic environment

5.11 Written and oral evidence to the inquiry identified the obesogenic environment as a major deterrent for many people trying to control their body weight. A number of submissions to the Committee indicated that societal changes have created an environment where we are time poor, rely on cars, walk less and have increased access to convenience foods. The National Centre for Epidemiology and Population Health at the Australian National University explained that such changes make controlling body weight very difficult for the individual because:

> … maintaining healthy weight has ceased to be a by-product of everyday life, and instead has become a personal project requiring constant vigilance and resistance to widespread cultural and social patterns.[10]

5.12 Witnesses presented the Committee with a large range of examples of how the environment makes it difficult for people to control the energy equation and make sure they use more energy than they consume. Dr Bell from Hunter New England Area Health described some of the problems:

> … yards are getting smaller, houses are getting bigger and television is much more central in terms of the way kids spend time. You can say, 'Be active more' – that is great, but PlayStation,

9 Dr DM Lawrence, Telethon Institute for Child Health Research, Official Transcript of Evidence, 6 November 2008, p 27.

10 National Centre for Epidemiology and Population Health, Australian National University, Submission No. 78, p 3.

> television and all of these other things make it very hard to do that.[11]

Figure 5.1 Embedding physical activity in school using the Basketball Clinic of St John the Evangelist Primary School, Melbourne, Victoria

5.13 A recurrent theme in evidence presented to the Committee was the increasing lack of 'walkability' in our environment. In Dubbo, for instance, the Committee was told that the only way to get to the local shopping centre was by car because there was no pedestrian access or cycleway.[12] Diabetes Australia pointed out that adapting our environment for car use has decreased opportunities for walking and been detrimental to our health:

> We have pandered to the motor car to look at quick, easy access for people from A to B. That has been at the expense of people substituting car travel in preference to walking.[13]

11 Dr C Bell, Hunter New England Area Health, Official Transcript of Evidence, 12 September 2008, p 14.

12 Mr Mark Coulton MP, Member for Parkes, Official Transcript of Evidence, 12 November 2008, p 8.

13 Dr I White, Diabetes Australia, Official Transcript of Evidence, 12 May 2008, p 5.

Psychological factors

5.14 The Committee was particularly concerned about the psychological factors that influence an individual's ability to control their weight. Evidence to the inquiry showed that people suffering from anxiety, depression and low self-esteem will find it very difficult to make the behavioural change necessary to alter their eating and exercise habits. The Australian Psychological Society explained that it can be very difficult to change thinking patterns and habits without help:

> We also have to have psychological interventions to change their thoughts about weight loss; their beliefs about how important it is to engage in weight loss; their values about their self-image and their health; and their self-efficacy and attitudes regarding how difficult it is to actually change.[14]

5.15 The Committee heard that these psychological factors and obesity often operate in a cyclical fashion so that someone who is overweight becomes depressed, or someone who is depressed puts on weight and can be difficult to distinguish which is the root cause. Professor Stewart from the Baker Heart Research Institute told the Committee that the conditions feed into each other:

> I think there is a very close link between the increased stressors we have in our society, increased levels of depression and poor habits because when depressed one tends to eat worse and exercise less.[15]

5.16 Psychological factors are complex and the Committee was moved by the honesty of a number of witnesses who, by sharing their experiences, helped the Committee understand the nuances of the difficulties they face. The emphasis on body image in our society exacerbates the mental and emotional problems associated with being overweight. These individuals spoke of denying their condition while at the same time being ashamed of their body image.[16] One witness indicated that the issues were complex. She told the Committee she had been able to ignore her body image while she was obese but, once she took control and began to successfully lose weight, she was overly focused on it, worrying about how much she had lost each week:

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14 Professor L Littlefield, Australian Psychological Society, Official Transcript of Evidence, 24 October 2008, p 32.

15 Professor S Stewart, Baker Heart Research Institute, Official Transcript of Evidence, 20 June 2008, p 5.

16 Ms A Mennen, Weight Watchers Australasia, Official Transcript of Evidence, 11 September 2008, p 30.

> You become much more compulsive and obsessive about it. That has huge consequences because in a way you become more self-loathing. You look at yourself and you think, 'How can I have gotten like this?' I think it becomes a much bigger issue than people realise. Psychological support is crucial.[17]

Socio-economic determinants

5.17 Oral and written evidence to the Committee identified a direct link between lower socio-economic status and obesity. Diabetes Australia provided the Committee with statistics indicating the extent of the difference between lower and higher socio-economic groups:

> The 2004-05 National Health Survey reported a higher proportion of people in the lowest socioeconomic group were overweight or obese (53%) and physically inactive (76%) compared with people in the highest socioeconomic group (47% and 62%) respectively.[18]

5.18 Witnesses to the inquiry indicated that the reasons for the connection between lower socioeconomic status and obesity are complex but a number of factors may contribute. The Committee heard that individuals are often trapped in a cycle of inter-generational disadvantage which contributes to ill health, and increases the risks of obesity.

> If you looked at anything related to health, you would see these social determinants.[19] We see it with smoking, heart disease, high blood pressure and type 2 diabetes. We see these social determinants of health, and we have been seeing them for decades.[20]

5.19 The common theme is a lack of access to, and the cost of, healthy food. At the hearing in Dubbo, Ms Gilmore from the Walgett Aboriginal Medical Service (WAMS) illustrated why people on a lower income may make less healthy choices:

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17 Private citizen, Official Transcript of Evidence, 11 September 2008, p 7.

18 Diabetes Australia, Submission No. 92, npn.

19 The social determinants of health are the circumstances in which people are born, grow up, live, work and age, and the systems put in place to deal with illness. These circumstances are in turn shaped by a wider set of forces: economics, social policies, and politics. Source World Health Organisation <http://www.who.int/social_determinants/thecommission/finalreport/key_concepts/en/index.html> accessed 13 May 2009.

20 Associate Professor J A O'Dea, University of Sydney, Official Transcript of Evidence, 11 September 2008, p 44.

> Often for some families, especially families that may be on a low income, it is often cheaper for them to buy $2 worth of chips and gravy to feed the whole family as opposed to buying a piece of meat or some mince and making spaghetti.[21]

5.20 The Committee saw this for themselves on a trip they made to the western New South Wales (NSW) town of Wilcannia. The town has a high unemployment rate and many residents are struggling to survive on welfare benefits. The single local supermarket gets supplies of fresh fruit and vegetables once a week and these sell out quickly. The choice of other food staples, including meat, is limited and prices are well above regional city prices. The distance, rising fuel prices and a lack of transport mean that many residents cannot undertake the two and a half hour journey to Broken Hill to buy supplies.

5.21 The difficulty is not restricted to remote or rural areas. The Committee heard that in urban areas it is often easier to access take-away food outlets than supermarkets. Several witnesses made reference to the fact that 'junk' food is cheaper than healthy foods. Dr White from Diabetes Australia was one of many witnesses who drew the Committee's attention to the cost of healthy food:

> The cost of those sorts of healthy foodstuffs is quite high and in some cases is beyond the reach of lower socioeconomic groups.[22]

5.22 The Committee was also told that people in a lower socioeconomic bracket often live in areas characterised by poor urban design and a lack of infrastructure and facilities. Individuals living in these areas don't have the opportunity to incorporate activity into their daily routine. Members noted this from their own experience. The Member for Parkes in NSW contrasted the walking areas in the newer parts of Dubbo with the older areas:

> … in the housing commission areas and in the shopping centre it is nearly impossible to get around on foot, without being run over, because there are absolutely no walkways.[23]

5.23 The Member for Swan in Western Australia told the same hearing about the lack of infrastructure he had noticed in some suburban developments:

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21 Ms K Gilmore, Walgett Aboriginal Medical Service, Official Transcript of Evidence, 10 September 2008, p 7.

22 Dr I White, Diabetes Australia, Official Transcript of Evidence, 12 May 2008, p 9.

23 Mr M Coulton MP, Member for Parkes, Official Transcript of Evidence, 12 November 2008, p 8.

> These areas only have a park with a fountain; they are not having a school oval, parks to play soccer or football in or anything like that. Another area with schools (without) sporting facilities.[24]

Knowledge and education

5.24 Another factor influencing the individual's ability to control their body weight is a lack of authoritative information. Witnesses told the inquiry that although most people know they need to eat less and exercise more to lose weight, the difficulty is in knowing how to go about it.[25] In their submission to the inquiry, Nutrition Australia wrote of the need to assist individuals to negotiate the abundance of information, some of which is conflicting:

> The development of targeted food skills and food literacy skills at the individual community and population levels is required to assist people with navigating their way through the plethora of foods and food messages that they are faced with in today's society.[26]

5.25 The Committee repeatedly heard that the confusion over food choice is compounded by the loss of basic food skills such as cooking. Evidence suggests that cooking is no longer learnt in the home and is not taught in schools, so people are unsure how to prepare nutritious meals. Associate Professor Collins, a dietician, academic and consultant to the *Biggest Loser Show*, summed up what many witnesses told the Committee:

> People do need help with the cooking skills because … if we go back to the good old days in the 1950s and 1960s, there were not meals that could be just put in the oven straight from the freezer, there were not packets of pastas and rices of the world where you just add water. People have lost their way in relying on the supermarket to tell them what to eat and what is the basis of a healthy meal.[27]

24 Mr S Irons MP, Member for Swan, Official Transcript of Evidence, 12 November 2008, p 8.

25 Professor L Littlefield, Australian Psychological Society, Official Transcript of Evidence, 24 October 2008, p 32.

26 Nutrition Australia, Submission No. 84, p 3.

27 Associate Professor CE Collins, Official Transcript of Evidence, 12 September 2008, p 33.

Family responsibility

5.26 As well as individual responsibility, the Committee was advised that families need to take responsibility for their own health and wellbeing. Witnesses to the inquiry stated that it is in the family setting that we first learn about food and activity. Associate Professor Collins told the Committee that parents have a significant influence on our nutritional behaviour:

> When you grow up all you know about healthy food is what you were fed at home. Intuitively, we know that our mums and dads love us and will do the best for us, so surely that means we were fed healthy food.[28]

5.27 Similarly we gain our view of exercise and activity from our parents. At the hearing in Mackay, Mr Eden from the City Fitness Health Club indicated the important role model parents provide, even for very young children. He reminded parents that children will carry the example they set throughout their life and asked:

> How can we as parents say to the kids, 'Get outside and play,' when we are sitting in front of the TV sucking on a stubby?'[29]

5.28 The Committee was interested to hear examples from a number of witnesses of how effectively people can influence their family members with regard to eating and activity habits. Ms Mennen the Weight Watchers 2008 Slimmer of the Year shared her experience with the Committee. Having lost 30 kilos, she no longer suffers from type 2 diabetes and has positively influenced her family as well. She called it a 'definite ripple effect':

> One of my sons has lost 20 kilos and another son has lost 10 kilos. … I have learnt so much and I have transferred that knowledge to my children. I have changed some of their behaviours … They now know how to make healthy choices. They know they should select wholegrain foods and eat more fruit and veg rather than the other things – although they do have those sometimes. Hey, they are teenage boys, so that is fine. But they do know that most of the time they need to make healthy choices.[30]

5.29 The Committee witnessed a reversal of this process with children teaching parents when they visited the Stephanie Alexander Kitchen Garden

28 Associate Professor CE Collins, Official Transcript of Evidence, 12 September 2008, p 33.

29 Mr SJ Eden, City Fitness Health Club, Official Transcript of Evidence, 18 August 2008, p 25.

30 Ms A Mennen, Weight Watchers Australasia, Official Transcript of Evidence, 11 September 2008, p 30.

Program in action at Westgarth Primary School in Melbourne on 20 June 2008. Students, teachers and volunteers shared some endearing stories that illustrate how children can have as much influence on their parents as their parents have on them. Students are helping at home to prepare meals, set the table and clear up afterwards. They contribute ideas for meals and want to know why their parents aren't buying and using different ingredients. One girl asked her mother, 'Why don't we have sage growing at home?' Another boy told the Members, 'I live with my dad and he used to cook everything out of packets and tins. I've shown him how to cook proper food. We go shopping and buy fruit and vegies and proper stuff.'

Figure 5.2 Cooking as part of the Stephanie Alexander Kitchen Garden Project at Westgarth Primary School, Melbourne, Victoria

Individual achievement

5.30 Throughout the inquiry the Committee was impressed by the stories they heard from individuals who have faced the challenge of obesity. They illustrate what we can all do to live more healthily.

5.31 Here are just two of the many stories the Committee heard that demonstrate:

- the many influences that can cause obesity problems to escalate; and
- the difference an individual can make to their own life and the lives of others.

5.32 In Sydney, one witness shared her story with the Committee, highlighting the difficulties overweight individuals can face. The witness has battled overweight and obesity all her life despite eating properly as a child and being extremely active.

5.33 She told the Committee how, in early adult life, she became a nurse and the long hours of shift work caused unhealthy and irregular eating patterns and reduced her activity levels. Despite being medically trained and well aware of the health risks, and after years of making concerted efforts to address her health issues which became increasingly complex as time went on, she made the decision with her doctor to undergo bariatric surgery. She found the decision extremely difficult and put off the surgery in 2006 but deteriorating health forced her to take the step in early 2008.

5.34 She went on to tell the Committee it was only through the support of her General Practitioner (GP) and specialist, that she was able to come to terms with her condition and find the courage to undergo the surgery. She also stressed to the Committee the need for ongoing support, explaining that even though she is doing well, she still needs help. Surgery is not 'the easy option'. She can only eat small amounts of food, adheres to a diabetic diet and exercises intensely every day:

> There has to be a multidisciplinary approach to this. You need the dietary assistance. You need the psychological assistance. You need the support from the general practitioner. You need the monitoring of your bloods.[31]

5.35 The Committee was impressed that she had completed her first fun run and asked what sort of difference the procedure had made to her professional and social life. She responded that her work colleagues had been very supportive but that the restriction on her food intake made socialising difficult and that those restrictions would be ongoing:

> I think I am always going to have to live the way that I live now. But I certainly feel better in myself and feel healthy.[32]

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31 Private citizen, Official Transcript of Evidence, 11 September 2008, p 7.

32 Private citizen, Official Transcript of Evidence, 11 September 2008, p 6.

5.36 At the hearing on the Gold Coast the Committee heard from a witness who has successfully changed his own habits and gone on to share the knowledge he gained with the wider community. After unsuccessfully trying a range of diets and exercise programs Mr Gillespie who was 40 kilograms overweight, began to do his own research into human metabolism and investigate why our ancestors had not had a problem with obesity. He identified an increase in people's fructose (the sugar found naturally in fruit) intake. Through cutting fructose out of his diet he lost 40 kilos which he has successfully kept off. But he did not rest there. He decided that 'the story of the sweet poison had to be written in language we all could understand' and using his skills as a lawyer built the case against fructose in a book he titled *Sweet Poison: Why sugar is making us fat*.[33] The Committee was impressed with his enthusiasm and drive and the anecdotal results reported by followers.

5.37 During the course of the inquiry the Committee met and spoke to many academics, medical and other professionals who are devoting their time and skills to helping people prevent and manage obesity. This report will only consider a couple of these individual contributions. The examples have been chosen to illustrate three important aspects of the evidence received by the inquiry:

- body image and childhood obesity; and
- multidisciplinary models of treatment for obesity.

5.38 Associate Professor O'Dea, a dietician and researcher from the University of Sydney who has studied body image and eating disorders in children and adolescents, voiced her concerns to the Committee regarding the treatment of childhood obesity. In her submission to the Committee she detailed the difficulties of defining obesity in children, cautioned against exaggerating the extent of the problem in Australian children and urged the importance of the 'first do no harm' message.[34] Associate Professor O'Dea stressed that there are many reasons for a heavier body weight in children including fat, water, muscle and bone density and that ethnic difference plays a role. For example, Greek and Lebanese boys tend to be more muscular which contributes to their overall body weight.[35] She advocates a more positive approach, including the use of positive language emphasising healthy growth and development and asked the Committee to remember that:

33 Gillespie, D 2008, *Sweet Poison: Why Sugar is Making Us Fat*, Penguin, Camberwell, p 4.

34 University of Sydney, Submission No. 68.

35 Associate Professor JA O'Dea, Official Transcript of Evidence, 11 September 2008, pp 39-40.

> A healthy child is physically healthy, mentally healthy, socially healthy, culturally healthy, spiritually healthy …[36]

5.39 The Committee was impressed by the dedication and passion of the many doctors and surgeons who provided evidence to the inquiry. Their evidence stressed the need for specialised, multidisciplinary clinics to allow obesity patients access to a range of professional care including medical, surgical, nutritional, physical and psychological services. The Committee had the opportunity to explore these concerns with a senior endocrinologist Associate Professor Samaras and to visit her clinic in Sydney where they met some of her patients.

5.40 In response to the lack of obesity services available in the public system, Associate Professor Samaras has set up her own clinic to provide a multidisciplinary model of treatment. In her written and oral evidence to the Committee she stressed the complexity of obesity and its multiple causes. At her private clinic in Sydney her patients spoke informally to Committee members, telling them that the personalised, tailored treatment programs were helping them after other approaches had failed. One woman, a diabetic, explained that the recommended diabetic diet was not controlling her weight or insulin levels. At the clinic, the diet was modified to her personal needs and she finally started to lose weight. Another patient who was achieving success after many years trying different approaches to control her weight, told the Committee:

> All of those things are really important. Having them all in the one place with a group who work together is really important.[37]

Committee comment

5.41 The Committee acknowledges the importance of individuals and families taking responsibility for their own weight control, dietary and activity habits in order to prevent and manage obesity.

5.42 However, there are clearly a number of obesogenic influences that can make it difficult for the individual to lose weight by lifestyle changes alone.

5.43 The Committee acknowledges the importance of ongoing psychological support for individuals attempting to change their lifestyle and control their body weight and thinks that the Medicare review should consider

36 Associate Professor JA O'Dea, Official Transcript of Evidence, 11 September 2008, p 39.

37 Private citizen, Official Transcript of Evidence, 11 September 2008, p 7.

changes to improve support in this regard (see Chapter 3 for more on Medicare).

5.44 The Committee thanks the many individuals who shared their stories with the Committee. These people helped the Committee understand the extent and complexity of the problem in a very personal way and the Committee commends the courage they displayed in discussing their experiences. The efforts of the many individuals around Australia who are doing so much to help and support people who are attempting to make the necessary lifestyle changes to take control of their body weight are also to be commended.