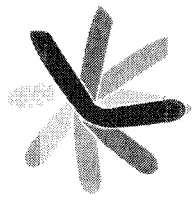
Submission No. 21
(Inq into Obesity)
16/05/08



NATIONAL RURAL HEALTH ALLIANCE INC.

ABN: 68 480 848 412

National Rural Health Conference
Australian Journal of Rural Health

PO Box 280 Deakin West ACT 2600
Phone: (02) 6285 4660 • Fax: (02) 6285 4670
Web: www.ruralhealth.org.au • Email: nrha@ruralhealth.org.au

Submission to

the House of Representatives

Standing Committee on Health and Ageing

Inquiry into Obesity in Australia

May 2008

This Submission is based on the views of the National Rural Health Alliance but may not reflect the full or particular views of all of its Member Bodies.

CONTENTS

Submission to the House of Representatives Standing Committee on Health and Ageing Inquiry into Obesity in Australia

> *"The physical environment affects the way we eat, live and play. Over the last twenty-five years contemporary lifestyles have changed dramatically, impacting on what we eat and how much we move. Commentators have described the environment as 'obesogenic' - it encourages the over consumption of food and makes it easier for people to be sedentary, rather than physically active. These changes have been driven by technological advancements, urbanisation and the rise of the car dependent society. The way we design our cities and organise our lives impacts on our health behaviours in many subtle, varied and complex ways. People are more likely to make healthy behaviour choices when these choices are easily available to them; and thus environments that support or discourage health behaviours critically influence health."*[1]

As suggested by the above quotation, this submission will take a broad, whole-of-government and whole-of-community view of the ways the obesity epidemic can be prevented and managed in rural and remote parts of Australia.

Introduction

The National Rural Health Alliance is the peak non-government body concerned with rural and remote health issues in Australia. It comprises 28 Member Bodies, each a national body in its own right, representing health professionals, service providers, consumers, educators and researchers. (A list of Alliance Members is at Attachment 1.)

The National Rural Health Alliance's vision is equal health for all Australians by 2020.

The health status of rural and remote Australians is substantially lower than that of people who live in metropolitan areas. Overall, the health of Australians deteriorates with increasing remoteness, and at the same time their exposure to health risk factors becomes greater.[2] On average, rural and remote (hereinafter 'rural') Australians are older and experience a higher incidence of disability. They are also poorer than their metropolitan cousins and are confronted by higher levels of health risk factors including poor nutrition, physical inactivity, obesity, smoking, harmful levels of alcohol consumption and high blood pressure.

Health services in rural areas are framed differently from those in cities. Therefore, whatever strategies are proposed to prevent and manage obesity, the implications for rural areas must be considered. Where there is a need for staff on the ground, account must be taken of smaller population groups, smaller workforce numbers, fewer facilities, and transport, distance and other access barriers. For the management and prevention of obesity, as with other health endeavours in rural areas, funds and services need to be provided and apportioned in a way that will ensure equity and sustainability for consumers and health professionals across all geographic locations. This will require collaborative planning and the maintenance of good relationships between governments, consumers and health services.

---

[1] NSW Centre for Overweight and Obesity, *Creating Healthy Environments* (2005), available at www.coo.health.usyd.edu.au/pdf/2005_creating_healthy_environments.pdf

[2] AIHW (2005), *Rural, regional and remote health – indicators of health*, Canberra, May 2005; cat. no. PHE 59.

Prevalence, health impacts and costs of obesity in Australia

The AIHW's *Indicators of health status and determinants of health,* released in March 2008, shows that people living in regional and remote areas are significantly more likely to be overweight or obese than those in major cities. This finding is consistent with inter-regional patterns reported in previous surveys. It is concerning to note that the prevalence of obesity has increased over time in all areas.[3] This growing epidemic of obesity may well contribute to greater ill-health and reduced life expectancy in coming generations compared with today's. Obesity therefore presents significant challenges for Australia's economy and its health system; and given that the situation is worse in rural and remote areas, it is critical to target them specifically.

Epidemiological studies provide good evidence that obese people face higher risks of suffering from diabetes, cardiovascular disease, osteoarthritis and some cancers. Mental health problems, poor self esteem and lack of confidence can also spring from being overweight.

In 2006 Julia Gillard confirmed that 90 per cent of type 2 diabetes, more than 50 per cent of cardiovascular disease and 50 per cent of cancers are preventable.[4] In 2007, Nicola Roxon observed that three million Australians are obese and that this figure is projected to rise to over seven million – almost 30 per cent of the population – by 2025.[5]

The recent National Prevention Summit asserted that more than $50 billion is spent annually on coping with mainly preventable ill health, such as depression, heart disease, cancer and diabetes.[6]

Access Economics has estimated that the financial cost of obesity in 2005 was $3.7 billion. Of this, productivity costs were estimated at $1.7 billion (45 per cent), health system costs $873 million (23 per cent) and carer costs $804 million (21 per cent). The deadweight loss from transfers (taxation revenue foregone, welfare and other Government payments) was $358 million (10 per cent) and other indirect costs were $40 million (1 per cent). Furthermore, the net cost of lowered wellbeing was dramatically valued at a further $17.2 billion, bringing the total cost of obesity in Australia in 2005 to $21 billion.[7]

Another impact of obesity seen in county areas is overweight residents having to travel away to receive medical attention because they are considered high risk for procedures closer to home. For the same reason, rural women who are obese are often required to deliver their babies in major centres rather than closer to home.

Factors affecting obesity in rural Australia

Knowledge, habit, level of formal education, level of access to fresh and appealing foods, ready availability of affordable processed foods and soft drinks, shortage of dieticians and other health professionals, insufficient resourcing for maternal and child health, and lack of

---

[3] AIHW, Indicators of health status and determinants of health, March 2008
[4] LaboreHerald, 9 March 2006.
[5] Speech to Australasian Society for the Study of Obesity 2007 Annual Scientific Meeting, September 2007.
[6] National Prevention Summit, co-hosted by the Australian Institute of Health Policy Studies and VicHealth, East Melbourne, 9 April 2008.
[7] Access Economics, The economic costs of obesity, 2006.

funding and workforce for exercise and other health promotion activities are all contributing factors to obesity in rural Australia.

Some well known programs which promote healthy eating, shopping and lifestyle skills can't even be started in towns with small populations, and some towns have not been able to sustain reputable weight loss programs because of not having sufficient numbers attending their programs.

Exercise and fitness

People living in rural areas are more likely to report sedentary levels of activity than their counterparts living in major cities. The differences are particularly marked for men aged 25-64 years. While the pattern of variations between regions was similar to that reported previously (1995 and 2001), the differences between major cities and regional/remote areas were more pronounced in 2004-05, showing that the situation is deteriorating in rural and remote areas.[3]

There are very few gyms in rural areas and, with the decline in populations, sporting facilities and teams are no longer in existence in many small towns. The distances to travel and the cost of fuel are disincentives to people participating in sport in larger centres. Sometimes it is a matter of attitude and self belief. Some in rural areas believe their physically demanding work is all the exercise they need.

Smaller Councils lack the financial capacity to maintain facilities and /or equipment or to develop new exercise programs to attract citizens to exercise. Fewer children walk to school or the shops for reasons of security and personal safety.

Food and nutrition

Compared with people living in major cities, people living in regional and remote Australia are significantly less likely to consume low fat or skim milk and the recommended two serves of fruit per day. This trend is worst in rural males aged 15-44 years.[3]

Healthy eating is dependent on the availability of good quality, fresh, affordable food and the capacity to store fresh food successfully. Some towns have deliveries of fresh fruit, vegetables and milk less than three times a week. One of the key findings in a 2006 state-wide survey in Queensland was that the cost of nutritious food in the two years from 2004 had increased significantly throughout the State in all areas except major cities.

Dieticians are in such short supply in rural areas that obese people are often given low priority on their waiting lists. As with other health professionals, dieticians have such heavy caseloads that there is little time for attention to health promotion to a wider audience. A reported low success rate is another factor which may impact on the way in which dieticians prioritise caseload. Many dieticians are employed at one rural site, but they are required to travel great distances to outreach to other communities. This results in a lot of unproductive time (and staff burnout). These observations illustrate the impact of workforce shortages on the health of people for which the price will be paid later when the person requires treatment for resulting illness. Health workers should be provided with support and mentoring, and upskilling in program planning and nutrition.

Social, economic and environmental factors

Apart from the obvious contributions of over-eating and under-exercising, there is a range of more subtle factors – social, economic and environmental – that feed the obesity epidemic. For example, it has been noted that:

- every extra hour in a car boosts obesity by 6 per cent;
- suburbs without jobs, schools or recreational facilities promote car use;
- friendly, open stairs promote stair climbing (as compared with obvious lifts and hidden stairs);
- curvy, blocked-off streets in poorly designed suburbs discourage walking;
- the bigger the portion sizes, the more you eat and drink;
- safe, attractive parks promote healthy activity;
- easy access to fast food promotes a fatty diet;
- accessible public transport encourages walking; and
- advertisements promoting high-fat, high-sugar foods target kids. [8]

A priority focus on Indigenous health

No health and wellbeing issue in Australia is worse or more urgent than the impoverishment and appalling health status of Indigenous people. Most indicators for poor health are worse for Indigenous Australians.

Indigenous females are 1.4 times as likely to be overweight or obese as the general population of females in major cities. Indigenous Australians are 1.6 times more likely than non-Indigenous Australians to report low levels of physical activity. For Indigenous females, the highest rates of sedentary behaviour are seen in outer regional areas (1.8 times the rates observed in the general population in major cities).[3]

Indigenous Australians are significantly less likely to consume low fat or skim milk, two serves of fruit and four or more serves of vegetables per day, although on one indicator – consumption of four or more serves of vegetables per day – Indigenous Australians in regional areas fared better than their Indigenous city counterparts.[3]

Indigenous Australians are significantly more likely to report food insecurity than the general population in major cities, and market basket surveys have consistently shown that the average price of food is more expensive in remote areas than the capital cities.

The most recent findings from the Australian Bureau of Statistics show that as a single risk factor, high body mass was the second leading cause of the burden of illness and injury among Indigenous Australians in 2003, accounting for 11 per cent of the total burden of disease and 13 per cent of all deaths.[9]

In 2004-05, 57 per cent of Indigenous people aged 15 years and over were overweight or obese. Between 1995 and 2004-05, rates of overweight/obesity among Indigenous people aged 15 years and over in non-remote areas increased from 48 per cent to 56 per cent.[9]

For most people living in remote Indigenous communities, the community store is the major source of food. Northern Territory market basket surveys estimate that families in remote locations would have to spend 35 per cent of their household income to buy basic healthy

---

[8] *Issues* volume 81, December 2007, http://issues.control.com.au/

[9] Australian Bureau of Statistics, 4704.0 - The Health and Welfare of Australia's Aboriginal and Torres Strait Islander Peoples, 2008, released 29/04/2008.

food. By contrast the average Australian household spends about 18 per cent of weekly expenditure (not income) on food.[10]

With the increasing cost of fuel, the food basket cost will also increase due to higher transport and production costs. As well as cost, choice and quality of food issues, Indigenous people also face major difficulties in both storing and preparing food.

Preventing and managing the obesity epidemic

Measures to prevent and manage the obesity epidemic will need to embrace public health initiatives and involve a whole-of-population approach. Health promotion will need to be for the long term, highly varied, coordinated and holistic – addressing multiple factors including food standards, advertising, nutrition education, access to fresh and affordable foods, and initiatives to address social, economic and environmental contributors to obesity, such as 'healthy' town planning to facilitate exercise, fitness and healthy lifestyles, and increased opportunity for education, employment and improved self-perception.

Despite the fact that many of the most serious health problems are amenable to prevention, Australia currently spends less than three per cent of its health expenditure on prevention.[11] This highlights the need for primary health and prevention measures to be included as components in the Australian Health Care Agreements (ACHAs) or the new National Healthcare Agreement (NHA) that will come into effect on 1 July 2009.

The Rudd Government has indicated its intention to focus more on illness prevention and health promotion so that the proportion of the dollar allocated to these purposes will hopefully soon increase. When it does, people in rural and remote areas will expect and deserve at least one third of the attention. The limited funding currently available for rural hospitals is just enough to keep the hospital open and functional and there is not much left for health promotion and illness prevention.

The fact that Australia as a whole, and rural areas in particular, have serious problems with some of the determinants of poor health like the abuse of alcohol, poor diet and inactivity can be seen as positive in the sense that these are issues where health promotion can bring substantial benefit – and not just for obesity but for a range of associated illnesses as well. Sound investment in health promotion and illness prevention, especially during the early years, has the potential to make a significant difference to the health of rural and remote Australians.

Tackling obesity could provide a case study on how illness prevention and early intervention can contribute both to the overall health of Australians and to reduced care costs, particularly for preventable chronic disease. Both the Prime Minister and the Health Minister have acknowledged that good health policy is also good economic policy,[12] with the Federal Health Minister stating recently that "perhaps the greatest disconnect of recent times has been the willingness of governments to treat preventative care and acute care as two separate aspects of the health system. It is simply not possible to separate the consequences of failing to invest in primary care from the attention we need to give to acute care."[13] The National Health and

---

[10] *Food North: food for health in northern Australia, July 2003.*

[11] Mike Daube, 9th National Rural Health Conference.

[12] Rudd and Roxon, Fresh Ideas, Future Economy – Preventative health care for our families and our future economy, June 2007.

[13] Nicola Roxon in a speech to the 10th Annual AFR Health Congress, Sydney 28 February 2008.

Hospitals Reform Commission should take account of this, and central agencies like the Departments of Treasury and Finance should recognise and promote the fact that providing resources for health promotion will be an investment rather than a net cost.

The extent to which our contemporary culture reinforces the psychological environment towards unhealthy lifestyles, seems poorly understood at both policy and community levels. The development of a rational economic theory of obesity might yet be one of the best drivers for anti-obesity policy. In other words, it would be useful to determine under what economic and social systems an individual, considering the sum of all rewards to themselves, would make healthier choices.

Health promotion

The National Prevention Summit called for "visionary national leadership in prevention" and recognised that coordination of effort between Federal and State Government health departments is critical. Summit proposals included a "national body for health improvement" and opportunity for all levels of society to be involved in setting the priorities and actions to prevent illness and promote health and wellbeing.[6]

Health promotion programs for people in rural areas need to be planned and implemented in ways that will make them effective in those areas. For example it would not make sense to roll out in more remote areas health promotion activities that have a high dependence on IT because not all rural people can access IT and some who do have very slow access and can't download or print.[14] It cannot be assumed that people in rural and remote areas have full-time power, eg to watch TV, so promotions need to employ a range of communication means. Public meetings are not always accessible, with habit, transport, distance and travel costs all providing barriers. It is important to take the message to where people go: sports events, pubs, agricultural shows, farmer updates and agricultural field days, school P and C meetings, and the shire office. The arts – including theatre, music and verse – can be used as an effective tool in education and communication, and also as the basis of activity which is intrinsically healthy. It is helpful to enlist the support and services of local government and local service groups, eg CWAA, Lions and Rotary in health promotion campaigns.

Health promotion activities should be people-centred and will be more effective if community members are involved in their development and implementation. Statistics and risk factors relating to obesity should be promoted in health advertising and in places where people may need to be reminded that being overweight has unwelcome consequences and costs. Factual information should be provided about dieting to lose weight, the danger of fad diets and the importance of healthy food choices.

Behavioural and attitudinal change takes time, so health promotion needs to be persistent and over a substantial period of time, eg over five years, not a one month 'blast'. Effective change requires commitment, training and the forming of new habits on the part of the individual. Expenditure on health promotion will be offset by lowered acute care costs, reduced absenteeism and higher productivity in the workforce.

Parent education is an important part of health promotion, and given that eating patterns are established early in life, promotion of healthy eating should include children.[15] An

---

[14] This is yet another example of the intra-relationship between information technology and community capacity in rural and remote areas - and explains why people in the rural and remote health sector have a continuing interest in just how affordable broadband will be made available to the 2 per cent as well as to the 98.

[15] Sally Woollett, *Issues* volume 81, December 2007, http://issues.control.com.au/

environment of healthy eating and exercise during childhood will set expectations for life. A national program to promote health in schools could focus on nutrition and physical activity.

Nurses are ideally suited to play a lead role in health promotion activities in rural and remote communities and need to be adequately resourced to do this in an effective and structured manner. School nurses could play a key role in providing nutrition information and programs to teachers, students and parents and by having input into decisions about what is or is not available in school tuck shops. Community diabetes education nurses work with local communities to provide health information about diabetes prevention.

Exercise and fitness

In responding to the obesity epidemic it is important to focus on exercise and fitness, which are more significant determinants of good health than weight loss. Regular moderately-vigorous exercise provides at least four benefits, namely greater protection against chronic diseases, fitness for living, weight reduction and the 'feel good' factor of endorphins, and possibly social benefits as well as physical pleasure.

A National Weight Control Registry in the USA records people who have lost over 30kg and kept it off for over five years. All of these people aim for 10,000 walking steps each day.[16] Weight loss programs risk failure if they do not educate people to sustain an ideal weight in the long term.

Affordable exercise programs or centres could be encouraged to promote 'biggest loser' type activities with a focus on supporting all participants through the process and thereafter to maintain an ideal weight.

Community sporting clubs provide excellent opportunities for people of all ages to develop sporting skills and benefit from exercise and social interaction. Informal off-season sporting opportunities, such as community football competitions, would promote health and be part of a broader program to keep children and young adults active. Other activities which require training, practice and energy output, can also assist by providing a cap on eating. These include dance, singing, theatre, playing a musical instrument, oration, performing poetry, building props, painting and sculpture,.

Once children reach primary school age, sporting clubs (reasonably) become more competitive and focus on those children who are committed to the particular sport, are physically capable and who are the best performers in competition. Much is made of the children who are good at sport and not enough encouragement is given to those who are not in the top league. There should be rewards for participation as well as 'best player' awards.

Few team sport opportunities are available for children who are disinclined to participate in sporting activities generally and who are, arguably, the ones most in need of incentives and opportunities for exercise and physical fitness. Community sporting clubs should be encouraged and enabled to provide short-term, non-competitive sporting opportunities for such children. This would provide the direct benefits derived from physical activity as well as allowing children to gain sporting experience in an inclusive, non-competitive environment with other children with similar predispositions. The emphasis should be on fun, activity, interaction and skill development. Such informal sporting experience might be a sufficient trigger for some children to consider a more committed involvement in organised sport. With

[16] *Issues*, Volume 81, December 2007.

government funding, schools could potentially provide after-school activities and school holiday programs to meet this need.

Children should be encouraged to walk or bicycle to school instead of travelling by car or bus.

Food and nutrition

Fresh vegetables and fruit are foundational for a healthy life. Part of the challenge in managing obesity in rural and (especially) remote areas is to improve access to good food and increase knowledge of nutrition and awareness of risk factors. For those in remote areas this poses particular transport, economic, management, and in some communities, cultural issues.

Government and non-government agencies should continue to work together to overcome the difficulties faced by people in remote areas in accessing healthy food and health hardware.

Issues of food security need to be addressed – not just in remote communities, but in rural areas as well which have many disadvantaged people facing problems caused by of lack of income. There should be a focus on improving food preparation skills in vulnerable groups, so that the ability to prepare and cook food from natural ingredients is enhanced. The quick alternatives often have high energy and low nutrient values. National standards should be set for food served in day care situations, preschool and school canteens and other meal programs.

Existing programs should be evaluated, and continued funding should be provided for those programs that have been successful so they can have adequate planning, implementation and evaluation to ensure ongoing sustainability. (Much of the current funding to address many of the public health issues is short term and not ongoing.)

With the shortage of dieticians in rural areas, utilising or expanding existing telemedicine facilities may be a way forward.

Consumers should be encouraged to support restaurants and food outlets that provide nutritious, low-fat food and moderate serving sizes.

Social, economic and environmental factors

The social, economic and environmental determinants of health must be recognised. For rural people this will include better education opportunities, improved career opportunities, and sustainable "regionalisation" of rural Australia, with greater community solidarity and inclusivity encouraging pride in progress and achievement.

A 'design for healthy living' influence should be brought to bear on rural planning and architecture, to ensure that regional centres and rural towns have open spaces, green parks, exercise playgrounds for children, sports ovals and safe walking access to schools. Local government needs to support the development of cycle ways, walking paths, swimming pools and sporting facilities – available at affordable prices – to encourage people to exercise more. These create opportunity for both formal and informal exercise. One local council has recently sought a grant to train and fund a facilitator for a range of exercise programs, even to including armchair exercises for the disabled. In another shire, pool fees are lower at non-peak times to provide greater affordability and encourage greater use.

For some people a healthy lifestyle will require a change in their work/leisure balance. Innovative workplaces will encourage 90 minute lunch breaks and/or variations to start and

finish times to allow staff to participate in fitness activities, and parents to be involved with their children's before and after-school sporting activities.

Mothers and babies

The Alliance is pleased to see the Government's strong emphasis on illness prevention and health promotion, including its plans to develop a National Preventative Health Strategy to provide a blueprint for tackling chronic disease.

The broader issue is for Australia to develop world's best-practice programs for supporting pregnant women and their babies in the first few years of life. Governments should give support to community-led initiatives to promote breastfeeding, healthy birth-weight and physical activity in children and young people. It is to be hoped that the first programs to be emphasised will include those focusing on child and maternal health for a range of health issues including managing and preventing obesity and establishing a healthy diet. All pregnant women, breastfeeding mothers, babies and children in rural (and particularly) remote areas, should have access to adequate affordable nutritious food.

Access to maternal and child health nurses during the child's early years is vital in helping to prevent many of the non-healthy lifestyles linked to obesity, particularly in 'at risk' families. However, maternal and child health nurses are already struggling to deal with an (unpredicted) increased birth rate.

Physiotherapists in rural and remote areas also work with their local communities to ensure the promotion of physical activity and health lifestyles.

The NRHA urges the Government to increase the national effort on early intervention in child and maternal health and for healthy parents, particularly through Healthy Mothers: Healthy Babies programs, and family services for rural areas.

A priority focus on Indigenous health

Indigenous people who live in remote communities face particular challenges in managing a healthy lifestyle and preventing obesity. Aboriginal and Torres Strait Islander children should be the highest priority for Government programs relating to maternal and child health.

Some of the issues impacting on Indigenous nutrition and wellbeing have been dealt with in detail at the recent National Nutrition Networks Conference (NNNC08) held in Alice Springs and at the Remote Indigenous Stores and Takeaways (RIST) Forum held in Adelaide in June 2006. (The conference resulted in a range of recommendations which are at Attachment 2 and the RIST Working Group and Forum Outputs are at Attachment 3.)

One important proposal is for a national nutrition unit which would have responsibility for the evaluation and revision of the National Aboriginal and Torres Strait Islander Nutrition Strategy and Action Plan (NATSINSAP), development of new goals and targets, securing funding for its next phase and leading implementation with accountability to the relevant Government departments. NATSINSAP has been a useful framework for the work of the State, Territory and Australian Governments. The conference emphasised the need to augment the workforce involved with Indigenous nutrition and the continued importance of collaborating with communities and community leaders in programs to improve nutrition.

Other key recommendations from the NNNC08 relate to child and maternal health, food security, and the particular issues of access to fresh and affordable food in more remote areas.

Traditionally Australian Indigenous people had a diet that was relatively low in energy but rich in micro-nutrients – the kind of diet which is now known to protect health and prevent chronic disease. It took much effort – and therefore energy – to obtain the food. Today, Indigenous people enjoy hunting for bush tucker but it is often a weekend activity, with the bulk of their diet coming from the community store.

Some Indigenous communities have an emphasis on equipping children to identify and gather bush foods and bush medicines. Their experiences could be used to develop a nation-wide program for schools in remote areas.

Community stores should be enabled to price fruit and vegetables more affordably than 'junk food', and fresh water should be readily available as an attractive alternative to soft drinks.

Governments should support dedicated nutrition positions which are needed for the development and delivery of maternal and child health programs which prioritise early life and are linked with pre-existing programs and structures for Aboriginal and Torres Strait Islander communities. Projects underway that have the potential to improve the situation include nutrition programs in schools, buying services across several communities, strategies to improve management of stores, employment, training, fair trading, food safety and hygiene, pricing and transport.

The capacity for Indigenous health professionals (especially Health Workers) to address health promotion, nutrition and obesity issues must improve. This can be achieved by making these topics core components in the education of Health Workers.

Building [on] the evidence base

Obesity might be seen not so much an epidemic as a growing sign and a symptom of 'living normally' in Australia early in the 21st century. But while the trend over time is towards greater weight gain, around half to two-thirds of our population stay relatively slim. This raises questions that, if answered, might contribute to understanding how to identify and address risk factors for obesity.

Endeavours to address these questions and find solutions to the identified problems should rest on a sound evidence-base. Existing research should be reviewed, knowledge gaps exposed and new areas for research identified. The focus of research needs to move from describing the problem to identifying and evaluating solutions.

<u>Evidence and case studies</u>

(1) During a diabetes project in a remote Northern Territory Aboriginal community, market basket surveys revealed that the community store increased its range of healthy food choices. Store turnover calculations demonstrated that the community's purchasing behaviour changed in favour of healthier foods. The findings of the evaluation support a more equitable balance in health sector investment between acute and preventive care.[17]

(2) The Royal Flying Doctor Service's experience of running a community development project under the Building Healthy Communities program in far north Queensland

[17] Marg Tyrrell, John Grundy, Pamela Lynch and John Wakerman, Laramba Diabetes Project: an evaluation of a participatory project in a remote Northern Territory community, Health Promotion Journal of Australia 2003;14:48-53.

demonstrated the value of a capacity building approach to engage small remote communities in increasing their consumption of healthy foods and levels of exercise. For example one small remote community was able to start up a community garden to grow fresh vegetables and another started up a walking group based on the 10,000 steps program

(3) The Diabetes Prevention Program has been picked up by the Council of Australian Governments and is currently being rolled out in the state of Victoria for 25,000 people. It is recognised by some in the health sector as the most effective program for weight loss and the only proven intervention for diabetes prevention in Australia. It has also been successful in reducing blood pressure and cholesterol, thereby reducing cardiovascular risk as well.

(4) A recent review of trials to prevent obesity in children found that 68 per cent of the interventions (17 out of 25) were effective based on a reduction of body mass index or skinfold. Physical activity at school and reducing television viewing appeared to be particularly effective components. A range of diet and physical activity strategies was found to work if they were implemented in the right way. Less effective was an over emphasis on education coupled with an under emphasis on environmental change to support the behaviours being sought. An identified advantage of a whole-of-community approach to obesity prevention is that scientific evidence can be produced in a solution orientated way where multiple strategies can be implemented in multiple settings. One such program is the Colac Be Active Eat Well established in mid 2002.[18]

It can be anticipated that obesity prevention research and activity will expand over the next 20 years in an effort to control and turn around the rising obesity epidemic. Whole-of-community interventions that can be sustained over time will provide evidence about what does and does not work at a community level. Evidence from research that is solutions-oriented and collaborative should be used as the basis for designing preventive strategies.[18] An adequate proportion of this research should focus on the distinctive requirements of people in rural and remote locations so that the 30 per cent of Australians who live outside metropolitan cities are also well served.

[18] Boyd Swinburn and Colin Bell, "Obesity Prevention", in Lawrence and Worsley (Eds) 2007, *Public Health Nutrition from principles to practice.*

Recommendations

1. The Government should increase its spending on health promotion and illness prevention, with at least one third of the allocation directed to people in rural and remote areas.

2. Primary health and prevention measures should be included as components in the Australian Health Care Agreements (ACHAs) or the new National Healthcare Agreement (NHA) that will come into effect on 1 July 2009.

3. The National Health and Hospitals Reform Commission should take account of the reduced care costs that derive from illness prevention and early intervention, and central agencies like the Departments of Treasury and Finance should recognise and promote the fact that providing resources for health promotion is an investment rather than a net cost.

4. The Government should ensure that there is a more equitable balance in health sector investment between acute and preventive care.

5. Funding for the management and prevention of obesity should be provided on the basis of collaborative planning between governments, consumers and health services and apportioned in a way that will ensure equity and sustainability for consumers and health professionals across all geographic locations.

6. Measures to prevent and manage the obesity epidemic will need to embrace public health initiatives and involve a whole-of-population approach.

7. Health promotion activities should be people-centred and will be more effective if community members are involved in their development and implementation.

8. Health promotion for a healthy weight will need to be for the long term, highly varied, coordinated and holistic - addressing multiple factors including food standards, advertising, nutrition education, access to fresh and affordable foods, and initiatives to address social, economic and environmental contributors to obesity, such as 'healthy' town planning to facilitate exercise, fitness and healthy lifestyles as well as increased opportunity for education, employment and improved self-perception.

9. Behavioural and attitudinal change takes time, so health promotion needs to be persistent and over a substantial period of time.

10. Health promotion programs for people in rural areas should take account of the special characteristics, challenges and diversity of Australia's rural and remote communities, and be planned and implemented in ways that will make them effective in those areas.

11. Statistics and risk factors relating to obesity should be promoted in health advertising and in places where people may need to be reminded that being overweight has unwelcome consequences and costs.

12. Consumers should be encouraged to support restaurants and food outlets that provide nutritious, low-fat food and moderate serving sizes.

13. Parent education is an important part of health promotion, and given that eating patterns are established early in life, promotion of healthy eating should include children.

14. Health professionals, such as dieticians, nurses and Aboriginal Health Workers, should be adequately resourced to deliver effective and structured health promotion activities in rural and remote communities.

15. Government should assist community sporting clubs to provide short-term, non-competitive sporting opportunities for children who are not otherwise involved in regular sporting activities. Such informal sporting experience should have an emphasis on fun, activity, interaction, and skill development.

16. Government and non-government agencies should continue to work together to address issues of food security and overcome the difficulties faced by people in remote areas in accessing healthy food and health hardware.

17. National standards should be set for food served in day care situations, preschool and school canteens and other meal programs.

18. Existing programs should be evaluated and, for those programs that have been successful, continued funding should be provided to enable adequate planning, implementation and evaluation to ensure ongoing sustainability.

19. Because of workforce shortages and heavy caseloads, dieticians should be supported in the use of telemedicine facilities and through expansion of existing telemedicine facilities.

20. A 'design for healthy living' influence should be brought to bear on rural planning and architecture, to ensure that regional centres and rural towns have open spaces, green parks, exercise playgrounds for children, sports ovals and safe walking access to schools.

21. Local government should support the development of cycle ways, walking paths, swimming pools and sporting facilities – available at affordable prices – to encourage people to engage in more formal and informal exercise.

22. The Alliance supports the Government's strong emphasis on illness prevention and health promotion, including its plans to develop a National Preventative Health Strategy.

23. Australia should develop world's best-practice programs for supporting pregnant women and their babies in the first few years of life.

24. Governments should give support to community-led initiatives that promote breastfeeding, healthy birth-weight and physical activity in children and young people.

25. All people, but importantly pregnant women, breastfeeding mothers, babies and children in rural (and particularly) remote areas, should have access to adequate affordable nutritious food.

26. The Alliance urges the Government to increase the national effort on early intervention in child and maternal health and for healthy parents, particularly through Healthy Mothers: Healthy Babies programs, and family services for rural areas.

27. Aboriginal and Torres Strait Islander children should be the highest priority for Government health promotion and illness prevention programs, including those relating to maternal and child health.

28. The Government should provide increased funding for dedicated permanent Aboriginal and Torres Strait Islander nutrition positions and continue to collaborate with communities and community leaders in programs to improve nutrition knowledge and encourage healthy eating.

29. Topics such as health promotion, nutrition and obesity should be included as core study components for Indigenous health professionals (including Health Workers) to increase their capacity to address these issues.

30. The Government should consider establishing a nation-wide program for schools in remote areas that has an emphasis on equipping children to identify and gather traditional bush foods.

31. Endeavours to address the obesity epidemic and find solutions to the identified problems for Australia's rural and Indigenous populations should rest on a sound evidence-base, both for an understanding of the problem as well as for identifying and evaluating strategies and solutions.

32. An equitable proportion of research into obesity prevention should focus on the distinctive requirements of rural and remote locations which are home to 30 per cent of Australia's population.

NRHA
May 2008

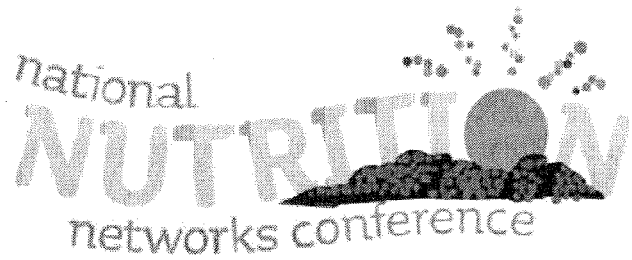
Attachment 1:

Member Bodies of the National Rural Health Alliance

ACHSE	Australian College of Health Service Executives
ACRRM	Australian College of Rural and Remote Medicine
AGPN	Australian General Practice Network
AHHA	Australian Healthcare & Hospitals Association
AHPARR	Allied Health Professions Australia Rural and Remote
AIDA	Australian Indigenous Doctors' Association
ANF	Australian Nursing Federation (rural members)
APA (RMN)	Australian Physiotherapy Association Rural Member Network
ARHEN	Australian Rural Health Education Network Limited
ARNM	Australian Rural Nurses and Midwives
CAA (RRG)	Council of Ambulance Authorities - Rural and Remote Group
CRANA	Council of Remote Area Nurses of Australia Inc
CRHF	Catholic Rural Hospitals Forum of Catholic Health of Australia
CWAA	Country Women's Association of Australia
FS	Frontier Services of the Uniting Church in Australia
HCRRA	Health Consumers of Rural and Remote Australia
ICPA	Isolated Children's Parents' Association
NACCHO	National Aboriginal Community Controlled Health Organisation
NRHN	National Rural Health Network
RACGP (NRF)	National Rural Faculty of the Royal Australian College of General Practitioners
RDAA	Rural Doctors' Association of Australia
RDN	Rural Dentists Network
RHWA	Rural Health Workforce Australia
RFDS	Royal Flying Doctor Service of Australia
RGPS	Regional and General Paediatric Society
RIHG	Rural Indigenous and Health-interest Group of the Chiropractors' Association of Australia
RPA	Rural Pharmacists Australia—Rural Interest Group of the Pharmacy Guild of Australia, the Pharmaceutical Society of Australia and the Society of Hospital Pharmacists of Australia
SARRAH	Services for Australian Rural and Remote Allied Health

Attachment 2:

NNC Priority Recommendations – March 2008



Priority Recommendations – March 2008

1 **Progress the NATSINSAP, in line with current government policy (and 'Close the Gap') led by the federal government, in partnership with State governments and Community Controlled Organisations, recognising needs of Aboriginal and Torres Strait Islander urban, rural and remote communities.**

Establish a national nutrition function with responsibility for the evaluation and revision of NATSINSAP, development of new goals and targets, securing funding for the next phase and leading implementation with accountability to the relevant government departments and AHMAC.

2 **Pregnant women, breastfeeding mothers, babies and children have access to enough available and affordable nutritious food.**

- Implement the provision of nutritious food to supplement at risk Aboriginal and Torres Strait Islander mothers, babies and children according to local need through existing programs (e.g. Maternal and Child Health and new nurse led home visiting programs)

- National breakfast/lunch initiatives are funded based on local need and community involvement and participation. e.g. women's centres, childcare, preschools, schools.

- Creation and ongoing support of dedicated Aboriginal and Torres Strait Islander nutrition positions prioritising early life, linked with pre-existing and new programs such as nurse home-visiting programs.

3 **Strengthen the nutrition workforce working with Aboriginal and Torres Strait Islander populations.**

- Increased funding for dedicated permanent Aboriginal and Torres Strait Islander nutrition positions across the workforce spectrum (Health workers specialising in nutrition, Community Nutritionists, Public Health Nutritionists and Clinical Dietitians) to achieve a **target: 100 nutrition positions per 100,000 Aboriginal and Torres Strait Islander population by 10 years in urban, rural and remote settings.**

- Establish career pathways, and increase retention rates for Aboriginal and Torres Strait Islander staff in the nutrition workforce; providing support through 'two way' mentoring programs and formal accredited training. Advocate for implementation of the cultural respect framework to ensure Indigenous health workers are valued for local nutrition knowledge around cultural processes and valuing traditional knowledge.

- Increased and sustained financial support for Aboriginal and Torres Strait Islander men and women to undertake undergraduate and tertiary nutrition training through access to current funding schemes, advocacy for new schemes (VET sector and secondary school based training) and provision of work place-based nutrition-specific government cadetship programs. Also, offer nutrition-specific tertiary level scholarships through new initiatives and existing scholarship schemes, e.g. NHMRC Postgraduate scholarships.

- Nutrition units be included as core units in the community care stream of the National Aboriginal and Torres Strait Islander Health Worker training package

4 Address the underlying food security issues facing Aboriginal and Torres Strait Islander people in urban, rural and remote Australia.

- Research, including an economic analysis is conducted to identify effective strategies of applying subsidies to achieve equity in the costs and availability of basic foods including fresh fruit and vegetables for Aboriginal and Torres Strait Islander people

- Subsidies for infrastructure and transport (particularly for communities with small populations) and food household infrastructure (including appropriate food storage, preparation and cooking facilities)

- Food security issues impacting on Aboriginal and Torres Strait Islander people living in urban, rural and remote locations are researched, reported and food security indicators developed for routine monitoring and reporting nationally

- Recognise and promote the value of traditional food systems and the role they play in food security for Aboriginal and Torres Strait Islander people

- Ensure that Nutrition and health expertise and community consultation is sought in key aspects of store licensing for remote communities.

5 National monitoring and surveillance for Aboriginal & Torres Strait Islander health, ensuring that all information is fed back to the community.

- Establish sustainable coordinated ongoing national monitoring and surveillance indicators, systems and targets for Aboriginal and Torres Strait Islander health, including healthy birth weight, healthy child growth, breastfeeding initiation and duration, nutritional status and oral health indicators linked to existing national targets and state KPI's

- Urban, rural and remote areas are included in a national food pricing enquiry with a plan for ongoing food price monitoring e.g. National market basket surveys

6 Communicating and disseminating good nutrition practice

- Funding to ensure that programs at all levels (local, statewide, national) are well evaluated, findings communicated and shared, and ongoing funding is secured for such programs

- Collaboration across all sectors of Aboriginal and Torres Strait Islander health and child development to address holistic approaches that recognise good nutrition as a necessary component of Aboriginal and Torres Strait Islander health improvement

- Secure funding for the communication and dissemination of good nutrition practice through current Aboriginal and Torres Strait Islander communication systems as well as other networking systems – i.e. journals, newsletters, indigenous HealthInfonet etc.

- Explore and secure funding options to ensure continuation of a biennial National Nutrition Networks Conference that enables networking and support for Aboriginal and Torres Strait Islander people and others working in food and nutrition programs and related areas, and to ensure the conference is accessible to all.

Attachment 3:

RIST Working Group and Forum Outputs

Remote Indigenous Stores and Takeaways Forum

Working Group and Forum Outputs

Government and community

- Government should consider food supply as an essential service and resources should be made available to assist communities reduce freight costs.
- The scope of the freight problem is not fully known and needs consultation; but freight and fuel costs are up, people are on low income, nutritious food is less affordable and infrastructure is deteriorating.
- DATSIP reports freight cost is up this year (2005–06) by 23% or $400 000 per annum.
- It is necessary to have a current database of all communities, stores and supply routes.
- Frequency of deliveries should be a minimum of weekly for food.
- Indigenous people need to have equity in the supply chain and employment opportunities in it.
- Need to introduce a freight equalisation scheme for efficient food supply chains.
- Registration fees should be reduced for freight operators serving remote Indigenous communities.
- Community stores should provide a bottom-up view to inform planning and strategy at a State then national level.
- There is a need to establish a national remote store managers group to act as a support, professional development and information network.
- It is important that there be community involvement in stores.
- Aboriginal involvement and expertise needs to be drawn upon.
- Need for professional assistance to prepare framework and agreements and submissions to government for assistance.
- Shared responsibility agreements and key performance indicators for freight need to be linked to benefit stores and communities.
- AQIS plant movement restrictions cause severe difficulties in Torres Strait community gardens (Woorabinda).
- Need to boost understanding of relationship between nutrition and health.
- Another forum is required to cover freight and broader issues such as tax, equity, profit or surplus etc.
- A regional approach is favoured rather than just a national approach.
- Better communication and information sharing on freight improvements is needed.
- Ongoing information flow through a regional coordination group would better link communities.

Freight management

- Some stores are not resourced sufficiently to manage freight issues.
- Freight must be well managed.
- Freight arrangements must be transparent.

- Reducing time from grower to supplier to store will assist product freshness, shelf life and appeal to consumer.
- Need for long-term relationships and 3 + 3 year contracts to enable freight operators to invest in specialised freight vehicles.
- A base stores purchasing and transport model tailored to the local environment (e.g. Torres Strait, Cape York, Mornington Island) is needed.
- Contract agreements are needed to provide security to trigger investment in transport by freight operators.
- Good communication is necessary between the customer and the freight service provider.
- Efficiency improvements can be gained by better on-time delivery, communication with suppliers, pallet consolidation and stores ordering on time.
- It is important for store managers to understand the consequences of not ordering on time, not receiving stock on time, and not unloading deliveries in a timely manner.
- Freight companies should have and be accountable for set procedures from receipt of loads to delivery.
- Stores should apply penalties for errors in transport.

Cold chain management

- Need for good temperature control and cold chain management.
- Cold chain needs improvement and data loggers should be used to bring this about.
- Stores need to specify product quality/temperature controls they require and check product on receival.
- Stores need to check quality on delivery and claim against poor quality.
- Random temperature checks need to be carried out on the food supply chain by government.
- Need to develop a uniform national quality standard for fruit and vegetables including HACCP, weights and measures, and packaging.
- Stores, suppliers and freight companies should adopt an accreditation scheme for all elements of the supply chain. The Cold Chain Centre provides training, chain performance benchmarks, accreditation and chain performance monitoring, reporting and diagnosis.

Cooperation and group freight buying

- Benefits of cooperation through group freight buying warrant investigation.
- Freight can be improved by increased volumes per shipment through collaboration on consolidation.
- Need for an organised group for collaboration in negotiations, consolidation and group freight buying.
- Look at NATS/APY Lands as working models.
- A whole-of-transport approach is required to investigate/verify the different transport models talked about in the Forum.
- Freight coordinator needed for community clusters working with a regional coordinator. Seek IBA support for this through its Outback Stores initiative.
- Group freight opportunity identified between Oak Valley, Yalata, and Koonibba.
- Opportunity to establish a dry goods and perishable consolidation and redistribution facility at Halls Creek.

Human resources and training

- Australia lacks a good information baseline on how many communities and stores there are, where they are and what type they are.
- Need for a skills and capability database to identify persons suitable for relieving store managers and staff and/or filling positions when a vacancy occurs.
- Stores need to be able to afford appropriate technology and training.
- Training needs to be available in communities.
- Need for access to information on how and where skill improvement training can be obtained.
- Communities need homemaker/healthy ways skills improvement, including what to do with good food and how to store and cook it.
- Homes need refrigerators.
- Community training and support needed for the handling, storage, preparation and cooking of food. Store managers to be directly involved.
- Teach stores and communities to reduce waste.
- Increased Aboriginal employment, skills development, training and education.
- Increased Aboriginal equity participation in the supply chain.
- Issue of stores rejecting sub-standard product being out of stock for a week to the detriment of the community.
- Private companies need to increase their involvement in promoting healthy food in stores.