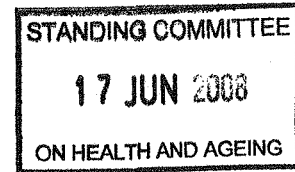


Submission No. 92
(Inq into Obesity)
18/06/08



13 June 08



The Secretary
Parliamentary Standing Committee on
Health & Ageing
House of Representatives
Parliament House
Canberra ACT 2600

Dear Sir,

Please find attached submission from Diabetes Australia to the House of Representatives Standing Committee on Health & Ageing – *Inquiry into Obesity into Australia*.

I thank you for the opportunity given to Diabetes Australia to make this submission.

Kind Regards,

A handwritten signature in black ink, appearing to read "Matt O'Brien", with a long horizontal flourish extending to the right.

Matt O'Brien
Chief Executive Officer

**Submission from Diabetes Australia to the
House of Representatives Standing Committee
on Health and Ageing**

Inquiry into Obesity in Australia

June 2008

Contact: Dr Ian White

National Policy Manager

Diabetes Australia

Ph 02 6232 3826

Fax 02 6230 1535

Mob 0418 389 671

Email iwhite@diabetesaustralia.com.au

**Submission from Diabetes Australia to the House of representatives Standing
Committee on Health and Ageing**

Inquiry into Obesity in Australia

Dear Mr. Catchpole

Diabetes Australia thanks the Parliamentary Standing Committee on Health and Ageing for this opportunity to make a submission to the inquiry into obesity in Australia and acknowledge the important work of the Parliamentary Diabetes Support Group at government level.

1. About Diabetes Australia

Diabetes Australia is the national peak body for diabetes in Australia. We have a direct relationship with almost 1,000,000 Australians with diabetes through the National Diabetes Services Scheme (NDSS) which is an Australian Government initiative providing management support for people with diabetes, their families and health professionals.

Diabetes Australia is a Federation of 12 organisations covering three key groups:

- consumers;
- health professionals; and
- researchers.

Diabetes Australia is a not for profit organisation relying on support from the community and government. We are a non-party political organisation.¹

Obesity is a worldwide epidemic associated with a variety and mix of complex causes. Obesity is a preventable and modifiable risk factor for many chronic diseases including diabetes. Diabetes Australia's response to the obesity epidemic is embedded in our vision, a world free of diabetes and in our mission, to turn diabetes around. To do this, Diabetes Australia has a simple strategy, to pursue clear objectives in five key areas of awareness, prevention, detection, management and cure.

The objectives we pursue have a clear and significant link to the reduction of obesity in the general population. These objectives are to:

- raise awareness of the seriousness of all types of diabetes;
- reduce the incidence of diabetes;
- increase early diagnosis of diabetes;

¹ www.diabetesaustralia.com.au/about_us/index.html

- maximise capacity to manage and care for all types of diabetes; and
- support and promote research for a cure for diabetes.

To achieve these objectives, Diabetes Australia is working to lead and deliver national activities that add value for people affected by diabetes. Our philosophy underpinning this work is that collaboration is the key to successful outcomes. The 'Diabetes Futures Forum' hosted by the Parliamentary Diabetes Support Group and held here at Parliament House on 13 August 2007 is a good example of collaboration within the wider diabetes community.

Historically, Diabetes Australia's relationship with the Australian Government has centred on diabetes management. This continues to be a strong and important focus. However, turning around the diabetes epidemic, is largely dependent on successfully addressing the growing obesity issues being faced by Australia. This means that the focus of our current relationship will be expanded to include the key areas of awareness, prevention, and early detection involving obesity.

2. Causes of Obesity and Solutions to the Obesity Epidemic

Obesity occurs when a person consumes more calories from food than they burn. Our bodies need calories to sustain life and be physically active, but to maintain weight we need to balance the energy we eat with the energy we use. When a person eats more calories than they burn, the energy balance is tipped toward weight gain and obesity. This imbalance between calories-in and calories-out may differ from one person to another. Genetic, environmental, and other factors may all play a part.

2.1 Genetics

Obesity tends to run in families, suggesting a genetic cause. However, families also share diet and lifestyle habits that may contribute to obesity. Separating genetic from other influences on obesity is often difficult but evidence shows a link between obesity and heredity.

2.2 Environment

Environment strongly influences obesity. Most people in Australia alive today were also alive in 1980, when obesity rates were lower. Since this time, our genetic makeup has not changed, but our environment has. Environment includes lifestyle behaviours such as what people eat and their level of physical activity. Too often Australians eat out, consume large meals and high-fat foods, and put taste and convenience ahead of nutrition. In addition, most Australians do not get enough physical activity.

Environment also includes the physical world around us and our access to places to walk and access to healthy foods. Today, more people drive long distances to work instead of walking, tend to eat out or get take away fast food, instead of cooking, or have vending machines with high calorie, high fat snacks at their workplace. Our environment often does not support healthy habits.

2.3 Social Factors

In addition, social factors including poverty and a lower level of education have been linked to obesity. One reason for this may be that high calorie processed foods cost less and are easier to find and prepare than healthier foods, such as fresh vegetables and fruits. Other reasons may include inadequate access to safe recreation places or the cost of gym membership, limiting opportunities for physical activity. The link between low socioeconomic status and obesity has been conclusively established.

Although people cannot change their genetic makeup, they can work on changing eating habits, levels of physical activity and other environmental factors if the environment promotes and supports change.

Diabetes Australia believes that obesity is primarily a health and social issue and that the main objective of any effort by individuals, communities, non-government organisations and governments in regard to obesity, should be addressing concurrently, both the risk factors for obesity and their underlying social determinants. The social determinants of health, provide avenues through which effective interventions and solutions to obesity can be found.

While we believe that the immediate risk factors for obesity lie in individual and collective behaviour. We also believe that this behavior is determined significantly by factors such as the social, economic, political and cultural environment in which society is shaped and by which it functions. Diabetes Australia believes that changes in these factors have led to health inequities and the development of an 'obesogenic' environment which promotes and sustains obesity. These factors, which are known collectively as the social determinants of health, provide avenues through which effective interventions and solutions to obesity can be found.

As a solution to the obesity epidemic, Diabetes Australia believes that Australia needs to develop a cross-portfolio and multi-sectoral approach to prevention and early intervention, which recognises and addresses the social determinants of health that underpin obesity and other chronic diseases and their risk factors. This will require universal, as well as targeted strategies aimed at building capacity, maximising protective factors and minimising risk factors.²

From research and policy initiatives internationally and in Australia, there is increasing evidence that the burden of disease associated with obesity is inequitably borne by those who are socially, economically and culturally disadvantaged. The vast majority of health disparities experienced by these groups defined by

² The provincial government of British Columbia, Canada, has established a ministry called 'ActNow' whose function is to address lifestyle issues including smoking, alcohol and obesity among other things. The ministry is separate from the Health department which deals with acute care and treatment. It is financed by taking a proportion of the budget from each of the other ministries. In this way other portfolios have a stake in the outcome of 'ActNow' and participate as required. The Minister for 'ActNow' reports to each ministry and parliament. The 'ActNow' model can be transposed to a federal level which has been discussed by the federal Canadian parliament as an option to address the increasing rate of chronic disease in Canada.

socioeconomic status, ethnicity or other positions of social disadvantage are avoidable. These avoidable health disparities are inherently unfair. This is why it is critical to improve the social determinants of health because in addition to the growing evidence base, it is the fair and just thing to do.³

3. Economic Burden of Obesity

An economic study of the cost of obesity in Australia, commissioned by Diabetes Australia and undertaken by Access Economics in 2005, showed that the total financial cost of obesity in 2005 was estimated as \$3.8 billion. Of this, productivity costs were estimated as 1.7 billion (45%); health system costs were \$873 million (23%) and carer costs were \$894 million (21%). Dead weight loss from transfers (taxation revenue forgone, welfare and other government payments) were \$358 million (10%) and other indirect costs were \$40 million (1%). The net cost of wellbeing (the dollar value of the burden of disease netting out financial costs borne by individuals) was valued at a further \$17.2 billion bringing the total cost of obesity in 2005 to \$21 billion. The Access Economic report estimated that in 2005, 102,204 Australians had type 2 diabetes as a result of being obese. Every day in Australia about 275 adults develop diabetes (about 100 000 adults each year). In 2005 the financial cost of diabetes due to obesity was \$1.1 billion.⁴

However, it should be noted that because of its close relationship to morbidity and disability, obesity will significantly increase the number of years that an individual suffers from ill health and may add much more to indirect as well as direct costs. Importantly, the escalating cost of health care with progression of an obesity related disorder, such as diabetes, has been calculated as almost doubling over time with normal progression of the disease. This suggests that the economic burden is not only significant, but is likely to get worse even if there is no further growth in the prevalence of obesity. Overseas studies have found that obese people attain lower levels of occupational prestige (and lower incomes) than non-obese people. In addition, other studies have found that obese people as a group receive more sickness and unemployment benefits than people within a normal weight range.

4. Obesity and the Most Vulnerable Populations

4.1 Aboriginal and Torres Strait Islanders

Diabetes Australia also strongly believes that extra effort must be put into reducing the obesity epidemic in our Aboriginal and Torres Strait populations. Support for health and social programs to help these communities must come from both Australian Government and State/Territory governments if substantial change is to be made. In 2001, the ABS National Health Survey (2001) classified 61% of Indigenous respondents over 15 years of age as overweight or obese compared with 48% of non-Indigenous respondents. Self reported results from the 2004-05 National Aboriginal and Torres Strait Health Survey showed that in each age group

³Social determinants of health: the solid facts. 2nd Edition/edited by Richard Wilkinson and Michael Marmot - <http://www.euro.who.int/document/e81384.pdf>

⁴ Economic Cost of Obesity 2005
www.diabetesaustralia.com.au/lib/doc_pdf/reports/obesity/Economic_Costs_of_Obesity.pdf

indigenous males and females were more likely to be obese than non-indigenous Australians.⁵

The high level of obesity puts the indigenous population at greater risk for type 2 diabetes and other chronic conditions. Type 2 diabetes is one of the major health conditions that a majority of Aboriginal Australians contend with during most of their life span. Many Aboriginal people living with diabetes have other priorities in life than health and are either in denial or may not acknowledge or fully understand the seriousness of the diabetes and tend to act only when they have to deal with long term complications.

Health statistics available do not reflect the true picture of Aboriginal people living with diabetes due to non-identification of Aboriginality.

However, it is estimated that between 10-30% of Aboriginal people live with diabetes. During 2004 and 2005, 6% of Aboriginal Australians were reported as having either diabetes or raised blood sugar levels. Aboriginal people are three times more likely than non-Aboriginal people to report some form of diabetes. In the remote areas of Australia 9% of Aboriginal people were reported as having diabetes. This is not unusual as during 1996 it was reported that the Kimberley population had the fourth highest prevalence of Type 2 diabetes in the world.

Within the Aboriginal community diabetes presents at a much younger age and the total incidence of diabetes is on the rise. Gestational diabetes (diabetes during pregnancy) is more common in Aboriginal women than non-Aboriginal women and the prevalence rates are estimated to be as high as 20%.⁶

Higher rates of morbidity and mortality for type 2 diabetes in Aboriginal populations can be attributed to a combination of factors connected to historical and political events, actions and laws. Effects of these factors have filtered down from generation to generation and were not dealt with immediately or effectively. Hence, resulting in a buildup of historical and contemporary stress and trauma that Aboriginal people have to deal with in the now whilst finding a balance to manage their diabetes.

Aboriginal people experience disadvantage through factors such as education, employment, income and housing. This disadvantage has meant that many are in the low socioeconomic category. Recent research has shown that adults who have a low socioeconomic status are more likely to die prematurely from diabetes and have more chronic disease risk factors than those of high socioeconomic status.

Certain factors directly impact on Aboriginal Australians having higher prevalence rates for the risk factors associated with diabetes, such as obesity, physical inactivity and stress. Also the extended period between the onset of diabetes and diagnosis, lack of access to health services and poor glycaemic control, may also contribute to the higher Aboriginal morbidity and mortality rates for diabetes.

For many Aboriginal people dealing with issues causing stress usually takes

⁵ ABS 2006cNATSIHS, 2004-05. ABS cat no 4715 Canberra ABS

⁶ Australia's Health 2006. AIHW. Canberra.

precedence over other health issues and can dramatically affect the self-management of diabetes. Stressors include cultural, social, environmental, spiritual, emotional, economic and/or psychosocial aspects, with themselves and family or extended family. Different levels of stress also influence the priority given or urgency of seeking treatment for diabetes by an individual.

4.2 Culturally and Linguistically Diverse Populations

Change must also be directed to some Culturally and Linguistically Diverse populations now emerging as significant numbers of new and established migrant populations in Australia. This applies especially to those people from the South West Pacific and South East Asia where overweight and obesity are increasingly linked to the rising incidence of type 2 diabetes.⁷

Australia is a multicultural nation with 28% of its population born overseas. Proportionally more overseas born people than Australian born people have diabetes. The prevalence of diabetes in people born in Australia is 3% while it is 4% for those born overseas. Rates of diabetes, hospitalisations and mortality are more common among people born in the South Pacific Islands (prevalence of diabetes 6%), Southern Europe (prevalence of diabetes 5%), Middle East (prevalence of diabetes 7%), North Africa (prevalence of diabetes 7%) and Southern Asia (prevalence of diabetes 6%).⁸

The prevalence of overweight and obesity in Australia was estimated in 2004-05 to be 63% for people born in Australia, 62% born in the South Pacific Islands and 67% in those born in Southern and Eastern Europe. It has been suggested that the global rise in type 2 diabetes is linked to rapidly increasing numbers of overweight and obese people which mirrors the growth in urbanisation and economic development, declining levels of physical activity and increasing availability of energy dense, nutrient poor processed foods, and may be due to maladaptation to a rapidly changing environment.⁹

4.3 Children

Obesity rates in children have more than doubled in just over 10 years with one in five Australian children overweight and one in ten obese. Current statistics show that some 652 children have now developed type 2 diabetes which is normally seen in adults and is largely obesity related. The most important long term consequence of childhood obesity is its persistence into adulthood.

Obesity is more likely to persist when its onset is in late childhood or adolescence and where children have obese parents. There is now evidence to support the theory that the association between obesity and chronic diseases like type 2 diabetes begins early in life.

⁷ Australia's Health 2006. AIHW. Canberra.

⁸ Diabetes Australian facts 2008. AIHW. Canberra

⁹ Diabetes Atlas 2003. International Diabetes Federation. 2003

Diabetes Australia strongly urges the Australian Government to support and implement the recommendations arising from the 'Healthy Lifestyle Forum to Help Combat Childhood Obesity' held in Canberra at Parliament House 20th June 2007.¹⁰

4.4 Socioeconomic Position

It is well understood that socioeconomic status is a complex concept and has a strong influence on health and wellbeing. It is often conceptualized around three main factors – education, employment status and income. Disadvantage in any of these areas has the potential to have an impact on prevalence of obesity and consequently diabetes. The prevalence of overweight and obesity and physical inactivity is higher in groups with lower socioeconomic position compared with groups with higher socioeconomic position.

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). People with diabetes were 20-50% as likely to be overweight or obese compared with those without diabetes across all socioeconomic groups. Except for those from the highest socioeconomic group, a higher proportion of people with diabetes than those without diabetes in all other socioeconomic groups were estimated to be physically inactive.¹¹

4.5 Geographic Location

People living in rural and remote regions of Australia generally have worse health in terms of mortality, hospitalization rates and risk factors compared with those living in metropolitan regions. This difference may be related to fewer educational and employment opportunities, poorer access to health services and the availability of basic necessities such as clean water, sewerage and food security.¹²

The relatively large proportion of indigenous people living in remote and very remote areas (12% and 45% respectively) compared with major cities, together with poorer overall ill health, is reflected in high death rates in remote areas. When the risk factors for diabetes in populations with and without diabetes in different geographical regions is compared, the proportion that is overweight or obese is consistently higher among people in all areas with diabetes than among those without diabetes.¹³

5. Diabetes Australia Action on Obesity

Diabetes Australia believes that if we, as the peak body for diabetes in Australia, are to achieve our mission and turn diabetes around, then there needs to be a concerted effort from all key stakeholders, government at all levels, non-government

¹⁰ www.guybarnett.com/index.php?page=speeches&category=6

¹¹ National Health Survey 2004-05. Australian Bureau of Statistics. Canberra

¹² Diabetes Australian facts 2008. AIHW. Canberra

¹³ National Health Survey 2004-05. Australian Bureau of Statistics. Canberra

organisations, community based agencies and their leaders to work in partnership with us to develop healthier lifestyles. This will require strategies beyond behaviourally based awareness raising campaigns focusing on physical activity and healthy eating. It will require concerted, committed and coordinated action at systems and organisational level to address the underlying social determinants of health that cause risk factors that in turn cause chronic disease like obesity and diabetes. Diabetes Australia believes we must deal with the obesogenic environment in this way if we are to effect any real change which is sustainable over the long term and help create an environment where healthy choices can be easier choices. Diabetes Australia intends to focus its strategic intent across five objectives on type 2 diabetes (and by inference obesity) though awareness, prevention, detection, management and cure. These objectives will be underpinned by two levels of action the first, aimed at the risk factors for obesity including physical inactivity and poor nutrition. At this level we will be working with other key stakeholder organisations like the Heart Foundation, Kidney Health Australia and the Dieticians Association who are likewise attempting to get similar health and wellbeing messages across to the public.

At the second level, and underpinning the risk factors for obesity, are the social determinants of health. These are known to be among the worst causes of poor health and inequalities. The determinants include unemployment, low levels of education and social connection, poor housing and public transport, unsafe workplaces, unplanned or poorly planned urbanisation, and lack of access to health services. At this level we are working with government to improve structural and organisational barriers to healthy lifestyle so that healthy choices are easier choices.

Diabetes Australia has developed an Interim Policy on Overweight and Obesity (May 2008) (**Attachment 1**) which it intends to use as a basis for advocacy and program development.

Diabetes Australia Recommendations

Diabetes Australia recommends that the Parliamentary Standing Committee on Health and Ageing accept the recommendations arising in the Diabetes Australia Interim Policy on Overweight and Obesity - section beginning - *Ageing Diabetes Australia recommends that the following steps be undertaken (page 5 of Attachment 1)*.

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Attachment 1

Diabetes Australia

Interim Policy Statement on Overweight and Obesity

(May 2008)

Preamble: Diabetes Australia notes the following information and issue concerning overweight and obesity:

1. That people who are overweight and particularly those who are obese have higher death rates than people of healthy weight both overall and from a range of specific conditions. These include type 2 diabetes, cardiovascular disease, hypertension, dyslipidemia, chronic obstructive pulmonary disease, stroke, renal disease, psychosocial problems (AIHW 2006).
2. Body mass index (BMI) is an internationally recognized standard for classifying overweight and obesity in adults. BMI is calculated by dividing body weight in kilograms by the square of the height in meters. For people aged 18 years and older of Anglo Celtic ancestry, a BMI of 25 or more is considered overweight and 30 or more is obese (AIHW 2006).
3. Measurement of waist circumference may be a simpler valid alternative to BMI for health promotion (Han et al 1996). Significant increased risk appears to occur when the waist circumference is greater than 102cm for men and 88cm for women (NHMRC 2003).
4. Many factors influence an individual's weight; overweight and obesity are due to an imbalance of energy intake from diet and energy expenditure through physical activity. Genetics play a role in weight gain however, modifiable risk factors, social, economic, political, cultural and environmental factors play a role in weight gain, weight loss and subsequent maintenance (AIHW 2006).
5. The 2000 Australian Diabetes, Obesity and Lifestyle Study indicated that 60% of Australians aged 25 and above were overweight. Of these, over 21% were obese. Of these, 67% of men were overweight compared to 52% of women. There has been a significant increase in the proportion of overweight and obese Australians over the last 20 years. From 1980 to 2000, for people aged 25-64 years, the proportion of overweight women increased from 27% to 47% and the proportion of overweight men increased from 47% to 66%. On average, women in 2000 weighed 4.8kg more than their counterparts in 1980 and men 3.6kg more.(National Obesity Taskforce).

6. In 2005, 3.24 million Australians were estimated to be obese (15.1% males, 16.8% females). The 55-59 year age group contained the largest number of obese people (159 000 males and 203 000 females) (The economic costs of obesity, access economics 2006).
7. A baseline prevalence projection indicates that by 2025 a total of 4.2 million Australians (16.7%) are forecast to be obese. However, if rates continue at historical levels, there could be as many as 7.2 million (28.9%) of Australians obese by 2025. In 2005 there were estimated to be 102 204 Australians with Type 2 diabetes as a result of being obese (10.8% of all people with Type 2 diabetes) (The economic costs of obesity, access economics 2006).
8. In 1995 an estimated 4.7% of boys and 5.5% of girls aged 7-15 years were obese and a further 15.3% of boys and 16% of girls were overweight but not obese (Margarey et al 2001).
9. In the ten year period from 1985 to 1995 the prevalence of obesity among 7-15 years tripled (Margarey et al 2001).
10. There is evidence of links between childhood eating behaviour, physical activity trends and obesity and their association with long term chronic conditions such as diabetes and cardiovascular disease.
11. School based interventions to reduce soft drink intake among children have shown potential to be effective in preventing excess energy intake and overweight (James et al 2004; Ebbeling et al 2006).
12. Interventions that show the greatest potential for reducing obesity in children are those that reduce sedentary behaviours at home – particularly hours spent viewing TV – and promote physical activity in and out of school hours as well as improved diets.
13. Many states in Australia have introduced policies and programs to promote healthier food choices in school canteens (NSW Health 2000).
14. The prevalence of obesity in ATSI population is 25% in males and 28% in females compared to an overall population prevalence of 18% (NHMRC 1997; NATSI Working party 2001).
15. The level of overweight and obesity is 2 to 3 times higher in people of Southern European and middle Eastern ethnic origin compared to those of British decent (NSW Health 2003).

16. Data suggests that rural and remote communities have higher levels of overweight and obesity. Access to appropriate foods and opportunities to engage in appropriate physical activity are likely to be major contributing factors to these differentials in rural and remote communities (NSW Health 2003).
17. Clustering factors such as low levels of education, low income and food insecurity and their association with overweight and obesity levels, requires complex and sensitive interventions. In the past, Australia enforced a reasonable level of physical activity and limited food choice. Currently Australia's population has access to a wide range of cheap, energy dense and nutrient poor foods (junk food) that is powerfully marketed, providing a disincentive for expending energy through physical activity. This 'obesogenic' environment inhibits appropriate dietary and physical activity patterns and encourages energy imbalance (Gebel et al 2005).
18. The total financial cost of obesity in 2005 was estimated to be \$3.767 billion. Of this, productivity costs were estimated at \$1.7 billion (45%), health system costs were \$873 million (23%) and carer costs were 804 million (21%). Dead weight losses from transfers (tax revenue forgone, welfare and other government payments) were \$358 million (10%) and other indirect costs were \$40 million (1%). Net cost of lost wellbeing was valued at a further \$17.2 billion, bringing the total cost of obesity in 2005 to \$21 billion. Financial costs are borne by a number of stakeholders including the individual (29.1%) family and friends (16.4%), the Australian Government (\$1.4 billion annually), State Governments (5%), employers (1%) and 12.4% by the rest of society. However, if the cost of lost wellbeing is included, the individual's share rises to 87.3% of the total (cost of obesity – access economics).
19. Research has generally focused on individual behaviour change with little attention to organisational and environmental change (Nat Cancer Prevention policy 2007-2009).
20. There is a lack of research on the efficacy of different approaches to high risk, hard to reach, low income and CALD populations that appear to experience higher rates of overweight and obesity (Nat Cancer Prevention policy).
21. Some short term intense programs are reported as being effective in terms of weight loss but there are doubts about sustainability (Huon et al 1999; Sahota et al 2001). Evidence shows that these interventions have tended to focus on highly motivated families through specialist clinics with little evidence that treatment interventions are more than moderately effective. Short term weight loss is generally reversed in the long term.
22. Obesity prevention interventions that have failed are those that address either diet alone or physical activity only and relied solely on education strategies

without considering environmental influences or that focused on activities and behaviours that only occur in limited settings such as school hours (Ebbeling et al 2002; Reily et al 2002; Micucci et al 2002).

23. Schools can be the delivery sites for interventions but must consider options to reach the whole family.
24. An excessive level of food advertising on TV contributes to an obesogenic environment. Evidence shows that food advertising contributes to poor food choices, poor overall diet and increased weight gain and obesity (Chapman et al 2006; Neville et al 2005; Hastings et al 2003; CFMDYC 2005).
25. Effective public health interventions are sustained, research based and multi-faceted and address social, cultural, behavioural, organizational and environmental factors (Nat Cancer Prevention Policy 2007-2009).
26. General practitioners are a vital link in the prevention of obesity. GPs have the potential to influence and encourage patients to take greater responsibility for the health including lifestyle changes (RACGP 2006).
27. The Australian Government and many of the states and territory governments have taken steps to develop and implement various frameworks and action plans to address overweight and obesity including several summit meetings between key stakeholders in a bid to reduce the rising incidence of overweight and obesity. (NPHP 2007).
28. The WHO has adopted a Global Strategy on Diet, Physical Activity and Health from which countries including Australia have taken as guidelines for the development of national policy on overweight and obesity (WHO, GSDPA).

Diabetes Australia affirms the following principles:

1. Overweight and obesity are serious national health problems that require urgent and immediate attention from all levels of government requiring an all of government approach.
2. Beyond the immediate obviating impact of government intervention on overweight and obesity, are underpinning socio-environmental and psychosocial issues requiring an all of society approach.
3. There should be a general awareness within the Australian population of the negative health consequences of being overweight or obese.

4. The Australian population should be aware of the health link between being overweight or obese and the development of type 2 diabetes and other chronic diseases.
5. Control of overweight and obesity requires the application of individual and population based interventions including encouraging healthy eating behaviours and regular physical activity concurrently with changes in the social determinants of health.
6. People who are overweight or obese should have reasonable access to information about their condition, its health consequences and avenues of treatment.

Diabetes Australia recommends that the following steps be undertaken:

1. Overweight as well as obesity must become a national health priority.
2. That the Australian Government immediately implement the recommendations arising from the relevant national health action plans and national service implementation frameworks including the National Diabetes Strategy and Implementation Plan 1998 which outlines evidence based issues of overweight and obesity in the Australian population and proposal for solutions.
3. Development of a cross-portfolio and multi-sectoral approach to prevention and early intervention which recognises and addresses the social determinants of health that underpin obesity and other chronic diseases and their risk factors. This will require universal as well as targeted strategies aimed at building capacity, maximising protective factors and minimising risk factors.
4. A comprehensive, coordinated Australian Government approach to develop and implement a national health promotion and chronic disease prevention program through a federally funded agency like a National Health Promotion Foundation which would develop national policy and programs required to address overweight and obesity beyond the political and budgetary cycles of governments at all levels.
5. There is an urgent need for a significant increase in funding and other resource allocation to community based interventions through the primary health care sector. The level of resource commitment to the primary health care sector is far too small at all levels of government to effect any significant long term, sustainable change in reducing population overweight and obesity. This will require a revisit to the health reform agenda to ensure an equitable distribution of resources across the continuum of care.

6. The Australian Government needs to legislate a simple and more effective form of food labeling like the 'traffic light' system used in some school canteens in Australia.
7. Introduce a tax on all energy dense/low nutrient foods (junk food).
8. Promotion of breastfeeding up to at least the first six months of life if practicable.
9. Provide subsidised fruit and vegetables in rural and remote communities.
10. The Australian Government should regulate to remove television advertising of junk food to children.
11. Re-introduce mandatory physical activity in all schools including a weekday afternoon designated to sport and recreational activity.
12. Provide subsidised membership registration fees to sporting clubs to offset the cost of insurance.
13. Provide funding for research into obesity as a risk factor for type 2 diabetes and other chronic diseases and as a consequential factor in the creation of obesogenic environments.
14. The Australian Government legislate to ban television advertising of junk food (energy dense, nutrient poor) directed at children and at times when most young children would be watching television.
15. Governments legislate to prohibit soft drink (high sugar content beverages) and junk food (energy dense, nutrient poor) vending machines in government owned or leased premises.
16. The Australian Government develop national standards for the nutrition of older people in residential aged care facilities.
17. Governments at all levels need to reduce rates of overweight and obesity in children through a variety of settings including schools, neighbourhoods and transport and through a focus on family cohesion and inclusion. The most important long term consequence of childhood obesity is its persistence into adulthood. Obesity is more likely to persist when its onset is in late childhood or adolescence and where children have obese parents. There is now evidence to support the theory that the association between obesity and chronic diseases like type 2 diabetes begins early in life. Diabetes Australia believes that effort must be made to address the rising incidence of childhood obesity through a targeted approach to family lifestyle and that this approach be linked to a life course strategy which emphasises health promotion and disease prevention throughout and across the stages of life including children, young people, adults and older adults.

18. Increase Australian Government research funding to population based approaches to overweight and obesity.
19. The Australian food and beverage industry take note of its corporate citizenship and place within Australian civil society. The food and beverage industry has a significant role to play in shaping the present and future health status of the Australian population not just in making profits for its shareholders. As a significant stakeholder in the health of the Australian population, the food and beverage industry, both producers and retailers, have an obligation to be honest and transparent about their products and reflect this in their product labeling so that content can quickly be identified and is easy to understand.
20. The Australian Government develop national accreditation standards for weight loss programs and centres.
21. The Australian fitness industry look beyond providing quick fix, non-sustainable programs for overweight people, to providing holistic programs in association with health professionals.
22. That general practitioners and other medical and clinical practitioners are well placed to identify, educate and support patients and clients who are overweight or obese.
23. That special attention is given to Aboriginal and Torres Strait populations and Culturally and Linguistically Diverse populations at risk from overweight and obesity through limited health literacy and access to appropriate information and services. Diabetes Australia strongly believes that extra effort must be put into targeted strategies to reduce the obesity epidemic in our Aboriginal and Torres Strait populations. Support for health and social programs to help these communities must come from both Australian Government and State/Territory governments if substantial change is to be made. Similarly, Culturally and Linguistically Diverse populations are now emerging as significant numbers of new and established migrant populations in Australia. This applies especially to those people from the south west pacific and south East Asia where overweight and obesity are increasingly linked to the rising incidence of type 2 diabetes. Diabetes Australia strongly believes that extra effort must be put into targeted strategies to reduce overweight and obesity in many of our CALD populations.
24. Re- invest in a national comprehensive primary health care system designed to work closely with communities in a multi-disciplinary and inter-sectoral way through health promotion and disease prevention programs.
25. That the Australian Government support and promote the use of health impact assessment tools in the design and implementation of policy and programs that impact on, or have the potential to impact on, overweight or obesity in the Australian population.
26. Negotiate at an international level to have an appraisal of the influence of unfretted trade agreements on food supply, particularly the impact of processed

foods to under-developed and developing nations and the increase influence of junk food on lifestyle.

Diabetes Australia resolves to undertake the following actions:

1. Advocate and lobby for the Australian Government to address the issues of overweight and obesity outlined in this policy relating to the general community; ATSI and CALD population; general practitioners and other stakeholder health professionals.
2. Urge STMOs to adopt this policy at jurisdictional level and from it, develop local policy and programs that address overweight and obesity in their communities.
3. Work with relevant Australian health professional associations and societies to assist them raise awareness and provide evidence based information to government and relevant food and beverage industries about the impact of policies and programs on overweight and obesity in the Australian population.
4. Encourage relevant general practitioner organisations to ensure GPs are adequately and regularly briefed about issues relevant to the prevention, early intervention, treatment and care of those diagnosed as overweight or obese.
5. Lobby key stakeholders to endorse this policy and develop guidelines to assist with putting the principles of this policy into practice.

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