3

What more can governments do?

3.1 Governments across Australia can display leadership in the overall direction taken to reduce the current unacceptable levels of overweight and obesity, and has the resources to enable healthier environments. As the Committee heard from a researcher at Flinders University:

> The government has the mandate to make sure that the environment supports optimal health and wellbeing of citizens. The government has the power to address structural and environmental determinants. It has the tools: legislation, policy and regulation.[1]

3.2 The Committee acknowledges that the actions that are required to lose weight must be undertaken by individuals; however governments can make these decisions easier for individuals. At a public hearing in Sydney, Professor Baur from the Children's Hospital at Westmead likened individual behaviour change to rolling a heavy ball up a steep environmental gradient, with the role of government being to reduce the environmental gradient:

> …people do need to seek to behave healthily but, if the environment is working against the individual, a huge amount of effort is needed. If that environmental gradient can be changed by having walkable neighbourhoods and easy public transport and with healthy food options being available, it makes it much easier for individuals to make healthy choices … the importance of governments … is in helping to make the environmental gradient much lower.[2]

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1 Ms K Mehta, Flinders University, Official Transcript of Evidence, 13 June 2008, p 31.

2 Professor LA Baur, Children's Hospital Westmead, Official Transcript of Evidence, 11 September 2008, p 74.

3.3 The diverse causes of obesity require a range of responses from government, and are not limited to health. The Committee recognises that each component will not have as significant an impact on obesity as the cumulative effect of all the components combined, and will be more effective if the elements of the strategy are self-reinforcing.[3]

3.4 This chapter will consider the role that government at all levels, federal, state and local, can play in providing supportive environments for Australians to be active and healthy. It will focus specifically on:

- national leadership;
- prevention;
- the health system;
- regulation;
- urban planning;
- provision of community facilities and activities; and
- research agenda.

National leadership

3.5 Any effective policy response to obesity must engage all tiers of government as well as research bodies, industry, communities and individuals. The Federal Government however, has the capacity and resources to drive the national response to obesity. As Ms King from the Institute for Obesity, Nutrition and Exercise put to the Committee at its Sydney hearing:

> … leadership is best delivered at a national level.[4]

3.6 Leadership can take several forms. Professor Swinburn spoke about the potential for the Federal Government, as one of the largest employers in Australia, to show leadership by implementing internal policies to promote and encourage healthy lifestyles for their employees.[5] The

3 Ms JE Martin, Obesity Policy Coalition, Official Transcript of Evidence, 20 June 2008, p 45; Ms L King, Institute of Obesity, Nutrition and Exercise, Official Transcript of Evidence, 11 September 2008, p 72.

4 Ms L King, Institute of Obesity, Nutrition and Exercise, Official Transcript of Evidence, 11 September 2008, p 73.

5 Professor BA Swinburn., WHO Collaborating Centre for Obesity Prevention, Official Transcript of Evidence, 20 June 2008, p 23.

Committee supports this concept and encourages departmental initiatives that provide and enhance healthy choices for their staff.

3.7 The Committee notes that there are government departments that already provide subsidies for employees to access gym and sporting facilities. For example, many departments reimburse staff who sign up for gym memberships or memberships of sports clubs. In addition, most government departments provide facilities for cyclists who choose to ride to work and also support the 10,000 steps program. However, the Committee thinks that the government, as an employer, can do more than merely subsidise fitness and club memberships. As is the case with other employers, discussed in Chapter 4, government employers must provide supportive environments to allow workers to be active and healthy.

3.8 Examples of the way the Federal Government can show leadership include:

- developing a whole-of-society response; and
- generating national guidelines.

Whole-of-society response

3.9 Evidence has been presented to the Committee about the need for a whole-of-society response to obesity. This whole-of-society response should be led by the Federal Government. Political leadership will be required to ensure that the diverse actors across government, non-government organisations (NGOs), the private sector and individuals are all involved in the policy response to increasing levels of obesity in Australia.[6] The Committee thinks that the Federal Government is best placed to deliver this type of leadership.

3.10 The need for a whole-of-society response to obesity is borne out of the fact that the causes of obesity are complex and diverse.[7] Therefore, it can be difficult for one sector or department to influence the causes of obesity, particularly when they fall outside of the jurisdiction of that specific department.[8] For example, the impact on levels of obesity caused by issues surrounding public transport and urban planning fall outside the purview of health departments. As Professor Baur from Westmead Children's Hospital explained:

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6 Professor BA Swinburn, WHO Collaborating Centre for Obesity Prevention, Official Transcript of Evidence, 20 June 2008, p 23.

7 Dr AM Margery, Flinders University, Official Transcript of Evidence, 13 June 2008, p 33.

8 Ms TA Browning, Private Capacity, Official Transcript of Evidence, 18 August 2008, p 4; Dr I White, Diabetes Australia, Official Transcript of Evidence, 12 May 2008, p 12.

> … health departments at both state and federal level are overwhelmed by obesity and have little ability to address the drivers of the obesity epidemic; it is beyond their portfolio remit. Involving those portfolios that are important in influencing the drivers of obesity—or of climate change, which is often very similar—will be vital.[9]

3.11 Examples of inter-governmental and inter-sectoral bodies working to address obesity at the state level were brought to the Committee's attention in Queensland and Western Australia.

3.12 Former Queensland Premier Beattie's obesity summit in 2006 resulted in the formation of the Eat Well, Be Active Taskforce in Queensland. The taskforce consisted of senior officers from a range of different departments. Queensland Health informed the Committee that one of the successes of the taskforce was a greater engagement with Sport and Recreation Queensland who:

> … are now taking a much more proactive approach to general physical activity.[10]

3.13 The Committee also heard about the Western Australian (WA) Premier's Physical Activity Taskforce which encourages inter-sectoral government cooperation. Representatives from WA Health informed the Committee that within this taskforce, Planning and Infrastructure had taken the lead on physical activity initiatives.[11] In addition, the Committee was particularly interested to learn that this taskforce also collaborated with organisations outside of government like the Heart Foundation.

3.14 Some witnesses to the inquiry called for the establishment of a specialised department or taskforce that is separate from existing departments. They argued that this body could independently administer the policy response to obesity.[12] The Commonwealth Science and Industrial Research Organisation (CSIRO) informed the Committee that there was a:

> …need to have a national obesity task force that really sits separately from the existing departments – it may be composed of

9 Professor LA Baur, Children's Hospital Westmead, Official Transcript of Evidence, 11 September 2008, p 73.

10 Dr LA Selvey, Queensland Health, Official Transcript of Evidence, 1 October 2008, p 4.

11 Ms S Leivers, Western Australian Department of Health, Official Transcript of Evidence, 6 November 2008, p 2.

12 Ms L King, Institute of Obesity, Nutrition and Exercise, Official Transcript of Evidence, 11 September 2008, p 72.

> representatives from departments and interested bodies – that has its own budget…to spend money in this area…[13]

3.15 The Committee notes the proposal to establish a national preventive health agency which appears in the National Partnership Agreement on Preventive Health agreed to by the Council of Australian Governments (COAG) in November 2008[14] and believes that this agency will perform a similar, if not more comprehensive, role to that of a taskforce.

3.16 The Committee supports the establishment of a dedicated preventive health agency which in addition to having its own budget to spend money in this area, will alert, inform and educate Australians more about the need for healthy lifestyles and the resources and choices available to them for these purposes.

National guidelines

3.17 A number of witnesses called for the Federal Government to show leadership by developing or improving the national guidelines for physical activity, nutrition, school canteens and urban planning. The Committee thinks that greater adherence to national guidelines developed by the Federal Government will have a number of benefits including consistency across jurisdictions. This consistency will ensure that there is a single message being delivered thereby preventing confusion and overlap.

3.18 The Committee acknowledges that there are already a number of well-written national guidelines in existence, namely the National Health and Medical Research Council (NHMRC) *Dietary Guidelines for all Australians*[15] and the Department of Health and Ageing (DoHA) *Physical Activity Guidelines*.[16] In many instances, these guidelines have been taken on board, supplemented and/or extended by state and territory governments.

3.19 Submissions to the inquiry called for the national guidelines to be updated to reflect the best available science on nutrition and activity.[17] With

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13 Professor P Clifton, Commonwealth Science and Industrial Research Organisation (CSIRO), Official Transcript of Evidence, 13 June 2008, p 44.

14 Council of Australian Government, National Partnership Agreement on Preventive Health, <http://www.coag.gov.au/intergov_agreements/federal_financial_relations/index.cfm> accessed 17 April 2009.

15 National Health and Medical Research Council, <http://www.nhmrc.gov.au/publications/synopses/dietsyn.htm> accessed 17 April 2009.

16 Department of Health and Ageing, <http://www.health.gov.au/internet/main/publishing.nsf/Content/health-pubhlth-strateg-phys-act-guidelines> accessed 17 April 2009.

17 Obesity Policy Coalition, Submission No. 94, npn; Queensland Health, Submission No. 56, p 20; Heart Foundation, Submission No. 106, p 5.

regards to nutrition, the Heart Foundation called for the nutrition guidelines to cover food quality, quantity and consumption. In addition, a witness at Dubbo, representing Walgett Aboriginal Medical Service (WAMS), called for the guidelines to focus on fruit and calcium, particularly because of the health benefits for children of adequate calcium intake.[18]

3.20 The Committee acknowledges that there is currently a review into the NHMRC dietary guidelines which were published in 2003, and hopes that the concerns raised throughout the inquiry will be addressed through that review process.[19]

3.21 The Committee was concerned to learn that the *2007 Children's Nutrition and Physical Activity Survey* unearthed evidence that 82 percent of girls aged 14 to 16 had a calcium deficiency.[20] This implies that just having national guidelines for nutrition and diet is not enough. The Federal Government also needs to monitor the nutritional intake of Australians to ensure that those guidelines are being followed. If, as in this case, significant deficiencies are found, then the government can act to reverse the trend, but these deficiencies will not be known without closer attention to the nutritional intake of the Australian population.

3.22 The Committee also heard that there should be an equal focus on the guidelines for physical activity because its impact on obesity is as important as nutrition.[21] Queensland Health submitted that physical activity guidelines for adults have not been reviewed since 1999 and they also called for the NHMRC to expand the guidelines for pregnant women.[22] Witnesses also raised the fact that many people in the community were unaware of the guidelines for Physical Activity, as Professor Byrne from the Australian and New Zealand Obesity Society (ANZOS) stated:

> …how many people actually know what the national recommendations for physical activity are?[23]

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

19 Queensland Health, Submission No. 21, p 21.

20 Ms AK Carnell, Australian Food and Grocery Council, Official Transcript of Evidence, 24 October 2008, p 72.

21 Professor C Gericke, University of Adelaide, Official Transcript of Evidence, 13 June 2008, p 17.

22 Queensland Health, Submission No. 56, p 21.

23 Associate Professor NM Byrne, Australian and New Zealand Obesity Society, Official Transcript of Evidence, 1 October 2008, p 31.

3.23 It was also suggested to the Committee that governments should give more consideration to promoting their existing guidelines. The Public Health Association of Australia recommended additional funding to promote guidelines more widely, not just to relevant professionals but to the general public.[24] The Committee is of the view that the current *How do you measure up?* campaign may be a good avenue to promote the current activity and nutrition guidelines to the general public.

3.24 In addition to diet and activity guidelines, witnesses to the inquiry raised concerns about the lack of guidelines controlling the types of foods sold in school canteens. Some witnesses went so far as to call for a ban on the sale of junk food and sweets.[25] Professor Cobiac from Flinders University informed the Committee that she was participating in the National Healthy Schools Canteens project which is considering national guidelines for the types of foods that should be included in school canteens.[26] The Committee is also aware that the Federal Government has provided funding for the development of healthy eating and activity guidelines for early childhood and child care centres.[27] Further, state and territory governments have also developed their own healthy canteen policies, for instance the NSW Healthy Canteen Strategy.[28]

3.25 Some witnesses argued that urban planning is another area where national guidelines could be established and made more effective. While planning is generally the remit of state, territory and local governments, more consistent approaches to planning across Australia would be beneficial. The Heart Foundation submitted that the Federal Government should support the development of national guidelines for planning for health and that there should be mandated physical activity impact assessments on all planning and policy decisions.[29] Uniformity of planning laws across Australia could have flow-on benefits for developers and designers, and this proposal should be considered in more detail.

3.26 The Committee is of the view that the scientific review and then promotion of the existing dietary and physical activity guidelines is a

24 Public Health Association of Australia, Submission No. 101, p 5; Associate Professor NM Byrne, Australian and New Zealand Obesity Society, Official Transcript of Evidence, 1 October 2008, p 31.

25 Professor C Gericke, University of Adelaide, Official Transcript of Evidence, 13 June 2008, p 21.

26 Professor L Cobiac, Flinders University, Official Transcript of Evidence, 13 June 2008, p 37.

27 Australian Government, 2008, *One year progress report*, p 63, <http://www.dpmc.gov.au/publications/one_year/index.cfm> accessed 17 April 2009.

28 NSW Department of Education and Training, *Fresh Tastes NSW Healthy School Canteen Strategy*, <https://www.det.nsw.edu.au/policies/student_serv/student_health/canteen_gu/PD20020058.shtml> accessed 17 April 2009.

29 Heart Foundation, Submission No. 106, p 24.

central tool to reversing the high levels of obesity in Australia. The Committee agrees that there is a need to develop and implement nationally consistent urban planning guidelines, and makes a recommendation about this issue in the urban planning section of this chapter. The Committee has been concerned by evidence that excellent guidelines already exist but are not being promoted or implemented, and strongly supports calls to promote existing national guidelines more effectively.

Prevention

3.27 Witnesses to the Committee have argued for a greater focus on the prevention of obesity. Prevention is important because it will limit the level of obesity in Australia and the attendant social and economic costs. And, prevention is a long-term solution to curb increased costs associated with obesity.[30] Witnesses argued that prevention should be given the highest priority when finding solutions for obesity.[31]

3.28 The Federal Government should take the lead in focusing on prevention of obesity; however a prevention strategy will not be effective without the involvement of state, territory and local governments. Therefore, prevention requires action by all three tiers of government.

3.29 The Committee acknowledges that this process is underway. Obesity is a priority with the National Preventative Health Taskforce (the Taskforce) set up to advise government and health providers and develop a National Preventative Health Strategy.[32] The promotion of 'healthy weight' has become the focus of activities under COAG through the Australian Better Health Initiative (ABHI) and the National Partnership Agreement on Preventive Health which was agreed by COAG on 29 November 2008.[33] As mentioned previously in this chapter, the Committee supports the establishment of a national prevention agency as foreshadowed in the National Partnership Agreement on Preventive Health. This agency will help to ensure that prevention activities by government are complementary and self-reinforcing.

30 Associate Professor K Samaras, Australian Healthcare and Hospitals Association, Official Transcript of Evidence, 12 May 2008, p 38.

31 Ms L King, Institute of Obesity, Nutrition and Exercise, Official Transcript of Evidence, 11 September 2008, p 71.

32 Department of Health and Ageing, Submission No. 154, p 37.

33 Department of Health and Ageing, Submission No. 154, p 34.

3.30 There were submissions to the inquiry that argued against prevention, including public health education campaigns, saying that prevention strategies have not been proven to be effective. The Centre for Independent Studies (CIS) submitted that:

> Studies that show higher provision of *primary care* produces better health outcomes – because it allows patients to receive timely diagnosis and referral to secondary care by other specialists and then to necessary tertiary, predominantly hospital-based treatments – contain no evidence that receipt of *preventive care* prevented chronic illness.[34]

3.31 The Committee took evidence about the value of various preventative programs, including the Colac intervention and the WellingTONNE project. These are discussed in detail in Chapters 5 and 6. In the next sections the Committee will consider the value of prevention, from a government perspective, by reflecting on the benefits of social marketing and the Active After-schools Communities (AASC) program.

Social marketing and education

3.32 Social marketing, if well directed, can play a significant role in educating Australians about healthy eating and living. The messages of social marketing campaigns can increase consumer demand for healthy products and embed physical activity and healthy eating into everyday life. Well developed and long running social marketing campaigns can play a central role in preventing and reversing the high levels of Australian obesity.

3.33 Witnesses to the inquiry have been critical of the lack of promotion of healthy eating and physical activity. They have argued that promotion of healthy eating and activity would prevent significant future costs as a result of obesity. As Professor Swinburn stated at a public hearing:

> … if you look at the health budget you cannot even find a line item for promotion of physical activity and healthy eating, and yet its downstream costs are huge and they blow out the health budget.[35]

3.34 There have, over the years, been a number of social marketing campaigns undertaken to promote healthy lifestyles. Currently the ABHI is running the *How do you measure up?* campaign which includes hard-hitting television ads and billboard posters. This campaign is the first stage of a rolling social marketing program implemented by the ABHI which was set

34 Centre for Independent Studies, Submission No. 60, p 5.

35 Professor BA Swinburn, WHO Collaborating Centre for Obesity Prevention, Official Transcript of Evidence, 20 June 2008, p 23.

up in February 2006 by COAG. One of the central tenets of the *How do you measure up?* campaign and the advertisements associated with the campaign is that it has been developed with cooperation from state and territory governments.[36] The campaign is aimed at adults between 25 and 60, and the objectives are:

- to increase awareness of the link between chronic disease and lifestyle risk factors (poor nutrition, physical inactivity, unhealthy weight);
- to raise appreciation of why lifestyle change should be an urgent priority;
- to generate more positive attitudes towards achieving recommended changes in healthy eating, physical activity and healthy weight;
- to generate confidence in achieving the desired changes and appreciation of the significant benefits of achieving these changes;
- to encourage Australians to make and sustain changes to their behaviour, such as increased physical activity and healthier eating behaviours, towards recommended levels; and
- thereby contribute to reducing morbidity and mortality due to lifestyle related chronic disease in Australian adults.[37]

3.35 Some witnesses told the Committee members that social marketing campaigns have only had a marginal impact on obesity:

> There is a wealth of literature, of evidence, that actually health promotion campaigns, at their best, have a marginal impact when it comes to obesity.[38]

3.36 This concern that social marketing campaigns can be ineffective emphasises the need to ensure that campaigns are well researched and well-targeted. The Committee recognises that social marketing alone is not the answer. A number of witnesses to the inquiry argued that these campaigns are only effective if they are targeted, are part of a broader campaign and encourage long-term, sustainable changes to diet rather

36 Dr L Roberts, Preventative Health Taskforce, Official Transcript of Evidence, 12 November 2008, p 5.

37 *How do you measure up?* campaign, <http://www.measureup.gov.au/internet/abhi/publishing.nsf/Content/About+the+campaign-lp> accessed 17 April 2009.

38 Professor C Gericke, University of Adelaide, Official Transcript of Evidence, 13 June 2008, p 15.

than fads.[39] As Professor Stewart from the Baker Heart Research Institute stated:

> … if social marketing is to be done well then it has to have good penetration, it has to carry the right messages and all these sorts of things, but it also has to be linked with policy and practice.[40]

3.37 An example of social marketing that has been successful is the Quit campaign. Witnesses to the inquiry argued that the success of this campaign is the fact that it has long-term, ongoing funding, and that it is not merely a marketing campaign, but is integrated with other services.[41]

3.38 The Committee is of the view that there is value in using social marketing to educate Australian consumers about healthy lifestyle choices and thinks that it can drive changes to our eating and physical activity patterns. However, the Committee recommends that before any social marketing campaign is implemented, research is undertaken to determine the most effective strategies to ensure such a campaign will be effective. The Committee acknowledges that there is evidence to show that social marketing alone is not sufficient. Any social marketing campaigns undertaken by governments, federal, state, territory and local, need to be integrated into a broader policy response to obesity and need to benefit from long-term ongoing funding. Raising awareness is not sufficient; these campaigns need to direct people to services and information which give practical advice on making long-term, sustained lifestyle changes.

Recommendation 3

3.39 **The Committee recommends that the Minister for Health and Ageing work with state, territory and local governments through the Australian Health Ministers' Advisory Council to develop and implement long-term, effective, well-targeted social marketing and education campaigns about obesity and healthy lifestyles, and ensure that these marketing campaigns are made more successful by linking them to broader policy responses to obesity.**

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39 Professor S Stewart, Baker Heart Research Institute, Official Transcript of Evidence, 20 June 2008, p 8.

40 Professor BA Swinburn, WHO Collaborating Centre for Obesity Prevention, Official Transcript of Evidence, 20 June 2008, p 26.

41 Professor BA Swinburn, WHO Collaborating Centre for Obesity Prevention, Official Transcript of Evidence, 20 June 2008, pp 21 and 26.

Active After-school Communities

3.40 One program that the Federal Government funds which promises preventative benefits is the Active After-school Communities (AASC) program. AASC encourages primary school aged children to be active by running after school sessions at various locations. Introducing children to physical activity at a young age could have significant implications for future health costs by preventing children from requiring treatment for obesity. It also has the potential to increase levels of physical activity in the community by establishing a life long enjoyment of physical activity.

3.41 The AASC has been widely mentioned as a successful model for targeting physical activity programs to primary school aged children.[42] This program is administered by the Australian Sports Commission (ASC), who briefed the Committee about the program. The Committee heard that AASC operates in 3,250 schools and out-of-school care centres nationally,[43] and offers a mix of activities that are non-competitive,[44] including circus skills and dance. The program has been running since 2005 and has funding until 2010.[45] In addition, officers from the ASC informed the Committee that this program has a significant unmet demand,[46] and is constrained from expanding to more sites by lack of funding.

3.42 The Committee was pleased to be able to visit a primary school in Lake Macquarie on 12 September 2008, Marks Point Primary School, which is participating in the AASC program. Here the Committee participated in, and felt the effects of, various sports including a tug-of-war. Committee members got to see first hand why the AASC is so successful and that the children were having fun while being active. This is an excellent program that should continue to be supported and expanded to more Australian schools. The AASC was audited by the Australian National Audit Office (ANAO) in 2008, who concluded that the program was, by and large, being successfully implemented by the ASC. [47]

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42 Mr NC Cox, YMCA Australia, Official Transcript of Evidence, 24 October 2008, p 49.

43 Mrs J Flanagan, Australian Sports Commission, Official Transcript of Evidence, 25 June 2008, p 2.

44 Mrs J Flanagan, Australian Sports Commission, Official Transcript of Evidence, 25 June 2008, p 4.

45 Mrs J Flanagan, Australian Sports Commission, Official Transcript of Evidence, 25 June 2008, pp 5-6.

46 Mrs J Flanagan, Australian Sports Commission, Official Transcript of Evidence, 25 June 2008, p 2.

47 Australian National Audit Office (ANAO), *Active After-school Community Program: Audit Report 2008/2009,* <http://www.anao.gov.au/director/publications/auditreports/2008-2009.cfm?item_id=0076E5CE1560A6E8AA1AD31D632CBD2F> accessed 17 April 2009.

Recommendation 4

3.43 **The Committee recommends that the Minister for Health and Ageing continue to support the Federal Government's Active After-school Communities program and consider ways to expand the program to more sites across Australia.**

Figure 3.1 Members visiting the Active After-school Communities program at Marks Point Public School, Lake Macquarie, NSW

Health system

3.44 The inter-relationship between federal, state, territory and local government in Australia is complex, in particular the division of responsibilities for health care. In some cases, the distinction between state and Federal Government functions is clear, but in others, like child and maternal health services, there is overlap of responsibility. As a generalisation, within the context of this report the health responsibilities of the Federal Government are:

- Medicare and the Pharmaceutical Benefits Scheme (PBS) which provide subsidy payments for doctors' services and pharmaceuticals;

- funding public hospitals through the Australian Health Care Agreements with the state and territory governments;
- subsidising private health insurance through rebates for the costs of premiums; and
- funding other programs including public health programs.

3.45 State and territory and local government responsibilities are as follows:

- management of and shared responsibility for funding public hospitals; and
- funding for and management of a range of community health services.[48]

3.46 The Committee has heard a number of suggestions for improvements to the health system in order to treat and reverse the rate of obesity in Australia. These changes focus on up-skilling the existing health workforce to better manage and treat obesity, as well as ensuring that there are sufficient treatment options available for those Australians who are already obese. This section will consider changes to the health system to better treat and manage obesity, including:

- current reviews of the health system;
- bariatric surgery;
- changes to the Medicare Benefits Schedule;
- a role for general practitioners (GPs);
- training;
- treatment options; and
- child and maternal health.

Current reviews of the health system

3.47 The Federal Government has announced a number of programs and reviews which will assist in providing better levels of health care to the Australian community. In relation to obesity and chronic disease, the Federal Government announced funding of a *Healthy Kids Check* and the development of a *National Primary Healthcare Strategy*. The *Healthy Kids Check* will ensure every four year old has a basic health check prior to

48 Boxall, AM & Buckmaster, L, 2009, *Background Note: Options for reforming Australia's health system*, Parliamentary Library, <http://www.aph.gov.au/Library/pubs/BN/2008-09/HealthReform.htm > accessed 17 April 2009.

beginning school.[49] This will provide an opportunity to discuss obesity with parents and recommend changes to levels of activity and diet that may be required.

3.48 The *National Primary Health Care Strategy* is still under development, with the discussion paper released in late October 2008. The goal of the strategy is:

- rewarding prevention;
- promoting evidence-based management of chronic disease; and
- encouraging a greater focus on multidisciplinary team-based care.[50]

3.49 The final large scale review which is currently taking place, and is relevant to this inquiry, is the *National Health and Hospitals Reform Commission*. The Commission was appointed in February 2008, and an interim report was released in early 2009. The goal of the Commission is to develop a long-term health reform plan for Australia.[51] The interim report includes a comprehensive review of the reform needs of the Australian health system and focuses on four broad themes:

- taking responsibility;
- connecting care;
- facing inequities; and
- driving quality performance.[52]

3.50 The Committee acknowledges that the results of these reviews may have implications for the recommendations contained in this report.

Bariatric surgery

3.51 The Committee heard significant evidence about the benefits of bariatric surgery and the limitations of public access to bariatric surgery.

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49 Australian Government, 2008, *One year progress report*, p 60, <http://www.dpmc.gov.au/publications/one_year/index.cfm> accessed 17 April 2009.

50 Australian Government, 2008, *One year progress report*, p 61, <http://www.dpmc.gov.au/publications/one_year/index.cfm> accessed 17 April 2009.

51 National Health and Hospitals Reform Commission, *A Healthier Future for all Australians: Interim Report December 2008*, p i, http://www.nhhrc.org.au/internet/nhhrc/publishing.nsf/Content/interim-report-december-2008 accessed 17 April 2009.

52 National Health and Hospitals Reform Commission, *A Healthier Future for all Australians: Interim Report December 2008*, p 1, <http://www.nhhrc.org.au/internet/nhhrc/publishing.nsf/Content/interim-report-december-2008> accessed 17 April 2009.

3.52 Bariatric surgery refers to a number of different procedures whereby the size of the stomach is reduced. The World Health Organisation (WHO) has endorsed bariatric surgery (gastric banding, sleeve gastrechtomy and Roux-en-Y gastric bypass) as the 'most effective way of reducing weight and maintaining weight loss in severely obese patients'.[53] The Committee heard that this surgery is usually only available to patients with a body mass index (BMI) over 40 but is sometimes recommended for patients with a BMI between 35 and 40 if they have other chronic health problems such as type 2 diabetes.

3.53 The Committee heard from a number of witnesses to the inquiry that bariatric surgery is a cost-effective intervention for those people who are already obese and for whom other interventions have not worked.[54] The reason that surgery is cost-effective is because bariatric patients often experience a considerable reduction in their co-morbidities, like type 2 diabetes, after surgery and that this results in a marked decrease in medical costs. As Dr Brown from the Centre for Obesity Research and Education explained:

> There is quite a body of evidence that, following bariatric surgery … and once we intervene with the lapband, we see a significant reduction in diabetes with weight loss.[55]

3.54 However, the Committee also heard that surgery is not a cure for obesity. Rather surgeons view the band as a tool for patients to utilise when losing weight. The success of the surgery depends on a 'partnership' approach,[56] which means that patients must be committed to the process and must have access to a multidisciplinary team including the surgeon, dietitians and psychologists. As a bariatric surgeon stated at a public hearing:

> We want it done responsibly with a team behind it – people who are committed to the process.[57]

3.55 The Committee is of the view that bariatric surgery should only be available as a 'last resort' once all other attempts at weight loss have been attempted and only advocates an increase in access to surgery for those

53 World Health Organisation (WHO) 2000, *Obesity: Preventing and Managing the Global Epidemic*, WHO, Geneva, p 198; Australian Medical Association (AMA), *AMA Position Statement on Obesity – 2008*, <http://www.ama.com.au/node/3033> accessed 17 April 2009.

54 Associate Professor K Samaras, Australian Healthcare and Hospitals Association, Official Transcript of Evidence, 12 May 2008, p 40.

55 Dr WA Brown, Centre for Obesity Research and Education, Official Transcript of Evidence, 20 June 2008, p 34.

56 Dr WA Brown, Centre for Obesity Research and Education, Official Transcript of Evidence, 20 June 2008, p 37.

57 Dr WA Brown, Centre for Obesity Research and Education, Official Transcript of Evidence, 20 June 2008, p 43 – 44.

who meet stringent clinical guidelines. The Committee agrees with the evidence presented to it that bariatric surgery is a tool for achieving weight loss, but has concerns that it will have limited success for those patients who receive surgery but are not supported by a multidisciplinary team of surgeons, dietitians and psychologists.

3.56 The Committee was repeatedly told that access to such multidisciplinary teams is essential to achieve success with bariatric surgery. In both her written and oral evidence to the Committee, Associate Professor Samaras outlined the need for a team to provide a range of ongoing support to patients including psychological and dietary care.[58] A witness who had undergone bariatric surgery told the Committee that it was only access to a multidisciplinary team that had enabled her to succeed:

> There has to be a multidisciplinary approach to this. You need the dietary assistance. You need the psychological assistance. You need the support from the general practitioner. You need the monitoring of your bloods.[59]

3.57 Witnesses have been critical of the lack of public access for bariatric surgery. A number of witnesses and submissions have stated that many patients, especially those of lower socioeconomic status, are unable to access surgery through the public system. [60] The Committee heard that this means a large section of the Australian population, a group which is often more likely to be obese, is denied access to a proven successful treatment.

3.58 The Committee questioned witnesses about the lack of public access to bariatric surgery and heard that there is a discrepancy between public access across states and territories. Some states have good public access and others do not. The Committee heard that this difference results from each individual state determining whether or not bariatric surgery is publicly available. As Dr Peeters from the Centre for Obesity Research and Education explained:

> There is an MBS [Medicare Benefits Schedule] code for it, but it is a state-by-state decision. As the states have divulged their budgetary responsibility down to health networks or to hospitals,

58 Associate Professor K Samaras, Australian Healthcare and Hospitals Association, Official Transcript of Evidence, 12 May 2008, p 39.

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

60 Dr A Peeters, Centre for Obesity Research and Education, Official Transcript of Evidence, 20 June 2008, p 41.

> in fact it really is the health services decision as to how they spend their money.[61]

3.59 Allergan's submission to the inquiry outlined the publicly funded lapbands that were provided in 2007. Their submission stated that:

> Of the 6,253 bands provided in 2007, 96% were in private hospitals, with the remaining 4% (223 bands) in public hospitals. When examined by state, usage varies widely. No publicly funded bands were supplied in SA, TAS or NT. Victoria provided the greatest number, 157; whilst NSW, Queensland and WA provided 10, 55 and 1 respectively.[62]

3.60 The Committee recognises that there is an increasing focus on the benefits of bariatric surgery and that access has changed over time. The figures quoted above are from 2007, and the Committee notes that there have been changes to the public funding for bariatric surgery since then. For example the Committee is aware that access to bariatric surgery in Tasmania is now 'fairly unrestricted',[63] and that New South Wales announced increased public access to bariatric surgery in August 2008.[64]

3.61 While the Committee is pleased to learn that states and territories are moving to make public bariatric surgery available, the Committee is nevertheless concerned about the inconsistencies in public access which vary from state to state. The Committee recommends that the Minister for Health and Ageing work with the relevant State and Territory Health Ministers to ensure equity in access to publicly funded bariatric surgery.

Recommendation 5

3.62 **The Committee recommends that the Minister for Health and Ageing work with State and Territory Health Ministers through the Australian Health Ministers' Conference to ensure equity in access by publicly funding bariatric surgery, including multidisciplinary support teams, for those patients that meet appropriate clinical guidelines.**

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61 Dr WA Brown, Centre for Obesity Research and Education, Official Transcript of Evidence, 20 June 2008, p 43.

62 Allegan, Submission No. 75, p 10.

63 Dr WA Brown, Centre for Obesity Research and Education, Official Transcript of Evidence, 20 June 2008, p 43.

64 The Hon Reba Meagher MP (NSW Minister for Health), *New $36 million statewide strategy to tackle rising obesity*, media release, <http://www.health.nsw.gov.au/news/2008/20080804_01.html> accessed 17 April 2009.

National bariatric register

3.63 The Committee heard from the Centre for Obesity Research and Education that a register is required to track the effectiveness of bariatric surgery. They argued that this register is needed to evaluate both the effectiveness and safety of this surgery over the long-term.[65] Given that this would need to be a national register, it would need federal support and would have to be driven from a federal level.

3.64 The Committee questioned Dr Peeters, from the Centre for Obesity Research and Education, about how such a register would work and she stated that:

> … for it to work in the way that we see and for it to take the world leading role that I would like it to take, it would be a compulsory registry. It would be basically a system of collecting data from all the groups doing this surgery around Australia and possibly New Zealand. It would have to be housed by an independent body. It would need state and federal support. It would need support of the relevant groups such as OSSANZ [ANZOS] and the surgical society … I think the drive needs to be from a national mandated position …[66]

3.65 The Committee agrees that a compulsory register could be useful, however, it is not clear exactly where or how this register could be kept or developed. There is however a role for the Federal Government to play in developing a dialogue with the relevant stakeholders in order to look at establishing this register. The register would, as Dr Peeters stated, allow Australia to take a world leading role in the monitoring and evaluation of the success of bariatric surgery.

Recommendation 6

3.66 **The Committee recommends that the Minister for Health and Ageing develop a national register of bariatric surgery with the appropriate stakeholders. The register should capture data on the number of patients, the success of surgery and any possible complications. The data that is generated should be used to track the long-term success and cost-effectiveness of bariatric surgery.**

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65 Dr A Peeters, Centre for Obesity Research and Education, Official Transcript of Evidence, 20 June 2008, p 33.

66 Dr A Peeters, Centre for Obesity Research and Education, Official Transcript of Evidence, 20 June 2008, pp 42 – 43.

Changes to the Medicare Benefits Schedule

3.67 A number of witnesses to the inquiry, including GPS, dietitians and psychologists have called for the Federal Government to recognise obesity as a chronic disease within the Medicare system. These witnesses argued that this would then allow patients who are obese to access a number of existing Medicare items to help them receive appropriate treatment.[67] These calls emphasised the fact that there is currently no Medicare Benefits Schedule (MBS) item which allows for the management of obesity as a condition in its own right.[68]

3.68 In Mackay, the Committee heard from a GP that recognising obesity as a chronic disease would allow GPs to develop a patient management plan similar to those used for patients with a mental health condition.[69] This would then allow obese patients to access the services of health professionals like dietitians, exercise physiologists and psychologists. The Dietitians Association of Australia (DAA), and the Australian Psychological Society[70] also argued for this change, with the DAA stating:

> The community… needs the government to urgently allocate a Medicare item number to allow visits to an APD [Accredited Practising Dietitian] to provide the dietetic services and complete this nutrition continuum of care for patients flagged by GPs.[71]

3.69 The Committee questioned the Department of Health and Ageing (DoHA) about the potential to list obesity as a chronic condition and therefore allow for the development of a patient management plan. DoHA informed the Committee that there is currently a review of MBS items underway. This review was due to be finalised by March 2009 (as this report went to print it was not yet completed). However, DoHA added that obesity may be managed under the current specific MBS items which are:

- Chronic Disease Management (items 721 and 723):
  - ⇒ generally obesity is regarded as a risk factor rather than a condition, but if the patient has complications or co-morbidities exacerbated by obesity they may be eligible under this MBS item;
- Type 2 Diabetes Risk Evaluation (item 713):

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67 Dr LA Selvey, Queensland Health, Official Transcript of Evidence, 1 October 2008, p 8.

68 Department of Health and Ageing, Supplementary Submission No. 154.1, npn.

69 Dr RJ Bidgood, Private Capacity, Official Transcript of Evidence, 18 August 2008, p 36.

70 Professor L Littlefield, Australian Psychological Society, Official Transcript of Evidence, 24 October 2008, p 35.

71 Ms KR Matterson, Dietitians Association of Australia, Official Transcript of Evidence, 12 September 2008, p 17.

- ⇒ the aim of this program is to assist patients between the ages of 40 and 49 years who are at risk of developing type 2 diabetes. Under this item, patients who are at risk may be referred to subsidised lifestyle modification programs as one of a number of treatment options, however the rebate is only payable once every three years for any eligible patient;

- 45 Year Old Health Check (item 717):
  - ⇒ the aim of this program is to support GPs to manage the health needs of their patient who are around 45 years of age and are at risk of developing a chronic disease. However, the Medicare rebate is only payable once for any eligible patient. There is a specific number available for Indigenous people under the Aboriginal and Torres Strait Islander Health Check (item 710).[72]

3.70 In addition to the MBS items outlined above and the current review into MBS numbers, DoHA explained that GPs are able to use their professional attendance item for regular consultations (eg at level B or C) to advise patients about lifestyle changes and weight management. And DoHA added that GPs can access the NHMRC Clinical Practice Guidelines for the management of obesity in children, adolescents and adults which includes a sample weight management plan.[73]

3.71 The Committee is of the view that GP consultations provide an excellent opportunity for discussions about healthy weight and diets. Therefore, there would be some benefit in exploring ways to assist GPs to treat patients before they develop chronic disease.

3.72 The Committee believes that there would be significant value in altering the MBS items to recognise obesity as a chronic disease. This will enable GPs to establish an obesity management plan similar to those available for asthma, diabetes, mental health and aged care. This will assist obese patients to receive the treatment and support they need to enable them to make lifestyle changes, and will contribute to the effective management of obesity in Australia by allowing treatment for obesity to be accessed at a community and primary care level.

72 Department of Health and Ageing, Supplementary Submission No. 154.1, npn.

73 Department of Health and Ageing, Supplementary Submission No. 154.1, npn.

Recommendation 7

The Committee recommends that the Minister for Health and Ageing place obesity on the Medicare Benefits Schedule as a chronic disease requiring an individual management plan.

A role for GPs

3.73 The Committee has heard that GPs are an excellent resource in the treatment, management and prevention of obesity. Evidence presented to the Committee stated that most Australians visit their GP each year and that these visits would present an opportunity for the patient's height and weight to be measured and discussed. Professor Clinton from the CSIRO explained:

> Most people see their GP at least once a year, some people a lot more…Probably you could capture 70 to 80 percent of the population when they go and see a GP, and that is the very time where the practice nurse can weigh them, get their height and tell them where they fit on a normative scale.[74]

3.74 The Committee heard that GPs are able to do more than identify patients who are at risk of obesity. GPs are able to implement management plans and take account of other significant issues that may have an impact on the patient's weight such as mental health.[75] However some witnesses have raised concerns about the capacity of GPs to undertake this type of work.

3.75 The major concern, raised with the Committee, about the capacity of GPs to play a greater role in the treatment of obesity relates to the specialised equipment, resources and training that are required. For example, witnesses were concerned that GPs do not have the appropriate equipment to accurately measure children and determine if they are obese or not.[76]

3.76 The Committee also heard that GPs do not realistically have the time to engage in an extensive consultation and discussion with patients about their diet and exercise regimes because the current Medicare system rewards short consultations. As a local GP explained to the Committee:

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74 Professor P Clifton, Commonwealth Science and Industrial Research Organisation (CSIRO), Official Transcript of Evidence, 13 June 2008, p 41.

75 Mr C Seiboth, South Australian Divisions of General Practice Inc, Official Transcript of Evidence, 13 June 2008, p 55.

76 Dr AM Margarey, Flinders University, Official Transcript of Evidence, 13 June 2008, p 34.

> It is very difficult for a GP to provide advice on preventative health in a five minute consultation. The current Medicare system provides GPs who conduct five-minute consultations with the best financial reward.[77]

3.77 Improved training may help GPs to play a greater role in addressing rising levels of obesity. Witnesses raised concerns about the training in weight management that is provided to GPs. As Associate Professor Byrne from ANZOS stated:

> Our GPs do not have great training themselves in weight management, and I think members of the AMA [Australian Medical Association] would support this concept. We do not spend, within medical training, a lot of time on weight management…[78]

3.78 Additionally, it was suggested to the Committee that GPs could play a significant role in collecting data on the prevalence of obesity in Australia and assist in the ongoing surveillance and monitoring recommended by the Committee in Chapter 2. Dr Williams from the Southern Division of General Practice told the Committee in Adelaide that GPs have 'the capacity and passion to provide the most accurate and up-to-date data on overweight and obesity'.[79] She went on to explain that many GPs are already collecting relevant information and are keen to share it. One GP provided Dr Williams with data covering the last nine years:

> All of those patients, 600 of them, have body mass indexes over 30. He goes on to talk about 72 patients with body mass indexes of over 40, All of this data is sitting there.[80]

77 Dr RJ Bidgood, Private Capacity, Official Transcript of Evidence, 18 August 2008, p 31.

78 Associate Professor NM Byrne, Australia and New Zealand Obesity Society, Official Transcript of Evidence, 1 October 2008, p 33.

79 Dr H Williams, Southern Division of General Practice Inc, Official Transcript of Evidence, 13 June 2008, p 53.

80 Dr H Williams, Southern Division of General Practice Inc, Official Transcript of Evidence, 13 June 2008, p 54.

Recommendation 8

The Committee recommends that the Minister for Health and Ageing explore ways that General Practitioners collate data on the height and weight of their patients, and the data be utilised to generate statistics on the level of obesity in Australia.

Training

3.79 It was raised time and again with the Committee that there is a need for improved training, not just for GPs but also for allied health professionals such as practice nurses. Witnesses have argued that the current health workforce does not, in many cases, have the skills to deal with the problem of obesity. As the Committee heard from ANZOS:

> We need upskilling of the existing health workforce and education of new professionals so that we have the competencies within the healthcare sector to treat people with weight problems.[81]

3.80 Other witnesses, including Professor Baur from Westmead Children's Hospital, drew attention to the special training needed for those health workers dealing with children who are obese. The Committee heard that there must be recognition and understanding that particular care is needed when discussing weight problems with children and their families.[82] The danger of insensitive care being provided is that children may become stigmatised as overweight and the negative result of that labelling could be life-long.[83]

3.81 Ongoing training for GPs and practice nurses is administered through respective professional bodies like the Royal College of Nursing or the Royal Australian College of General Practitioners. The Committee agrees with the evidence presented to it that there would be a benefit in ensuring that GPs and practice nurses receive training to enable them to manage and treat obesity, but this is something for the relevant professional bodies to explore and manage.

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81 Associate Professor NM Byrne, Australia and New Zealand Obesity Society, Official Transcript of Evidence, 1 October 2008, p 29.

82 Professor LA Baur, Westmead Children's Hospital, Official Transcript of Evidence, 11 September 2008, p 70.

83 Associate Professor JA O'Dea, University of Sydney, Official Transcript of Evidence, 11 September 2008, p 42.

Figure 3.2 The Committee meets with staff from Weight Management Services at the Children's Hospital at Westmead, NSW

Treatment options

3.82 The responsibility of improving access to treatment for patients who are either overweight or obese falls to all levels of government. Making changes to the way GPs operate is a responsibility of Federal Government, whereas improving access to community health services and public hospitals falls to state, territory and local governments. The Committee heard that there are a number of changes required to improve the provision of treatment services for obesity.

3.83 One response to the difficulties that GPs face in dealing with obesity is the provision of allied health professionals in a multidisciplinary care setting.[84] The Committee heard that these allied health professional teams should be psychologists, exercise physiologists and dietitians, who are trained and equipped to deal with the diverse drivers of obesity. As Associate Professor Byrne stated:

84 Mr C Seiboth, South Australian Divisions of General Practice Inc, Official Transcript of Evidence, 13 June 2008, p 57.

> I do believe a GP alone would find this a difficult problem to deal with. The allied health approach, but in a recognised centre, would work most effectively.[85]

3.84 However, witnesses stated that these types of specialised care centres will only be useful if there is a referral pathway established.[86] It was argued that without a clear referral pathway patients will be unable to access the multidisciplinary care that is available.

3.85 A number of witnesses stressed that the treatment of obesity will require a tiered approach, where patients can access treatments at various levels of the health system depending on the severity of their obesity. This would result in acute care provided to those who need it and less acute care services made available as part of a preventative strategy.[87]

3.86 The Committee heard that a tiered approach would allow less severely affected patients to access care in their home or community setting and with support of primary care like GPs. The level of care then escalates depending on the level and severity of obesity and related co-morbidities.[88] The Committee has experienced some of these different levels of care throughout the inquiry. It has heard evidence from GPs and primary care providers, which would be the first tier of a tiered approach. The Committee has also visited acute care services, which would be level 3 of a tiered approach, like Associate Professor Samaras' obesity clinic at St Vincent's Hospital and Weight Management Services at the Children's Hospital at Westmead.

3.87 This tiered approach has been very successful in various overseas locations, and has been adapted from the Kaiser Permanente model. The relevant component of the Kaiser Permanente approach was outlined for the Committee by Dr Paul Gross from Health Group Strategies who stated that:

> …the world's best health maintenance organisation, Kaiser Permanente, [is] a not-for-profit organisation in the United States covering the lives of about 9.5 million Americans … The core components of Kaiser are, firstly, to treat both the preventative aspects of weight gain and the care aspects – to view this as a problem that has the soft behavioural sciences background as well

85 Associate Professor NM Byrne, Australian and New Zealand Obesity Society, Official Transcript of Evidence, 1 October 2008, p 33.

86 Dr AM Margery, Flinders University, Official Transcript of Evidence, 13 June 2008, p 29.

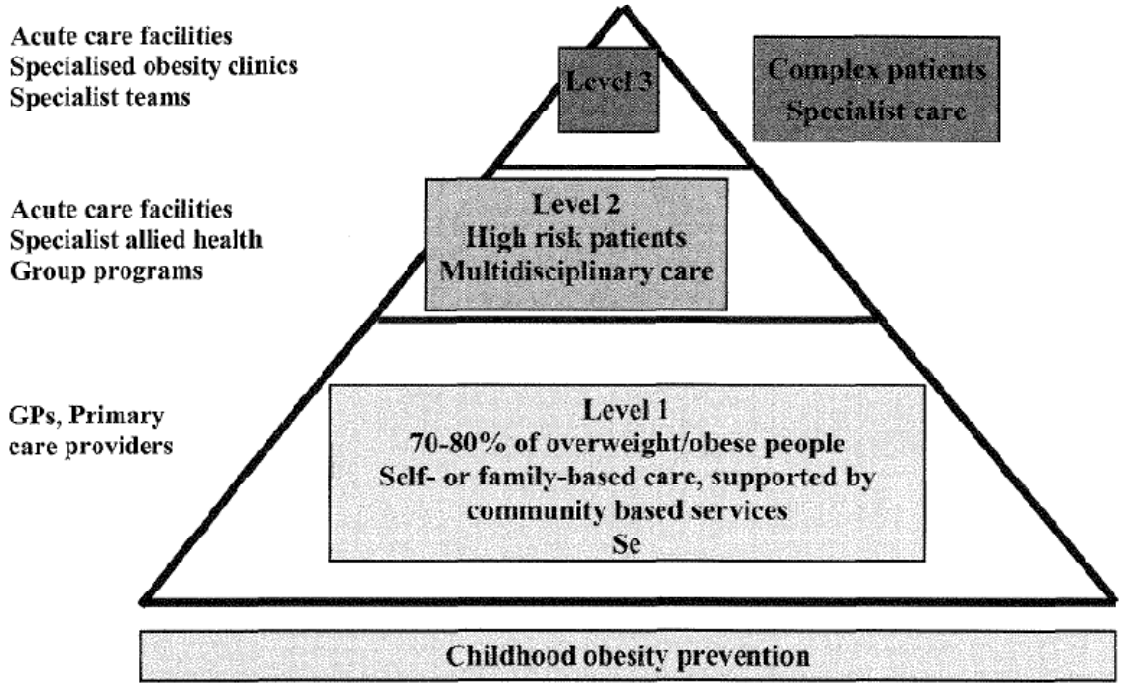
87 Associate Professor NM Byrne, Australian and New Zealand Obesity Society, Official Transcript of Evidence, 1 October 2008, p 29.

88 Westmead Children's Hospital, Submission No. 5, p 5.

as the clinical sciences that you have heard piles of evidence from.[89]

3.88 An illustration of such a tiered approach was provided to the Committee by Westmead Children's Hospital (at Figure 3.1) who adapted it from the Kaiser Permanente Chronic Disease Management Pyramid of Care. While this figure specifically addresses childhood obesity, it provides a useful illustration of a tiered model of care.

Figure 3.3 Chronic disease care model for paediatric overweight and obesity



Source *Westmead Children's Hospital, Submission No. 5, p 5.*

3.89 The Committee is of the view that developing a tiered approach to the provision of health care for obese patients would have significant benefits within the Australian context. This approach would strengthen the treatment options for those people with obesity and manage the levels of people accessing acute care by ensuring early detection and treatment of obesity.

89 Dr PF Gross, Health Group Strategies Pty Ltd, Official Transcript of Evidence, 8 December 2008, p 14.

Recommendation 9

3.90 **The Committee recommends that the Minister for Health and Ageing work with State and Territory Health Ministers through the Australian Health Ministers' Advisory Council to consider adopting a tiered model of health care for obesity management, incorporating prevention, community-based primary care and acute care.**

Child and maternal health

3.91 Good child and maternal health services are recognised as creating a sound foundation for a healthy life. The Committee heard about a number of ways to improve the provision of child and maternal health services which may in turn help reduce rates of obesity. The evidence presented to the Committee stressed:

- establishing life-long patterns early;
- the importance of child and maternal health nurses; and
- the benefits of breastfeeding in preventing obesity.

3.92 The field of child and maternal health services provision is complex. Service provision in this area cuts across all tiers of government. For example, if a woman with a new baby visits her GP then she is using a federally funded service, if she accesses the services of a public hospital then she is using a state funded service and if she visits a baby health clinic, then she is accessing a service generally funded by local government.

3.93 Child and maternal health matters have been the subject of a number of reviews, at the federal, state, territory and local government level, over the past 20 years.[90] Currently the *National Health and Hospitals Reform Commission* is again considering this sector, with a view to improving services.[91]

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90 For example: NSW Health Department 1989, *Maternity Services in New South Wales: Final report of the Ministerial Taskforce on Obstetric Services in New South Wales (Shearman Report)*, Sydney; National Health and Medical Research Council 1998, *Review of Services Offered by Midwives*, Australian Government Publishing Service; Senate Standing Committee on Community Affairs 1999, *Rocking the Cradle: a report into childbirth procedures*, Commonwealth of Australia, Canberra.

91 National Health and Hospitals Reform Commission, *A Healthier Future for all Australians: Interim Report December 2008*, <http://www.nhhrc.org.au/internet/nhhrc/publishing.nsf/Content/interim-report-december-2008> accessed 17 April 2009.

3.94 Focusing on child and maternal health is an important tool to combat levels of obesity in Australia. These services can work to address health inequities across various socioeconomic groups by supporting new parents to make healthy choices. This age group is vital because it allows good patterns, in terms of eating and exercise, to be established early[92] and also ensures that our health care system takes a whole-of-life approach.[93] In addition, witnesses have justified the focus on children, within the debate about obesity, because obese children are more likely to become obese adults. WA Health submitted that:

> Reversing the growing rates of obesity in children must be a priority, given that obesity not only causes significant problems during childhood, but also predisposes children to be obese in adulthood, and increases the risk of associated harm at that time.[94]

3.95 Child and maternal health nurses are an essential resource for new parents. Witnesses to the inquiry have argued that the role of these nurses is largely to provide support and education to parents. The nurses could be utilised to provide simple education about food and nutrition, especially to young and new mums.[95] As the Committee heard at a public hearing:

> … maternal and child health nurses … They are principally concerned with engaging with parents and young people and supporting and helping people make good decisions through good information…[96]

3.96 The Committee also heard that increasing rates of breastfeeding may be an important tool to combat obesity. Witnesses to the inquiry have argued that breastfeeding can have a protective effect against obesity, and that babies that are breastfed are less likely to be obese as adults. The positive impact of breastfeeding was outlined for the Committee:

> It is also associated with lower risk factors for cardiovascular diseases including high blood pressure and obesity.[97]

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92 Mr M Coulton MP, Federal Member for Parkes and Ms K Duncan, Walgett Aboriginal Medical Service, Official Transcript of Evidence, 10 September 2008, p 11.

93 Dr L Roberts, National Preventative Health Taskforce, Official Transcript of Evidence, 12 November 2008, p 15.

94 Department of Health, Western Australia, Submission No. 51, p 8.

95 Associate Professor JA O'Dea, University of Sydney, Official Transcript of Evidence, 11 September 2008, pp 40 – 41.

96 Mr M Crake, Western Australian Department of Health, Official Transcript of Evidence, 6 November 2008, p 7.

97 Australian Nursing Federation, Submission No. 103, p 4.

3.97 During the previous Parliament, the Committee undertook an inquiry into the health benefits of breastfeeding. The evidence about the benefits of breastfeeding is contained in the report *The Best Start: report on the inquiry into the health benefits of breastfeeding*, August 2007.[98] The Committee reiterates the recommendations of that report, which has received a Government response. The Government response agreed to most of the Committee's recommendations in that report and recognised that:

> Breastfeeding ensures the best possible start to a baby's health, growth and development.[99]

3.98 In the course of this inquiry, the Committee heard once again that the excellent NHMRC *Infant Feeding Guidelines for Health Workers* are not being widely promoted or enforced, and thinks that this is yet another example of the need for wide promotion of national guidelines, as argued earlier in this chapter. The Committee continues to encourage breastfeeding generally and, in the context of this inquiry, views it as a part of the strategy to reduce the risks of childhood obesity.

Regulation

3.99 Throughout the inquiry, witnesses have consistently raised the need for stronger regulations to be initiated by the Federal Government to help curb rising obesity levels. It can be argued that these regulatory changes are another form of prevention because they will result in broad structural changes which will create supportive environments for Australians to be fit and healthy. In addition, it is argued that regulatory changes are beneficial because they focus on all Australians and not one particular group, as Professor Gericke from the University of Adelaide explained:

> … we need structural changes that affect the whole population, instead of focusing on target groups such as the obese… These structural changes are largely legislative in nature…[100]

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98 House of Representatives Standing Committee on Health and Ageing 2007, *The Best Start: Report on the inquiry into the health benefits of breastfeeding*, <http://www.aph.gov.au/house/committee/haa/breastfeeding/report.htm> accessed 17 April 2009.

99 Australian Government response to *The Best Start: Report on the inquiry into the health benefits of breastfeeding*, <http://www.aph.gov.au/house/committee/haa/bfgovresp.pdf> accessed 17 April 2009.

100 Professor C Gericke, University of Adelaide, Official Transcript of Evidence, 13 June 2008, p 17.

3.100 Regulation is an area in which the Federal Government can act to modify the food supply and embed healthy eating and living in the Australian lifestyle. The regulatory changes that have been presented to the Committee, and will be addressed in detail here, are:

- taxation and subsidies;
- advertising;
- food labelling; and
- reformulation.

3.101 The Committee notes that the Taskforce discussion paper foreshadows regulatory changes including taxation, reformulation, subsidies, advertising and food labelling.[101] As such, this report will not propose specific regulations because the Taskforce is better equipped to make technical recommendations of this nature. However, the Committee still received significant evidence in this area and considered these issues in depth.

Taxation and subsidies

3.102 A number of witnesses to the inquiry argued for the Federal Government to introduce a tax on high fat, salt and sugar products.[102] This tax would raise the cost of unhealthy food, and reduce the gap in prices between healthy and unhealthy food products. Witnesses argued that the revenue raised from this tax could be used for social marketing and education campaigns to encourage healthy eating.[103]

3.103 While the Committee heard that such regulation would cost the Government relatively little to implement, there were concerns about the effectiveness of such a measure. As researchers from the Centre for Burden of Disease and Cost-effectiveness stated at a public hearing:

> …energy-dense and nutrient-poor foods would have a levy placed on them because of their harmful effects. Unfortunately there is not much evidence about whether these would actually work.

101 National Preventative Health Taskforce 2008, *Australia: The healthiest country by 2020*, Department of Health and Ageing, pp 15 – 16.

102 Diabetes Australia, Submission No. 92, npn; WHO Collaborating Centre for Obesity Prevention, Submission No. 95, p 8.

103 Professor P Howat, Public Health Association of Australia, Official Transcript of Evidence, 6 November 2008, p 18.

> However, one thing I would say is that it would be quite a low-cost measure that you could implement.[104]

3.104 In addition, concerns have been raised that a tax on unhealthy or 'junk' food would adversely impact on Australians of lower socioeconomic status. [105] The regressive nature of a tax, it was argued, could be counteracted by a subsidy[106] on healthy foods:

> It seems a tax on junk food would need to be offset by a subsidy on healthy foods otherwise it is too regressive and has too many negative effects.[107]

3.105 The Committee questioned the Taskforce about the potential to institute such a tax and heard that this would be a complex measure to properly design and implement. A member of the Taskforce, Dr Roberts, stated that taxation had been very effective in the area of tobacco but the difficulty of taxing elements of the food supply needed special consideration. However, she stated that subsidies could prove to be an effective tool to change the food supply and decrease the price differential between healthy and unhealthy food products.[108]

3.106 A possible subsidy that has been argued for during this inquiry is a subsidy on gym memberships.[109] Proponents argue that this would increase access to physical activity programs. Some witnesses have argued that gym memberships should be made tax deductible under certain conditions including number of visits. The Committee heard from a gym owner in Mackay that gyms could easily provide clients with details of the number of visits over a 12 month period which could then be claimed as part of an individual's tax return.[110] The Committee has also heard that the affordability of gym memberships could be increased by the use of a voucher system or government support to gyms to offer lower cost classes.[111]

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104 Mrs M Forster, Centre for Burden of Disease and Cost-effectiveness, Official Transcript of Evidence, 1 October 2008, p 15.

105 Professor T Vos and Mrs M Forster, Centre for Burden of Disease and Cost-effectiveness, Official Transcript of Evidence, 1 October 2008, p 15.

106 University of Queensland, Submission No. 38; WA Department of Health, Submission No. 51, p 6; Diabetes Australia, NSW, Submission No. 90, pp 3-4.

107 Professor BA Swinburn, WHO Collaborating Centre for Obesity Prevention, Official Transcript of Evidence, 20 June 2008, p 24.

108 Dr L Roberts, National Preventative Health Taskforce, Official Transcript of Evidence, 12 November 2008, p 5.

109 Dr L Roberts, National Preventative Health Taskforce, Official Transcript of Evidence, 12 November 2008, p 4.

110 Mr SJ Eden, City Fitness Health Club, Official Transcript of Evidence, 18 August 2008, p 26.

111 Dr L Roberts, National Preventative Health Taskforce, Official Transcript of Evidence, 12 November 2008, p 4.

3.107 Dr Selvey from Queensland Health argued that perhaps the Federal Government could consider allowing people to claim the cost of weight loss programs through Medicare. However, she argued that these programs must demonstrate success, they should focus on nutrition and activity and should not just be a diet that does not change lifestyle.[112]

3.108 The Committee notes that in 2008 the Federal Government launched a major review of Australia's tax system to be chaired by the Secretary to the Treasury, Dr Ken Henry AC.[113] The review is examining, among other things, the range and nature of eligible deductions, and is due to report to the Treasurer by the end of 2009.

3.109 The Committee supports the general premise of using taxation and subsidies to improve the affordability of, and access to, healthy food and physical activity programs. The Committee believes that once the findings of the taxation review become available, the Federal Government should explore the extent to which a future tax system or tax incentives may be used to encourage modifications in eating behaviour and physical activity levels.

Recommendation 10

3.110 **The Committee recommends that the Treasurer and the Minister for Health and Ageing investigate the use of tax incentives to improve the affordability of fresh, healthy food and access to physical activity programs for all Australians, particularly those living in rural and remote areas.**

Advertising

3.111 Throughout the inquiry the Committee heard significant criticism of the advertising of junk food to children and the need for stronger regulations in this area. These concerns relate to the promotion of energy-dense, nutrient–poor foods.[114] In addition to traditional television advertising, witnesses raised concerns with other advertising that is occurring, for example online[115] and the sponsorship of children's sport.[116] The Dietitians

112 Dr LA Selvey, Queensland Health, Official Transcript of Evidence, 1 October 2008, p 9.

113 Australian Government, Treasury website, <http://taxreview.treasury.gov.au/Content/Content.aspx?doc=html/home.htm> accessed 17 April 2009.

114 Ms K Mehta, Flinders University, Official Transcript of Evidence, 13 June 2008, p 30.

115 Ms JE Martin, Obesity Policy Coalition, Official Transcript of Evidence, 20 June 2008, p 52.

Association of Australia (DAA) called for tighter regulation of marketing to children,[117] while the Obesity Policy Coalition called for an act to govern marketing, saying:

> We would like to see something like an act on food advertising to children that applies comprehensively to all forms of marketing and promotion to children.[118]

3.112 The advertising industry argues that there is no evidence that advertising affects children's eating habits in a significant adverse manner, adding that the Australian Communications and Media Authority (ACMA) has been unable to find a link between obesity and television advertising.[119] The industry is critical of restrictions that prevent the advertising of healthy food products.[120]

3.113 The advertising and food industries also argue that there are codes of practice in place which form part of the industry's self-regulation, and therefore government regulation is not required. Self-regulation is discussed in more detail in Chapter 4. However, Ms Carnell from the Australian Food and Grocery Council (AFGC) acknowledged if self-regulation failed then the government could impose stronger regulations. She stated that:

> … if we did not deliver, then we would expect what we got, which would probably be a significant amount of public criticism but also government having a look at other options [for regulating advertising].[121]

3.114 The issue of television advertising to children is regulated by the Children's Television Standards (CTS). The CTS regulates the content of children's programs and the amount of advertising during children's television viewing times.[122] Witnesses to the inquiry have been critical of the CTS saying that it does not restrict the content or number of

116 Professor S Stewart, Baker Heart Research Institute, Official Transcript of Evidence, 20 June 2008, p 10: Mr RG Nicholson, YMCA Australia, Official Transcript of Evidence, 24 October 2008, p 43.

117 Mrs K Paul, Dietitians Association of Australia, Official Transcript of Evidence, 12 September 2008, p 22.

118 Ms SB Mackay, Obesity Policy Coalition, Official Transcript of Evidence, 20 June 2008, p 48.

119 Mr C Segelov, Australasian Association of National Advertisers, Official Transcript of Evidence, 1 October 2008, p 47.

120 Professor WGT Wiggs, Foundation for Advertising Research, Official Transcript of Evidence, 1 October 2008, p 40.

121 Ms AK Carnell, Australian Food and Grocery Council, Official Transcript of Evidence, 24 October 2008, p 79.

122 Australian Communications and Media Authority, Children's Television Standards, <http://www.acma.gov.au/WEB/STANDARD/pc=PC_90095> accessed 17 April 2009.

advertisements for unhealthy food,[123] that it does not actually cover the times when children are most likely to be watching television[124] and that it does not include other forms of non-television advertising.[125] The Committee notes that ACMA is currently reviewing the CTS and the revised CTS are due for release in mid 2009. Further information can be found on the ACMA website.[126]

3.115 Researchers have admitted to the Committee that there is little evidence in this area to support either argument. But they added that a lack of evidence does not mean that there is no evidence, rather:

> The reason that there is not much evidence is because it is difficult to study.[127]

3.116 The Committee is aware that some states are considering advertising bans within their jurisdictions, for example South Australia.[128] It remains to be seen what action can and will be undertaken by these state governments.

3.117 The Senate Standing Committee on Community Affairs considered the issues in the context of a bills inquiry into protecting children from junk food advertising in 2008. That Committee determined that it was premature to bring forward [national] legislative changes to food and beverage advertising while the National Obesity Strategy is being developed by the Taskforce and before the industry's initiatives in relation to responsible advertising can be properly assessed.[129]

3.118 The Committee notes community concerns about the lack of regulation of advertising to children, and supports the argument that marketing of unhealthy products to children should be restricted and/or decreased. However, the Committee favours a phased approach and thinks that self-regulation may prove successful through the reduction of advertisements for unhealthy food products on television during children's prime viewing times. But, consistent with a phased approach and industry's own

123 National Children's Youth Law Centre, Submission No. 50, p 4.

124 Ms JE Martin, Obesity Policy Coalition, Official Transcript of Evidence, 20 June 2008, p 46.

125 Ms JE Martin, Obesity Policy Coalition, Official Transcript of Evidence, 20 June 2008, p 52.

126 Australian Communications and Media Authority, Review of the Children's Television Standards (CTS), <http://www.acma.gov.au/WEB/STANDARD/pc=PC_310463> accessed 17 April 2009.

127 Mrs M Forster, Centre for Burden of Disease and Cost-effectiveness, Official Transcript of Evidence, 1 October 2008, p 20.

128 Government of South Australia, *SA call to ban junk food ads for kids*, <http://www.ministers.sa.gov.au/news.php?id=2743> accessed 17 April 2009.

129 Senate Standing Committee on Community Affairs, *Protecting Children from Junk Food Advertising (Broadcasting Amendment) Bill 2008*, <http://www.aph.gov.au/Senate/committee/clac_ctte/protecting_children_junk_food_advert/report/c01.htm> accessed 17 April 2009.

recognition of the limitations of self-regulation, should self-regulation not result in a decrease in the number of unhealthy food advertisements directed at children, the Committee supports the Federal Government considering more stringent regulations on the advertising of unhealthy food products directed at children.

Recommendation 11

The Committee recommends that the Minister for Health and Ageing commission research into the effect of the advertising of food products with limited nutritional value on the eating behaviour of children and other vulnerable groups.

Food labelling

3.119 The Committee heard overwhelming support for the introduction of an improved food labelling system in Australia to assist consumers to make informed choices. Food labels provide information regarding energy intake and key nutrients in a product. However, there was a lack of agreement about the most effective type of food labelling system and the way to present the information in a clear, simple and easily understood format.

3.120 The Committee heard significant support for the traffic-light labelling system from a number of witnesses. This system ranks and colour codes total fat, saturated fat, sugar and salt: high (red), medium (amber) or low (green). The Committee heard that this type of system is simple and easy for consumers to understand. Ms Martin from the Obesity Policy Coalition explained that the system is already in use in hospitals and schools so children grow up understanding the system.[130] Professor Stewart from the Baker Heart Research Institute supported this view adding that it is useful for consumers with low literacy levels:

> The traffic-light system would be far simpler for people.[131]

3.121 The AFGC and other industry representatives advocate the use of the percentage daily intake (%DI) system. This system uses a thumbnail format (often in very small print) to provide information on the amount of energy per serve in a product plus information on key nutrients in relation

130 Ms JE Martin, Obesity Policy Coalition, Official Transcript of Evidence, 20 June 2008, p 47; Vic Health, Submission No. 59, p 7.

131 Professor S Stewart, Baker Heart Research Institute, Official Transcript of Evidence, 20 June 2008, p 9.

to the daily food intake of an average adult. In their submission to the inquiry, the AFGC explains that the system allows consumers to see, at a glance, the:

> … amount of energy and nutrients a product contains and how much a serve contributes towards their daily requirements.[132]

3.122 It is not only the food industry that supports this system. The Committee heard that the DAA supports the %DI system and stated that there was evidence that some parents had found it a useful tool.[133]

3.123 Advocates for the %DI system raised concerns about the traffic-light system arguing that it could 'red-light' foods that are considered essential to healthy eating. As Mr Hall from Woolworths explained:

> We know that there is a desire in the community for understanding through better labelling…but it needs to be made simple and to be done in a way that the consumer understands. We think the traffic-light system is probably fundamentally flawed because it potentially red-lights something that should be in a balanced diet anyhow. Dairy products are a good example; cheese potentially could be red-lighted.[134]

3.124 Another concern that the Committee encountered with the traffic-light system is that consumers may not understand the implications of mixing different products together. As Dr Roberts from the Taskforce stated:

> …when you are buying a basketful of food on a daily or weekly basis how do you balance out that red, green and yellow to make up what is going to be your meal for that evening? I think we need to be able to put a lot more assistance and help around it because people need to know what happens when you take that can of this with this and then add it to that. If you add lots of fruit and veggies into whatever your meal is then you might have a perfectly healthy meal but if you add two or three of those cans together, although you have had the best intentions, you might have just put together a meal that is not balanced at all.[135]

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132 Australian Food and Grocery Council, Submission No. 54, p 22 (Appendix one of this submission provides detailed guidelines on this system).

133 Mrs K Paul, Dietitians Association of Australia, Official Transcript of Evidence, 12 September 2008, p 23.

134 Mr A Hall, Woolworths Ltd, Official Transcript of Evidence, 11 September 2008, p 21.

135 Dr L Roberts, National Preventative Health Taskforce, Official Transcript of Evidence, 12 November 2008, p 10.

3.125 The Committee heard that there is limited evidence to prove that food labelling substantially affects consumer behaviour.[136] A number of witnesses stressed that whichever labelling system is implemented in Australia it would need to be supported by an education program to ensure consumers understand and benefit from the information provided.[137] Dr Byrne from the ANZOS stated:

> We can all become obese by consuming healthy food, so it is about understanding how much to eat. It is about understanding portion size. It is about not placing it all on the food label but understanding the consequence.[138]

3.126 Food Standards Australia New Zealand (FSANZ) announced in October 2008 that it has commissioned a review into the food labelling system including front of pack labelling and food labelling law and policy.[139]

3.127 In 2006 the United Kingdom (UK) Food Standards Agency (FSA) recommended voluntary use of the traffic-light system; however it is currently reviewing the main types of front of pack labelling in the UK and their effectiveness.[140] These reviews were acknowledged by Dr Roberts from the Taskforce who stated:

> I think Australia is in a quite unique position to step back and look at all the research that is there and to think about what it is we want to achieve with the food labelling system.[141]

3.128 The Committee agrees and awaits the results of the FSANZ review with interest. Notwithstanding the argument about which form of food labelling is most effective, the Committee considers the current food labelling system in Australia to be relatively ineffective and confusing to consumers. The Committee strongly argues that Australian food labels can and should be improved, and encourages FSANZ and the Federal

136 Professor BA Swinburn, WHO Collaborating Centre for Obesity Prevention, Official Transcript of Evidence, 20 June 2008, p 30.

137 Associate Professor NM Byrne, Australian and New Zealand Obesity Society, Official Transcript of Evidence, 1 October 2008, pp 31 and 34; Dr L Roberts, National Preventative Health Taskforce, Official Transcript of Evidence, 12 November 2008, p 9.

138 Associate Professor NM Byrne, Australia New Zealand Obesity Society, Official Transcript of Evidence, 1 October 2008, p 32.

139 Food Standards Australia New Zealand, *Food Ministers consider food labelling review,* media release, 24 October 2008, <http://www.foodstandards.gov.au/newsroom/mediareleases/mediareleases2008/24october08jointcomm4087.cfm> accessed 17 April 2009.

140 Food Standards Agency, Signposting policy review, <http://www.food.gov.uk/foodlabelling/signposting/policyreview/> accessed 17 April 2007.

141 Dr L Roberts, National Preventative Health Taskforce, Official Transcript of Evidence, 12 November 2008, p 9.

Government to look to improving the information that is currently available on food labels.

Recommendation 12

The Committee recommends that the Federal Government use the results of the Food Standards Australia New Zealand food labelling review to create a set of standard guidelines to ensure that food labels provide consistent nutritional information. Using these guidelines the Federal Government should work with industry to develop and implement this standardised food label within a reasonable timeframe.

Reformulation

3.129 Dr Roberts from the Taskforce emphasised to the Committee that any labelling system has to be implemented in conjunction with moves to reformulate food and to control portion sizes.[142] Reformulation will drive changes to the food supply and allow Australians to enjoy a healthier diet with minimal changes to their current eating patterns and food choices. And there will be significant health benefits as a result of reducing levels of salt, sugar and fat in the food supply. It has been argued, by Diabetes Australia among others, that regulation is required to achieve these changes.[143]

3.130 The food industry argues that it has already taken steps to reformulate some of their products. The steps that industry has taken in this regard are addressed in more detail in Chapter 4. Industry representatives cited McDonald's and Nestle as examples saying that McDonald's Australia has modified a number of their meals to enable them to earn the Heart Foundation Tick and Nestle has developed the Lean Cuisine range of healthy meals and reduced sugar levels in a range of their top-selling children's food.[144]

3.131 However, the Committee has heard that mandatory regulations on salt, fat and sugar are needed. Witnesses argued that without regulation, the pace of change will be slow and uneven. Professor Howat from the Public Health Association of Australia stressed it 'needs government regulation'

142 Dr L Roberts, National Preventative Health Taskforce, Official Transcript of Evidence, 12 November 2008, p 11.

143 Dr I White, Diabetes Australia, Official Transcript of Evidence, 12 May 2008, p 11.

144 Professor WGT Wiggs, Foundation for Advertising Research, Official Transcript of Evidence, 1 October 2008, p 40.

to enforce change, provide uniform standards and increase the pace of this process.[145]

3.132 Ms Anderson from the Heart Foundation indicated that reformulation is 'very achievable' and will promote sustainable change to the current obesogenic environment.[146] Witnesses to the inquiry pointed to the success that the UK has achieved in reformulating products. A voluntary system introduced in the UK in 2006 through the FSA aimed to reduce salt intake to 6g per day, and proved successful.[147] Further, the UK has extended its focus on reformulation of products. It is currently focusing on decreasing levels of saturated fat intake by working with industry to reformulate foods.[148]

3.133 Increased regulation, in particular, of advertising, taxation, reformulation and food labelling is complex. As indicated, there are a number of reviews currently looking into the detail of all these issues and the Committee looks forward to learning the review outcomes.

3.134 The Committee thinks that changes to the advertising, reformulation and labelling of food will drive changes to the food supply. The Committee favours a phased approach to the imposition of more stringent regulations on reformulation, food labelling and advertising, and as such thinks that industry should first be encouraged to undertake self-regulation. However, the Committee is of the view that should industry fail to make concrete changes in relation to advertising, food labelling and reformulation, then the Federal Government should explore potential regulatory changes.

Urban planning

3.135 Urban planning plays a significant role in creating healthy urban environments which increase levels of physical activity and decrease sedentary behaviour. Healthy urban environments can encourage healthy living and urban planning has been identified as a key driver of obesity

145 Professor P Howat, Public Health Association of Australia, Official Transcript of Evidence, 6 November 2008, p 18; Dr LA Selvey, Queensland Health, Official Transcript of Evidence, 1 October 2008, p 11.

146 Ms S Anderson, Heart Foundation, Official Transcript of Evidence, 24 October 2008, p 53.

147 Heart Foundation, Submission No. 106, p 20; Dr L Roberts, National Preventative Health Taskforce, Official Transcript of Evidence, 12 November 2008, p 10.

148 Food Standards Agency, First Steps to reduce saturated fat, <http://www.food.gov.uk/news/newsarchive/2008/feb/satfats> accessed 17 April 2009.

and an area where action must be taken in order to reduce the levels of obesity in Australia.

3.136 In Australia, in most cases, planning authority resides with the state or territory government. While ultimate responsibility for the implementation of design strategies lies with local government, it is state and territory governments' policy and legislative frameworks which set the scene for environments that embed physical activity and healthier environments.[149] As discussed earlier in the chapter, the Committee has heard that the Federal Government can exhibit greater leadership by developing nationally consistent urban planning guidelines.

3.137 The Committee heard that the Planning Institute of Australia, the Australian Local Government Association and the Heart Foundation are developing national planning guidelines together.[150] The Committee received evidence from representatives of the Planning Institute of Australia, the Australian Local Government Association and the Heart Foundation who have collaborated on a project titled *Healthy Spaces and Places*. This project has received support from the DoHA and is designed to address the disconnect that exists between planning and health. It has identified the following areas for consideration with regard to urban planning:

- suburbs and neighbourhoods that people can walk easily around, and to key facilities such as schools, shops and public transport;
- provision of walking and cycling facilities (footpaths and cycleways);
- facilities for physical activity (eg swimming pools);
- activity centres with a variety of uses; and
- transport infrastructure and systems, linking residential, commercial and business areas.[151]

3.138 Additionally, some state governments have also developed useful guidelines for the development and implementation of healthy environments.[152]

3.139 One of the areas where state and territory governments need to do more is the greater provision of public transport. The Committee heard

149 Australia and New Zealand Obesity Society, Submission No. 11, p 12; Queensland Health, Submission No. 56, p 17; Planning Institute of Australia, Submission No. 77, p 3; Heart Foundation, Submission No. 106, p 5.

150 Ms K Wright, Planning Institute of Australia, Official Transcript of Evidence, 24 October 2008, p 63.

151 Planning Institute of Australia, Submission No. 77, p 2.

152 *Liveable Neighbourhoods: A Western Australian Government sustainable cities initiative*, Western Australian Planning Commission; *Creating Healthy Environments*, NSW Health.

international studies had found that an additional 30 minutes driving per day is associated with a three percent increase in the likelihood of obesity. Australian studies have found that one-third of daily car journeys are shorter than three kilometres and 10 percent are less than one kilometre. Active transport options, for these journeys, like walking, cycling or public transport would increase the incidental activity of Australians.[153]

3.140 Local government has responsibilities for providing a healthy environment for communities and as such can play a central role in helping reverse rates of obesity. It owns and manages local infrastructure and is best positioned to identify local needs and understand local conditions.[154] In addition to planning, designing and developing the urban environment, local government provides sporting facilities and recreational programs. Local government can play a significant role in improving urban built environments. Professor Baur from Westmead Children's Hospital stated that local government could:

> … look at issues around things like walkability of neighbourhoods, car policies, pedestrian precinct policies and even some planning policies about where fast food restaurants of types of local markets may occur.[155]

3.141 The Committee was pleased to learn about some excellent initiatives that are already being implemented by local governments across Australia. In particular the Committee received a submission from the City of Fremantle, and heard evidence about the developments at Port Phillip in Victoria.

3.142 In Western Australia, the City of Fremantle has developed the Physical Activity Impact Assessment Framework which provides:

> …a framework for the assessment of development impacts on those aspects of the physical environment that support physical activity as part of the land use planning and development processes.[156]

3.143 This framework is a tool to increase awareness of physical activity considerations for urban designers and will facilitate inter department communication within council as well as promote partnerships across the

153 Mrs K Wright, Planning Institute of Australia, Official Transcript of Evidence, 24 October 2008, p 64.

154 Planning Institute of Australia, Submission No. 77, p 4; City of Fremantle, Submission No. 151, npn.

155 Professor LA Baur, Children's Hospital at Westmead, Official Transcript of Evidence, 11 September 2008, p 73.

156 City of Fremantle, Submission No. 151, npn.

community.[157] The Framework has not yet been trialled or piloted, largely due to a lack of funding, but it has already won awards and is receiving interest from other local governments.

3.144 Witnesses from the Planning Institute of Australia informed the Committee that particular effort had been undertaken to improve the walkability of the City of Port Phillip. One program that planners have undertaken is the 'green light' program. This program was aimed at encouraging children to walk to school. Planners timed the length of time it took children to cross the road safely and then worked with VicRoads to adjust the frequency of the 'green man' on pedestrian signals accordingly. This increased the safety of the children and had additional benefits for elderly and frail people within the community who previously may also have felt unsafe crossing the roads.

3.145 In addition, the Committee heard that Port Phillip has invested in signage and public toilets to encourage people to use walking paths, which are now lit at night, by informing them of the length of the walk, the location of restroom facilities and making seats available for resting. The council has also built cycle and footpaths around the bay to encourage physical activity. The addition of better street lighting will also encourage people to walk, particularly after work or during winter months. These simple initiatives make all the difference to people wanting to use the walking paths, and are to be commended.

3.146 The Committee supports the call to develop and implement nationally consistent urban planning guidelines. The Committee recommends that the Federal Government consider using the guidelines developed by the Heart Foundation, the Australian Local Government's Association and the Planning Institute of Australia as a model for future national urban planning guidelines. These guidelines will have significant benefits for the environment in which Australians live by embedding physical activity and healthy living into everyday life. They will contribute to ensuring that barriers to physical activity and healthy eating are removed and help to ensure that the healthy lifestyle choice becomes the easiest lifestyle choice.

3.147 In developing the guidelines, the Federal Government should consult with the private sector and innovative urban planners such as those outlined in Chapter 4.

157 City of Fremantle, Submission No. 151, npn.

Recommendation 13

3.148 **The Committee recommends that the Federal Government work with all levels of government and the private sector to develop nationally consistent urban planning guidelines which focus on creating environments that encourage Australians to be healthy and active.**

Community facilities and activities

3.149 Local government is ideally positioned to take the lead and develop sustainable, long-term changes to the liveable environment but they require support and capacity.[158] Federal, state and territory governments can provide this through a cooperative legislative framework and adequate funding arrangements. As one witness said to the Committee:

> I would like to make the point that local government carries most of the financial burden of providing opportunities for people at a local level to get access to sport and recreation, yet the real savings are incurred in the health budgets at both the state and the Federal Government level.[159]

3.150 The Young Men's Christian Association (YMCA) was particularly concerned that local government's charging fees to use fitness facilities was reinforcing the inequalities and disadvantage of some members of the community. Mr Nicholson from the YMCA used the example of libraries, which are a free service, and said:

> If you look at libraries, they are generally free, yet the local swimming pool or the local recreation facility and fitness facility run by the council is increasingly moving towards being run on a private enterprise basis, wanting cost recovery and cost recovering capital. This inevitably means that a section of the community is denied access.[160]

3.151 Nonetheless, the Committee has been impressed by a number of initiatives and programs that local governments across the country are implementing. These programs work to increase levels of physical activity within the community and reinforce the healthy living messages which governments are sending through social marketing and education

158 Professor BA Swinburn, WHO Collaborating Centre for Obesity Prevention, Official Transcript of Evidence, 20 June 2008, pp 26-27; City of Fremantle, Submission No. 151, npn.

159 Mr RG Nicholson, YMCA Australia, Official Transcript of Evidence, 24 October 2008, p 42.

160 Mr RG Nicholson, YMCA Australia, Official Transcript of Evidence, 24 October 2008, p 45.

campaigns. Local governments are able to determine locally appropriate solutions, which means that interventions are more likely to be sustainable.

3.152 When the Committee visited the Gold Coast, members of the Committee participated in a Tai Chi class as part of the Gold Coast City Council's Active and Healthy Program. This program offers 'an activity that you can participate in every day of every week across the city' and runs for 48 weeks of the year.[161] The programs are provided free or at low cost and cater for all age groups and levels. The program is largely funded by the Council with approximately 25percent of funding coming from the Queensland Government.

Figure 3.4 The Tai Chi Class that is part of the Gold Coast Active and Healthy Program

3.153 During its hearing in Mackay, the Committee was pleased to learn about the Mackay Active Parks Program. This program was funded by Sport and Recreation Queensland and Queensland Health and aimed to increase physical activity opportunities for the Mackay community.[162] The

161 Ms SR Hughes, Gold Coast City Council, Official Transcript of Evidence, 8 December 2008, p 29.

162 Mrs KM Gooch, Mackay City Council, Official Transcript of Evidence, 18 August 2008, p 10.

program allowed residents to access free activities within the parks of Mackay. However, the Committee was disappointed to learn that this program had not been continued due to lack of funding.

3.154 The Committee notes that in late 2008, the Federal Government announced $300 million of additional funding for local community infrastructure to representatives from Australia's 565 councils in the Great Hall of Parliament House, to be spent by September 2009.[163] The Committee expects that some of this money will be spent on improving sporting and community facilities that benefit the health and wellbeing of Australians around the country.

Research agenda

3.155 The Committee heard from several witnesses that our understanding of the causes and drivers of obesity is limited. In particular, the Committee heard that more research is needed to understand the impact on body weight of various issues like psychology,[164] genetic factors and metabolism.[165] There is a real sense that more can still be learnt about obesity, as a researcher from Flinders University stated:

> I would argue that there is still much to be learnt about overweight and obesity, and we do not have all of the answers just yet.[166]

3.156 The Committee questioned DoHA about the extent of the current research agenda. The representatives responded that the NHMRC has recognised the importance of this area and is setting priorities for upcoming research accordingly.[167]

3.157 The Committee heard from many submitters that the solution lies in a comprehensive research program which includes large scale repetitive

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163 The Hon Kevin Rudd MP, Prime Minister and The Hon A Albanese MP, Minister for Infrastructure, Transport, Regional Development and Local Government, *Local communities to receive $300 million for regional and local infrastructure*, media release, 18 November 2008, <http://www.pm.gov.au/media/Release/2008/media_release_0617.cfm> accessed 17 April 2009.

164 Ms J Bryant, Department of Health and Ageing, Official Transcript of Evidence, 4 February 2009, p 3.

165 Dr DM Lawrence, Telethon Institute for Child Health Research, Official Transcript of Evidence, 6 November 2008, p 26.

166 Professor L Cobiac, Flinders University, Official Transcript of Evidence, 13 June 2008, p 27.

167 Ms J Bryant, Department of Health and Ageing, Official Transcript of Evidence, 4 February 2009, p 3.

surveys and longitudinal studies as well as evaluation of intervention and treatment strategies.[168]

3.158 The Committee heard that a long-term commitment to adequate, ongoing funding is necessary to develop and implement a sustainable strategy and that this funding needs to be directed to 'community and professional capacity building, social marketing, evaluation and research, monitoring, and changes to the built environment.'[169] There are significant concerns that unreliable, non-ongoing funding will have a significant impact on the success of interventions, [170] and that unsustainable funding will result in the benefits of successful programs being dissipated.

3.159 The establishment of a research agenda which seeks to increase our understanding of obesity must focus on:

- monitoring and evaluation of interventions; and
- collection of data on physical activity and dietary behaviour.

3.160 Evidence to the inquiry raised significant concerns about the monitoring and evaluation of interventions, and our ability to capture and measure the success of those interventions. As a primary funding source for research and interventions into obesity, the Federal Government needs to ensure that their success or otherwise is measured and captured. This is an essential element of a research agenda into obesity and will contribute to our understanding of how best to address the levels of obesity in Australia.

3.161 A research agenda needs to generate adequate data about the levels of physical activity and the dietary choices of Australians. This data collection must operate on a long-term sustained basis in order to measure and capture changes to activity and eating habits. The Committee reiterates its comments, outlined in Chapter 2, about the inadequacies of current Australian data and support for the proposal to develop a National Health Risk Survey Program.

168 Professor L Cobiac, Flinders University, Official Transcript of Evidence, 13 June 2008, p 27; Associate Professor NM Byrne, Australian and New Zealand Obesity Society, Official Transcript of Evidence, 1 October 2008, p 29; Professor S Stewart, Baker Heart Research Institute, Official Transcript of Evidence, 20 June 2008, pp 2-3; Professor BA Swinburn, WHO Collaborating Centre for Obesity Prevention, Official Transcript of Evidence, 20 June 2008, p 22; Professor P Clifton, CSIRO, Official Transcript of Evidence, 13 June 2008, p 41; Ms KJ Roediger, Australian Institute of Health and Welfare, Official Transcript of Evidence, 12 May 2008, p 28.

169 WHO Collaborating Centre for Obesity Prevention, Submission No. 95, p 7.

170 National Rural Health Alliance Inc., Submission No. 21, p 16; Mr T Slevin, Cancer Council Western Australia, Official Transcript of Evidence, 6 November 2008, p 51; Associate Professor NM Byrne, Australian and New Zealand Obesity Society, Official Transcript of Evidence, 1 October 2008, p 29.

3.162 The Committee supports the development and implementation of an ongoing research agenda into obesity and recognises the need for secure funding for such a program.

Recommendation 14

The Committee recommends that the Minister for Health and Ageing fund research into the causes of obesity and the success or otherwise of interventions to reduce overweight and obesity.

Committee comment

3.163 The Committee is aware that overweight and obesity affects different population and socioeconomic groups differently. However, the Committee considers the strategies outlined in this chapter to be applicable to all sectors of Australian society. Nevertheless, the implementation of policies to address obesity in Australia must be locally appropriate, take account of cultural and socioeconomic differences and be modified accordingly.

3.164 The role of all three tiers of government in addressing the rate of obesity in Australia is central. The Committee acknowledges that there is work occurring at all levels of government to address the currently high levels of obesity, but thinks that there is more work to be done. At the federal level work is being undertaken by the Taskforce. The Committee considers their national strategy to be the overarching framework for working out how best to prevent obesity at the national level.

3.165 The Federal Government's focus on prevention will be strengthened by the development of a national preventive health agency, and the Committee endorses the establishment of such an agency.

3.166 There are likely to be relevant reforms to the healthcare sector arising from the current reviews by the *National Health and Hospitals Reform Commission* and the *Primary Healthcare Reform Commission*. That said, the Committee argues there are changes to the health system which can be made now. These include increasing public access to bariatric surgery, improving the role and training of GPs and allied health professionals and developing a tiered approach to the treatment and management of obesity.

3.167 Urban planning is a significant contributor to the high levels of obesity in Australia. As such, the Committee believes that urban planning guidelines

and laws must be improved, with responsibility shared by federal, state, territory and local governments alike. Changes in this arena will result in significantly healthier environments being created for Australians to live and work in.

3.168 The Committee was heartened by the evidence presented to it by representatives from various states that demonstrated the extent to which work is already occurring at the state government level to address obesity. In particular, the Committee supports the whole-of-society bodies operating in both Queensland and Western Australia.

3.169 The Committee also acknowledges and supports the extensive work already being undertaken by many local councils across Australia to increase the community's access to facilities and programs for physical activity. These programs can be locally appropriate and reinforce the approach of the Federal Government by embedding physical activity and healthy eating in everyday life.

3.170 The Federal Government needs to drive the development of a national research agenda into obesity. Ongoing funding for obesity research and the monitoring and evaluation of programs to counter overweight and obesity as well as the collection of up-to-date data are essential components of our national obesity prevention and management strategy.