
The Parliament of the Commonwealth of Australia

Weighing it up

Obesity in Australia

House of Representatives
Standing Committee on Health and Ageing

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Canberra

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Foreword

On 11 May 2009, the Australian Bureau of Statistics (ABS) published the latest National Health Survey 2007-08 figures. The Survey found that more adult Australians were overweight or obese in 2007-2008 compared with 1995 (when the previous survey was conducted). The Survey found that 68 percent of adult men and 55 percent of adult women were overweight or obese. This shows a growing incidence over 12 years as only 64 percent of men and 49 percent of women were overweight or obese in 1995. For children, there was a significant increase in the proportion who are obese from 5.2 percent in 1995 to 7.8 percent in 2007-08.¹

This inquiry into obesity in the Australian population, focusing on future implications for Australia's health system, has revealed that there are high personal and economic costs associated with this increasing prevalence. The Committee has heard there is a vast array of direct and indirect costs to - not just the health system - but individuals, families, communities, and employers.

Access Economics recently updated its report on the economic costs of obesity in Australia and deemed the total annual cost in 2008 to be growing and in the region of \$58.2 billion. The financial costs account for \$8.283 billion (\$3.6 billion productivity costs; \$2 billion health system costs; and \$1.9 billion carer costs) with the net cost of lost wellbeing amounting to a further \$49.9 billion.² These costs are staggering.

Throughout the course of this inquiry Committee members travelled the length and breadth of the country, visiting capital cities, regional areas and rural and remote communities to gather information on what these costs actually mean.

The Committee held 13 public hearings to canvass the views of different people with an interest in the subject including: doctors, allied health professionals and

1 Australian Bureau of Statistics, National Health Survey: Summary of Results 2007-08, <<http://www.abs.gov.au/ausstats/abs@.nsf/Latestproducts/4364.0Main%20Features62007-08?opendocument&tabname=Summary&prodno=4364.0&issue=2007-08&num=&view>>, 11 May 2009.

2 Access Economics, Official Transcript of Evidence, 26 November 2008, p. 4.

patients; hospital administrators; health economists and academic experts; urban planning bodies; and the food industry. We visited a number of hospitals, schools and programs that promote healthy eating and the benefits of physical exercise, in various guises. We heard from federal, state and local government officials about diverse public health campaigns, policies and activities that seek to prevent and manage the obesity epidemic in children, youth and adults.

The Committee's inquiry has been conducted at the same time as the Federal Government's National Preventative Health Taskforce examines the burden of chronic disease caused by obesity, tobacco and the excessive consumption of alcohol, in order to develop a national preventative health strategy, which will also be presented to the Minister for Health and Ageing in the near future. The National Preventative Health Taskforce report will deliver comprehensive technical recommendations and an action timeline.

Our report complements the National Preventative Health Taskforce process insofar as we make general recommendations on what governments, industry, individuals and the broader community can do to reverse our growing waistlines. Our report differs in that it also, importantly, serves as a platform for many stakeholders to share their views and tell their stories. As some of the text and photos in our report attest, there are some quite exciting and innovative solutions already underway, spanning from well-designed urban developments to council-run exercise programs in parks to community gardens and cooking classes.

The Committee has been pleased by the interest in the inquiry and believes that there is real momentum in the community to do more.

The Committee hopes that our report, together with the Preventative Health Taskforce Strategy, takes the debate forward but moreover results in actions that reverse the trend of overweight and obesity in Australia.

On behalf of my Committee colleagues, I would like to thank all those who took part in the inquiry process, from providing written submissions and/or oral evidence at public hearings, to supporting the Committee's inspections or providing private briefings to the Committee on other occasions.

I would also like to thank my Committee colleagues for their work on this inquiry, and the Secretariat staff.

Mr Steve Georganas MP
Chair



Membership of the Committee

Chair Mr Steve Georganas MP

Deputy Chair Mr Steve Irons MP (from 12/11/08)
Hon Kevin Andrews MP (to 10/11/08)

Members	Mr James Bidgood MP	Mrs Julia Irwin MP
	Mr Jamie Briggs MP (from 25/9/08)	Mrs Margaret May MP
	Mr Mark Coulton MP	Mr Scott Morrison MP (to 25/9/08)
	Ms Jill Hall MP	Ms Amanda Rishworth MP
	Ms Catherine King MP	

Committee Secretariat

Secretary	Mr James Catchpole
Inquiry Secretary	Ms Sara Edson
Senior Research Officer	Ms Penny Wijnberg
Research Officer	Dr Narelle McGlusky
Administrative Officers	Mrs Gaye Milner
	Ms Tarran Snape



Terms of reference

The Committee will inquire into and report on the increasing prevalence of obesity in the Australian population, focusing on future implications for Australia's health system.

The Committee will recommend what governments, industry, individuals and the broader community can do to prevent and manage the obesity epidemic in children, youth and adults.



List of abbreviations

%DI	Percentage Daily Intake
AANA	Australian Association of National Advertisers
AASC	Active After-school Communities
ABHI	Australian Better Health Initiative
ABS	Australian Bureau of Statistics
ACCC	Australian Consumer and Competition Commission
AFGC	Australian Food and Grocery Council
AIHW	Australian Institute of Health and Welfare
AMA	Australian Medical Association
ANAO	Australian National Audit Office
ANZOS	Australian and New Zealand Obesity Society
APD	Accredited Practising Dietitian
ASC	Australian Sports Commission
AWASH	Australian Division of World Action on Salt and Health
BEACH	Bettering the Evaluation and Care of Health
BMI	Body Mass Index
CFAC	Coalition on Food Advertising to Children

CIS	Centre for Independent Studies
COAG	Council of Australian Governments
CO-OPS	Community Obesity Prevention Sites Collaboration
Committee	House of Representatives Standing Committee on Health and Ageing Committee
CSIRO	Commonwealth Science and Industrial Research Organisation
CTS	Children's Television Standards
CVD	Cardiovascular Disease
DAA	Dietitians Association of Australia
DALY	Disability Adjusted Life Year
Delfin	Delfin Lend Lease
DoHA	Department of Health and Ageing
Foresight	Tackling Obesities: Future Choices project report
FSA	Food Standards Agency (UK)
FSANZ	Food Standards Australia New Zealand
GP	General Practitioner
HACC	Home and Community Care
HIKCUPS	Hunter Illawarra Kids Challenge Using Parent Support
HRS	Health Risk Survey
MBS	Medicare Benefits Schedule
NGO	Non-government Organisation
NHMRC	National Health and Medical Research Council
NHS	National Health Service
NSA	National Seniors Australia

NSW	New South Wales
OECD	Organisation for Economic Cooperation and Development
PBS	Pharmaceutical Benefits Scheme
PE	Physical Education
Qld	Queensland
SA	South Australia
Taskforce	National Preventative Health Taskforce
UK	United Kingdom
Vic	Victoria
WA	Western Australia
WAMS	Walgett Aboriginal Medical Service
Weight Watchers	Weight Watchers Australasia
WHO	World Health Organisation
Woolworths	Woolworths Limited
YMCA	Young Men's Christian Association



List of recommendations

2 Future implications for Australia

Recommendation 1

The Committee recommends that the Minister for Health and Ageing commission economic modelling in order to establish the cost implications of obesity to Australia and the cost-benefits of various interventions.

Recommendation 2

The Committee recommends that the Minister for Health and Ageing commit to regular and ongoing surveillance and monitoring of Australians' weight, diet and physical activity levels, and that the data gathered is used to formulate, develop and evaluate long-term policy responses to obesity in Australia. This data collection should build on the foundation established by the *2007 Australian National Children's Nutrition and Physical Activity Survey*, and proposed National Nutrition and Physical Activity Survey and National Health Risk Survey, providing up-to-date information about the prevalence of obesity in Australia.

3 What more can governments do?

Recommendation 3

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.

Recommendation 4

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.

Recommendation 5

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.

Recommendation 6

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.

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.

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.

Recommendation 9

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.

Recommendation 10

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.

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.

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.

Recommendation 13

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.

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.

4 A role for industry

Recommendation 15

The Committee recommends that the Minister for Health and Ageing adopt a phased approach regarding regulations on the reformulation of food products. Industry should be encouraged to make changes through self-regulation but if industry fails to make concrete changes within a reasonable timeframe the Federal Government should consider regulations.

Recommendation 16

The Committee recommends that the Minister for Health and Ageing engage with peak bodies such as the Australian Food and Grocery Council, the Dietitians Association of Australia, and the Heart Foundation, to develop and implement a *Healthy Food Code of Good Practice* tailored to Australian conditions.

Recommendation 17

The Committee recommends that the Minister for Health and Ageing review the adequacy of regulations governing weight loss products and programs with the intention of ensuring that they can only be sold and promoted if nutritionally sound and efficacious.

The review should also examine ways to improve industry compliance with the Weight Management Council of Australia's Weight Management Code of Practice.

Recommendation 18

The Committee recommends that the Minister for Health and Ageing encourage private and public employers to adopt programs and incentives that will promote active and healthy lifestyle choices by all Australians within the workplace.

6 Community programs and partnerships

Recommendation 19

The Committee recommends that the Federal Government continue to support initiatives such as community garden projects, cooking classes and the Stephanie Alexander Kitchen Garden Program, in order to teach children and adults about:

- The benefits of growing and eating fresh fruit and vegetables; and
- Preparing and enjoying healthy and nutritious meals.

Recommendation 20

The Committee recommends that the Minister for Health and Ageing explore ways to enhance the *How do you measure up?* campaign website and further develop it as a central repository of information about the benefits of healthy eating and exercise.

Introduction

Australia is one of the most overweight developed nations, with overweight and obesity affecting about one in two Australian adults and up to one in four children.¹

‘The big picture’

- 1.1 The issue of a growing overweight and obese population is a pressing health concern for Australia. The 2007-08 National Health Survey (which measures the exact height and weight of adults and children using the Body Mass Index (BMI) approach) found that 68 percent of adult men and 55 percent of adult women are overweight or obese. This has increased from 64 percent of men and 49 percent of women found to be overweight or obese in the 1995 survey.²
- 1.2 The increase supports data from the Bettering the Evaluation and Care of Health (BEACH) study (which collects information from general practitioners across Australia)³ that indicates that the prevalence of adult overweight and obesity has risen significantly in the last decade, from 51.1 percent in 1998-99 to 58.5 percent in 2006-07.⁴

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

2 Australian Bureau of Statistics,
<<http://www.abs.gov.au/ausstats/abs@.nsf/Latestproducts/4364.0Media%20Release12007-08?opendocument&tabname=Summary&prodno=4364.0&issue=2007-08&num=&view=>> accessed 11 May 2009.

3 The BEACH Project: Bettering the Evaluation and Care of Health,
<<http://www.fmrc.org.au/beach.htm#1>> accessed 17 April 2009.

4 Britt, H et al, 2008, *General Practice Activity in Australia 2006-07*,
<<http://www.aihw.gov.au/publications/gep/gpaa06-07/gpaa06-07.pdf> > accessed 17 April 2009.

- 1.3 It is not just the adult population that is becoming heavier. The growing rate of obesity amongst Australian children is equally concerning.
- 1.4 In October 2008, the Department of Health and Ageing (DoHA) released the *2007 Australian National Children's Nutrition and Physical Activity Survey*. The survey stated that 17 percent of children in Australia are classified as overweight and six percent are classified as obese. While research from the University of South Australia's School of Health Sciences indicates that the rate of obesity in children may have levelled off in the past 15 years,⁵ the general consensus amongst obesity experts is that it is too early to say whether this is the case and that children are still growing up in an increasingly sedentary and calorie-rich environment.
- 1.5 In addition to the costs of overweight and obesity incurred by individuals, families and communities, there are huge financial costs for the health system. In 2008 Access Economics released its report, *The Growing Cost of Obesity in 2008: three years on*, which updated an earlier report of theirs titled *The Economic Costs of Obesity*, published in 2006. The latest report found that the total cost of obesity in 2008 was \$58.2 billion which included the attributable cost of diseases such as diabetes, cardiovascular disease, various types of cancer and osteoarthritis. Of this total, the financial cost was estimated at \$8.283 billion and the estimated cost of lost wellbeing \$49.9 billion.⁶ This figure had risen from an earlier estimate of \$21 billion for the total cost of obesity.⁷ Access Economics informed the Committee that the earlier report had been 'quite conservative in its projections of obesity prevalence.'⁸ The higher figures strengthen calls for action to reverse the rates of obesity.
- 1.6 Should nothing be done to address obesity, the outlook is likely to worsen. The 2008 Access Economics report predicts that population ageing alone will result in 4.6 million Australians being classified as obese by 2025. If the growth rates in obesity continue at the current rate over the next 20 years, an estimated 6.9 million Australians will become obese by 2025.⁹

5 See Ryan, S & Bitá, N 2009, 'Childhood obesity epidemic a myth, says research', *The Australian*, 9 January 2009, <<http://www.theaustralian.news.com.au/story/0,25197,24889986-2702,00.html>> accessed 17 April 2007.

6 Access Economics 2008, *The growing costs of obesity in 2008: three years on*, <<http://www.accesseconomics.com.au/publicationsreports/showreport.php?id=172&searchfor=2008&searchby=year>> accessed 17 April 2009.

7 Access Economics 2005, *The economic costs of obesity*, <<http://www.accesseconomics.com.au/publicationsreports/showreport.php?id=102&searchfor=2006&searchby=year>> accessed 17 April 2009.

8 Ms ML Pezzullo, Access Economics, Official Transcript of Evidence, 26 November 2008, p 1.

9 Access Economics 2008, *The growing costs of obesity in 2008: three years on*, <<http://www.accesseconomics.com.au/publicationsreports/showreport.php?id=172&searchfor=2008&searchby=year>> accessed 17 April 2009.

Additional prevalence data

- 1.7 In addition to the Access Economics report, other major studies support the notion of Australia's growing weight problem.
- 1.8 The AusDiab base-line study which was conducted under the auspices of the International Diabetes Institute in 1999/2000 (and the largest Australian longitudinal population-based study ever done into diabetes, heart disease and kidney disease)¹⁰ unearthed high prevalence rates with 19.1 percent of men and 20.1 percent of women found to be obese and a further 60 percent of men and almost half of all adult females found to be overweight.¹¹
- 1.9 The Baker Heart Research Institute's report *Australia's Future Fat Bomb* contains more recent data that shows that, as of 2008, approximately four million adult Australians are obese and that seven in ten men and six in ten women are classed as being overweight or obese.¹² This data reveals that the prevalence of obesity may therefore be higher than currently thought.
- 1.10 International data adds further credence to the growing concerns about the level of obesity in Australia. The 2007 Organisation for Economic Cooperation and Development (OECD) report, *Health at a Glance 2007: OECD indicators* found that Australia had the fifth largest rate of adult obesity (21.7 percent) behind the United States (32.2 percent), Mexico (30.2 percent), United Kingdom (23 percent) and Greece (21.9 percent).¹³
- 1.11 It is crucial to note that there are a range of co-morbidities (that is the presence of two or more illnesses in the same person at the same time) associated with overweight and obesity. These include type 2 diabetes, cardiovascular disease, high blood pressure, some cancers, sleep apnoea, osteoarthritis and psychological disorders. These conditions can be caused

10 International Diabetes Institute, Australian Diabetes, Obesity & Lifestyle Study, <<http://www.diabetes.com.au/research.php?regionID=181>> accessed 17 April 2009.

11 Australia New Zealand Obesity Society, Submission No. 11, p 5.

12 Stewart, S et al., 2008, *Australia's Future 'Fat Bomb': a report on the long-term consequences of Australia's expanding waistline on cardiovascular disease*, Baker Heart Research Institute, Melbourne, p 2.

13 Organisation for Economic Co-operation and Development (OECD) 2007, *Health at a Glance: OECD Indicators*, OECD, p 51.

or exacerbated by excess body weight.¹⁴ According to the Access Economics report, these conditions also incur significant financial costs.¹⁵

What is overweight and obesity?

1.12 It is important to define overweight and obesity for the purposes of this report. Traditionally, overweight and obesity are measured using the Body Mass Index (BMI). The BMI measures a person's weight in relation to their height.¹⁶ Adults with a BMI between 25 and 30 are classified as overweight, while those with a BMI greater than 30 are characterised as obese. However, the BMI is not always a suitable measurement tool for all body types, ethnic groups and growing children.¹⁷ For instance, overweight and obesity in growing children should be measured using a combination of the BMI, growth charts and other measures of fat.¹⁸

1.13 Notwithstanding criticism of the BMI as an imperfect measuring tool for obesity (especially its ability to provide a nuanced result specific to an individual), it remains a useful tool to assess obesity at the population level. As the senior statistician from the Telethon Institute for Child Health Research told the Committee:

I think the BMI is a crude tool. It can work reasonably well at the population level with some assumptions, because sometimes when you are collecting data ... the easiest thing to do is height and weight and out you go ... You would not tend to use it at the individual level ... but as a broad population measure, sometimes it is all you have got.¹⁹

1.14 BMI is not the only tool that can be used to determine whether an individual is in a healthy weight range. Another common measurement is a person's waist circumference. This measures intra-abdominal fat, which is associated with increased risk of chronic disease. Men with a waist

14 Parliamentary Library 2007, *Parliamentary Library Briefing Book: Key issues for the 42nd Parliament*, <http://libiis1/library_services/BriefingBook42p/BriefingBook_2007.pdf> accessed 17 April 2009.

15 Access Economics 2005, *The economic costs of obesity*, <<http://www.accesseconomics.com.au/publicationsreports/showreport.php?id=102&searchfor=2006&searchby=year>> accessed 17 April 2009.

16 The formula for calculating BMI is one's weight (in kilograms) divided by one's height (in metres) squared.

17 Organisation for Economic Co-operation and Development (OECD) 2007, *Health at a Glance: OECD Indicators*, OECD, p 50.

18 The Australian and New Zealand Obesity Society, 'Obesity in Australian Children', <http://www.asso.org.au/freestyler/gui/files//factsheet_children_prevalence.pdf> accessed 17 April 2009.

19 Mr F Mitrou, Telethon Institute for Child Health Research, Official Transcript of Evidence, 6 November 2008, p 32.

circumference larger than 94 centimetres and women with a measurement greater than 80 centimetres are at an increased risk of chronic disease. The risk of chronic disease is significantly increased when men's waist circumference is greater than 102 centimetres and women's greater than 88 centimetres. Recently the Federal Government launched the *How do you measure up?* campaign as part of the Australian Better Health Initiative (ABHI), which is a joint Australian, State and Territory Government initiative. The campaign encourages Australians to measure their waist circumference and change their lifestyles to reduce the risk of chronic diseases including cancers, cardiovascular disease and type 2 diabetes.²⁰

Subject of increased attention and reason for inquiry

- 1.15 Obesity has garnered a significant amount of attention over the last few years, and this has gathered pace and momentum throughout the duration of the inquiry. Barely a day has gone by without a piece appearing in the media, newspapers or television, about some aspect of the issue, in Australia or overseas. It is a reality of modern society and governments, industry, communities and individuals all have a stake.
- 1.16 In December 2007 the then new Minister for Health, the Hon Nicola Roxon MP, attended a summit aimed at tackling childhood obesity in Australia. Here she stated the new government's commitment to making obesity prevention a National Health Priority Area.²¹
- 1.17 In addition to the Minister for Health identifying obesity prevention as a national health priority, in early 2008 the Prime Minister announced that the Government would convene a 2020 summit at Parliament House in Canberra in April 2008. One of the policy areas debated at the summit was a long-term health strategy for Australia, including the prevention of

20 Further information on the *How do you measure up?* campaign can be found at <<http://www.measureup.gov.au/internet/abhi/publishing.nsf/Content/Home>> accessed 17 April 2009.

21 Hon N Roxon, Minister for Health and Ageing, Speech to the *Tackling Childhood Obesity in Australia Summit, 11 December 2007*, <<http://www.health.gov.au/internet/ministers/publishing.nsf/Content/sp-yr07-nr-nrsp111207.htm?OpenDocument&yr=2007&mth=12>> accessed 17 April 2009.

chronic and acute health problems such as overweight and obesity.²² At the summit, overweight and obesity were identified as key health issues.²³

1.18 Subsequent to the emerging data about the scale of overweight and obesity in Australia, the Minister for Health requested that the House of Representatives Standing Committee on Health and Ageing (the Committee) investigate the issue of overweight and obesity in Australia.

1.19 Therefore, on 19 March 2008, the Committee adopted the following self referred terms of reference for the inquiry into obesity in Australia:

The House of Representatives Standing Committee on Health and Ageing has reviewed the 2006-07 annual report of the Department of Health and Ageing and, pursuant to Standing Order 215 (c), resolved to conduct an inquiry into obesity in Australia.

“The Committee will inquire into and report on the increasing prevalence of obesity in the Australian population, focusing on future implications for Australia’s health system.

The Committee will recommend what governments, industry, individuals and the broader community can do to prevent and manage the obesity epidemic in children, youth and adults.”²⁴

1.20 At around the same time that the Committee’s inquiry was established, the Prime Minister announced the formation of the National Preventative Health Taskforce (the Taskforce) whose objective is to provide a framework to government to address the burden of disease caused by alcohol, tobacco and obesity.²⁵ The Taskforce is comprised of a panel of experts who will develop a blueprint for tackling the burden of disease caused by excessive alcohol consumption, smoking and obesity. Their focus is on primary prevention and their recommendations will cover both health and non-health sectors.²⁶

22 Prime Minister, *Australia 2020 Summit*, media release, Canberra, 3 February 2008, <http://www.pm.gov.au/media/Release/2008/media_release_0054.cfm> accessed 17 April 2009.

23 *A long-term national health strategy*, Australia 2020 Summit - Final Report, p 163, <http://www.australia2020.gov.au/docs/final_report/2020_summit_report_5_health.pdf> accessed 17 April 2009.

24 House of Representatives Standing Committee on Health and Ageing, Minutes of Proceedings, Meeting No. 2, 19 March 2008, p 2.

25 Preventative Health Taskforce, <<http://www.preventativehealth.org.au/>> and <<http://www.preventativehealth.org.au/internet/preventativehealth/publishing.nsf/Content/national-preventative-health-strategy-11p>> accessed 17 April 2009.

26 Preventative Health Taskforce, <<http://www.preventativehealth.org.au/internet/preventativehealth/publishing.nsf/Content/terms-of-reference-11p>> accessed 17 April 2009.

- 1.21 Also in 2008, the Council of Australian Governments (COAG) committed to a Health Prevention National Partnership, with the goal of improving the health of all Australians, at their meeting of 29 November.²⁷ The focus on prevention is central to the debates surrounding overweight and obesity and the impact on the health system given that obesity is such a major risk factor for chronic disease and its effects can be felt throughout the entire health system.²⁸
- 1.22 While the increased attention on obesity – through near constant media coverage - has done much to raise people’s awareness of the extent of the problem, the Committee believes that much of the reporting has been overly negative, alarmist and almost defeatist in nature. Popular weight loss television shows are somewhat extreme. No one discounts the powerful personal journeys and incredible transformations that the contestants on these shows clearly undergo. However, they do perhaps mislead people to believe that everyone can, or indeed should, lose vast amounts of weight in a very short amount of time. This sort of dramatic weight loss and increased physical activity is a severe approach to adopting a healthier lifestyle. Rather than people feeling either overwhelmed and that there is no way forward, or that they must take extreme measures to change their lives, this report seeks to show that obesity is an opportunity, as much as it is a challenge for the Australian populace to embrace healthier ways of living and that there are many different paths toward this goal. Incremental and even-handed steps can lead to more sustainable changes.

Carving out a niche for the Committee

- 1.23 As described in the previous section, there are a number of concurrent government processes which aim to find better solutions to chronic health problems, including obesity. The Committee does not seek to replicate these processes, but rather to complement them. The most important complementary process to our inquiry is that of the Taskforce. However, it is necessary to note upfront that the role of the Committee is very different to that of the Taskforce. The Taskforce is a panel of experts that have been asked to develop a technical national preventative health strategy. In addition, their focus is on three areas; alcohol, tobacco and obesity; and

27 Details on the Health Prevention National Partnership can be found on the website of the Council of Australian Governments, <http://www.coag.gov.au/coag_meeting_outcomes/2008-11-29/attachments.cfm#attachmenta> accessed 17 April 2009.

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

the burden of disease each cause.²⁹ This Committee has a less technical focus. Our public hearings have been a forum for members of the community - experts and citizens alike- to meet with Members of Parliament to discuss their knowledge and experiences in the context of taking the debate(s) forward where possible. These different approaches will result in different, yet complementary reports. Having consulted extensively with the Taskforce throughout the duration of our inquiry, the Committee expects that its report will broadly support and feed into the Taskforce's national strategy, due out in the middle of 2009.

- 1.24 The Committee has been keen to foster national debate on the issues of overweight and obesity across the country. Throughout the inquiry, Committee members have taken the opportunity to travel across Australia, visiting urban and rural Australians, in the health system and out of it, to hear directly from the community how obesity impacts them. The Committee has seen first hand the complexity of the problem. And, the Committee has seen for itself many programs that are seeking to redress the many related problems.

29 Dr L Roberts, National Preventative Health Taskforce, Official Transcript of Evidence, 12 November 2008, p 2.

Figure 1.1 The Committee meeting with members of the community in Wilcannia, NSW



- 1.25 Throughout the inquiry, the Committee has been impressed by the many individuals and organisations across Australia making positive changes, be it in their own lives, families, communities or workplaces. Many of these stories are yet to be shared at a national level, and this report seeks to showcase some of the excellent initiatives that already exist.
- 1.26 These initiatives are a counter to the negativity surrounding overweight and obesity and indicate that it is possible to reverse the numbers of overweight and obese Australians. Solutions include initiatives as diverse as fruit first policies at schools which encourage children to consume fruit at recess; community cookbooks in remote indigenous communities which feature simple ideas on how to prepare cost-effective healthy food; kitchen gardens in schools as well as community gardens that share the joy of food production with Australians of all ages; and an emerging focus on healthy urban environments where physical activity is embedded in urban design.

Parameters of the report

- 1.27 While there is a distinction between overweight and obesity as conditions, for a broad ranging inquiry such as this it is useful to consider the

implications for the population across the spectrum from overweight through to morbidly obese. Therefore, throughout the report the term obesity will be used, and will generally refer to the excess body weight that is carried by individuals who are both overweight and obese. Some sections of the report will clearly be more relevant for people who are at one end of the spectrum. For example, the Committee is not advocating bariatric surgery³⁰ as the solution for everyone that is overweight. However it is an option for the severely obese, in consultation with their clinician.

- 1.28 The report will not elaborate in detail on the various causes of obesity in Australia. Issues such as poor urban design, lifestyle, lack of time or lost art of cooking skills and affordability of fresh health food have been canvassed through many other forums. The United Kingdom (UK) Government's 2007 report on obesity, *Tackling Obesities: Future Choices* (Foresight Report) expertly details a comprehensive causal relationship.³¹ The Committee accepts that there are various factors, including the aforementioned ones, which contribute increasing levels of obesity within society. The Committee well understands how much more complex than a simple energy in – energy out equation the problem is and that it is a multifaceted issue. If anyone is in any doubt they should consult the obesity system map in the Foresight Report for an illustration of how tangled and interconnected the issues are. The UK Health Secretary has gone so far as to say that the phenomenon of obesity is as serious a threat to modern societies as climate change.³²
- 1.29 The fact that obesity has so many contributing factors and impacts means that there will be no one or simple solution. The Committee is wary of recommending solutions of a 'one size fits all' nature. A balance must be

30 In adjustable gastric banding, insertion of a band restricts the size of the opening from the oesophagus to the stomach. The size of the opening to the stomach determines the amount of food that can be eaten. The size of the opening can be controlled by the surgeon by inflating or deflating the band through a port that is implanted beneath the skin on the abdomen. The band can be removed at any time.

In contrast to gastric banding, gastric bypass (sometimes referred to as roux-en-Y gastric bypass) is a permanent reduction in the size of the stomach. The proximal portion of the stomach is used to create an egg-sized pouch that is connected to the intestine in a location that bypasses about 2 feet of normal intestine. The amount of food that can be eaten is limited by the size of the pouch and the size of the opening between the pouch and the intestine. Source: <www.medicinenet.com.>

31 Butland, B et al 2007, *Tackling Obesities: Future Choices*, Government Office for Science, <<http://www.foresight.gov.uk/Obesity/17.pdf>>. Evidence to this inquiry about the causes of obesity can be found in Department of Health and Ageing, Submission No. 154, pp 25–33.

32 'Obesity as bad as climate risk', BBC News, 14 October 2007, <<http://news.bbc.co.uk/2/hi/health/7043639.stm>> accessed 17 April 2009.

struck between taking swift action, and ensuring that any major interventions are supported by evidence.

The inquiry process

- 1.30 As mentioned, the Committee adopted the terms of reference for the inquiry at a private meeting on 19 March 2008. The following day, the Chair issued a media release announcing the inquiry and calling for submissions from interested organisations and individuals. In order to publicise the inquiry more broadly, an advertisement was also placed in *The Australian* on 2 April 2008. Letters were sent to individuals, peak bodies and government agencies inviting them to make submissions to the inquiry.
- 1.31 A total of 158 submissions (listed at Appendix A) and 97 exhibits (listed at Appendix B) were accepted as evidence to the inquiry. The Committee was particularly pleased to receive submissions from a diverse range of stakeholders including; state and federal health departments; McDonalds Restaurants Australia; Woolworths Australia; the Australian and New Zealand Obesity Society; Weight Watchers Australasia; Weight Management Services at the Westmead Children's Hospital; the Stephanie Alexander Kitchen Garden Project; the Obesity Policy Coalition; the National Rural Health Alliance; the Parents Jury; the Australian Association of National Advertisers; the Heart Foundation; the Planning Institute of Australia; and the Australian Local Government Association.
- 1.32 In order to further public involvement in the inquiry, the Committee travelled across Australia for a total of 13 public hearings. The hearings took place in most states and territories, capital cities, outer metropolitan areas and regional Australia. For instance, the Committee held hearings in Sydney, Perth, Adelaide, Lake Macquarie, Broken Hill and Dubbo.
- 1.33 At these public hearings the Committee heard from academics, public servants, dieticians, doctors, nurses, teachers, and people who had undergone treatment for obesity. The Committee was humbled to hear first hand from people who had undergone bariatric surgery and been on Weight Watchers, including the Slimmer of the year for 2008 and a Weight Watchers meeting leader. Their courage in coming before the Committee to share their personal struggles with weight gave the Committee a much greater understanding of the complexity of this health problem.
- 1.34 To complement the inquiry process the Committee also went on 16 inspections throughout the course of the inquiry. These inspections included visits to hospitals, to see the equipment challenges that obesity

presents to hospital staff; schools, to see kitchen and community gardens instilling a love of food in our children; and a remote indigenous community, to learn more about the particular problems these communities face in terms of access to food, sporting facilities and medical care. In addition, members of the Committee were pleased to be able to participate in community sports events including the Active After-schools Program (AASC) and an Active Gold Coast Tai Chi class. Details of the hearing and inspection venues appear at Appendix C.

Figure 1.2 The Committee discussing the Premier's 'Be Active' challenge with students at Adelaide High School, South Australia



1.35 The diverse evidence gathered by the Committee was complemented by seven private briefings to the Committee on the topic of obesity and the evidence received at four of these briefings was subsequently authorised for publication and placed on the website.³³ These included briefings from the Australian Sports Commission to learn more about the Active After-school Communities program; from Access Economics to hear about the financial implications of obesity; and from Stephanie Alexander to better understand the positive impact that growing and cooking food can have

33 Parliament of Australia, House of Representatives, Standing Committee on Health and Ageing, <<http://www.aph.gov.au/house/committee/haa/obesity/hearings.htm>>.

on a child. The Committee was also pleased to receive a briefing from and meet with the Taskforce in order to exchange ideas about policy solutions to this public health problem. The Chair of the Committee also met separately with the Chair of the Taskforce.

- 1.36 Media releases about the inquiry, copies of the submissions received, transcripts of the evidence from the public hearings, and a copy of the report are available on the inquiry's web site.³⁴
- 1.37 The Department of the House of Representatives *About the House* magazine featured three articles on the obesity inquiry, 'Fighting Fat' (September 2008), 'Heart disease spreads with obesity' (December 2008) and 'Fresh Harvest: Feeding our children's health' – on the Stephanie Alexander Kitchen Garden Programme (December 2008).³⁵
- 1.38 The Committee's inquiry was referred to repeatedly on the radio and in print media as we travelled around the country for hearings and also made national news on television several times.³⁶

Structure of the report

- 1.39 The report is structured around the inquiry's terms of reference and therefore the focus of the report is on the future implications of obesity for the long-term health of Australia and Australians and the role that governments, industry, the community and individuals can all play in its prevention and management.
- 1.40 Some key themes that the report will cover are:
- the current and future costs of obesity;
 - the need for national leadership and a whole-of-society response;
 - the capacity of governments to create health enabling environments and the tools available to achieve this including:
 - ⇒ regulation;
 - ⇒ urban planning;
 - ⇒ providing better treatment options; and

34 Parliament of Australia, House of Representatives, Standing Committee on Health and Ageing, <<http://www.aph.gov.au/house/committee/haa/obesity/index.htm>>.

35 About the House, Australian Parliament House, <http://www.aph.gov.au/house/house_news/index.asp>.

36 For example, A Current Affair 15 May 2008, Seven Morning News 20 June 2008, and SBS World News 20 June 2008.

⇒ developing and driving a research agenda;

- the role that industry must play;
- the responsibility of individuals; and
- the importance of community in any policy response to obesity.

1.41 Chapter 2 deals with the future implications of overweight and obesity for Australia's health system. Chapter 3 focuses on the role that governments at all levels; federal, state and local, can play in addressing overweight and obesity. Chapter 4 deals with what more industry can do. Chapters 5 and 6 highlight the important role of individuals and communities within the obesity debate. Chapter 7 outlines the Committee's concluding remarks.

Future implications for Australia

- 2.1 Increasing levels of obesity among the Australian population will have significant impacts on the health system, and on Australia as a whole. This chapter will outline the costs and future implications of obesity, focusing specifically on:
- costs of obesity:
 - ⇒ economic costs;
 - ⇒ individual costs; and
 - ⇒ social costs;
 - future implications:
 - ⇒ cost of co-morbidities;
 - ⇒ hospital costs;
 - ⇒ monitoring interventions; and
 - the United Kingdom's perspective.
- 2.2 Understanding the implications of these increasing costs is important because they underscore the need for action to reverse the rate of obesity in Australia.

Costs of obesity

Economic costs

- 2.3 The Committee heard that in 2008 the estimated cost of obesity to the Australian economy was \$8.283 billion. If the cost of lost wellbeing is

included the figure reaches \$58.2 billion.¹ These figures are only estimates for the cost of obesity, not the costs of overweight. Yet, these figures alone demonstrate the strain that obesity is having on the Australian economy and the need to put in place an effective treatment and prevention strategy.

- 2.4 Evidence to the Committee showed that the costs have increased over the past decade. Witnesses repeatedly referred to a report commissioned by Diabetes Australia from Access Economics in 2005 that found the estimated cost of obesity to be \$3.8 billion. Including the cost of wellbeing raised the figure to \$21 billion.² At a private briefing in Canberra, Access Economics told the Committee that they had changed their methodology between the 2005 and 2008 reports and revised their figures accordingly.

We realised that we had been quite conservative – overly conservative – in our 2005 estimate, so we thought it worthwhile putting the less conservative if perhaps less comfortable estimates on the table [in the 2008 version].³

- 2.5 The Committee questioned the Department of Health and Ageing (DoHA) at a private briefing regarding the lack of more comprehensive economic modelling for the Australian case and were told that the Preventative Health Taskforce (the Taskforce) would decide the type of modelling required in their final report.⁴ DoHA acknowledged the need for such modelling in their submission to the inquiry:

... it is likely the Australian situation would be broadly comparable with the UK scenarios. This needs to be tested using Australian data.⁵

- 2.6 The Committee believes that there would be significant benefit in modelling the economic costs of obesity in Australia and strongly recommends that the Minister for Health and Ageing commission economic modelling to establish the economic costs of obesity and model the cost-benefits of various interventions.

1 Access Economics 2008, *The growing costs of obesity in 2008: three years on*, <<http://www.accesseconomics.com.au/publicationsreports/showreport.php?id=172&searchfor=2008&searchby=year>> accessed 17 April 2009.

2 Diabetes Australia, Submission No. 92, npn.

3 Ms ML Pezzullo, Access Economics, Official Transcript of Evidence, 26 November 2008, p 15.

4 Mr PT Morris, Department of Health and Ageing, Official Transcript of Evidence, 4 February 2009, p 9.

5 Department of Health and Ageing, Submission No. 154, p 21.

Recommendation 1

- 2.7 **The Committee recommends that the Minister for Health and Ageing commission economic modelling in order to establish the cost implications of obesity to Australia and the cost-benefits of various interventions.**

Difficulties in determining costs

- 2.8 Throughout the inquiry the Committee took evidence time and time again about the difficulty of accurately estimating the cost of obesity to the Australian economy and Australian society. This is due to two significant factors:
- the hidden costs of obesity; and
 - weaknesses in the data on the prevalence of obesity.
- 2.9 These factors will be addressed in detail in the following section.

Hidden costs

- 2.10 The complexity of obesity and its inter-relation with a range of co-morbidities⁶ makes it difficult to accurately estimate the cost impact of obesity in Australia. It can be difficult to work out which costs involved in a patient's treatment are connected to obesity and which are connected to other conditions.
- 2.11 A number of witnesses to the inquiry cited examples of hidden costs. Associate Professor Samaras from St Vincent's Hospital told the Committee:
- Every time a coronary artery stent is put in, and obesity is the cause of that, that costs \$10,000. You will not see it as an obesity statistic; you will see it as a cardiac statistic.⁷
- 2.12 To try and disentangle the cost of obesity from the cost of the other conditions it is linked with, expert witnesses to the inquiry told the Committee that they use a scientific calculation to estimate how much of a condition is caused by obesity. This calculation is referred to as an 'attributable fraction'. The easiest way to understand 'attributable fractions' is by using an example, like bowel cancer:

6 A co-morbidity is a disease or illness which is caused or worsened by obesity including type 2 diabetes, hypertension, sleep apnoea, osteoarthritis, cardiovascular disease, and a number of cancers.

7 Associate Professor K Samaras, Australian Healthcare and Hospitals Association, Official Transcript of Evidence, 12 May 2008, p 35.

What they mean is that, for example, 20.5 per cent of all bowel cancer is attributable to obesity. That is what that attributable fraction means. It means that, with conditions, you can allocate how much of them are due to particular factors, whether it is physical inactivity, overweight, obesity or high blood pressure.⁸

- 2.13 Ms Pezzullo from Access Economics explained to the Committee that in 2008 obesity contributed to the costs of a range of other conditions:

The attributable fractions suggest that in the year 2008 there were 242,033 Australians who had type 2 diabetes as a result of being obese, there were 644,843 Australians who had cardiovascular disease as a result of being obese, there were 422,274 Australians who had osteoarthritis as a result of being obese and there were roughly 30,000 Australians who had the various cancers as a result of being obese.⁹

- 2.14 The Committee was also concerned about the intangible, but no less important costs, associated with obesity. The Committee learnt that obesity severely affects productivity and lessens an individual's life expectancy. Associate Professor Moss from the University of Adelaide noted:

...the inability of people who have an established condition to make the level of contribution to society that they might otherwise have expected to.¹⁰

- 2.15 The Committee heard that to calculate the cost of the loss of productivity, statisticians have developed the disability adjusted life year (DALY) which works out the years of life lost due to disability and the years of life lost due to premature death. The DALY allows statisticians to quantify the overall burden on society of a particular disease. In Australia, high body weight has been estimated to contribute 7.5 per cent to the burden of disease which is nearing the 7.8 per cent attributable to tobacco use. DoHA warns:

High body mass is likely to overtake tobacco as the leading modifiable cause of burden as smoking rates decline.¹¹

8 Ms ML Pezzullo, Access Economics, Official Transcript of Evidence, 26 November 2008, p 3.

9 Ms ML Pezzullo, Access Economics, Official Transcript of Evidence, 26 November 2008, p 3.

10 Associate Professor JR Moss, University of Adelaide, Official Transcript of Evidence, 13 June 2008, p 20.

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

Data weaknesses

- 2.16 Evidence to the inquiry confirmed the scale of the obesity epidemic in Australia but witnesses identified a number of weaknesses in the available data. The prevalence of obesity is not being measured in any systematic, nation wide way on a regular basis, and the data that is available is often out-of-date. Weaknesses in data collection make it difficult to determine the true cost of obesity to the Australian economy and society.
- 2.17 At the public hearing in Melbourne, the Committee heard evidence from the Centre for Obesity Research and Education that there are approximately 2.5 to 3 million Australians living with obesity, and that the number of morbidly obese Australians, whose BMI is 40 or more, is estimated to be 2 percent of the adult Australian population.¹²
- 2.18 Individual organisations and departments provided written and oral evidence to the Committee that demonstrate the extent of the problem within their own areas. For example, the Committee heard from staff from Hunter New England Health who work at Manning Base Hospital. Staff there noted that in 2001, 37 bariatric patients weighing a total of 5 tonnes and 342 kilograms with an average weight of 144 kilograms per patient had been admitted. By comparison, in 2008, 265 patients were admitted with a total weight of 39 tonnes and 220 kilograms and an average weight of 148 kilograms. The staff stated that in that seven year period there had been a total of 1,387 bariatric patients admitted to the hospital.¹³
- 2.19 The Committee took evidence from Queensland Health about their statistics:
- ...58 percent of adults over 18 years of age were overweight or obese while 21 percent of children aged five to 17 were either overweight or obese.¹⁴
- 2.20 When the Committee visited South Australia for a public hearing, evidence was presented that the latest South Australian data showed that nearly 13 percent of four year old boys in that state were overweight, and almost five percent were obese.¹⁵
- 2.21 While this evidence highlights the scale of the obesity epidemic in specific areas of the Australian population, the lack of national, up-to-date

12 Dr A Peeters, Centre for Obesity Research and Education, Official Transcript of Evidence, 20 June 2008, p 32.

13 Mr E Wood, Hunter New England Health, Official Transcript of Evidence, 12 September 2008, p 5.

14 Dr LA Selvey, Queensland Health, Official Transcript of Evidence, 1 October 2008, p 2.

15 Professor C Gericke, University of Adelaide, Official Transcript of Evidence, 13 June 2008, p 16.

prevalence data on obesity was repeatedly brought to the attention of the Committee. Among others, the Commonwealth Scientific and Industrial Research Organisation (CSIRO) raised this point in its submission to the inquiry:

It must be noted that there are significant limitations to Australian national data available on food intake, weight and health status. The last comprehensive survey of adult dietary intakes was conducted in 1995. Unlike the US National Health and Examination Survey which is conducted every 5 years, Australia does not have objective diet and health monitoring and surveillance. As such, it is not possible to track reliably over time the relationships between food intake, body weight and health status.¹⁶

- 2.22 The Australian and New Zealand Obesity Society (ANZOS) reiterated the concern about inadequate data collection in their submission:

It is perplexing that in a country as well resourced as Australia that has such well developed data collection systems and agencies that we do not collect regular data on dietary intake, physical activity and measured weight status on a regular basis.¹⁷

- 2.23 The Committee notes the release of the *2007 Australian National Children's Nutrition and Physical Activity Survey* which was completed and published during the course of the inquiry, but several witnesses emphasised that it had been 13 years since similar data had been collected. Professor Swinburn, from the World Health Organisation (WHO) Collaborating Centre for Obesity Prevention expressed the frustration of many witnesses:

It is unbelievable that the latest nationally representative data on childhood obesity in this country is 13 years old. If you want to act, you have to measure it...¹⁸

- 2.24 It is not merely the age of the data that is of concern but the methodology used to collect the information. Obesity data is collected by the Australian Bureau of Statistics (ABS) on a triennial basis, however this data is self-reported.¹⁹ The Taskforce discussion paper on obesity notes that self-

16 Commonwealth Scientific and Industrial Research Organisation (CSIRO), Submission No. 113, p 11.

17 Australian and New Zealand Obesity Society (ANZOS), Submission No. 11, p 5.

18 Professor BA Swinburn, World Health Organisation Collaborating Centre for Obesity Prevention, Official Transcript of Evidence, 20 June 2008, p 22.

19 Commonwealth Scientific and Industrial Research Organisation (CSIRO), Submission No. 113, p 9.

reported data is likely to be an underestimation because people tend to overestimate their height and underestimate their weight.²⁰

- 2.25 The Committee was advised that to rectify this lack of data, regular surveillance of obesity prevalence within the Australian population needs to be implemented.
- 2.26 In their submission to the inquiry, the CSIRO calls for 3-5 yearly surveillance of diet, physical activity, and height and weight to be undertaken, and states that there are many innovative ways in which this can be done. One of their suggestions is to get General Practitioners (GPs) to check the height and weight of each patient at each visit. CSIRO add that this would provide an opportunity for data collection and tracking as the information could be collated at state/national level.²¹
- 2.27 In their submission, the Australian Institute of Health and Welfare (AIHW) similarly draws attention to the need to improve Australian population surveillance and data collection. Their submission recommends that:
- Efforts to harmonise and standardise jurisdictional surveillance systems continue – and be expanded to jurisdictions without ongoing surveillance programs – so that annual national estimates can be obtained;
 - A comprehensive population survey (as outlined above, and including physical and biomedical measures) be established and repeated at regular intervals;
 - Better measures of physical activity and sedentary behaviours be developed and implemented in population surveys; and
 - The AIHW's monitoring role be enhanced to actively monitor the prevalence and trends in overweight and obesity in the Australian population, and integrate this with broader disease monitoring.²²
- 2.28 The Committee strongly believes that there needs to be regular monitoring and surveillance of height and weight, nutritional intake and physical activity levels in Australia. The Committee was pleased to note the release of the recent and comprehensive *2007 Australian National Children's Nutrition and Physical Activity Survey* and acknowledges that the Department of Health and Ageing will commence an ongoing National Nutrition and Physical Activity Survey Program in late 2009. The Committee is of the opinion that both of these surveys are long overdue.

20 Preventative Health Taskforce, Technical Report No. 1, Obesity in Australia, p 5.

21 Commonwealth Scientific and Industrial Research Organisation (CSIRO), Submission No. 113, p 23.

22 Australian Institute of Health and Welfare (AIHW), Submission No. 10, p 8.

- 2.29 The Committee notes that DoHA is currently developing a proposal for a National Health Risk Survey Program (HRS) which will expand the National Nutrition and Physical Activity Survey Program. The HRS will continue to collect self-reported data on nutrition and physical activity but will broaden the scope of the survey to include such things as:
- overweight and obesity status;
 - blood pressure status;
 - socioeconomic status;
 - stress status;
 - depression status;
 - blood lipid status;
 - cardiovascular health status;
 - kidney function status;
 - diabetes status; and
 - blood nutrient status.²³
- 2.30 The survey will initially focus on adults but will expand to include children in the future. It is proposed to commence the first survey in mid-2010 and it is hoped that funding will allow a sample from the HRS to form the basis for a continuing longitudinal study.²⁴ Data collected will be made available through a permanent, centralised, national data base for health research.²⁵ The Committee strongly endorses this proposal as well as the proposed National Nutrition and Physical Activity Survey and believes that these surveys will fill some of the gaps identified by witnesses to the inquiry.
- 2.31 The Committee is supportive of the proposal for GPs to collate data on the height and weight of their patients, and that this data be utilised to generate statistics on the level of obesity in Australia.

23 Department of Health and Ageing, *National Health Risk Survey: Consultation Paper*, March 2009, p 5.

24 Department of Health and Ageing, *National Health Risk Survey: Consultation Paper*, March 2009, p 4.

25 Department of Health and Ageing, *National Health Risk Survey: Consultation Paper*, March 2009, p 6.

Recommendation 2

2.32 **The Committee recommends that the Minister for Health and Ageing commit to regular and ongoing surveillance and monitoring of Australians' weight, diet and physical activity levels, and that the data gathered is used to formulate, develop and evaluate long-term policy responses to obesity in Australia. This data collection should build on the foundation established by the 2007 *Australian National Children's Nutrition and Physical Activity Survey*, and proposed National Nutrition and Physical Activity Survey and National Health Risk Survey, providing up-to-date information about the prevalence of obesity in Australia.**

Individual costs

2.33 The Committee was concerned by the extensive personal costs that individuals affected by obesity incur. Witnesses to the inquiry identified a number of areas, in addition to financial ones, where people bear a personal burden for obesity including:

- discrimination;
- stereotyping;
- abuse and bullying; and
- premature death.

2.34 At their first public hearing in Canberra, the Committee heard that obesity 'is one of the last bastions of discrimination in our community'²⁶ and this message was reinforced throughout the inquiry. Professional and personal evidence identified the pain, frustration and inconvenience caused by discrimination as a major cost to individuals. One submission mentioned an inability to obtain income protection insurance or life insurance because of being overweight.²⁷ A number of surgeons drew the Committee's attention to the lack of access to bariatric surgery through the public health system as a form of discrimination²⁸ (see Chapter 3 for more on bariatric surgery). Professionals working with children and young

26 Associate Professor K Samaras, Australian Healthcare and Hospitals Association, Official Transcript of Evidence, 12 May 2008, p 36.

27 Name withheld, Submission No 136, p 3.

28 See, for example, Dr WA Brown, Monash University, Official Transcript of Evidence, 20 June 2008, p 33.

people spoke of the hurt that children suffer when they are not chosen for games and sports teams because they are overweight.²⁹

- 2.35 The Committee learnt that discrimination is linked to stereotypes that have developed around obesity. Witnesses told the inquiry that overweight and obese people can be perceived as lazy, bad, weak, stupid and lacking in self-discipline.³⁰ The Committee was particularly concerned to hear from Queensland Health that these misperceptions had been perpetrated by some health professionals:

These negative attitudes not only exist within the general public but also among many health professionals, which can seriously affect the treatment of overweight and obese individuals.³¹

- 2.36 The Committee was told that a consequence of such typecasting is the personal abuse and bullying that obese people suffer. Unfair treatment contributes to the lack of confidence and low self-esteem that often characterises individuals who are overweight or obese. One witness told the Committee of her 'overwhelming sense of shame and hurt' at the remarks passed by strangers, friends and work colleagues about her weight.³² An academic working with overweight children told the Committee that children are well aware of their weight problem and provided an example of one boy:

... who had not been to school for two days prior to coming to the program because he just could not cope with the bullying.³³

- 2.37 There are high treatment costs associated with obesity-related conditions. In a written submission to the Committee, one witness detailed the cost of their bariatric surgery and associated care for one financial year as \$16,500 (of which only \$2,445 had been refunded through private health insurance).³⁴ In another submission, a witness stated that, although she wished to be proactive and take control of her weight, the cost of gym membership and a weight loss program were beyond her family's budget.³⁵

29 See, for example, Associate Professor PJ Morgan, Official Transcript of Evidence, 12 September 2008, p 27; University of Sydney, Submission No. 68, Attachment 2, p 4.

30 Name withheld Submission No. 136, p 1; University of Sydney, Submission No. 68, Attachment 2, p 3.

31 Queensland Health, Submission No. 56, p 8.

32 Name withheld, Submission No. 136, p 2.

33 Associate Professor CE Collins, Official Transcript of Evidence, 12 September 2008, p 31.

34 Name withheld, Submission No. 136, p 11.

35 Name withheld, Submission No. 18.

2.38 The ultimate cost for many people who are overweight or obese is premature death. Associate Professor Moss from the University of Adelaide told the Committee that people with excess body weight:

... may lose anything up to 10 years of their life span.³⁶

Social costs

2.39 The Committee was told that the costs of obesity to the individual collectively create social and economic costs at the community level. The issues that impact on social costs are:

- wellbeing;
- employment; and
- productivity.

2.40 At a private briefing in Canberra, Access Economics informed the Committee that it had estimated the cost of lost wellbeing to the Australian economy in 2008 at \$49.9 billion.³⁷ Lost wellbeing refers to the likelihood of obese people being unable to contribute their full potential to society because of ill health, the development of disability and premature death. This is a significant cost, and the Committee is concerned about the overall affect on Australian society and the Australian economy.

2.41 The Committee heard that the stigma and discrimination suffered by obese individuals leads to social isolation and this can have an impact on employment prospects and increases welfare dependency. Diabetes Australia identified the social costs facing obese people:

...obese people attain lower levels of occupational prestige and lower incomes than non-obese people. In addition, other studies have found that obese persons as a group receive more sickness and unemployment benefits than people within a normal healthy weight range.³⁸

2.42 Lower workforce participation and increasing levels of absenteeism have a direct impact on productivity, which has a wider social impact.³⁹ Access Economics calculated that the cost of this lost productivity was \$3.6 billion

36 Associate Professor JR Moss, University of Adelaide, Official Transcript of Evidence, 13 June 2008, p 20.

37 Access Economics 2008, *The growing costs of obesity in 2008: three years on*, <<http://www.accesseconomics.com.au/publicationsreports/showreport.php?id=172&searchfor=2008&searchby=year>> accessed 17 April 2009.

38 Dr G Deed, Diabetes Australia, Official Transcript of Evidence, 12 May 2008, p 4.

39 Mr A Phillips, National Rural Health Alliance, Official Transcript of Evidence, 10 September 2008, p 16.

to the Australian economy in 2008.⁴⁰ The importance of this, as the CSIRO submission states, is that:

Productivity is, in the long-term, the key to building a more internationally competitive economy.⁴¹

2.43 The Committee argues that understanding these social costs is important because they indicate a reduction in the community's potential and its economic output. The potential long-term impact of these social costs was recognised by Associate Professor Samaras at a public hearing when she commented that:

If we are looking at a workforce for the future, we have to look at people not achieving their full potential and also having a shorter working life through illness and premature death.⁴²

Future implications

2.44 Witnesses to the Committee identified three main areas where the obesity epidemic could have future implications for the Australian economy and society:

- cost of co-morbidities;
- hospital costs; and
- the need for ongoing monitoring of interventions.

Cost of co-morbidities

2.45 The Committee was advised that the link between obesity and a range of co-morbidities will produce substantial future cost increases for the health system. These co-morbidities take time to develop and given the current high rates of obesity it is difficult to accurately predict the number of people who will experience obesity-associated disease down the track. In addition, any changes to obesity rates will take years to filter through and impact on the levels of chronic disease. As the Committee heard from the University of Adelaide researchers:

40 Access Economics 2008, *The growing costs of obesity in 2008: three years on*, <<http://www.accesseconomics.com.au/publicationsreports/showreport.php?id=172&searchfor=2008&searchby=year>> accessed 17 April 2009.

41 Commonwealth Science and Industrial Research Organisation (CSIRO), Submission No. 113, p 16.

42 Associate Professor K Samaras, Australian Healthcare and Hospitals Association, Official Transcript of Evidence, 12 May 2008, p 36.

This is a sleeping time bomb. So far the economic estimates for the costs of obesity to society ... are largely underestimated. The real impact is going to be in a few years time.⁴³

- 2.46 This view is shared by the Organisation for Economic Cooperation and Development (OECD). In their 2007 *Health at a glance* report they stated that:

Because obesity is associated with higher risks of chronic illnesses, it is linked to significant additional health care costs...there is a time lag of several years between the onset of obesity and related health problems, suggesting that the rise in obesity over the past 2 decades observed in most OECD countries will mean higher health care costs in the future.⁴⁴

- 2.47 At the hearing in Melbourne, Dr Stewart from the Baker Heart Institute identified two co-morbidities that will have a significant impact in Australia: type 2 diabetes and cardiovascular disease (CVD). He told the Committee that 4 per cent of Australians have type 2 diabetes and that a further 8 per cent do not know they have it. In respect of CVD he commented:

...fat alone will contribute an extra 70,000 cardiovascular admissions in the next 20 years.⁴⁵

- 2.48 Although there are a range of co-morbidities associated with obesity, to understand the future implications for the Australian economy and society, we will consider diabetes and CVD in some detail below.

Diabetes

- 2.49 In Australia, diabetes is the fastest growing chronic disease, with approximately 275 Australians developing the condition everyday.⁴⁶ There are two types of diabetes: in type 1 diabetes the body does not produce insulin which is required to convert sugar into energy; in type 2 diabetes the body produces insulin but cannot use it properly. Type 1 diabetes is usually diagnosed before a person turns 30 and is treated with insulin injections. While type 2 diabetes generally affects older people, there are emerging concerns about the increasing prevalence in children. It

43 Professor C Gericke, University of Adelaide, Official Transcript of Evidence, 13 June 2008, p 16.

44 Organisation for Economic Cooperation and Development (OECD), 2007, *Health at a glance: OECD Indicators*, OECD, p 50.

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

46 Diabetes Australia, <<http://www.diabetesaustralia.com.au/Understanding-Diabetes/Diabetes-in-Australia/>> accessed 17 April 2009.

is often associated with lifestyle factors including overweight and obesity.⁴⁷

2.50 In 2005, the AusDiab study showed that there were 1.7 million Australians affected by diabetes. Their research also estimated that up to half of the cases of type 2 diabetes remain undiagnosed.⁴⁸ While these statistics refer to both type 1 and type 2 diabetes, they are considerable and the fact that half of type 2 diabetes remains undiagnosed is of significant concern. Further, according to ANZOS, over 60 percent of the burden of diabetes is attributable to obesity.⁴⁹

2.51 The Committee heard that treatment of diabetes places a significant annual burden on the health system. The 2008 Access Economics report calculated that the economic cost of type 2 diabetes as a result of obesity was \$8.3 billion. This figure includes \$3.0 billion in financial costs and \$5.3 billion in cost of lost wellbeing.⁵⁰ The Committee heard at a public hearing in Melbourne that the annual cost of diabetes was significant:

Currently if you become a type 2 diabetic, in federal dollars, in 2006 dollars, it is \$11,000.⁵¹

2.52 And the costs of treating type 2 diabetes are predicted to increase significantly over the next 30 years. A large proportion of these cost increases is attributable to obesity. Recent data from the AIHW highlights the significant problem that type 2 diabetes will present in the future, due in large part to the high levels of obesity in Australia.

2.53 It is projected that the cost of type 2 diabetes will increase by 520 percent from \$1.3 billion to \$8.0 billion by 2033. Factors that are projected to increase expenditure for type 2 diabetes are ageing (\$1.4 billion), overall population growth (\$1.0 billion), an increase in the prevalence rate of diabetes - largely driven by an expected increase in obesity (\$1.8 billion), extra volume of services per case of disease (\$2.5 billion) and treatment of diabetics who are currently untreated (\$0.1 billion).⁵²

47 Diabetes Australia, <<http://www.diabetesaustralia.com.au/en/Understanding-Diabetes/What-is-Diabetes/>> accessed 17 April 2009.

48 Diabetes Australia, <<http://www.diabetesaustralia.com.au/Understanding-Diabetes/Diabetes-in-Australia/>> accessed 17 April 2009.

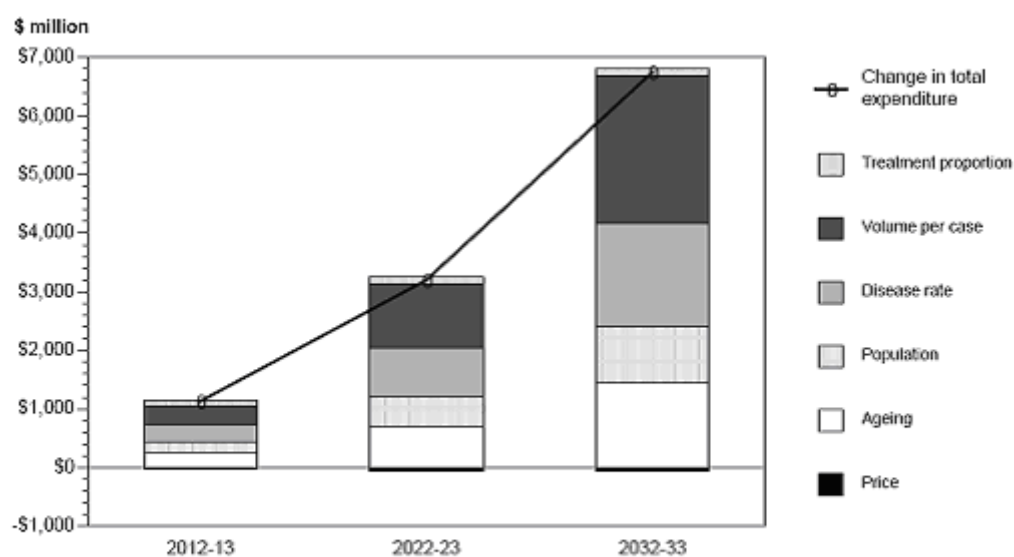
49 Australian and New Zealand Obesity Society (ANZOS), Submission No. 11, p 7.

50 Access Economics 2008, *The growing costs of obesity in 2008: three years on*, <<http://www.accesseconomics.com.au/publicationsreports/showreport.php?id=172&searchfor=2008&searchby=year>> accessed 17 April 2009.

51 Mr GJ Fyfe, Be Well Australia Pty Ltd, Official Transcript of Evidence, 24 October 2008, p 18.

52 Goss, J 2008, *Projection of Australian health care expenditure by disease, 2003 to 2033*, Australian Institute of Health and Welfare, Canberra, p 21.

Figure 2.1 Treatment costs of type 2 diabetes 2012 – 2033



Source: AIHW Disease expenditure projection model.

Source Australian Institute of Health and Welfare, 2008, *Projection of Australian health care expenditure by disease, 2003 to 2033*, p 21

Cardiovascular disease (CVD)

2.54 The National Heart Foundation states that CVD affects more than 3.5 million Australians, and that it is the leading cause of death in Australia, accounting for more than 34 percent of all deaths in 2006.⁵³ As type 2 diabetes is a risk factor for CVD, increases in one will lead to increases in the other, and excess weight compounds the risk in both.⁵⁴

2.55 The Committee was interested to learn that the incidence of CVD has actually declined over time. Professor Vos stated:

Over time we have seen dramatic declines in cardiovascular disease. It has dropped by 70 percent over the last 30 or 40 years.⁵⁵

2.56 However, while the incidence of CVD will continue to decline, the increase in obesity will contribute to a cost increase in its treatment. The DoHA submission points out that:

53 The Heart Foundation, <http://www.heartfoundation.org.au/Heart_Information/Statistics/Pages/default.aspx> accessed 17 April 2009.

54 Stewart, S et al., 2008, *Australia's future 'fat bomb': A report on the long-term consequences of Australia's expanding waistline on cardiovascular disease*, Baker Heart Research Institute, Melbourne, p 3.

55 Professor T Vos, School of Population Health, University of Queensland, Official Transcript of Evidence, 1 October 2008, p 13.

...while incidence will continue to decline, one of the factors driving increased expenditure will be a 96% (\$0.6 b) increase in the proportion of those with the CVD risk factors of hypertension and hyperlipidemia (also associated with obesity, poor diet and sedentary lifestyle) being treated with blood pressure and lipid lowering drugs to prevent cardiovascular events.⁵⁶

- 2.57 Of utmost concern of course is the potential for obesity to undermine the reductions in CVD that have been achieved thus far. This possibility was underscored by DoHA in their submission to the inquiry:

...the projected growth in obesity has the potential to reverse reductions in heart disease mortality achieved over the past two to three decades.⁵⁷

- 2.58 The Access Economics report estimated that the economic costs of CVD in 2008 was \$162.0 billion and the net cost of lost wellbeing was \$99.1 billion. The report went on to state the cost of CVD as a result of obesity was \$34.6 billion, with \$2.8 billion being financial costs and \$31.8 billion the cost of lost wellbeing.⁵⁸

Hospital costs

- 2.59 Hospitals bear a significant cost as a result of overweight and obesity, and the evidence presented to the Committee reinforced the significant impact that obesity will have on our hospital system.
- 2.60 The Committee heard that the increased cost of specialised equipment was a major concern for hospitals. At Greenslopes Private Hospital, the Committee was shown the specialised equipment which is required to provide adequate treatment to obese patients, including special beds and theatre equipment. Staff from Greenslopes told the Committee that a standard bed cost approximately \$8,000 to \$10,000 while specialised beds were estimated to cost \$40,000.⁵⁹ Mattresses for the larger beds are also more expensive to replace and need to be replaced more often than regular ones owing to greater wear and tear.
- 2.61 The costs of obesity to a hospital are more diverse than just equipment costs. Professor Samaras from St Vincent's Hospital in Sydney alluded to a

56 Department of Health and Ageing, Submission No. 154, p 19.

57 Department of Health and Ageing, Submission No. 154, p 20.

58 Access Economics 2008, *The growing costs of obesity in 2008: three years on*, <<http://www.accesseconomics.com.au/publicationsreports/showreport.php?id=172&searchfor=2008&searchby=year>> accessed 17 April 2009.

59 Inspection, Greenslopes Private Hospital, 1 October 2008.

range of other costs, including higher staff number requirements and health and safety concerns:

The demands on hospital services are extensive. They impact on our cardiac services and, obviously, on our diabetes services; they impact on our orthopaedic services; most of the sleep apnoea we see is due to obesity; and, increasingly, obesity impacts on our cancer services, as we come to realise that the majority of cases of oesophageal carcinoma, endometrial carcinoma and non-genetic breast cancer are obesity related. The demands on staff are huge particularly when you have only two nurses per ward after hours and it takes eight people to shift somebody to do a reposition. You can imagine what that does to services across the whole hospital.⁶⁰

- 2.62 The issue of staffing, and the impact of obesity on hospital staffing was also raised at the public hearing in Lake Macquarie. Here the Hunter New England Health Service presented evidence to the Committee about the extraordinarily high levels of staff required to physically manage some patients within the hospital. The Committee heard a case study for a 188.2 kilogram patient, who was a non compliant insulin dependent diabetic. The patient had to have an amputation and over the course of their six month stay at hospital had 10,912 staff attendances.⁶¹
- 2.63 Of additional concern to hospital administrators is the increase in potential injuries to staff and related health care workers due to handling overweight and obese patients. Evidence to the Committee suggests that this will be a growing problem and will impact on a variety of long-term cost areas including insurance. Mr Wood, the Manual Handling Coordinator for Hunter New England Health Service told the Committee of an ambulance officer who was injured lifting a 167 kilo patient and ended up with rotator cuff injury, a shoulder injury which required considerable time off work.⁶²
- 2.64 Another issue brought to the attention of the Committee is the increased care required by obese patients when they present with wounds. At the hearing in Sydney, KCI Medical Australia (KCI) explained that obese or overweight patients are often in poor health and suffering from co-morbidities such as diabetes and cardiovascular disease which make it difficult for them to heal. Additionally their skin may be thin and fragile

60 Associate Professor K Samaras, Australian Healthcare and Hospitals Association, Official Transcript of Evidence, 12 May 2008, p 36.

61 Mr E Wood, Hunter New England Health Service, Official Transcript of Evidence, 12 September 2008, p 5.

62 Mr E Wood, Hunter New England Health Service, Official Transcript of Evidence, 12 September 2008, p 4.

and they may have problems with blood circulation and oxygenation.⁶³ KCI provided evidence to the Committee that in 2004-05, 54.3 percent of the 126,800 hospital admissions presenting for diseases relating to skin or subcutaneous tissue, were overweight.⁶⁴ KCI outlined the complications that excess body weight can cause for wound management:

[Patients have] increased visits to GPs, multiple visits to community nursing services and multiple attendances at clinics. They have the need for long-term medical specialist involvement ... They have lots of hospital admissions and, due to the complication rates, they can be extended admissions. They have a need for amputation and complex reconstructive surgeries associated with the wounds ...⁶⁵

- 2.65 Another medical procedure affected by the rise in obesity is knee and hip replacement surgery. A recent study alerted the Committee to the influence of obesity on osteoarthritis and the ageing Australian population, and the subsequent increase in demand for joint replacement surgery:

The obesity epidemic ... is likely to have a significant impact on the future demands for knee and hip replacements for osteoarthritis ...⁶⁶

- 2.66 The Committee also learnt of the need for new, heavy-duty ambulances which are able to transport obese patients. In Newcastle, a witness told the Committee of an ambulance stretcher collapsing under the weight of a patient and in Adelaide, a patient had to endure the undignified experience of being transported to hospital by truck because there was not an ambulance available with the capacity to carry her.⁶⁷ State and territory governments are spending large sums to provide these custom built vehicles. Ambulance Victoria ordered four such vehicles in early 2009 at a cost of \$350,000 each.⁶⁸

63 Ms C-L Burnard, KCI Medical Australia Pty Ltd, Official Transcript of Evidence, 11 September 2008, pp 9-10.

64 Ms C-L Burnard, KCI Medical Australia Pty Ltd, Official Transcript of Evidence, 11 September 2008, p 9.

65 Ms C-L Burnard, KCI Medical Australia Pty Ltd, Official Transcript of Evidence, 11 September 2008, pp 9-10.

66 Wang, Y et al, 'Relationship between body adiposity measures and risk of primary knee and hip replacement for osteoarthritis: a prospective cohort study', *Arthritis Research & Therapy*, <<http://arthritis-research.com/content/11/2/R31>> accessed 17 April 2009.

67 Mr E Wood, Official Transcript of Evidence, 12 September 2009, p 12; Associate Professor K Samaras, Official Transcript of Evidence, 12 May 2009, p 39.

68 'Obesity epidemic forces Ambulance Victoria to buy bigger ambulances', *The Herald Sun*, 27 February 2009.

Figure 2.2 The Committee hears about the cost implications of special equipment for heavy patients from the Royal Flying Doctor Service, Broken Hill, NSW



Monitoring interventions

- 2.67 Evidence to the Committee identified the need for ongoing monitoring and evaluation of intervention programs as well as central data storage to facilitate data sharing. At a public hearing in Canberra, the AIHW told the Committee that the lack of monitoring and evaluation meant that the effectiveness of intervention programs is not being assessed.⁶⁹ They added that, where program evaluation was occurring, it was often of program roll-out and not program success.⁷⁰
- 2.68 ANZOS also raised concerns about the lack of close and independent monitoring of interventions. They were particularly concerned that a lack of evaluation would prevent interventions from being improved. As their submission states:

69 Mrs K Roedinger, Australian Institute of Health and Welfare, Official Transcript of Evidence, 12 May 2008, p 23.

70 Mrs K Roedinger, Australian Institute of Health and Welfare, Official Transcript of Evidence, 12 May 2008, p 24.

Community-based prevention programs and clinical services also need close (and sometimes independent) evaluation to ensure that they are delivering improvements in height and weight status and health and to help identify a way of improving their outcomes.⁷¹

- 2.69 The Committee was told that the data that is gathered from these evaluations should be made centrally accessible to researchers and public health advocates to build knowledge and expertise, and to ensure that funding is directed towards proven successful interventions. Professor Vos said:

So we take the population-wide approaches and the targeted approaches and try, in a similar way, to evaluate them so that we can make judgements on what the bang for your buck is for each of them, but also what would be a useful cobbling together of a total strategy. If you have a limited amount of money, where would you put it and what would be your priority amongst the interventions that we know are there?⁷²

- 2.70 A few submissions suggested practical ways to improve the monitoring and evaluation of interventions, and information sharing. The WHO Collaborating Centre on Obesity Prevention submitted that the establishment of Centres of Excellence could help to improve evaluation and data sharing.⁷³ The Public Health Association of Australia recommended that funding should be made available with program grants to:

...allow for the evaluation and dissemination of intervention outcomes.⁷⁴

- 2.71 The Australasian Child and Adolescent Obesity Research Network called for support for a national network of obesity researchers to assist with collaborative research. They also stressed the need for expert reviewers of research grant applications utilising, if needed, international experts.⁷⁵

71 Australia and New Zealand Obesity Society, Submission No. 11, p 13.

72 Prof T Vos, School of Population Health, University of Queensland, Official Transcript of Evidence, 1 October 2008, p 16.

73 World Health Organisation Collaborating Centre on Obesity Prevention, Submission No. 95, pp 7-8.

74 Public Health Association of Australia, Submission No. 101, p 6.

75 Australasian Child and Adolescent Obesity Research Network, Submission No. 131, p 6.

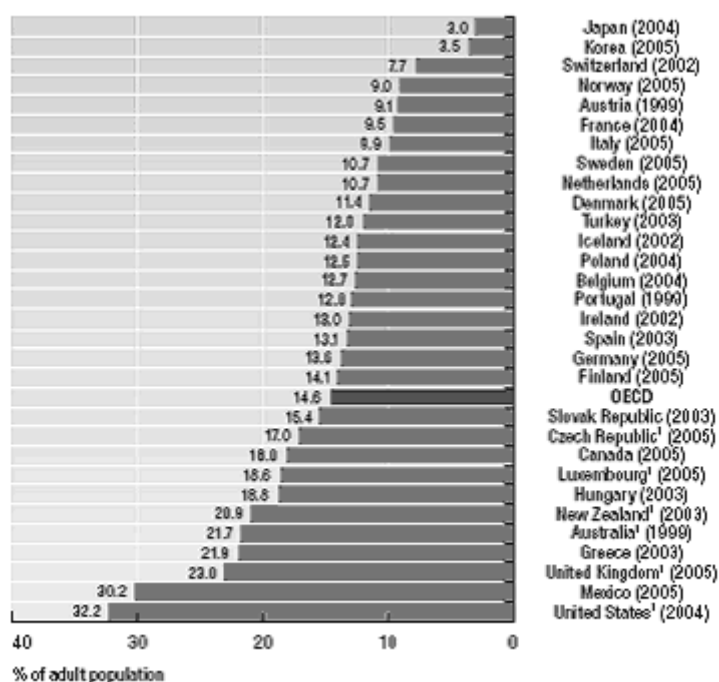
International perspective

2.72 While the costs of obesity in Australia are significant, the international evidence tells us that Australia is not alone in facing increasing rates of obesity. The WHO has classified obesity as a chronic disease,⁷⁶ and in 1997 declared that:

...overweight and obesity represent a rapidly growing threat to the health of populations in an increasing number of countries worldwide.⁷⁷

2.73 The latest OECD figures indicate that Australia has the fifth highest rate of population with a BMI over 30. These latest OECD statistics are illustrated in Figure 2.3.

Figure 2.3 Percentage of adult population with Body Mass Index over 30 (obese population), 2005 (or latest year available)



Source *Health at a Glance 2007: OECD indicators*, p 51

2.74 Within the global context of high levels of obesity, it is useful to consider the approaches of other governments, to see if there are lessons that Australia can learn from their policy directions and approaches. Throughout the course of the inquiry, the Committee has been informed of a number of other country's approaches, in particular those of the United Kingdom (UK). Given that there are many similarities between the

76 Australian General Practice Network, Submission No. 49, p 7.

77 Public Health Association of Australia, Submission No. 101, p 3.

UK and Australian experiences, it is opportune to consider the UK's approach in more detail.

The United Kingdom

2.75 The spiralling costs associated with obesity in Australia are mirrored in the UK where obesity is predicted to cost the National Health System (NHS) £10 billion by 2050. Further, it is expected that the wider costs to society will be £49.9 billion per year.⁷⁸ The UK Government has stated that their goal is:

... to be the first major nation to reverse the rising tide of obesity and overweight in the population by ensuring that everyone is able to achieve and maintain a healthy weight. Our initial focus will be on children: by 2020, we aim to reduce the proportion of overweight and obese children to 2000 levels.⁷⁹

2.76 To facilitate their goal, the UK Government commissioned the Foresight Programme, an agency of the Government Office for Science to produce a comprehensive report on obesity in the UK. The resulting report *Tackling Obesities: future choices project* (the Foresight Report) has been repeatedly brought to the attention of the Committee throughout the inquiry as a fresh and visionary approach. The report was launched in October 2007 and its aim is:

...to produce a long-term vision of how we can deliver a sustainable response to obesity in the UK over the next 40 years.⁸⁰

2.77 The report presents an extensive review of the scale of the UK obesity problem and covers:

- the complex causes and system of obesity;
- the evidence and uncertainty relating to tackling obesity;
- possible scenarios to 2050;
- the consequences of obesity; and
- options for a sustainable response.⁸¹

78 Butland, B et al., 2007, *Tackling Obesities: Future Choices*, <<http://www.foresight.gov.uk/Obesity/17.pdf>> accessed 17 April 2009.

79 United Kingdom Department of Health, *Healthy Weight, Healthy Lives: A cross-government strategy for England*, <http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_082378> accessed 17 April 2009.

80 Foresight Project, <<http://www.foresight.gov.uk/OurWork/ActiveProjects/Obesity/Obesity.asp>> accessed 17 April 2009.

2.78 Of particular interest to the Committee is Section 7 of the Foresight Report where several possible policy interventions were modelled to gauge their potential costs and effectiveness. From the modelling, the report concluded that the top five policy responses which had the greatest impact on obesity were:

- increasing walkability/cyclability of the built environment;
- targeting health interventions for those at increased risk (dependent on ability to identify these groups and only if reinforced by public health interventions at the population level);
- controlling the availability of/exposure to obesogenic⁸² food and drinks;
- increasing the responsibility of organisations for the health of their employees; and
- early life interventions at birth or in infancy.⁸³

2.79 The most significant finding of Foresight's modelling was that, irrespective of any interventions, the direct costs of obesity in the UK were still likely to rise and that:

...direct obesity-related health costs will not be less than today's levels in the foreseeable future.⁸⁴

2.80 However, the report went on to say that should nothing be done to reverse overweight and obesity, the related healthcare costs would become 'insupportable'.⁸⁵ The Foresight Report calls for action to reverse overweight and obesity that is 'comprehensive, coherent and sustained'.⁸⁶

2.81 In response to the Foresight Report, the UK government developed the policy document, *Healthy Weight, Healthy Lives: a Cross-Government Strategy for England*. Released by the Prime Minister, Gordon Brown, in January 2008, the strategy outlines the responsibility of the UK Government in assisting individuals to maintain a healthy weight. It states that:

81 Butland, B et al., 2007, *Tackling Obesities: Future Choices*, <<http://www.foresight.gov.uk/Obesity/17.pdf>> accessed 17 April 2009.

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

83 Butland, B et al., 2007, *Tackling Obesities: Future Choices*, p 109, <<http://www.foresight.gov.uk/Obesity/17.pdf>> accessed 17 April 2009.

84 Butland, B et al., 2007, *Tackling Obesities: Future Choices*, p 116, <<http://www.foresight.gov.uk/Obesity/17.pdf>> accessed 17 April 2009.

85 Butland, B et al., 2007, *Tackling Obesities: Future Choices*, p 116, <<http://www.foresight.gov.uk/Obesity/17.pdf>> accessed 17 April 2009.

86 Butland, B et al., 2007, *Tackling Obesities: Future Choices*, p 117, <<http://www.foresight.gov.uk/Obesity/17.pdf>> accessed 17 April 2009.

The responsibility of Government, and wider society, is to make sure that individuals and families have access to the opportunities they want and the information they need in order to make healthy choices and exercise greater control over their health and their lives.⁸⁷

- 2.82 The Healthy Weight, Healthy Lives Strategy outlines various areas for policy interventions including focusing on healthy growth and weight in children, promoting healthier food choices, embedding physical activity into daily life, creating incentives for better health and developing a mechanism to provide personalised advice and support. There will also be an annual review of the UK Government's progress toward halting and reversing the rates of obesity which will be made publicly available.⁸⁸
- 2.83 The UK Government has also focused on the quality of food in the UK and developed a food strategy to manage changing food production and consumption trends.⁸⁹ The strategy has been detailed in the *Healthy Food Code*.⁹⁰ The Food Standards Agency (FSA) is working closely with the food industry to promote healthy eating, including reducing levels of salt, fat and sugar in products, portion sizes, front of pack labelling, product marketing and provision of information to consumers. FSA has, for example, been working with industry to reduce the salt content of a wide range of foods, particularly processed foods. Implemented in 2003, the program has a target of 6 grams of salt per person per day by 2010 and has already seen a reduction from 9.5 to 8.6 grams per person per day.⁹¹
- 2.84 The question of food labelling is of major concern in the UK as it is here in Australia and they are currently implementing a series of rigorous tests on

87 UK Department of Health, *Healthy Weight, Healthy Lives: a cross government strategy for England*, p iii, <http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_082378> accessed 17 April 2009.

88 UK Department of Health, *Healthy weight, healthy lives: a cross government strategy for England*, pp xi - xv, <http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_082378> accessed 17 April 2009.

89 UK Cabinet Office, *Food Matters: towards a strategy for the 21st Century*, p i, <http://www.cabinetoffice.gov.uk/strategy/work_areas/food_policy.aspx> accessed 17 April 2009.

90 UK Food Standards Agency, 'Taking forward the Healthy Food Code of Good Practice', <<http://www.food.gov.uk/news/newsarchive/2008/jul/healthyfoodcode>> accessed 17 April 2009.

91 UK Food Standards Agency, 'Progress with industry in relation to salt reduction', <<http://www.food.gov.uk/healthiereating/salt/saltprogressstatement/>> accessed 17 April 2009.

the various options.⁹² The UK is considerably ahead of Australia in this area and it will be useful to consider their experience when formulating an Australian policy. Both food labelling and the reformulation of food products are dealt with in more detail in Chapters 3 and 4 of this report.

- 2.85 Most importantly, the Foresight Report and the UK experience show that obesity is a major challenge that will require a 'substantial degree of intervention'.⁹³ Further, the Foresight Report states that:

The challenge is to produce a range of solutions that are effective across different areas of government policy rather than within them to deliver a corrective population-wide shift.⁹⁴

- 2.86 To meet this challenge, the UK Prime Minister asked the Cabinet Office to set up a cross-government Food Strategy Task Force⁹⁵ to oversee and coordinate the response to obesity. The Task Force has been charged with implementing the UK Government's policy *Food Matters: Towards a Strategy for the 21st Century* and will review progress on a quarterly basis and publish an annual report. A detailed list of actions has been formulated assigning individual tasks to relevant departments and agencies. A copy of the list is provided in Appendix D.

Committee comment

- 2.87 There are inherent difficulties in attempting to calculate the true cost of obesity to the Australian economy and society. Nonetheless the Committee acknowledges that the present and future costs of the epidemic are substantial.
- 2.88 The Committee is concerned that inadequate and outdated data on the prevalence of obesity in Australia may obscure the true levels of the problem, and argues that there is a need to monitor and evaluate intervention strategies and data share to promote successful strategies.

92 See UK Food Standards Agency, <<http://www.food.gov.uk/foodlabelling/researchandreports>> for the latest research reports. Accessed 17 April 2009.

93 Butland, B et al., 2007, *Tackling Obesities: Future Choices*, p 12, <<http://www.foresight.gov.uk/Obesity/17.pdf>> accessed 17 April 2009.

94 Butland, B et al., 2007, *Tackling Obesities: Future Choices*, p 12, <<http://www.foresight.gov.uk/Obesity/17.pdf>> accessed 17 April 2009.

95 The Task Force brings together senior officers from: the Department for the Environment, Food and Rural Affairs; the Department for Business, Enterprise and Regulatory Reform; HM Treasury; the Department of Health; the Department of International Development; the Department for Children, Schools and Families; and the Food Standards Agency.

- 2.89 The current obesity epidemic will add significantly to Australia's future health costs through the relationship between excess body weight and a range of co-morbidities. The Committee is concerned that overweight and obesity have the potential to undo many health gains made in the past few decades, particularly in regard to the decline in cardiovascular disease.
- 2.90 The UK's largest report into obesity - the Foresight Report - is an excellent reference and tool and for obesity prevention and management policies. It is especially useful for framing strategic thinking and government leadership in the short, medium and long-term.

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

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:

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 2008¹⁴ 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

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-publhlth-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

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
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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.**

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

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.

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 gastrectomy 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.**

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.**

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 Society⁷⁰ 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):

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:

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.

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.

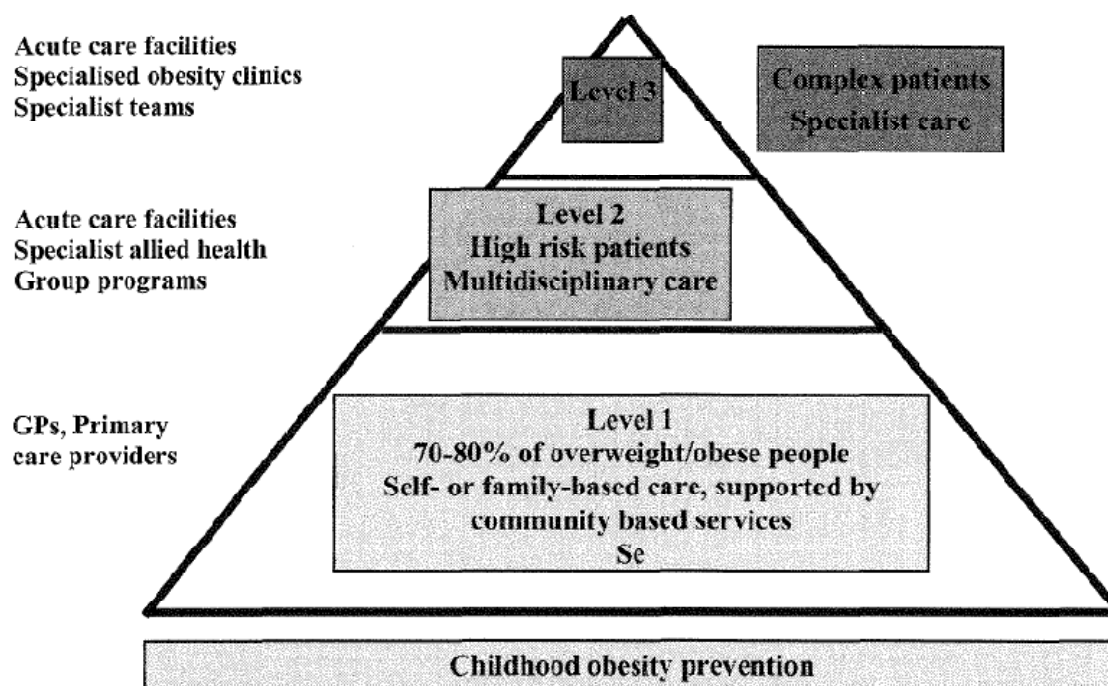
87 Associate Professor NM Byrne, Australian and New Zealand Obesity Society, Official Transcript of Evidence, 1 October 2008, p 29.

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

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 early⁹² 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

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

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 subsidy¹⁰⁶ 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

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 online¹¹⁵ 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 television¹²⁴ 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

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

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.

A role for industry

- 4.1 The private sector has a role to play in addressing the obesity problem in Australia. While a number of submissions to the inquiry were critical of industry, the Committee recognises the positive steps that some industries are already taking to combat obesity. However, there is much more to be done.
- 4.2 This chapter seeks to broaden the debate to include a number of industries, not just the food industry, but also the diet industry; the fitness industry; the insurance industry; the urban planning and design industries; and employers across Australia. Each of these can make a positive contribution to mitigating the high levels of overweight and obesity in Australia.

Work with industry

- 4.3 If some of the blame for the levels of obesity in Australia is attributed to industry, then industry must be part of the solution to obesity in Australia. The National Preventative Health Taskforce (the Taskforce) states that a 'partnership approach' is required:¹

...successfully reducing the incidence of overweight and obesity requires a broad cross-sectoral approach involving a partnership between several government portfolios, the food industry (manufacturing and retailing) and non-government organisations.²

1 Dr L Roberts, National Preventative Health Taskforce, Official Transcript of Evidence, 12 November 2008, p 2.

2 Australian Food and Grocery Council, Submission No. 54, p 9.

- 4.4 An encouraging example of the role that the food industry is playing in reducing the levels of obesity in Australia was brought to the attention of the Committee by the Commonwealth Science and Industrial Research Organisation (CSIRO). Researchers involved in developing the *CSIRO Total Wellbeing Diet* indicated that they collaborate with a number of food companies to help make their products healthier.

We liaise a lot with them to get them to change the kinds of food they make so that they have a lower energy value per 100 grams and make people feel fuller.³

- 4.5 Internationally, the North Karelia Project from Finland is often cited as another positive example that industry can play in encouraging healthier lifestyles. This project was a response to alarmingly high rates of heart disease in the region, and involved a range of interventions across the community. The Taskforce explained that key to the success of the work in the North Karelia project was getting industry to change levels of saturated fat in the food supply and improve labelling, and that this cooperative work has resulted in a reduction in heart disease in Finland over the past 40 years.⁴

The Heart Foundation 'tick'

- 4.6 Established 20 years ago, the Heart Foundation's Tick Program has played a significant role in the Australian food industry's reformulation of products. The program sets a target for components like serving size, calorie content, type of fat and the amount of fibre in a given product. Industry works towards achieving these targets in order to obtain the tick.⁵ The Heart Foundation told the Committee:

The tick on a food means that it is a healthier choice compared to similar foods in that category, so what we have literally done through that program is set some benchmarks for industry.⁶

- 4.7 In other words, the tick indicates the healthiness of a product relative to other foods, rather than its absolute healthiness.

3 Professor P Clifton, CSIRO, Official Transcript of Evidence, 13 June 2008, p 41.

4 Dr L Roberts, National Preventative Health Taskforce, Official Transcript of Evidence, 12 November 2008, p 6.

5 Ms S Anderson, Heart Foundation, Official Transcript of Evidence, 24 October 2008, p 56.

6 Ms S Anderson, Heart Foundation, Official Transcript of Evidence, 24 October 2008, p 56.

Figure 4.1 The Heart Foundation Tick



Source *The Heart Foundation, Heart Foundation Tick Program, Heart Foundation website⁷*

4.8 The Heart Foundation told the Committee that its tick program covers a broad spectrum of food (some 52 categories), but does not include confectionary or salty snack foods.⁸

4.9 There are criticisms of the Heart Foundation tick, around the public's perception of the tick as an endorsement of the food item as a healthy choice per se, and the fact that companies pay a fee to the Heart Foundation in order to receive the tick. The Committee asked the Heart Foundation:

Do you think that there is an understanding that this is not actually saying to you 'look, this is healthy', but it is saying, 'this is healthier than its competitor next door?'⁹

4.10 The Heart Foundation responded that they tracked Australians' understanding of the tick annually and so far the research demonstrated that Australians had a good understanding of the meaning of the tick.¹⁰ The Heart Foundation used the example of ice-cream that had the tick:

We have not seen ice-cream sales go through the roof because the Heart Foundation has put a tick on a healthier option in that category.¹¹

4.11 The Heart Foundation recommended that multiple strategies be used to educate consumers, and noted that the tick is but one of these strategies. They argue for consistent healthy eating messages and social marketing campaigns to complement the tick program.¹²

7 The Heart Foundation, Heart Foundation Tick Program, <http://www.heartfoundation.org.au/Professional_Information/Tick/Pages/default.aspx> accessed 17 April 2009.

8 Ms S Anderson, Heart Foundation, Official Transcript of Evidence, 24 October 2008, p 57.

9 Mr J Briggs MP, Member for Mayo, Official Transcript of Evidence, 24 October 2008, p 57.

10 Ms S Anderson, Heart Foundation, Official Transcript of Evidence, 24 October 2008, p 57.

11 Ms S Anderson, Heart Foundation, Official Transcript of Evidence, 24 October 2008, p 57.

12 Ms S Anderson, Heart Foundation, Official Transcript of Evidence, 24 October 2008, p 57.

4.12 The Committee questioned other organisations about what they thought of the Heart Foundation tick program. The CSIRO was supportive of the fact that the program encourages industry to reformulate products:

...the tick represents one of the most sophisticated systems of assessing the food supply. Fundamentally though, it is a system that is designed not only for the consumer but rather for food manufacturers to benchmark. We have seen many examples of how food manufacturers have changed formulations to achieve those benchmarks. Those benchmarks continue to improve, depending on the prevailing changes in the food supply.¹³

4.13 The Committee acknowledges that the Heart Foundation Tick Program plays a useful role in encouraging manufacturers to make healthier products for consumers.

More work to be done

4.14 This section will consider areas where industry could do more including:

- food industry;
 - ⇒ self-regulation of marketing;
 - ⇒ reformulation of products;
 - ⇒ portion sizes; and
 - ⇒ affordability and availability of healthier foods.
- weight loss industry;
- urban planning industry; and
- employers.

Food industry

Self-regulation of marketing

4.15 The issues surrounding government regulation of advertising to children have already been canvassed in Chapter 3. However, it is useful to consider the issue again here in order to see if industry might do more on a voluntary basis to counter the popular public perception that junk food is marketed to children 'open slather'.

13 Associate Professor M Noakes, Commonwealth Science and Industrial Research Organisation (CSIRO), Official Transcript of Evidence, 13 June 2008, p 46.

- 4.16 Several submissions to the inquiry voiced their concerns. The Coalition on Food Advertising to Children (CFAC) describes the marketing of 'junk' food to children as an 'unfair tactic'.¹⁴ A 2007 poll of Parents Jury members indicated that 97 percent of parents would like to see a ban on the advertising of unhealthy food during television programs in which children comprise a significant proportion of the audience.¹⁵ Their submission called for bans on the advertising of unhealthy food and beverages to children, restrictions of other types of marketing of unhealthy food to children and bans on the sponsorship of sports clubs and children's sport by unhealthy food companies.¹⁶
- 4.17 Submissions to the inquiry from industry groups, including Free TV Australia and the Australian Association of National Advertisers (AANA) reject calls for greater governmental regulation and state that the link between obesity and television viewing has not been scientifically proven.¹⁷ Advertisers add that there are already regulations, in the form of codes of practice, which apply to advertising. The regulations currently in existence include:
- The AANA Code of Ethics;
 - The Advertising to Children Code;
 - The Alcohol Beverages Advertising Code; and
 - The Weight Management Code of Practice.¹⁸
- 4.18 The Free TV Australia submission claimed that these codes, although voluntary, are followed by advertisers.¹⁹
- 4.19 There has been significant criticism of the self-regulation of marketing to children. Submitters state that is an inherent conflict in that premise because the reason for advertising is to:
- ...market vigorously and make profits.²⁰
- 4.20 Advocates like Professor Swinburn have argued that self-regulation does not limit the number of unhealthy food advertisements that are on television. He explained to the Committee:

14 Coalition on Food Advertising to Children, Submission No. 41, p 2.

15 The Parents Jury, Submission No. 7, p 2.

16 The Parents Jury, Submission No. 7, pp 2 - 4.

17 Australian Association of National Advertisers, Submission No. 20, p 2.

18 Free TV Australia, Submission No. 83, p 4.

19 Free TV Australia, Submission No. 83, p 5.

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

Self-regulation, which is what the industry is pushing for at the moment, is quite a different beast to statutory regulations. At the moment, the self-regulation is aimed at ensuring that individual advertisements are not illegal, indecent, misleading et cetera. That is for individual advertisements. It does not stop our kids being bombarded by a huge volume of totally legal, decent, not misleading advertisements that get them to pester their parents et cetera. So I do not think self-regulation is an appropriate response.²¹

- 4.21 The Committee notes that a further self-regulatory standard was announced by the Australian Food and Grocery Council (AFGC) in October 2008. The *Responsible Children's Marketing Initiative* addresses many of the issues raised in evidence to the inquiry including the use of popular personalities and licensed characters, product placement, use of products in interactive games, advertising in schools and use of premium offers. The initiative requires that individual companies develop and sign an action plan committing the company to only advertise products to children under 12 that promote healthy dietary choices and healthy lifestyles.²²
- 4.22 The current self-regulatory environment clearly has limitations though, which are illustrated in two recent Australian Competition and Consumer Commission (ACCC) rulings.
- 4.23 In April 2009, the ACCC ordered Coca Cola South Pacific to run a national corrective ad for earlier ads that had misled consumers with campaigns fronted by the Australian actress Kerry Armstrong claiming that Coca Cola does not contribute to obesity or dental decay.²³ The Committee was pleased to see the corrective ads ordered by the ACCC.
- 4.24 Yet, in another ruling, the ACCC permitted the same company to continue advertising their 'fruit flavoured' Vitaminwater drink products. Consumer advocate group Choice had complained to the ACCC that advertising of this product was misleading regarding actual fruit content and nutritional value, expressing concern at the high levels of sugar in the drinks, comparable to Coca Cola products. The ACCC ruled that while Vitaminwaters kiwi and strawberry drink contained neither fruit, there

21 Professor BA Swinburn, WHO Collaborating Centre for Obesity Prevention, Official Transcript of Evidence, 20 June 2008, p 22.

22 Australian Food and Grocery Council, *The Responsible Children's Marketing Initiative*, <<http://www.afgc.org.au/index.cfm?id=726>> accessed 17 April 2009.

23 Canning, S, 'ACCC slams Coca Cola ads featuring Kerry Armstrong as misleading', *The Australian*, 2 April 2009, <<http://www.theaustralian.news.com.au/story/0,25197,25279622-601,00.html>> accessed 17 April 2009.

were no claims on the bottle that it was 'made with' or 'contains' a specified juice.²⁴

- 4.25 The Committee appreciates that the Vitaminwater labels do not contravene the law and are therefore permissible, and that the claims examined by the ACCC have a different focus. However, the Committee is concerned that the two ACCC rulings may be viewed as sending out mixed messages.

Reformulate products

- 4.26 As discussed in Chapter 3, there have been encouraging moves made by the food industry to reformulate products over the past decade or so. The AFGC told the Committee that over the past five years there has been a significant increase in the number of low-kilojoule, low-fat, low-sugar, low-salt products on supermarket shelves.²⁵ Increasingly consumers are seeking organic options with the Organic Federation of Australia claiming a 50 percent increase in buyers over the last 5 years.²⁶ Ms Carnell from the AFGC stressed that efforts to reformulate products to make them healthier and match consumer demand would continue.²⁷
- 4.27 However, throughout the course of the inquiry, the Committee heard from witnesses that considerable levels of sugar and salt remain in our processed food products.
- 4.28 The Australian author of a book on the ill-effects of sugar, *Sweet Poison: why sugar makes us fat*, Mr David Gillespie provided compelling evidence to the Committee at its public hearing on the Gold Coast regarding the increased levels of sugar in our diet. In his book, Mr Gillespie equates the increase in sugar consumption of the modern western diet (which he claims has gone from a diet of no added sugar to consuming a kilo of sugar a week over the last 150 years) with excess calorie consumption and the rise of obesity. The author points out that it is not just added sugar one need worry about. Sugar is 'hidden' in food products which one might assume were not sweetened ones. For instance, mayonnaise contains

24 Russell, M, 'Let them drink sugar: watchdog', *The Sunday Age*, 5 April 2009, p 12, <<http://www.theage.com.au/national/let-them-drink-sugar-watchdog-20090404-9sk2.html>> accessed 17 April 2009.

25 Ms AK Carnell, Australian Food and Grocery Council, Official Transcript of Evidence, 24 October 2008, p 71.

26 Organic Federation of Australia, *Survey Shows that 61% of Consumers buy Organic Products*, media release, <http://www.ofa.org.au/media//sixty_percent_of_consumers_buy_organic.pdf> accessed 17 April 2009.

27 Ms AK Carnell, Australian Food and Grocery Council, Official Transcript of Evidence, 24 October 2008, p 71.

approximately 15 to 20 percent sugar and tomato sauce is approximately 20 to 25 percent sugar. Bread can also contain between 5 and 10 percent sugar.²⁸

- 4.29 Salt levels in food are similarly too high. The Australian Division of World Action on Salt and Health (AWASH) estimates that Australians consume approximately 9 grams of salt per day, which is well above the recommended 6 grams and that 75 percent of salt intake comes from processed foods.²⁹ Excess salt consumption has been linked with obesity, high blood pressure and cardiovascular disease.³⁰
- 4.30 The Committee took anecdotal evidence about how confusing it can be for consumers doing the family shopping to negotiate which product is actually healthier for them overall. For instance, yoghurt or muesli bars which often claim to be 97 or 99 percent fat-free might instead have very high levels of sugar added ostensibly 'for flavour.' A staple item like a tin of canned tomatoes or cheese can have vastly different amounts of salt in it 'for flavour', with some brands containing up to 10 times the amount of salt than others. Similarly, different brands of tomato sauce can have significantly different amounts of sugar and salt in them. Often the organic brand (which one might well assume to be the healthier option) of tomato sauce contains more sugar and salt than the regular versions. The Committee thinks that consumers should not be forced to trade low fat for high sugar, low sugar for high salt, or high sugar for low salt.
- 4.31 Reformulation of products can help Australians improve their diets. If industry is on board, significant reductions in the levels of salt, sugar and fat in the Australian diet can be achieved. The Heart Foundation referred to the example of the United Kingdom saying that their reformulation efforts have achieved marked benefits in a variety of foods including breakfast cereals, potato chips and tinned products like soups.
- The UK has also looked into this, and they are seeing some fantastic results. They have seen levels of salt come down from 9.5 to 8.6 grams within three years. That is quite a large achievement from a population level in a very short period of time...³¹
- 4.32 AWASH is running a campaign titled *Drop the Salt* which aims to decrease the levels of salt in processed foods by 25 percent over the next five years in Australia. Coordinated by the George Institute of International Health

28 Mr D Gillespie, Private Capacity, Official Transcript of Evidence, 8 December 2008, p 4.

29 Australian Division of World Action on Salt and Health, <<http://www.awash.org.au/index.html>> accessed 17 April 2009.

30 Australian Division of World Action on Salt and Health, Submission No. 123, p 3.

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

in Sydney, AWASH is working with government, industry and consumer organisations to educate the public and bring about change in the industry. AWASH states that their campaign has had support from key food industry members, including Coles and Smiths Snackfood Company, who have committed to reduce salt in their products by 25 percent over the next 5 years in line with the AWASH food industry strategy.³²

- 4.33 The Committee commends companies that reduce excessive salt in their processed products and urges others to consider signing up to the campaign.
- 4.34 Similarly, the Committee would like to see campaigns introduced and supported in Australia that reduce excessive sugar and fat in processed food products.
- 4.35 The Committee wonders too about the potential for consumers to be more vociferous about what they want and do not want in other manufactured food products. A couple of recent examples in the media suggest areas ripe for debate and dialogue between consumers and food manufacturers and suppliers.
- 4.36 The Australian Consumer Association Choice recently tested 97 cakes sold in supermarkets and discovered several types of cake that had between 25 and 40 ingredients per cake, mostly additives, including some food colourings which are known to cause hyperactivity in children.³³ The questions begs whether these baked goods constitute cakes as we know them and whether this is indeed what Australian consumers think they are purchasing and/or want to purchase?
- 4.37 Also recently, the Heart Foundation reported on its study that found that cheaper in-house brands of generic food products often contain significantly more salt, saturated and trans-fats and more calories than branded products. Woolworths has challenged the findings, claiming that branded and unbranded products are often identical.³⁴ The subject matter suggests scope for a wider debate that perhaps Australian consumers need to have with food manufacturers and suppliers about the ingredients of the everyday products that they are purchasing.

32 Australian Division of World Action on Salt and Health, Strategic Review 2007-08, p 3, <http://www.awash.org.au/documents/AWASH-Strategic-Review-2007_08.pdf> accessed 17 April 2009.

33 The Sunday Telegraph, "Coles and Woolworths cakes send kids hyper", 29 March 2009, <http://www.news.com.au/story/0,23599,25254917-421,00.html?from=public_rss> accessed 17 April 2009.

34 The Sydney Morning Herald, "Generic brands could cost health", 16 April 2009, <<http://www.smh.com.au/lifestyle/wellbeing/generic-brands-could-cost-health-20090415-a7jq.html>> accessed 17 April 2009.

Recommendation 15

The Committee recommends that the Minister for Health and Ageing adopt a phased approach regarding regulations on the reformulation of food products. Industry should be encouraged to make changes through self-regulation but if industry fails to make concrete changes within a reasonable timeframe the Federal Government should consider regulations.

Portion sizes

4.38 The issue of portion size is another area where industry can contribute to Australians eating more healthily. Increased portion size has been identified as a contributor to obesity.³⁵ VicHealth's submission stated that 'upsizing' of food at fast food restaurants provided a 50 percent increase in calories for a 15 percent increase in price.³⁶ Their submission added that a standard packet of chips in the 1970's weighed 30g whereas today they weigh 50g, and international studies confirm that portion sizes have increased in the last two decades. The AFGC acknowledges the role that portion size plays in causing overweight and obesity stating:

That is why we believe it is really important to encourage manufacturers, my members, to have portion control packs – to have packs for one serving and where there are multi-serving packs, to ensure that this is a four serving pack, not something where someone eats four times what they should be eating.³⁷

4.39 The Committee is also concerned about the lack of standardisation of serving sizes. In accordance with Australian food standards set by the Food Standards Australia New Zealand (FSANZ), food labels are required to provide nutrient information per 100 grams of a product, nutrient information per serving size and the number of servings in a container.³⁸ However, the serving size is determined by food manufacturers, not FSANZ, and can vary from product to product within the same food group, for example cereals. This is confusing for consumers trying to compare nutrient value and energy content of similar foods.

35 CSIRO, Submission No. 113.

36 VicHealth, Submission No. 59, p 5.

37 Ms AK Carnell, Australian Food and Grocery Council, Official Transcript of Evidence, 24 October 2008, p 73.

38 Food Standards Australia New Zealand, *Nutrition Information Requirements: User Guide*, pp 10-14, <http://www.foodstandards.gov.au/_srcfiles/revised_NIP_User_guide_july02.pdf> accessed 17 April 2009.

4.41 The issue of the higher costs of groceries in rural and remote areas was raised with the Committee on a number of occasions. The regional director of the Maari Ma Aboriginal Health Corporation told Committee Members at a public hearing that while prices and availability of fresh food were adequate in Broken Hill, the further away from Broken Hill the higher the price and the lower the availability of fresh food items.⁴² This sentiment was echoed by a government official from the Western Australian Department of Health who observed that:

I find it intriguing that we can pay the same price for a packet of cigarettes across the nation – it does not matter where we are – or a can of coke, but when it comes to lettuce or a can of tomatoes, the differential rates, ranging from \$1.89 in a capital city to \$4.80 just for a can of tomatoes I saw recently in [a remote area store]...⁴³

4.42 At a hearing, the Committee questioned Woolworths about the pricing of products and perceived regional disparities in their stores. Woolworths replied that it operates seven Australian price groups, largely following state lines, where prices are standardised. They added that there were also 13 remote stores which had different costs, in particular transport and freight, which were not part of the seven price groups. According to Woolworths, the only factor that affects price variations is local area competition, which forces them to lower prices to match or beat the competition's prices. They added that an independent study had found that major supermarket chains in rural and remote areas contributed to prices in those areas being similar to prices in metropolitan areas.⁴⁴

4.43 The fact remains that prices are generally higher in regional and remote areas than cities in Australia. The Committee was particularly concerned about stories of exorbitant prices in more remote and community stores and visited one such store in Wilcannia. The Committee was surprised to see that some staple foods were significantly more expensive, for example milk and baked beans, whilst others were similar to city prices.

4.44 For years, community leaders in some remote and indigenous areas have called for government to subsidise freight charges for healthier food. The Committee did not receive detailed advice on this topic in the course of this inquiry but believes that it is an idea worthy of further consideration,

42 Mr R Weston, Maari Ma Aboriginal Health Corporation, Official Transcript of Evidence, 9 December 2008, p 9.

43 Professor KG Wyatt, Western Australian Department of Health, Official Transcript of Evidence, 6 November 2008, p 5.

44 Mr A Hall and Ms N Samia, Woolworths Ltd, Official Transcript of Evidence, 11 September 2008, pp 18 - 19.

perhaps by a body like the soon-to-be established Preventive Health Agency.

- 4.45 The Committee also notes that the House of Representatives Standing Committee on Aboriginal and Torres Strait Islander Affairs is currently conducting an inquiry into community stores, and that several of the submissions to that inquiry raise the freight subsidy issue.⁴⁵

A partnership model

- 4.46 The Committee endorses moves to develop a partnership between government, industry and relevant stakeholders to address the issues raised regarding the food industry. In its written submission to the inquiry, the AFGC indicated the willingness of the food industry to participate in such a partnership.⁴⁶ Dr Roberts from the Taskforce told the Committee that the food industry was an integral part of any solution to the issue of obesity in Australia:

We see the food industry as being a part of the solution. I think there is a lot that they can do in terms of helping to contribute to the work in Australia for people to be able to make healthier food choices.⁴⁷

- 4.47 The Committee notes the steps taken by the UK Government to work with the food industry to establish a Healthy Food Code of Good Practice following the findings of the Foresight Report and recommends that a similar process be implemented in Australia. In the UK the process has been led by the Department of Health and the Food Standards Agency and has engaged industry leaders and other relevant stakeholders. The Code is based on work already done by industry on a voluntary basis and expects companies to make seven commitments:

- A single, simple and effective approach to food labelling, based on principles that will be recommended by the Food Standards Agency in light of the research currently being undertaken;
- Smaller portion sizes for energy-dense and salty foods;
- Rebalance marketing, promotion, advertising and point-of-sale placement, in order to reduce the exposure of children to the promotion of foods that are high in fat, salt or sugar, and to increase their exposure to the promotion of healthy options;

45 Standing Committee on Aboriginal and Torres Strait Islander Affairs, <<http://www.aph.gov.au/house/committee/atsia/index.htm>> accessed 17 April 2009.

46 Australian Food and Grocery Council, Submission No. 54, p 4.

47 Dr L Roberts, National Preventative Health Taskforce, Official Transcript of Evidence, 12 November 2008, p 3.

- Help reduce the consumption of and levels of saturated fat and sugar in food – in particular the consumption of drinks with added sugar, along the lines of the continuing action on salt;
- Increase consumption of healthy foods, particularly fruit and vegetables;
- Work with the Food Standards Agency, the Department of Health and other stakeholders to deliver a single set of key healthy eating messages; and
- Provide information on the nutritional content of food in a wide range of settings (for example, theme parks, visitor attractions, restaurants, takeaway foods) that is clear, effective and simple to understand.⁴⁸

4.48 In the UK the policy was published in January 2008 and in July the Department of Health and the Food Standards Agency sent a comprehensive letter to food manufacturers, retailers, health professionals, consumer groups, food service and catering groups, detailing the implementation process.⁴⁹ In that letter the UK Government recognised the good work already being undertaken by the various sectors of the food industry and clearly set out which government departments would be responsible for overseeing the implementation of the seven elements of the Code. A round of meetings, discussions and seminars were planned for 2008 to engage the food industry and make them aware of their responsibilities under the Code. A monitoring and evaluation program has been put in place and an annual report will be compiled ‘that clearly sets out where progress has been made, highlighting particular examples of good practice and setting out areas where further effort is needed’.⁵⁰ The Committee recommends that the Department of Health adopt a similar process in Australia to develop a code of good practice, a detailed implementation plan and a monitoring and reporting mechanism with identified milestones and outcomes.

48 UK Cabinet Office, *Food Matters: towards a strategy for the 21st Century*, p 78, <http://www.cabinetoffice.gov.uk/strategy/work_areas/food_policy.aspx> accessed 17 April 2009.

49 UK Food Standards Agency, ‘Taking forward the healthy Food Code of Good Practice’, <<http://www.food.gov.uk/news/newsarchive/2008/jul/healthyfoodcode>> accessed 17 April 2009.

50 Food Standards Agency, Department of Health, Consultation Letter, 15 July 2008, <<http://www.food.gov.uk/multimedia/pdfs/dhfcgp.pdf>> accessed 17 April 2009.

Recommendation 16

- 4.49 **The Committee recommends that the Minister for Health and Ageing engage with peak bodies such as the Australian Food and Grocery Council, the Dietitians Association of Australia, and the Heart Foundation, to develop and implement a *Healthy Food Code of Good Practice* tailored to Australian conditions.**

Weight loss industry

- 4.50 Another sector which can make significant improvements is in the weight loss industry. The Committee has heard disturbing evidence about the effects of substandard diet programs. One witness referred to the recently popular Lemon Detox Diet which only provides half to a third of the minimum recommended kilojoule intake for someone on a diet.⁵¹ A researcher at the Telethon Institute for Child Health explained how extreme diets such as this one can alter a person's metabolism and can, in the long-term, actually hinder their weight loss efforts.⁵²

- 4.51 Mr O'Neill from Smart Shape reinforced concerns regarding the proliferation and ramifications of quick-fix diets:

So, in terms of linking health with the damage that these quick-fix diets do, it is a compromise of metabolic rate, and that means that somebody could end up fatter as a result of that, and we grow the obesity problem if we continue to let programs which are substandard – and the proposition is that these programs are substandard – operate in the marketplace.⁵³

- 4.52 Mr O'Neill is particularly concerned about the legitimacy or otherwise of products which appear to be endorsed by medical practitioners or pharmacists, and product advertisements that claim their diet and exercise methods use 'trained professionals' or 'qualified consultants', who may or may not have undergone proper training or certification.⁵⁴ He mentioned one particular product which was advertised by a member of the Royal Australian College of General Practitioners and said:

... in Australia we have got to a point where a weight loss program which is seriously deficient nutrient-wise is being promoted in advertisements by a medical practitioner. I would

51 Mr M O'Neill, Smart Shape, Official Transcript of Evidence, 24 October 2008, p 3.

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

53 Mr M O'Neill, Smart Shape, Official Transcript of Evidence, 24 October 2008, p 3.

54 Mr M O'Neill, Smart Shape, Official Transcript of Evidence, 24 October 2008, p 5.

propose that the public has no chance of distinguishing whether this program is suitable.⁵⁵

- 4.53 Mr O'Neill's concerns are shared by the Dietitians Association of Australia (DAA) who state that there is a need to protect consumers from unproven weight loss products that are often harmful, and that these products require a proof of 'safety and efficacy'.⁵⁶
- 4.54 The Committee recognises that many of these weight loss products are regulated by the Therapeutic Goods Administration (TGA) but is concerned that some products evade scrutiny by that body. The Committee also recognises that the ACCC may have the power to investigate some weight loss programs but, again, some programs evade the system. There appears to be a grey area where some products and programs escape scrutiny by any regulating body, and Australian consumers are left vulnerable to deception.
- 4.55 The Committee was told that a *Weight Management Code of Practice* was developed by the Weight Management Council of Australia in 1994 but that the Code is voluntary and to-date only five companies have signed up to the Code.⁵⁷ The Committee thinks that the voluntary Code of Practice should be adopted by more companies and promoted more widely as a benchmark measure.

Recommendation 17

- 4.56 **The Committee recommends that the Minister for Health and Ageing review the adequacy of regulations governing weight loss products and programs with the intention of ensuring that they can only be sold and promoted if nutritionally sound and efficacious.**

The review should also examine ways to improve industry compliance with the Weight Management Council of Australia's Weight Management Code of Practice.

Urban planning industry

- 4.57 The provision of healthy food choices within urban environments can and should be improved in Australia. Planners and developers should ensure

55 Mr M O'Neill, Smart Shape, Official Transcript of Evidence, 24 October 2008, p 4.

56 Ms KR Matterson, Dietitians Association of Australia, Official Transcript of Evidence, 12 September 2008, p 19.

57 Mr M O'Neill, Smart Shape, Official Transcript of Evidence, 24 October 2008, p 6.

that healthy choices are made available in public places like shopping centres and airports.

4.58 The lack of healthy food options at large shopping centres was raised repeatedly in public hearings.⁵⁸

4.59 Witnesses to the inquiry repeatedly spoke of cities across Australia that are not especially pedestrian-friendly,⁵⁹ and that urban planning has engineered incidental activity out of everyday life. The Committee Chair agreed:

We now have huge shopping centres that have been plonked in satellite cities and everyone has to drive to them ... if you are opening a restaurant or shop, you need X-number of car spaces, which means we all expect to drive and park right out the front of these particular premises, meaning that we do not do any physical exercise whatsoever.⁶⁰

4.60 Our approach to urban design needs to shift and focus on providing environments where people can easily be active and make healthy eating choices. As Professor Baur stated at a public hearing:

...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.⁶¹

Employers

4.61 One of the biggest gaps in the overall response to obesity that has confronted the Committee is the lack of support given by employers to workers to be active and healthy. Throughout the inquiry, the Committee made a concerted effort to find examples of employers that were doing more to encourage their employees to make healthy lifestyle choices. The Committee found very few employers who went beyond providing rebates for gym and sporting memberships.

4.62 The UK Government's strategy *Healthy Weight, Healthy Lives: a Cross-Government Strategy for England*, which was developed as a response to the Foresight Report and is discussed in Chapters 2 and 3 of this report,

58 Associate Professor K Samaras, Australian Healthcare and Hospitals Association, Official Transcript of Evidence, 12 May 2008, p 43.

59 See for example, Mr A Phillips, National Rural Health Alliance, Official Transcript of Evidence, 10 September 2008, p 23.

60 Mr S Georganas MP, Member for Hindmarsh and Chair of the Health and Ageing Committee, Official Transcript of Evidence, 12 May 2008, p 42.

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

specifically identifies the role that employers can play in supporting working adults to make healthy choices. In fact, employers are identified as one of the five ways to achieve a reduction in obesity levels in the UK. The strategy calls for cultural change in order to maximise the workplace as an arena to support health and fitness. Some of the issues that the strategy identifies to encourage greater health and fitness are:

- healthy canteens and food choices;
- provision of and investment in fitness facilities; and
- providing adequate facilities for cyclists.⁶²

4.63 While the Committee appreciates that these benefits create additional costs for employers, it is an indisputable fact that healthy employees are more productive ones. The benefits of investing in an active and healthy workforce can exceed the costs of providing the facilities and support. As the Committee heard from the Australian and New Zealand Obesity Society (ANZOS):

The workplace is a difficult one. It comes down, of course, to profit generally. One of the positives about having physically active workers is that they work better. They have fewer sick days and they are able to attend to the tasks for a greater period of time before needing breaks. However, I imagine putting movement into a work model is going to be difficult.⁶³

62 Department of Health, *Healthy Weight, Healthy Lives: A cross-government strategy for England*, pp 22-23, <http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_082378> accessed 17 April 2009.

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

Recommendation 18

The Committee recommends that the Minister for Health and Ageing encourage private and public employers to adopt programs and incentives that will promote active and healthy lifestyle choices by all Australians within the workplace.

Industry leading improvements

4.64 Throughout the inquiry a range of interesting initiatives were presented to the Committee which demonstrate that industry groups can lead change for the better. Some of these are described below:

- food industry;
 - ⇒ McDonald's Australia;
 - ⇒ Woolworths;
 - ⇒ the Australian Food and Grocery Council; and
 - ⇒ Nestlé.
- diet industry;
 - ⇒ Weight Watchers.
- urban planning and design;
 - ⇒ Delfin Lend Lease.
- employers;
 - ⇒ mining companies;
 - ⇒ Greenslopes Private Hospital; and
- the insurance industry.

Food industry

McDonald's Australia: a step in the right direction

4.65 There is significant criticism of the role of fast food in exacerbating the overweight and obesity problem around the world. Much of this criticism is directed at McDonald's Australia (McDonald's) but applies equally to other fast food companies like KFC and Hungry Jack's. The Committee was pleased that McDonald's Australia submitted to the inquiry and appeared at a public hearing to respond to criticisms.

- 4.66 McDonald's has made positive changes to their menus. At the public hearing in Sydney, they outlined the changes made to their products to the Committee. These include:
- 50 percent reduction in the sugar content of the buns;
 - use of canola oil for cooking;
 - trans-fatty acid free oil used in all cooking;
 - introduction of ready to eat salads to the menu;
 - nutritional labelling, the first fast food company in the world to do so; and
 - introduction of %DI (percentage daily intake) labelling on all products.⁶⁴
- 4.67 Further, McDonald's has worked with the Heart Foundation over a period of three years to reformulate products, in order to achieve the Heart Foundation tick on some products. Customers can at least now choose healthier options when they go to a McDonald's restaurant.
- 4.68 One dietitian praised McDonald's for being proactive:
- I think it is a great initiative and it is strong leadership for any fast food company to make moves to reduce those levels of fat, salt and sugar and to increase fibre in line with our public health guidelines.⁶⁵

Woolworths Limited

- 4.69 The Committee also had the opportunity to hear from Woolworths Limited (Woolworths) about the initiatives it is undertaking to combat obesity in Australia. The Committee was particularly pleased to learn that Woolworths is reformulating some of its home brand products to lower the levels of fat, salt and sugar:
- ...Woolworths labels ... looking at having lower fat, lower sugar and fewer additives, and you are to be commended for that.⁶⁶
- 4.70 Woolworths informed the Committee that they are also looking to emphasise their range of fresh products. One of the mechanisms to achieve this is changing their store layouts.⁶⁷ This will ensure that the first

64 Mr P Bush, McDonald's Australia, Official Transcript of Evidence, 11 September 2008, p 48.

65 Ms KR Matterson, Dietitians Association of Australia, Official Transcript of Evidence, 12 September 2008, p 24.

66 Ms J Hall MP, Member for Shortland, Official Transcript of Evidence, 11 September 2008, p 21.

67 Mr A Hall, Woolworths Ltd, Official Transcript of Evidence, 11 September 2008, pp 17-18.

area a customer encounters in a Woolworths store is the fresh fruit and vegetable section, thereby giving these food items prominence.

- 4.71 The Committee is very supportive of the Woolworths *Fresh Food Kids* campaign. This campaign is aimed at making fresh food fun for kids and includes television advertisements where children use fruit and vegetables to create fun figures and objects like rockets. The goal of the campaign is to:

...promote fresh food in the same way as some confectionary products are promoted.⁶⁸

- 4.72 Woolworths added that one of their most successful product lines now were the pre-cut fruit in bags promoted via the *Fresh Food Kids* campaign.⁶⁹

The Australian Food and Grocery Council

- 4.73 The AFGC *Responsible Children's Marketing Initiative*, mentioned earlier in this chapter, is an industry response to concerns about excess junk food advertising to primary school-aged children. Ms Carnell explained how the initiative will work:

Taking that concern seriously, we have put on the table today an initiative that will mean that people who sign up, or companies that sign up, to this initiative – which at the moment we have no reason to believe will not be all of the major advertisers – will not advertise food that do not represent healthy choices to primary school aged children on the sorts of shows that they watch.⁷⁰

- 4.74 The AFGC noted that their initiative covered the use of licensed characters and personalities only allowing them to be used in promoting a healthy message.⁷¹
- 4.75 The Committee questioned the AFGC about how a 'healthy choice' food would be defined. The AFGC responded that companies would place on the public record how they determined which foods were healthy and which were not, adding that they could use Australian standards or perhaps overseas scientific work.⁷²

68 Ms N Samia, Woolworths Ltd, Official Transcript of Evidence, 11 September 2008, p 24.

69 Mr A Hall, Woolworths Ltd, Official Transcript of Evidence, 11 September 2008, p 22.

70 Ms AK Carnell, Australian Food and Grocery Council, Official Transcript of Evidence, 24 October 2008, p 73.

71 Ms AK Carnell, Australian Food and Grocery Council, Official Transcript of Evidence, 24 October 2008, p 74.

72 Ms AK Carnell, Australian Food and Grocery Council, Official Transcript of Evidence, 24 October 2008, p 74.

Nestlé Australia

- 4.76 The Committee was pleased to read media reports towards the end of 2008 which indicated that Nestlé has moved to restrict the marketing of unhealthy food products to children. In response to growing international concerns, Nestlé has implemented a set of 'global marketing to children principles' based on World Health Organisation (2003) and US Institute of Medicine (2006) recommendations. In Australia these principles have been incorporated into their company action plan in response to the AFGC initiative.⁷³ Implementation includes a nutritional profiling system to define which foods can be marketed to children and which need to be reformulated to meet marketing guidelines.⁷⁴
- 4.77 The Committee applauds the AFGC initiative and notes that a number of well known Australian companies including Kraft Food Australia/New Zealand, Coca Cola, Cadbury and Unilever have signed action plans in accordance with the initiative. However, it remains to be seen whether or not self-regulation is sufficient in and of itself to have the desired effect across the board.

Weight loss industry

Weight Watchers Australasia: a positive story

- 4.78 Weight Watchers Australasia (Weight Watchers) are signatories of the Weight Management Code of Practice, one of only 5 companies to be signatories of the code.⁷⁵ The Committee heard from Matt O'Neill that this code restricted the types of weight loss claims that organisations could make and strengthened refund policies and guarantees.⁷⁶
- 4.79 The Committee was pleased to take evidence from Weight Watchers who have been operating in Australia for 40 years.⁷⁷ At the hearing in Sydney, Weight Watchers told the Committee that it views its program as a lifestyle change program rather than a diet.⁷⁸

73 Nestlé Australia, *The Responsible Children's Marketing Initiative Company Action Plan*, <<http://www.afgc.org.au/cmsDocuments/Nestle%20CAP.pdf>> accessed 17 April 2009.

74 Canning, S, 'Food giant Nestle takes sugar hit to sweeten image', *Australian*, 19 November 2008, <<http://www.theaustralian.news.com.au/story/0,25197,24673501-601,00.html>> accessed 17 April 2009.

75 Weight Management Council Australia Ltd., <<http://www.weightcouncil.org/>> accessed 17 April 2009.

76 Mr M O'Neill, Smart Shape, Official Transcript of Evidence, 24 October 2008, p 6.

77 Mr J Saad, Weight Watchers Australasia, Official Transcript of Evidence, 11 September 2008, p 26.

78 Ms EJ Stirling, Weight Watchers Australasia, Official Transcript of Evidence, 11 September 2008, p 31.

4.80 Weight Watchers submitted that it is a scientifically developed program that is modified and updated to reflect emerging evidence about weight management. Weight Watchers utilises expertise from international experts as well as a scientific advisory board comprising a medical advisor and obesity expert, a dietician and nutrition advisor and exercise physiologists.⁷⁹ At the public hearing, Weight Watchers stated that there is also a Weight Watchers global advisory board adding that:

A lot of very eminent scientists around the world sit on the Weight Watchers global advisory board.⁸⁰

4.81 The Committee was pleased to hear that Weight Watchers has developed an *At work* program to deliver Weight Watchers programs into the workplace. In addition, Weight Watchers is also partnering with Myer to deliver consultations in Myer department stores through Weight Watchers Lifestyle Centres.⁸¹ These are good initiatives to make Weight Watchers more accessible to Australians.

Urban planning industry

Delfin Lend Lease plans the future

4.82 Traditional urban design, which involves a separation of land uses, is blamed for contributing to declining levels of physical activity and increased reliance on motor vehicles.⁸² However, there has been a move away from traditional planning process, with some new developments incorporating living and working areas within the single development. Delfin Lend Lease (Delfin) was one example presented to the Committee of this new type of development.

Some of the developments that we have seen, certainly from Delfin – and there is a good example in Queensland, in the Gold Coast area, which I think is called Varsity Lakes – are where the development initially perhaps started with the built environment residential but at the same time now it is looking at what other economic opportunities there are. The Varsity Lakes development happens to have the great advantage of having the university next

79 Weight Watchers Australasia, Submission No. 138, p 6.

80 Ms EJ Stirling, Weight Watchers Australasia, Official Transcript of Evidence, 11 September 2008, p 35.

81 Weight Watchers Australasia, Submission No. 138, p 6.

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

door, so it is a location where people can move around, rather than getting into a car.⁸³

- 4.83 The Committee visited the Varsity Lakes project at the Gold Coast and was taken on a tour of the Varsity Lakes area by Delfin who later appeared at a public hearing. The Committee was particularly impressed that Delfin had employed a sport and recreation officer whose job is to connect people living in Varsity Lakes with the diverse range of physical activity programs available to them. Mr Patterson from Delfin explained his role:

My role specifically is to implement initiatives and programs which facilitate that opportunity for people to be active in a convenient and timely manner. I am the only full-time designated sport and recreation manager of any developer...⁸⁴

Employers that are raising the bar

- 4.84 The Committee was glad to learn that some of Australia's large mining companies are promoting physical activity programs within their workforce by providing on site fitness programs for miners. At the public hearing in Mackay, the Committee heard from a physical trainer who had been contracted to provide these activities. Mr Eden told the Committee that:

We have been involved with the mining industry for probably six or seven years now. We were first approached by Macarthur Coal about providing facilities and activities for their workers ... We have expanded that involvement to a couple of other sites which we now look after.⁸⁵

- 4.85 The Committee also visited Greenslopes Private Hospital which has a Wellness Program for their staff. This program covers physical activity, nutrition, counselling and financial planning services to employees. The Committee was particularly interested in the *Wellness2go* service, which provides staff with modified programs delivered at a departmental level.⁸⁶ This allows time poor employees who may be unable to leave their work area during the day to have the *Wellness2go* program delivered to them in their work area. Greenslopes was also making use of new technology with members of the staff gym utilising USB recorders to track and measure

83 Ms KJ Owen, Municipal Association of Victoria, Official Transcript of Evidence, 24 October 2008, p 67.

84 Mr D Patterson, Delfin Lend Lease, Official Transcript of Evidence, 8 December 2008, p 35.

85 Mr SJ Eden, City Fitness Health Club, Official Transcript of Evidence, 18 August 2008, p 20.

86 Greenslopes Wellness Program brochure, Exhibit No. 70, 1 October 2008.

their progress on the fitness equipment, much the same way as a personal trainer. This allows staff to have accurate information about their progress and to follow personalised exercise programs.

Insurance industry

- 4.86 The Committee was pleased to hear about initiatives that the health insurance industry is taking to keep its members out of hospital. Their approach involves providing services for patients who have been in hospital to access lifestyle change programs, and also to provide assistance to their members more broadly.
- 4.87 The Committee heard from one insurer, Australian Unity, at its first hearing in Melbourne. Australian Unity stated that it was the first organisation to implement the COACH program in the private sector. The COACH program is aimed at people who have recently undergone a cardiac admission to hospital, reducing their risk factors (blood pressure, blood cholesterol and weight) to prevent readmission to hospital. Australian Unity informed the Committee that a randomised controlled trial of this program had shown a 12 to 14 percent reduction in readmission to hospital in the 24 months following a cardiac event.⁸⁷
- 4.88 The Committee was interested to learn more about incentives from health insurers to enable customers to remain healthy. Australian Unity stated that the private health insurance industry is tightly regulated in terms of the incentives that they can offer customers, but that they do offer discounts and benefits for approved programs, for example Weight Watchers.⁸⁸
- 4.89 Of particular interest to the Committee was Australian Unity's study which showed that Australians find health insurers to be a credible source of health information.⁸⁹ This presents another network through which health promotion messages can be disseminated.

Committee comment

- 4.90 Industry needs to be a part of the solution to obesity in Australia. The private sector has taken some positive steps which will help to improve the health and wellbeing of Australians. However, there remain areas where industry can do more to contribute to reversing the levels of
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87 Ms CM Grindlay, Australian Unity, Official Transcript of Evidence, 20 June 2008, p 14 – 15.

88 Ms CM Grindlay, Australian Unity, Official Transcript of Evidence, 20 June 2008, p 16.

89 Ms CM Grindlay, Australian Unity, Official Transcript of Evidence, 20 June 2008, pp 18 – 19.

Australian obesity. Action to reduce obesity cannot be effective without the involvement of industry; therefore work to engage and involve industry in addressing levels of obesity is central to a successful policy response.

4.91 Within the debate about obesity, there is significant criticism of the role of industry. The Committee is of the view that some of the criticism is well founded, and there are areas where industry, in particular the food and weight loss industries, must make more of an effort.

4.92 While the Committee does not feel that the banning of marketing, in its various forms, of unhealthy foods to children will be the panacea which will reduce obesity levels in Australia, it is sceptical of the industry's proposition that:

There is no such thing as bad food, only bad diets.⁹⁰

4.93 This spurious argument absolves industry of any responsibility for marketing and selling foods that are sometimes very high in fat, salt, sugar and saturated fat. It is the view of the Committee that obesity is not simply a matter of individual responsibility. While individuals are responsible for their own health, the environment in which they live should support healthy choices. This notion was stated upfront in the UK Foresight Report:

...the evidence presented in this report provides a powerful challenge to the commonly held assumption that an individual's weight is a matter solely of personal responsibility or indeed personal choice. Rather, the evidence supports the concept of 'passive obesity' (where obesity is encouraged by wider environmental conditions, irrespective of conditions).⁹¹

4.94 However, the Committee is pleased that some companies within the food industry have taken positive steps. That said, the changes that McDonald's and Woolworths are implementing are the first steps to improve their products, and the Committee hopes to see their work in this area continue.

4.95 The Committee believes that Australian consumers also need to be more vocal to food manufacturers and suppliers about what they do and do not want in their food products.

4.96 The Committee is concerned about the apparent lack of adequate regulation of the weight loss industry, and thinks that urgent work needs

90 Advertising Federation of Australia, Submission No. 35, npn.

91 Butland, B et al., 2007, *Tackling Obesities: Future Choices*, <<http://www.foresight.gov.uk/Obesity/17.pdf>> accessed 17 April 2009.

to be done to improve the regulation of weight loss companies and products.

- 4.97 The Committee notes the criticism of urban planning, and the significant contribution of urban planning on obesity levels. However, there are positive changes within the area of urban planning and the Committee commends Delfin for its proactive approach.
- 4.98 The Committee feels that there is a significant contribution to be made by Australian employers to the health of their employees. The Committee was pleased by the types of health and wellbeing programs on offer at Greenslopes Private Hospital as well as the stories of mining companies taking a proactive approach to the health of its workforce.

Individuals

- 5.1 This chapter will examine the role that individuals can play in preventing and managing the obesity epidemic, and cover:
- individual responsibility for body weight;
 - other factors that influence individual body weight;
 - family responsibility; and
 - examples of individual achievement.

Individual responsibility

- 5.2 Throughout the course of the inquiry, the Committee repeatedly heard that ultimately individuals must take responsibility for their own health, including their weight. Obesity is caused by an imbalance in energy intake (from diet) and expenditure (from activity). Individually we make the decisions as to how much we eat and how much activity we undertake.
- 5.3 Evidence to the Committee indicated that a small, seemingly insignificant energy imbalance results in weight gain over time, implying that each of us can control our own weight by controlling what we eat and how much we exercise. In their submission, the Department of Health and Ageing (DoHA) told the Committee that over the past 20 years the average weight of Australian adults has increased by 0.5-1kg. This gain is caused by a daily extra energy intake of as little as 100 kcal, equivalent to:
- ... one slice of bread, a soft drink or 30 minutes of sitting instead of brisk walking.¹

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

- 5.4 To correct the energy imbalance, individuals need to develop a healthy lifestyle by making changes to correct their dietary habits and increase their activity levels. The Committee was advised that the best way for individuals to achieve success in changing their lifestyle is to undertake small, incremental changes. Professor Stewart from the Baker Heart Research Institute advocated the 'five in five' approach where people are encouraged to lose a kilo a month for five months by eating less and exercising more.²
- 5.5 However, even small lifestyle changes require behavioural change and a large amount of evidence to the inquiry stressed how difficult this type of change can be. The Committee noted that changing our behaviour is possible but that individuals require motivation and ongoing support from a variety of sources to succeed. Professor Littlefield from the Australian Psychological Society identified the elements for success:

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

Other factors

- 5.6 Oral and written evidence to the inquiry showed that self discipline is not always, or indeed the only, answer. A number of other important factors influence the ability of individuals to control their body weight. These include:
- biological reasons;
 - the obesogenic environment;⁴
 - psychological factors;
 - socio-economic levels; and
 - knowledge/education.

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

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

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

Biological reasons

- 5.7 Expert witnesses to the Committee advised that there are biological reasons why some people have difficulty controlling their weight. The Committee was provided with scientific evidence showing that this may occur for three reasons:
- human evolution;
 - some people carry a gene or genes that pre-dispose them to obesity; and
 - homeostatic regulation which can cause the body to maintain or increase its weight in response to changes in diet or activity levels.
- 5.8 A number of witnesses referred to our evolutionary background telling the Committee that because our ancestors were hunter gatherers living in a feast or famine environment, our bodies naturally store fat during times of plenty. One witness explained:
- The body is designed to store fat as an energy reserve for lean times – a feature we developed during the thousands of years when a regular meal could not be guaranteed. It explains why weight is relatively easy to put on – but hard to get off.⁵
- 5.9 In their submission to the inquiry, the University of Melbourne Obesity Consortium (the Consortium) explained that there are two genetic reasons for obesity: genes mutating or some genes being either over or under active. These genetic conditions upset the balance between the hormones that regulate our appetite and make us feel hungry or full, making it difficult to lose weight by lifestyle changes alone.⁶ The Consortium quoted studies on twins and adopted children to show that genetic predisposition has a strong influence on an individual's ability to control their weight. Studies of twins indicate that '70percent of the influence on body weight is genetic while 30percent is environmental', while studies of adopted children show that the children resemble their biological parents rather than their adoptive parents.⁷ The Consortium is calling for more research to understand these genetic conditions and to help develop evidence based strategies for prevention and treatment.⁸
- 5.10 The Committee heard that a related biological factor that influences a person's ability to lose weight is the body's homeostatic regulation. Dr Lawrence from the Telethon Institute for Child Health Research explained

5 National Association of Retail Grocers of Australia, Submission No. 121, Attachment p 15.

6 The University of Melbourne Obesity Consortium, Submission No. 13, npn.

7 The University of Melbourne Obesity Consortium, Submission No. 13, npn.

8 The University of Melbourne Obesity Consortium, Submission No. 13, npn.

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

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

The obesogenic environment

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

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

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

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

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

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

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

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



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

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

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

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

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

Psychological factors

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

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

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

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

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

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

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

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

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

Socio-economic determinants

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

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

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

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

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

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

18 Diabetes Australia, Submission No. 92, npn.

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

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

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

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

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

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

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

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

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

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

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

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

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

Knowledge and education

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

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

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

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

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

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

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

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

Family responsibility

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

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

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

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

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

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

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

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

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

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

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

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



Individual achievement

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

- 5.31 Here are just two of the many stories the Committee heard that demonstrate:
- the many influences that can cause obesity problems to escalate; and
 - the difference an individual can make to their own life and the lives of others.
- 5.32 In Sydney, one witness shared her story with the Committee, highlighting the difficulties overweight individuals can face. The witness has battled overweight and obesity all her life despite eating properly as a child and being extremely active.
- 5.33 She told the Committee how, in early adult life, she became a nurse and the long hours of shift work caused unhealthy and irregular eating patterns and reduced her activity levels. Despite being medically trained and well aware of the health risks, and after years of making concerted efforts to address her health issues which became increasingly complex as time went on, she made the decision with her doctor to undergo bariatric surgery. She found the decision extremely difficult and put off the surgery in 2006 but deteriorating health forced her to take the step in early 2008.
- 5.34 She went on to tell the Committee it was only through the support of her General Practitioner (GP) and specialist, that she was able to come to terms with her condition and find the courage to undergo the surgery. She also stressed to the Committee the need for ongoing support, explaining that even though she is doing well, she still needs help. Surgery is not 'the easy option'. She can only eat small amounts of food, adheres to a diabetic diet and exercises intensely every day:
- There has to be a multidisciplinary approach to this. You need the dietary assistance. You need the psychological assistance. You need the support from the general practitioner. You need the monitoring of your bloods.³¹
- 5.35 The Committee was impressed that she had completed her first fun run and asked what sort of difference the procedure had made to her professional and social life. She responded that her work colleagues had been very supportive but that the restriction on her food intake made socialising difficult and that those restrictions would be ongoing:
- I think I am always going to have to live the way that I live now. But I certainly feel better in myself and feel healthy.³²

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

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

- 5.36 At the hearing on the Gold Coast the Committee heard from a witness who has successfully changed his own habits and gone on to share the knowledge he gained with the wider community. After unsuccessfully trying a range of diets and exercise programs Mr Gillespie who was 40 kilograms overweight, began to do his own research into human metabolism and investigate why our ancestors had not had a problem with obesity. He identified an increase in people's fructose (the sugar found naturally in fruit) intake. Through cutting fructose out of his diet he lost 40 kilos which he has successfully kept off. But he did not rest there. He decided that 'the story of the sweet poison had to be written in language we all could understand' and using his skills as a lawyer built the case against fructose in a book he titled *Sweet Poison: Why sugar is making us fat*.³³ The Committee was impressed with his enthusiasm and drive and the anecdotal results reported by followers.
- 5.37 During the course of the inquiry the Committee met and spoke to many academics, medical and other professionals who are devoting their time and skills to helping people prevent and manage obesity. This report will only consider a couple of these individual contributions. The examples have been chosen to illustrate three important aspects of the evidence received by the inquiry:
- body image and childhood obesity; and
 - multidisciplinary models of treatment for obesity.
- 5.38 Associate Professor O'Dea, a dietician and researcher from the University of Sydney who has studied body image and eating disorders in children and adolescents, voiced her concerns to the Committee regarding the treatment of childhood obesity. In her submission to the Committee she detailed the difficulties of defining obesity in children, cautioned against exaggerating the extent of the problem in Australian children and urged the importance of the 'first do no harm' message.³⁴ Associate Professor O'Dea stressed that there are many reasons for a heavier body weight in children including fat, water, muscle and bone density and that ethnic difference plays a role. For example, Greek and Lebanese boys tend to be more muscular which contributes to their overall body weight.³⁵ She advocates a more positive approach, including the use of positive language emphasising healthy growth and development and asked the Committee to remember that:

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

34 University of Sydney, Submission No. 68.

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

A healthy child is physically healthy, mentally healthy, socially healthy, culturally healthy, spiritually healthy ...³⁶

- 5.39 The Committee was impressed by the dedication and passion of the many doctors and surgeons who provided evidence to the inquiry. Their evidence stressed the need for specialised, multidisciplinary clinics to allow obesity patients access to a range of professional care including medical, surgical, nutritional, physical and psychological services. The Committee had the opportunity to explore these concerns with a senior endocrinologist Associate Professor Samaras and to visit her clinic in Sydney where they met some of her patients.
- 5.40 In response to the lack of obesity services available in the public system, Associate Professor Samaras has set up her own clinic to provide a multidisciplinary model of treatment. In her written and oral evidence to the Committee she stressed the complexity of obesity and its multiple causes. At her private clinic in Sydney her patients spoke informally to Committee members, telling them that the personalised, tailored treatment programs were helping them after other approaches had failed. One woman, a diabetic, explained that the recommended diabetic diet was not controlling her weight or insulin levels. At the clinic, the diet was modified to her personal needs and she finally started to lose weight. Another patient who was achieving success after many years trying different approaches to control her weight, told the Committee:

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

Committee comment

- 5.41 The Committee acknowledges the importance of individuals and families taking responsibility for their own weight control, dietary and activity habits in order to prevent and manage obesity.
- 5.42 However, there are clearly a number of obesogenic influences that can make it difficult for the individual to lose weight by lifestyle changes alone.
- 5.43 The Committee acknowledges the importance of ongoing psychological support for individuals attempting to change their lifestyle and control their body weight and thinks that the Medicare review should consider

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

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

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

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

Community programs and partnerships

Introduction

- 6.1 Throughout the course of the inquiry, the Committee was impressed by the range of excellent community initiatives being implemented across Australia. Focusing on both dietary and physical activity, these programs and partnerships are contributing to the behavioural and societal change required to achieve long-term results in better health and wellbeing. Any strategy to successfully combat the growing problem of obesity will need to include community involvement and community centred programs/projects.
- 6.2 The variety of initiatives and programs is enormous and this chapter will only attempt to provide a brief description of a few. They include individual and community initiatives as well as school, organisational and government programs and touch all demographics. This chapter will examine how these projects are successful in three areas:
- motivating people;
 - sustaining change; and
 - providing flow on benefits for communities.

Motivation

- 6.3 The Committee recognises the difficulty of motivating communities and individuals to become involved and make lifestyle changes. The following

strategies were identified by witnesses to the inquiry as effective motivators:

- a supportive environment;
- structured programs;
- accessible programs;
- inclusive programs;
- variety;
- hands-on experience; and
- community ownership.

Supportive environment

6.4 Oral and written evidence to the inquiry identified a supportive environment as a crucial motivator for many people wishing to lose weight. It became apparent to the Committee that both emotional and practical advice and assistance help individuals to apply knowledge, make changes and overcome challenges with success.

6.5 Weight Watchers Australasia (Weight Watchers) told the Committee that a supportive environment enhances the chances of success for many individuals. Weight Watchers is a weight management program based on four key principles:

- changing your diet by making smarter food choices;
- behaviour modification;
- a supportive environment; and
- exercise.¹

6.6 While the program provides scientifically based information on diet, exercise and behaviour change, it is the help provided by program leaders and regular meetings that participants credit with helping them succeed. A Weight Watchers leader who lost 30 kilos and has maintained her loss for over 12 years told the Committee that the ongoing support supplied by the program was critical to her success:

I found the greatest difference was in receiving support from week to week with trying to deal with all the ups and downs that come with trying to lose weight. At the core of my success in losing and

1 Weight Watchers Australasia, Submission No. 138, p 7.

keeping off my weight were the support and motivation of my leader and fellow members in the room and that continued support I received from week to week.²

- 6.7 A supportive environment provides an opportunity to talk about difficulties as they arise and for people to share experiences and solutions. The Weight Watchers Slimmer of the Year for 2008 explained to the Committee that these conversations reinforce an individual's commitment to change their lifestyle and lose weight:

The environment was incredibly supportive, with that feeling of 'shared experience'. Every week that I went, I would learn something from one of the other members, or there would be someone who had done really well to be cheered on.³

- 6.8 A number of other witnesses to the inquiry stressed the importance of knowing others who are sharing your experience. Nutrition Australia told the Committee that they use group encouragement with many different groups, including refugees adapting to Australian life, when delivering their food skills programs. They teach these food skills in a 'social setting where people have the opportunity to cook together, to shop together and to discuss topical issues in relation to food choices'.⁴ Nutrition Australia called this approach a 'powerful motivator for positive behaviour changes in relation to food intake'.⁵

- 6.9 The ongoing support and encouragement of others in a group situation also helps individuals stay committed with regard to physical activity. At its hearing on the Gold Coast, the Committee heard of the wide variety and easy accessibility of physical activities provided by the Gold Coast City Council. However, the Senior Active Parks Officer admitted that encouraging participation is still difficult. She gave a personal example where she had taken three years to convince her own sister to participate in an activity run close to her home. The Officer credited having the encouragement and support of the other members of the group as the real motivator for her sister's participation:

2 Mrs MT Elliott, Official Transcript of Evidence, 11 September 2008, p 29.

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

4 Ms J Phillips, Nutrition Australia, Official Transcript of Evidence, 24 October 2008, p 21.

5 Ms J Phillips, Nutrition Australia, Official Transcript of Evidence, 24 October 2008, p 21.

It is the motivation of having other people in a group environment that really seems to get them over the line.⁶

- 6.10 By comparison, witnesses to the inquiry warned that a competitive atmosphere can discourage engagement and deter participation. The Committee was told that, while many people thrive on competition, some find it threatening. The need to prove themselves against others can be daunting and induce anxiety and stress. Associate Professor Morgan, an academic responsible for implementing the Hunter Illawarra Kids Challenge Using Parent Support (HIKCUPS)⁷ program, stressed the need to create a supportive environment where children will be confident enough to become involved:

The programs that we designed were meant to be taught in a non-threatening supportive learning environment with lots of opportunities for success and positive reinforcement.⁸

- 6.11 Associate Professor Morgan explained that the major reason children felt threatened by a competitive environment was a lack of the necessary skills to carry out the task successfully. The HIKCUPS program was designed to tackle this issue. A community-based family weight management program, it trialled three intervention strategies centred on physical activity levels, dietary modification, and a combination of physical activity levels and dietary modification. The physical activity intervention focuses on teaching and improving children's basic motor skills so they build confidence. Associate Professor Morgan told the Committee that instead of using competitive, structured sports and games, the program concentrates on separate skills like running, kicking, catching, and hopping. The key to engaging the children is 'making physical activity fun'.⁹
- 6.12 Creating a positive, supportive environment and using fun activities to develop confidence and a skills base improved the self-esteem of these children and encouraged them to engage in regular sporting activities.

6 Ms SR Hughes, Gold Coast City Council, Official Transcript of Evidence, 8 December 2008, p 31.

7 Hunter & Illawarra Kids Challenge Using Parent Support (HIKCUPS), Child Obesity Research Centre, University of Wollongong, <http://www.uow.edu.au/educ/research/CORe/files/HIKCUPS_Program_Summary.pdf> accessed 17 April 2009.

8 Associate Professor PJ Morgan, Private capacity, Official Transcript of Evidence, 12 September 2008, p 31.

9 Associate Professor PJ Morgan, Private capacity, Official Transcript of Evidence, 12 September 2008, pp 28-29.

Associate Professor Morgan felt this was the most important outcome of the project and shared some of the powerful stories that had come out of the program:

Children who had never played sport were then selected to play in a Newcastle baseball team, or there were others who were quite emotional because for the first time they had been invited to play cricket at recess because they had learnt how to throw and catch.¹⁰

Structured program

6.13 Another key motivational strategy identified by witnesses to the inquiry is the provision of structured programs. The Committee heard that people can be overwhelmed by the amount of information available, particularly with regard to weight loss, and welcome structured programs that tell them clearly what they need to do.¹¹

6.14 Compounding the plethora of information on diet, weight loss and activity is the round the clock availability of food that has created distorted eating patterns. A number of witnesses indicated the dangers engendered by the deregulation of food availability. Associate Professor Noakes from the Commonwealth Science and Industrial Research Organisation (CSIRO) identified some of the consequences of the deregulation for the Committee, including extended shopping hours and the increase in non-traditional food outlets like petrol stations.¹²

6.15 Associate Professor Collins who is working with the HIKCUPS program, referred to the enormous amount of choice available at supermarkets and called it living in 'the most delectable, unimaginable giant lolly shop':

The lolly shop has become more enticing, it is allowed to stay open 24/7, it will do home deliveries, it will send us out messages to say, 'Hey everybody is in here tasting everything and its great, come on in.'¹³

6.16 This need to restore structure and order to eating patterns was a driving force behind the creation of the *CSIRO Total Wellbeing Diet*, one of the

10 Associate Professor PJ Morgan, Private capacity, Official Transcript of Evidence, 12 September 2008, p 32.

11 Associate Professor PJ Morgan, Private capacity, Official Transcript of Evidence, 12 September 2008, p 33.

12 Associate Professor M Noakes, Commonwealth Science and Industrial Research Organisation (CSIRO), Official Transcript of Evidence, 13 June 2008, p 42.

13 Associate Professor CE Collins, Official Transcript of Evidence, 12 September 2008, p 30.

successful programs the Committee encountered throughout the course of the inquiry. The *Total Wellbeing Diet* provides a twelve week eating plan, recipes, shopping lists and exercise guidelines. The Committee was advised that upward of one million copies of the diet have been sold and that approximately 540,000 people have successfully followed the diet plan, lost up to six kilograms, and maintained that loss.¹⁴

- 6.17 At the hearing in Adelaide, the Committee asked CSIRO to identify what had made the program so successful. Professor Clifton, a co-author of the program, attributed success to the diet's detailed information and simplicity:

... it is a very structured approach – 'You follow this and you will lose weight.' That is true; if you follow it, you will lose weight. And it is not hard to follow. It is not a radical diet that deviates you wildly from your normal daily pattern. It is very similar to what you do. It just makes little changes around the edges, so most people do not notice they have actually gone on a diet. That is its success. It is very structured and it tells you exactly what to do.¹⁵

Accessible programs

- 6.18 Accessibility to facilities and programs is important to achieve ongoing participation and engagement. The easier it is for individuals to participate the more likely they are to become involved. Witnesses identified a number of factors that affect accessibility, including:

- frequency and availability;
- cost; and
- taking programs to people rather than expecting them to come to the program.

- 6.19 The Gold Coast City Council identified frequency and availability as the key. The Council's Senior Active Parks Office explained they had increased availability in order to encourage ongoing participation:

We started off by doing a couple of weeks in a block. We found that residents were really quite interested in continuing on and they really did not enjoy the break in between. Every time we had

14 Professor P Clifton, Commonwealth Science and Industrial Research Organisation (CSIRO), Official Transcript of Evidence, 13 June 2008, p 40.

15 Professor P Clifton, Commonwealth Science and Industrial Research Organisation (CSIRO), Official Transcript of Evidence, 13 June 2008, p 45.

a break it was always hard for the instructors to get people motivated again. You found that they participated and went on a regular basis, and as soon as you stopped they would lose that motivation and persistence.¹⁶

- 6.20 The Council has developed a program in partnership with community groups and commercial providers that offers a wide variety of activities across the city. Conducted indoors and outdoors, the programs cover all demographics from toddlers to senior citizens as well as people with disabilities and special needs. For seniors there is a 'Fun and Friendship Morning' where they can join in gentle exercise such as indoor bowls, table tennis or cards. For mums there are a wide range of activities from the gentle 'Mum and Bubs' yoga group to the demanding 'Super Mums Triathlon Training Squad'.¹⁷ The overall program runs seven days a week, 48 weeks of the year and had approximately 140,000 participants in 2008.¹⁸
- 6.21 The Young Men's Christian Association (YMCA) Australia told the Committee that one of the most significant factors inhibiting access was cost. The Chief Executive Officer of the YMCA said that their organisation ensures that no-one is denied access to their programs or services due to cost. Through their Open Doors program YMCA raises funds specifically to:
- ... cover the cost of providing access to people who, for a range of reasons – special needs, low income; those sorts of things – would not otherwise be able to access programs.¹⁹
- 6.22 A number of witnesses stressed the need to go to people where they are, rather than expecting them to come to you. The Australian Sports Commission with their Active After-school Communities (AASC) program and the YMCA both provide programs for children in schools. Weight Watchers has an *At Work* program that can be tailored to the workplace offering either group meetings or individual consultations.²⁰ The Committee heard from a number of employers who have successfully implemented the Weight Watchers *At Work* program. The Gold Coast City

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

17 Gold Coast City Council, Active and Healthy Citywide Program, <http://www.goldcoast.qld.gov.au/t_standard2.aspx?PID=4364> accessed 17 April 2009.

18 Ms SR Hughes, Gold Coast City Council, Official Transcript of Evidence, 8 December 2008, p 29. See Gold Coast City Council, Active and Healthy Program, <http://www.goldcoast.qld.gov.au/t_standard2.aspx?pid=4291> for further details.

19 Mr RG Nicholson, YMCA Australia, Official Transcript of Evidence, 24 October 2008, p 44.

20 Weight Watchers Australasia, Submission No. 138, p 8.

Council testified that they had collectively lost a tonne of weight over 24 weeks using the program.²¹

- 6.23 Another group of people who benefit from programs coming to them rather than having to go to the programs are those who are housebound, including some older Australians. As mobility and independence lessens they cannot get out and participate in activities easily. National Seniors Australia (NSA) told the Committee about a program that has been piloted in Victoria utilising Home and Community Care (HACC) workers to support elderly people to implement dietary and activity programs. The HACC workers regularly visit them in their homes and can encourage, support and motivate them to persevere. The NSA provided the Committee with a copy of the write up of their project in the *Australian Health Review*. The journal includes an anecdotal story that illustrates the effectiveness of the program in helping an elderly person gain the confidence to increase her activity level:

One participant recounted that her physical activity plan was to walk, and her long-term goal was to walk her rather energetic dog. At first, she walked to and from her letterbox under the watchful eye of a homecare [HACC] worker, then she progressed to walking around the block in the company of her granddaughter, who walked the dog. By the end of the 6-month project, the client reported that she walked her dog around the block.²²

- 6.24 The Committee also expressed concern about retirees who have not been especially active during their working life and, while they may be mobile, are reluctant to take up exercise and change lifelong habits. In their written submission, NSA suggested that locations where seniors gather for recreational and social interaction such as Seniors Clubs 'could be encouraged and supported to provide appropriate physical activities and nutritious food'.²³ Such a setting provided the opportunity to introduce new ideas and activities and gave older people the confidence to try new things. The YMCA strength training programs were cited as an example, where:

21 Ms SR Hughes, Official Transcript of Evidence, 8 December 2008, p 29. See also Mr A Hall, Woolworths Ltd, Official Transcript of Evidence, 11 September 2008, p 18.

22 Cameron, M et al., 'A pilot program of physical activity promotion among clients receiving home and community care', *Australian Health Review*, August 2008, vol 32, no 3, p 448.

23 National Seniors Australia, Submission No. 79, p 10.

They start off as a social thing and then they go on to participate in walking programs and strength training programs.²⁴

Inclusive programs

6.25 Throughout the course of the inquiry, the Committee took evidence that children and adults alike feel less inclined to take part in exercise programs if they feel self-conscious, embarrassed, or unable to participate for any number of reasons, including cultural restrictions. The Director of Community Sport at the Australian Sports Commission (ASC) told the Committee that:

If children are not confident, the one thing that they do not want to happen is to be exposed so that their peers can see them not doing something well. That often happens when you put kids into large team game-type environments.²⁵

6.26 Associate Professor O'Dea spoke about a school she worked with in Sydney that had a lot of Muslim girls that were veiled, who would not do physical education (PE), sport or swimming.²⁶ Associate Professor O'Dea told the Committee she had worked with the school and had designed a PE uniform that was veiled and covered the girls, and that they were able to swim in. A time was set aside for the girls to 'swim, splash and giggle in privacy'. Associate Professor O'Dea said that everyone in the community was happy with this solution - the imam, the parents, teachers and children.²⁷

6.27 At its hearings, the Committee sought advice on ways to make sport and exercise programs more accessible and/or appealing to people who might otherwise shy away from organised physical activity.

6.28 Both the ASC and Associate Professor O'Dea spoke about the importance of developing programs that make people feel more comfortable about participating, that people prefer choices and control over the sort of activity they do, and that the activities should cater to different abilities. People are then more likely to enjoy the exercise, rather than perceive it as a chore and/or too hard for them.

24 Ms A Perfect, National Seniors Australia, Official Transcript of Evidence, 1 October 2008, p 58.

25 Mrs J Flanagan, Australian Sports Commission, Official Transcript of Evidence, 25 June 2008, p 5.

26 Associate Professor JA O'Dea, University of Sydney, Official Transcript of Evidence, 11 September 2008, p 47.

27 Associate Professor JA O'Dea, University of Sydney, Official Transcript of Evidence, 11 September 2008, p 5.

- 6.29 The ASC said that their approach included small team games rather than large team games:

...two on two and three on three. We get them all engaged so that they are not all standing around watching while one person missed as they try to get the basketball into the net and things like that.²⁸

- 6.30 At the Committee's Perth hearing, a doctor with many years experience of working in remote areas with indigenous communities, Dr Jeffries Stokes, Chief Investigator of the Western Desert Kidney Health Project, pointed out to the Committee that a lot of Aboriginal people in an area she had lived in, Mount Margaret, 'could not see the point in wasting energy with meaningless exercise [such as walking groups], for exercise's sake', especially in a hot harsh climate where one might encounter wild dogs and snakes on a stroll.²⁹ However, after consultation with community members, activities like dance, drumming, yoga and even gardening (not usually considered a form of exercise) had been instigated and proven very popular:

We went for things that people did not think of as exercise... They were much more fun and that was more successful.³⁰

- 6.31 The ASC described how it had expanded its AASC program over the years to include a range of non-traditional sport activities like flying discs, circus skills and dance for children who didn't want to do traditional sports, for example games like football or cricket.

...programs which are a lot of fun, and again engaging for [children].³¹

- 6.32 The Committee had the opportunity to visit and participate in a Tai Chi class on the Gold Coast on 8 December 2008. Organised by the Gold Coast City Council and taking place in a number of locations, the Tai Chi class had between 50-60 participants and catered to all levels, from beginners through to advanced Tai Chi practitioners. The local Council sponsors the program, paying the instructor \$80 per class. The Committee enjoyed
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28 Mrs J Flanagan, Australian Sports Commission, Official Transcript of Evidence, 25 June 2008, p 5.

29 Dr C Jeffries-Stokes, Western Desert Kidney Health Project, Official Transcript of Evidence, 6 November 2008, p 39.

30 Dr C Jeffries-Stokes, Western Desert Kidney Health Project, Official Transcript of Evidence, 6 November 2008, p 39.

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

speaking with the instructor and some of the regular participants after the class who were clearly very enthusiastic. Several participants told members how much they enjoyed the class and wished it was available more than once a week. Interestingly, the instructor told the Committee what a difference the class had made to elderly participants in this class and in some nursing homes in the surrounding area at which he also taught Tai Chi classes. In his experience, the classes reduced the number of falls the elderly experienced and increased their strength, flexibility and general feelings of wellness.

Figure 6.1 Members participating in a Tai Chi class on the Gold Coast, Queensland



Variety

- 6.33 Variety is another important motivator for adults and children alike. Evidence to the inquiry suggests that variety provides individuals with choice, the opportunity to pursue their own interests and to gain confidence. Variety can make healthy choices fun, interesting and exciting.
- 6.34 Variety was a driver for participation in the WellingTONNE Challenge program. At the hearing in Broken Hill the Committee learnt more about this program that had been implemented in the mid western New South

Wales town of Wellington. Organised by the Wellington Community Health Centre, the intervention was designed to tackle increasing levels of obesity, diabetes and heart disease. The program was conducted over a 12 week period and challenged the population of the town to collectively lose a tonne of weight. The Director of the Broken Hill Centre for Remote Health Research explained how variety was incorporated into the program:

It was voluntary and not prescriptive and offered a range of activities in which community members could choose to be involved, including lectures about dietary information, shopping information, exercise circuits of one sort or another and participant weigh-ins to see how they were going.³²

- 6.35 As well as providing different ways for people to participate, the program provided flexibility. Activities were conducted at a range of venues and at different times of the day and week, so that everyone in the community had an opportunity to participate. Additionally, community activities were conducted throughout the period including a family sports day, an orienteering family fun day, and a gala night.³³ The Committee heard that participants appreciated the choices available to them and that they understood that any involvement was better than none. Commenting on the versatility of the program, the Director said:

I think one of the issues is that, in a sense, different people will take very different approaches to exercise. For some people it will be a 30-minute walk or something. Others will get the bug, and they will be on their mountain bikes or whatever it is. So some will be managing their weight by major investments in exercise and not much dietary change; others will be doing it by dietary change and less exercise.³⁴

- 6.36 Another organisation that emphasised the importance of variety as a motivator was the YMCA. The Development Manager for YMCA Australia told the Committee that they implement their programs across Australia in urban, regional and remote areas and the programs were

32 Associate Professor D Perkins, Broken Hill Centre for Remote Health Research, Official Transcript of Evidence, 9 December 2008, p 2.

33 Australian Department of Health, *A healthy lifestyle resource based on experiences from the WellingTONNE Challenge*, Exhibit No. 95, pp 32-34.

34 Associate Professor D Perkins, Broken Hill Centre for Remote Health Research, Official Transcript of Evidence, 9 December 2008, p 5.

designed to appeal to a diverse range of people across age groups and socioeconomic levels. The objective of the programs is:

... getting the young people involved, getting the families involved, often getting older adults involved for the first time, and, whether that be a game of badminton or a workout in the gym or a swim in the pool, it is about trying to reach a whole range of areas of interest that they might choose to take up.³⁵

- 6.37 Variety is also one of the tools used to break down the competitive atmosphere that can hinder engagement and participation. Mrs Flanagan from the ASC explained that the inclusion of many small games and lots of equipment in the AASC program encouraged children to take part. The program targets inactive children and variety provides them with the opportunity and confidence to try new things:

I think they do like a lot of variety. Particularly if they are not confident, they do not like to feel exposed – that they are going to go out there and not catch a ball, not hit a ball or whatever it is they are doing. The program is taking that away and making it a lot of fun rather than that rigid competitiveness.³⁶

- 6.38 Throughout the inquiry, the Committee heard of many small, innovative ideas that use variety to encourage dietary change as well as physical activity. For example, at the hearing in Dubbo the Principal of St Pius X Primary School told the Committee of a simple technique that is encouraging students to eat fruit:

I do not know what it is called but we place an apple in a slicer, the apple is sliced up like a long worm, and the kids love that. They take an apple to school and they might pay 10c extra to get their apple sliced. It does not taste any different but they love it as it is a bit of a novelty.³⁷

- 6.39 The Committee experienced the importance of variety when they visited the AASC program at Marks Point Public School. The Committee commented on the inclusive nature of the program and the 'clever design'

35 Mr NC Cox, YMCA Australia, Official Transcript of Evidence, 24 October 2008, p 46.

36 Mrs J Flanagan, Australian Sports Commission, Official Transcript of Evidence, 25 June 2008, pp 4-5.

37 Mr G Cant, St Pius X Primary School, Official Transcript of Evidence, 10 September 2008, p 28.

of the games so that no-one excelled and everyone, including the politicians, could make a worthwhile contribution.³⁸

Figure 6.2 Members participating in the Active After-school Communities program at Marks Point Public School, Lake Macquarie, New South Wales



Hands-on experience

- 6.40 The Committee heard that another way to encourage participation in healthy eating and activity is to provide hands-on experiences and practical demonstrations. Giving people the opportunity to actively participate and apply knowledge is far more helpful than simply providing them with information.
- 6.41 Hands-on experience is at the heart of the kitchen garden projects being introduced in many schools, such as the Stephanie Alexander Kitchen Garden Project. A number of witnesses to the inquiry mentioned the success that this program is having. During a private briefing, the Committee heard from Stephanie Alexander that the program aims to introduce children to the pleasure of food by emphasising the link between growing, cooking and eating seasonal produce. The project is

38 Mr M Coultton MP, Member for Parkes, Official Transcript of Evidence, 12 September 2008, pp 30-31.

integrated into the curriculum and run by a Program Coordinator, who is a trained teacher, a Kitchen Specialist, a Garden Specialist and a number of volunteers.³⁹

- 6.42 The Committee visited the project in action at one school, Westgarth Primary School in Melbourne on 20 June 2008 and was impressed by the skill and enthusiasm that the children displayed working in their garden and preparing a meal in the kitchen. Exploring the garden with the children, Committee members learnt from students about natural pesticides and fertilizers. One student explained, 'The bugs don't like the chilli in the spray, so they won't eat the leaves.' In the kitchen Members were curious about which recipe a group of students were following to create a dressing for a salad. 'Oh we made it up sir. We've been cooking for two years.' This display of confidence was impressive as was the assurance and dexterity with which children handled utensils and kitchen equipment (including sharp professional knives which they are taught how to use properly and safely).
- 6.43 Sharing the food that they prepare with each other and the adult volunteers and conversing at the table is an intrinsic part of the program. Teachers told the Committee that students were taught table manners, how to set a table and decorate it with flowers from the garden. The socialisation component of the program is as important a part of the program as eating the meal.
- 6.44 Members were impressed with the lively discussions taking place around the room and the social interaction between children and adults.
- 6.45 NSA told the Committee that they use the Men's Sheds project to deliver hands-on programs to older men and veterans to help them learn to shop for and prepare healthy meals. Developed in response to the growing number of older men who are unemployed, retired, divorced or widowed, the Men's Sheds project is a grass roots initiative that provides a shed or workshop type space where older men can gather. Men in this cohort are often reluctant to discuss personal problems or health issues and the Sheds are used by a variety of organisations and agencies to reach them with health programs and information in a relaxed, friendly environment. NSA explained they use Men's Sheds to support a program targeting

39 Stephanie Alexander Kitchen Garden Project, Submission No. 1; see also Alexander, S., 2006, *Kitchen Garden Cooking with Kids*, Lantern, Camberwell and Stephanie Alexander Kitchen Garden Foundation, <<http://www.kitchengardenfoundation.org.au/index.shtml>> accessed 17 April 2009.

clients who have not traditionally been responsible for shopping or cooking and now find themselves having to perform these duties:

They are really hands-on programs. They go with people, help them pick out nutritious food, show them how to cook it and how to develop a healthy eating program.⁴⁰

- 6.46 Reiterating the benefit of the practical demonstrations in the Men's Sheds project, the Committee heard from one participant how useful this approach was for him:

The best thing for people like me ... is more a personal approach. We need somebody to show us ... not talk to us ... about how to put our own kitchen in order, not books, but real in the home practical stuff.⁴¹

- 6.47 It is not only children and older men who benefit from practical demonstrations. At the hearing in Dubbo, the Program Practice Manager from Walgett Aboriginal Medical Service (WAMS) spoke of a program they have implemented in the local high school for young mums. They take these young women shopping and show them how to choose healthy foods. Then they provide cooking lessons so the young mums can learn how to prepare the food for their families:

We are physically going up there, picking them up, teaching them how to budget and we take them to the grocery store. We demonstrate how to cook recipes and how to freeze vegetables, et cetera, and prepare them for a week in advance and correctly store them.⁴²

- 6.48 A range of community activities such as the ones described above play an integral role in not just reducing obesity but engendering a sense of community identity and wellbeing.

Community ownership

- 6.49 Evidence to the Committee showed that communities are more likely to succeed in tackling obesity and related issues if the community has ownership of the program. The Committee heard that community ownership can be created and supported in a number of ways, including:

40 Ms A Perfect, National Seniors Australia, Official Transcript of Evidence, 1 October 2008, p 59.

41 National Seniors Australia, Submission No. 79, p 11.

42 Ms K Gilmore, Walgett Aboriginal Medical Service, Official Transcript of Evidence, 10 September 2008, p 9.

- engaging local interest and getting people actively involved;
- supporting the community to find local solutions for local problems;
- encouraging local leaders and champions; and
- fostering grassroots movements.

6.50 In Adelaide, the Committee heard about the Fit2play program which was implemented in primary schools in the Gawler area but engaged the broader community innovative ways. Fit2play is a behavioural change program that encourages lifelong physical activity and healthy eating habits. It is delivered in schools through the existing curriculum and runs from reception to year 7. The program is built around five simple key messages:

- aim to watch less TV;
- aim to do more physical activity on most days of the week;
- aim to eat more fruit;
- aim to eat more vegetables; and
- aim to drink more water.⁴³

6.51 Teachers were happy to get involved because the program offered them a professional development opportunity and ongoing support. Program organisers ran a poster competition for children and invited local dignitaries, politicians, business people and community leaders to judge the competition. Gawler High School students wrote a play promoting the program and performed it to 690 primary school age children in the area. Ms Flint from the Gawler Health Service told the Committee she had never experienced such a positive response from a community health promotion project:

It is the most exciting program I have ever worked with in my 20 years of working for community health. I was absolutely amazed at the reaction from the community when we asked them to help us with the project.⁴⁴

6.52 On a smaller scale, but no less important, was the engagement of groups in localised communities such as schools. The Committee learnt that supporting community ownership in this type of setting produced some

43 Fit2play, <<http://www.fit2play.com.au/SA/default.asp>> accessed 17 April 2009.

44 Ms E Flint, Gawler Health Service, Official Transcript of Evidence, 13 June 2008, p 3.

extraordinary results. The Committee visited the Dubbo College Delroy Campus where students proudly showed off their school canteen. Teachers told the Committee they obtained funding to promote a healthy eating campaign and students were involved in growing vegetables and cooking dishes in the canteen. The Year 7 students had revamped the canteen, named it the 'Snak-Shak' and repainted it in vivid colours depicting a tropical theme. Allowing the students to run with their ideas and produce such a tangible result gave them a stake in the changes and helped reinforce the messages about healthy eating.

Figure 6.3 Members visiting the Snak-Shak at Delroy Campus, Dubbo College, New South Wales



6.53 Several witnesses to the inquiry cited the Colac project in Victoria and suggested that its success was due to community involvement in its development and implementation. This project aimed to encourage healthy eating and activity levels in children aged 4 to 12. It was a collaboration between Colac Area Health, Colac-Otway Shire and Colac Neighbourhood Renewal while Deakin University provided support, training and evaluation.⁴⁵ The project involved a wide range of intervention strategies covering diet and activity spread across the whole

45 The WHO Collaborating Centre for Obesity Prevention Deakin University, Submission No. 95, Attachment, npn.

community: families; schools; food outlets; sporting clubs; media; and community gardens. Professor Swinburn from Deakin University explained that agencies and stakeholders in the community designed and planned the program according to local needs. He called this a 'community capacity building approach' and told the Committee capacity building started by encouraging the community to find solutions not by imposing solutions from outside:

The Colac project did not say: 'Here's a bunch of programs that we worked out how to do sitting in the university. Let's take them down to Colac and see if they work.' It was not that at all. It was: 'How do you give some money and the support to a community to work out its own solutions?'⁴⁶

- 6.54 The Committee heard that involving community leaders from the start encourages engagement and participation. This was evident in a number of the projects the Committee examined including, for example, the WellingTONNE Challenge. Associate Professor Perkins, who evaluated that program, told the Committee that leadership can come from many different sources within the community but it always plays a pivotal role in developing and sustaining motivation:

Community leadership is important. Whether it is a health relations specialist, the local mayor or some people in the community who are willing to meet, I think that active, energetic leadership is critical. The combination of education and leadership leads to community motivation ...⁴⁷

- 6.55 While the Colac and Wellington community projects involved community organisations, councils, schools and universities developing and implementing a program, the Committee also learnt about grassroots initiatives that originate with individuals or small groups. These types of programs often combine local solutions and community leadership and fostering them can achieve outstanding results at a community level.
- 6.56 Another example, provided to the Committee by the Area Director of Population Health in the Western Australian (WA) Department of Health, demonstrated how small local initiatives can snowball and have a ripple effect. In the small wheat belt town of Dalwallinu, 250 kilometres north-east of Perth, the Area Director was approached by a member of the

46 Professor BA Swinburn, Deakin University, Official Transcript of Evidence, 20 June 2008, p 29.

47 Associate Professor D Perkins, Broken Hill Centre for Remote Health Research, Official Transcript of Evidence, 9 December 2008, p 6.

community requesting financial support to be trained to provide an exercise program. The community member also approached the local council for money to purchase equipment. She was refused on both accounts. The Area Director and the council felt her motivation was personal as her son had a weight problem.⁴⁸

- 6.57 However, this knock-back only prompted the community member to find other avenues to further her case. She energised the community, starting up a submission to pressure the hospital and council to support her. Eventually she got results and the community ended up having a personal stake in the program:

She got some support in the end from the hospital. We did pay for her training to provide a course, but that was it, and the shire subsidised a building that was not used, but did not pay for any equipment. That ended up being paid for and bought by the community at large.⁴⁹

Sustainability

- 6.58 The Committee recognises the importance of community programs and partnerships in combating overweight and obesity. Some of the programs mentioned in this chapter have been taken up enthusiastically and produced impressive results. However, more often than not, they are only available for a limited time and when they finish participants are left with no ongoing support or encouragement to continue. The Committee heard that the following components were fundamental to the sustainability of programs including:

- ongoing funding;
- parental involvement; and
- a whole-of-community approach.

48 Mrs K Gatti, Western Australian Department of Health, Official Transcript of Evidence, 6 November 2008, p 5.

49 Mrs K Gatti, Western Australian Department of Health, Official Transcript of Evidence, 6 November 2008, pp 5-6.

Funding

- 6.59 The Committee acknowledges the importance of ongoing, secure funding for community programs and partnerships. This is discussed further in Chapter 3 in the context of government assistance.
- 6.60 The issue of ongoing funding for programs was brought to the attention of the Committee time and time again throughout the course of the inquiry. For instance, Dr Jeffries-Stokes, from the Western Desert Kidney Health Project, told the Committee about a multifaceted, community based intervention program that had been implemented on the Goldfields of Western Australia. The program was triggered by very high rates of renal disease in the Aboriginal communities in the area. The program proposed an intervention that would reduce the risk factors by:
- ... the provision of culturally appropriate and relevant advice about the disease process, diet and lifestyle.⁵⁰
- 6.61 This program used art to engage and motivate communities and was extraordinarily successful. Dr Jeffries-Stokes told the Committee that the program was very innovative, using Indigenous artists to produce culturally appropriate material that would get the relevant health messages across to the community:
- They worked with the community for six weeks, developing their own health promotion materials that were specific for their communities, in appropriate language, but also the process of doing that meant that people learnt the messages, internalised them and were then able to teach them to their own families and their communities.⁵¹
- 6.62 However, when the Committee enquired whether the project would continue, Dr Jeffries-Stokes replied that unfortunately they were experiencing difficulties in securing ongoing funding:
- We are working to expand it to the whole of the Goldfields now, to 10 communities over three years. We are working to get the funding for that. We had no problem getting the arts funding but,

50 University of Western Australia, *Wanti Sugarba: a report of the intervention phase of the Northern Goldfields Kidney Health Project*, July 2007, Exhibit No. 85, p 3.

51 Dr C Jeffries-Stokes, Western Desert Kidney Health Project, Official Transcript of Evidence, 6 November 2008, p 36.

sadly, the health funding is extremely difficult to secure. There has been very little commitment from state and federal health.⁵²

6.63 At the Adelaide hearing, the Committee was told about the excellent results that the Fit2play program had achieved. When asked how long the program would continue Committee members were told 'one term'.⁵³ The organisers told the Committee they are attempting to put in place a fundraising scheme within the schools participating in the program which will eventually allow the program to be self-funded and sustainable. However, this will take time and, meanwhile, the program will need ongoing commitment from a funding source to continue.⁵⁴

6.64 The Committee heard from local governments responsible for providing recreation programs and facilities, that they too find it difficult to obtain ongoing funding. The Mackay Regional Council in North Queensland told the Committee they had instigated a very successful Active Parks program that attracted 1300 participants over approximately ten months. The program was funded from a one-off grant from Sport and Recreation Queensland and Queensland Health. The Locality Development Officer receives frequent inquiries from the public wanting to know when the activities will be run again and told the Committee:

I had to explain that unfortunately it was a funded program and we do not have any more money, so we are not doing it again ... It is a kind of catch 22, where the community really want it and we would love to give it to them but we are under resourced to be able to deliver this as an ongoing thing.⁵⁵

6.65 The Committee was delighted to learn that secure, ongoing funding will ensure sustainability of the Stephanie Alexander Kitchen Garden National Program with \$12.8 million being committed over four years. Stephanie Alexander told the Committee that she and her team had deliberately started the program on a small scale to make sure that it would work before committing to the large scale program. Careful planning and selection of a start up school gave the program a chance to work through

52 Dr C Jeffries-Stokes, Western Desert Kidney Health Project, Official Transcript of Evidence, 6 November 2008, p 40.

53 Mr M Henderson, Queen Elizabeth Hospital Research Foundation, Official Transcript of Evidence, 13 June 2008, p 9.

54 Mr M Henderson, Queen Elizabeth Hospital Research Foundation, Official Transcript of Evidence, 13 June 2008, p 12.

55 Mrs KM Gooch, Mackay Regional Council, Official Transcript of Evidence, 18 August, 2008, p 11.

any difficulties. The program was trialed in Victoria to further modify and refine the process and test adaptability to different types of schools and determine what was required to ensure success before being rolled out nationally.

6.66 In 2009 the program was rolled out nationally and at a private briefing in Canberra the Committee was updated on the outcome of the first round of grants. The Department of Health and Ageing (DoHA) informed the Committee that 44 schools had received grants to implement the Program in 2009: 7 demonstration schools in metropolitan areas, 20 city schools and 17 rural/remote schools. DoHA explained that the application process is designed to enhance sustainability. By gathering the information required and completing the application a school demonstrates the commitment and capacity to successfully run the program. The reasons schools missed out on selection highlighted areas that would compromise the school's ability to implement the program and included a combination of the following:

- lack of adequate garden space;
- lack of space to convert to kitchen use;
- insufficient capacity to fund staff; and
- lack of capability to generate local, in-kind support.

6.67 The Committee also raised with DoHA the issue of extending the program beyond the school system, perhaps to youth and unemployed groups. DoHA assured the Committee that once the program is well established in the school system it will look at expansion, but this will not be for several years. They told the Committee that DoHA is developing an evaluation strategy which will ensure the program improves and grows. The Committee endorses the program and Members have written to schools in their constituency to encourage them to apply for grants in coming rounds.

Recommendation 19

6.68 The Committee recommends that the Federal Government continue to support initiatives such as community garden projects, cooking classes and the Stephanie Alexander Kitchen Garden Program, in order to teach children and adults about:

- The benefits of growing and eating fresh fruit and vegetables; and
- Preparing and enjoying healthy and nutritious meals.

Figure 6.4 Members visited Westgarth Primary School in Melbourne to learn more about the Stephanie Alexander Kitchen Garden Program, Victoria



Parental involvement

6.69 The Committee heard substantial evidence that programs targeting children are more likely to be sustainable if parents and carers are involved. Parental involvement and interest ensures children will be encouraged and supported to make and continue behavioural change.

6.70 Associate Professor Collins from the HIKCUPS program identified the parent-centred interventions as the most successful part of that program. She put the reason succinctly to the Committee:

... parents are the gatekeepers of the kitchen and you have to change energy intake in order to affect weight loss ...⁵⁶

6.71 Mr Georgalli, the creator of the Fit2play program, told the Committee that parental involvement ensured behavioural change for both the children and parents. He demonstrated how this flow on effect works:

So children endorse the values of the program and go home to mum and dad; mum and dad see that Johnny all of a sudden wants to have broccoli on his plate as opposed to fried chips. What is the first thing that a parent is going to be doing? They are going to think, 'Wow, this is great. I'm going to support Johnny in what he wants to do.' So all of a sudden, when they are in the supermarket they are purchasing broccoli as opposed to those chips that are pre-prepared and have trans-fatty acids inside.⁵⁷

6.72 This example also demonstrates that parents find it easier to encourage behavioural change in their children when they are given external support. This was borne out by other programs. At the hearing in Dubbo, the Committee heard from a teacher at St Pius X Primary School where they introduced a policy of 'Fruit First Monday' that required every child to eat a piece of fresh fruit at the beginning of their recess on Mondays. Parents who had been finding it difficult to get their children to eat fruit could now insist it was school policy:

Parents now say, 'The teacher said that you have to have it, we say that you have to have it, so it is coming along.' That was the biggest change of mindset. We were supporting parents and they were supporting us.⁵⁸

6.73 Mr Cant, the Acting Principal of St Pius X Primary School went on to explain that parent support had not only sustained the program but expanded it. Instead of just one day a week, the program now runs five days a week and this was instigated by the parents:

56 Associate Professor CE Collins, Official Transcript of Evidence, 12 September 2008, p 34.

57 Mr M Georgalli, The Queen Elizabeth Hospital Research Foundation, Official Transcript of Evidence, 1 October 2008, p 24.

58 Mrs M Gabb, St Pius X Primary School, Official Transcript of Evidence, 10 September 2008, p 29.

They brought it up at a meeting and said, 'Why do you not do it for five days? If you guys do it we will do it.' We said, 'You are the ones who are packing the lunchboxes. We will go along with it.' It has gone from there and it is now second nature.⁵⁹

A whole-of-community approach

- 6.74 The Committee heard that a whole-of-community approach also contributes to long-term results and sustainability by developing skills and resources within the community and creating environmental change. By making changes within the community and building its strength the community is given the capability to continue programs.
- 6.75 The town of Dalwallinu in Western Australia, mentioned earlier in this chapter, is a good example. Instead of a program being imposed from outside and offered for a limited time, the initiative of the community member resulted in Dalwallinu gaining a trained exercise provider, exercise space and equipment. WA Health told the Committee that in the five years since the town has collectively lost a lot of weight and taken steps to incorporate healthy dietary practices into the physical activity program. Currently, approximately 50 members of the town travel 150 kilometres every week to attend a Weight Watchers program in a neighbouring town because nothing similar is available in Dalwallinu.⁶⁰
- 6.76 The Committee received an evaluation of the Colac intervention that showed the project had promoted sustainability through the development of skills and resources within the community, but it also found that the program had contributed to changing the overall environment of the community. For example, both the school canteen and take-away food outlets in the community now offer healthier food choices.⁶¹
- 6.77 The Committee heard that one of the important benefits for the Wellington community from the WellingTONNE Challenge was the training of local people as exercise group leaders.⁶² In this community too, the environment changed with local food outlets improving food choices. For

59 Mr G Cant, Acting Principal, St Pius X Primary School, Official Transcript of Evidence, 10 September 2008, p 29.

60 Mrs K Gatti, Western Australian Department of Health, Official Transcript of Evidence, 6 November 2008, p 6.

61 WHO Collaborating Centre for Obesity Prevention, Submission No. 95, npn.

62 Associate Professor D Perkins, Broken Hill Centre for Remote Health Research, Official Transcript of Evidence, 9 December 2008, p 7.

example, local hotels began to offer grills and salads instead of schnitzel and chips.⁶³

Flow-on benefits

- 6.78 The Committee discovered that the benefits of community programs and partnerships reached far beyond the targeted area of obesity prevention or intervention. By changing lifestyles, either through dietary or activity interventions, these programs contributed to building a sense of community and provided social benefits, including improving mental health and reducing individual isolation.
- 6.79 The Committee was provided with anecdotal evidence identifying the following additional benefits from the WellingTONNE Challenge:
- The recently bereaved, discovering a reason to socialise again.
 - The program providing a social function that everyone could attend.
 - 'Community awareness also made it okay to talk about being overweight.'
 - 'Fun, friendly atmosphere created within the Wellington Community. Good positive media coverage for the community, made us all feel proud to be part of it.'
 - 'Feeling motivated because everyone is doing it.'
 - 'I've had depression for three years. In the past four weeks, I've felt better than [I have] in a long time because I'm socialising and exercising.'⁶⁴
- 6.80 Many of the community and school garden projects that the Committee came into contact with demonstrated numerous flow-on-benefits. The Committee experienced this first-hand at the West Leederville Community Gardens in Perth where they met parents, teachers, children and volunteers working together, forming friendships and sharing knowledge. Escorted to the gardens by students from nearby West Leederville Primary School, the Members met a variety of local community people involved in the garden project. While the garden is a source of fresh produce for the community, it is also an important centre for community

63 'The Wellington Challenge', *Local Government Focus*, September 2005, <<http://lgfocus.com.au/editions/2005/september/september.shtml>> accessed 17 April 2009.

64 Australian Department of Health, *A healthy lifestyle resource based on experiences from the WellingTONNE Challenge*, Exhibit No. 95, p 33.

interaction. Members met a range of people involved, including a local bariatric surgeon and resident retirees passing on gardening knowledge from one generation to the next. The Committee was told that barbeques are held on Saturday afternoons when everyone has finished work in their gardens. Committee members lent a hand with pitchfork and shovel while children and adults alike shared their stories of growing, harvesting and enjoying fresh produce. One Committee member commented on the sense of community spirit being reclaimed by the project.

Figure 6.5 West Leederville Community Gardens, Perth, Western Australia



6.81 Gardening was also a component of the Western Desert Kidney Health Project, albeit taking a different approach. Dr Jeffries-Stokes told the Committee that conventional community gardens projects had failed in the past so instead they:

... taught people how to set up household gardens, growing things in pots, and school gardens. Now all the schools have fruit

trees in their yards and they have school gardens growing vegetables, and lots of people are growing stuff at home.⁶⁵

- 6.82 Dr Jeffries-Stokes went on to speak about an unexpected benefit of the project. Many of the able-bodied adults have left the communities for work due to the resources boom. The children, elderly and less able-bodied left behind often felt they are not contributing to the community but growing fresh produce in their gardens makes them feel valued again:

... it is also very rewarding for those people who may not be feeling very productive, very useful or very valued, because they can be the ones that grow stuff, who stand there with a hose and water it.⁶⁶

- 6.83 In Adelaide, the Committee heard about another community changing event. The Fit2play program was successfully implemented in a number of schools in the Gawler area. Ms Flint from the Gawler Health Service shared a story with the Committee that demonstrates the power of children to effect community change:

... one of our supermarket owners rang up after the program had been going a few weeks and he said, 'I'm sick and tired of all these people coming through stores with their children on Thursday nights, because they are all reading labels' - and that was one child to the other reading the same label. He said, 'Could you please stop it, because it is becoming a nuisance.' I do not know what happened, but the store had to close for two days and they had to alter their aisles. There was not the correct regulated space in between the aisles. That was the power of children.⁶⁷

Committee comment

- 6.84 The Committee was impressed by the strength and breadth of the community programs and partnerships they saw and heard about during the inquiry. The Committee was also encouraged by the positive stories and tangible results that came out of these programs.

65 Dr C Jeffries-Stokes, Western Desert Kidney Health Project, Official Transcript of Evidence, 6 November 2008, p 41.

66 Dr C Jeffries-Stokes, Western Desert Kidney Health Project, Official Transcript of Evidence, 6 November 2008, p 41.

67 Ms E Flint, Gawler Health Service, Official Transcript of Evidence, 13 June 2008, p 12.

- 6.85 While these programs are not the whole solution, they are a vital part of the overall solution. These often small, local programs initiate incremental change that creates a snowball effect, contributing substantially to the effort to combat the national obesity epidemic.
- 6.86 Community programs reinforce moves by governments and health agencies to encourage physical activity and healthy eating. The programs demonstrate practical ways that increased physical activity and healthy choices can be embedded in everyday life. These types of projects are successful because they draw on the large pool of expertise and knowledge existing in our communities. The Committee notes the potential for community skills to be tapped further to provide innovative and lasting solutions to the obesity epidemic. Programs of this ilk have in developing and maintaining motivation for individuals and the contribution they make to long-term and sustainable solutions.
- 6.87 The Committee acknowledges the important role that community programs and partnerships play in addressing the issue of obesity in Australia. What is needed, however, is work to correlate and disseminate information about successful programs. In this regard the Committee supports the work being done by Deakin University through the Community Obesity Prevention Sites Collaboration (CO-OPS) which will provide this type of information. This project has been funded by the Department of Health and Ageing for four years (2008-2011) and will collect, correlate and disseminate the knowledge gained from the implementation of a number of community-based projects. CO-OPS will establish a collaboration network to share knowledge and develop an evaluation system and best practice principles for communities and other interested stakeholders.
- 6.88 To complement the Deakin work, the Committee suggests that the Department of Health and Ageing develop some information kits and fun educational resources for use by children, parents, teachers and community organisations across Australia. These should highlight a selection of the community programs and projects promoting healthy diets and active lifestyles that have been brought to the attention of the Committee during this inquiry. The resources might take the form of posters, booklets, and/or CD/DVDs.
- 6.89 The resources should be made available quickly to interested families, schools and community organisations across Australia to enable the good ideas gathered in this inquiry to be disseminated as widely as possible, and hopefully inspire other communities to try them or their own versions. The Committee believes that it would be useful to have these

resources available through a central repository and that the website of the *How do you measure up?* campaign could be expanded into such a repository. This type of information would complement the tape measure kit already available through the website and give concrete examples of actions that individuals and communities can undertake in order to be more healthy and active.

Recommendation 20

- 6.90 **The Committee recommends that the Minister for Health and Ageing explore ways to enhance the *How do you measure up?* campaign website and further develop it as a central repository of information about the benefits of healthy eating and exercise.**

Concluding remarks

- 7.1 There is no doubt that obesity presents a serious challenge to the health of Australians. In the course of this inquiry, the Committee has examined the future implications that obesity presents for Australia and the contribution that governments, industry, communities and individuals can all make to reverse the currently too high levels of overweight and obesity in this country. This report follows the story of the Committee's inquiry.
- 7.2 Obesity has grabbed the public's attention throughout 2008 and 2009. The almost daily references to obesity in the television and print media have raised awareness of the attendant issues. Many of the reports have presented a doom and gloom view. The Committee would like its report to show that there are grounds for optimism. There is an impetus within Australia to respond to obesity. There is energy and support within the community for action now.
- 7.3 The Committee looks forward to the release of the National Preventative Health Taskforce's (the Taskforce) *National Preventative Health Strategy* in late June 2009. The Committee believes that while the two processes, that of this inquiry and the Taskforce, may on the surface appear similar, there are in fact some differences. The Committee has had an opportunity to focus on personal stories as it visited communities and met individuals, while the Taskforce has had the expertise to draw on the technical and scientific aspects of preventative health practice in order to develop a comprehensive national prevention framework. The Committee hopes that our report will complement the Taskforce's evidence-based strategy by telling the human stories as seen through the eyes of individuals, families, health workers, the private sector, governments and communities all around Australia.
- 7.4 An over-arching theme of this report is the need for national leadership, with the Federal Government driving and/or supporting changes, to

address obesity across the spectrum of Australian society. Such leadership is required in order to develop a whole-of-society response to obesity, engaging with industry, non-government organisations, communities and different levels and portfolios of government. Government has the opportunity at this time to 'set the scene' and create the conditions for a comprehensive response to obesity within Australian society. In this respect, the Committee sees the value of the Taskforce's recommendation to establish a new stand-alone national agency for promoting health and preventing illness.

- 7.5 One of the major issues that has confronted the Committee throughout the inquiry, which is discussed in detail in Chapter 2, is the lack of up-to-date data about the rate of obesity, the nutritional intake of Australians and the level of physical activity within the community. This inadequate data makes it difficult to accurately determine the cost of obesity and the future implications for and costs to the health system. The Committee urges the Federal Government to undertake detailed economic modelling of the projected costs of obesity and interventions, similar to those proposed in the 2008 Foresight Report on obesity prevention and management in the United Kingdom. The Committee strongly supports plans to remedy the existing data gaps through an adults nutrition and physical activity survey, and the proposed biomedical health risks survey, and wants to see these initiatives not simply considered 'one-offs' but updated regularly and sustained over the long-term.
- 7.6 The role of governments at all levels in addressing obesity is central. Broadly, governments need to consider modifying urban planning requirements, using regulation and legislation as tools to drive changes to the food supply and improving the management and treatment of overweight and obesity in the health system. Obesity has been compared to climate change insofar as it is a major modern phenomenon which requires a multiplicity of responses from government. In this respect the Committee notes the United Kingdom's report, *Food Matters: Towards a Strategy for the 21st Century* (2008). The report can provide a useful conceptual and practical guide to nations like Australia for developing more integrated policies that deal with the long-term trends in food production, consumption, safety and nutrition impact on the health of citizens. The Committee hopes that the current global financial crisis does not distract the government from giving the issues of overweight and obesity, and preventative health the attention that they deserve.
- 7.7 There is no doubt that the private sector has made some positive steps to contribute to reducing the growing rates of obesity in Australia. Industry must be part of the solution to obesity in Australia, which is why the Committee has recommended that the Federal Government adopt an

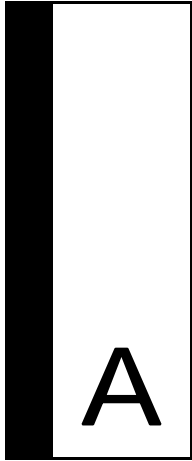
approach similar to that of the United Kingdom whose *Healthy Food Code of Good Practice* challenges all sectors of the food industry to promote healthy eating. The Committee believes that the Federal Government and industry need to work together more collaboratively on these issues.

- 7.8 Individuals need to take responsibility for their own weight but the Committee notes that there are factors that impact on the ability of people to control their weight. These include biological factors, the obesogenic environment, psychological factors, lack of knowledge and/or education and socioeconomic factors. The Committee considers these issues to be a whole-of-society responsibility with redress falling to governments, communities, industry and individuals.
- 7.9 One of the most rewarding discoveries for Committee members as they travelled across Australia for public hearings and inspections has been to see first-hand the role that communities can and are currently playing in addressing the levels of obesity in Australia. Throughout the inquiry, the Committee has been impressed with the breadth and depth of activities that are having demonstrated success within communities.
- 7.10 While the community programs and partnerships the Committee witnessed throughout the inquiry are not the total solution to obesity in Australia, they make a positive contribution. Key to the successful programs are a sense of community ownership, involvement and connection, which the Committee believes will be integral to underscoring the Federal Government's strategy and government programs. The Committee has been impressed by the degree of community engagement it has seen in programs like the Stephanie Alexander Kitchen Garden Program, the Colac intervention and the Hunter Illawarra Kids Challenge Using Parent Support (HIKCUPS) project, to name but a few. The Committee has enjoyed learning more about the different contributions that the various projects, programs and partnerships have made, and their often unforeseen flow-on benefits for healthier communities.
- 7.11 The Committee hopes that this report will move the debate surrounding obesity forward. While the Committee is of the view that the high levels of overweight and obesity are of very serious cause for concern and possibly even underestimated at the current time, there has been significant evidence that across Australia positive steps are being undertaken by governments, communities, individuals and industry.
- 7.12 There are many individuals who are working tirelessly in Australia to control their weight or help others to adopt healthier lifestyles. The Committee thanks the many doctors, specialists and allied health and community workers who took the time to attend public hearings and share their knowledge. These are the unsung heroes of the Australian

health system and the battle against overweight and obesity. The Committee is confident that the work it has witnessed, ranging from community programs to medical treatments, will serve to reinforce the strategy that is currently being devised by the Taskforce. The Committee appreciates the Taskforce's input into the inquiry and the opportunity to have discussions about policy options with the Taskforce Chair, members, and secretariat staff alike.

- 7.13 Evidence presented to the Committee highlights the fact that obesity is a real and pressing problem in need of a comprehensive and multifaceted solution. The Committee is confident that the public support for action which it has witnessed throughout the inquiry will contribute to the success of the Taskforce's strategy, and thinks that the public momentum for change should be captured and built upon. This drive has left the Committee feeling optimistic, rather than pessimistic, that the concerted effort of all sectors of Australian society can bring the public health issues of obesity under control and reduce the burden to Australian society and the economy.

Steve Georganas MP
Chair
May 2009



Appendix A - Submissions

1. Stephanie Alexander Kitchen Garden Foundation
2. Ms Melanie Rieger
3. Research Australia
4. Ms Susanna Scurry
5. Weight Management Services, The Children's Hospital at Westmead
6. Institute of Obesity, Nutrition and Exercise, The University of Sydney
7. The Parents Jury
8. Baker Heart Research Institute
9. Alzheimer's Australia
10. Australian Institute of Health and Welfare
11. Australian and New Zealand Obesity Society
12. Professor Roger Magnusson
13. The University of Melbourne Obesity Consortium
14. Sydney Medical Weight-Loss Centre
15. Women & Newborn Health Service, Department of Health, WA
16. Foundation for Advertising Research
17. The Australian Psychological Society Ltd
18. Name Withheld

19. Professor Jan Wright
20. Australian Association of National Advertisers
21. National Rural Health Alliance Inc
22. Queensland Association of School Tuckshops Inc
23. Centre for Physical Activity and Nutrition Research, Deakin University
24. Lachesis Biosciences
25. WA Country Health Service
26. Mr Daryl Sadgrove
27. Australian Physiotherapy Association
28. ACT Health
29. Outdoor Council of Australia Inc
30. The Jean Hailes Foundation for Women's Health
31. Horticulture Australia Ltd
32. Bunbury Community Health Service
33. Wesley Weight Management Clinic
34. Centre for Physical Activity Across the Lifespan, Australian Catholic University
35. Australian Federation of Australia Ltd
36. Australian Nut Industry Council and Nuts for Life
37. Bushwalking Australia
38. Children's Nutrition Research Centre, The University of Queensland
39. Mrs Megan Forster, The University of Queensland
- 39.1 Mrs Megan Forster, The University of Queensland (Supplementary)
40. A/Professor Katherine Samaras, St Vincent's Hospital
41. Coalition on Food Advertising to Children
42. Infant Formula Manufacturers Association of Australia Inc
43. Ms Margarita Tsiros, University of South Australia
44. Fitness Australia

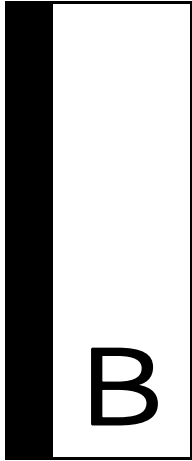
45. Tasmanian Breastfeeding Coalition
46. Centre for Obesity Research and Education, Monash University
47. Young Media Australia
48. Fit2play, The Queen Elizabeth Hospital Research Foundation Inc
49. Australian General Practice Network
50. National Children's and Youth Law Centre
51. Department of Health, Western Australia
52. Name Withheld
53. South Australian Government
54. Australian Food and Grocery Council
55. Lifestyle Medicine Pty Ltd
56. Queensland Health
57. Mr Rory Poulter
58. Australian Association for Exercise and Sports Science
59. VicHealth
60. The Centre for Independent Studies
61. The Australian Council for Health, Physical Education and Recreation
62. LOOK (Lifestyle of Our Kids)
63. Australian Hypnotherapists' Association
64. Sports Medicine Australia
65. Mr Nicholas Pucius
66. Professor Wendy Brown, University of Queensland
67. Blueearth Institute
68. Faculty of Education and Social Work, The University of Sydney
69. Recreation, Sports and Aquatics Club
70. Faculty of Health Sciences, The University of Sydney
71. SlimMinds
72. Professor Colin Binns, Curtin University

73. Public Health Information Development Unit, The University of Adelaide
74. Merck Sharp & Dohme (Australia) Pty Ltd
75. Allergan
76. Confectionery Manufacturers of Australasia Ltd
77. Planning Institute Australia
78. National Centre for Epidemiology and Population Health, Australian National University
79. National Seniors Australia
80. Sanofi Aventis
81. Centre for Clinical Research Excellence in Respiratory and Sleep Medicine, The University of Sydney
82. Pharmaceutical Society of Australia
83. Free TV Australia
84. Nutrition Australia
85. Australian Bureau of Statistics
86. Murdoch Children's Research Institute, Royal Children's Hospital
87. Choice
88. McDonald's Restaurants Australia Ltd
89. COTA, Council on the Ageing SA
90. Diabetes Australia NSW
91. Dietitians Association of Australia
92. Diabetes Australia
93. TeleMedCare
94. Obesity Policy Coalition
95. WHO Collaborating Centre for Obesity Prevention, Deakin University
96. Australian Unity
97. Australian Beverages Council
98. Associate Professor Jeff Walkley, RMIT University

99. Mr Geoff Russell
100. Australian Council for Health, Physical Education and Recreation,
Victorian Branch
101. Public Health Association of Australia
102. Healthy Changes
103. Australian Nursing Federation
104. Name Withheld
105. SP Health Co
106. Heart Foundation
107. Ms Pauline Hancock
108. Tasmanian Government
109. Cancer Council Australia
110. Mr David Brigden
111. Australian Little Athletics
112. Mrs Christianne Goss
113. CSIRO Human Nutrition
114. Dr Trevor Beard, University of Tasmania
115. Australian Sports Commission
116. Mr Michael Mathai, Victoria University
117. Mr Paul Jones
118. Association of Health Professions, New South Wales
119. Woolworths Ltd
120. Australian Healthcare and Hospitals Association
121. National Association of Retail Grocers of Australia
122. Australian Medical Association
123. Australian Division of World Action on Salt and Health
124. Johnson and Johnson Medical Pty Ltd
125. Department of Nutrition and Dietetics, Flinders University
126. Ms Tracey Browning

127. Dr Rachel Bidgood
128. Hunter New England Population Health
129. YMCA Australia
130. City Fitness Health Club
131. Australasian Child and Adolescent Obesity Research Network
132. Telethon Institute for Child Health Research
133. Covidien
134. NSW Government
135. Walgett Aboriginal Medical Service
136. Name Withheld
137. KCI Medical Australia Pty Ltd
138. Weight Watchers Australasia
139. Australian Lifestyle Medicine Association
140. Tai Chi Productions
141. Mr Chris Gillham
142. Linda and Brian
143. Mr Dean O'Rourke
144. Victorian Government
145. The Hon Dick Adams MP
146. Ms Lynn Barratt
147. SmartShape
148. Mr Paul Gross, Health Group Strategies Pty Ltd
149. Mr David Gillespie
150. Miss Jessica Tidemann
151. City of Fremantle
152. Slow Food Perth
153. Growing Communities WA
154. Department of Health and Ageing
155. Mr Arthur Henderson

156. Hon Dr Bob Such MP
157. Dr Stanley Robinson
158. The Freemasons Foundation Centre for Men's Health, The University of Adelaide



Appendix B - Exhibits

- 1 Stephanie Alexander Kitchen Garden Foundation
'Go for your life' Kitchen Garden Project with Stephanie Alexander Year 1 (2007)
(Related to Submission No. 1)

- 2 Research Australia
Health and Medical Research Public Opinion Poll 2007
(Related to Submission No. 3)

- 3 Research Australia
Health Planet, Places and People, Booklet
(Related to Submission No. 3)

- 4 Ms Susanna Scurry
State of Food and Nutrition in NSW Series: Report on breastfeeding in NSW 2004
(Related to Submission No. 4)

- 5 LOOK Lifestyle of Our Kids Project
Presentation notes from Professor Telford

- 6 LOOK Lifestyle of Our Kids Project
Summary of the LOOK study
- 7 LOOK Lifestyle of Our Kids Project
Front cover of article in press, " The lifestyle of our kids (LOOK) project: Outline of Methods"
- 8 LOOK Lifestyle of Our Kids Project
Bluearth, "The Bluearth Approach"
- 9 Foundation for Advertising Research
Report: Advertising's Role in Diet and Exercise in Australia and New Zealand: Developing a Research Agenda, 2006

(Related to Submission No. 16)
- 10 Australian Psychological Society Ltd
Health education or weight management in schools?

(Related to Submission No. 17)
- 11 Australian Psychological Society Ltd
Obesity and Public Policy: Thinking Clearly and Treading Carefully, by Dr Michael Ward, July 2007

(Related to Submission No. 17)
- 12 Mr Daryl Sadgrove
An Epidemic of Obesity Myths

(Related to Submission No. 26)
- 13 Australian Nut Industry Council

The Role of Nuts in Heart Health, The Role of Nuts in Weight Management, leaflets

(Related to Submission No. 36)

14 Associate Professor Katherine Samaras

Increasing incidence of type 2 diabetes in the 3rd Millennium, article, Diabetes Care Vol 23, April 2000

(Related to Submission No. 40)

15 Associate Professor Katherine Samaras

WHO Report on Marketing Food to Children, 2004

(Related to Submission No. 40)

16 Associate Professor Katherine Samaras

Effects of Bariatric Surgery on Mortality in Swedish Obese Subjects, Article, New England Journal of Medicine, August 2007

(Related to Submission No. 40)

17 Associate Professor Katherine Samaras

Lifestyle, Diabetes and Cardiovascular Risk Factors 10 years after Bariatric Surgery, Article, New England Journal of Medicine, December 2004

(Related to Submission No. 40)

18 Fitness Australia

Fitness Australia: 2008 Pre-Budget Submission

(Related to Submission No. 44)

19 Horticulture Australia Limited

Go for 2 & 5: increasing fruit and vegetable consumption, leaflet

(Related to Submission No. 31)

- 20 Young Media Australia
Healthy Viewing for Healthy Eating - Parent Information Session
(Related to Submission No. 47)
- 21 Young Media Australia
Healthy Viewing Healthy Eating - Resource Package Evaluation
(Related to Submission No. 47)
- 22 Young Media Australia
Fact Sheet - Fighting Childhood Obesity
(Related to Submission No. 47)
- 23 Young Media Australia
*Television Food Advertising - parent survey analysis full report
September 2006*
(Related to Submission No. 47)
- 24 Young Media Australia
*DVD - Healthy Viewing for Healthy Eating - a resource for parents of
children under 7*
(Related to Submission No. 47)
- 25 The Queen Elizabeth Hospital Research Foundation Inc.
Fit2Play Program Evaluation SA
(Related to Submission No. 48)
- 26 The Queen Elizabeth Hospital Research Foundation Inc.
Fit2play Diary SA
(Related to Submission No. 48)

- 27 The Queen Elizabeth Hospital Research Foundation Inc.
Fit2play DVD, "Segments about Fit2play on Channel 9's Feeling Good 12 January - 1 March 2008."
(Related to Submission No. 48)
- 28 The Queen Elizabeth Hospital Research Foundation Inc.
Fit2play Overview
(Related to Submission No. 48)
- 29 The Queen Elizabeth Hospital Research Foundation Inc.
Speaking notes from Ms Flint at public hearing on 13 June 2008
(Related to Submission No. 48)
- 30 Flinders University
"Obesity Prevention: the role of policies, laws and regulations" in Australian and New Zealand Health Policy 2008, 5:12, Boyd A Swinburn
- 31 Flinders University
"Recommendations for an International Code on Marketing of Foods and Non-Alcoholic Beverages to Children, " Consumers International and International Obesity Taskforce
- 32 Flinders University
"Parental Awareness and Attitudes about Food Advertising to Children on Australia Television", Belinda Morley et al
- 33 Flinders University
"Children's health or corporate wealth: The case for banning television food advertising to children," A briefing paper by the Coalition on Food Advertising to Children, January 2007

- 34 Flinders University
Foresight report, "Tackling Obesities: Future choices", UK Government Office of Science (2007)
- 35 Public Health Association of Australia
"Overweight and obesity prevention framework – a health promotion approach," Professor Peter Howat, Centre for Behavioural Research in Cancer Control, Faculty of Health Sciences, Curtin University and Public Health Association of Australia (WA Branch)
- 36 Blueearth Institute
Physical Activity, Health and Quality of Life: A review of recent literature

(Related to Submission No. 67)
- 37 Mr Geoff Russell
Long Term Effects of a High Protein Weight Loss Diet, Extract from the American Journal of Clinical Nutrition, P.Clifton et al, 2008

(Related to Submission No. 99)
- 38 Mr David Brigden
The Unstoppable Australian Obesity and Diabetes Juggernaut. What should Politicians do? Editorial MJA, vol 185, no. 4, 21 August 2006

(Related to Submission No. 110)
- 39 Mr David Brigden
Diabetes-bad luck or wrong food? Article Salt Skip News No 142 August 2006

(Related to Submission No. 110)
- 40 Mr David Brigden

*Traffic Light Food Labels in Depth. Article Salt Skip News, No 143
October 2006*

(Related to Submission No. 110)

41 Mr David Brigden

*Traffic Light Food Labels. Web page supporting the letter on Traffic
Light Food Labels in Medical Journal of Australia 1 January 2007.*

(Related to Submission No. 110)

42 Mr David Brigden

*Front of Pack Traffic Light Signpost Labelling Technical Guidance, Food
Standards Agency, Issue 2, November 2007.*

(Related to Submission No. 110)

43 Confidential

44 Flinders University

*"Maintenance of relative weight loss 12, 18 and 24 months post
intervention: outcomes of PEACH RCT, a family-focused weight
management program for 5-9 year olds*

(Related to Submission No. 125)

45 Flinders University

*CASE STUDY: family focused weight management program for five-
nine year olds incorporating parenting skills training with healthy
lifestyle information to support behaviour modification, Nutrition &
Dietetics 2007; 64: 144-150, R. Golley et al.*

(Related to Submission No. 125)

46 Flinders University

"Twelve-month effectiveness of a parent-lead, family-focussed weight management program for prepubertal children: a randomised controlled trial, Pediatrics 2007; 119: 517-525

(Related to Submission No. 125)

47 Flinders University

"Nonsurgical Management of Obesity in Adults", The New England Journal of Medicine, R. Eckel M.D., May 1, 2008

(Related to Submission No. 125)

48 Walgett Aboriginal Medical Service Co-Operative Ltd.

Walgett Aboriginal Medical Service - Profile of Services, Program and Staff

(Related to Submission No. 135)

49 Walgett Aboriginal Medical Service Co-Operative Ltd.

Walgett Aboriginal Medical Service, Eat Well Live Well Cookbook

(Related to Submission No. 135)

50 Ms Noeline Rudland

Advertising material about bariatric surgery at the Sydney Institute for Obesity Surgery

(Related to Submission No. 136)

51 McDonald's Restaurants Australia Ltd

McDonald's Australia Corporate Social Responsibility Report 2007

(Related to Submission No. 88)

52 Institute of Obesity, Nutrition and Exercise

Material from the NSW Centre for Overweight and Obesity (COO)

(Related to Submission No. 6)

-
- 53 Hunter New England Health Service
Good for kids good for life brochure
(Related to Submission No. 128)
- 54 Hunter New England Health Service
Staff attendance figures for a bariatric surgery level 6 patient
(Related to Submission No. 128)
- 55 National Heart Foundation of Australia
Heart Foundation material
(Related to Submission No. 106)
- 56 Weight Watchers Australasia
Weight Watchers Pamphlets
(Related to Submission No. 138)
- 57 Weight Watchers Australasia
Weight Watchers book, K. Kovach, "Healthy parent Healthy child".
(Related to Submission No. 138)
- 58 The University of Newcastle
University of Newcastle, "Healthy Dads Healthy Kids" program leaflet
- 59 Ms Kate Paul
*Media release, "Obesity highest in children from lower income areas,"
forwarded by Ms Kate Paul, witness at Lake Macquarie Hearing*
- 60 Mr Dean O'Rourke B.Ed H & PE (Hons)

Email from parents and staff at Hunter Christian School to Dean O'Rourke, PE Teacher

(Related to Submission No. 143)

61 Victorian Government

COAG's National Reform Agenda: Victoria's plan to address the growing impact of obesity and type 2 diabetes, April 2007

(Related to Submission No. 144)

62 Victorian Government

'Go for your life', Victoria leading the way to a healthy and active community, Strategic Plan 2006-2010

(Related to Submission No. 144)

63 Victorian Government

Victorian Department of Human Services, "Future prevalence of overweight and obesity in Australian children and adolescents, 2005-2025."

(Related to Submission No. 144)

64 The Hon Dick Adams MP

The Advocate, 'We need to ask why is a teen 300kg', 9 August 2008

(Related to Submission No. 145)

65 The Hon Dick Adams MP

The Advocate, 'On the band wagon', 9 August 2008

(Related to Submission No. 145)

66 Centre for Burden of Disease and Cost-effectiveness, University of Queensland

The Burden of Disease and Injury in Australia 2003, by S Begg et al

- 67 Centre for Burden of Disease and Cost-effectiveness, University of Queensland
The Burden of Disease and Injury in Aboriginal and Torres Strait Islander Peoples 2003, by T Vos et al
- 68 Foundation for Advertising Research
Food for Thought: The impact of advertising bans, Frontier Economics Paper, Jan 2008
- 69 Centre for Burden of Disease and Cost-effectiveness, University of Queensland
An Alternative Approach to Projecting Health Expenditure in Australia, Article, by S Begg et al, Australian Health Review Feb 2008
- 70 Greenslopes Private Hospital
Greenslopes Wellness Program materials
- 71 School of Rural Health, University of Sydney
Health Promotion for Young Adult Males in a Rural Environment - the mobile phone as a potential tool, Report by K Mendis, R McLean and J Canalese
- 72 NSW Department of Health
Material provided by the Heart Foundation further to the hearing in Lake Macquarie on 12 September 2008
- 73 University of Sydney, Faculty of Education and Social Work
Everybody's Different: A positive approach to teaching about health, puberty, body image, nutrition, self-esteem and obesity prevention, by J O'Dea, ACER Press, 2007

- 74 National Seniors Australia
A pilot program of physical activity promotion among older clients receiving home & community care, by M Cameron et al, Australian Health Review, 2008
- 75 Australian Psychological Society Ltd
“Psychological interventions for overweight or obesity (Review),” in The Cochrane Collaboration, By Shaw K et al (2008)
- 76 Australian Psychological Society Ltd
“Australian Psychological Society Triage Model of Care.”
(Related to Submission No. 17)
- 77 Australian Food and Grocery Council
The Daily Intake: Informing Consumer Choice (Australian Food and Grocery Council).
(Related to Submission No. 54)
- 78 Australian Food and Grocery Council
Main findings of the Australian Children’s Nutrition and Physical Activity Survey (2008).
(Related to Submission No. 54)
- 79 Australian Food and Grocery Council
“The responsible marketing to children initiative of the Australian Food and Beverage Industry” (October 2008).
(Related to Submission No. 54)
- 80 Melbourne City Council
Active Melbourne Strategy and miscellaneous papers.

- 81 Department of Health, WA
Slides: Deaths, indigenous versus non-indigenous; Renal Disease incidence in indigenous population; proportion of indigenous people in WA; WA Aboriginal communities by ABS remoteness; and map of WA Country Health Service
- 82 Confidential
- 83 Confidential
- 84 Department of Health, WA
The Burden of Disease and Injury in Aboriginal and Torres Strait Islander Peoples, Report, 200, T Vos et al..
- 85 Dr C Jeffries-Stokes, Rural Clinical School, University of Western Australia & Notre Dame
A Report of the Intervention Phase of the Northern Goldfields Kidney Health Project, July 2007, and photo of Disneyland fruit stands
- 86 Heart Foundation
Healthy by Design: a Planners' Guide to Environments for Active Living, Publication 2004
- 87 Ms Frances Reid
Obesity and Overweight in Indigenous Australia, Paper, prepared by F Reid an intern with ANU internships program, November 2008.
- 88 Public Health Association of Australia
Overweight and Obesity Prevention Framework: a Health Promotion Approach, Paper, prepared for the PHAA (WA Branch)
- 89 Mr David Gillespie

Sweet Poison: Why Sugar Makes us Fat, by David Gillespie 2008

(Related to Submission No. 149)

90 Mr David Gillespie

Articles from the American Society for Nutrition on Fructose, 2007

(Related to Submission No. 149)

91 Professor Greg Gass

Step Forward Program Data and Overview

92 Gold Coast City Council

Papers on the Gold Coast City Council Physical Activity Strategy and Programs

93 Delfin Land Lease

Delfin Land Lease, Active Infrastructure paper (Dec 2008), and miscellaneous papers on Varsity Lakes

94 Maari Ma Health Aboriginal Corporation

Folder of material from Maari Ma Aboriginal Health Corporation

95 University of Sydney, Broken Hill Department of Rural Health

Australian Department of Health, "A healthy lifestyle resource based on experiences from the Wellington Challenge."

96 Frontier Economics

The impacts of advertising bans on obesity in Australia, December 2008

97 KCI Medical

Presentation notes from public hearing on 11 September 2008



Appendix C – Public Hearings, Inspections and Private Briefings

Public Hearings

Monday, 12 May 2008 - Canberra

Australian Healthcare and Hospitals Association

Ms Cydde Miller, Policy and Projects Officer

Associate Professor Katherine Samaras

Australian Institute of Health and Welfare

Mr Mark Cooper-Stanbury, Head, Population Health Unit

Dr Paul Magnus, Medical Adviser

Mrs Kathryn Roediger, Deputy Director

Diabetes Australia

Dr Gary Deed, President

Mr Matthew O'Brien, Chief Executive Officer

Dr Ian White, National Policy Manager

LOOK Lifestyle of Our Kids Project

Mr Malcolm Freake, Research Facilitator

Dr Tony Lafferty, Investigator

Professor Richard Telford, Director of Research

Royal North Shore Hospital

Miss Vanessa Brenninger, Senior Clinical Dietician

Friday, 13 June 2008 - Adelaide

Private capacity

Associate Professor Elizabeth Handsley

Commonwealth Science and Industrial Research Organisation

Professor Peter Clifton, Obesity Theme Leader, Preventative Health
Flagship

Associate Professor Manny Noakes, Stream Leader, Diet and Lifestyle
Programs

**Discipline of Public Health, School of Population Health and Clinical Practice,
University of Adelaide**

Professor Christian Gericke, Professor of Public Health Policy

Miss Allison Larg, PhD Student

Associate Professor John Moss, Head

Department of Nutrition and Dietetics, Flinders University

Professor Lynne Cobiac, Head of Department,

Dr Anthea Magarey, Senior Research Fellow

Ms Kaye Mehta, Senior Lecturer

South Australian Divisions of General Practice Inc

Mr Chris Seiboth, Chief Executive

Southern Division of General Practice

Dr Helena Williams, Chief Executive Officer

**The Queen Elizabeth Hospital Research Foundation and University of South
Australia**

Dr Murray Drummond, Senior Lecturer

The Queen Elizabeth Hospital Foundation and Gawler Health Service

Ms Elizabeth Flint

The Queen Elizabeth Hospital Research Foundation Inc.

Mr Maurice Henderson, Executive Director

Friday, 20 June 2008 - Melbourne

Australian Unity

Ms Cate Grindlay, Program Manager

Baker Heart Research Institute

Professor Simon Stewart, Professor and Head, Preventative Cardiology

Centre for Obesity Research and Education, Monash University

Dr Wendy Brown, Head, Clinical Research

Dr Anna Peeters, Head, Public Health Unit

Obesity Policy Coalition

Ms Sarah Mackay, Legal Policy Adviser

Ms Jane Martin, Senior Policy Adviser

**World Health Organisation Collaborating Centre for Obesity Prevention,
Deakin University**

Professor Boyd Swinburn, Director and Professor of Population Health

Monday, 18 August 2008 - Mackay

Private capacity

Dr Rachel Bidgood

Ms Tracey Browning

City Fitness Health Club

Mr Steven Eden, Owner

Mrs Linda Nugent, Activity Development Coordinator

Mackay Regional Council

Mrs Kathleen Gooch, Locality Development Officer

Wednesday, 10 September 2008 - Dubbo

National Rural Health Alliance Inc

Professor Bruce Harris, Program Coordinator and Counsellor, School of Rural Health

Mrs Sophie Heathcote, Board Member

Ms Louise Lawler, Affiliate Member

Mr Andrew Phillips, Policy Advisor

School of Rural Health, University of Sydney

Dr Kumara Mendis, Senior Lecturer

St Pius X Primary School

Mr Greg Cant, Acting Principal

Mrs Myra Gabb, Teacher

Walgett Aboriginal Medical Service Co-Operative Ltd.

Mrs Christine Corby, Chief Executive Officer

Ms Skye Duncan, Health Service Coordinator

Mr Peter Fernando, Deputy Chief Executive Officer

Ms Kylie Gilmore, Program Practice Manager

Thursday, 11 September 2008 - Sydney

Private capacity

Mr Michael Agostini

Ms Noeline Rudland

The Children's Hospital at Westmead

Professor Louise Baur, Director, Weight Management Services and Chair,
Board of Directors, NSW Centre for Overweight and Obesity

Faculty of Education and Social Work, University of Sydney

Associate Professor Jennifer O'Dea, Associate Professor of Health
Education and Nutrition Education

Institute of Obesity, Nutrition and Exercise

Ms Lesley King, Executive Officer, Prevention Research Division

KCI Medical Australia Pty Ltd.

Ms Cathy-Lyn Burnard, Reimbursement Business Development and
Government Relations Manager

Mr Peter Hickey, Managing Director

McDonalds Australia

Mr Peter Bush, Managing Director and Chief Executive Officer

Ms Kristene Mullen, Director of Corporate Communication

Mrs Catriona Noble, Chief Operating Officer

Weight Watchers Australasia

Ms Clair Cameron, Public Relations Manager Australasia

Mrs Marie Elliott, Leader

Ms Ann Mennen, Member and 2008 Slimmer of the Year

Mr Joseph Saad, Managing Director

Ms Emma Stirling, Dietitian and Nutrition Advisor

Woolworths Ltd

Mr Andrew Hall, Director, Corporate and Public Affairs

Ms Nathalie Samia, Group Manager, Government Relations

Friday, 12 September 2008 - Lake Macquarie

Private capacity

Associate Professor Clare Collins

Associate Professor Philip Morgan

Australian Lifestyle Medicine Association Inc

Dr Garry Egger, Committee Members

Mr Troy Grogan, Chief Executive Officer

Dietitians Association of Australia

Ms Karyn Matterson, Accredited Practising Dietitian Representative

Mrs Kate Paul, Practice and Professional Development Dietitian

Hunter New England Population Health

Dr Colin Bell, Program Director, Good for Kids, Good for Life

Ms Amanda Gore, Nurse Educator, John Hunter Hospital Operating Suite

Ms Jocelyn Grant, Project Officer, Aboriginal Fitness Leaders Project

Ms Helen Jackson, Area Profession Director, Nutrition and Dietetics

Mr Eddie Wood, Manual Handling Coordinator

National Heart Foundation of Australia

Dr Amanda Nagle, Heartmoves Program Manager, NSW Division

NSW Sport and Recreation

Mr Brendan Callander, Development Officer

Wednesday, 1 October 2008 - Brisbane

Australian Association of National Advertisers

Mr Collin Segelov, Executive Director

Australian and New Zealand Obesity Society

Associate Professor Nuala Byrne, Treasurer

Foundation for Advertising Research

Professor Glen Wiggs, Director

National Seniors Australia

Ms Anna Perfect, Senior Policy Officer

Queensland Health

Dr Linda Selvey, Senior Director, Population Health Queensland

The Queen Elizabeth Hospital Research Foundation

Mr Michael Georgalli, Director Fit2play Program

School of Population Health, University of Queensland

Mrs Megan Forster, Research Fellow

Professor Theo Vos, Director, Centre for Burden of Disease and Cost-Effectiveness

Friday, 24 October 2008 - Melbourne

Australian Food and Grocery Council

Ms Anne Carnell, AO, Chief Executive Officer

Australian Psychological Society Ltd

Dr Helen Lindner, Manager Strategic Projects and Liaison

Professor Lyn Littlefield, Executive Director

Be Well Australia Pty Ltd

Mr Gordon Fyfe, Director

Heart Foundation

Ms Susan Anderson, National Director Healthy Weight

Ms Kellie-Ann Jolly, Director, Cardiovascular Health Programs

Municipal Associations of Victoria

Ms Kaye Owen, Director, Research and Policy

Nutrition Australia

Miss Lucinda Dobson, Executive Officer, Victorian Division

Ms Jodi Phillips, Chief Executive Officer

Planning Institute of Australia

Ms Stephanie Knox, Consultant

Mrs Karen Wright

SmartShape Centre for Weight Management

Mr Matthew O'Neill, Director and Nutritionist

Young Men's Christian Association Australia

Mr Nicholas Cox, Development Manager

Mr Robert Nicholson, Chief Executive Officer

Thursday, 6 November 2008 - Perth**Cancer Council Western Australia**

Mr Iain Pratt, Manager, Cancer Smart

Mr Terry Slevin, Director, Education and Research

Public Health Association of Australia

Professor Peter Howat, President Western Australian Branch

Rural Clinical School, University of Western Australia and University of Notre Dame

Dr Christine Jeffries-Stokes, Medical Coordinator and Chief Investigator,
Western Desert Kidney Health Project

Slow Food Perth

Mr Jamie Kronborg, Co - leader

Telethon Institute for Child Health Research

Dr David Lawrence, Senior Statistician

Mr Francis Mitrou, Senior Analyst

Western Australian Department of Health

Mr Mark Crake, Acting Director, Child and Adolescent Community Health Policy (statewide)

Mrs Kathryn Gatti, Area Director, Population Health, Western Australia Country Health Service

Ms Susan Leivers, Manager, Population Health Policy Branch, Public Health Division

Professor Kenneth Wyatt, Director, Office of Aboriginal Health

Monday, 8 December 2008 - Gold Coast

Private capacity

Mrs Shirley Entsch

Mr David Gillespie

Bond University

Professor Greg Gass

Delfin Lend Lease

Mr Michael Chapman, National Design Manager

Mr Dean Patterson, Manager, Sport and Recreation

Gold Coast City Council

Ms Samantha Hughes, Senior Active Parks Officer

Mr Richard Pascoe, Executive Coordinator, Recreation, Planning and Services

Health Group Strategies Pty. Limited and Institute of Health Economics and Technology Assessment

Dr Paul Gross, Director

Tuesday, 9 December 2008 - Broken Hill

Broken Hill Centre for Remote Health Research

Ms Frances Boreland, Research Officer (PHC RED Program)

Associate Professor David Perkins, Director, Research Centre, Broken Hill Centre for Remote Health Research

Maari Ma Health Aboriginal Corporation

Mr Richard Weston, Regional Director

Wednesday, 4 February 2009 - Canberra

Department of Health and Ageing

Ms Jennifer Bryant, First Assistant Secretary, Population Health Division

Mr Peter Morris, Assistant Secretary, Population Health Strategy Unit

Ms Catherine Peachey, Acting Assistant Secretary, Healthy Living Branch

Mr Colin Sindall, Senior Adviser, Population Health Strategy Unit

Inspections

Friday, 13 June 2008

Premier's Be Active Challenge

Adelaide High School, Adelaide, South Australia

Friday, 20 June 2008

Stephanie Alexander Kitchen Garden Program

Westgarth Primary School, Melbourne, Victoria

Monday, 18 August 2008

Mater Misericordiae Hospital, Mackay, Queensland

Wednesday, 10 September 2008

Betty Orth Memorial Diabetes Unit

Dubbo Base Hospital, Dubbo, New South Wales

Snak Shak School Canteen

Delroy Campus, Dubbo College, Dubbo, New South Wales

Friday, 12 September 2008

Active After-school Communities Program

Marks Point Public School, Lake Macquarie, New South Wales

Wednesday, 1 October 2008

Greenslopes Private Hospital, Brisbane, Queensland

Friday, 24 October 2008

Basketball Clinic

St John the Evangelist Primary School, Melbourne, Victoria

Tuesday, 28 October 2008

Professor Samaras' Clinic

St Vincent's Clinic, St Vincent's Hospital, Sydney, New South Wales

Weight Management Services

Children's Hospital at Westmead, Sydney, New South Wales

Thursday, 6 November 2008

West Leederville Kitchen Garden

West Leederville Primary School, Perth, Western Australia

West Leederville Community Gardens

West Leederville, Perth, Western Australia

Monday, 8 December 2008

Active and Healthy Tai Chi Class

Justin Park, Gold Coast, Queensland

Varsity Lakes suburb

Gold Coast, Queensland

Tuesday, 9 December 2008

Royal Flying Doctor Service

Broken Hill Airport, Broken Hill, New South Wales

Wilcannia community facilities and meetings with community leaders

Wilcannia, New South Wales

Private Briefings

Wednesday, 19 March 2008

Department of Health and Ageing

Ms Jennifer Bryant, First Assistant Secretary, Population Health Division

Mr Peter Morris, Assistant Secretary, Population Health Strategy Unit

Mr Colin Sindall, Senior Adviser, Population Health Strategy Unit

Wednesday, 25 June 2008

Australian Sports Commission

Mr Brenton Espeland, Director, Sport Performance and Development

Mrs Judy Flanagan, Director, Community Sport

Wednesday, 17 September 2008

Stephanie Alexander Kitchen Garden Foundation

Ms Stephanie Alexander, Director

Ms Ange Barry, Chief Executive Officer

Wednesday, 24 September 2008

The Hon D Adams MP

Wednesday, 12 November 2008

National Preventative Health Taskforce

Dr Lyn Roberts, Member

Wednesday, 26 November 2008

Access Economics

Ms Margaret Pezzullo, Director

Wednesday, 3 December 2008

Commonwealth Science and Industrial Research Organisation

Dr Joanne Daly, Group Executive, CSIRO Agribusiness

Dr Richard Head, Flagship Director, Preventative Health Flagship



Appendix D – Food Matters: UK Government review of food and food policy

Register of Action Leads¹

Food Matters: Register of Action Leads

TAKING FORWARD FOOD MATTERS – REGISTER OF ACTION LEADS

Action Number	Issue	Lead	Contact
3.1	<i>Strategic policy objectives for food</i>	All Departments	n/a
3.2	<i>A vision and strategy for food</i>	Defra leading a partnership of Defra, Department of Health and FSA	Elen Watkin, Defra Elen.Watkin@defra.gsi.gov.uk
4.1	<i>Making it easier for consumers to access information on a healthy, low impact diet</i>	Food Standards Agency, with input from the Food Strategy Task Force	Liz Niman, FSA Liz.Niman@foodstandards.gsi.gov.uk
4.2	<i>Making it easier for consumers to make healthy choices when eating out</i>	Food Standards Agency	Corinne Vaughan, FSA Corinne.Vaughan@foodstandards.gsi.gov.uk
4.3	<i>Align marketing and communications campaigns about food</i>	Food Strategy Task Force	n/a
5.1	<i>Effective competition throughout the grocery supply chain</i>	BERR	Government response to Competition Commission report was issued on 29 th July 2008 and is available at http://www.berr.gov.uk/files/file47089.pdf
5.2	<i>Whole food-chain approach to food safety risks</i>	FSA	Ceri Cooper, FSA Ceri.Cooper@foodstandards.gsi.gov.uk
5.3	<i>Animal feed and regulation of GM products</i>	Defra, Food Standards Agency	Renaud Wilson, Defra Renaud.Wilson@defra.gsi.gov.uk Clair Baynton, FSA Clair.Baynton@foodstandards.gsi.gov.uk (food) Keith Millar, FSA Keith.Millar@foodstandards.gsi.gov.uk (feed)

¹ UK Government, Food Matters, http://www.cabinetoffice.gov.uk/strategy/work_areas/food_policy.aspx accessed 17 April 2009.

Food Matters: Register of Action Leads

Action Number	Issue	Lead	Contact
5.4	<i>Taking forward 5-A-DAY in England</i>	Department of Health, FSA	Geoff Dessent, Department of Health Geoff.Dessent@dh.gsi.gov.uk
5.5	<i>The future of food production in a low carbon world</i>	Foresight (Government Office for Science, DIUS), Defra, DfID	Government Office for Science Jane.Mardell@dius.gsi.gov.uk
5.6	<i>A smarter system for calculating greenhouse gas emissions from agriculture to help farmers to adopt the best methods for reducing emissions</i>	Defra	Victoria Turner, Defra Victoria.Turner@defra.gsi.gov.uk
5.7	<i>Recognition of the challenges and opportunities that climate change presents for farming across Europe</i>	Defra	Victoria Turner, Defra Victoria.Turner@defra.gsi.gov.uk
5.8	<i>A new food packaging strategy for England</i>	Defra, BERR	Judicaelle Hammond, Defra Judicaelle.Hammond@defra.gsi.gov.uk
5.9	<i>Reduction of food waste</i>	WRAP, Defra, FSA	Mark Barthel, WRAP Mark.Barthel@wrap.org.uk Andrew Parry, WRAP Andrew.Parry@wrap.org.uk
6.1	<i>Raising the nutritional standards of food served in the public sector in England</i>	Department of Health, FSA	Geoff Dessent, Department of Health Geoff.Dessent@dh.gsi.gov.uk
7.1	<i>A Food Strategy Task Force</i>	Cabinet Office	n/a
7.2	<i>Public Service Agreement for Food</i>	Food Strategy Task Force, Cabinet Office	n/a
7.3	<i>A Joint Research Strategy for Food</i>	Defra lead with DIUS, DH, FSA, DfID with OGDs, DAs, Research Councils	To be confirmed

Action Number	Issue	Lead	Contact
7.4	<i>Reporting progress</i>	Food Strategy Task Force	n/a
7.5	<i>Clarifying the DH/FSA interface on healthy eating</i>	Department of Health, Food Standards Agency	Letter to stakeholders issued was issued 15 July 2008 and is available at http://www.food.gov.uk/multimedia/pdfs/dhfcgp.pdf