Chapter 1
Introduction

Referral of inquiry and terms of reference

1.1 The Select Committee into the Obesity Epidemic in Australia was established on 16 May 2018. The committee is composed of seven Senators.

1.2 The committee is tasked with inquiring into and reporting on the following terms of reference:

a. The prevalence of overweight and obesity among children in Australia and changes in these rates over time;
b. The causes of the rise in overweight and obesity in Australia;
c. The short and long-term harm to health associated with obesity, particularly in children in Australia;
d. The short and long-term economic burden of obesity, particularly related to obesity in children in Australia;
e. The effectiveness of existing policies and programs introduced by Australian governments to improve diets and prevent childhood obesity;
f. Evidence-based measures and interventions to prevent and reverse childhood obesity, including experiences from overseas jurisdictions;
g. The role of the food industry in contributing to poor diets and childhood obesity in Australia; and
h. any other related matters.

1.3 This report is comprised of 10 chapters, as follows:

- This chapter (Chapter 1) provides some background information around the prevalence of obesity, and defines some key terms;
- Chapter 2 discusses the importance of language and the high degree of stigma attached to the term 'obesity';
- Chapter 3 examines strategic policy directions which could help tackling obesity;
- Chapter 4 discusses the issue of food labelling;
- Chapter 5 focuses on the critical role of reformulation to improve the availability of healthier products;
- Chapter 6 examines the benefits of introducing a tax on sugary drinks;
- Chapter 7 focuses on the issues associated with the marketing and advertising of discretionary foods;
- Chapter 8 discusses the importance of education campaigns;
- Chapter 9 looks at the benefits of health care interventions; and

- Chapter 10 discusses promising multi-strategy prevention programs to prevent and address the prevalence of obesity at community level.

Conduct of the inquiry

1.4 The committee received 150 submissions to the inquiry from individuals and organisations. These submissions are listed in Appendix 1.

1.5 The committee also conducted four public hearings:

- 06 August 2018 in Sydney;
- 07 August 2018 in Melbourne;
- 04 September 2018 in Melbourne; and
- 05 September 2018 in Melbourne.

1.6 Transcripts from these hearings, together with submissions and answers to questions on notice are available on the committee's website. Witnesses who appeared at the hearings are listed in Appendix 2.

Acknowledgments

1.7 The committee would like to thank the individuals and organisations that made written submissions to the inquiry, as well as those who gave evidence at the four public hearings. We are grateful for their time and expertise.

Note on terminology and references

1.8 References to submissions in this report are to individual submissions received by the committee and published on the committee's website. References to *Committee Hansard* are to official transcripts.

Definitions

1.9 The committee received evidence from a number of submitters on how to define some of the terms used across the spectrum of issues covered by the committee's terms of reference. Reaching an agreed definition on some of these terms underpins an understanding of the problems faced, and helps focus potential solutions.

1.10 The terms range from the technical definition of particular types of food, to how overweight and obesity themselves are defined, right through to how children are defined in relation to areas such as advertising.

Food

1.11 Discretionary foods were the subject of much discussion in evidence to the inquiry. The Australian Beverages Council describes discretionary foods as:

> …foods and drinks [that] are not necessary for a healthy diet and are high in saturated fat and/or added sugars, added salt or alcohol and low in fibre (22), e.g. alcohol, cakes, biscuits, confectionery, chocolate and some non-alcoholic beverages.[1]

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1 Australian Beverages Council Ltd., *Submission 22,* p. 10.

1.12 The Australian Bureau of Statistics (ABS) similarly cites the Australian Dietary Guidelines' description of these foods as being non-essential, although they may add variety and can still be consumed safely in small quantities depending on one's lifestyle:

> …foods and drinks not necessary to provide the nutrients the body needs, but that may add variety. However, many of these are high in saturated fats, sugars, salt and/or alcohol, and are therefore described as energy dense. They can be included sometimes in small amounts by those who are physically active, but are not a necessary part of the diet.[2]

1.13 While all sugar is processed by the body in the same way, sources of that sugar determine how that sugar is treated in regard to dietary guidelines and food preparation. Free sugars are those naturally present in food substances such as honey and fruit juice, while 'added sugars' are those added during the manufacture of food, and include 'sucrose, fructose, dextrose, lactose and sugar syrups such as glucose syrup'.[3]

Body Mass Index (BMI)

1.14 The ABS describes the BMI as 'a simple index of weight-for-height that is commonly used to classify underweight, normal weight, overweight and obesity. It is calculated from height and weight information, using the formula weight (kg) divided by the square of height (m)'.[4]

1.15 The limitations of BMI as the sole indicator of a healthy weight, particularly in relation to children, were discussed by submitters throughout the inquiry.[5]

Overweight and obesity

1.16 Overweight and obesity are defined as abnormal or excessive fat accumulation that may impair health. For adults, the World Health Organisation

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2 Australian Bureau of Statistics, *4364.0.55.007 - Australian Health Survey: Nutrition First Results - Foods and Nutrients, 2011-12,* available at: http://www.abs.gov.au/ausstats/abs@.nsf/Lookup/by%20Subject/4364.0.55.007~2011-12~Main%20Features~Discretionary%20foods~700, accessed 22 November 2018.

3 Australian Bureau of Statistics, *4364.0.55.011 - Australian Health Survey: Consumption of added sugars, 2011-12,* available at: http://www.abs.gov.au/ausstats/abs@.nsf/Lookup/by%20Subject/4364.0.55.011~2011-12~Main%20Features~Added%20Sugars%20and%20Free%20Sugars~7, accessed 22 November 2018.

4 Australian Bureau of Statistics, 4364.0.55.003 - *Australian Health Survey: Updated Results, 2011-2012,* available at: http://www.abs.gov.au/ausstats/abs@.nsf/Lookup/4364.0.55.003Glossary402011-2012, accessed 22 November 2018.

5 See: Australian Taxpayers' Alliance, *Submission 123*, p. 2; The Grattan Institute, *Submission 50,* p. 8; Monash Centre for Health Research and Implementation, *Submission 16, Supplementary Submission*, p. 9; The Royal Children's Hospital Melbourne, *Submission 17*, Attachment 1; Obesity Policy Coalition, *Submission 135*, p. 25.

defines overweight as a BMI greater than or equal to 25; and obesity as a BMI greater than or equal to 30.[6]

Children

1.17 For the purposes of this inquiry the definition of children is important not only in terms of how to measure and assess a healthy weight, but it is crucial in relation to how particular foods are marketed and advertised.

1.18 A number of perspectives around advertising and marketing aimed at children were explored throughout the inquiry. TV advertising in particular categorises its audience in terms of age, so how children are defined is important in this context. This is further discussed in Chapter 2.

Background information

1.19 In Australia, rates of overweight and obesity have risen dramatically in recent decades in all age groups, with the increase most marked among obese adults.[7]

1.20 Overweight and obesity in adults and children is associated with significant health impacts. Poor diets and high BMI are the major risk factors contributing to Australia's disease burden, ahead of smoking-related illness.[8]

Prevalence of overweight and obesity in Australian adults

1.21 In 2014–15, 63 per cent of Australian adults were overweight or obese. Seventy-one per cent of men were overweight or obese, compared with 56 per cent of women.[9]

1.22 Prevalence of overweight and obesity is higher for adults living outside major cities. Sixty per cent of Australians in major cities are overweight or obese, compared to 69 per cent in inner regional Australia and 70 per cent in outer regional and remote Australia.[10]

1.23 For women, the prevalence of overweight and obesity varies according to socioeconomic group. In 2014–15, about three in five women in the lowest socioeconomic group were overweight or obese, compared with less than half of those in the highest socioeconomic group. However, for men, prevalence of overweight or obesity was similar across socioeconomic groups.[11]

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6 World Health Organization, 'Obesity and overweight', available at: http://www.who.int/news-room/fact-sheets/detail/obesity-and-overweight, accessed 22 November 2018.

7 Obesity Policy Coalition, *Overweight, obesity and chronic diseases in Australia*, January 2018, p. 1.

8 Obesity Policy Coalition, *Overweight, obesity and chronic diseases in Australia*, January 2018, p. 2.

9 Australian Institute of Health and Welfare, *A picture of overweight and obesity in Australia*, 2017, p. vi.

10 Obesity Australia, *Obesity: A national epidemic and its impact on Australia*, 2014, p. 10.

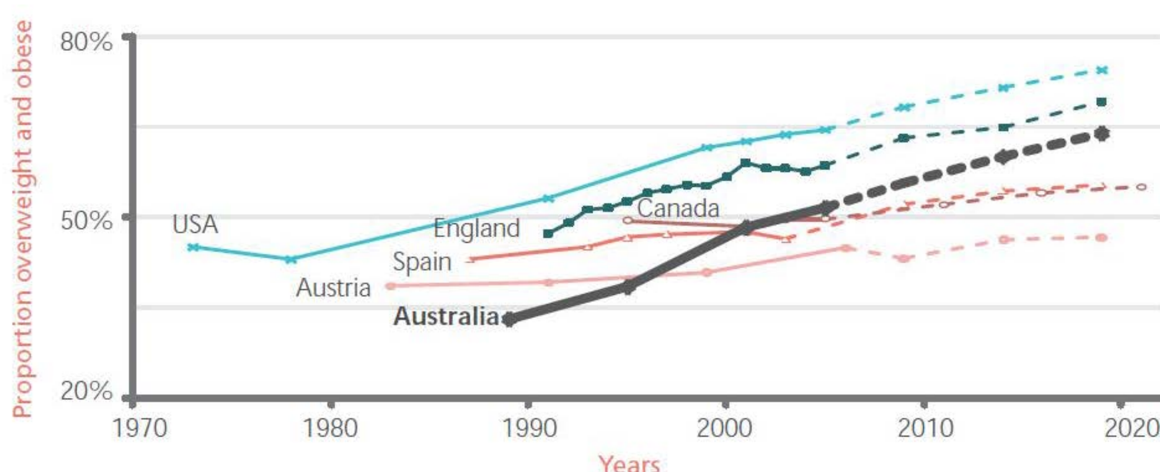
11 Obesity Australia, *Obesity: A national epidemic and its impact on Australia*, 2014, p. 10.

1.24 In 2012–13, after adjusting for differences in age structure, Aboriginal and Torres Strait Islander adults were 1.2 times as likely to be overweight or obese as non-Indigenous adults, and 1.6 times as likely to be obese.[12]

International comparisons

1.25 Among 22 Organisation for Economic Co-operation and Development countries, more than half (57 per cent) of people aged 15 and over are overweight or obese (based on data for 2016 or the closest available year). Of those countries, Australia's obesity rate (28 per cent of the population aged 15 and over) was the 5th highest, behind the United States of America (38 per cent), Mexico (33 per cent), New Zealand (32 per cent), and Hungary (30 per cent), and was higher than the 23 per cent average rate.[13]

Graph 1.1—Proportion of overweight and obese by country



Source: Obesity Australia, *Obesity: A national epidemic and its impact on Australia*, 2014, p. 7.

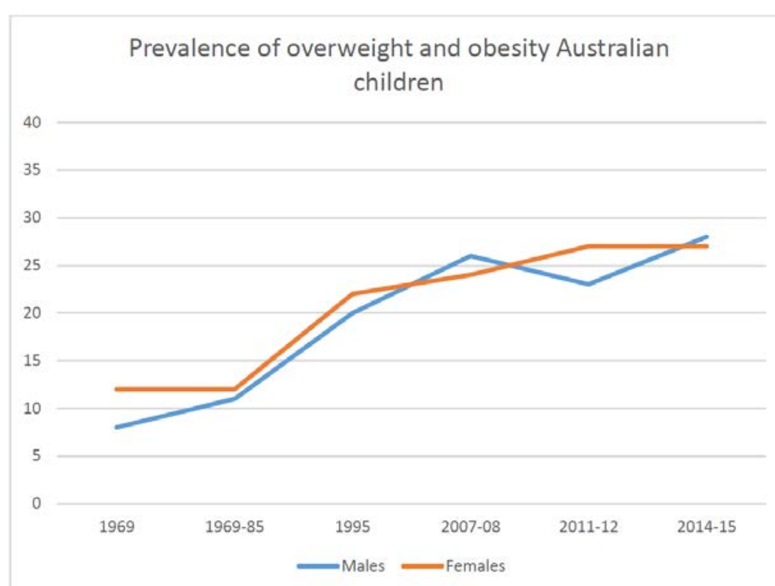
Prevalence of overweight and obesity in children

1.26 Over the past 40 years, the prevalence of overweight and obesity among Australian children increased at an alarming rate (see graph 1.2).

12 Australian Institute of Health and Welfare, *A picture of overweight and obesity in Australia,* 2017, p. vii.

13 Australian Institute of Health and Welfare, *A picture of overweight and obesity in Australia,* 2017, p. 24.

Graph 1.2—Prevalence of overweight and obesity among Australian children from 1969 to 2014-2015



Source: Australian Health Policy Collaboration, *Submission 59,* p. 6.

1.27 There are currently over one million children in Australia who are overweight or obese.[14]

1.28 In 2014–15, 20 per cent of children aged 2–4 were overweight or obese—11 per cent were overweight, and 9 per cent were obese. Twenty-seven per cent of children and adolescents aged 5–17 were overweight or obese—20 per cent were overweight, and 7 per cent were obese. For both children aged 2–4 and 5–17 years, similar proportions of girls and boys were obese.[15]

1.29 Aboriginal and Torres Strait Islander children and adolescents are more likely to be overweight or obese than non-Indigenous children and adolescents. In 2012–13, 30 per cent of Aboriginal And Torres Strait Islander children and adolescents aged 2–14 were overweight or obese, compared with 25 per cent of their non-Indigenous counterparts.[16]

International comparisons

1.30 The prevalence of infant, childhood and adolescent obesity is rising around the world. Although rates may be plateauing in some settings, in absolute numbers

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14 Obesity Policy Coalition, *Submission 135*, p. 6.

15 Australian Institute of Health and Welfare, *A picture of overweight and obesity in Australia,* 2017, p. vi.

16 Australian Institute of Health and Welfare, *A picture of overweight and obesity in Australia,* 2017, p. 14.

there are more children who are overweight and obese in low and middle-income countries than in high-income countries.[17]

Short and long-term harm to health associated with obesity

1.31 The link between obesity and poor health outcomes is well established. Overweight and obesity lead to heightened risk of developing chronic diseases, including cardiovascular disease and type 2 diabetes. In particular, visceral fat, which is stored around the body's vital organs, has been associated with increased risk of heart disease and metabolic disorders.[18] Being overweight or obese also increases risk for at least 13 types of cancer, including breast and colon cancer.[19]

Childhood Obesity

1.32 Overall, children with overweight and obesity are more likely to experience poorer health status and lower emotional functioning.[20]

1.33 Children's and adolescents' short-term health impacts include chronic conditions such as breathing difficulties, fractures, hypertension, insulin resistance and early markers of cardiovascular disease.

1.34 The most significant long-term health impacts of childhood obesity that manifest in adulthood are cardiovascular disease, diabetes, musculoskeletal disorders (osteoarthritis), and certain types of cancer (endometrial, breast and colon).[21]

1.35 Many submitters and witnesses focussed strongly on how childhood obesity can be prevented, given the serious implications all through life that being overweight or obese in childhood brings.

1.36 In purely economic terms, the committee heard that early intervention is the key to preventing higher healthcare costs. Dr Shirley Alexander from The Children's Hospital Westmead told the committee:

> [R]aising the issue to enable early intervention for greater success. Research indicates that healthcare costs for children with obesity, even as young as between two and five years of age, are much higher than those for children of a healthy weight. Interventions using family-centred behavioural change in diet and activity have been shown to be effective. [22]

1.37 In health terms, the picture is similarly bleak:

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17 World Health Organisation, *Ending Childhood Obesity*, 2016, p. vi.

18 Swinburne University of Technology, *Submission 75, Supplementary Submission*, p. 15.

19 Obesity Policy Coalition, *Overweight, obesity and chronic diseases in Australia*, January 2018, p. 2.

20 Australian Health Policy Collaboration, *Submission 59,* p. 8.

21 World Health Organisation, 'Why does childhood overweight and obesity matter?', http://www.who.int/dietphysicalactivity/childhood_consequences/en/, accessed 24 July 2018.

22 Dr Shirley Alexander, Staff Specialist and Head of Weight Management Services, The Children's Hospital, Westmead, *Committee Hansard,* Sydney, 6 August 2018, p. 2.

> Worryingly, the prevalence of severe obesity in the paediatric population has increased significantly, to the point that we [are] now see children as young as eight years old with type 2 diabetes.[23]

1.38 The overall impact of obesity on a person's life course was also discussed by a number of witnesses. Dr Nicole Black from the Centre for Health Economics at Monash University cited research showing the pervasive reach of the obesity:

> There's been quite a lot of research looking at the health consequences of childhood obesity as well as the psychosocial and developmental consequences during childhood. We know that these consequences can affect children over their whole life course. There's evidence suggesting that, for example, obesity in children is likely to lead to more emotional problems and it's likely to lead to more social problems during school. Other research has shown that these problems can lead to problems in academic achievement, it can affect their educational attainment and it can affect their employment prospects later in life. We've also got evidence from studies that look at the social and economic impacts of adolescent obesity. As these adolescents enter adulthood, if they were obese during adolescence they're less likely to be married, for example, and they're less likely to have a high household income than adolescents who were of normal weight.[24]

1.39 The grave concerns are supported by Mrs Belinda Smith from The Root Cause, an organisation that focuses on children making healthier food choices. Mrs Smith outlined the misconceptions around what children will eat, and the consequences of this lack of understanding:

> There's also a frightening lack of understanding amongst many parents and children about the impact these foods are having on health, behaviour, concentration and academic results. Sadly, we are growing a generation of children who are likely to go into adulthood with expensive chronic illness such as fatty liver disease, type 2 diabetes, heart disease and obesity, and neurological disorders like dementia and mental illness.[25]

1.40 Dr Seema Mihrshahi from the Centre of Research Excellence in the Early Prevention of Obesity in Childhood outlined many of the factors that influence whether children will become overweight or obese in their early years:

> So it's not just caused by the imbalance of intake and expenditure; there are a multiple levels of influence. With little children it's also the family level influences: the availability of healthy food; mothers breastfeeding; parents' preferences and modelling; physical activity; and the knowledge, education and skills of the parents. Then there are the community level influences,

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23 Dr Shirley Alexander, Staff Specialist and Head of Weight Management Services, The Children's Hospital, Westmead, *Committee Hansard,* Sydney, 6 August 2018, p. 2.

24 Dr Nicole Black, Senior Research Fellow, Centre for Health Economics, Monash University, *Committee Hansard*, Melbourne, 7 August 2018, p. 45.

25 Mrs Belinda Smith, Founder/Director, The Root Cause, *Committee Hansard*, Sydney, 6 August 2018, p.41.

such as parks and green space around for parents to take their children to, and cycle ways and cycle paths. Then there are the government and societal influences: government policies, marketing of unhealthy foods to children and so forth. So it's those societal influences that have really changed over the last 20 years.[26]

26 Dr Seema Mihrshahi, Research Translation Coordinator and Senior Research Fellow, Centre of Research Excellence in the Early Prevention of Obesity in Childhood, *Committee Hansard*, Sydney, 6 August 2018, p. 5.