Chapter 3

Obesity Strategy

3.1 The causes of obesity are myriad, as are the impacts, and the potential solutions. The committee heard extensive evidence around the importance of bringing all factors in the obesity policy debate under one roof.

National Obesity Strategy

3.2 Australia does not have an overarching strategy to combat obesity. Many of the policy areas required to identify the causes, impacts and potential solutions to the obesity problem span every level of government. There was broad support across the spectrum of evidence received for a whole-of-government strategy to be put in place.

3.3 Submitters highlighted the need for coordination to ensure that policy drivers are in place across social, education, economic and health policy fields. Professor Steve Allender from the Global Obesity Centre at Deakin University proposed a 'comprehensive national obesity strategy with high-impact and sustained public education campaigns around diet, physical activity and sedentary behaviour.'[1] This was a view supported by the Australian Medical Association among others.[2]

3.4 The Charles Perkins Centre at the University of Sydney also emphasised the broad policy reach that is required from a national strategy, and the levers necessary to ensure it is being implemented and evaluated effectively:

> If Australia is to make significant progress on halting and reversing the rise in childhood obesity, there is a need for a much stronger regulatory approach on issues such as the marketing, labelling, content, and pricing of unhealthy foods and beverages. This must take place within a comprehensive policy approach that addresses the social, economic and cultural drivers of unhealthy diets, and is underpinned by a national obesity strategy, accompanied by appropriate federal government infrastructure, monitoring and surveillance of food, nutrition, physical activity, and obesity, and substantial, sustained funding.[3]

3.5 The Queensland Nurses and Midwives' Union concurred and recommended that a strategy be developed involving 'business, communities, schools, childcare and healthcare facilities'.[4]

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1 Professor Steve Allender, Director, Global Obesity Centre, World Health Collaborating Centre for Obesity Prevention, Deakin University, *Committee Hansard*, Melbourne, 7 August 2018, p. 1.

2 Dr Tony Bartone, President, Australian Medical Association, *Committee Hansard*, Melbourne, 4 September 2018, p. 40.

3 Charles Perkins Centre, University of Sydney, *Submission 58*, p. 12.

4 Queensland Nurses and Midwives' Union, *Submission 55*, p. 3.

3.6 Others cited international examples of national strategies to tackle obesity such as those in the United Kingdom (UK), Canada, and New Zealand.[5]

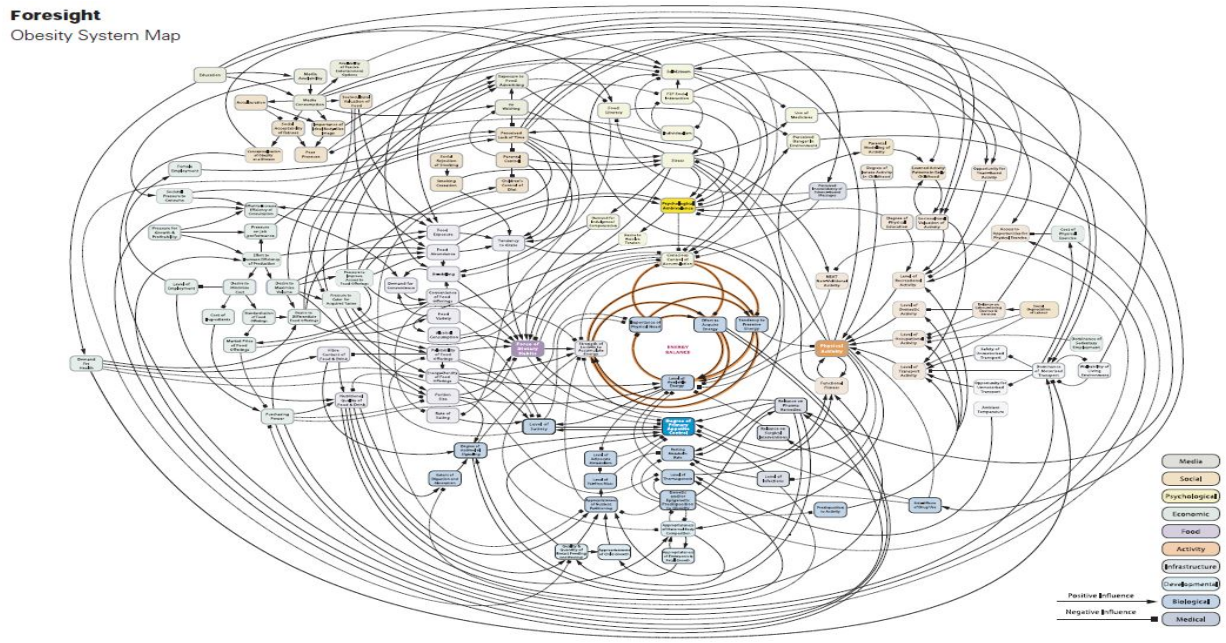
3.7 The Consumers Health Forum of Australia (CHF) stressed that a strategy was needed because education campaigns focussing solely on the role of the individual to arrest or reduce obesity have failed:

> CHF has consistently advocated for a national, whole-of-society obesity strategy. This is because recent reports show that years of public education campaigns have failed to reverse the rise in obesity, showing that it is well past time for individual-oriented prevention to become a priority. Most alarming is the rising rate of childhood obesity, which indicates a future where health levels and life expectancy will decline.[6]

3.8 The committee explored reasons why such a strategy has not been developed to date. The Public Health Association of Australia (PHAA) suggested that the complexity of such a strategy, and the necessity for it to align with other broader public policy goals, such as increased physical activity and healthy nutrition, was a significant barrier.[7]

3.9 Dr Alan Barclay, a practicing dietician, provided the committee with an illustration of the complexity of all the factors that influence obesity:

Figure 3.1—Obesity System Map



5 Council of Presidents of Medical Colleges, *Submission 3*, p. 2; Ms Jennifer Thompson, *Submission 4*, p. 5.

6 Consumers Health Forum of Australia, *Submission 129*, p. 4.

7 Mr Terry Slevin, Chief Executive Officer, Public Health Association of Australia, *Committee Hansard*, Melbourne, 4 September 2018, p. 21.

3.10 Largely impenetrable, the map, originally devised by the UK Government Office for Science as part of its Foresight Programme, was provided by a number of submitters[8] to show how many variables impact the propensity of obesity, and the measures required to address it.

3.11 In addition to a national strategy, NCDCFREE (Non-Communicable Diseases) proposed that governments of all levels have their own obesity strategies:

> [W]e understand and emphasise the importance of local action for global health – that is, states, cities, local governments and individual communities should be supported and encouraged to develop their own obesity strategies and obesity prevention projects.[9]

National Obesity Taskforce

3.12 In April 2008, the Australian Government established the National Preventative Health Taskforce to develop a National Preventative Health Strategy by June 2009. The strategy was to provide a blueprint for tackling the burden of chronic disease caused by obesity, tobacco and excessive consumption of alcohol.[10] The agency responsible for the taskforce and strategy, the Australian National Preventative Health Agency, ceased operations on 30 June 2014.[11]

3.13 Many submitters proposed the establishment of a new national obesity taskforce, tasked with the responsibility of developing and managing a national obesity strategy. The Heart Foundation proposed the taskforce due to the complexity of the issue, and the requirement for a coordinated, whole-of-government response:

> Existing dietary and physical inactivity patterns are a result of the lack of health supportive policies across a broad range of government portfolios such as health, agriculture, transport, urban planning, environment, food processing, distribution, marketing, and education. In the Australian context this responsibility is also spread across all levels of government.
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> These complex contributing factors and policy settings highlight the need for a centrally coordinated national obesity taskforce to drive programs across government portfolios and promote cooperation across all levels of government.[12]

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8 See for example: Australian Beverages Council, *Submission 22*, p. 52; Alan Barclay, *Submission 36*, p. 2; Australian Medical Association, *Submission 126*, p. 11.

9 NCDFREE, *Submission 82*, p. 2.

10 Medical Journal of Australia, *Australia: the healthiest country by 2020*, 17 November 2008, available at: https://www.mja.com.au/journal/2008/189/10/australia-healthiest-country-2020, accessed 22 November 2018.

11 Australian Government, 'Australian National Preventive Health Agency', 17 May 2018, https://www.directory.gov.au/portfolios/health/australian-national-preventive-health-agency, accessed 22 November 2018.

12 Heart Foundation, *Submission 139*, p. 7.

3.14 This was a view espoused by the Obesity Policy Coalition (OPC),[13] and shared with a number of other submitters.[14]

3.15 The role of the taskforce and its various responsibilities is discussed throughout the report. The driving theme when the taskforce was discussed was that it should be responsible for providing a whole-of-government strategic direction to tackle obesity. For this to occur, submitters stressed the importance of a consistent funding stream to support the taskforce, and for membership from all levels of government, and all key stakeholders. The taskforce would be responsible for the management and distribution of funding.

3.16 Many submitters cited the OPC's eight recommendations, as outlined in its *Tipping the Scales* report, as being the responsibility of a taskforce to implement:

1. Toughen restrictions on junk food advertising
2. Set food reformulation targets
3. Make Health Star Ratings mandatory
4. Develop an active transport strategy
5. Fund public health education campaigns
6. Add a 20 per cent health levy to sugary drinks
7. Establish a national obesity taskforce
8. Monitor diet, physical activity, and weight guidelines[15]

The role of the food industry in a national obesity strategy

3.17 The membership of a taskforce was subject to some commentary during the inquiry. The central point was how much of a role the food industry should have in driving the policy agenda. This is a point that was repeated in the context of national dietary guidelines and healthy food partnerships.

3.18 The issue of undue influence from the food manufacturing sector concerned a number of submitters, and is discussed in greater detail in the context of the health star rating system in Chapter 4. The PHAA pointed to the inherent conflict of interest of the food industry and efforts to curtail overweight and obesity:

> [T]here are various industry forces that see it as a threat to their market share. It may be the sugar industry in Australia and the concerns with the prospect of being able to sell that sugar. The majority of sugar that's grown in Australia, as I understand, is exported, but if, for example, there's a levy

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

14 Council of Presidents of Medical Colleges, *Submission 3*, p. 2; Western Australian Cancer Prevention Research Unit, *Submission 8*, p. 2; Centre of Research Excellence in the Early Prevention of Obesity in Childhood, *Submission 10*, p. 9.

15 Obesity Policy Coalition, *Tipping the Scales: Australian Obesity Prevention Consensus*, September 2017, available at: http://www.opc.org.au/what-we-do/tipping-the-scales, accessed 22 November 2018.

> on sugar-sweetened beverages, and that means less sugar in that product nationally, that means a reduction in the sale of sugar. That is one example. We've got junk food industries. We've got industries that essentially promote and sell food that is unhealthy, and we're seeing a pushback from those industries, absolutely unquestionably, in trying to stop whatever policies might influence their market share.[16]

3.19 As discussed in Chapter 4, the industry needs to be involved in many aspects of a comprehensive strategy, and in particular how that strategy is implemented, however the committee heard that this role should be limited given the impact of previous steps to increase healthy food and lifestyle choices:

> [T]here has been evidence, where industry has been involved, of watering down of strategy—for example, front-of-package labelling shifting from a mandatory approach to a voluntary approach. So I think it's important to recognise that industry does have an impact on how policies are generated and how they're regulated.[17]

National Dietary Guidelines

3.20 The Australian Dietary Guidelines (ADG) are developed by the National Health and Medical Research Council with advice from experts on the Dietary Guidelines Working Committee and funding from the Australian Government Department of Health.[18] The current version was released in 2013, and is the fourth iteration since first developed in 1982.[19]

3.21 The frequency of the guidelines being reviewed was raised by the committee, in response to concerns around ensuring they are underpinned by the best available scientific knowledge. This point was addressed by Dr Barclay who suggested that the guidelines be updated every five years rather than the current 10 years:

> Dietary guidelines are fairly conservative. They need to be updated, though, and they need to be updated every five years, as they are in the [United States]. Getting back to Senator Di Natale's question about what we can do, one thing is to have a five-year rolling update of dietary guidelines, like North America has. That way we keep on top of the science, and we don't still promote what was the best science of the day because now new science has proven that that maybe wasn't as accurate as we would have liked it to be.[20]

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16 Mr Terry Slevin, Chief Executive Officer, Public Health Association of Australia, *Committee Hansard*, Melbourne, 4 September 2018, p. 21.

17 Ms Katherine Silk, Integration and Innovation Manager, Australian Healthcare and Hospitals Association, *Committee Hansard*, Melbourne, 4 September 2018, p. 23.

18 EatforHealth.gov.au, *Australian Dietary Guidelines*, available at: *https://www.eatforhealth.gov.au/*, accessed 22 November 2018.

19 Food and Agriculture Organization of the United Nations, 'Food-based dietary guidelines – Australia', available at: http://www.fao.org/nutrition/education/food-based-dietary-guidelines/regions/countries/australia/en/, accessed 22 November 2018.

20 Dr Alan Barclay, private capacity, *Committee Hansard*, Sydney, 6 August 2018, p. 57.

Committee view

3.22 While many of the elements that would constitute a strategy are being undertaken at various levels, this fragmented approach has not been able to deliver the necessary impetus to alter the trajectory of the obesity problem in Australia.

3.23 The committee is therefore strongly of the view that what is required is a whole-of-government approach at the federal level, a coherent and committed Council of Australian Governments' position, both underpinned by the inclusion in a taskforce of key stakeholders from all sectors. There is an excellent and so far under-utilised research and evidence base for what works in different jurisdictions, and locally around Australia. The committee wants to see all of this evidence utilised in the development of the strategy.

3.24 Key to the success of a strategy is the composition, role and responsibilities of the Taskforce. The inclusion of all stakeholders from all sectors is critical to the taskforce adopting a comprehensive and coordinated response to the obesity problem. The committee's view is that the taskforce should be the single authority responsible for the national obesity strategy, and it should be managed by the Commonwealth Department of Health and furnished with the requisite authority and budget to drive the agenda forward.

3.25 The ADG are a crucial benchmark in terms of recommended nutrition for the population. They appear to be generally uncontroversial and supported by all stakeholders. However, given the ongoing advances in nutritional science, the committee was convinced of the value of updating the guidelines more regularly than they are currently.

3.26 The membership of the taskforce, and in particular the inclusion of the food manufacturing sector, was raised by several submitters. Public health advocates maintain that while the sector should be key stakeholders, their contribution should be limited to a consultancy role, but should not take any part of the decision-making of the taskforce. The committee concurs with this view.

Recommendation 3

3.27 The committee recommends the establishment of a National Obesity Taskforce, comprising representatives across all knowledge sectors from federal, state, and local government, and alongside stakeholders from the NGO, private sectors and community members. The Taskforce should sit within the Commonwealth Department of Health and be responsible for all aspects of government policy direction, implementation and the management of funding.

Recommendation 4

3.28 The committee recommends that the newly established National Obesity Taskforce develop a National Obesity Strategy, in consultation with all key stakeholders across government, the NGO and private sectors.

Recommendation 5

3.29 The committee recommends that the Australian Dietary Guidelines are updated every five years.