Public Health Association
AUSTRALIA

National Nutrition Strategy

Background Paper

This paper provides background information to the National Nutrition Policy Position Statement, providing evidence and justification for the public health policy position adopted by Public Health Association of Australia and for use by other organisations, including governments and the general public.

Summary

Poor diet is now the leading preventable risk factor contributing to the burden of disease globally and a leading risk factor contributing to cardiovascular disease, diabetes, some cancers, dental disease, obesity and many other conditions in Australia. There is broad agreement around the most cost-effective nutrition policy actions to help make healthier dietary choices the easier options. However, relatively little is being done to improve diets in Australia, and there is an urgent need for implementation of a comprehensive, co-ordinated National Nutrition Policy.

The Public Health Association of Australia calls for the Australian Government to develop a new National Nutrition Strategy. Such a policy would be an essential component of a National Obesity Strategy, and would deliver multiple complementary benefits in terms of health, equity and environmental sustainability.

20 Napier Close Deakin ACT Australia 2600 – PO Box 319 Curtin ACT Australia 2605
T (02) 6285 2373 **E** phaa@phaa.net.au **W** www.phaa.net.au

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Diet and nutrition: health, equity and environmental sustainability data

1. Poor diet is now the leading preventable risk factor contributing to the burden of disease globally and is a leading risk factor in Australia.[1]
2. According to the Global Burden of Disease study[1] poor diet contributed to more than 28,000 deaths (almost 18%) in Australia in 2015, closely followed by high blood pressure. Poor diet is a significant risk factor for hypertension, with one in six cases attributable to poor diet.
3. Prevalence of key preventable conditions and risk factors influenced by poor diet in Australia include:[2]
    - 63% of adults (11.2 million) are either overweight or obese;
    - 34% of adults (6 million) have measured high blood pressure (≥ 140/90 mm Hg) or are taking medication for hypertension;
    - 10% of adults (1.7 million) have biomedical signs of chronic kidney disease;
    - nearly 1 million Australian adults have diabetes;
    - 600,000 Australians have ischaemic heart disease.
4. If Australians consumed healthy diets consistent with the NHMRC Australian Dietary Guidelines[3] the disease burden would be reduced by 52% for coronary heart disease, 38% stroke, 34% diabetes, 37% mouth, pharyngeal and laryngeal cancer, 29% bowel cancer, 20% oesophageal cancer, 12% prostate cancer, 8% lung cancer and 2% stomach cancer.[4]
5. Nationally, less than 1% of the population report dietary intakes consistent with the Australian Dietary Guidelines[5] and more than 35% of energy intake in adults and more than 39% of energy intake in children is derived from discretionary food and drinks (those that these are not required for health and are high in added sugar, saturated fat, salt and/or alcohol).[3, 4] Australian families are now spending 58% of their food budget on discretionary foods and drinks.[6]
6. Further, dietary risks are not distributed equally; those groups who experience greater social disadvantage through relative lack of opportunities in education, employment, and income, including Aboriginal and Torres Strait Islanders, have poorer diets, and suffer increased risk of malnutrition, obesity and diet-related chronic disease.
7. In 2012-13, compared with the non-Indigenous population, Aboriginal and Torres Strait Islander people were:[7-9]
    - more than three times as likely to have diabetes;
    - twice as likely to have signs of chronic kidney disease;
    - twice as likely to have high triglyceride levels;
    - more likely to have multiple diet-related chronic conditions;
    - twice as likely to have a heart attack;
    - 60% more likely to die of heart disease;

- at least 5 times more likely to die of diabetes.

8. Obesity rates for Aboriginal and Torres Strait Islander adults and children were significantly higher than the comparable rates for non-Indigenous people in almost every age group.[7, 10] Aboriginal and Torres Strait Islander men were 40% more likely to be obese than non-Indigenous men; Aboriginal and Torres Strait Islander women 70% more likely to be obese than non-Indigenous women.[7, 11]
9. In 2011-12, Australian adults living in outer regional and remote areas of Australia were more likely to be overweight or obese (69.5%) compared with adults living in major cities (60.2%). More adult women living in areas of most disadvantage were overweight or obese (63.8%) compared with women living in areas of least disadvantage (47.7%). This pattern was not seen in men.[2]
10. Australians aged 25-44 years living in the poorest parts of Australia are 2 times more likely to die from coronary heart disease than those living in the wealthiest parts.[9] People living in remote and very remote Australia are 40% more likely to die of cardiovascular disease than people living in major cities. They are also 30% more likely to be hospitalised for cardiovascular disease.[12] If all Australians had the same rates of coronary heart disease as the most advantaged groups, we could prevent about 20% of coronary heart disease deaths (5,100) and 30% of hospitalisations.[9]
11. Healthy foods cost around 30% more in rural and remote areas than in capital cities.[13]
12. The United Nations World Food Summit of 1996 declared food security existed 'when all people at all times have access to sufficient, safe, nutritious food to maintain a healthy and active life'.[14] Australia is a food secure nation with enough food for its population. However, in 2011-2012, 4.0% of people lived in households that had run out of food in the previous 12 months and could not afford to buy more.[2] This was even higher in Aboriginal or Torres Strait Islander people, with more than one in five (22%) reporting food insecurity.[6] The 1995 National Nutrition Survey reported higher levels of food insecurity in unemployed people (11.3%), in the bottom 30% of income earners (10.6%) and those on a government pension or benefit (9.0%). Among recently arrived refugees, 71% reported food insecurity.[15]
13. Deficiency of some nutrients, including iodine, folate, iron and vitamin D, is also a concern for some groups.[3] Inadequate levels of folate, iodine or iron during pregnancy have adverse effects on the physical and mental development of infants.[16-18] In 2011-12, iodine levels were relatively low for women of childbearing age. One in five (18.3%) were iodine-deficient and two-thirds (62.2%) had an iodine level below that recommended for women who are pregnant, breastfeeding or considering pregnancy. One in four adults had a Vitamin D deficiency, with higher rates in Victoria, the ACT and Tasmania compared with Queensland and the Northern Territory.[19]
14. Breastfeeding is beneficial to infants, mothers, families and society, and is the biological and social norm for feeding infants and young child feeding. it is recommended that infants are exclusively breastfed until around 6 months of age when solid foods are introduced, and that breastfeeding is continued until 12 months of age and beyond, for as long as the mother and child desire.[20] While

Australia's breastfeeding initiation rate is currently high at 96%, only 15% of infants are exclusively breastfed at 5 months.[21]

15. Environmental sustainability is critical to human diet and health, as the foods consumed affect the environment, and the environment in turn affects aspects of food production and supply, hence the food available for consumption. There is increasing evidence that the types of foods that minimise environmental impacts, including greenhouse gas emissions, use of natural resources such as water, and pressure on biodiversity are those associated with health benefits. There are strong synergies between dietary patterns for health and those which have minimal environmental impact.[3]

Diet and nutrition: economic consequences

16. Poor diet is a major contributor to the estimated $8.6 billion (in 2014-15 dollars in annual health care costs and lost productivity from overweight and obesity in Australia.[22]
17. In 2008/09, direct health care costs associated with diseases impacted by poor diet, including heart disease, stroke, diabetes and colon cancer, totalled more than $5 billion. Most of this cost was from medications and hospital services for admitted patients. In 2008/09, health care expenditure included:
    - $2.38 billion for coronary heart disease, with three quarters allocated to hospital services for admitted patients;[23]
    - $1.5 billion for diabetes, with one-third for medications;[24]
    - $732 million for stroke, with about 90% for hospital services for admitted patients;[23]
    - $427 million for colon/rectal cancer, with more than 90% for hospital services for admitted patients.[25]
18. Wider costs to Australians and the economy are even more significant:
    - In 2009, the estimated total financial and economic costs of heart attack and chest pain in Australia were $15 billion;[26]
    - In 2012, the estimated total financial costs of stroke in Australia were $5 billion. Decreased productivity was the largest component at $3 billion;[27]
    - Estimated cost of diabetes to the Australian economy was $14.6 billion.[28]

Diet and nutrition: environment sustainability

19. Dietary intake is affected by the available food supply, which in turn is affected by the environment. Dietary patterns consistent with the Australian Dietary Guidelines provide health benefits and also reduce the environmental impact associated with foods.[3]

20. Overconsuming and wasting foods and drinks, including the disposal of waste food and packaging, involves greater use of natural resources and increases pressure on the environment. To ensure the food supply supports choices consistent with the dietary guidelines now and into the future, we need an environmentally sustainable food system.[3]
21. Sustainable diets are those with low environmental impacts that contribute to food and nutrition security and to a healthy life for present and future generations. Sustainable diets protect and respect biodiversity and ecosystems, and are culturally acceptable, accessible, economically fair and affordable. They are also nutritionally adequate, safe and healthy, and optimise natural and human resources.[14]

Background and priority

22. Optimum nutrition is fundamental to good health throughout life. It is essential for the normal growth and development of infants and children, contributes significantly to quality of life and well-being, resistance to infection and protection against chronic diseases, obesity and premature death.[3, 15]
23. The International Congress on Nutrition declared "Food is the expression of values, cultures, social relations and people's self-determination, and the act of feeding oneself and others embodies our sovereignty, ownership and empowerment. When nourishing oneself and eating with one's family, friends and community, we reaffirm our cultural identities, our ownership over our life course and our human dignity. Nutrition is foundational for personal development and essential for overall well-being".[14]
24. The World Health Organization (WHO) has called on member states to reduce the preventable and avoidable burden of morbidity, mortality and disability due to chronic disease. This requires multi-sectoral collaboration and cooperation at national, regional and global levels. If chronic diseases are no longer a barrier to well-being or socioeconomic development, populations can reach high standards of health and productivity at every age.[29]
25. The WHO suggests a series of 'policy options' for member states to adopt under a national policy and action plan.[29] These include the WHO Global Strategy on Diet, Physical Activity and Health which asks nations to support food and agriculture policies, marketing campaigns and education programs to encourage healthy eating and promote physical activity. The strategy recommends limiting fat, sugar and salt in the diet and promoting increased consumption of fruits, vegetables, legumes, whole grains and nuts.[30]
26. The WHO's voluntary global targets for the prevention and control of NCDs encourages member states to promote a healthy diet include a 30% relative cut in mean population intake of

salt/sodium, halting the rise in type 2 diabetes and obesity, and a 25% relative drop in the prevalence of raised blood pressure.[29]

27. The WHO recommends "developing or strengthening national food and nutrition policies and action plans…"[29] (p30, WHO 2013) to progress these voluntary global targets.
28. In 2015, the World Health Assembly backed the Rome Declaration on Nutrition[14] and a Framework for Action[31] recommending a series of policies and programmes across the health, food and agriculture sectors to address malnutrition in all its forms, including overweight and obesity. Governments had previously agreed to both documents at the Second International Conference on Nutrition (ICN2), organised by WHO and the Food and Agriculture Organization of the United Nations (FAO) in November 2014.
29. The World Health Assembly called on governments to commit to policy changes and investments aimed at ensuring all people have access to healthier and more sustainable diets. They asked WHO to report on progress every 2 years.[32]
30. Following advice from the World Health Assembly, in April 2016 the United Nations General Assembly proclaimed a UN Decade of Action on Nutrition from 2016 to 2025.[33] This provides an umbrella framework for aligning actions and galvanizing commitment by all nutrition stakeholders for achieving the WHOs NCD targets, the Global Targets to improve infant and young child nutrition. Sustainable food systems and nutrition is further recognised as a bedrock for achieving the Sustainable Development Goals, including Goal 2 Target 2.2 on ending all forms of malnutrition by 2030.[34]
31. The FAO has called on decision-makers to prioritise and promote sustainable diet concepts in policies and programmes in the agriculture, food, environment, trade, education and health sectors. FAO recommends that plant and animal breeders emphasise nutrition, and encourages research on the nutrient levels achieved with food biodiversity.[39]
32. Nationally, under Australia's Food and Nutrition Policy, developed in 1992, a range of policies and guidelines have included the Infant Feeding Guidelines for Health Workers[35] and the Dietary Guidelines for Australians.[3]
33. In 2008, the National Preventative Health Taskforce recommended that the Australian Government establish a National Food and Nutrition Framework.[36]
34. In response to the report of the National Preventative Health Taskforce, the Department of Health and Ageing launched a National Preventative Health Strategy in June 2009. The Strategy recommended interventions aimed at reducing the chronic disease burden associated with three lifestyle risk factors – obesity, tobacco and alcohol. This was to involve a National Food and Nutrition Framework that would consider preventative health in general, and the role of prevention in reducing the rates of overweight and obesity in Australia. Food policy was to be framed in the context of practical measures to address access to food and food security, how to

achieve healthier diets, food safety, and food production and agricultural policies to ensure a safe and environmentally sustainable food supply chain.[37]

35. The Australian National Preventative Health Agency (ANPHA) was set up in 2010 to fulfil the recommendations of the National Preventive Health Strategy. The Agency was closed in 2014, and its functions transferred to the Commonwealth Department of Health.
36. In 2011, the Council of Australian Governments asked the Australia and New Zealand Food Regulation Ministerial Council to commission a review of food labelling law and policy.[38] The Legislative and Governance Forum on Food Regulation replaced the Ministerial Council and agreed to develop a comprehensive National Nutrition Policy. This would provide an overarching framework to identify, prioritise, drive and monitor nutrition initiatives within the government's preventive health agendas.
37. The 2012 Federal budget included funding to develop the National Nutrition Policy. This was expected to take 2 years.[39]
38. Following a tender process, in 2012, the Department of Health and Ageing commissioned Queensland University of Technology to produce a Scoping Study on such a policy. The study systematically reviewed what nutrition policy actions were working in OECD countries and why, and what was not working and why not, identified barriers and enablers to effective implementation of national nutrition policies. It recommended a contemporary, comprehensive National Nutrition Policy aligned with international recommendations to replace the 1992 policy and provided an exemplar nutrition policy framework. However, the report was never enacted as intended, but was released fully after a Freedom of Information request in March 2016.[39]
39. The Department of Agriculture, Fisheries and Forestry developed and launched an Australian National Food Plan in 2013. It aimed to integrate food policy by considering the food supply from paddock to plate. The Plan included a chapter on Families and Communities with significant nutrition content and referred to the development of a National Nutrition Policy.[40] The Plan was rescinded and archived on 19 July 2013.
40. Following a Freedom of Information request, the Evaluation of the National Aboriginal and Torres Strait Islander Nutrition Strategy and Action Plan 2000-2010 (NATSINSAP) was released in 2015. It showed that lack of co-ordinated governance and inadequate allocation of resources compromised the capacity to drive implementation of the Strategy and Action Plan.[41] It is essential that future policy initiatives learn from this evaluation – including a future National Nutrition Policy.

Current situation

41. A National Nutrition Policy would aim to increase Australia's health, well-being and prosperity, improve nutrition, support environmental sustainability and reduce the incidence and prevalence of diet-related risk factors and diseases among all Australians.[39]
42. Poor diets are driven predominantly by obesogenic food environments that encourage unhealthy eating; such food environments are influenced by political, economic, social and cultural factors as part of the broader food and nutrition system.[42]
43. There is an urgent need for co-ordinated evidence-based nutrition policy actions to be implemented in Australia; the 1992 policy needs updating and expanding so it aligns with recommendations from the World Health Organization (WHO), the United Nations Steering Committee on Nutrition (UNSCN) and the Food and Agriculture Organization. In addition to PHAA, this call is supported by the National Heart Foundation of Australia, the Dietitians Association of Australia and Nutrition Australia and many other professional and non-government organisations.
44. As the United Nations General Assembly identifies, strategic government leadership is essential for policies and programs to support health initiatives and community based interventions.[31, 33] A coordinated 'whole-of government' approach is required to support national, state and local governments to work together with non-government organisations and civil society to reduce the incidence and prevalence of diet-related health problems and promote health and wellbeing.[43]
45. A major finding of the scoping study for a new National Nutrition Policy is that regulatory and legislative reforms are the most cost-effective nutrition policy actions, but are rarely included in national nutrition policies and there are few examples of quality, multi-strategy, co-ordinated, inter-sectoral evidence-based nutrition policies being implemented internationally.[39] Given this, it is not surprising that rates of obesity and chronic diet-related conditions are increasing globally.
46. While the influences on population diets and nutrition are complex, there are many potential leverage points, at different levels, for intervention in the food and nutrition system, and broad global consensus among the public health community on the multiple policy actions needed.[29-33]
47. It is clear that comprehensive action to improve population diets needs to involve action at different levels and also across a diversity of sectors, including agriculture, trade, food manufacturing, food retail, employment, education, social protection, health, housing, transport, and planning.[42, 44]
48. Recent research applied the INFORMAS Healthy Food Environment Policy Index (Food-EPI) to assess national, state and territory government actions across 42 policy areas related to food environments to benchmark the diet-related aspects of obesity prevention policies of Australia and compare it to international best practice. While results showed that Australia is meeting best practice in the implementation of some policies, including food prices (no GST on basic foods),

there are a number of areas where Australia is lagging significantly behind other countries in their efforts to address unhealthy diets and obesity, including healthy levies/taxes to increase the price of unhealthy foods (especially sugary drinks) and regulations to reduce exposure of children to marketing of unhealthy food. State and Territory governments varied in their level of implementation of internationally recommended policies, especially around menu labelling regulations, support and training systems to help schools and other organisations to provide healthy foods, independent statutory health promotion agencies and mechanisms to incorporate population health considerations into all policy development processes. Greater national policy co-ordination and consistency is required, and the priority recommendation of the report was for Australia to development a national strategy and implementation plan for improving population diet and nutrition.[45]

49. Policy making is rarely a rational process in which evidence is used to assess the relative costs and benefits of options. Recent investigation into the factors that drive political commitment for nutrition to inform the United Nations Decade of Action on Nutrition found that actors, institutions, political and societal contexts, knowledge, evidence and framing, and, capacities and resources are critical factors.[46] In Australia, recent studies have identified opportunities to better influence decision making, such as through application of political science policy process theories,[47] and that, for policy change to occur, there needs to be political, organisational and/or public will for the proposed policy problem and solution.[48-51] Pressure from sections of the food industry,[48, 49] use of emotions and values, and public profile[48-51] are common barriers and enablers influencing this process. Nutrition policy systems analysis, including through network analysis, suggests pressure from some sections of the food industry and a lack of policy coherence across different sectors of government, and between government, community organisations and industry, are common barriers influencing nutrition policy implementation.[47-51]
50. In 2017, more than 35 leading community, public health, medical and academic groups, including the PHAA, united under "Tipping the Scales" to call for eight single policy initiatives, including four specific nutrition policy actions, to address obesity.[52] These specific nutrition policy actions would be most effective embedded within a comprehensive, evidence-based food and nutrition policy.[39]

Policy options

51. The report of the Scoping Study for a new National Nutrition Policy included the following recommendations:
    a. Recommendation 1: Four key principles should frame the National Nutrition Policy in Australia:
        i. Food, nutrition and health;
        ii. Social equity;
        iii. Environmental sustainability; and
        iv. Monitoring and surveillance; evaluation and review.
    b. Recommendation 2: The National Nutrition Policy should be guided by the recommendations of the World Health Organisation for national nutrition policies and the framework for effective policy action developed by the United States Nutrition and Obesity Policy Research and Evaluation Network.
    c. Recommendation 3: The development process for the National Nutrition Policy should involve a broad range of stakeholders and enable all interested Australians to contribute.
    d. Recommendation 4: Development, implementation and evaluation of the National Nutrition Policy should be underpinned by strong whole-of-government governance mechanisms with cross sectoral and expert representation.
    e. Recommendation 5: The National Nutrition Policy should set clear aims, goals, objectives and targets that are specific, measurable, achievable, realistic and timely.
    f. Recommendation 6: A comprehensive, multi-strategy approach should be adopted that includes interventions to:
        i. improve the sustainable supply of healthy foods;
        ii. promote healthy foods; and
        iii. decrease the supply and promotion of "discretionary choices".
        iv. The strategy mix should be evaluated to determine effectiveness and reviewed regularly.
    g. Recommendation 7: Develop a National Nutrition Implementation and Action Plan that details funding and resourcing commitments, including capacity-building initiatives.
    h. Recommendation 8: The National Nutrition Policy should be readily accessible to all stakeholders, should cover a 10 year period and be reviewed after the first 5 years.[39]
52. The report of the Scoping Study for a new National Nutrition Policy also included an exemplar policy framework (Table 5.1) consistent with the recommendations, that included four goals:
    - To increase the proportion of Australians consuming dietary patterns consistent with the Australian Dietary Guidelines;

- To improve diet and nutrition in vulnerable groups and reduce related health disparities;
- To secure an environmentally sustainable food and nutrition system that promotes health and wellbeing both now and into the future; and
- To implement effective, coordinated food and nutrition monitoring and surveillance and information systems to track progress and inform the evidence base for policy and practice.[39]

53. Steps in the development of a new National Nutrition Policy would be:
    - Develop a discussion paper informed by the Scoping Study and release it for public consultation. This paper should cover the rationale, vision, objectives and strategies for a National Nutrition Policy and could be developed readily from the information available.
    - Assign funding and set up governance structures to develop a National Nutrition Policy that includes existing government initiatives, prioritises new initiatives and uses a clear strategy to outline accountability.
    - Appoint an oversight group and engage external consultants to develop the National Nutrition Policy in a similar fashion to the development of the Australian Dietary Guidelines.
    - Release the draft National Nutrition Policy for public consultation.
54. Steps in the implementation of a new National Nutrition Policy;
    - Complete, release, fund and set up the National Nutrition Policy through a ten year implementation and action plan. This will outline accountability and responsibility of all key stakeholders.
    - Identify long-term funding for continued investment and capacity to achieve long-term outcomes through a multi-strategy, multi-sectoral approach.
55. Steps in the evaluation of a new National Nutrition Policy:
    - Commit to, and implement, a quality food and nutrition monitoring and surveillance system to support evaluating the National Nutrition Policy and its continued implementation and review.
    - Report key targets to the WHO, and FAO as part of the response to the Rome Declaration, the United Nations 'Decade of Nutrition Action' and the WHO Voluntary Global NCD Targets.[14, 29, 32, 33]
56. A new National Nutrition Policy would:
    - Address the high cost and increasing rates of diet-related chronic diseases, including coronary heart disease, stroke, hypertension, atherosclerosis, some forms of cancer, Type 2 diabetes, dental caries and erosion, osteoporosis, some forms of arthritis and kidney disease, gall bladder disease, dementia, nutritional anaemias and failure to thrive.
    - Equitably provide food and nutrition security for all Australians.

- Promote sustainable diets which have low environmental impact.
- Reflect the NHMRC's Australian Dietary Guidelines and their underpinning scientific evidence base, and implement policy actions that at support the guidelines, including food labelling, advertising and relevant healthy levies.
- Involve sectors beyond health and consider areas such as agriculture and trade.
- Be an essential component of a National Obesity Strategy[39]

Recommended action

1. The Australian Government should:
    - Start public consultation with a discussion paper informed by the best available evidence. This should align with international (WHO, UNSCN, FAO) policy advice and national advice from the commissioned Scoping Study for a new national nutrition policy and the National Aboriginal and Torres Strait Islander Nutrition Strategy and Action Plan (NATSINSAP) Evaluation Report.[1A-4A, 7A-9A]
    - Allocate funding and the structure to develop a National Nutrition Policy and a National Nutrition Implementation Action Plan.
    - Commit to a comprehensive national food and nutrition monitoring program to benchmark and assess Australia's food and nutrition system to support evaluation of the policy and its strategies.
    - Report key targets to the WHO and the FAO as part of the response to the Rome Declaration, the United Nations 'Decade of Nutrition Action' and the WHO Voluntary Global non-communicable disease targets.[14, 29]

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