Public Health Association of Australia:

Policy-at-a-glance – Promoting Healthy Weight Policy

Key message: PHAA will –

1. actively contribute to policy and advisory forums relating to the promotion of healthy weight for adults, children and young people.
2. recommend that governments and other agencies contribute and co-ordinate efforts to achieve a national, integrated, multi-sectoral and multidimensional approach to tackling overweight and obesity.
3. advocate that the high prevalence of obesity is appropriately addressed in the National Nutrition Policy.
4. encourage the Federal Minister for Health and the NHMRC to adequately resource the Australian National Preventative Health Agency to tackle the rising prevalence of obesity in Australia.
5. inform and mobilise its members in support of this policy.
6. monitor progress on the implementation of these recommendations.

Summary:

Despite a large number of reports, strategies and plans, the prevalence of obesity and overweight in Australia continues to rise in adults and is high in children. Obesity and overweight is associated with substantial present and future social, health and economic costs. No single public health strategy can be expected to reverse the high prevalence of overweight and obesity in Australia – multiple strategies across all sectors are needed which require effective partnerships between stakeholders. All levels of government, the food industry, other industries in the private sector, and relevant non-government organisations should support and implement programs of action that have the potential to contribute to reduced levels of obesity and overweight. Obesity prevention for children through the development and implementation of programs and policy (including regulations where necessary) should be prioritised. However effective measures for the reduction of obesity and overweight in adults should concurrently be pursued. The implementation of all aspects of the Preventative Health Taskforce “Preventative Health Taskforce Roadmap for Action” obesity recommendations must be promptly enacted with sufficient funding and policy support to ensure their success.

Audience: Australian, State and Territory Governments, policy makers, program managers and key non-government and industry stakeholders.

Responsibility: PHAA’s Food and Nutrition Special Interest Group (SIG).

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PROMOTING HEALTHY WEIGHT POLICY: THE PREVENTION AND MANAGEMENT OF OVERWEIGHT AND OBESITY IN AUSTRALIA

The Public Health Association of Australia notes that:

1. The World Health Organization (WHO) states that obesity is a rapidly growing threat to the health of populations in an increasing number of developed and developing countries worldwide [1-2]. WHO ranked obesity as one of ten preventable conditions that require urgent attention and considers the dramatic rise in childhood obesity over the last decade as one of the most serious challenges of the 21st century [3-4].

2. The prevalence of overweight and obesity in Australian adults (aged 18 years and over) has risen from 56.3% in 1995 and 61.2% in 2007-8 to 63.4% in 2011/2012 [5]. The rate of obesity in Australian adults in 2011/2012 was 28.3%, while the rate of overweight was 35.0%.

3. The prevalence of overweight and obesity in children (5 to 17 years) has stabilised at 25.3% in 2011-12 [5]. The prevalence rate of obesity was 7.6% and the rate of overweight was 17.7%.

4. In Australia, the National Health and Medical Research Council (NHMRC) has recognised that overweight and obesity pose a major public health problem [6]. Overweight, including obesity, contributes 7.6% of the burden of premature death and disability, the largest contributor of the biomedical and behavioural risk factors measured [7].

5. The social and economic costs of overweight and obesity are high [1]. The total cost of obesity in Australia in 2008 was estimated at $58 billion, including $8.3 billion in financial costs and $49.9 billion in the cost of lost wellbeing [8].

6. Epidemiological studies show that obesity is associated with a greater risk of mortality and morbidity from conditions including Type 2 diabetes mellitus, coronary heart disease, hypertension, hyperlipidemia, reproductive abnormalities, osteoarthritis, back pain and certain cancers [9]. Obesity is a central component of the Metabolic Syndrome, which encompasses factors such as abdominal adiposity, insulin resistance, hypertension and atherogenic lipid profiles [10]. There is also evidence that psychosocial health of overweight and obese individuals is reduced [11-12].

7. Once obese, it is difficult to lose weight through physical activity and diet. Approximately 80% of overweight children become overweight adults [13].

8. A healthy body weight is a body weight that is associated with normal growth and development in children. Overweight and obesity in children and adolescents is associated with adverse levels of risk factors for cardiovascular disease, diabetes and fatty liver disease [14].
9. The Body Mass Index (BMI), the ratio of weight in kilograms divided by height in metres squared (kg/m\(^2\)), is frequently used as an indicator of healthy body weight. For adults, a weight resulting in a BMI < 18.5 kg/m\(^2\) is underweight; 18.5 kg/m\(^2\) to < 25 kg/m\(^2\) is a healthy weight; ≥ 25 kg/m\(^2\) to < 30 kg/m\(^2\) is overweight, and ≥ 30 kg/m\(^2\) is obese [15]. Children with a BMI from greater than the 85\(^{th}\) centile to the 95\(^{th}\) centile (for age and sex) are considered overweight while those with BMI > 95\(^{th}\) centile are considered obese.

10. Waist circumference is a better indicator of cardiovascular disease risk factors in children and adults than BMI [16, 17]. A waist circumference of ≥ 94 cm for men and ≥ 80 cm for women is classified as abdominal overweight; and ≥ 102 cm for males and ≥ 88 cm in females is classified as abdominal obesity.

11. Accurate BMI estimation requires measured height and weight as Australian adults underestimate their true height and weight, resulting in a lower BMI [18]. Therefore measured height and weight should be obtained in surveys. However, it is noted that most Aboriginal adults in a 2003-4 Darwin survey with BMIs over 25 kg/m\(^2\), correctly identified themselves as overweight [19].

12. Overweight and obesity are more common in lower-socioeconomic groups [20-22], in some immigrant groups [21] and are much higher in Aboriginal and Torres Strait Islander (ATSI) people [7-8]. These sub-populations have different values and beliefs regarding weight status, food and physical activity that need to be acknowledged when developing interventions [23-27]. Prior studies have confirmed that those with easier access to fast food restaurants consume more [28-30], particularly if they are low income residents [31].

13. Food security and improved access to inexpensive healthy foods remain key determinants for maintaining healthy weight amongst vulnerable population groups, however people of low socioeconomic status also often have relatively poor access to facilities for physical activity [26]. The risk of obesity is 20–40% higher in women experiencing food insecurity and poverty [32-33]. The hidden costs of obesity are substantial with obese individuals living for many years with high health care costs and lost productivity. Obesity-related disorders such as diabetes and its complications further add significantly to the financial burden [7].

14. The fundamental causes of the continuing rise in obesity are considered to be societal, resulting from an environment that promotes sedentary lifestyles and over consumption of food, particularly through energy-dense diets [34]. The effect of neighbourhood design and both physical activity and food environments (including household food security) particularly in disadvantaged urban areas but also more broadly warrants further investigation in Australia [35-37]. Market basket surveys in Australia have highlighted the disproportionately high cost of healthy food particularly in rural and remote communities where the affordability and availability of fresh food items is a significant issue [38-41].

15. The Australian Government recognised reducing overweight and obesity as a “priority area for action” and has developed a National Preventative Health Strategy with key action areas [42-43]. The Australian National Preventative Health Agency has been resourced with a mandate to address the high Australian prevalence of overweight and obesity [44]. The NHMRC has released Clinical Practice Guidelines for the Management of Overweight and Obesity in Adults, Adolescents and Children in Australia which argues
for complementary clinical initiatives, public health measures and environmental changes [9].

16. Prevention of overweight and obesity should be well resourced and prioritised on the basis that the health consequences of obesity are often cumulative and may not be fully reversible by weight loss; that weight loss in obese populations in clinical situations is often poor; and that it is more efficient and cost effective to prevent weight gain rather than to treat overweight and obesity [1].

17. From a public health perspective, prevention of weight gain may be achieved through interventions to change the physical, policy, economic, educational and social environments to support increased healthy eating and physical activity in the community. Sedentary behaviours are an independent predictor of weight gain. In addition, further health gains beyond healthy weight, including improving nutrition, can be achieved by such interventions [1].

18. As an early priority, prevention of overweight and obesity in children should be prioritised using multiple strategies and in a range of settings. Targeting women during pregnancy has the potential for double benefit by positively impacting the weight status of two generations [45]. Prevention is more effective than treatment, and there is a community obligation to protect the health of children with the strong likelihood of widespread community support for strong and effective measures to prevent excess weight gain in childhood.

19. Effective measures must also be directed towards reducing the prevalence of overweight and obesity in adults because the faster accrual of economic and health benefits enhance the cost-effectiveness of such actions.

The Public Health Association of Australia affirms the following principles:

20. Avoid contributing to bias and discrimination against individuals and groups on the basis of body weight.
21. Base the selection and resourcing of interventions to promote healthy weight on the best available evidence
22. Ensure that children are protected and prioritised in the development of healthy weight policies and related public health activities.
23. Ensure that interventions are supportive of positive body image.
24. Ensure that culturally appropriate health services and programs for the management of overweight and obesity are available to those most in need.
25. Ensure that obesity prevention interventions incorporate a balance between individual and societal responsibility. This means an active role for individual behaviour change as well as governments, business and non-government organisations.
26. Consider and monitor the impact of any chosen intervention on vulnerable groups, such as those with low socioeconomic status, since these groups are at higher risk of obesity and already experience considerable disadvantage in society.
27. Accept that effective partnerships between communities, governments, the media and industry are required to ensure that interventions achieve their goals and are sustainable. This approach will also allow obesity prevention and management strategies to be harmonised with existing public health policies and programs for the control of non-communicable diseases [1].
28. Acknowledge that for population health, a range of strategies are needed to address weight loss among individuals who are overweight, and prevention of weight gain and weight maintenance among healthy weight individuals.

29. Recognise that since there are multiple causes of obesity, no single public health strategy can be expected to solve Australia’s obesity problems; therefore a range of strategies are needed. These strategies should take into consideration both environmental and social determinants of health.

The Public Health Association of Australia endorses:

30. The recommended actions for government and the private sector to tackle chronic disease caused by obesity outlined in the “Preventative Health Taskforce Roadmap for Action” produced by the National Preventative Health Taskforce (NPHT), July 2009 [43]. The NPHS Roadmap advocates for cross-sectoral initiatives focussed on urban design, tax incentives, industry partnerships, social marketing, subsidies and advertising controls.

31. The Australian Government priority actions to prevent obesity outlined in “Taking Preventative Action – A Response to Australia: The Healthiest Country by 2020 – The Report of the National Preventative Health Taskforce”, May 2010, while noting that they are limited in scope and do not endorse all of the recommendations of the NPHT Roadmap [42, 46].

32. The House of Representatives Standing Committee on Health and Ageing’s Weighing it up. Obesity in Australia recommendations.

33. The recommendations of the WHO publication Obesity: Preventing and Managing the Global Epidemic Report for selective prevention of obesity in population subgroups with an above average risk of developing obesity, and targeted prevention directed at high risk individuals with existing weight problems but who are not yet obese [1].

34. The recommendations in the WHO Diet, Nutrition and the Prevention of Chronic Diseases Report of the Global Strategy on Diet Physical Activity and Health [47, 48]. Priority strategic actions include: surveillance of nutrition, physical activity and related disease burden; ensuring a healthy food supply is available to all; and comprehensive strategies addressing nutrition and physical activity together with other risks such as tobacco use. Actions should be inter-sectoral with the Australian Government having a central steering role in developing strategies, ensuring actions are implemented, and monitoring their impact over time. The Australian National Preventative Health Agency addresses this need and is strongly endorsed.

35. The actions identified in the WHO Population-Based Prevention Strategies for Childhood Obesity Report (2010) [3].

36. The National Obesity Taskforce (NOTF) report titled Healthy Weight 2008 - shaping Australia’s future [49]. The report recommends a focus on young people and their families, supportive environments and prevention of obesity.

37. The National Obesity Taskforce (NOTF) report titled Healthy Weight for Adults and Older Australians - a National Action Agenda to Address Overweight and Obesity in Adult Australians [50]. This Agenda aims to prevent weight gain at the population level, with specific actions directed toward people living in rural and remote areas, Aboriginal and Torres Strait Islander communities, and people with established risk for weight-related chronic conditions.
38. The recommendations from the National Obesity Taskforce (NOTF) Aboriginal Torres Strait Islander Workshop (2003) [51].

39. The recommendations from the former National Public Health Partnership’s *Eat Well Australia: an Agenda for Action for Public Health Nutrition* and the National Aboriginal and Torres Strait Islander Nutrition Strategy and Action Plan, 2000-2010 [52-53] and *Be Active Australia - A Framework for Health Sector Action for Physical Activity 2005–2010*. These plans provide an agenda for action to improve nutrition and physical activity for all Australians, with a particular focus on ATSI peoples and have guided jurisdictional action. They were inadequately resourced, expired in 2010 and the follow-up strategy is unclear.

40. The establishment of a Nutrition sub-committee to the Australian Health Ministers Advisory Council’s Australian Population Health Development Principal Committee (APHDPC).

41. The rapid publication and dissemination of results from the Australian Health Survey, 2011/2012, to measure chronic disease risk factors (including BMI, nutrition and physical activity status, and health risks assessed from blood and urine testing).

42. The Food Regulation Policy statement on Front of Pack Labelling [54].


*The Public Health Association of Australia believes that the following steps should be undertaken:*

44. That additional resources be directed to the Australian National Preventive Health Agency to increase efforts to co-ordinate and drive the agenda to prevent an increase in obesity.

45. That all levels of government, industries such as food manufacturing, retailing and marketing, advertising, media, sports and recreation, and relevant non-government organisations ensure that action on obesity is high on their agenda.

46. That implementation of all aspects of the Preventative Health Taskforce “Preventative Health Taskforce Roadmap for Action” obesity recommendations must be promptly enacted with sufficient funding and policy support to ensure their success.

47. That funding for a social marketing campaign be provided to disseminate and promote NHMRC guidelines which support healthy weight. These include the physical activity guidelines for adults and children, NHMRC dietary guidelines including *The Australian Guide to Healthy Eating* and NHMRC guidelines on obesity management for adults, children and adolescents.

48. That federal and state health departments, and non-government organisations support research to identify effective public health interventions aimed at reversing the trend of unhealthy weight gain and to identify ways in which to promote weight loss among those who are already overweight.

49. That state and local governments incorporate public health considerations into urban planning, land use and transportation design to create less obesogenic environments.

50. That Government and non-Government organisations support research into the effectiveness of fiscal and other approaches, including taxes and subsidies, to improve access to safe, nutritious and affordable foods for all, particularly those at higher obesity risk such as socioeconomically disadvantaged and ATSI groups.
51. That State health departments provide appropriate weight management services to those Australians whose weight is already impacting on their health.

52. That a nationally coordinated, ongoing systematic monitoring and surveillance program for physical activity, sedentary behaviour, dietary intake and overweight/obesity be established and adequately funded, following on from the 2011/2012 Australian Health Survey.

53. That initiatives aimed at preventing obesity have a well-designed and resourced evaluation component to further inform the necessary evidence base for preventive strategies, and that socioeconomically disadvantaged and ATSI groups are a high-priority in research and programs aimed at obesity prevention.

54. That new national nutrition and physical activity strategies be developed (as the current strategies ended in 2010).

The Public Health Association of Australia resolves to undertake the following actions:

55. To actively contribute to policy and advisory forums relating to the promotion of healthy weight for adults, children and young people.

56. To recommend that governments and other agencies contribute and co-ordinate efforts to achieve a national, integrated, multi-sectoral and multidimensional approach to tackling overweight and obesity.

57. To advocate that the high prevalence of obesity is appropriately addressed in the National Nutrition Policy.

58. To encourage the Federal Minister for Health and the NHMRC to adequately resource the Australian National Preventative Health Agency to tackle the rising prevalence of obesity in Australia.

59. To inform and mobilise its members in support of this policy.

60. To monitor progress on the implementation of these recommendations.

ADOPTED 2010, REVISED AND RE-ENDORSED IN 2013

First adopted at the 2010 Annual General Meeting of the Public Health Association of Australia. The latest revision has been undertaken as part of the 2013 policy review process.

References:


