Public Health Association of Australia submission on the Senate Inquiry into the Obesity Epidemic in Australia

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Preamble

The Public Health Association of Australia

The Public Health Association of Australia (PHAA) is recognised as the principal non-government organisation for public health in Australia working to promote the health and well-being of all Australians. It is the pre-eminent voice for the public’s health in Australia.

The PHAA works to ensure that the public’s health is improved through sustained and determined efforts of the Board, the National Office, the State and Territory Branches, the Special Interest Groups and members.

The efforts of the PHAA are enhanced by our vision for a healthy Australia and by engaging with like-minded stakeholders in order to build coalitions of interest that influence public opinion, the media, political parties and governments.

Health is a human right, a vital resource for everyday life, and key factor in sustainability. Health equity and inequity do not exist in isolation from the conditions that underpin people’s health. The health status of all people is impacted by the social, cultural, political, environmental and economic determinants of health. Specific focus on these determinants is necessary to reduce the unfair and unjust effects of conditions of living that cause poor health and disease. These determinants underpin the strategic direction of the Association.

All members of the Association are committed to better health outcomes based on these principles.

Vision for a healthy population

A healthy region, a healthy nation, healthy people: living in an equitable society underpinned by a well-functioning ecosystem and a healthy environment, improving and promoting health for all.

The reduction of social and health inequities should be an over-arching goal of national policy and recognised as a key measure of our progress as a society. All public health activities and related government policy should be directed towards reducing social and health inequity nationally and, where possible, internationally.

Mission for the Public Health Association of Australia

As the leading national peak body for public health representation and advocacy, to drive better health outcomes through increased knowledge, better access and equity, evidence informed policy and effective population-based practice in public health.
Introduction

PHAA welcomes the opportunity to provide input to the Senate Select Committee Inquiry into the Obesity Epidemic in Australia. This inquiry is dealing with one of the most important population health challenges facing Australia.

Obesity is a global health priority and is one of the nine targets in the Global Action Plan for the Prevention and Control of Non-communicable Diseases 2013-2020. Australia, as a member state of the World Health Organization, has committed to addressing non-communicable diseases, including the target of halting the rise in diabetes and obesity by 2025. The 2012 World Health Assembly recognised the significant burden of overweight and obesity on children, and has set a similar target for ‘no increase in overweight’.

Based on current trends, there is little evidence to suggest that the targets will be met.

Obesity prevention requires multiple strategies and interventions, including clear responses to environmental factors such as strong regulation of the marketing, labelling, content and pricing of foods and beverages, as well as promotion of healthy eating and physical activity.

PHAA is a member of the Obesity Policy Coalition, and supports the suggested actions for tackling obesity outlined in their report, ‘Tipping the Scales’.

This Senate Select Committee inquiry, as well as the actions that follow, will be an important step in ensuring that Australia and Australians benefit from a reduction in the economic, social and health costs associated with obesity.
PHAA Response to the Inquiry Terms of Reference

a. The prevalence of overweight and obesity among children in Australia and changes in these rates over time

Obesity rates in Australia are among the highest in the world, with 27% of children and adolescents age 5-17 years overweight (20%) or obese (7%) in 2014-15.

Studies in the USA and some low-income countries show similar high rates of overweight and obesity prevalence in childhood, evidence of the spread of a worldwide epidemic. Increases in Australia are evident from a still very concerning 21% in 1995. Aboriginal and Torres Strait Islander children, as well as those living outside major cities, and those in lower socioeconomic groups, are more likely than other Australian children to be overweight or obese.

Children from culturally and linguistically diverse backgrounds are also at greater risk of overweight and obesity, particularly children from Pacific Islander, North African and Middle Eastern backgrounds. Similar patterns of ethnic inequalities in obesity have been observed in adults, highlighting the important opportunities of family-oriented interventions to address obesity across generations.

Dietary risks are not distributed equally. Those 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 increased risk of malnutrition, obesity and diet-related chronic disease.

b. The causes of the rise in overweight and obesity in Australia

While the fundamental causes of obesity arising from population changes in diet and physical activity are not disputed, the ‘causes of the causes’ or the question of what is driving the changes in dietary and physical activity behaviours, is the much deeper question that needs to be answered. The key to stopping and reversing the rise in overweight and obesity in Australia is creating environments that stimulate healthy diets and facilitate physical activity.

There is no evidence to support the notion that the fundamental causes of the rise in obesity are a sudden loss of willpower by Australians. Nor are they because parents have at this point in history unaccountably become negligent in their responsibilities toward the health and wellbeing of their children. Rather, the evidence suggests that it is the environments in which we live that have shifted substantially over the past 30 years. This has contributed to dramatic changes in population-level bodyweight, leading to and coining the term, the ‘rising tide’ of obesity. These environmental causes of obesity have been referred to as ‘obesogenic environments’: environments that encourage the consumption of energy-dense, nutrient-poor foods and discourage physical activity.

The many complex and interacting biological, behavioural, cultural and societal factors contributing to causing overweight and obesity can be classified into seven cross-cutting themes:

- Biology
- the physical activity environment
- individual physical activity levels
- societal influences
- individual psychology
- food environment
- food consumption
The rise in overweight and obesity in Australia may be attributed to a combination of changes in these factors. Many of these factors are modifiable by public policy decisions in 3 areas - food and nutrition, physical activity and environmental influences.

It is also important to consider that obesity is not evenly distributed across the population. Rather, obesity is geographically, socioeconomically and ethnically patterned. Evidence shows that some groups in the population are disproportionately impacted by obesity (see above).

Poor diet and physical inactivity are undisputed direct causes of unhealthy weight. Recent findings in health statistics show that 39% of children aged 2-5 years old, 74% of children aged 5-12 years and 92% of young people aged 13-17 years did not meet Australian physical activity guidelines. In terms of diet, only 4% of Australian children aged 2-18 years consume the recommended five serves of vegetables per day (young children are recommended fewer serves), and only a third of children eat the recommended serves of fruit per day.

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 are not required for health and are high in added sugar, saturated fat, salt and/or alcohol). Australian families are now spending 58% of their food budget on discretionary foods and drinks.

Addressing obesity will require addressing the reasons behind the causes such as poor diet and physical inactivity. Foods available in Australia are becoming increasingly processed, more convenience-oriented, and more heavily marketed and this, combined with technological advancements, has increased sedentary lifestyles. Environments such as schools and neighbourhoods are affected, as well as broader policy and social influences such as the increased use of motorised transport. This obesogenic environment clearly places obesity as a public health issue, much bigger and more complex than simply one of personal responsibility.

Reducing obesity rates in Australia will not be possible without significant focus and investment on the environmental determinants of obesity and addressing the inequitable burden of obesity as part of a national, multi-level, obesity prevention strategy.

c. The short and long-term harm to health associated with obesity, particularly in children in Australia

The long term health risks of obesity – particularly among children – are significant. Obesity is recognised as a chronic disease associated with life-limiting co-morbidities and a reduction in quality of life.

Approximately 80% of overweight children become overweight adults, because once overweight, losing weight is difficult.
A UK longitudinal study showed that 60% of children obese at the age of 16 years were obese at the age of 30 years, and the prevalence of obesity increased for adults who were obese as children.\(^1\)\(^{27}\) Therefore preventing weight gain at early ages is vitally important.

Childhood overnutrition and undernutrition together comprise malnutrition.\(^1\)\(^,\)\(^{28}\) The implications for poor nutrition in the context of a person’s lifestyle across the life course contribute to non-communicable disease burden of chronic disease in the form of obesity, ischaemic heart disease, and diabetes.\(^5\)\(^,\)\(^{29}\)

For children, these implications impaired cognitive, physical (growth and motor skills) and social development, correlating to poor education, health and economic outcomes in adulthood.\(^5\) Adverse outcomes have been shown to be reinforced inter-generationally, evidenced by repeated poor health and economic experiences of generations of families within the same communities.\(^30\) In consequence, a lack of investment in the early years is associated with population wide health and economic outcomes related to reduced quality of life, reduced productivity, and, the cost of providing health services to society.

In the 2011 AIHW burden of disease study, high body mass was found to be responsible for 52% of the diabetes burden, 38% of chronic kidney disease burden, 23% of coronary heart disease burden and 17% of stroke burden.\(^{31}\)

The long-term health risks of obesity are wide ranging. The Royal Australasian College of Physicians (RACP) released a position statement in 2018 outlining action to prevent obesity and reduce its impact across the life course.\(^{32}\) For example, obesity is an evidence-based and modifiable risk factor for dementia.\(^{33}\)\(^,\)\(^{34}\) In Australia, dementia is among the leading causes of death.\(^{35}\)

Obesity leads to hormonal changes which reduces both male and female fertility,\(^{36}\) and the chance of having a healthy baby. Overweight and obese women are more likely to experience high blood pressure and diabetes during pregnancy, miscarriage, induced labour,\(^{37}\)\(^,\)\(^{38}\) still birth,\(^{39}\) high birthweight babies\(^{40}\) and caesarean section deliveries,\(^{41}\) and give birth to children at increased risk of future childhood and adult obesity.\(^{42}\)

d. The short and long term economic burden of obesity, particularly related to obesity in children in Australia

With the significant health risks across the life course associated with overweight and particularly obesity, the economic burden to Australia is high. Overweight and obesity contributed 7% of the total health burden in 2011 and was estimated to have cost the Australian economy $8.6 billion in 2011-12.\(^6\) One estimate by PriceWaterhouseCoopers (PwC) concluded that without additional and increased investment in well-designed obesity interventions, there will be 50% more obese people by 2025, and the cumulative marginal economic costs to Australia will reach $87.7 billion, not including the impact on the quality of life of the obese, their families and carers.\(^{43}\)\(^,\)\(^{44}\)

The costs to health systems are important and are being grappled with by many countries.\(^{45}\) The Australian Institute of Health and Welfare outlines the economic implications of obesity in Australia.\(^5\) These can include direct (e.g. cost of health services) and indirect (e.g. forgone income taxation revenue through decreased capacity to work while receiving inpatient care) costs.\(^{43}\) Different studies/reports have projected different costs for obesity, due to different methods of measuring these direct and indirect costs.\(^{43}\)\(^,\)\(^{44}\)\(^,\)\(^{46}\) However, all studies agree that the current and project economic impacts of obesity are large.

PwC have estimated a cost to the economy of $8.6 billion in 2011-12 (in 2014-15 $A); $3.8 billion of these via direct costs.\(^{44}\)
For example, in 2014-15, Medicare was billed $25.7 million, for more than 124,600 weight loss-related procedures.\textsuperscript{47}

A 2010 report prepared for the Productivity Commission (PC) commented that there was insufficient evidence to assess the specific cost of obesity in children.\textsuperscript{48} The PC cited a single study for the United States which found the costs for obese children to be broadly similar to those of other children.\textsuperscript{49} However, subsequently 1.62 times greater healthcare costs for Sydney-based obese children aged 2 to 5 years followed for three years, compared to children of healthy weight as been reported.\textsuperscript{50} A life course approach also recognises that obese children can grow into obese adults, with associated health and costs consequences.

e. The effectiveness of existing policies and programs introduced by Australian governments to improve diets and prevent childhood obesity

\begin{quote}
\textit{Australia is lagging behind other countries – such as the United Kingdom – in that we do not have a comprehensive ongoing national obesity plan, despite recommendations for one stretching back almost a decade.}\textsuperscript{51}
\end{quote}

The increasing rates are evidence that current initiatives to prevent and manage overweight and obesity and promote healthy eating and physical activity run by Commonwealth, State and Territory governments, and other organisations, are insufficient to halt and reverse obesity rates.\textsuperscript{52}

Governments may also be criticised for an overly individual-level focus on obesity prevention policy.\textsuperscript{53} The notion of individual responsibility, while it is important, must be placed in the context of the capacity that individuals actually have to respond to the obesogenic environment. Policies that focus on educating individuals or raising awareness, in isolation, have been shown to have little impact on population obesity. On the other hand, creating supportive environments for healthy living through appropriate regulation of the environment is one of the most effective methods to bring about population-level change.\textsuperscript{54}

Reductions achieved in smoking rates in Australia are a good example of effective public health regulation, as supported by the recent decision of the World Trade Organization.

PHAA encourages the Australian Government to follow this example and become a global leader in comprehensive obesity prevention strategies.

There is evidence that public health efforts to improve diets are being undermined actively by those sectors of the food industry with vested interests.\textsuperscript{3, 55} The WHO has recently published technical guidance on managing conflicts of interest in nutrition policy decision-making and programme implementation.\textsuperscript{56} This issue is discussed in further detail below.

f. Evidence-based measures and interventions to prevent and reverse childhood obesity including experiences from overseas jurisdictions

The World Health Organization’s 2016 report on childhood and adolescent obesity reinforced the need for multiple strategies to halt rising rates. The report also urges consideration of the environmental context and three critical periods in the life course – preconception and pregnancy, infancy and early childhood, and older childhood and adolescence. Finally, it emphasises the importance of treating children who are already obese.\textsuperscript{28}
Environments that support physical activity and healthy eating are amenable to change. For example, environments shown to support physical activity in children include proximity to recreation facilities and walking/biking friendly neighbourhoods including footpaths, pedestrian safety structures and street trees.\textsuperscript{57}

To effectively prevent excessive weight gain, interventions are required to change the physical, policy, economic, educational and social environments to support healthy diets and physical activity and reduce sedentary behaviours.

Both whole of population strategies and targeted strategies for high risk population groups are required to cost-effectively prevent and manage overweight and obesity.\textsuperscript{58}

Education and personal responsibility alone will not be effective in changing the obesogenic environment and creating healthy environments which enable people to exercise their personal responsibility in relation to food choices and physical activity levels.

Food and nutrition

The most effective national food and nutrition policies internationally have common features, typically being:

- comprehensive
- multi-sectoral
- multi-strategy
- co-ordinated from a central agency with adequate resources, expertise and capacity
- include shared and sector-specific goals supported by detailed implementation strategies
- adequately financed with built-in performance and results incentives for implementing bodies
- supported by high-level champions within and outside of government
- underpinned by governance structures that include civil society groups and sub-national stakeholders
- developed without influence from stakeholders with vested interests
- regularly monitored, reviewed, revised and evaluated.\textsuperscript{59}

Interventions are required across multiple domains to impact on food composition, labelling, promotion, provision, retail availability, prices and trade and investment.\textsuperscript{60} A Government Healthy Food Environment Policy Index has been proposed which includes specific good practice for each of these domains.\textsuperscript{61}

Similarly, the ‘Nourishing’ policy framework developed by World Cancer Research Fund International outlines policy actions needed in the food environment, food system and behaviour change to support healthier eating, and prevent obesity and non-communicable diseases. These actions include:

- nutrition label standards and regulations on the use of claims and implied claims on food
- offer healthy food and set standards in public institutions and other specific settings
- use economic tools to address food affordability and purchase incentives
- restrict food advertising and other forms of commercial promotion
- improve nutritional quality of the whole food supply
- set incentives and rules to create a healthy retail and food service environment
- harness supply chain and actions across sectors to ensure coherence with health
- inform people about food and nutrition through public awareness
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- nutrition advice and counselling in healthcare settings
- give nutrition education and skills\textsuperscript{62}

Some evidence-based strategies have been shown to be simple, effective and inexpensive. For example, breastfeeding teaches babies to self-regulate according to hunger,\textsuperscript{63} and reduces the risk of obesity by 13%,\textsuperscript{64} whereas infant formula increases the risk through increasing the number of fat cells laid down in the body.\textsuperscript{65}

**Physical activity**

In the face of powerful societal pressures to be physically inactive, a response consisting of population-wide, coordinated, multiplatform strategies are required to create the policies, services, physical and cultural environments that provide maximum opportunity to be active.\textsuperscript{66-70} Policy and environmental initiatives include educational outreach activities, community and street urban design, active transport policies and practice and community wide policies and planning, supported by an overarching policy such as a national physical activity plan.\textsuperscript{68}

For adults, interventions in communities, worksites, health care settings, and at home have been successful in increasing physical activity.\textsuperscript{67, 71} Physical activity choices need to be convenient, easier, safer and more enjoyable so that they can be incorporated into people’s everyday activities.

A number of individual, social and structural barriers need to be addressed in the design of physical activity interventions for older adults.\textsuperscript{72, 73} For example, walking for transportation as part of daily life for many older adults can be another option for increasing physical activity however, specific challenges exist including: lack of benches; absent or poorly maintained sidewalks; and excessive traffic speed.\textsuperscript{71, 73, 74}

**g. The role of the food industry in contributing to poor diets and childhood obesity in Australia**

The Nourishing and INFORMAS frameworks – which aim to promote healthy diets to prevent obesity, non-communicable diseases and their inequalities – highlight the important role of food environments.\textsuperscript{60, 75} Food environments have been identified as a driver of poor diet\textsuperscript{25, 60, 75} and are believed to contribute to the global obesity epidemic.\textsuperscript{76}

One aspect includes the within-store environment of food outlets such as supermarkets,\textsuperscript{76} which can influence food purchasing decisions and eating behaviour via the ‘4Ps’ of product, price, placement and promotion.\textsuperscript{77} Supermarkets decide which products are available, how they are arranged within stores by aisle and shelf location, their price, promotional activity, and point of sale merchandising.\textsuperscript{78} Most Australian food purchases are made in supermarkets (62% in 2012-13).\textsuperscript{79} The two largest chains, Coles and Woolworths, account for 70% of all grocery sales,\textsuperscript{80} and hold a powerful position in the Australian food system.\textsuperscript{81}

Australian supermarkets are powerful influencers of public health outcomes, but few positive public health impacts can be identified from their practices.\textsuperscript{81} Supermarkets shape the food choices and preferences of consumers\textsuperscript{82} by predetermining what products are available,\textsuperscript{83} and influence norms and values around foods that meets modern lifestyle needs.\textsuperscript{84} Snack foods (crisps, chocolate and confectionery) are prominently displayed at highly visible supermarket locations such as the ends-of-aisles and checkouts.\textsuperscript{85, 86} Parents report that the most difficult areas of a supermarket when shopping with children were checkout displays of confectionery, and prominent displays of food packaging designed to appeal to children,\textsuperscript{87} which were widespread in Australian supermarkets.\textsuperscript{88-90}
Astoundingly, fewer than half of the packaged foods commonly available in supermarkets can be classified as healthy.91

The proportion was even lower for snack foods (9-22%) and beverages (14-27%).92 Industrially processed foods, also referred to as ultra-processed foods (UPF),93 typically have higher saturated fat, sugar and sodium content compared with less processed foods94 and are prevalent in Australia, which ranked sixth out of eight nations for total annual UPF sales.95

Marketing of unhealthy food, including packaging and retail promotion, advertising, and sponsorship, presents a major threat to public health, particularly for children.96 Food packaging is an important marketing tool used by food manufacturers and retailers to communicate product attributes to shoppers.97 Most supermarket purchases are made on impulse and packaging plays a crucial role.90 Consumers select foods after considering labels for only a few seconds.98 Therefore, the front-of-pack plays a vital role in capturing attention and influencing consumer food preferences.99

Sixteen marketing techniques have been used on packaging to appeal to children including cartoons and celebrities, and most products marketed to children via packaging are unhealthy.90

A recent study by the Obesity Policy Coalition found that almost all children’s snacks and breakfast cereals featuring cartoon characters on the packaging are high in sugar.100

Excessive marketing to children of these nutrient-poor discretionary foods encourages overconsumption.101 Australian parents are concerned about food marketing to children102 and believe it influences their children’s food preferences.103 Packaging of Australian UPF were found to incorporate multiple marketing techniques, and extensively utilised nutrition and health statements and claims, despite many products being rated a less healthy choice.104 This is concerning, and urgent action to prevent marketing practices on packaging that mislead consumers into thinking unhealthy products are healthy is recommended.104

Other recommendations to assist parents to select healthy foods include adding a separate added sugars line on nutrition information panels (similar to the USA) and modifying the Health Star Rating front-of-pack labelling device (HSR) so that it correctly identifies the nutritional quality of UPF, before wider application of a modified HSR across all food products.104

Supermarkets shape the environment in which consumers select foods,105 and hold the potential to support healthy food choices.106 This is a role that UK supermarkets have publicly acknowledged.107 Supermarkets have control over own brand products and can determine the choice of ingredients and nutritional content,108 which presents an opportunity for public health professionals to work with them to improve the nutritional quality of the food supply.77 Australian supermarkets could also undertake to make fresh, healthy foods more available, affordable and accessible.105 In Britain, Tesco and Sainsbury aim to improve the nutritional quality of their supermarket own brand foods.109,110 Other overseas supermarket-led initiatives include: restricting multi-buy promotions that encourage bulk purchase of unhealthy foods; 111 removing lunchbox sized sugar sweetened drinks from sale; 112 introducing a supermarket-wide shelf-edge labelling system that identifies healthy foods;113 and introducing personalised shopper profiles that track the amount of healthy foods purchased.114 Supermarket food environments provide a key setting for public health interventions to improve food purchasing behaviour.

Public health interventions in supermarket settings are generally effective in increasing purchases of targeted healthy foods.115,116 Supermarket interventions have used pricing, monetary incentives, product
availability and placement, and promotional messages to increase the availability, appeal and purchase of healthy foods.\textsuperscript{117,118} Interventions can improve food purchasing behaviours, particularly when they manipulate prices, or products available, or suggest swaps for healthier products.\textsuperscript{119} A review of Australian food environments studies found eight store-based intervention studies that aimed to improve purchasing or dietary behaviour.\textsuperscript{106} Successful strategies included a 20\% price reduction for fruit and vegetables in metropolitan supermarkets,\textsuperscript{120} and a 20\% price reduction for fruit and vegetables in remote community stores which was further enhanced by consumer education.\textsuperscript{121} Policies and practices to improve placement, promotion, pricing and availability of healthy foods hold potential to improve health outcomes, including obesity.

Food manufacturers and food service outlets such as takeaway and fast food outlets, cafes and restaurants also impact food supply and promotion. The average fast food meal in Australia provides about half of an adult’s daily kilojoule needs, with some children’s meals exceeding daily recommendations for sodium and saturated fat in a single meal. Even when healthy options are available, they represent less than 1\% of purchases.\textsuperscript{122} There are clear gains to be made in the availability and promotion of healthier fast and convenient foods in Australia. Healthy and convenient are not mutually exclusive.

\textbf{Evidence exists of industry having a strategic advantage over nutrition professionals in nutrition policy making in Australia,\textsuperscript{55} and being a barrier to progress on public health issues in Australia, including obesity.\textsuperscript{3}}

While the food industry clearly has a key role to play in addressing childhood obesity, they also have an unavoidable conflict of interest since their primary responsibility is to increase profits to the benefit of their shareholders. It is therefore important that the food industry involvement in the policy process takes this conflict of interest into account. The food industry should be involved in the implementation phase of the policy process, but not during the policy development phase. Such as approach, in line with the WHO recommendations,\textsuperscript{56} has successfully been implemented in Quebec, Canada.

\textbf{h. Any other related matters}

\textbf{The role of early childhood education and care (ECEC) settings in Australia.}

The introduction of healthy eating in the early years has potential to initiate a cumulative effect, providing not only a foundation for optimal health throughout life but also providing an evidence-based approach to public health initiatives accessible throughout life.\textsuperscript{123} The Australian ECEC setting is important for the purposes of public health intervention for many reasons. National statistics show 71\% of 2-3 year olds and 87\% of 4-5 year olds attending some form of ECEC setting for an average of 16 hours per week.\textsuperscript{124} The ECEC setting is regulated by the National Quality Standard (NQS), and includes the eating occasions, meals and snack times children participate in.\textsuperscript{125} Healthy eating guidelines recognise the importance of the promotion of nutrition for normal growth and development by means of early years’ curriculum and practice.\textsuperscript{126,127} The potential therefore exists, to provide healthy food influences for young children in addition to food-related influences provided in the home environment, and particularly for children from disadvantaged households.\textsuperscript{128-132}
Educators have responsibilities related to providing for the nutritional needs of children in their care during mealtimes in ECEC, including feeding practices, providing a role models and communicating healthy eating messages and policies to children and their families. Peers in the ECEC setting provide additional role models for children. As children grow and progress to primary and secondary school years’ education, it may be increasingly difficult to change food preferences and impact future food choices, as food preferences are likely to have been formed prior to this. Therefore, the ECEC setting presents great potential for the development of healthy eating behaviours for all children by harnessing the regulatory framework in place along with the human resources in the form of educators, families and peers.

The role of the education sector in Australia

Beyond ECEC, the primary and secondary schooling sector in Australia has a responsibility to address the nutritional and physical activity needs of children whilst fulfilling its own educational agenda. The Melbourne Declaration on the Educational Goals for Young Australian’s (MDEGYA), advocates that for each student their schooling experience aims to equip them for a healthy, productive and rewarding future. It can be considered, however, that this goal remains unfulfilled for many Australian children due to inadequate nutrition and insufficient physical activity, which directly impacts on health and wellbeing while also reducing the capacity of children to fulfil their academic potential. Obese children not only experience greater risk of chronic disease but also experience stigmatisation which can impact on social-emotional functioning that inhibits academic resilience, autonomy, competence, social success and relatedness.

The MDEGYA states that it sees the role of schools as vital in “promoting the intellectual, physical, social, emotional, moral, spiritual and aesthetic development and wellbeing of young Australians, and in ensuring the nation’s ongoing economic prosperity and social cohesion”. In fulfilling this responsibility, the education sector presents great opportunity to promote the nutritional and physical activity needs of young Australians through curriculum, pedagogy, environment, infrastructure, partnership and policy. Initiatives such as the Health Promoting Schools framework, as adapted the Western Australia Healthy Schools Project, can be applied to provide such strategic actions that encapsulates a multi-dimensional approach to embedding food, nutrition and physical activity across the education sector.

The World Health Organisation has championed Health Promoting Schools as best practice for addressing leading public health priority including areas such as inadequate nutrition, and for this reason it is recommended as a key strategy for national obesity action. In adapting such an initiative within the Australian context, it is further recommended that Food and Nutrition be endorsed as a cross-curriculum priority area within the Australian Curriculum. Cross-curriculum priority areas are included as a construct of the Australian Curriculum designed to ensure national priorities for education, as identified by the MDEGYA, are embedded and made relevant across an engaging curriculum.

Embedding these recommendations as consistent and comprehensive ‘whole-of-school’ approaches to food, nutrition and physical activity has the potential to support the healthy development of children, enhance food literacy skills essential for a healthful adult life, and instil cultural values for health and wellbeing. Schools have significant public health capacity and should be positioned as sanctuaries that protect children from the influence of food industry and as a pillar of healthful behaviour.
The effects of obesity on dental health

Oral diseases, obesity and type 2 diabetes (T2D) share common risk factors as they are dietary related chronic diseases. Dental caries is one of the most prevalent diseases of childhood.\textsuperscript{155} There is a two-way association between periodontal (gum) disease and T2D. Poor glycaemic control impacts on the immune host response to wound healing and fighting infections. People living with T2D have significantly higher risks of having moderate-severe periodontitis, a severe form of gum disease. There is a 3-4 fold increased risk, and its severity is associated with poor glycaemic control.\textsuperscript{156} Severe levels of periodontitis can lead to tooth loss. Increasing numbers of missing teeth affects chewing ability, optimal nutrition intake and quality of life. There is strong evidence that good oral health is associated with better diabetes care.\textsuperscript{157}

People with the largest burden of obesity and oral diseases are those from socio-economic disadvantaged groups and priority populations (Aboriginal and Torres Strait Islanders, culturally and linguistically diverse backgrounds).\textsuperscript{158-160}

There are opportunities to strengthen obesity prevention via the implementation of 20% sugar tax, with growing evidence of significant benefit as a population health prevention strategy.\textsuperscript{161, 162} For example, a 20% sugar tax would save an estimated $666 million in dental costs over 10 years.\textsuperscript{163}

The Child Dental Benefits Schedule (CDBS) has been implemented since 2014. The uptake is significantly low in the younger population (0-4 age group). The projected annual utilisation rate of the CDBS at the end of the first two-year cycle was estimated about 30%.\textsuperscript{164} Research has shown 77% of children aged 0-4 have never had a dental visit.\textsuperscript{165} This program should be promoted more broadly because it is a targeted scheme towards lower income households.

There are opportunities to strengthen and promote the prevention of oral diseases, addressing obesity and oral health inequities, which would contribute to obesity prevention. A CDBS review from a cost-effectiveness and funding arrangement perspective has not been conducted but is necessary to ensure the long-term return on investment and program sustainability, and/or program expansion to other high risk populations.

A 2017 Productivity Commission review of government service delivery recommends that:

- State and Territory Governments should introduce a consumer directed care approach to public dental services. Under the new approach, participating providers should be paid based on a blended payment model that incorporates:
  - risk-weighted capitation payments for preventive and restorative services for enrolled patients that encourages the provision of clinically- and cost-effective treatments. Governments should weight capitation payments based on the treatment needs of different population groups (including adults and children)
  - performance-based outcome payments, incorporating payments for clinical and patient outcomes
  - activity-based payments for complex and hard to define procedures (such as dentures). The dental treatments that would be eligible for activity-based payments should be determined by governments based on available evidence on the clinical- and cost-effectiveness of treatments.\textsuperscript{166}

The benefits from introducing an added sugar levy

Currently 34 countries and 10 sub-national jurisdictions around the world have introduced taxes on sugar-sweetened beverages (SSBs),\textsuperscript{167, 168} in line with recommendations from the WHO.\textsuperscript{169} SSBs contain minimal or no nutritional benefits, and there is growing evidence of the health and fiscal benefits that emerge from
taxing SSBs. For example, in Australia it has been estimated that an SSB tax would result in almost 4 million fewer decayed, missing or filled teeth over 10 years, which represents a cost savings of $666 million.\footnote{163} Following the introduction of a 10% tax on sugar sweetened beverages in Mexico, purchases of taxed drinks experienced sustained decline over the 2 year study period, with the largest declines in the households with the lowest socioeconomic status.\footnote{170} In other words, the greatest benefits were felt among those who needed them most.

An SSB tax is one important piece of the puzzle of multiple strategies required to address obesity. The revenue from an SSB tax should be used for public health initiatives that aim to improve public health nutrition and population health, particularly for socioeconomically disadvantaged population sub-groups. An SSB tax could be used to offset the cost of other elements of a comprehensive program of activities to address obesity in Australia.

**The need for restrictions on junk food advertising**

The fact that marketing affects children’s food choices and intake is largely self-evident. The food industry would be in direct breach of their obligations to shareholders to maximise profits in continuing to spend so much time, effort and money on the marketing if it were not so successful.

Exposure to marketing of unhealthy foods is associated with increased consumption which is not compensated for at subsequent meals, and is stronger for children with a heavier weight status.\footnote{171} The evidence of the impact of this marketing is strong enough that it may be considered a modifiable risk factor for children’s health. In recognition of this, the World Health Organization produced a set of recommendations on the marketing of foods and non-alcoholic beverages to children, and accompanying framework for implementation, calling for more responsible marketing, with a supportive and enabling policy environment, and requiring a global multi-sector approach.\footnote{172,173} Current marketing predominately promotes these low nutrition foods and beverages, and there has been little progress in changing this in the past 15 years, despite the WHO global framework for doing so.\footnote{174} Systematic reviews have found that voluntary codes are insufficient and ineffective in reducing this marketing.\footnote{175}

**The need for national strategies**

A National Obesity Strategy designed to address obesity as a clear public health issue, rather than simply one of personal responsibility, is required to address the obesity epidemic gripping Australia.

Such a strategy must include population level interventions and attention to socioeconomic, geographic and ethnic inequities in obesity. This strategy should bring together Commonwealth and State and Territory governments, in recognition of the need for coordinated policies and programs at all levels of government.

The strategy must work together with a National Nutrition Strategy and National Physical Activity Strategy, recognising the clear overlaps and synergies among them, but also their independent roles and functions, as depicted in Figure 1 below:
For example, a national nutrition strategy aiming to improve diet quality and health outcomes for the Australian population, will have addressing obesity as one of its outcomes.\textsuperscript{53}

A comprehensive and well-resourced national strategy to promote physical activity with a multisector, multidisciplinary public health response incorporating researchers, research funds and practitioners in: culture, education, health, leisure, planning, transport and civil society will help to align physical and health objectives with broader social, environmental and sustainable goals.\textsuperscript{176} The strategy should include a national system to monitor and evaluate progress towards this goal and ensure that physical activity is a policy priority of the major political parties.\textsuperscript{177} The development of these strategies should be an Australian Government priority.

**Recommendations**

There is no one quick fix on this issue. Significant and comprehensive changes are required to end the obesity epidemic in Australia.

Overweight and obesity must be established as a national priority of both Commonwealth and State and Territory governments. A National Obesity Taskforce or equivalent high-level governance body that includes public health researchers, practitioners, policy makers and representatives from groups disproportionately affected by obesity, should be established. The Taskforce would provide coordinated, evidence-based advice and reporting to Government achieve real progress on halting the rise in obesity in Australia. The combination of making overweight and obesity a national priority, and establishing the Taskforce, would also play an important role in engaging with local government, industry (eg: food manufacturing, retailing and marketing, advertising, media), non-government organisations, and sport and recreation groups to unite obesity-prevention efforts and maximise outcomes.

For the Committee’s consideration, PHAA recommends evidence-based priorities that will address the drivers of obesity in Australia and make a difference to the health and wellbeing of Australian children. These recommendations incorporate those of the Obesity Policy Coalition’s ‘Tipping the Scales’ actions.\textsuperscript{4}
**PHAA submission to the Senate Inquiry into the Obesity Epidemic in Australia**

**Food and nutrition**
- Extending current food labelling policies to make the Health Star Rating system mandatory on all packaged foods and at point of sale for non-packaged fresh foods (following adjustments to the formula based on technical feedback) (Tipping the Scales); and extending mandatory menu kilojoule labelling in chain food outlets across all Australian states and territories
- Nutrition information panels to include a separate line for added sugars
- Restrict placement of confectionary, sweetened beverages, and snack foods at supermarket checkouts
- Restrict multi-buy offers (e.g. buy one, get one free) on foods classified as unhealthy
- Set food reformulation targets to reduce sugar, salt and unhealthy fats (Tipping the Scales).

**Physical activity**
- Increased investment in place-based approaches to support and encourage physical activity and healthy eating, in areas of high socioeconomic disadvantage, Aboriginal and Torres Strait Islander communities, outer regional areas of Australia, and areas where there is intersecting disadvantage
- A commitment to investing in designing healthy, livable cities and towns that facilitate walking, cycling and the use of public transport
- A comprehensive national active transport strategy integrating walking, cycling and public transport and changes to the built environment and neighbourhood social environments to encourage people to use these transport modes (Tipping the Scales).

**Obesogenic environment factors**
- Regulation to restrict under-16 children’s exposure to unhealthy food and drink marketing across all mediums, starting with free to air televisions up to 9pm (Tipping the Scales)
- A health levy on sugar-sweetened beverages of at least 20%, hypothecated to fund health programs (Tipping the Scales)
- Establishing and supporting the adoption and implementation of healthy eating and physical activity guidelines in settings including early childhood services, schools, health services, sporting clubs, community organisations and workplaces
- Fund public health education campaigns (Tipping the Scales). High impact, sustained social education campaigns to increase knowledge and awareness of the health risks associated with poor diet, physical inactivity and sedentary behaviour and to improve attitudes towards breastfeeding, healthy eating, physical activity and healthy weight
- Implement policies to prevent marketing practices on packaging that mislead consumers into thinking unhealthy products are healthy
- Restrict food industry involvement in the policy process to the implementation stage in recognition of conflicts of interest
- A new national nutrition strategy, physical activity strategy, and obesity strategy which include a focus on addressing the inequitable burden of overweight and obesity
- Establish obesity as a national health priority and appoint a taskforce to guide and oversee implementation, and report annually on the effectiveness of the government and state and territory responses to meeting the targets of: by 2025 halting the rise in obesity and no increase in overweight children in Australia (Tipping the Scales)
- Monitor diet, physical activity and weight guidelines (Tipping the Scales)
Conclusion

PHAA strongly supports action to address the obesity epidemic in Australia which is costing our people and our country so much. We are keen to ensure that the obesogenic environment is the focus of these efforts, in line with this submission. We are particularly keen that the following points are highlighted:

- Individuals should take responsibility for their choices, but Government has a role in ensuring the healthy choices are the easiest choice to make – available, accessible, and affordable
- Multiple strategies will be required to address obesity involving
  - Improving nutrition intake and diets
  - Improving physical activity levels
  - Addressing the obesogenic environment
  - Establishing strategic public policy foundations that aid in achieving these objectives

The PHAA appreciates the opportunity to make this submission and the opportunity to contribute to addressing obesity in Australia.

Please do not hesitate to contact me should you require additional information or have any queries in relation to this submission.

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