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AMA Submission to Select Committee into the obesity epidemic in Australia

Executive Summary

As the peak professional organisation representing medical practitioners in Australia, the Australian Medical Association (AMA) welcomes the opportunity to provide a submission to the *Inquiry into the obesity epidemic in Australia*. An increasing number of Australians are obese, and obesity is challenging tobacco smoking as the major cause of preventable death in Australia. Obesity substantially contributes to preventable, non-communicable diseases, shortened life expectancy and impaired quality of life.¹ The implications for the Australian health system are drastic and rapidly growing.

Education and awareness raising have been the foundation of efforts to address obesity in Australia. Undoubtedly good intentioned, education and awareness raising alone will not result in the population level changes we need to achieve in relation to overweight and obesity. Governments and the food industry must also contribute to the socially responsible and strategic response that we need in Australia. The AMA makes the following recommendations for reducing the proportion of adults and especially children in Australia who are either overweight or obese:

1. Combatting obesity demands a whole of society approach, requiring the participation of governments, non-government organisations, the health, medical and food industries, the media, employers, schools and community groups. A coordinated national strategy would underpin these efforts.
2. The major focus and effort in preventing obesity should be in children and adolescents. Prevention and early intervention should start with preconception and pregnancy and continue throughout infancy and childhood.
3. There is a need for greater and more sustained investment in research, monitoring and evidence collection to determine which individual and population measures are successful, which are not, and which may be promising. Further, community-based pilot programs should be established to address obesity in local communities, and best practice knowledge translation and exchange platforms supported for the collection and sharing of information about their success and challenges.
4. Food and beverage choices are influenced by a range of factors. Price signals influence consumer choice. For this reason, the AMA supports the implementation of a tax on sugar sweetened beverages (SSBs) as a matter of priority.

5. Creating healthy communities is an important goal. Planning regulations that govern housing, urban development and transport infrastructure should mandate the incorporation of measures to promote and facilitate physical activity. Schools and workplaces are also important avenues that can support ongoing engagement in physical activity, as well as reducing the time spent being sedentary.
6. Sophisticated food and beverage marketing and advertising is known to influence food choice / preference. Developmentally, children may not always have the skills to critically analyse the food advertising and marketing to which they are exposed. The AMA believes that the marketing of energy dense, nutrient poor foods and beverages to children should be prohibited.
7. National dietary, physical activity and weight management guidelines must be kept up to date and evidence based. Practical material for GPs and their patients should be developed in consultation with the profession to support their efforts in supporting patients wishing to lose weight, and
8. Bariatric surgery is not a population level intervention for obesity. However, for some patients who have been unsuccessful in reducing their weight by other means, bariatric surgery may reduce the associated co-morbidities. Equitable access to bariatric procedures is needed.

Introduction

Combatting obesity demands a whole of society approach, with the participation of governments, non-government organisations, the health and food industries, the media, employers, schools and community organisations.

For many people, their weight is a complex and sensitive issue. Medical practitioners are a highly trusted source of information and advice,ⁱⁱ making them well placed to identify and support patients who are overweight or obese. Advice to lose weight from a medical practitioner increases motivation to lose weight, as well increasing engagement in weight loss behaviours.ⁱⁱⁱ However, the reality is that medical practitioners can only help their patients individually (the benefits may extend to family members in some instances). The high prevalence of overweight and obesity in Australia means that change must occur at a population level. As an organisation representing the interests of medical practitioners, the AMA supports the role of medical practitioners who treat and support their patients in weight loss efforts, but recognises that real reductions in obesity will only be achieved through the implementation of population wide measures. Governments are uniquely placed to implement these measures.

Governments at all levels should employ the full range of measures available to them to modify the behaviours and social practices that promote and sustain obesity.^{iv} Further, the Federal Government must lead a strategic, coordinated and well-resourced response, committing to specific national goals for reducing obesity in Australia.

Obesity became a designated National Health Priority Area in 2008. However, rates of obesity continue to increase. Today, there is universal support among health groups for a tax or levy to be placed on sugar sweetened beverages in order to reduce consumption of these products,

which are known to contribute to obesity. Decisive action is also required to reduce children's exposure to the advertising and marketing of unhealthy foods and beverages, particularly on television. Despite the growing costs for individuals, health systems and the broader community, there continues to be a preference to invest in education and awareness initiatives. While such initiatives are part of the solution, alone they will not be effective in addressing the problem.^v

Recommendation 1

Combatting obesity demands a whole of society approach, requiring the participation of governments, non-government organisations, the health, medical and food industries, the media, employers, schools and community groups. A coordinated national strategy would underpin these efforts.

A) The prevalence of overweight and obesity among children in Australia and the changes in these rates over time

The most recent national data indicates that over a quarter (27.4 per cent) of children and adolescents (5-17 years) were overweight or obese, with 7 per cent considered obese and the other 20 per cent considered overweight but not obese.^{vi} Similar proportions of boys and girls were overweight and obese. This was a slight increase from the 2011-12 data which showed that 25.7 per cent of children and adolescents were overweight or obese. In 1995 the prevalence of overweight and obesity among children and adolescents was 21 per cent.

The prevalence of overweight and obesity in children also varies by:

- Birth cohort – children and adolescents of today are far more likely to be overweight or obese than their counterparts 20 years ago.
- Where they reside / live – children living in outer regional and remote areas are more likely to be overweight or obese than their city dwelling counterparts.^{vii}
- Socioeconomic status – children from lower socioeconomic backgrounds are more likely to be overweight or obese.
- Whether they are Indigenous – Aboriginal and Torres Strait Islander children are more likely to be overweight or obese than non-Indigenous children.
- Whether or not their parents are overweight or obese.

There are a number of very concerning aspects related to childhood obesity. Excess weight in childhood is a strong predictor of obesity or health problems in adulthood. The prevention of obesity in children is a vital part of efforts to address overweight and obesity in Australia.

Unfortunately, the higher prevalence of obesity in children in some geographic areas has resulted in obesity becoming normalised. Research shows that parents are not always able to identify that their child is overweight.^{viii} Further, in instances where children are overweight, parents may not be concerned.^{ix} This can make for difficult discussions with general practitioners and other health care providers who raise concerns about a child's weight. Resources to support general practitioners in these discussions are needed.

Experts agree that gains in life expectancy will soon be undermined by obesity.^x Today's children may not live as long and they may experience extended periods of poor health and reduced quality of life due to obesity.

Recommendation 2

The major focus and effort in preventing obesity should be in children and adolescents. Prevention and early intervention should start with preconception and with pregnancy and continue throughout infancy and childhood.

B) The causes of the rise in overweight and obesity in Australia

At a basic level, it may be argued that the main drivers of obesity can be explained in terms of diet and physical activity – individuals consuming too much energy or being insufficiently physically active. However, we know there is a complex interplay between individual, environmental and societal factors that contribute to the problem. In the United Kingdom Foresight projects are established in a range of policy areas, utilising knowledge from government, experts and academics in order to enhance policy responses over the course of 12 months. Once such project resulted in the development of the 'obesity systems map' which presents a causal model of obesity that begins with energy balance at the individual level and builds to a peripheral set of 108 variables that directly or indirectly influence energy balance. This visual tool illustrates the complex causes of overweight and obesity. For a copy of the map please refer to Attachment A (p11).^{xi}

This is not to suggest that individuals are never responsible for their behaviour, only that an effective response to the obesity crisis will need to be as comprehensive and multi-faceted as the factors that generate and sustain it. While obesity is recognised as a National Health Priority Area there is no national document that seeks to coordinate a strategic national response to obesity in Australia.

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

For children, the short-term consequences of excess weight include physical and social discomfort, as well as bone and joint problems. Excess weight in children may also be associated with shortness of breath during physical exertion, heat intolerance, tiredness and asthma. An extremely worrying trend that is emerging is overweight and obese children are increasingly developing health problems typically confined to adults including high blood pressure, abnormal blood fat levels and type 2 diabetes. Obese children are also more likely to experience sleep apnoea which can contribute to problems with concentration and learning. Overweight and obese children may also encounter psychological distress related to their weight, their appearance and how they are treated by their peers and others.^{xii}

Perhaps the most significant concern is that obesity in childhood is associated with obesity in adulthood. For many adults the health complications associated with obesity include:

- Hypertension
- Type 2 diabetes
- Coronary heart disease
- Stroke
- Gall bladder disease
- Osteoarthritis
- Sleep apnoea and respiratory problems
- Mental health disorders
- Some cancers (including endometrial, prostate, breast and colon).

Obesity also increases the chances of complications during surgery and other medical procedures, and it also makes the management of existing health conditions and diseases more difficult / complex.

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

Obesity in early childhood is associated with poorer health outcomes and higher healthcare expenditure in adulthood.^{xiii} A strong economic argument for obesity prevention in early years is the potential for future healthcare expenditure savings through prevention of chronic disease. Obesity in early childhood is also negatively associated with a child's immediate health, quality of life and educational outcomes.^{xiv} Early childhood obesity prevention may result not only in long-term health expenditure savings, but also short-term economic benefits.

Overall, the exact costs of obesity are difficult to determine, but are likely to be extensive. A recent estimate of the costs for governments (including higher healthcare spending, higher welfare spending and lower tax revenue due to lower employment rates) put the amount at \$5.3 billion per annum (including \$2.6 billion in extra health care spending).^{xv} There are also costs for individuals and families. In addition to the health care costs, obese people may also have reduced wellbeing because of illness and quality of life, foregone earnings due to lower employment rates, and possibly discrimination.^{xvi}

E) the effectiveness of existing policies and programs introduced by Australian governments to improve diets and prevent childhood obesity

State governments facilitate a wide range of programs aimed at preventing and reducing obesity among children, including programs that aim to improve eating habits and increased physical activity. It is not within the scope of this submission to provide commentary on all of these programs, however it is important to highlight that one of the benefits of a national obesity prevention / reduction strategy would include improved coordination of these programs, as well

as the opportunity to share the learning (evaluation) about what works in the various jurisdictions and within particular population groups.

Recommendation 3

There is a need for greater and more sustained investment in research, monitoring, and evidence collection to determine which individual and population measures are successful, which are not, and which may be promising. Further, community-based pilot programs should be established to address obesity in local communities, and best practice knowledge translation and exchange platforms supported for the collection and sharing of information about their success and challenges.

F) evidence-based measures and interventions to prevent and reverse childhood obesity including experiences from overseas jurisdictions;

Internationally, there is plenty of research undertaken in relation to obesity. Unfortunately, much of this research is low quality. The delivery of health care and education is also different in most countries which means international measures can be difficult to translate to the Australian context. This is not to suggest that we cannot learn from the international experience.

After a thorough assessment of the evidence, the World Health Organisation's Commission on Ending Childhood obesity recommended action in the following areas:

- Implement comprehensive programmes that promote the intake of healthy foods and reduce the intake of unhealthy foods and sugar-sweetened beverages by children and adolescents;
- Implement comprehensive programs that promote physical activity and reduce sedentary behaviours in children and adolescents;
- Integrate and strengthen guidance for non-communicable disease prevention with current guidance for preconception and antenatal care, to reduce the risk of childhood obesity;
- Provide guidance on and support for healthy diet, sleep and physical activity in early childhood to ensure children grow appropriately and develop healthy habits, and
- Implement comprehensive programmes that promote healthy school environments, health and nutritional literacy and physical activity among school age children and adolescents.^{xvii}

The international experience shows measures sending price signals to consumers do work. When a tax on sugar sweetened beverages (SSBs) was introduced in Mexico, the result was a 12 percent reduction in purchases of taxed beverages and a 4 per cent increase in untaxed beverages, mainly bottled water.^{xviii} The proposal is also widely supported domestically with thirty five leading community, public health, medical and academic groups having voiced their support for the tax.^{xix} An SSB tax also makes sense from an economic perspective.

Recommendation 4

Food and beverage choices are influenced by a range of factors. Price signals influence consumer choice. For this reason, the AMA supports the implementation of a tax on sugar sweetened beverages (SSBs) as a matter of priority.

Recommendation 5

Creating healthy communities is an important goal. Planning regulations that govern housing, urban development and transport infrastructure should mandate the incorporation of measures to promote and facilitate physical activity. Schools and workplaces are also important avenues that can support ongoing engagement in physical activity, as well as reducing the time spent being sedentary.

G) the role of the food industry in contributing to poor diets and childhood obesity in Australia;

The food and beverage industry does have a role to play in helping to combat poor eating habits and obesity in Australia. Offering more healthier products and generating income for shareholders are not mutually exclusive. This is evidenced by the development and implementation of the Health Star Rating (HSR) System, which is a simplified and uniform 'front of pack' labelling approach that has been developed in partnership with the health sector, the food industry and governments. The HSR has led some food producers to reformulate their products to achieve a higher HSR rating. Positively, research has shown that shoppers use the HSR, that it supports the identification of healthier food choices, and that these healthier product choices are maintained in the longer term. The HSR confirms that some sections of the food industry are willing to consider actions such as reformulation and more realistic portion sizes. Unfortunately, some sections of the food and beverage industry are more resistant.

Representatives from the food and beverage industries have rallied against efforts to reduce sugar consumption in Australia. The Australian Beverages Council (ABC), which claims to represent a \$7 billion industry, publicly declared in an annual report that vast amounts of resources were being spent to lobby politicians and bureaucrats to undermine proposals for a tax on sugar sweetened beverages. More recently the ABC pledged to reduce its sugar use by 20 per cent by 2025. In considering the detail of the announcement, the ABC has only pledged to reduce the average amount of sugar across their product range, and this will likely be done by creating more beverage products. There is no commitment to genuinely look at reformulation options, or the perverse incentive that exists which encourage consumers to purchase large containers of soft drink. A cynical view would suggest that the pledge is another step in efforts to combat a tax on SSBs.

Reducing children's exposure to the targeted marketing of junk foods and drinks is another component in the fight against obesity which is supported by the health sector. Advertising influences children's food and beverage choices. Australian children are exposed to large volumes of this advertising. Recent research confirms that five to eight years olds, viewing 80 mins of television each day (between 6-9am and 4-9pm), would be exposed to 1100 junk food ads per year, amounting to around five and a half hours.^{xx} This exposure occurs in the context of industry self-regulation and clearly undermines any efforts to improve childhood nutrition, particularly school-based programs on health eating. The extent of Australian children's exposure to

unhealthy food advertising raises obvious questions about the effectiveness of industry self-regulation in this area. A number of countries have implemented restrictions on unhealthy food advertising to children including Canada, Chile, France, Ireland, Mexico, Norway and Taiwan, providing Government with a range of models to consider.

Recommendation 6

Sophisticated food and beverage marketing and advertising is known to influence food choice / preference. Developmentally, children may not always have the skills to critically analyse the food advertising and marketing to which they are exposed. The AMA believes that the marketing of energy dense, nutrient poor foods and beverages to children should be prohibited.

H) any other related matters.

Population level measures are an important aspect of efforts to address obesity in Australia. While these measures are often referred to as 'nanny state' proposals, they will provide the biggest impact and warrant far more consideration than currently received. Population level measures should be complemented by more focused and targeted interventions. Obesity is estimated to contribute to 16 per cent of the health gap between Aboriginal and Torres Strait Islander people and the total Australian population. Obesity is associated with risk factors for the main causes of morbidity and mortality among Aboriginal and Torres Strait Islander peoples through health conditions such as diabetes and ischemic heart disease. Targeted culturally appropriate programs, services and supports are an essential aspect of reducing the impacts of obesity in Aboriginal and Torres Strait Islander peoples.

General Practitioners (GPs) are a trusted and highly trained source of health information and advice. Over 80 per cent of Australians visit their GP at least once per year.^{xxi} GPs have a significant role in identifying patients who are overweight and obese. GPs also support patients who wish to lose weight.^{xxii} However, the identification and management of overweight and obesity is just one component of a GP's workload that includes providing care for patients with chronic or complex health conditions. Providing up-to-date, practical, evidence informed resources to support GPs in this area is vital.

Recommendation 7

National dietary, physical activity and weight management guidelines must be kept up to date and evidence based. Practical material for GPs and their patients should be developed in consultation with the profession to support their efforts in supporting patients wishing to lose weight.

While the prevention of obesity in childhood is an important goal, we must also recognise that medical intervention may be required for those who have been unsuccessful in reducing their weight by other means. For some patients, bariatric surgery provides the best chance of losing weight and reducing the impact of serious medical

comorbidities. This improves quality of life and can significantly reduce health related costs. Unfortunately, the lower a person's income, the more likely they are to be obese. For some patients this means having to access superannuation to fund the procedure, potentially exacerbating financial hardship. It is also understood that a number of health insurers are removing bariatric surgery from their basic policies, meaning patients seeking to access bariatric surgery privately will either need to upgrade their health insurance or look for other ways to fund the procedure. For patients who are unable to fund the procedure, access to bariatric surgery in the public health system is extremely difficult, despite its clear benefits. Governments must work with clinical experts and stakeholders to develop equitable responses to this problem.

Recommendation 8

Bariatric surgery is not a population level intervention for obesity. However, for some patients who have been unsuccessful in reducing their weight by other means, bariatric surgery may reduce the associated co-morbidities. Equitable access to bariatric procedures is needed.

Conclusion

In summary the AMA would like to reiterate its recommendations for future efforts around childhood obesity and obesity more generally:

1. Combatting obesity demands a whole of society approach, requiring the participation of governments, non-government organisations, the health, medical and food industries, the media, employers, schools and community groups. A coordinated national strategy would underpin these efforts.
2. The major focus and effort in preventing obesity should be in children and adolescents. Prevention and early intervention should start with preconception attention and continue throughout infancy and childhood.
3. There is a need for greater and more sustained investment in research, monitoring, and evidence collection to determine which individual and population measures are successful, which are not, and which may be promising. Further, community-based pilot programs should be established to address obesity in local communities, and best practice knowledge translation and exchange platforms supported for the collection and sharing of information about their success and challenges.
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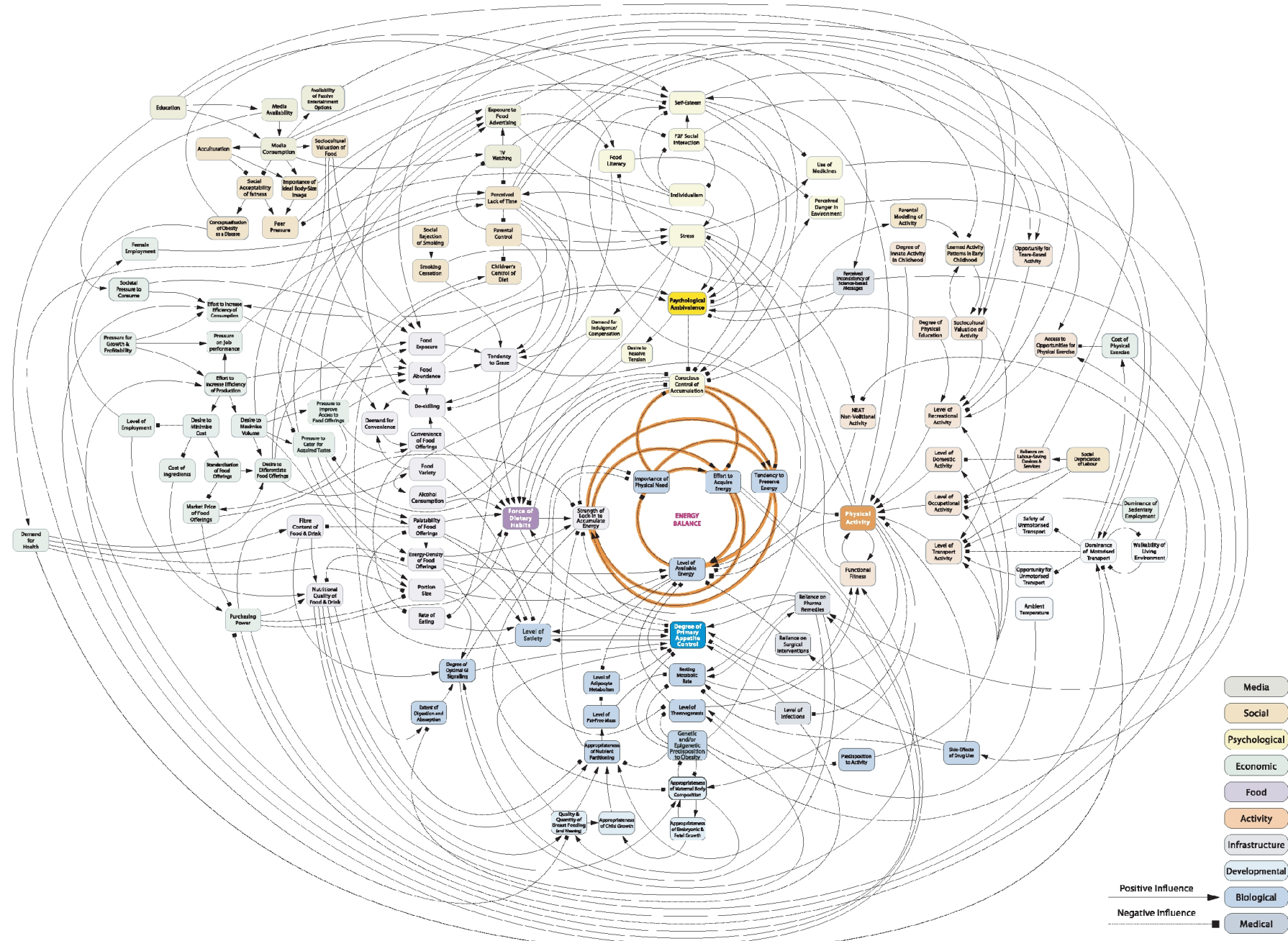
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