5 July 2018

Inquiry into the Obesity Epidemic in Australia
Committee Secretary
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Dear Senate Committee Members

Submission to Parliament of Australia Senate Committee: Inquiry into the Obesity Epidemic in Australia from the Action on Obesity Collective

We are pleased to have the opportunity to contribute to the Senate Inquiry into the Obesity Epidemic in Australia. With more than a quarter of Australian children overweight or obese, we applaud that policy makers are devoting time to consider appropriate actions to help better prevent and manage this serious public health problem.

There have been a number of previous taskforces, reports, strategy documents and plans of action addressing this issue in Australia. Their recommendations have been consistent but the challenge has been to translate them into a sustained program of action.

Action at a Government level alone will not be sufficient to deal with the complex, community problem of childhood obesity – all sectors of society will need to be involved. However, Government policies and programs are essential to provide the leadership and appropriate framework for action and to enable and support action by other sectors. We hope that the work of your committee will help galvanise and lead the whole of society response required to deal with this problem that has such significant impacts on the health and wellbeing of our children.

The Obesity Collective

The Obesity Collective had its origins in November 2016 at a workshop hosted at Price Waterhouse Coopers, Sydney. This meeting followed release of the Weighing the Costs of Obesity report in late 2015, which had been prepared by PWC for Obesity Australia. The report was socialised at a series of roundtable discussions held around Australia, and the clear message coming from across sectors was that the time has come to transform the national response to the obesity epidemic. The Obesity Collective will formally launch its strategy to achieve such a transformation on 31st July at the Charles Perkins Centre in Sydney.

We are a group of committed individuals and organisations spanning all sectors of society, who are working collectively to support a new, society-wide model for addressing the obesity epidemic based on collaboration and shared responsibility. We are working to transform the way society thinks, speaks, and acts on obesity to reduce the impact obesity has on us all. We believe that with a more unified voice, connected efforts across treatment and prevention, and aligned commitments, we can create the momentum, pressure, and opportunity needed to drive change in the prevention and treatment of obesity. Our members include individuals who have experience in academia, research, non-profits, industry, and work across all levels of government. By collaborating and using our diverse skills and expertise, the Collective can provide expert leadership across different facets of the obesity epidemic to make effective change. Our focus is on reframing the issue of obesity so that the
community understands more fully that reversing the epidemic, particularly among children, is imperative for the collective physical and economic health of Australia.

We take a whole of society approach that considers the social, biological, political, and cultural drivers of health and health inequality. The Collective is informed by evidence and prepared to innovate, while willing to listen to and respecting other perspectives.

Our submission to the Senate Committee for the Inquiry into the Obesity Epidemic highlights key issues, including:

- The continued high prevalence of childhood overweight and obesity. International comparisons show Australia has some of the highest rates of childhood overweight among developed countries. Children today are gaining weight more quickly than in previous generations.
- Commentaries often identify a lack of will power (cognitive control over personal behaviours) as the key factor leading to a positive energy balance, but this ignores the powerful genetic, epigenetic and biological drivers that influence or bypass these behaviours to promote weight gain, especially when combined with our current obesity-promoting (obesogenic) environment.
- Childhood and adolescent obesity is associated with a wide range of immediate health concerns, as well as increasing the risk of disease in adulthood. In addition, obesity in childhood and the stigma associated with it, also negatively impacts a child's mental health, quality of life and educational outcomes.
- Obesity in children is associated with increased direct health care costs, but also increases the risk of chronic disease later in life. Overweight and obesity was responsible for 7% of the total health burden in Australia in 2011, through its impact on early death and the risk of developing other chronic diseases including type 2 diabetes and cardiovascular disease.
- Childhood obesity has been recognised as an issue of concern by all Australian governments, but the response has varied greatly among different jurisdictions. Currently there is no region or country that has come to terms with the complex array of drivers of obesity to develop programs of actions to effectively address the problem of obesity. However, there are lessons to be learned from some countries that have invested in exploring the range of strategies most likely to make a change.
- There have been numerous assessments of the evidence around effective actions to address childhood obesity, including a number of strategy reports prepared for Australian Governments. The recommendations have been reasonably consistent over time. It is now time to start acting on these reports.
- We believe that the families of children with overweight and obesity in every part of Australia should have access to weight management services under a unified, national approach to managing the growing epidemic of childhood obesity.
- The food industry has made valuable contributions providing access to safe, healthy, and affordable food; however, the evidence shows that it has also played a role in promoting and benefitting from the overconsumption of energy from food and beverages in Australia. More proactive work is needed in helping to make healthier choices easier and more accessible to all Australians.
- The framing of discussions around actions to address obesity in terms of personal responsibility or “nanny state” objections are simplistic and counterproductive responses to a serious and complex societal problem. We need to transform the way society thinks, speaks, and acts on obesity to reduce the impact obesity has on us all. This requires a whole of society response – the Collective stands ready to support government in achieving such a transformation.
Our submission to the Senate Select Committee is informed by the program of work conducted by the Collective.

We address the terms of reference below:

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

International comparisons show Australia has some of the highest rates of childhood overweight among developed countries, with prevalence rates for both boys and girls being above the OECD average (OECD report 2017). The latest data from the ABS and AIHW analyses of the weight status of children is presented below (AIHW 2017a):

- In 2014–15, 1 in 5 (20%) children aged 2–4 were overweight or obese—11% were overweight but not obese, and 9% were obese. By age 5 years combined overweight or obesity affects almost one in four children

- The same data in 2014-15 shows that obesity affects 8.8% of 2-5 year olds, 7.5% of 6-9 year olds, 6.1% of 10-13 year olds and 7.6% of 14-17 year olds and combined overweight & obesity affect 21% of 2-5 year olds, 22.8% of 6-9 year olds, 30.8% of 10-13 year olds and 29.8% of 14-17 year olds. See Figure 3.2 below

- For both children aged 2–4 and 5–17 years, similar proportions of girls and boys were obese although more boys were overweight.

Social inequalities in overweight and obesity are strong in Australia, with low socioeconomic areas having higher rates of obesity compared to wealthier areas. In 2014–15, one-third (33%) of boys in the lowest socioeconomic group were overweight or obese, compared with 22% of those in the highest socioeconomic group. Similarly, more than one-third (38%) of girls in the lowest socioeconomic group were overweight or obese, compared with 24% of those in the highest socioeconomic group. In addition, children and adolescents living in outer regional/remote areas are more likely to be overweight and obese than those in major cities (AIHW 2017a).

Childhood overweight and obesity is also more prevalent amongst Indigenous Australians. In 2012–13, almost one-third (30%) Aboriginal and Torres Strait Islander children aged 2–14 years were overweight or obese (20% and 10% respectively), whilst 8% were classified as underweight (ABS 2013).

The relative weight of Australian children has been increasing since the 1950s, although overweight and obesity began to increase rapidly from the 1980s (Olds and Harten 2001). Children today are gaining weight quicker than in previous generations. At age 10–13, 30.8% of children and adolescents born in 2002–2005 were overweight or obese, compared with 23.9% of those born in 1982–1985. At age 14–17, 29.8% of adolescents born in 1998–2001 were overweight or obese, compared with 18.7% of those born in 1978–1981 (AIHW 2017b). This is of concern because the earlier that children develop a weight problem and the greater the degree of overweight greatly increase the risk of developing chronic diseases such as type 2 diabetes earlier in adult life.

A number of surveys suggest that rates may be stabilising, especially in children from upper SES grades, although they continue to increase steadily in low SES and disadvantaged groups (Hardy et al, 2017 and AIHW 2017a).
2. The causes of the rise in overweight and obesity in Australia;

*Complex interplay of factors*

Simple explanations of the development of obesity often focus on an imbalance of energy where calories (energy) intake exceeds energy expenditure, leading to weight gain. However, a complex and diverse range of factors contribute to a positive energy balance, and it is the interaction between a number of these influences, rather than any single factor acting alone, that is thought to be responsible. Ill-informed commentaries often identify a lack of will power (cognitive control over personal behaviours) as the key factor leading to a positive energy balance, but this ignores the powerful genetic, epigenetic and biological drivers that influence or bypass these behaviours to promote weight gain, especially when combined with an obesogenic environment (Gill et al 2011). It is now clear that our biological predisposition combined with multiple changes in the way we live, eat, travel and work has influenced the rise in obesity rates across Australia and the world (AIWH 2017a). The environment has been transformed into one that supports and encourages unhealthy diet and physical activity behaviours and makes appropriate behaviour change difficult to institute and sustain.

*Obesity-promoting (obesogenic) environments*

The external social, political and economic environment in which people live has a profound effect on the way people live and behave. A number of studies have attempted to document the profound changes in this aspect of our life to identify the elements that have contributed to the changes in dietary and physical activity patterns associated with weight gain. Our diet today is influenced by the wide availability of highly processed, high energy-dense but nutrient-poor foods that are relatively low in price, sold in large portion sizes and aggressively marketed. This has led to a disproportionate intake of what are termed “discretionary” or non-core food and beverage products which encourages excess calorie intakes. In addition, we now consume up to one third of food away from home and eat a large amount of ready prepared foods (Osei-Assabay et al 2012). An analysis of the 2011-12 National Nutrition and Physical Survey showed that Australian children and adolescents aged 2–18 years continue to source nearly 40% of their daily energy intake from discretionary foods that are high in saturated fat, sodium, and/or added sugars (Johnson et al, 2017). Of particular concern is the large amount of sugar-sweetened beverages that Australian children consume, as these have been closely linked to the development of obesity in children (Buher Della Torre et al 2016).

Fewer opportunities for physical activity due to changing modes of study and leisure also contribute to the rise of overweight and obesity in Australian children. Physical activity habits have changed over time with the prevalence of the Internet and ‘screen time’ encouraging more sedentary behaviour, as have reductions in the amount of time children engage in physical activity for play, and active transport is a key obesity risk factor (Healthy Active Children Australia 2016). Parents indicate concerns over traffic, as well as stranger safety, prevent children from more play outside, and an absence of footpaths inhibits walking and cycling to school and for play (Aarts et al, 2012).

*Genetics and epigenetic factors*

In combination with an obesogenic environment, what is also clear is that heritable biological factors explain why some individuals or groups are more at risk of developing obesity compared to others within the community. In particular, our genes and ‘epigenetic’ modifications to the way those genes are expressed (created by environmental exposures, including in utero and even preconception) have profound effects on our regulation of energy balance and how and where we store fat generated by
excess calories (Gill 2011). Parents with obesity are more likely to have children who are at risk for excess weight; often these can be due to both genetic and socioeconomic and sociocultural determinants – for example, shared family meal patterns, food knowledge and behaviours (Haire-Joshu & Tabak 2016).

**Early life exposures**

Research has also found that early life period, including pre-conception, in utero, infancy and early childhood is a critical period for the development of obesity. A range of biological and behavioural factors occur during this period that influence the adiposity of the child or imprint diet and physical activity behaviours which persist throughout childhood (Gill et al 2011). These included higher maternal pre-pregnancy BMI, prenatal tobacco exposure, maternal excess gestational weight gain, high infant birth weight, and accelerated infant weight gain in the first year. Other factors for which there is less evidence as risk factors for childhood obesity include curtailed infant sleep, inappropriate bottle use, introduction of solid food intake before age 4 months, and infant antibiotic exposure (Woo-Bartel et al, 2016).

The drivers of obesity within the community are many and complex. As such, there are no simple answers, and effectively addressing the problem of obesity at a community level will require significant action over time (Gill et al 2011). However, it is not necessary to have fully elucidated the multiple and complex causes of the obesity epidemic before instituting and evaluating interventions to address aspects of the problem we do understand.

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

Obesity is associated with detrimental short and long term health for both adults and children. Most ill health effects of obesity comes from years of exposure to overweight. Overweight and obesity was responsible for 7% of the total health burden in Australia in 2011, 63% of which was fatal burden (AIWH 2017). As a major risk factor for other chronic diseases including type 2 diabetes and cardiovascular disease, obesity in children also increases the risk of chronic disease earlier in life. In addition to direct impact on physical health, the stigma of obesity is linked to bullying, leading to mental health problems and low self-esteem. This has a flow-on effect in severe cases, affecting participation at school and work. The stigma attached to overweight and obesity can also lead to forms of discrimination in both professional and social spheres of life (PWC 2015), contributing to the cycle of inequality that inhibits health literacy to improve outcomes.

Childhood and adolescent obesity is associated with a wide range of immediate health, social and learning concerns, as well as increasing the risk of disease in adulthood. Children with obesity are also less likely to engage in healthy lifestyle behaviour, such as good oral health, regular breakfast, and the recommended intake of fruit and vegetables (SPANS 2015), further inhibiting good health outcomes as they get older. Childhood weight problems have also been linked to poorer academic performance, social skills and community participation, which not only contribute to health issues but also feed into reduced workforce participation (Booth et al 2014).
Childhood obesity increases the risk of high blood pressure and high cholesterol (risk factors of cardiovascular disease), type 2 diabetes, respiratory problems including asthma and sleep apnoea, joint problems and musculoskeletal discomfort, fatty liver disease, gallstones, and heartburn (US Centers for Disease Control and Prevention; WHO 2000). The common pattern of obesity progressing into adulthood leads to earlier development of chronic diseases (Gill et al 2011), making reversal of obesity and its associated risks more difficult, particularly when poor diet and lifestyle habits have set in. Overweight and obesity among adults increases the likelihood of developing many chronic conditions, including some cancers, cardiovascular disease, asthma, back pain and problems, chronic kidney disease, dementia, diabetes, gallbladder disease, gout, and osteoarthritis (AIWH 2017).

While obesity is a disease in its own right, it is a key risk factor for other non-communicable diseases including diabetes and coronary heart disease, in addition to smoking, high blood pressure and hypercholesterolaemia (WHO 2000). Developing complications impacts on the patient’s life and ability to participate fully, and also increases the likelihood of requiring professional care services or additional care from family. Studies relating obesity to mortality have included biases in their design that led to a systematic underestimate of the impact of premature mortality (WHO 2000, Gill et al 2011), particularly when considered with other comorbidities.

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

Obesity has direct and indirect costs to individuals, families, governments, private health insurers, employers, and society more broadly. Obesity impacts not only on physical health, but the mental health and wellbeing of those living with obesity and in some cases, those caring for people with obesity (PWC 2015). The long and short term costs include the management of obesity itself, and the costs associated with its comorbidities. The overall direct costs of obesity to Australia in 2011-12 Australia were determined to be $3.8 billion, while indirect costs were calculated to be $4.8 billion (PWC 2015).

Obesity in early childhood also negatively impacts a child’s immediate health, quality of life and educational outcomes which creates additional economic burdens. The highest direct cost of childhood obesity is from healthcare costs, which are 1.62 times higher than healthy weight children (Hayes et al 2016). Annual direct costs of obesity in children aged 2-4 years were estimated at $17 million to the healthcare system (Brown et al 2017).

Indirect, or hidden costs to the community, include loss of productivity through absenteeism (needing to take time off work for health issues) and presenteeism (inability to function at full capacity at work due to health problems), government subsidy payments and forgone tax revenue. A National Health Survey found that employees with obesity were 17% more likely to have been absent from work than other employees (PWC 2015). Additionally, with a strong correlation between obesity and disability, extreme obesity can lead to impaired functionality, while some disabilities can also lead to obesity (PWC 2015). Individuals with obesity faces costs in managing their condition, as well as impacting on those who care for them. Modifying spaces to facilitate access to and comfort in buildings and spaces, for example, may be some costs borne by those living with obesity. The PWC report also argues that there are incalculable costs incurred from the stigma of obesity, including discrimination across
education, work, and social spheres. Obesity damages labour market outcomes that, in turn, contribute to reinforcing existing social inequalities (Devaux and Sassi, 2015 in OECD 2017). People with obesity have poorer job prospects compared to healthy weight people, and lower earnings due to poorer educational outcomes. They are less likely to be employed and have more difficulty re-entering the labour market (OECD/EU, 2016). The stigma associated with obesity can lead to discrimination, including fewer opportunities for job promotions and career progression (PWC 2015).

There is a strong economic argument for obesity prevention in early years based on the potential for future healthcare expenditure savings through prevention of chronic disease (Brown et al 2017). Early childhood obesity prevention may result not only in long-term health expenditure savings but also short-term economic benefits, for example, in reducing healthcare expenditure. Successful intervention into childhood obesity can also prevent overweight and obesity in adulthood, negating the additional costs of managing obesity and its eventual associated long-term health implications.

In terms of the societal cost, there are complex inequities in who bears the cost of childhood obesity in the community – from the strain on the health system and pressure on health care providers, to presenteeism in the workplace and the ability to contribute to the overall economic system.

Based on current trajectories calculated by PWC (2015), if nothing is done to address the prevalence of obesity in Australia, it is estimated to cost $87.7 billion in additional costs over the years 2015 to 2025. Implementing a suite of selected obesity interventions would generate a return on investment of $2.1 billion for Australia (benefit cost ratio of 1.7) over 10 years. Meeting the WHO target of halting the rise in obesity based on 2010 levels would lead to a benefit of $10.3 billion for Australia over 10 years (PWC 2015). Current interventions are not sufficient to meet the WHO target, meaning further investment is needed in a range of established and innovative approaches for obesity prevention and intervention.

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

Childhood obesity has been recognised as an issue of concern by all Australian governments, but the response has varied greatly among different jurisdictions. There has been a series of well researched and structured policy documents and action plans produced for federal and state governments over the past 25 years but the recommendations from these reports have at best only been selectively implemented. There has been a reluctance by governments of all persuasions to take up policy initiatives that may create negative responses from any sector of society, regardless of the validity of the opposition (Baker et al 2017). Research from the Global Obesity Centre at Deakin University (supported by The Australian Prevention Partnership Centre), examined the extent to which each jurisdiction in Australia is implementing globally recommended government policy action to address obesity and improve population diets (Globe 2017). This project identified that while there are a few areas where Australian governments were progressing recommended actions, there are a number of areas where Australia is significantly lagging behind other countries in their efforts to address unhealthy diets and obesity.

Currently there is no region or country that has come to terms with this complex array of drivers of obesity to develop programs of actions to effectively address the problem of obesity. However, there
is a growing body of evidence which indicates the types of interventions that will be required to be integrated into a comprehensive program of action to tackle the problem and some countries have already started investing in this approach. For example, the UK Government Childhood obesity: a plan for action (UK Government 2017) includes a mix of fiscal, regulatory and educational strategies together with family, school and community based nutrition and physical programs coordinated across multiple agencies with clear evaluation objectives. Chile has also produced a coordinated national strategy which includes new regulations that mandate interpretative front of pack labelling, advertising regulations, school food sales restrictions and a tax on sugar-sweetened beverages. This has been combined with social marketing campaigns and school and community programs to promote healthy eating and activity especially in children (Rodriguez Osiac et al 2017).

Some Australian jurisdictions have also worked collaboratively to develop comprehensive, broad-based programs which have been implemented across all sectors of the community and based on a whole of government approach. For example the NSW Government Premier’s priority Healthy Children’s Initiative includes multiple programs developed specifically for different ages of children and different setting but which have similar objectives. The program is implemented through partnerships with key stakeholders in childcare, education, community, junior sport and disadvantaged youth services settings (Innes-Hughes et al, 2017).

Analysis of other successful public health actions indicate that no single intervention will be sufficient alone to allow the community to return to energy balance, but a portfolio of actions may make progressive contributions to a solution (Gill et al 2011). Where comprehensive programs of action combining behavioural with environmental and structural interventions have been undertaken and sustained, there have been promising improvements in childhood weight status, particularly in younger children (aged 6 to 12 years) (Innes-Hughes et al, 2016, SPANS 2015). A review of these programs by Bauman et al (2016) found that the most effective programs included the below strategies:

- School curriculum that includes healthy eating, physical activity and body image.
- Increased sessions for physical activity and the development of fundamental movement skills throughout the school week.
- Improvements in nutritional quality of the food supply in schools.
- Environments and cultural practices that support children eating healthier foods and being active throughout each day.
- Support for teachers and other staff to implement health promotion strategies and activities (e.g. professional development and capacity building activities).
- Parental support and home activities that encourage children to be more active, eat more nutritious foods and spend less time in screen-based activities.

Many existing funded programs are variations of an approach of supporting interventions in schools or workplaces for healthier diet and lifestyle practices. While this approach increases the knowledge and awareness of certain groups of adults and children, it is not an effective population-wide approach that benefits the greatest number of the population as possible, and relies on the adherence and engagement of the school or workplace (Bauman et al, 2016). The WHO Commission on Ending Childhood Obesity suggests a comprehensive program requires a strong infrastructure of governance, government support, and standardised guidelines across nutrition and physical activity. According to WHO, the Obesity Policy Coalition, and the Global Obesity Centre, a comprehensive program to
prevent and reduce obesity also needs to address aspects of the obesogenic environment. The Obesity Policy Coalition report ‘Tipping the scales’ developed the key components of a national obesity prevention campaign for Australia. It also addresses recommendations highlighted in the WHO report on ‘Ending Childhood Obesity’, and, among its recommendations suggests measures to restrict advertising of unhealthy food to certain time periods during the day, reformulation targets and timelines for packaged food, a public education campaign to better inform Australians of the impact of diet and physical activity, and a health levy on sugary drinks.

WHO Commission on Ending Childhood Obesity says:

“Governments bear the ultimate responsibility for ensuring their citizens have a healthy start in life. Preventing childhood obesity requires the coordinated contributions of all governmental sectors and institutions contributing to policy development and implementation. Resources need to be dedicated to policy implementation and workforce capacity strengthening”.

Action at a Government level alone will not be sufficient to deal with the complex, community problem of childhood obesity – all sectors of society need to be involved. However, Government policies and programs are essential to provide the leadership and appropriate framework for action and to enable and support action by other sectors.

Over the last decade, there have been a range of well-planned child obesity prevention programs or structures (based on the principles set out above) initiated by various Australian governments. However, many of these have not been sustained, or supported to scale-up or innovate due to funding cuts and shifting priorities. For example, the Australian National Preventive Health Agency, the National Partnership Agreement on Preventive Health and the CO-OPS Collaboration (Federal), OPAL-Obesity Prevention and Lifestyle (SA) and Healthy Together Victoria.

Weight management services for those children with an existing weight problem

Currently one in four Australian families have children who are already overweight but they find it difficult to identify and access appropriate services to help manage this problem. A recent report from the Australian Prevention Partnership Centre highlighted the absence of any national program of weight management services available to families and no routine monitoring or screening of growth and weight status in children (Vidgen and Love 2017). This was despite the report identifying clear evidence of the effectiveness of child obesity management programs.

The World Health Organization’s Commission on Ending Childhood Obesity lists identifying and treating children and adolescents already affected by obesity as one of its six overarching goals. It recommends universal availability of family-based, multicomponent (including nutrition, physical activity and psychosocial support) and delivered by multi-professional teams with appropriate training and resources (WHO 2016).
6. Evidence-based measures and interventions to prevent and reverse childhood obesity, including experiences from overseas jurisdictions;

Evidence-based measures and interventions are those which are supported by data from numerous well-designed studies. However in complex public health problems such as obesity, incontrovertible evidence around specific interventions may be difficult to obtain. This is where it is important to collate and assess the best available (rather than the best possible evidence) to provide guidance on recommended action. Following an “evidence-informed” approach allows the implementation of well-designed programs that generate understanding whilst addressing community needs (Bowen and Zwi, 2005).

The quality of evidence and its application to the prevention and management of childhood obesity has been addressed by numerous existing analyses and reports within Australia and overseas, including evidence assessments by the Australian National Preventative Health Taskforce, World Health Organization (WHO), World Obesity Federation, US Centers for Disease Control and Prevention (CDC), UK parliament, Scottish Government and Health Canada. This work has been used as the basis for formulating obesity action plans for most Australian jurisdictions as well as the generation of policy by most major Australian NGOs and professional bodies (including the Australian Medical Association) and most recently the Australian Obesity Prevention Consensus. In addition there have been numerous reviews of the literature by academic groups to assess the quality and consistency of this evidence (e.g. Bauman et al 2016) as well as the cost effectiveness of various options (e.g. Gortmaker et al 2015).

The findings of these academic reviews and the assessment of health agencies and NGOs have been very consistent in relation to the most appropriate actions to address childhood obesity. Most recently, 35 leading community, public health, medical and academic groups came together to review the evidence and produce a set of clear, practical recommendations to address obesity in Australia under the ‘Tipping the scales’, Australian Obesity Prevention Consensus (2017). Their recommendations were in line with those of the WHO Commission on Ending Childhood Obesity (2016) which recommended action to:

i. 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;
ii. Implement comprehensive programmes that promote physical activity and reduce sedentary behaviours in children and adolescents;
iii. Integrate and strengthen guidance for non-communicable disease prevention with current guidance for preconception and antenatal care, to reduce the risk of childhood obesity;
iv. Provide guidance on and support for, healthy diet, sleep and physical activity in early childhood to ensure children grow appropriately and develop healthy habits
v. Implement comprehensive programmes that promote healthy school environments, health and nutrition literacy and physical activity among school-age children and adolescents;
vii. Provide family-based, multicomponent, lifestyle weight management services for children and young people who are obese.

The evidence clearly shows that a comprehensive range of policy and program interventions will be required to address childhood obesity in Australia. However, it is essential that these actions be directed at the environment (aimed at making healthy choices easier) in addition to the individual
(compelling them to take the healthy choices) (Swinburn et al 2011, Bauman et al, 2016, Gortmaker et al, 2015). It is equally important to ensure that benefits of such interventions to address obesity will bring benefits to the most disadvantaged Australians. While obesity affects people of all socioeconomic levels, rates of obesity increase among those with lower socioeconomic background (Hardy et al, 2017, NHPA 2013).

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

Obesity is fostered by an obesogenic environment, where people are faced with certain choices for their diet and lifestyle, and are socialised and educated into certain habits. The food industry has an important role in providing Australians with nutritious, safe and affordable food. Despite making valuable contributions to many of these objectives, it has also played a role in promoting and benefitting from the overconsumption of energy from food in Australia. Obesity is driven by the environment in which people find themselves – the food that is available and the way it is marketed, the nutritional and dietary information and education available, access and affordability of certain kinds of food, in addition to limited opportunities for sufficient levels and types of physical activity for many who work full time with competing responsibilities.

A range of issues across the food system, such as the wider availability and access to cheap, highly marketed, high energy dense, nutrient poor food and beverage products available in large serving sizes have been implicated in the consumption of excess calories and the increase in obesity in Australia and other countries (Swinburn et al. 2011). Many sectors of society have contributed to the creation of our current obesogenic environment that encourages unhealthy eating behaviours and inhibits change to more appropriate ones. However, all domains of the food industry, including manufacturers, retailers, catering, ready-to-eat, and marketers have played an integral role in driving the current food supply in the wrong direction.

Mialon et al. (2016) conducted a systematic examination of publicly available information from the food industry and their contribution to the conversation about obesity in Australia. This analysis indicated that major Australian food industry actors engage in diverse and extensive practices to protect their interests which can have a negative influence on public health policies and programs. Examples of this competition between industry interests and public health highlighted in the study by Mialon et al (2016) include opposition to independent regulation around the marketing of unhealthy foods to children, new planning regulations for fast food restaurant sites, compulsory front of pack and menu board nutrition labelling and any form of fiscal strategy to improve the quality of food supply and consumer choice.

The food industry has explored positive contributions to the quality of the food supply through the Food and Health Dialogue/Partnership. This initiative by the Australian Government brings together industry with public health and government agencies to consider opportunities for improving the food environment and consumer awareness around food and health issues. This dialogue led to the development of the Healthy Star rating system and the food industry has committed to some important food reformulation targets. However, concern is being expressed about progress towards achieving set targets for food reformulation (Jones et al 2016) and around the unwillingness to accept
the mandatory labelling of all packaged foods and the misuse of the negotiated Healthy Star Rating system.

8. Other issues

The framing of discussion around comprehensive action to address obesity.

The Obesity Collective would like to raise some key issues around the framing of discussion around the comprehensive programs of action that will be necessary to effectively address the major public health problem of childhood obesity in Australia. These relate to concepts of personal responsibility for the development of obesity and the accusation of “nanny state” around proposed interventions to enable and encourage health behaviour change in the Australian community.

As indicated earlier in the submission, the misperception that obesity develops within an individual purely as a result of gluttony or sloth remains prevalent within the Australian community and underlies much of the discussion around strategies to address the problem. The prevailing narrative is that obesity is a result of personal failings and thus the solutions must come from the individual and should not impinge upon the rest of the community. The limitations of that argument is the fact that two out of three adults and one quarter of children in Australia are already overweight or obese. The truth is that obesity in any individual results from a complex interplay of biological predisposition with the social, political and economic environment that drives behaviours and as such it is a societal problem requiring whole of community solutions. This does not diminish each person’s requirement to commit to appropriate behaviours to maintain a healthy weight for themselves and their children, but society also needs to commit to providing an environment that supports rather than inhibits their efforts to achieve these outcomes. Failure to accept our communal responsibility for the drivers and solution to obesity results in the discrimination and stigmatisation of individuals who already suffer the consequences of obesity (Puhl and Heuer, 2010). This current narrative needs to be challenged especially when delivered by policy makers. The stigma and shaming of children with a weight problem has profound effects on their mental health and wellbeing (Pont et al, 2017).

A corollary of the “personal responsibility” objection is the criticism of community-wide regulatory and policy approaches to addressing obesity represent a ‘nanny state’ that represents unjustified interference with people’s lives or with commercial freedoms. This rhetoric is often used indiscriminately to describe initiatives which are aimed at protecting or empowering personal freedoms such as providing more useful nutrition information on the front of packaged foods. The right to health is a fundamental and widely recognized aspect of human rights. Governments have a fundamental requirement to intervene to protect the health and well-being of the community (Brownell et al 2010). Accepting our collective responsibility to find solutions to protect the health of our children from obesity will help negate the “nanny state” derision advanced by those who do not wish to participate constructively in finding solutions to this problem.

Concluding remarks
Once again, we thank you for the opportunity to contribute to the Senate Inquiry into the Obesity Epidemic in Australia. We appreciate the Australian Government’s efforts to reduce the burden including the substantial health consequences of this issue.

The Action on Obesity Collective would be pleased to provide further advice and assistance on this issue. We hope that together we can make a real impact on finding and implementing solutions for the prevention of obesity in the next generation of children.

Yours sincerely,

Professor Stephen Simpson AC
On behalf on The Obesity Collective
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