06 July 2018

Committee Secretary
Department of the Senate
PO Box 6100
Parliament House
Canberra ACT 2600

Dear Committee Secretary

The Australian Healthcare and Hospitals Association (AHHA) is pleased to provide this submission in response to the Senate Select Committee Inquiry into the Obesity Epidemic.

AHHA is Australia's national peak body for public hospitals and health care providers. Our membership includes state health departments, Local Hospital Networks and public hospitals, community health services, Primary Health Networks and primary healthcare providers, aged care providers, universities, individual health professionals and academics. As such, we are uniquely placed to be an independent, national voice for universal high-quality healthcare to benefit the whole community.

Obesity prevalence

Obesity is an Australian health priority and has taken over from smoking as the leading cause of preventable death or illness in Australia (Institute for Health Metrics and Evaluation 2015). In 2014–15 an estimated 1 million (27%) Australian children aged 5–17 years were overweight or obese (ABS 2016). There were an estimated 11.2 million (63%) Australian adults who were overweight or obese in 2014–15 (ABS 2016), up from 38% in 1989–90 (ABS 2004). Australia has the fifth highest obesity rates among OECD countries (OECD 2017).

The prevalence of overweight and obesity is higher among those from more socioeconomically disadvantaged backgrounds, including Aboriginal and Torres Strait Islander people and those living in regional areas (AIHW 2017). Children living in single-parent families or in low socioeconomic groups are also more likely to be overweight or obese (AIHW 2014). Childhood obesity has been described by the World Health Organisation as one of the most serious public health problems (WHO 2012).

Costs of obesity

AHHA recognises that increasing rates of overweight and obesity are impacting on the health of Australians in an unprecedented way, with significant social and economic consequences. Obesity has high economic and human consequences at an individual and societal level.

Australian modelling shows that the direct health costs of obesity in 2011–12 were estimated to be $3.8 billion, with total costs estimated at $8.6 billion (PwC 2015). The majority of these costs are borne by individuals, employers and governments.

Small improvements in obesity population prevalence can substantially reduce Australia's chronic disease burden and reduce preventable mortality (AIHW 2017; Kearns et al. 2014; Veerman et al. 2016).

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Causes of obesity

Various factors influence overweight and obesity. Population changes in diet and physical activity are overlayed by a complex inter-play of social and environmental determinants.

The increasing prevalence of people being overweight or obese is a reflection of multifaceted changes that have occurred in our society. Examples include food manufacturing and consumption habits, changes in community physical activity behaviours, lifestyle changes driven by an evolving consumer environment focussed on passive engagement and changes to the lived environment that reinforce obesogenic behaviour.

Short and long-term harm to health associated with obesity

Obesity is a risk factor for coronary heart disease, high blood pressure, stroke, type 2 diabetes, abnormal blood fats, metabolic syndrome, cancers, osteoarthritis, sleep apnoea, obesity hypoventilation syndrome, reproductive problems, liver disease and gallstones (AIHW 2017; NIH 2012). In 2011 it is estimated that people being overweight or obesity was responsible for 7.0% of the total health burden in Australia (AIHW 2017).

A high BMI in adulthood is responsible for 52% of the diabetes burden, 45% of the osteoarthritis burden, 38% of chronic kidney disease burden, 23% of coronary heart disease burden and 17% of stroke burden (AIHW 2017).

Australian policies and programs

Australia's efforts to address obesity in Australia have traditionally focused on educational campaigns and programs. While these actions are important in achieving behavioural change, they are not comprehensive and will only result in limited success unless complemented with actions that create supportive food and physical activity environments.

Similar to the comprehensive approaches used to reduce rates of tobacco smoking in Australia, a multi-pronged effort is necessary to achieve a reduction in the prevalence of people being overweight or obese. Control measures that were successfully used to reduce tobacco smoking include marketing restrictions, increased taxation, restriction on usage and mandatory changes to packaging including graphic imagery, health warnings and common plain packaging.

Recommended actions

The rising prevalence of overweight and obesity in Australia requires urgent and comprehensive action, to slow, halt and reverse the current trends.

Investment is needed in a broad array of evidenced-based strategies to incrementally reduce the prevalence of people being overweight or obese and to improve health outcomes. This multifaceted approach should include primary and secondary prevention measures.

Sustained investment in chronic disease and preventive health programs

This will benefit the wellbeing and long-term health of all Australians and requires:

- Developing comprehensive and coherent policies that share responsibility across all levels of government, industry and the community. This should include a national obesity strategy and a national physical activity strategy;

- Consideration of the unequal distribution of overweight and obesity among more disadvantaged populations in policies and programs, with an emphasis on policy to preferentially benefit these groups;

- Regular and timely performance and information reporting to provide rigorous measurement and monitoring of overweight and obesity in Australia;
- Preventive health and chronic disease programs that are informed by evidence, local and international experience, local engagement and respond to community need;
- Emphasis on early detection and targeted secondary prevention of chronic disease;
- Implementing recommendations from the World Health Organisation Commission on Ending Childhood Obesity Implementation Plan (WHO 2017) and from the WHO Global Action Plan for the Prevention and Control of Noncommunicable Diseases 2013–2020 (WHO 2013);
- A commitment to evidenced-based consumer health literacy programs as they relate to weight and chronic disease management;
- A concerted focus on achieving better integrated care across the preventive, health, aged and disability care sectors to encourage healthier lifestyle choices and an improved balance between energy consumption and expenditure by individuals;
- Mandatory interpretive front-of-package labelling for packaged foods and beverages; and
- Funding targeted and evidenced-based public education campaigns to improve the attitudes and behaviours of Australians around diet, physical activity and sedentary behaviour.

Action to support reduction of the consumption of sugar sweetened beverages

Sugar-sweetened beverages are a major source of added sugar in the diet. They contribute to overweight and obesity (Malik et al. 2013; Vartanian, Schwartz and Brownell 2007) and are estimated to account for at least one-fifth of weight gain (Woodward-Lopez, Kao and Richie 2011). These beverages include cordials, soft drinks, energy drinks, sports drinks, fruit and vegetable drinks, and fortified waters. Consumption of sugar-sweetened beverages is associated with obesity, type 2 diabetes, cardiovascular disease, bone density problems, tooth erosion and tooth decay (Singh et al. 2015; Narain et al. 2016).

Sugar-sweetened beverages are discretionary as they do not contribute significantly to essential nutritional requirements and can be substituted with water, making preventive health interventions to reduce their consumption ideal. Australians are among the highest per capita consumers of sugar-sweetened beverages globally (Allman-Farinelli 2009) with Australians purchasing on average approximately 377kJ per person per day (Popkin and Hawkes 2016), or the equivalent of around 76 litres of cola soft-drink per year. Consumption of sugar sweetened beverages is higher in young Australians and those with higher levels of socioeconomic disadvantage (ABS 2015).

Action should include changes to regulate availability, improve labelling, restrict promotion, reduce consumption and increase public awareness of the potential harm of sugar sweetened beverages, for example:

- Taxation of sugar-sweetened beverages to improve population diet and reduce consumption of sugar-sweetened beverages, resulting in a meaningful reduction in obesity and associated rates of chronic disease;
- The revenue raised from the taxation of sugar sweetened beverages should be hypothecated to preventive health measures including approaches to improve diet, increase physical activity, prevent obesity and educate on nutrition;

- Restrictions on the sale of sugar-sweetened beverages in public institutions such as hospitals and schools;
- Strengthened advertising restrictions for sugar-sweetened beverages, particularly during children's television viewing times;
- Mandatory interpretive front-of-package labelling of sugar-sweetened beverages (Hawley 2013);
- Public awareness campaigns to ensure consumer awareness of health risks associated with sugar-sweetened beverages.

Similar changes are recommended around the consumption of energy-dense nutrient-poor foods where evidence exists. For example, around strengthening of advertising restrictions particularly during children's television viewing times and restrictions on the sale of these products in public institutions.

The Australian Beverages Council's proposal for Australian soft-drink businesses to voluntarily lower the average sugar content in their beverages by 20% over nine years demonstrates an inadequately scaled response to the present context. This move is too slow and too little, delivering a tokenistic gesture from industry taking nominal action to evade strengthening calls for mandatory regulation. This is in contrast to the response of beverage manufacturers in the United Kingdom, who over only a couple of years have reformulated many products to significantly reduce the sugar content prior to the introduction of mandatory introduction of a soft drinks industry levy in April 2018 (Hashem, He and MacGregor 2017; Roache and Gostin 2017; Pym 2018).

AHHA welcomes the opportunity to contribute to the Senate Select Committee Inquiry into the Obesity Epidemic in Australia. This Senate inquiry, and the actions that follow, provides the opportunity to make crucial progress in reversing Australia's growing prevalence of people who are overweight or obese and suffering from or at greater risk of the associated chronic diseases.

Yours sincerely

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