CHAPTER 2: Obesity In Australia: A need for urgent action

Contents

The case for prevention 88
Targets 93

Key action areas 94

Key action area 1: Drive environmental changes throughout the community that increase levels of physical activity and reduce sedentary behaviour 95

Key action area 2: Drive change within the food supply to increase the availability and demand for healthier food products, and decrease the availability and demand for unhealthy food products 103

Key action area 3: Embed physical activity and healthy eating in everyday life 111

Key action area 4: Encourage people to improve their levels of physical activity and healthy eating through comprehensive and effective social marketing 119

Key action area 5: Reduce exposure of children and others to marketing, advertising, promotion and sponsorship of energy-dense nutrient-poor foods and beverages 121

Key action area 6: Strengthen, skill and support primary healthcare and public health workforce to support people in making healthy choices 126

Key action area 7: Address maternal and child health, enhancing early life and growth patterns 127

Key action area 8: Support low-income communities to improve their levels of physical activity and healthy eating 129

Key action area 9: Reduce obesity prevalence and burden among Indigenous Australians 132

Key action area 10: Build the evidence base, monitor and evaluate effectiveness of actions 136

Summary Tables 140

References 156
CHAPTER 2: Obesity in Australia: A need for urgent action

The case for prevention

Australia is one of the most overweight nations in the developed world, with over 60% of adults and one in four children overweight or obese. This is one of the greatest public health challenges confronting Australia and many other industrialised countries.

The prevalence of overweight and obesity has been steadily increasing over the past three decades, sharply escalating in the last 10–15 years. In the decade between 1995 and 2004/05, the number of Australians who were overweight and obese increased by two million, rising to 7.4 million. If current trends continue, it is predicted that almost two-thirds of the population will be overweight or obese in the next decade. By 2025, 6.9 million Australians will be obese.

Australian health survey results paint a disturbing picture. The 2007–08 National Health Survey has for the first time since 1995 measured the exact height and weight of adults and children rather than using only self-report data. Preliminary results suggest that overweight and obesity prevalence in adults has continued to increase. The 2004–05 data indicated overweight and obesity increased from 2001 levels. In 2001 58% of men and 42% of women were overweight or obese based on self-report data for height and weight. The 2004–05 survey found 62% of men and 45% of women were overweight or obese. Men in the 45–54-year age group had the highest rates of obesity (23.2%), and men in the 55–64-year age group had the highest rates of overweight (45.9%). Women in the 55–64-year age group had the highest rates of obesity (21.7%), and women in the 65–74-year age group had the highest rates of overweight (30.8%).

The problem of overweight and obesity is not evenly distributed across Australian society. It is most prevalent among the more disadvantaged groups in society, Indigenous Australians and some ethnic population groups, exacerbating existing health inequalities.

Approximately 60% of Indigenous Australians aged over 18 are overweight, of whom 31% are obese. Indigenous Australians are 1.2 times as likely as non-Indigenous Australians to be overweight, 1.9 times as likely to be obese and over three times as likely to be morbidly obese. Men in the most disadvantaged economic group are also significantly more likely to be obese than those in the most advantaged group (19.5% compared with 12.7%), while for disadvantaged women the rate is nearly double (22.6% compared to 12.1%).

Obesity is linked to many chronic diseases that can have a devastating impact on individuals, families and communities. Recent estimates show that obesity causes almost one-quarter of cases of type 2 diabetes (23.8%) and osteoarthritis (24.5%), and around one-fifth of cardiovascular disease (21.3%) and colorectal, breast, uterine and kidney cancer (20.5%). In 2003 high body mass was responsible for 7.5% of the total burden of disease and injury in Australia, ranked behind only tobacco (7.8%) and high blood pressure (7.6%).

There is also evidence that overweight and obese Australians have a lower life expectancy compared to those in the healthy weight range. Research shows that moderately obese people died two to four years earlier than those with a healthy body mass index (BMI). Being morbidly obese (a BMI of 40–45) reduced life expectancy by 8–10 years. Similarly, other research estimating the impact of obesity on life expectancy (from age 40) found a mean loss of seven years associated with obesity – similar to the life expectancy loss from smoking.

1 The standard definition of obesity is BMI>30. The health effects of ‘high body mass’ in the Burden of Disease study were estimated using new methods – see references (9) and (10).
The social and economic costs associated with overweight and obesity are significant. It has been estimated that the overall cost of obesity to Australian society and governments was $58.2 billion in 2008 alone.2(3) In terms of productivity, in 2001 more than four million days were lost from Australian workplaces due to obesity. Obese employees tend to be absent from work due to illness significantly more often and for a longer time than non-obese workers, and are more likely to be ‘not in the labour force’.13

Of particular concern, however, is the increasing prevalence of overweight and obesity in children. As shown by the 2007 National Children’s Nutrition and Physical Activity Survey14 nearly a quarter of all children are now overweight or obese. Data from the survey found that for children aged 2–16 years, 17% were overweight, 6% obese and 5% were found to be underweight. Other studies suggest that the prevalence may be much higher among low socioeconomic groups, Indigenous people and some ethnic population groups.15-17

Overweight and obese children face many of the same health conditions as adults, and can be particularly sensitive to the effects on their self-esteem and peer-group relationships.18 Symptoms in children and adolescents include poor psychosocial functioning, increased cardiovascular disease risk factors and abnormal glucose metabolism.8 Overweight in adolescence has been shown to be significantly associated with long-term mortality and morbidity.8

However, the most significant outcome of childhood obesity is the likelihood that these children will progress to being obese adults and suffer chronic diseases at a much younger age.8, 18

Figure 2.1 below clearly illustrates the disturbing trend of increasing overweight and obesity among children that has emerged over the past 20 years. Among boys aged 7–15 years, overweight and obesity increased from 11% in 1985 to 20% in 1995, rising to almost 24% in 2007. In girls the prevalence increased from 12% in 1985 to 21.5% in 1995, rising to 25.8% in 2007.19

RECENT DEVELOPMENTS IN AUSTRALIA

Governments have recognised the need for action on obesity at federal, state and territory levels. The Council of Australian Governments (COAG) National Partnership on Preventive Health has allocated funds ($872 million over six years 2009–15) for social marketing, extending the Measure Up campaign, and recommended enhancements in child health interventions (targeting physical activity and improved nutrition), and for healthy living programs established in the workplace and in the broader community. Infrastructure funds are identified to support the establishment of a National Prevention Agency (NPA), to enhance and extend the Nutrition and Physical Activity Survey, undertake a national survey of the preventative health workforce, leading to a long-term strategy, and to establish a preventative health research fund.
The Taskforce welcomes these initiatives and sets out a number of recommendations and actions that can contribute to, inform and enhance the work of COAG in these areas, ensuring a sustainable and effective national response to overweight and obesity.

Other major developments in Australia have included the release of the House of Representative’s Inquiry into Obesity. Their report, *Weighing It Up*, released in May 2009, complements the National Preventative Health Taskforce process. The report has made general recommendations on the role of governments, industry, individuals and the community and has provided a platform for sharing of ideas, views and stories from a wide range of stakeholders. Their recommendations in the prevention area are largely consistent with the strategic actions outlined in the Taskforce’s National Preventative Health Strategy.[20]

The Senate Standing Committee on Community Affairs released its report on the *Protecting Children from Junk Food Advertising (Broadcast amendment) Bill 2008* in December 2008. The Committee stated that they considered it was premature to bring forward legislative changes to food and beverage advertising whilst the National Preventative Health Taskforce was developing a national strategy and before the industry’s voluntary initiatives had been assessed. They also referred their report and the information received by the Committee to the Taskforce for consideration.[21]

**There is a need for urgent action and a comprehensive response**

‘In a political economy that measures progress in terms of growth and consumption, there are many underlying environmental, social and political determinants of obesity. In this context the introduction of policy and regulatory interventions is essential to make real impacts on the prevention of obesity’

(Quote from submission)

There is an urgent need to act immediately to address the causes of obesity. A failure to address rising obesity rates among adults and children will lead to significant increases in chronic disease, eroding many of the health gains of past decades.

**If current trends continue:**

- Australians will continue to become more overweight and obese.
- There will be six million obese Australians by 2020 and 6.9 million by 2025.[3]
- The percentage of the Australian population who will be overweight or obese will have grown to a record 73% in 2025. This includes one-third of our children and three-quarters of our adult population.[22]
- Recent trends in Australian children predict that their life expectancy will fall two years by the time they are 20 years old, setting them back to levels seen for males in 2001 and for females in 1997.[23]
- A projected rise in the rates of type 2 diabetes, mainly due to expected growth in the prevalence of obesity, will increase healthcare costs by $6.7 billion (from $1.3 to $8.0 billion) by 2032.[24]
- The burden of disease attributable to high body mass is likely to overtake tobacco as the leading preventable cause of burden as smoking rates decline.[25]
The complexity and multitude of health, social, economic, cultural and environmental determinants demand a long-term, comprehensive and well-funded response to overweight and obesity. No single measure in isolation will solve the problem. Action is required from all levels of government, industry, non-government organisations, individuals and communities.

Changes are needed in our environments, transport systems, food supply, workplaces, schools, local communities and healthcare systems to make the healthy choices the easy choices, and to empower and motivate individuals and families to lead healthier lives. (26)

**Sedentary lifestyles**

Highly prevalent and pervasive elements of the obesity-promoting environment are clearly identified in the research literature – including passive forms of entertainment, transport such as cars, and labour-saving devices which are widely available and heavily promoted and which encourage sedentary behaviour. (27) In addition, many people lead busy lives with little time for recreation and sport. While individuals ultimately ‘choose’ what activities to undertake, there is good evidence that environmental factors are a major influence on these ‘choices’. (27) Prolonged sitting and insufficient physical activity have become a part of daily life for many people, and changes in transport, occupations, domestic tasks and leisure activities have had negative effects on daily energy expenditure.

Figure 2.2 below illustrates the complexity and diversity of a broad range of factors that influence body weight.

**Figure 2.2:**

The influence of individual, social, lifestyle/behavioural and environmental factors on energy balance and BMI

Globally, obesity prevention and control is relatively new. Therefore, evidence of effective approaches in some areas is still being developed. For other areas, strong evidence exists from other aspects of public health, such as tobacco control. These factors speak to a ‘learning by doing’ approach – that is, the staged trialling of a package of interventions accompanied by comprehensive monitoring, evaluation and research. Achieving long-term sustainable change is likely to be difficult and resource-intensive, and will take time. It is not something that individuals or governments can do alone.

To be effective, the approach needs to focus on engaging individuals, families and communities to make changes to their lives that will enable them to improve their nutrition and increase physical activity levels. Programs and strategies will need to be coordinated across all levels of government and across diverse portfolios, such as Transport, Treasury, Education, Health, Sport and Recreation. Partnerships with a range of industry groups and sectors will need to be strengthened and new alliances developed. In particular, partnerships with the food industry, private health insurance, media and advertising industry will be necessary for success. There is a need to build on the programs already undertaken by state, territory and local governments, and by the non-government sector.

The priorities discussed in this strategy are critical to achieving change. These priorities focus on embedding healthy eating and physical activity in the everyday lives of every Australian. Delivering programs and policies in key settings where people live, work and play is essential. Social marketing campaigns supporting these programs are required to encourage and motivate individuals and families to make changes to their lifestyle and to the built environment. Partnerships with industry to influence the availability and consumption of healthy food are vital, as are measures to reduce children’s exposure to advertising of unhealthy food and drink. Additional support will be provided to those most at risk, and the program of work will be underpinned by ongoing population data collection, evaluation and research.

If current trends in overweight and obesity continue in Australia, there will be approximately 1.75 million deaths at ages 20+ years caused by overweight and obesity in the years 2011 to 2050, and 10.3 million premature years of life lost (PYLL)\(^3\) at ages 20–74 years. Each Australian aged 20–74 years who dies from overweight and obesity in 2011 to 2050 will lose, on average, 12 years of life before the age of 75 years.\(^{29}\)

If we can halt or stabilise obesity rates in Australia over this time period, we could save half a million lives.\(^{29}\)

---

3 The person-years of life lost as a result of exposure of the population to a particular condition, in this case overweight/obesity.
Targets

The aim of this strategy is to halt and reverse the rise in overweight and obesity in Australia by 2020.

A range of targets relevant to obesity have been agreed upon as part of the COAG National Partnership Agreement on Preventive Health. The outcomes and detailed performance benchmarks are detailed in the Monitoring and Evaluation chapter. The Taskforce accepts these measures as appropriate long-term and interim targets for this strategy.

The Agreement sets the following medium to long-term outcomes for obesity:

- Increase the proportion of children and adults with healthy body weight by 3% within 10 years.
- Increase the proportion of children and adults meeting national guidelines for healthy eating and physical activity by 15% within six years.
- Help assure Australian children a healthy start to life, including through promoting positive parenting and supportive communities, and with an emphasis on the newborn.
Key action areas

**Key action area 1:** Drive environmental changes throughout the community that increase levels of physical activity and reduce sedentary behaviour

**Key action area 2:** Drive change within the food supply to increase the availability and demand for healthier food products, and decrease the availability and demand for unhealthy food products

**Key action area 3:** Embed physical activity and healthy eating in everyday life

**Key action area 4:** Encourage people to improve their levels of physical activity and healthy eating through comprehensive and effective social marketing

**Key action area 5:** Reduce exposure of children and others to marketing, advertising, promotion and sponsorship of energy-dense nutrient-poor foods and beverages

**Key action area 6:** Strengthen, upskill and support the primary healthcare and public health workforce to support people in making healthy choices

**Key action area 7:** Address maternal and child health, enhancing early life and growth patterns

**Key action area 8:** Support low-income communities to improve their levels of physical activity and healthy eating

**Key action area 9:** Reduce the obesity prevalence and burden in Indigenous communities

**Key action area 10:** Build the evidence base, monitor and evaluate effectiveness of actions
Key action areas

The key action areas are described below, followed by details of the specific actions required. The Taskforce considers all key action areas to be important. They should be considered as a package – a phased set of actions that, when combined, will provide the most effective roadmap to address the overall targets.

At the end of the chapter, a summary table provides an overall implementation plan to guide action by the relevant parties.

Key action area 1: Drive environmental changes throughout the community that increase levels of physical activity and reduce sedentary behaviour

‘The environmental quality of cities, towns and suburbs will be of critical importance to the health and wellbeing of their communities over the next twelve years to 2020 and beyond’ (Quote from submission)

It is well established that the physical environment, which incorporates the built and natural environments, impacts on our health and wellbeing – both at the individual level and at the community level. The design of our local environments and neighbourhoods influences walking, cycling and public transport use, as well as recreational physical activity.[27]

Prolonged sitting and insufficient physical activity have become a part of daily life for many people – changes in transport, the nature of work, labour saving devices and less active leisure activities have all had negative effects on daily energy expenditure. In general, more physically active societies are healthier and have less obesity.

In 2007–08, more than 70% of Australians (aged 15 years and over) reported being sedentary or having low levels of physical exercise – a proportion virtually unchanged since 1995. The Active Australia Surveys, conducted between 1997 and 2000, also found no change or a slight increase in physical inactivity levels for some age groups.

An example of the gradual environmental and behavioural changes that have affected participation in physical activity is seen in a recent analysis of household travel surveys in New South Wales. This study found that the percentage of children aged 5–9 that walked to school was 57.7%, 44.5%, 35.3% and 25.5% in 1971, 1981, 1991 and 1999–2003, respectively, whereas the percentage of children aged 5–9 that were driven to school by car in the four surveys was 22.8%, 37.3%, 53.9% and 66.6%, respectively. This suggests that a complete reversal of the proportion walking versus driving occurred over a period of 30 years.

In 2005–06, almost one in three of the population aged 15 years and over participated in sports and physical activity twice per week (32% of females and 27% males). However, approximately 5.5 million people (34%), reported that they did not participate in any such activity in the 12 months before being interviewed.

The 2003 Victorian Neighbourhood Lifestyle Environment (VicLANES) study[30] conducted across Melbourne found that people living in more disadvantaged areas, who were more likely to be overweight or obese, were less able to exercise due to health conditions and childcare responsibilities. The more disadvantaged areas had better street connectivity, a predictor of walking and cycling for transport, but traffic conditions were worse and there were fewer bicycle lanes.[31]

There is already a range of measures to encourage sporting and recreation activities. Additionally, through the Australian Government’s Health portfolio, grants are provided for 98 community projects that provide a range of sporting and recreational opportunities to Australian families ($46.8 million over three years), including support for the 2009 World Masters Games in Sydney and in 2007–08 providing funding for the Football Federation of Australia to promote participation in and
support for football in Australia. The Taskforce welcomes these initiatives and recommends further development of a coordinated national effort to enhance sport and recreation opportunities across Australia.

Sport plays a major role in Australia. It helps define our national identity, and provides avenues for participation, physical activity, learning of individual and team skills, and social connection, as well as being a significant employer and major leisure and entertainment industry. The Taskforce sees great synergies between the Preventative Health Strategy and the work of the Independent Sport Panel’s review to build our national capacity in junior sport, community participative sport, informal active recreation and elite sport. The Taskforce also believes there is a need to strengthen and encourage partnerships between preventative health agencies and sporting groups, and suggests that greater collaboration between the NPA, the Australian Sports Commission and national sporting bodies would deliver benefits in terms of encouraging healthy lifestyles.

A greater focus on active transport to and from work can increase opportunities for physical activity among working populations,[30] as illustrated by the UK Healthy Weight Healthy Lives Walking into Health initiative.[32, 33] Results from the pilot of a UK program, Sustainable Travel Towns, indicate that walking has increased by around 20% and cycling by almost 50% in two years, accompanied by reductions in car and public transport use.[32]

There is evidence that well-designed and sustained initiatives which influence attitudinal, behavioural and environmental factors can lead to significant improvements in population rates of physical activity, through increases in both incidental (for example, walking to catch public transport) and organised (for example, participating in active recreation or sporting activities) activities. They include:

- Good urban design and land use at a street level (improved lighting, ease and safety of street crossings, pathway continuity, presence of traffic calming structures, aesthetic enhancements) increase physical activity levels by 35%.
- Each kilometre walked reduces the odds of being obese by 4.8%, whereas every additional 60 minutes per day spent in a car increases the odds of being obese by 6%.
- Having access to places for physical activity (trails, facilities, parks, safety, affordability) increases physical activity by 48.4%.[34]
- Each quartile increase in land use mix (combining residential with other uses such as retail, workplaces etc) is associated with 12.2% reduced odds of being obese.[35]

Increasingly, however, many of our built environments are reinforcing sedentary behaviour and contributing to inactive lifestyles, particularly by encouraging car dependence.[36]

State and local governments play a critical role in influencing the shape and design of the built environment and, ultimately, the health of their communities. There is strong support from consumers for communities that support healthy, sustainable living and which understand the connections between the environment, climate change and our economy. Creating built environments that help individuals to be more active and to eat healthier food will benefit the whole population.
There are a number of opportunities to build on current initiatives at the state, territory, local government and non-government level, some of which are described below.

Australian initiatives illustrating the importance of long-term planning, policy and infrastructure measures to address the urban obesity-promoting environment:

**THE HEALTHY SPACES AND PLACES PROJECT**

This project is funded ($700,000 in 2008–09) through the Australian Government to develop a national guide for local planners. A partnership has been established between the Australian Local Government Association, the National Heart Foundation of Australia and the Planning Institute of Australia.

An evidence-based national planning guide has now been developed to assist practitioners and decision makers at all levels of government, industry, private sector and community groups to understand the connections between planning and health. Due for release in mid-2009, the guide showcases existing initiatives and draws on current practices that apply to and are consistent with the proposed framework and principles. In particular, it demonstrates effective policy development and implementation that encourages and requires integrated outcomes for wellbeing.

**DESIGNING PLACES FOR ACTIVE LIVING**

The NSW Premier’s Council for Active Living (PCAL) has developed a comprehensive web-based resource with six design areas of focus: cities, towns and neighbourhoods; walking and cycling routes; public transport; streets; open space; and retail areas. The resource includes a design objective, important design considerations and links to key references. Additional resources for detailed design guidelines and specifications are provided for each focus area.

**THE LIVABLE NEIGHBOURHOODS PROJECT**

The project comprises principles and guidelines for health-promoting urban planning. Liveable Neighbourhoods applies to structure planning and subdivision for “green field” sites and for the redevelopment of large “brown field” and urban infill sites. This development demonstrates an increasing acceptance of good design principles over time, and of regulation as an acceptable means of achieving more active, liveable communities. Mandatory requirements establish consistency, a level playing field for developers, and more equitable access to good urban design for residents.

The guidelines have been adopted by the Western Australian Planning Commission as operational policy, and are required in all design and approval of urban development.

**HEALTHY BY DESIGN**

The National Heart Foundation’s Healthy by Design (38) is a guide for professionals such as planners, developers and urban designers. The guide presents considerations, evidence, tools and case studies to facilitate the design of environments for active living.
The Taskforce recognises the importance of building on initiatives such as those described above. For example, the development of a resource for transport planners similar to *Healthy Spaces and Places* (that is, a national guide to assist transport planners to design transportation systems that foster health and wellbeing) would be a useful initiative that could be commenced immediately. Similarly, to enhance infrastructure development, linking funding allocation for built environment programs to specific criteria and to the introduction of health impact statements would strengthen the focus on identifying the health impacts (in particular, the likely impact on physical activity and sedentary behaviour) at an early stage in the process.

Transport systems are a key component of the built environment, as they shape the ways in which people carry out the diverse activities of daily life. Car-reliant cities encourage sedentary transport choices and contribute to obesity as well as additional health, environmental, transport and social harms.\(^{[36]}\)

Transport systems in Australia are often designed to move cars rather than people, and have resulted in urban environments that limit opportunities for walking, cycling and using public transport resulting in low rates of active travel.\(^{[39]}\)

When countries adopt more balanced transport systems, citizens have a greater choice of travel mode, car use declines (though not necessarily car ownership), and walking and cycling increases.\(^{[40]}\) Obesity levels are also lower.\(^{[40, 41]}\)

There are also social benefits associated with increased active living. For example, reducing car dependency would reduce traffic congestion, improve air quality and community liveability, lower car space requirements and costs, reduce energy and fossil fuel use, and reduce greenhouse gas emissions.\(^{[27, 36]}\)

Traffic safety concerns are a major barrier to active transport in Australia.\(^{[42-44]}\) Improved cycling and walking infrastructure is often the focus of attention to address these concerns, but supportive ‘invisible infrastructure’ is also a key feature of transport policies in countries with high rates of active travel.\(^{[40]}\)

It is acknowledged that solutions to address the obesity-promoting environment, such as changes in public policy, transport infrastructure and urban design, can be difficult and expensive; however, these environmental strategies are likely to impact on a large proportion of the population and are fundamental to improving the health of Australians.\(^{[45]}\)

It is well documented that public policies across a range of government portfolios impact on obesity levels and health more broadly. Health is an outcome of a wide range of factors – such as changes to the natural and built environments, and to social and work environments – many of which lie outside the activities of the health sector and require a shared responsibility and an integrated and sustained policy response across government. Accordingly, government policies can have positive or negative impacts on the determinants of health. Such impacts are reflected in the health status of the population today, and in the health prospects of future generations.\(^{[46]}\)
Health in All Policies is an innovative strategy adopted by the South Australian Government, which recognises that public policies across all government portfolios have an impact on health. It aims to address health challenges through an integrated policy response across portfolio boundaries, introducing population health outcomes and ‘Closing the Gap’ as shared goals across government. By incorporating a concern with health impacts into the policy development process of all sectors and agencies, it allows government to address the key determinants of health in a more systematic manner. It also takes into account the benefit of improved population health for the goals of other sectors. Fundamental to the successful implementation of this approach has been high-level commitment from both the central government agency (Department of Premier and Cabinet) and the Health Department.

In November 2007 the South Australian Government convened the Health in All Policies conference. A significant outcome was the development of a set of core principles articulating the values that underpin the Health in All Policies approach.

The South Australian Government is now considering how best to support the continued application of a Health in All Policies approach as part of the implementation of their Strategic Plan. This includes developing effective ongoing governance mechanisms, building the capacity of all sectors to consider the health impacts of their policies, and expanding the technical skills of the health sector to support agencies to use Health in All Policies tools and processes. Other potential actions include experimenting in the application of this methodology to other portfolios such as Education, considering issues such as gender and the health gap, and further expanding this process to include other actors, in particular local government.

Adapted from an editorial, Health Promotion International Vol 23 No 1 by Kickbusch, McCann and Sherbon. (46)

The Taskforce believes that consideration should be given to the introduction of health impact assessments across priority government policy areas (including urban planning, school education and transport) to ensure that health impacts associated with new policies are explicitly identified and considered in a systematic way early in the policy development process. Governments and policy makers can then determine the need for any policy changes or additional supporting strategies that may need to be implemented at the same time as the policy.

The Taskforce is convinced by the evidence that there are social and environmental benefits associated with active living. As people walk and cycle more, and make greater use of public transport, the accompanying reductions in car use can help reduce traffic congestion, improve air quality, enhance community liveability, lower car space requirements and costs, reduce energy and fossil fuel use, and reduce greenhouse gas emissions.

There is now an opportunity to draw together many of these current, but diverse activities – such as Travel Smart, Healthy Spaces and Places, recent infrastructure programs and investment, the Review of Sport in Australia – into a comprehensive, sustained, national approach to support ‘getting Australians moving’. This idea was strongly supported in submissions to the Taskforce.

The Taskforce therefore proposes the establishment of a Prime Minister’s Council for Active Living to provide high-level leadership on this issue, and drive the development of a comprehensive National Framework for Active Living that addresses the built environment, transport and social engagement.

The National Framework for Active Living will also inform the development of a business case for consideration by COAG to deliver a new funding partnership agreement between governments. The partnership agreement would leverage future infrastructure funding for the built environment, transport and social engagement against agreed active living outcomes.
A National Framework for Active Living would identify key impediments and enablers of physical activity in relation to the built environment, transport and social engagement. This will include reviewing:

- Built environment – relevant Australian and state government legislation, including building codes; and planning guidelines, including examples of good practice that incorporate healthy living (for example, Healthy Spaces and Places, Healthy by Design).

- Transport – relevant transport policy and guidelines, including examples of good practice in active transport (for example, TravelSmart, national cycling strategy).

- Social engagement – strategies and initiatives to promote social engagement in active living and sport, which may include consideration of the recommendations of the forthcoming Independent Sport Panel Review, social marketing and community engagement programs.

The development of an Active Living Business Case for COAG consideration would provide governments with options to increase active living through the built environment, active transport and social engagement, with objective measures and outcomes to monitor the impact of various options, and ultimately lead to a new funding partnership agreement between governments.

**Action 1.1**

*Establish a Prime Minister’s Council for Active Living and develop and implement a National Framework for Active Living encompassing local government, urban planning, building industry and developers, designers, health, transport, sport and active recreation.*

**Action 1.2**

*Develop a business case for a new COAG National Partnership Agreement on Active Living.*

**Action 1.3**

*Australian and state governments to consider the introduction of health impact assessments in all policy development (including urban planning, school education and transport), using partnership models such as the Health in All Policies (HiAP) approach in South Australia.*

**DRIVING CHANGE THROUGH ECONOMIC AND TAXATION POLICY**

Currently there are few Australian Government tax breaks, subsidies or incentives for active transport, particularly walking and cycling. Within the policy/regulatory environment, a range of government transport policies encourage inactivity by effectively promoting private motor vehicle use and discouraging walking, cycling and public transport.

**FOR EXAMPLE:**

- Funding for road infrastructure but not public transport or bicycle facilities[43]
- Reduction in fuel excise to offset the price of carbon emissions[47]
- Financial support for car manufacturers[27]
- Taxation incentives through fringe benefits tax (FBT) for private motor vehicle use but not for forms of transport such as public transport or walking and cycling to work[48]
Under the current FBT system in Australia, private transport is encouraged, as cars of higher-income workers are subsidised. As the taxable value of the car and therefore the FBT payable is reduced with the number of kilometres travelled each year, there is incentive for people using the scheme to maximise car use during the FBT year in order to qualify for the greatest FBT benefit. Numerous groups and several parliamentary inquiries have called for this tax concession to be repealed.\(^{48}\)

An important first step will be to undertake a review and conduct research on economic barriers and enablers, policies and tax incentives to inform a national active living framework and actions. This review would also inform the development of the National Strategy on Active Living and the development of the business case for COAG on Active Living.

There are no comparable financial incentives for people to use active transport modes such as public transport, walking, and cycling. The introduction of similar tax advantages would encourage and support increased physical activity among Australian workers, and is likely to have a subsequent beneficial environmental impact through a reduction in greenhouse gas emissions and urban traffic congestion.

Many workplaces currently provide subsidies that promote private and company motor vehicle use, such as subsidised car parking and novated leases. Inducements that encourage employees to walk, cycle or take public transport to work could be promoted in place of such subsidies. These might include fare rebates, shower and safe bicycle parking facilities, bicycle maintenance vouchers and bonuses for use of alternative forms of transport.

Taxation relief and financial subsidies could also make it easier to participate in physical activity, helping to make active choices a cheaper and easier alternative for individuals, families and business.

FOR EXAMPLE:

- Employer contributions towards activities such as cycling to work or subsidised corporate gym membership\(^ {49}\)
- Tax deductibility for physical activity participation (such as club memberships, sporting equipment, bicycles and clothing) in a range of settings
- Subsidised sporting club fees for children, especially in families that experience financial hardship
- Taxation deductions for families for children’s registration and tuition in organised sport (as occurs in Canada and has been suggested for Australia)\(^ {50, 51}\)

Some of the suggestions from the fitness industry in submissions to the Taskforce called for the provision of tax incentives or rebates for gym memberships in order to remove an initial barrier to participation. However, the rebate or subsidy would not be given until evidence of actual use of the membership was provided, such as gym attendance records. Under such a scheme, setting minimum participation levels for eligibility for an additional activity rebate would encourage at least minimum levels of activity.

The Canadian Government has implemented programs providing healthy living tax credits.\(^ {51}\) The United Kingdom is also currently piloting several initiatives that link economic incentives with physical activity.\(^ {52}\) These initiatives may provide a useful model for further consideration by Australian governments.
CASE STUDY 1: THE UK’S FREE SWIMMING PROGRAM

The Free Swimming Program is a partnership between the national government, local councils, Sport England and the Amateur Swimming Association. The program has been developed to support Change4Life, a national movement that aims to prevent people from becoming overweight through the promotion of healthier eating and physical activity.

Local councils apply for funds to help meet the cost of providing free access to pools during standard swimming sessions, including improving existing facilities or building new ones.

At launch, the scheme involved more than 1000 pools run by almost 300 local councils. The program also includes a national network of swimming experts recruited to work with participating councils and 100,000 free lessons offered to non-swimmers.

Incentives in the form of extra funding are offered to participating councils with the best record in developing the scheme and making an impact in their communities.

It is hoped the scheme will be extended to the whole population by 2012. (53)

CASE STUDY 2: HEALTHY LIVING TAX CREDIT

Since 2005, the government in Nova Scotia, Canada, has provided a Healthy Living Tax Credit to help with the cost of registering children and youth in eligible sport or recreation activities that offer health benefits. (51) Initially based on a maximum annual spending of $150 per child, it is estimated that the tax credit costs the Nova Scotia Government $2.2 million annually.

In 2006 the Children’s Fitness Tax Credit was announced, which allowed parents to claim a non-refundable tax credit of up to $500 in fees for the enrolment of a child under the age of 16 in an eligible program of physical activity. An evaluation is currently being completed. (51)

Action 1.4

Commission a review of economic policies and taxation systems, and develop methods for using taxation, grants, pricing, incentives and/or subsidies to promote active living and greater levels of physical activity and decrease sedentary behaviour.
Key action area 2: Drive change within the food supply to increase the availability and demand for healthier food products, and decrease the availability and demand for unhealthy food products

In the course of the consultations undertaken and in reviewing the submissions to the Taskforce, the need for the Australian Government to establish a comprehensive National Food and Nutrition Framework was repeatedly raised. Among those submissions that supported this measure, a significant number specifically nominated the integrated and comprehensive approach detailed in the United Kingdom’s strategy Food Matters as a useful model worthy of consideration.\(^{(54)}\)

In the first instance, a comprehensive framework to drive change within the food supply is needed. All stakeholders in the food system will need to engage in the development of the framework, and in the future implementation of a national food strategy. Stakeholders include primary producers, processors, food manufacturers, retailers, individuals in the transport, storage and retail sectors, and consumers.

The framework would consider the context of preventative health in general, and more specifically the role of prevention in reducing the rates of overweight and obesity in Australia. Such a strategy needs to consider food policy in the context of providing practical measures for addressing access to food and food security, achieving healthier diets, food safety, and issues related to food production and agricultural policy that ensure a safe and environmentally sustainable food supply chain.

A National Food and Nutrition Framework will articulate a policy framework and key actions for government, industry and other partner organisations to achieve a safer, healthier and more sustainable food supply. It will:

- Ensure that issues relating to healthy eating and nutrition are considered appropriately within the same policy context as food safety, food supply and environmental issues
- Provide an opportunity to strengthen partnerships
- Develop a voluntary Healthy Food Code of Practice where signatory companies in the food sector commit to the promotion of healthy eating in line with the elements of the code
- Identify and implement strategies by which affordable, healthy, fresh, good-quality foods are available to all Australians
- Target population groups at particular risk; for example, males and people of lower socioeconomic status (SES) who have lower levels of fruit and vegetable consumption

**Action 2.1**

*Develop and implement a comprehensive National Food and Nutrition Framework, covering:*

- **Price, choice and access to food and food security through open and competitive markets**
- **Achieving healthier eating patterns**
- **Food safety**
- **Issues related to food production and agricultural policy that ensure a safe and environmentally sustainable food chain and food supply**
DRIVING CHANGE THROUGH ECONOMIC POLICY AND TAXATION

**Taxing unhealthy foods**

To promote improvements in the food supply, the use of economic instruments such as a tax on unhealthy foods may encourage food manufacturers to produce healthier foods by reformulating existing products or developing new ones to maintain market share.\(^{51}\) As consumers are responsive to price, taxes on unhealthy foods that increase the price to consumers may be effective in discouraging and lowering consumption.\(^{55}\)

- **UK modelling data has estimated that taxing a wide range of food products to reduce fat, salt and sugar intake to maximise health outcomes would prevent up to 3200 deaths from heart disease and stroke annually, and increase food expenditure by 4.6%**.\(^{56}\)
- **In Denmark, it has been estimated that the population’s diet would be consistent with national guidelines if tax exemptions for ‘healthy’ products such as fruit, vegetables, rice, pasta and fish products were combined with a 30% tax increase on ‘unhealthy’ products.**\(^{57}\)

However, further evidence on the outcomes of economic policies such as targeted food taxes is required, as it is unclear whether such policies would actually change consumers’ buying habits; the magnitude of resulting health gains is also unknown.\(^{55, 56, 58}\)

Modelling of scenarios in the United Kingdom indicates the need for a cautious approach to targeted taxes. Modelling showed a reduction in saturated fat consumption but a concomitant rise in salt intake and reductions in polyunsaturated and monounsaturated fat intake.\(^ {56}\)

An important first step for Australia will be to undertake a review and conduct research into economic barriers and enablers, policies and tax incentives influencing the promotion production, access to and consumption of healthy and unhealthy foods. Targeted taxation on unhealthy foods is considered by some people to be regressive, as it would impact disproportionately on individuals and families on lower incomes who spend a larger proportion of their income on food than higher income earners.\(^{55, 59}\)

An alternative is to subsidise healthy foods, specifically targeting subsidies to support the most disadvantaged consumers. This highlights interventions encouraging a greater intake of healthy (lower energy density) foods rather than policies encouraging a decreased intake of unhealthy foods. There is research suggesting that there may be more weight loss benefit in increasing the intake of healthy foods rather than decreasing the consumption of unhealthy foods.\(^{55, 60}\)

A recent comprehensive review of evidence on the effects of food prices on weight outcomes found the evidence supported a multi-pronged approach to changing prices - taxing unhealthy foods and subsidising healthier products.\(^ {61}\) The study concluded that fiscal policies could be used to improve weight outcomes, noting that substantial price changes are required to ensure significant improvements. Most importantly, these effects were particularly likely to be observed among children and adolescents and low SES groups, who are most at risk of being overweight.\(^ {61}\)

Several countries have targeted taxation policies on widely available popular foods and beverages such as soft drinks, which are inherently high in energy and empty of any important nutrients. Results of a meta-analysis found that the intake of sugared beverages displaces the consumption of healthier beverages, and is associated with higher body weight and poor nutrition.\(^ {62}\) In addition, the risk of obesity and diabetes increases with rising intake. Drinks such as soft drinks that are rich in sugars (both added and natural) have also been shown to reduce appetite control, leading to increases in weight gain and increased risk of obesity.\(^ {63}\) Increased liquid carbohydrate consumption is not accompanied by a
reduction in solid food consumption; (63) In fact, soft drink intake has been identified in a range of research as a key contributor to increasing levels of overweight and obesity. (62) as well as increased rates of dental decay. (64)

**EXAMPLES OF SOFT DRINK TAX:**

- In the United States, 40 states have small taxes on sugared beverages and snack foods. (65) Large taxes on sugared beverages have been proposed in Maine and New York (NY) State; in New York, an 18% tax on non-diet soft drinks has been proposed for implementation in June 2009. (65, 66) Small soft drink taxes have been introduced by individual states to reduce consumption, raise revenue and improve public health; as the taxes were extremely low, impacts on health were not expected to be large. During the 1990s, around half of all states taxed soft drinks and 20 states changed their soft drink tax rate. An evaluation of the impact of changes in state soft drink taxes on BMI indicated that soft drink taxes modestly reduced BMI. The impact varied across demographic groups. The results were extrapolated to conclude that if the soft drink tax was as high as cigarette tax, the proportion of obese adults would decrease by nearly 1 percentage point. (62)

- In Denmark in February 2009, the government announced the extensive restructuring of its income tax system. Under the government’s proposals, pollution, cigarettes and unhealthy food (foods and drinks with a high sugar and fat content) will be subject to higher taxation. Ice cream, sweets and chocolate will see a duty increase of 25%, while saturated fats in dairy products and oils will be levied at 20 kroner per kilogram.  

**Action 2.2**

Commission a review of economic policies and taxation systems, and develop methods for using taxation, grants, pricing, incentives and/or subsidies to:

- Promote the production of healthier food products, including reformulation of existing products
- Increase the consumption of healthier food and beverage products
- Decrease production, promotion and consumption of unhealthy food and beverage products
- Promote healthy weight

**INCREASING THE AVAILABILITY OF HIGH-QUALITY FRESH FOOD – THROUGH PRICING POLICIES**

There is a need to reduce and to minimise the barriers to people selecting and consuming fresh fruit and vegetables, particularly concerning cost and access to fresh, high-quality, healthy food. Pricing is a crucial issue to consider in shifting consumer demand. Food prices have risen significantly in Australia recently, including large increases in the price of many fresh products. These price rises have been associated with factors such as the drought, adverse weather conditions, increasing costs of raw materials and other products crucial to farm production, such as petrol and fertiliser, as well as rising international food commodity prices. (67)

Food is more costly in rural areas compared to metropolitan areas across Australia, (68-70) and the availability, accessibility and costs of nutritious food can influence consumers who are socially or geographically disadvantaged, affecting their ability to consume healthy food. (71) Australians at particular risk of food insecurity include older people, those living in rural and remote areas, and those with a disability. (72)

---

Action 2.3

Examine and develop systems and subsidies that increase the availability of high-quality fresh food for regional and remote areas, focusing on:

- Regional and remote transport
- Increasing the production of high-quality, locally grown fresh foods that are available to the local community

DRIVING CHANGES TO THE FOOD SUPPLY – IMPROVING POPULATION NUTRITION

The development and reformulation of existing food products is one way to increase the availability and accessibility of healthy food options, and to help create a supportive environment for behaviour change. Such changes to the food supply can increase the availability of healthier products and drive consumer demand, with consequent improvements in population health.

Addressing diet as a key risk factor for largely preventable chronic diseases, through improvements in population nutrition, has been successful in the prevention of chronic disease. (63) Policy examples of population reductions in nutrient intake and overall health improvements associated with national policies targeting nutritional behaviours are illustrated below (80):

While both food and non-food items have seen a fairly similar rise in price in recent years, there has also been an increase in the general affordability of food over the last 20 years. This is associated with substantial increases in consumer incomes. (73)

Trend data on the price of 57 items designed to meet the nutritional needs of a family of five (a healthy food basket), collected in the Illawarra region of New South Wales at five time points between 2000 and 2007, indicated an increase over time in food prices of 20.4%. (73) The affordability of the basket items relative to income (based on average weekly earnings and on welfare payments) showed little change over seven years. The largest increases were seen in the prices of vegetables (55.7%) and fruit (46.7%), (73) a trend also found in Queensland data. (70) There is a discrepancy between such price rises and consumer campaigns promoting increased consumption of these foods, such as the national Go for 2&5 campaign. (74)

Low-income Australians report lower levels of consumption of fruits and vegetables, often related to difficulties in accessing, purchasing and storing these foods. (75) People on lower incomes spend a higher proportion of their income on food, (76) and are less likely to meet dietary guideline recommendations for levels of fruit and vegetable consumption than higher income consumers. (77) They are more likely to consume energy-dense foods (high in fat and sugar) and lower amounts of plant-based foods (fruits and vegetables and wholegrain bread). While it is not known whether this is due mainly to food prices or access issues (for example, accessibility of food outlets and appropriate transport), (73) energy-dense foods are often perceived as being more affordable, more filling, more acceptable to family members and more readily available in disadvantaged areas. (78)
INTERNATIONAL EXAMPLES:

- In the United Kingdom, the government partnered with the food and drink manufacturing industry to reduce salt content in almost a quarter of manufactured foods over several years.

- In Mauritius, a government-led effort lowered the population’s cholesterol largely by promoting soybean oil rather than palm oil for cooking.

- In Japan, government-led health education campaigns have reduced blood pressure population-wide, and stroke rates have fallen by more than 70%.

- In Finland, health education and nutrition labelling led to population-wide reductions in cholesterol and many other risks, followed by a precipitous decline in heart disease.

- In the United States, a decrease in saturated fat intake in the late 1960s began the large decline in coronary heart disease deaths seen in the last few decades.

- In New Zealand, introduction of recognisable food labelling logos for healthier foods led many companies to reformulate their products. The benefits included large decreases in the salt content of processed foods.

- In Norway, combined food subsidies, price manipulation, retail regulations, clear nutrition labelling and public education focused on individuals were effective in turning around a population shift towards high-fat, energy-dense diets.

One of the most successful national programs to improve population health through sustained changes in behaviour is the North Karelia Heart Health Program in Finland, which incorporated an integrated food policy approach. Significant changes in the diet included the increased consumption of fish, vegetables, fruit and berries over 20 years; an increase in the proportion of people using mainly vegetable oil for cooking between 1972 and 1997; and the decreased consumption of salt and energy from saturated fats between 1972 and 1997, with an associated major decline in cholesterol levels (18% over 25 years). Stroke and cancer mortality also decreased, with impacts on life expectancy and diminished mortality. Heart disease rates dropped by 65% between 1971 and 1995. The major factor in the reduction in cardiovascular disease has been identified as improved diet associated with decreased blood pressure and cholesterol.

The Finnish experience indicates that obesity levels did not stabilise or decline over this period but rather increased. While specific risk factors such as high blood pressure and cholesterol were targeted and successfully reduced, weight was not a focus of the intervention. Factors relating to the prevalence of obesity in the Finnish population over this time that were not taken into account in the study include frequency and quantity (serve size) of food consumption. Soft drink and alcoholic beverage intake also increased over this time. The roles of many other factors such as foods and beverages consumed outside the home, consumption of energy-dense snacks and physical activity and sedentary behaviour levels are also unknown. Clearly, it is crucial to consider overall energy balance (intake and expenditure) and implement strategies to address all factors in order to make a difference in weight.

It is important that a comprehensive approach is taken to address population nutritional factors such as energy, sugar, saturated fats, salt and trans fats. Each of these factors has a significant role to play in health, but it is necessary to address whole foods rather than
individual nutrients in order to produce a healthier food supply. When specific nutrients are targeted alone, there is a risk that the profile of food products is improved for one nutrient (for example, reduced fat) at the expense of another (for example, increased sugar), resulting in high energy-dense foods that consumers identify as healthier options, unaware of the impact of the food over time on their weight and overall health. Encouraging the reformulation of existing products and the development of new products to produce healthier options in which all nutrients are considered is therefore crucial.

THE ROLE OF INDUSTRY AND THE NON-GOVERNMENT SECTOR

Both the food industry and the non-government sector play an influential role in shaping the population’s health. Governments recognise the importance of collaborative approaches with industry and with the non-government sector.

Industry sectors have already demonstrated their willingness and ability to work in partnership with others to develop strategies and products that enhance the health of Australians in response to policy changes and/or market demands. This has been indicated through the development of new products and the reformulation of existing recipes, such as reductions in salt or using healthier oils that are low in saturated fats and do not contain trans fat for cooking.

Industry can make an important contribution through:

- The provision of information (for example, product and menu labelling and responsible marketing; the placement of healthy products in more prominent positions in supermarkets)
- Improving the food supply (for example, making healthier and affordable food products available)

FOR EXAMPLE:

- The Australian Government, together with the Australian Food and Grocery Council developed a national physical activity and nutrition survey of over 4400 children. The survey results were released in October 2008.

- As part of the COAG National Partnership in Preventive Health agreement (2009–15), $1 million over four years is allocated for the establishment of partnerships with relevant industry and non-government sectors. The aim is to progress cooperative approaches that reshape consumer demand and industry supply towards healthy living choices.
OBESITY

EXAMPLES OF PARTNERSHIPS BETWEEN GOVERNMENT, NGOS AND INDUSTRY:

- In March 2006, the UK Food Standards Agency (FSA) set voluntary targets for the level of salt in 85 categories of food. An estimated 75% of salt intake comes from foods people purchase, highlighting the key role product reformulation by industry must play. The UK program involved around 70 firms and trade associations, and a broad range of products. The most recent survey evidence (July 2008) indicates daily average salt consumption in the United Kingdom has fallen from 9.5g to 8.6g since 2000. The FSA is currently reviewing the targets and considering further reductions to maintain progress towards the daily average intake target of 6g of salt.

- In April 2009 multinational food company Unilever announced that, rather than targeting salt reductions based on individual products, it would be reducing salt across its 22,000 products globally. The aim is to achieve a daily intake of 6g of salt per person by 2010, and the World Health Organization (WHO) recommended 5g maximum by 2015.

- In Australia, partnerships with the food industry include reformulating food products with lower salt options through the Heart Foundation Tick program and the Australian Division of World Action on Salt and Health (AWASH) Drop the Salt! campaign.

Action 2.4

Drive change within the Australian food supply by establishing a Healthy Food Compact between governments, industry and non-government organisations to:

- Reduce the production and promotion of foods and beverages that are energy dense and nutrient poor, are high in sugar, saturated fats and salt, and which contain trans fats, by setting targets for these nutrients.

IMPROVING FOOD LABELLING ON FRONT OF PACK AND ON MENUS

There is strong consumer support for front-of-pack food labelling consistent across all food products. Food labelling needs to be clear and comprehensible, as well as effective in enabling consumers to make informed purchasing decisions and influence consumer behaviour. Labelling can also provide incentives for food companies to improve the nutritional composition of products. A food labelling system needs to guide people to healthier food and drink choices rather than further confuse them or provide insufficient information on important nutritional messages. This information should be on energy, fat, saturated fats, sugar, salt, trans fats and a standard serve/portion size.

Presenting nutrient information on menu boards at the point of purchase also provides incentives for the food service industry to reformulate healthier products, and provides significant benefits to consumers. In the United States, legislative measures such as mandated menu labelling and restrictions on trans fat use has been introduced in several jurisdictions: California, Philadelphia, New York City, Seattle and Montgomery County, Maryland. Many other US states are now considering legislating to ban the use of trans fats in food service establishments and to introduce restaurant menu labelling.

---

5 In May 2009 the FSA released new salt reduction targets which represent the next step towards achieving the daily average intake target of 6g of salt. See www.salt.gov.uk/industryactivity.

6 See www.nutraingredients.com/content/view/print/244336.
In the United Kingdom, the FSA introduced a voluntary scheme for food service outlets to display calorie counts in January 2009. By June 2009, more than 450 food outlets, including workplace caterers, sit down and quick-service restaurants, theme parks and leisure attractions, pub restaurants, cafes and sandwich chains, are expected to have introduced calorie information, some on a pilot basis. Outlets include 18 major catering companies and businesses such as Burger King, KFC, Marks and Spencer, Sainsbury’s Cafes, Pizza Hut, Subway, and Tesco and Unilever staff restaurants. Each company will:

- Display calorie information for most food and drink they serve
- Print calorie information on menu boards, paper menus or on the edge of shelves
- Ensure the information is clear and easily visible at the point where people choose their food

Research is planned to assess customer understanding and use of the system, as well as practicalities and costs. This will be used to inform the next steps for a wider rollout of calorie labelling on menus.

Evidence suggests that displaying information about restaurant menu items at point of sale or on menus is more effective than making this information available to the public via other means, such as on the internet, and may be associated with lower calorie purchases by consumers who see the information.

National policy on front-of-pack food labelling is currently being considered in Australia. The four options presented for consideration in a February 2009 consultation paper developed by the Food Regulation Standing Committee (FRSC) ranged from maintaining the status quo to a scheme which may require some prior knowledge from consumers (for example, percentage daily intake) or a colour-coded interpretive scheme (for example, traffic light labelling).

The Taskforce believes that the best approach involves a front-of-pack food labelling system based on extensive consumer testing, readily understood by most demographic groups, especially people of lower SES. The scheme must support consumers to select healthier products through clear, simple and easy to interpret information that is consistent across all products and uniformly applied throughout Australia, based on Nutrient Reference Values and Dietary Guidelines. The scheme must be actively enforced with appropriate penalties, and closely monitored and evaluated against its specified goals and objectives.

The Taskforce recommends a phased approach over three years for the introduction of a front-of-pack food labelling system. Implementation would commence with a national trial of appropriate approaches across a sample of products. Following the evaluation of the effectiveness of the approaches, a national system would be implemented.

Action 2.5

Introduce food labelling on front of pack and menus to support healthier food choices, with easy to understand information on energy, sugar, fats, saturated fats, salt and trans fats, and a standard serve/portion size within three years.

---

7 In October 2008 the Australia New Zealand Food Regulation Ministerial Council agreed that the FRSC should develop a draft policy guideline on front-of-pack labelling for Council consideration in May 2009. Consolidated feedback from consultation and a draft policy guideline was to be provided to the Ministerial Council in May 2009, with the Council providing a progress report to COAG on the food labelling law and policy review in July 2009. The Ministerial Council has sought input into the review from the Australian Health Ministers Conference (AHMC).
Key action area 3: Embed physical activity and healthy eating in everyday life

ACTING WHERE ADULTS, CHILDREN AND FAMILIES LIVE, WORK, LEARN AND PLAY

Interventions to counter obesity are premised on the need for simultaneous action in the structural environment – through legislation and regulation – and at the local community and individual level. The notion of a ‘settings’ approach becomes particularly important. A ‘setting’ is a context – and a complex set of relationships and structures – within which people live, work, trade and socialise. A settings approach has long been seen as a way of reaching a captive audience, providing entry points and access to specific populations as well as channels for delivering health promotion programs. Settings are also understood as ‘creating supportive environments’ to ‘make healthy choices easy choices’.

‘There are many positive changes that families and individuals can make, but if the environment in which they exist – where they work, play, interact and experience life – is not conducive to health, the impact of individual behaviours may be severely limited’ (Quote from submission)

For these reasons, it is important to undertake a combination of interventions in schools and workplaces, as well as in local government areas to make local environments healthy and active. Local governments are in a unique position to shape the local natural and built environment, and to integrate efforts in different sectors. The linking of the work within these settings at the local level may particularly benefit disadvantaged communities.

The potential benefits in terms of health and from an economic perspective are significant. It is estimated that:

- Increasing fruit and vegetable consumption in Australia by just one serve a day would save between $8.6 million and $24.4 million in healthcare costs relating to various types of cancer. In addition, over $150 million would be saved in costs related to cardiovascular disease.
- If more people were physically active for 30 minutes a day, the Australian healthcare system could save $1.5 billion annually.
- $8 million per year could be saved for every 1% increase in the proportion of the adult population that is sufficiently active.

For children, the home environment can influence active recreation and play through factors such as whether children have television sets in their bedrooms and a yard large enough to play in. These characteristics are within the ‘micro-environments’ of families, and therefore potentially amenable to parental control. For example, parents can instigate simple but effective rules such as limiting the amount of television that their child watches and switching off the television during meal times. Support for families to modify home environments can assist parents to create more active environments for children. Workshops and other resources can be used to empower parents to overcome the ‘nag factor’ and restrict screen-based activities and television viewing.

Limiting the delivery of extended teaching blocks where children are sitting for up to 90 minutes at a time in class, and encouraging schools to provide children with physical activity ‘breaks’ during class time may substantially benefit children’s health.
Active play and sports participation at school can be increased by providing open spaces (not necessarily grass), fixed equipment (such as basketball hoops), playground markers, loose equipment (such as balls) and teacher supervision. Physical education and sport can be promoted by having a classroom teacher who encourages physical activity, core curriculum requirements for physical education/sport, and access to sporting equipment and playing fields. In particular, health and physical education should be included in the national core curriculum for schools. (27)

**Addressing ‘too much sitting’**

A body of new evidence identifies the time that adults spend sitting as being an important ingredient of the physical activity and health equation. (101) Research has shown a dose-response relationship between sitting time and mortality, independent of leisure time activity. (102) In the context of chronic disease prevention, the impacts on health of too much sitting need to be considered, in addition to the well-established preventative-health concerns about too little exercise. Findings from the national AusDiab study (101, 103) have shown television viewing time—which may reflect some people’s broader dispositions to spending a lot of time sitting—(104) to be significantly related to metabolic health. Prolonged television viewing time (particularly more than four hours a day) has been shown to be associated with:

- Higher waist circumference
- Higher blood sugar levels
- Higher blood fat levels
- Higher risk of the metabolic syndrome

The detrimental associations of television viewing time with metabolic health were observed even in adults who met the criteria for the National Physical Activity Guidelines for Adults. (105)

AusDiab findings also show that the average person spends more than half of their waking hours (~9 hours) in sedentary behaviours—primarily prolonged sitting. The remainder of the day is spent in light-intensity activities, with only 4–5% of the day spent in moderate-to-vigorous intensity physical activity. (106, 107) Importantly, participation in light-intensity activities (which can include housework, standing and moving about in office environments or shopping) has been shown to be beneficially associated with blood sugars and waist circumference. (101, 106) Additionally, those who interrupted their sedentary time more frequently (for example, got up to get a drink, stood up to answer the phone) had a better health profile, compared to those whose sitting time was mostly uninterrupted. (106)

Key components of the approach will include:

- Broadening Australia’s Physical Activity and Health Guidelines to address explicitly increasing ‘incidental’ activity and reducing prolonged sitting time in all aspects of daily life
- Funding, implementation and promotion of the:
  - National Physical Activity Recommendations for Children 0–5 years (due to be released in late 2009)
  - National Physical Activity Recommendations for Children and Youth (these cover 5–18-year-olds)
  - National Physical Activity Guidelines for Adults
  - National Physical Activity Recommendations for Older Australians (released in March 2009)
- Ensuring that physical activity is embedded in the national school curriculum
Preschools and schools are agencies for social change and offer opportunities to build understanding and awareness, as well as creating healthy environments’ (Quote from submission)

Schools are able to influence the nutrition and physical activity environment, and to educate children, families and the broader community about healthy lifestyles.

Promotion of healthy eating in schools may be weakened by a high level of unhealthy foods and beverages available in school canteens, and the presence of soft drink and confectionery vending machines. Recent Australian data indicate that children purchasing foods from school canteens had a higher energy intake from energy-dense foods than those who did not use the canteen.

Evidence-based guidelines recommend ensuring that all school policies and the school environment help children and young people to maintain a healthy weight, eat a healthy diet and be physically active. This includes policies relating to building layout and recreational spaces, catering (including vending machines) and the food and drink children bring into school, the curriculum (including physical education) and school travel plans (including provision for cycling).

The United Kingdom has recently announced that it will implement a ban on fizzy drink and junk food in school vending machines. France banned vending machines in schools in 2005. In 2006, former President Bill Clinton and the American Heart Association brokered a deal with the beverage industry in the United States, removing most soft drinks from almost every US primary and secondary school by the 2009–10 school year. Following the introduction of the agreement, the level of calories due to beverages delivered to schools in the 2007–08 school year decreased by 58%.

The Taskforce recognises that significant work has already been undertaken at the state and territory level to improve nutrition and physical activity in schools, particularly in relation to healthy school canteens. The Taskforce believes that there are significant opportunities to build on this action and develop policies and programs that support children and their families to adopt healthier lifestyles. The Taskforce proposes that schools should maintain a priority focus on health, nutrition and physical activity in the curriculum.

CASE STUDY: PRIMARY SCHOOL CHILDREN AND HEALTHY EATING

The Stephanie Alexander Kitchen Garden Program (SAKGP) is a school-based program providing primary school children with the opportunity to grow, harvest, prepare and eat fresh nutritious food. The program aims to positively influence children’s food choices and attitudes towards environmental sustainability. In April 2009 there were 49 Victorian schools and 43 schools participating nationally, with a further 147 schools to undertake the program over the next three years. Longitudinal evaluation of the program by researchers from Melbourne and Deakin universities is being conducted over 2.5 years to assess the program’s impact on school communities and students, including an economic appraisal. Preliminary findings indicate that school community members state they are willing to donate time to fundraising and general program maintenance, while parents have indicated willingness to pay increased voluntary school levies for the introduction or maintenance of the program at their school. Interestingly, each of the six matched comparison schools in Victoria (not participating in the program) indicated that they had an existing or planned garden program at the school.
and believes that the provision of mandated opportunities for all children to undertake appropriate levels of physical activity as part of their education is a fundamental strategy in addressing rising obesity levels in children. The Taskforce recommends that the existing policy requirement of at least two hours of physical activity per week for all K–10 students should be maintained in the state and territory government education/curriculum policy requirements of all schools, regardless of the system or sector. Further, the Taskforce recommends that the two hours of physical activity should form part of the quality assurance and reporting framework for all schools.

Other key approaches will include:

- Building on partnerships with the education sector to promote physical activity and healthy eating in schools
- Ensuring a curriculum entitlement to Health and Physical Education (HPE) for all Australian children by incorporating HPE into the second stage of National Curriculum development
- Australian and state governments to establish a national program to support implementation of the new curriculum, including teacher curriculum guidance and professional development opportunities
- Education sector to encourage all schools to develop, implement and evaluate health, nutrition and physical activity policies
- Ensuring implementation of the policy requirement of at least two hours of physical activity per week for all students K–10
- Expanding coverage of out of school care health programs such as Active After School, and Eat Smart, Play Smart
- Education sector to examine how to build the capacity of schools and teachers to promote health and resilience more effectively

- Development of comprehensive health policies in schools including:
  - Implementation of policies relating to building layout and recreational spaces
  - Strengthened school nutrition policies (for example, provide a healthy breakfast program for disadvantaged children; modify school canteen service; increase healthy options; provide healthy eating education; increase the availability, appeal and encouragement of fruit and vegetables at school; and increase the availability of healthy food options in all school environments: canteens, vending machines, fundraising, classroom rewards, excursions, and the food and drink children bring into school) and use of alternatives to foods in fundraising and other programs
  - Introduction of school travel plans and support for active transport options to and from school, including cycling and walking
  - Improved access to school-based recreational facilities by the community, especially after hours and in neighbourhoods that lack park and recreational facilities
  - Promotion and support through state and territory governments for the National Healthy School Canteens Project, ensuring a nationally consistent approach to making healthy food available in school canteens, and the provision of foods and beverages in line with Australian dietary guidelines
  - A comprehensive national approach to phasing out soft drinks in school canteens and vending machines

There is also a need to ensure key policy elements are appropriately reflected within the National Prevention Agreements.
**Action 3.1**

*Fund, implement and promote school programs that encourage physical activity and enable healthy eating.*

**WORKPLACES**

‘The workplace provides an ideal opportunity to engage individuals in taking more control of their own health’ (Quote from submission)

Workplaces represent an arena for social leadership and peer support in tackling behaviour change, while work and employment policies and practices can enable or work against positive changes within the workforce. Furthermore, workplaces provide an ideal opportunity to reduce sedentary behaviour in the population.

Prolonged inactivity, such as sitting, is now common during working, domestic and recreational time, and typically comprises over half of waking time activity. Over one-quarter of Australians (26%) report sitting for eight or more hours during a typical day. Recent Australian research has demonstrated the benefits of avoiding prolonged uninterrupted periods of sedentary (mainly sitting) time, interspersing periods of inactivity with breaks, and substituting (at minimum) light-intensity activity for sedentary time. These benefits include improved weight and metabolic outcomes.

While it is important to continue to promote the significant health benefits of regular moderate to vigorous physical activity, this research indicates that extended periods of sedentary time (as are common among office workers) may undo the benefits of such activity. The results suggest that simple interventions that can be implemented in the workplace and domestically to decrease passive sitting time and increase the number of breaks can also lead to substantial health improvements. The evidence highlights behaviours that may be more appealing and feasible for some people to undertake, which can still result in improved weight and metabolic effects; for example, the importance of lower-intensity activity throughout the day (including incidental activity such as standing) rather than a focus on more purposeful moderate to vigorous activity, such as going to the gym or jogging.

Simple strategies, such as standing up while talking on the telephone or watching television, using a telephone headset at the office to keep moving during phone calls and arranging regular short breaks during sit-down meetings, can be introduced and sustained in daily routines.

‘Workplaces are best placed to provide the supportive cultures often needed to sustain lifestyle change’ (Quote from submission)

Common factors of worksite health promotion programs with successful outcomes include regular participation, intervention intensity, the inclusion of dietary advice, supervised physical activity, support for physical activity outside the workplace, counselling and plant reorganisation. A meta-evaluation of research into economic returns associated with worksite health promotion programs found strong evidence that worksite health promotion was associated with average reductions in sick leave, health plan costs and workers’ compensation and disability costs of just over 25%. A review of workplace-based interventions targeting dietary behaviours through various education and environmental initiatives that were focused around the work canteen found positive modest changes in diet and food purchases or no impact. Some workplace initiatives promoting physical activity (interventions included health checks, motivational prompts and physical activity programs) have found inconsistent or inconclusive evidence, with some strong evidence for increased physical activity behaviour but inconsistent or no evidence for improvements in cardiovascular outcomes, body weight or general health. More comprehensive interventions, incorporating...
individual approaches and changes in workplace culture and organisational structure, were more successful.\(^{119}\)

WorkHealth is a recent initiative of the Victorian Government.\(^9\) It is a five-year, $218 million program aimed at improving the health and wellbeing of Victorian workers through workplace-based health checks, and providing access to advice and education programs to help workers reduce their risk of chronic disease. The aims are to reduce absenteeism, improve productivity, reduce injuries and reduce the burden of chronic disease on the Victorian health system. This initiative uses the workplace as an opportunity for health promotion and disease prevention, and establishes partnerships between government, employers and workers, develops joint effective health solutions, and creates links to existing health initiatives and services.

These kinds of programs and opportunities could be provided to Australian employees more broadly as a standard condition of employment. Workplaces could offer risk assessment and risk modification programs, nutritional education for workers and families, and physical activity embedded in, or in association with, regular daily work practice. Incentives could be provided to employers to reduce the chronic disease risk profile of their employees.

‘Not only does the workplace provide a captive audience to which messages can be targeted, but there is also a secondary effect through the influence on family and friends’ (Quote from submission)

The Taskforce believes that the development of comprehensive healthy workplace programs will provide new opportunities to promote healthy living. Therefore the Taskforce proposes the funding, implementation and promotion of comprehensive workplace programs through the COAG Healthy Workers initiative, including:

- Development of a national accord to establish best practice principles for workplace programs including protecting the privacy of employees, workplace risk monitoring, risk assessment or risk modification programs
- Development of a voluntary industry scorecard, benchmarking and award scheme for workplace health
- Development of nationally agreed accreditation standards for providers of workplace health programs
- Development of a national action research project to strengthen the evidence of effective workplace health promotion programs in the Australian context
- Establishment of a national workplace health leadership program and a series of resources, tools and best practice guidelines
- A review of potential legislative changes to promote the take-up of workplace health programs, including options such as:
  - Changes to Fringe Benefits Tax Assessment Act and Income Assessment Act to provide incentives
  - Employer commitment to a percentage of annual payroll allocated to workplace health programs (similar to the former Training Guarantee Levy)
  - Reforms to the Private Health Insurance Act 2007, to enable private health insurance firms to provide health screening to workplaces
  - Investigation of the feasibility of rewarding employers – through grants or tax incentives – for achieving and sustaining benchmark risk factor profiles in their workforce

**Action 3.2**

*Fund, implement and promote comprehensive programs for workplaces that support healthy eating, promote physical activity and reduce sedentary behaviour.*

**COMMUNITY INITIATIVES**

The community is where prevention actually happens. Every sector of society will need to change in order to reduce obesity rates and achieve healthier lifestyles. Shifts of this magnitude are not simple but the rewards will be great – both for ourselves and our children.

There are number of community-wide interventions already under way that aim to control childhood obesity. For example, *Eat Well Be Active* recently published results following several years of community implementation in Colac, in regional Victoria. The program was designed to build the community’s capacity to address childhood obesity through the promotion of healthy eating, physical activity and healthy weight in 4–12-year-olds and their families. The action plan was designed and implemented by local organisations, including schools and parents, and local health, housing and government services. The program used nutrition strategies such as support from school-appointed dietitians, canteen menu changes, training for canteen staff and healthy breakfast days, while physical activity strategies included walking to school programs, sporting club equipment and coach training.

While overweight and obesity levels in children from both the campaign and the nearby comparison areas did not differ significantly and increased over time, children in the project area gained less weight and had smaller waist circumference measures (about 3cm) after several years of the project. Project results were also promising in reducing obesity-related health inequalities: in Colac, changes in weight and other measures were not related to children’s SES, while in the comparison group the more disadvantaged children experienced greater unhealthy weight gain.

There are also a number of international community based obesity prevention programs.

*Ensemble prévenons l’obésité des enfants (EPODE) – ‘together, let’s prevent obesity in children’* – is a community-based, family-oriented nutrition and lifestyle education methodology from France. The initiative involves local physical activity and healthy eating strategies aimed at parents and children, with engagement of influential community groups and individuals, including education and health professionals, retailers and the media.

At the local level, the program is led by a number of key partners supported by the Ministry for Health and Family, with private sector partners (including food and insurance companies) that have committed human and technical resources as well as US$1 million. While results from the 10 pilot towns will be published in 2009, initial results appear promising; for example, in one town, the prevalence of overweight children decreased markedly between 2004 and 2005 (from 19% to 13.5%).

The EPODE program now covers almost 1.8 million inhabitants in 225 French cities, 32 cities in Spain and 13 cities in Belgium (in all communities) and five cities in Greece, with implementation also planned for South Australia. In South Australia, it is called the *Obesity Prevention and Lifestyle (OPAL)* program and is to be implemented over five years with $22.3 million investment, with approximately 20 councils involved.
The challenge is to increase the number and reach of sustainable community programs that build on existing efforts and to prioritise those most in need” (Quote from submission)

The Taskforce believes that it is important to generate new evidence about community-based obesity prevention initiatives within the Australian context. However, it is important that these community-based interventions are of a sufficient intensity and are adequately funded for a period of time that allows evidence of effectiveness to be assessed. Experience tells us that small-scale, ad hoc projects will not deliver results in obesity prevention. An integrated, well-funded, sustained effort is required.

The Taskforce suggests the following approaches:

- Establishing, as part of the COAG Healthy Communities initiative, a national series of comprehensive five-year intervention trials in 10 to 12 communities (including low SES and Indigenous communities), with a major focus on healthy eating and active living, building on effective approaches within Australia and internationally

- Development of strategies to mobilise and engage local communities including:
  - Development and delivery of a national healthy community leadership and education program
  - Establishment of an online national forum for organisations, local governments, businesses and industry, community groups, families and individuals to share their commitments and plans to making Australia the healthiest country
  - The development of a national recognition and award scheme for outstanding contributions, large and small, to making Australia the healthiest country by 2020

- Development, piloting and implementation of a new Healthy and Active Families initiative as an additional intervention to the activities proposed for Healthy Communities sites, beginning with the intensive intervention sites and rolling out successful program elements as results become available. This may include:
  - Provision of education that encourages parents to be positive role models for their children through healthy eating and regular physical activity
  - Locally targeted information on family-oriented physical activity opportunities
  - Development of programs that involve all family members within sporting and community clubs
  - Offering free/subsidised physical activity and nutrition programs in public spaces such as parks, beaches and recreation centres (for example, introduce free outdoor gym equipment in recreational areas)

The Taskforce recognises the important role that local governments can play in promoting healthy lifestyles. The role of local government in relation to urban design and infrastructure and the link to physical activity and sedentary living has already been discussed. The Taskforce suggests that as part of the Healthy and Active Families initiative outlined above, funding should be allocated to local governments and community organisations to support development of programs that aim to get families healthy and active and include a focus on existing infrastructure (for example, fun at the pool days, active parks programs).

**Action 3.3**

*Fund, implement and promote comprehensive community-based interventions that encourage people to improve their levels of physical activity and healthy eating, particularly in areas of disadvantage and among groups at high risk of overweight and obesity.*
Key action area 4: Encourage people to improve their levels of physical activity and healthy eating through comprehensive and effective social marketing

Effective and coordinated social marketing campaigns are needed to increase physical activity levels and improve eating habits. These campaigns should inform, encourage and motivate individuals and families to make changes to their lifestyles.

The best evidence on the effectiveness of social marketing campaigns indicates that long-term, well-funded, sustained campaigns underpinned by qualitative research are necessary to achieve behaviour change. Compelling evidence from areas such as tobacco control, drink driving/road safety, immunisation, sun protection and HIV/AIDS, as well as the commercial sector, shows that appropriately targeted investment in social marketing can provide health and economic gains across populations. Lessons from these campaigns are transferable to obesity management and prevention.

The Go for 2&5 campaign in Western Australia, conducted between 2002 and 2005, comprised a comprehensive range of strategies including mass media advertising, public relations events, a website, point-of-sale promotions, and school and community activities. Over the campaign period, awareness of dietary fruit and vegetable recommendations increased among the target audience of adults. In addition, there was an increase in population consumption of 0.2 servings for fruit and 0.6 servings for vegetables per day.

Queensland Health has invested $4.4 million over 4.5 years (2005–10) in a statewide Go for 2&5 social marketing campaign strategy. Prior to the implementation of the campaign in 2005, adult consumption of fruit and vegetables was 3.5 serves per day, around half the recommended intake. Phase one increased fruit and vegetable consumption by an average 0.4 serves per person per day in the target age group in January–March 2006. Ongoing campaign tracking has shown a peak increase of 1.1 serves per person per day. Data suggests that recent price increases in fruit and vegetables and long off-air periods have eroded some of the gains in fruit and vegetable consumption. Final evaluation data will be available in mid-2010.

The eventual evaluation of the Australian Government’s Measure Up campaign will provide valuable evidence in refining and targeting future communication strategies. Building on these campaigns at the state and territory and national level is essential to an effective approach.

Results demonstrate the importance of extended periods of campaign implementation to sustain accompanying knowledge, intentions and behaviour changes. The importance of televised media campaigns broadcast at sufficient exposure levels over relatively frequent intervals in achieving population behaviour change has been clearly demonstrated for tobacco in decreasing population smoking levels. This research highlights the need for such campaigns to be ongoing to sustain population-level change.

A significant challenge to the promotion of healthy eating and physical activity behaviours is the fact that advertising for energy-dense nutrient-poor (EDNP) products generally promotes behaviours that compete with public health recommendations and strengthen potentially negative or challenging behaviours. Even during a major national nutrition campaign, exposure to healthy fresh food advertising is likely to be much lower than that for unhealthy food, unless investment in social marketing is significantly increased. Data collection on food advertising undertaken in 2005, at the same time as the Go for 2&5 fruit and vegetable promotion was screened, showed fruit and vegetable advertisements to comprise 4.6% of total food advertisements during children’s viewing periods (as defined by the Children’s Television Standards). During the same period, high-fat, high-sugar food
advertising comprised 81.5% of total food advertisements; the observed differences have significant implications for the impact of nutrition promotion campaigns. (134)

SMALL CHANGES CAN MAKE A DIFFERENCE

Some studies have found that using an approach aiming at small changes (such as increasing daily walking) in a community setting has been effective in halting weight gain and in achieving weight loss. A ‘small changes’ approach has also been successful in increasing total physical activity, decreasing total energy intake, and halting or lowering excessive weight gain. It has been suggested that such approaches could thus be used to stop the rise in obesity while broader environmental and societal changes are made. (135)

Even small estimates of behavioural change associated with health programs can translate into significant impacts at the population level. (132) Research suggests that an additional 2000 steps daily is adequate to prevent weight gain in adults, increasing energy expenditure by around 100 kilocalories. This level of activity is achievable by most people through brisk walking for around 20 minutes. (135) Reducing energy intake by the same amount is equivalent to the consumption of one chocolate biscuit.

The Taskforce proposes that the NPA would work with Australian, state and territory governments to develop and implement a comprehensive, sustained social marketing strategy to increase healthy eating, physical activity and reduce sedentary behaviour. This strategy would build on existing campaigns, including Measure Up and state campaigns such as Go for 2&5, Find Thirty and Go for Your Life. The key elements of these social marketing campaigns would include:

- Fund media campaigns long term, at national and state level, on a par or potentially above what should be expended on tobacco to achieve this sustainability and level of impact – to ensure commercially realistic funding
- Ensure mass media is accompanied by funded local programs and skills development at the local level
- Implementation is repeated and broad, with scaled-up campaigns nationally, using above and below the line media nationally, using above and below the line media that are sustainable and have impact beyond immediate timeframe
- Place media for maximum reach among low SES groups and others at particular risk of overweight and obesity, including providing extra reach for the most socially disadvantaged groups and areas through, for example, further television, radio, outdoor, transit and other local advertising
- Establish governance around social marketing activities and co-ordination of approaches – determine the overseeing role of the NPA in partnership with government and non-government sectors
- Choose messages most likely to reduce prevalence in socially disadvantaged groups and provide extra reach to these groups

Action 4.1

Fund effective national social marketing campaigns to increase physical activity and healthy eating and reduce sedentary behaviour; and support people to make informed choices about their health.
It is now accepted by international health agencies such as WHO that restrictions on food and beverage marketing directed to children should form part of a comprehensive and multifaceted strategy to address the growing problem of childhood obesity. WHO has recognised that food marketing to children, particularly television advertising, is an important area for action to prevent obesity, and has called upon governments to implement policies and strategies that reduce the impact of foods high in fat, sugar and salt, and promote the responsible marketing of foods and beverages to children.

There is also growing international consensus that food advertising influences children’s food preferences, diet and health, and that this influence is harmful to children’s health, as most advertising to children is for products high in salt, sugar and fat. International reviews have concluded that heavy marketing of fast food outlets and energy-dense micronutrient-poor foods and beverages is likely to be causative in weight gain or obesity. Statistical evidence indicates that exposure to television advertising is associated with adiposity or body fatness in children aged 2–11 years and young people aged 12–18 years. US research examining the effects on childhood obesity of television fast food restaurant advertisements targeted at children has found a strong association between exposure to fast food restaurant advertising and the probability of children being overweight. Similarly, modelling to estimate the potential effects of reducing the exposure of 6–12-year-old US children to television food advertising on overweight and obesity prevalence predicts that reducing exposure to zero would lower the prevalence of obesity from 17.8% to 15.2% for boys and from 15.9% to 13.5% for girls.

Australian children’s exposure to television food advertising is amongst the highest in the world, and a large proportion of these advertisements are for non-core or extra (EDNP) foods. Australian children watching 20 hours of television or more per week (two hours and 51 minutes per day) are twice as likely to be overweight or obese as children who watch less television. Evidence indicates higher rates of high-fat/high-sugar food advertisements on Australian television during children’s viewing hours, compared with adults’, and during popular children’s programs.

The Taskforce has noted that the Australian Communications and Media Authority (ACMA) has released its draft Children’s Television Standards 2008 for public and industry comment. At this stage, ACMA is not proposing to introduce general restrictions on food and beverage advertising to children.

The draft standards do not impose general restrictions in relation to food and beverage advertising, arguing it would be a blunt form of regulatory intervention. However, they do propose to strengthen certain provisions regulating advertising to children. These proposals would further restrict the use of licensed characters, popular personalities and celebrities to promote and endorse products immediately before, during and after ‘C’ and ‘P’ periods. They would also clarify rules for premium offers, such as toys offered with food and beverage purchases.

The Taskforce believes there is a need to address persuasive marketing techniques (including premium offers, such as competitions, and the use of promotional characters, including celebrities and cartoon characters) to children. Persuasive marketing techniques are frequently used to advertise non-core foods to children, to promote children’s brand recognition and preference for advertised products. Recent Australian research examined children’s exposure to the...
use of persuasive marketing (within television food advertisements). The study found that significantly more food advertisements were broadcast during children’s peak viewing times, compared to non-peak times, contained promotional characters and premium offers. During programs most popular with children, there were 3.3 non-core food advertisements per hour containing premium offers, compared to 0.2 per hour during programs most popular with adults. The majority of advertisements containing persuasive marketing during all viewing periods were for non-core foods. (145)

The Taskforce believes that restrictions on the advertising and promotion of unhealthy food and drink are required to reduce children’s overall exposure to the marketing of EDNP foods. In addition, the Taskforce also believes there is a need to curtail the use of specific persuasive marketing techniques in the marketing of these foods. A staged approach will be required, commencing with the phasing out of marketing of these products on free-to-air and Pay TV before 9 pm. Television advertising has significant reach, and has been shown to independently influence children’s food preferences and purchasing requests. (137, 146)

Phasing out the marketing of unhealthy foods during peak viewing periods and during periods when children and young people are likely to be watching television would help to reinforce and normalise healthy eating for Australian children, and enable them to make healthier food choices. Children are a distinct group of media consumers whose cognitive abilities require special consideration in relation to the content and presentation of advertising.

DISPLACEMENT OF ADVERTISING

Experience from tobacco control indicates that when restrictions do not cover all media, marketing is likely to become concentrated in those media that are not covered, or not as heavily restricted. (147) This will need to be monitored carefully over time.

Research indicates that food marketers are responding to pressures to reduce television advertising by increasingly using print and new technologies, such as the internet, mobile phone text messaging and email to target children. (148) These other non-broadcast media are often used by children without parental supervision, making them more difficult for parents to monitor and control. (149)

CURRENT INDUSTRY SELF-REGULATION IN AUSTRALIA

The Responsible Children’s Marketing Initiative, (150) developed by the Australian food and beverage industry, came into effect in January 2009, with the stated aims:

- ‘to ensure that a high level of social responsibility in marketing communication and marketing food and beverage products in Australia is maintained’

- ‘to provide a framework for food and beverage companies to promote healthy dietary choices and lifestyles to Australian children’. (150)

RESPONSIBLE CHILDREN’S MARKETING INITIATIVE

Member organisations of the Australian Food and Grocery Council (AFGC) have voluntarily committed to the initiative, with 15 companies signed up at 24 April 2009.

Participating companies are required to publish individual company action plans outlining how they will meet the core principles of the initiative, including publicly committing to marketing food and beverages to children under 12 only when the products are healthy dietary choices consistent with government standards, AND when they are presented in the context of a healthy lifestyle encouraging good dietary habits or physical activity. The standards by which their products are assessed include Dietary Guidelines for Australians and School Canteen Guidelines.

This initiative applies to marketing communications directed to children under 12 in media where the audience is predominantly children and/or the programs are directed primarily to children. The key to determining whether programs are designed for children is whether the themes, visuals, language and concepts are those that are appropriate to children under 12. This includes all ‘P’ and ‘C’ programs, but also includes a number of G-rated programs which, based on the criteria outlined above, are considered to be designed for children.

The program is supported by an independent complaints resolution mechanism run by the Advertising Standards Bureau, with The George Institute for International Health acting as an independent arbiter.

Independent evaluation of this initiative will be important to assess the effect on children’s exposure to food marketing and promotion. The AFGC has announced it will commission a study over a period of 12 months from the commencement of the initiative, to monitor advertising to children and assess industry response. Industry is currently working on an independent monitoring project. Participating companies have also agreed to report our marketing activity and communication against their plans on an annual basis.

Source: Information provided by the AFGC

The limitations of this approach include:

- Specific times when the code applies are not specified, and the onus is on individual companies to ensure that they do not advertise in programs where the audience is predominantly children and/or having regard to the theme, visuals, and language used are directed primarily to children.12
- Only some companies in the food industry are represented, due to the voluntary nature of the scheme.(151)14
- There are no specified nutrient criteria used to define healthy and unhealthy foods; making monitoring difficult.
- While complaints and compliance systems have been developed, including a public complaints program, there are no specified deterrents to ensure food companies will comply with the industry’s code. However, the AFGC advises that sanctions are to be developed.(152)
- The code does not cover food marketing on food companies’ own websites, only paid advertising on third-party websites.
- The code does not cover forms of promotion such as sports sponsorship.

The AFGC has announced it will commission a study over a period of 12 months from the commencement of the initiative, to monitor advertising to children and assess industry response. However, independent evaluation of this initiative will be important to assess the...
effect on children’s exposure to food marketing and promotion, and determine whether there is a need for further action.

INTERNATIONAL REGULATION

There are extensive legislative prohibitions on advertising to children in Sweden and Norway, and in the Canadian province of Quebec. In Sweden and Norway, commercial advertising directed to children on television is prohibited, while in Quebec the commercial advertising (of all products and services, not just food) targeted at children via any medium is prohibited. In all of these countries, the ban is enforced by a government agency.\(^{153}\)

The UK’s broadcasting regulator Ofcom began phasing in restrictions on the advertising of food products high in fat, salt and sugar (HFSS products) to children in 2007, in response to concerns about child obesity. HFSS advertisements were banned from children’s programming (aimed at children aged under 16 years) on most channels, and progressively reduced on children’s channels. The first review of these restrictions compared children’s exposure to HFSS advertising in 2005 with that in July 2007–June 2008. The review estimated that over this period the amount of HFSS advertising seen by children on television fell by 34%. Children were also reportedly exposed to less food and drink advertising using licensed characters such as cartoon and film characters, and fewer advertisements with brand equity characters, free gifts and health claims, while advertising featuring celebrities had increased.\(^ {154}\)

Ofcom expects further reductions in children’s exposure to advertising to have occurred following the implementation of the final phase of restrictions which occurred in January 2009, when all remaining HFSS advertising on children’s channels (on Pay TV) was required to be removed.\(^{154}\)

In the United States, legislation was passed in March 2009 establishing an Interagency Working Group on Food Marketed to Children.\(^{155}\) The group will examine how food is marketed to children, develop recommendations on food marketing standards to children under the age of 17 and establish which products are suitable to be advertised to this age group, as well as the scope of the media to which the standards should apply. Members will come from the Federal Trade Commission, Food and Drug Administration and the Centers for Disease Control and Prevention, as well as the Secretary of Agriculture. The group is to report by July 2010.

COMMUNITY VIEWS

There is strong community support for the introduction of restrictions on advertising to children. Significant concern about the frequency and nature of unhealthy food advertising targeted at children and support for restrictions has been demonstrated in numerous state and national community surveys in Australia,\(^{156, 157}\) including strong support for government regulation.\(^ {156, 158}\)

In 2007, the Coalition on Food Advertising to Children (CFAC) led a campaign supporting the need for better regulations to protect children from food advertising. Member organisations collected over 20,000 postcards signed by community members supporting the campaign.\(^{159}\) Several state jurisdictions are considering regulating the marketing of unhealthy food and beverages to children. For instance, the South Australian and Queensland governments announced consultations into television food and drink advertising for children in late 2008. In South Australia, the government has indicated a preference for national action, but will consider the introduction of state-based restrictions if national agreement is not reached. Health ministers in New South Wales and Western Australia have also called for restrictions on unhealthy food advertising to children.\(^ {160}\)
IN SUMMARY

In the area of food advertising to children, a topic that has been the subject of much controversy and community debate, several important new studies and reviews have been published (referred to above). These add to the substantial body of evidence that has been accumulating since the 2007 publication of the review of children’s television advertising prepared for ACMA. The Taskforce also commissioned work in this area.

The Taskforce finds that, on balance, the weight of evidence of the negative effects of inappropriate food advertising on children’s knowledge, attitudes, food preferences and consumption is now sufficiently compelling to recommend ameliorative action.

The Taskforce notes that reducing children’s exposure to the promotion of unhealthy foods alone will not solve the obesity problem, but in concert with the other actions recommended we believe – based on the available evidence – that it will make a significant contribution.

The Taskforce therefore recommends that a phased approach to reduce the exposure of children and others to marketing, advertising, promotion and sponsorship of EDNP foods and beverages is required as one of the key areas of action needed to tackle the obesity epidemic.

The Taskforce proposes that the marketing of EDNP foods and beverages on free-to-air and Pay TV before 9pm should be phased out within four years.

The Taskforce proposes that this measure should be accompanied by a focus on phasing out the use of premium offers, toys, competitions and promotional characters, including celebrities and cartoon characters, to market EDNP food and drink to reduce the exposure of children to this advertising across all media sources.

The Taskforce also proposes that the advertising of EDNP food and drink across other media sources is monitored as restrictions come into place across television to determine if there is a need to develop additional measures across other media sources.

To inform the implementation of this process, an appropriate set of definitions and criteria for determining EDNP food and drink will be developed and adopted.

The phased approach would include:

- Monitoring and evaluating the impact of self-regulation in reducing children’s exposure to unhealthy food advertising
- Identifying shortfalls and any other issues in the current voluntary approach, and addressing these through the introduction of a co-regulatory agreement; monitor and evaluate the effectiveness of co-regulation
- Introduce legislation if these measures are not effective in phasing out
- Marketing of EDNP food and beverages on free-to-air and Pay TV before 9 pm
- Premium offers such as toys, competitions and the use of promotional characters, including celebrities and cartoon characters, to market EDNP food and drink to children
- Consider whether there is a need for additional measures to address EDNP advertising across other media sources

Action 5.1

Phase out the marketing of energy-dense nutrient-poor food and beverages on free-to-air television and Pay TV before 9 pm within four years. Phase out premium offers, toys, competitions and the use of promotional characters, including celebrities and cartoon characters, to market EDNP food and drink to children across all media sources. Develop and adopt an appropriate set of definitions and criteria for determining EDNP food and drink.
Key action area 6: Strengthen, skill and support primary healthcare and public health workforce to support people in making healthy choices

‘The Primary Health Care system has an important role within the whole of society, integrated approach to chronic disease’
(Quote from submission)

The role and contribution of the primary healthcare setting in terms of preventative health are outlined in Chapter 1 of this Strategy. Around 85% of Australians visit their GP each year. Primary healthcare is therefore an important setting because it is often the first point of contact with the health system for a person seeking information about their own health or that of their family. GPs and the broader primary care workforce can provide assessment, information and support to encourage Australians to be healthier throughout their life.

In tackling obesity, it is crucial to target patients in primary care settings, at all levels of prevention. The first priority is to reduce the risk of becoming overweight – to interrupt, prevent or minimise the progress of unhealthy weight gain at an early stage, and to attempt to halt and reduce existing disability and damage associated with unhealthy weight gain.

For those who are already overweight or obese, there is a need to offer services and support to ensure that they do not continue to gain weight, and ideally to support them to lose weight. This often requires access to suitable specialist care and high-quality, expert, multidisciplinary team care.

There is evidence that programs delivered by multidisciplinary teams may be more effective at maintaining weight loss when typically there is a high degree of relapse in weight loss for overweight and obese people. Multidisciplinary patient care teams may include health professionals from a range of areas, such as a physician, dietitian, exercise expert, nurse and behavioural therapist/psychologist.

There are a range of measures that could be implemented to improve the effectiveness of the primary healthcare setting in promoting health. The approach recommended by the Taskforce is outlined in Chapter 1.

Specifically in relation to the prevention of obesity, the Taskforce recommends a focus on workforce strategies for allied health to expand the supply of the allied health workforce available, particularly within the public system and in rural areas. The Taskforce also recognises that there are a number of existing barriers to individuals accessing health services that are appropriately resourced and skilled to deliver integrated assessment, support, advice and follow up regarding nutrition, physical activity and weight loss consistent with best practice.

Funding, implementing and promoting evidence-based clinical guidelines and other multidisciplinary training packages for health and community workers, and ensuring a quality-driven approach to prevention in primary care, are specifically recommended. Also, there are a number of existing clinical guidelines relating to overweight and obesity that have not been fully implemented due to a number of barriers. Strategies should be developed to ensure the increased awareness and implementation of best practice clinical approaches as set out in the guidelines.

It is recognised that addressing the lifestyle factors relevant to the prevention of obesity is most appropriately integrated with other risk factors for chronic disease; for example, drinking at risky levels and smoking. There is also a need to ensure Australia has an appropriate workforce with expertise in health promotion. This workforce will be essential to supporting and facilitating the cultural and organisational changes that will be required in key settings such as workplaces, local government and...
schools. The Taskforce believes that the approach outlined in Chapter 1 will deliver benefits in terms of achieving an integrated best practice approach to preventative health.

**Action 6.1**

Contribute to relevant national policies (for example, the National Primary Health Care Strategy) to ensure key actions to improve preventative health are considered and implemented in the primary care setting. These may include:

- Expanding the supply of relevant allied health workforce and number of funded positions
- Ensuring all individuals have easy access to health services that provide physical activity, weight loss and healthy nutrition advice and support
- Funding, implementing and promoting evidence-based clinical guidelines and other multidisciplinary training packages for health and community workers

**Key action area 7: Address maternal and child health, enhancing early life and growth patterns**

**THE CASE FOR PREVENTION**

The importance of maternal and child health in ensuring a healthy start to life is outlined in Chapter 1. There is a growing realisation and a substantial body of evidence highlighting the important links between maternal health and subsequent child health.

The epidemiological and experimental evidence supports a relationship between growth and development during foetal and infant life, and health in later years, noting two major implications:

‘First, it reinforces the growing awareness that investment in health and education of young people in relation to their responsibilities during pregnancy and parenthood is of fundamental importance. Secondly, any rational approach to healthcare should embrace a life course perspective.’[166]

These considerations have been recognised by WHO in consultations on diet, nutrition and chronic disease:

‘The outcome of a pregnancy must be considered in terms of maternal and neonatal health, the growth and cognitive development of the infant, its health as an adult, and even the health of subsequent generations.’[63]

The evidence for this paradigm has come through numerous epidemiological studies of men and women in middle life, who have accurate birth weight records. Typical of these studies is the UK study of individuals from Hertfordshire, used by the Barker group. (167) Such studies provide evidence for the association of low birth weight and increased risk for hypertension, type 2 diabetes, metabolic syndrome, depression, cardiovascular diseases and mortality. As obesity prevalence is highest in low-income populations, intensive efforts will be required in disadvantaged communities.

A baby’s growth rate in utero and beyond is, in part, determined by parental factors, especially with regard to the mother’s diet, and what and how she feeds her baby, as well as other environmental factors (for example, smoking and alcohol intake), and potentially dietary toxins. Conditions in early life may continue to have an impact on health risks in adult life, illustrating one aspect of the intergenerational component of obesity.

There is also evidence that the period soon after birth is a time of metabolic plasticity. Factors in the environment, such as nutrition, can have long-lasting consequences in that they appear to set the baby on a particular developmental trajectory. While there is less evidence of a direct link between birth weight and obesity, weight gain in early life appears to be critical.
There are serious adverse effects of overweight during pregnancy, with the risk of complications increased for both mother and baby. Obstetric risk increases with BMI among overweight and obese women. Therefore, programs targeting pregnant women that cover healthy eating, physical activity and maintaining a healthy weight could enhance obstetric outcomes and reduce healthcare costs of obesity-related increases in maternal and neo-natal morbidity.

**PREGNANCY**

The intrauterine environment influences the risk of developing type 2 diabetes. Hyperglycaemia in pregnancy is associated with an increased risk of childhood obesity. More research is needed to determine whether Gestational Diabetes Mellitus (GDM) may be a modifiable risk factor for childhood obesity.

There is increasing evidence that the presence of obesity and/or type 2 diabetes in the mother can be associated with the development of obesity and/or type 2 diabetes in the child in later life. The offspring of diabetic pregnancies are often large and heavy at birth, developing obesity in childhood and at high risk of developing type 2 diabetes at an early age. Such individuals have lower insulin secretion than similarly aged offspring of non-diabetic pregnancies. A substantial part of the excess risk of diabetes in the offspring of diabetic pregnancies appears to be the result of exposure to the diabetic intrauterine environment. Among offspring born to mothers before and after the development of type 2 diabetes, those born after the mother developed diabetes have a three-fold higher risk of developing diabetes than those born before. The enhanced risk among the offspring from diabetic pregnancies among such women is therefore the result of intrauterine programming that has long-term effects on the child in later life.

**BREASTFEEDING AND NUTRITION IN CHILDHOOD**

Breastfeeding and early growth patterns provide the only period in which there is clear evidence to support the concept of a critical period of development associated with long-term consequences. Other stages of childhood, however, may offer good opportunities to modify behaviour. For example, there is limited evidence that behaviours such as liking fruit and vegetables can be established in early childhood. Breast-fed babies show slower growth rates than formula-fed babies, and this may contribute to the reduced risk of obesity later in life shown by breast-fed babies. Observational studies suggest a longer duration of breastfeeding to be associated with a decrease in the risk of overweight in later life. As a result, in Europe and the United States high priority has been placed on research strategies investigating the effects of breastfeeding to prevent the development of obesity.

In addition to the protective role breastfeeding may have in several chronic diseases, breastfeeding (including delaying the introduction of solids until babies are six months old) plays an important role in helping to prevent obesity in children. This has been attributed to physiological factors in human milk as well as feeding and parenting patterns associated with breastfeeding. Weaning practices are also thought to be important, given the association between the characteristic weight gain seen in early childhood at approximately five years of age (early adiposity rebound) and later obesity. The proportion of children receiving breast milk declines steadily with age. While the proportion of Australian infants ever breast-fed was around 86–88% between 1995 and 2005, in 2001 less than half (48%) of all infants were receiving any breast milk at the age of six months, and none were being exclusively breast-fed.
In 2001, the proportion of Australian children receiving breast milk was higher among more highly educated and older mothers (aged over 30 years). Indigenous mothers in non-remote areas appear to be less likely to initiate and continue breastfeeding than other Australian mothers.

There is a need to ensure the development of targeted interventions to improve maternal and child health among low SES and Indigenous women, as well as for younger and less educated mothers, particularly in regard to increasing levels and duration of breastfeeding.

The national toll-free breastfeeding helpline was recently upgraded (March 2009) to provide 24-hour support and breastfeeding information through Australian Government funding. Funding has also been allocated to providing training for health professionals and research to support breastfeeding, including indicators of breastfeeding rates and the development of dietary guidelines for pregnant and breastfeeding women.

It is recognised that the Taskforce should work with other relevant groups to ensure the implementation of programs in maternal and child health that are likely to deliver benefits in relation to obesity prevention.

**Key action area 8: Support low-income communities to improve their levels of physical activity and healthy eating**

**SOCIAL DETERMINANTS OF INEQUALITIES IN OBESITY**

“The proposed approach (as described in the October 2009 Taskforce discussion paper) addresses the need for specific initiatives for disadvantaged groups, recognises the value of health workforce development and the value of building the evidence base.” (Quote from submission)

Any serious effort to promote wellbeing, prevent ill health and reduce health inequities must address the social determinants that shape the way people grow, live, work and age, which ultimately affect their health. Social determinants are the combination of structural factors and daily living conditions that ultimately determine health and health equity. An unequal distribution of factors supporting the opportunity to be a healthy weight underlies the unequal distribution of obesity observed in developed countries.

The effect of social structure on inequalities in the distribution of weight is suggested by epidemiological trends and patterns of obesity, illustrated in Figure 2.3 below.

---

**Action 7.1**

*Establish and implement a national program to alert and support pregnant women and those planning pregnancy to the ‘lifestyle’ risks of excessive weight, insufficient physical activity, poor nutrition, smoking and excessive alcohol consumption.*

---

**Action 7.2**

*Support the development and implementation of a National Breastfeeding Strategy in collaboration with the state and territory governments.*
Interventions directly aimed at encouraging people to improve their eating behaviours and increase their physical activity levels will not address underlying social determinants. There is a need to acknowledge the role of the complex global social system that is driving the obesity epidemic and determines the social gradient of obesity rates. Obesity prevention can only be achieved through addressing inequities in the social system, providing:

- A sufficient, nutritious food supply
- Local urban planning and design that provide access to healthier choices for all, especially low-income earners
- Sufficient, equal material and psychosocial resources to support healthy living options for individuals and communities across all social groups

‘The global obesity epidemic is unequally distributed within and between countries. It is being fuelled by economic and psychosocial factors as well as the increased availability of energy-dense food and reduced physical activity. Tackling it requires concerted action at national and international levels to promote a more equal distribution of affordable nutritious food, and improved, more equitable living and working conditions.’
The increased prevalence of obesity is associated with significantly decreased energy expenditure, as well as dietary changes that have been occurring around the world since the mid-20th century, involving a greater intake of more refined foods, meat and dairy products containing high levels of saturated fats. Significant changes in food systems and behaviours have meant that dietary energy is increasingly available and readily accessible, with factors including: trade liberalisation exposing more countries to international markets; food subsidies contributing to a food supply that favours unhealthier food products; a global market in which EDNP foods cost little to produce; buying in bulk, convenience foods and supersized serves being promoted through the displacement of small stores and stalls by supermarkets and chains.[81]

BARRIERS TO HEALTHY LIVING AMONG LOW-INCOME AUSTRALIANS

Prices influence behaviour and choices, particularly among those on lower incomes, pensioners and the unemployed. Low income should not be a barrier to participation in physical activity or access to healthy food options.[49]

Poorer families, the elderly and Indigenous people are more likely to live in the outer suburbs, and more likely to live in depressed rural communities with poor or ageing physical activity infrastructure. Poorer members of the community are further disadvantaged by:[49]

- Transport policy and urban planning that is dominated by the car (rather than public transport, walking and cycling)
- Urban planning that fails to provide for accessible physical activity, sport, recreation, walking and cycling
- The high cost of physical activity, recreation and sport

Action 8.1

Fund, implement and promote effective and relevant strategies and programs to address specific issues experienced by people in low-income communities, such as lack of access to affordable, high-quality fresh food.

Action 8.2

Fund, implement and promote multi-component community-based programs in low SES communities.

Action 8.3

Provide resources for brief interventions from the primary healthcare setting.
Key action area 9: Reduce obesity prevalence and burden among Indigenous Australians

Among Aboriginal and Torres Strait Islander people, high body mass is the second highest contributor to disease burden (11.4%), after tobacco use (12.1%). In comparison, among the general Australian population, high body mass is the third highest contributor to disease burden (7.5%), after tobacco use (7.8%) and high blood pressure (7.6%).

In 2004–05, approximately 60% of Indigenous Australians aged 18 years and over were overweight, of whom 31% were obese. Indigenous Australians were 1.9 times as likely to be obese and over three times as likely to be morbidly obese (BMI >40).

The proportion of the health gap attributable to alcohol, tobacco and obesity is also distributed unevenly. While Indigenous people in remote areas make up 26% of the total Indigenous population, they contribute 38% of the health gap due to high body mass.

NUTRITION-RELATED HEALTH AND INDIGENOUS AUSTRALIANS

“The enormous inequity in food availability and affordability for Indigenous Australians alone is a very fundamental issue to be addressed if there is any hope of 'Closing the Gap'” (Quote from submission)

The majority (75%) of Indigenous Australians live in urban areas, while 25% live in remote communities. Reflecting this distribution, those living in urban areas constitute 60% of the health gap. Therefore strategies to improve Indigenous health must include a focus on rural, remote and urban communities.

Diet has been indicated as a risk factor in 57% of all deaths in Australia, based on Australian Bureau of Statistics (ABS) deaths data in 1983. Many of the main causes of ill health among Aboriginal and Torres Strait Islander peoples are nutrition-related conditions, such as heart disease, type 2 diabetes and renal disease.

Recent Aboriginal and Torres Strait Islander-specific health data indicate that the majority of Aboriginal and Torres Strait Islander peoples aged 12+ years reported some daily intake of vegetables (95%) and/or fruit (86%). Access to such fresh food may be more difficult for Aboriginal and Torres Strait Islander peoples in remote areas, as one in five (20%) of those living in remote areas reported no usual daily fruit intake compared with one in eight (12%) in non-remote areas. This difference was even greater for vegetables: 15% of people in remote areas reported no usual daily intake compared with 2% in non-remote areas.

Among those living in non-remote areas, 42% were eating the recommended daily intake of fruit and 10% the recommended daily intake of vegetables. While the intake of vegetables was broadly similar between Aboriginal and Torres Strait Islander and non-Aboriginal and Torres Strait Islander peoples, Aboriginal and Torres Strait Islander people generally reported eating less fruit than non-Aboriginal and Torres Strait Islander people. These questions were not recorded for remote and urban locations.

PHYSICAL ACTIVITY AND HEALTH OF INDIGENOUS AUSTRALIANS

The rationale for increasing the focus on physical activity among Aboriginal and Torres Strait Islander people is compelling. In 2004–05, information was collected relating to the frequency, intensity and duration of exercise undertaken by Aboriginal and Torres Strait Islander people living in non-remote areas. The proportion of Aboriginal and Torres Strait Islander people in non-remote areas who were sedentary or engaged in low-level exercise in the two weeks prior to interview was higher in
2004–05 (75%) than in 2001 (68%).[191] In 2001 around 43% of Aboriginal and Torres Strait Islander adults living in remote areas reported no leisure-time physical activity, compared to about 30% of other Australians in the same areas.[192]

Recreation, fitness, sports, active living, access to parks, arts and culture all contribute to social and emotional wellbeing, enhanced quality of life, fine motor skill development, overall health and weight control.[193]

KEY ACTIONS TO REDUCE THE BURDEN OF OBESITY AMONG INDIGENOUS AUSTRALIANS

Key specific actions to reduce the high burden of disease due to obesity among Indigenous Australians include resourcing of interventions from the primary healthcare setting; strengthening antenatal, maternal and child health systems for Indigenous communities; and implementing multi-component community-based programs.[189]

INTERVENTIONS FROM THE PRIMARY HEALTHCARE SETTING

Brief interventions on diet and exercise have been shown to be effective in the mainstream community to decrease fat consumption, increase fibre consumption and increase physical activity.[194, 195] There is no evaluated evidence specific to the Australian Indigenous context. Brief intervention programs for physical activity and nutrition for Aboriginal and Torres Strait Islander peoples are being piloted in Queensland,[16] with future impact and outcome evaluation to be included in service expansion.

Successful interventions are likely to be dependent on the same factors as for alcohol and tobacco: adequate resourcing to allow a focus on non-acute issues, training, public health expertise on staff, and quality improvement systems. Follow-up sessions to the initial consultation are critical to improvements over the long term.[195]

ANTENATAL, MATERNAL AND CHILD HEALTH SERVICES

Poor nutrition in the first years of life and low birth weight are associated with lifetime higher rates of overweight and obesity, and increased risk of chronic disease later in life.[196] Well-resourced and best-practice antenatal, maternal and child health services are a core component of comprehensive primary healthcare, and should include antenatal care, encouragement and support of breastfeeding, programs to monitor infant growth and development, support and advice to parents about child nutrition, and child growth monitoring and action. All primary healthcare services serving Indigenous communities should be resourced to deliver such services as a critical investment in future health.

There are numerous examples of health services that have acted on maternal and child health effectively, including Central Australian Aboriginal Congress, the Townsville Aboriginal and Islander Health Service, Nganampa Health Council, Maari Ma Health Aboriginal Corporation and the Northern Territory Government’s Strong Women, Strong Babies, Strong Culture.

Notwithstanding the powerful effects of social determinants of health such as relative and absolute poverty, lack of education and powerlessness, a well-resourced and robust primary healthcare has significant potential to contribute to closing the Indigenous health gap. (189)

MULTI-COMPONENT COMMUNITY-BASED HEALTHY LIFESTYLE PROGRAMS

“Healthy lifestyle” programs have been shown to be effective in the Australian Indigenous context in improving biochemical markers of chronic disease risk and health indicators, (197-200) and effective in overseas Indigenous populations in increasing physical activity. (201)

There are lessons to be learned from some interesting examples of interventions targeting Indigenous communities that are currently being implemented in Queensland. For example, Living Strong is a healthy lifestyle program for Aboriginal and Torres Strait Islander communities. (17) Process evaluation has guided the development of the program, while impact and outcome evaluation is still to be conducted.

Depending on local community priority and capacity, possible areas for action in community-based health programs include nutrition, the availability and affordability of healthy food (for example, at community stores), and physical activity. Increasing opportunities for activity could include subsidised, affordable access to gyms, swimming pools and sporting facilities. (189) Ensuring that the physical and social environment in Indigenous communities is conducive to safe participation in physical activity would need to be addressed, along with providing participation opportunities for Aboriginal and Torres Strait Islander children at school and at home, including physical education at school. (49)

Possible models for implementation to maximise the affordability and availability of fresh food in remote areas include the Outback Stores program set up by the Australian Government in 2006, now running in stores across the Northern Territory and in Western Australia, and the subsidisation of fresh food costs in remote areas. (202)

It is also important to note the strong evidence that outstation living and access to traditional lands is associated with reduced risk of obesity, improved physical health and overall lower chronic disease risk and mortality. (203-207)

THE COST OF FOOD

Australians living in rural and remote areas are among those at particular risk of food insecurity. (72) In 2006 a healthy food basket cost on average 29% more (ranging from 24% to 56%) in remote areas of the Northern Territory compared with Darwin. (208)

A study in a remote Northern Territory Indigenous community found that food in general cost 50% more than in Darwin, and that families spent an average of 38% of their income on food and non-alcoholic beverages, compared with 14% for the average Australian household and 30% for low-income non-remote Australian households. (208)

At least 44% of household income and significant changes in purchasing patterns would be required to achieve dietary recommendations. While community members reported a preference for fresh produce, more than half the average energy intake in the community came from white bread and flour, sugar and milk powder, products that provide most calories for least cost, store well and divert hunger. However, when factors including store management and leadership, workforce development and improved infrastructure were addressed through a ‘whole of store’ approach, sales of fruit and fresh vegetables increased. Thus, while still facing significant economic barriers, people in the community purchased more fruit and vegetables when given the opportunity. (208)

The actions recommended in this strategy to address the availability of fresh food will have a positive impact on Indigenous communities in regional and remote locations. Strategies to improve access to healthy foods among rural and remote Indigenous Australians include:

- The provision of vouchers to buy a weekly basket of nutritious foods
- The examination of patterns of transport and marketing to reduce barriers to the trade of fresh local foods
- The support of economic development opportunities such as agriculture and horticulture, and the development of traditional food resources
- The provision of adequate remote food storage infrastructure
- The development of the Indigenous workforce in remote and rural stores

It is critical to ensure the implementation and maintenance of relevant recommendations from the National Indigenous Health Equality Summit, including targeting healthy living practices such as the ability to store, prepare and cook food being available in three-quarters of all houses by 2013. Poor-quality diet in the Indigenous population is a significant risk factor for three of the major causes of death (cardiovascular disease, cancer and type 2 diabetes). Poor nutrition among many Indigenous people is associated with disadvantaged socioeconomic circumstances.

**INTERVENTIONS AMONG INDIGENOUS COMMUNITIES**

There is a lack of well-evaluated nutrition, physical activity and health programs for Aboriginal and Torres Strait Islander peoples. The results of research in remote Aboriginal and Torres Strait Islander communities of Australia indicate that community-directed nutrition programs, addressing both food supply and demand issues, can clearly improve a range of risk factors for chronic disease and that improvements can be maintained. A decrease in the prevalence of low birth weight children has been seen in Aboriginal and Torres Strait Islander communities associated with the implementation of culturally appropriate maternal and child health and nutrition programs.

Community involvement, management and ownership have been identified as essential components of any program promoting health in Aboriginal and Torres Strait Islander peoples, including those addressing overweight and healthy lifestyles.

---

**Action 9.1**

**Fund, implement and promote effective and relevant strategies and programs to address specific issues experienced by people in Indigenous communities, such as lack of access to affordable, high-quality fresh food.**

**Action 9.2**

**Strengthen antenatal, maternal and child health systems for Indigenous communities.**

**Action 9.3**

**Fund, implement and promote multi-component community-based programs in Indigenous communities.**

---

18 On 18–20 March 2008, the National Indigenous Health Equality Summit was held in Canberra. The outcome was a statement of intent and a report detailing a series of targets aimed at achieving health status and life expectancy equality between Indigenous and non-Indigenous Australians by 2030. In December 2007 the Council of Australian Governments (COAG) agreed to a partnership between all levels of government to ‘Close the Gap’ on Indigenous disadvantage; notably, to close the 17-year gap in life expectancy within a generation and to halve the mortality rate of Indigenous children within 10 years. The report is available at www.hreoc.gov.au/social_Justice/health/targets/index.html.
Key action area 10: Build the evidence base, monitor and evaluate effectiveness of actions

DEVELOP A COMPREHENSIVE NATIONAL RESEARCH AGENDA FOR OVERWEIGHT AND OBESITY

“Creating new evidence from innovative and untested strategies and projects should be considered alongside those strategies and interventions that we know work”
(Quote from submission)

There is a clear need to increase the evidence base regarding obesity prevention and management through research, evaluation, monitoring and surveillance. This requires a much higher investment in research and evaluation related to weight reduction interventions and the causes of obesity.19

The development of a comprehensive national research agenda for obesity is essential. It is also vital to develop an agreed national assessment tool and reporting levels for overweight and obesity, particularly as they relate to children, young people and minority groups. A specific research agenda must be developed with appropriate levels of public and private funding, which must be supported by improved monitoring and harmonisation of surveillance systems across Australia. If the relative lack of evidence on obesity prevention and management is to be addressed, existing and future interventions require well-designed, rigorous evaluation (including economic analysis such as the assessment of cost-effectiveness).

19 The Australasian Child and Adolescent Obesity Research Network (ACACORN) has called for increased funds targeted specifically at childhood obesity research, and for a national childhood obesity research agenda. In an examination of funds allocated by major medical research funding bodies to obesity, ACACORN found, for example, that 5% of funding in the NHMRC December 2008 statement was for obesity-related projects (with a small proportion for childhood obesity). Baur LA, Wake M, Espinel PT. Audit of Australian childhood obesity research funding 2005–09. On behalf of the Australasian Child and Adolescent Obesity Research Network (ACACORN). April 2009.

Partnerships between the NPA and the National Health and Medical Research Council (NHMRC), the Australian Research Council (ARC) and other state-based research funding organisations such as health promotion foundations and non-government organisations will be important to ensure a coordinated investment in research and evaluation. Clearly the establishment of the NPA would greatly assist a coordinated approach and would be a mechanism for achieving this. Such an agency would be able to commission research and develop targeted social marketing and public education campaigns. This mechanism would also be used to coordinate national media advertising with local program delivery, and to evaluate campaign effectiveness. The success of the National Tobacco Campaign and the recent Measure Up campaign clearly indicates that such models for campaign development, implementation and evaluation are feasible and well accepted by all those involved. There is a unique opportunity to build upon the recent experience with the Measure Up campaign, and to ensure this momentum is maintained.

NATIONAL DATA COLLECTION – ADULTS

The Taskforce has identified the need to establish a comprehensive national surveillance system focused on the behavioural, environmental and biomedical risk factors for chronic disease (including factors such as food availability and food composition) to track and report on performance and outcomes, including the impact of health inequalities. The current plans to enhance nutrition and physical activity data through the collection of national biomedical data are strongly supported by the Taskforce. This data should be collected on an ongoing basis every five years through the National Health Risk Survey and other national data bases, and must include the capacity to collect data from the Australian Indigenous population.
Such a database will assist with the monitoring and reporting of the COAG National Partnership Agreement on Preventive Health performance indicators and allow reports on progress in achieving the COAG partnership interim targets.

**NATIONAL DATA COLLECTION – CHILDREN AND ADOLESCENTS**

There is also a need to ensure there is an appropriate mechanism for the ongoing collection of national data on children. This should cover two components. Firstly, the capacity to repeat at regular intervals the Australian National Children’s Nutrition and Physical Activity Survey undertaken in 2007. Secondly, the Taskforce is very supportive of the national data collection to be undertaken among adolescents by the state Cancer Councils, Cancer Council Australia and the National Heart Foundation of Australia, which will commence in 2009.

This survey aims to build on the well-established Australian Secondary Students’ Alcohol and Drug (ASSAD) surveys, and will monitor overweight and obesity prevalence, eating and physical activity behaviours among a nationally representative sample of around 20,000 secondary school students from year levels 8 to 11. Measured height, weight and waist circumference, food intake, dietary habits, physical activity, sedentary behaviour, barriers and enablers of physical activity and data on the school food and activity environment will be collected. This will be a rich data source and will enable ongoing monitoring of the attitudes and behaviour of adolescents, a group that is very important to influence if we are going to successfully halt and reverse the current trend in overweight and obesity in Australia.

**EVALUATION OF INTERVENTIONS IN INDIGENOUS COMMUNITIES**

There are several key principles for successful interventions in the Indigenous context,(189) including ensuring programs are adequately resourced for evaluation and monitoring so they can contribute to intervention policy knowledge. The evidence of ‘what works’ to address alcohol, tobacco or obesity is in some cases highly developed, but this evidence base is predominantly from mainstream and/or overseas populations. Taking account of this evidence is important. However, given the need to work with Indigenous communities’ own histories, priorities and capacities, flexibility and innovation on the basis of the evidence is likely to be more effective than attempts to rigidly apply interventions that worked elsewhere. It is important to ensure that programs contribute to evidence-based intervention policy knowledge through adequate resourcing for evaluation.

Indigenous communities require evidence-based approaches that are reflective and that involve the local community in adapting what is known to be effective elsewhere to local conditions and priorities. Obesity, tobacco and alcohol are not necessarily the top priorities for all communities. Any sustainable program needs to make provision for flexibility and negotiation between local priorities and program priorities. Community-controlled health services and their peak bodies provide an important arena in which the dialogue between community priorities and an evidence-based approach to population health challenges can take place.

**Action 10.1**

NPA to develop a national research agenda for overweight and obesity with a strong focus on public health, population and interventional research.
Action 10.2

Ensure that the National Health Risk Survey Program will cover:
- Adults
- The Indigenous population

Action 10.3

Ensure that the National Children’s Nutrition and Physical Activity Survey is repeated on a regular basis to allow for the ongoing collection of national data on children.

Action 10.4

Support ongoing research on effective strategies to address social determinants of obesity in Indigenous communities.

ISSUES OUTSIDE THE SCOPE OF A NATIONAL PREVENTATIVE HEALTH STRATEGY

A few issues highlighted during the consultation and submission process were outside the scope of a National Preventative Health Strategy. The Taskforce provides the following comments in relation to two of these issues in the obesity area.

IS THERE A ROLE FOR THE COMMERCIAL WEIGHT-LOSS INDUSTRY IN PREVENTION?

There are currently inadequate regulations and voluntary codes of practice which apply to weight loss products and programs. A plethora of over-the-counter products and programs are available and promoted for weight loss in Australia, including through pharmacies, many with unsubstantiated claims of efficacy. Insufficient consultant training, lack of qualified supervision and no capacity to individually tailor advice and plans have been identified as common problems in a range of pharmacy-based weight loss programs in Australia. While these kinds of products and services cannot be recommended as part of a national obesity prevention strategy, it is an area that needs to be addressed through adequate action to ensure Australians have access to effective weight loss products and services. For complementary medicines, this would be addressed through the Therapeutic Goods Association (TGA); for the weight-loss industry, this is likely to be achieved through the Trade Practices Act.

There is a need to develop mechanisms that ensure safe industry practices within the commercial weight-loss industry and ensure access to effective weight loss products and services, including:
- Development of a national accreditation system (for example, based on the Weight Management Code of Practice, administered by the Weight Management Council of Australia) for weight management programs (including minimum training standards for consultants, nutritional standards, and eligibility criteria such as age of clients)
- Identification of a responsible administering body, and consideration of monitoring, compliance, enforcement and sanctions
- Implementation of industry and consumer education regarding the accreditation standards and criteria

20 Consultation was undertaken by the TGA for a draft guideline on evidence for listed medicines with indications and claims for weight loss (February–April 2009). See www.tga.gov.au/cm/consult/drweightloss.htm. The effectiveness of TGA requirements for listings of herbal and complementary medicines (for example, lack of burden of proof and product analysis) compared with requirements for registration of pharmaceutical drugs has been questioned; see www.thelaw.com.au/story/0,25197,25306329-23289,00.html.

21 This would require review as the Weight Management Code of Practice applies to businesses in the Weight Management Industry who are members of the Weight Management Council of Australia; this has very limited membership (five companies) given the size of the commercial weight-loss industry. See www.weightcouncil.org/Activity.asp?page=350.
BARIATRIC SURGERY

Bariatric surgery is the most effective weight-loss treatment in severely obese patients.\(162\) It is being increasingly used in the treatment of obesity, particularly in the private health sector. However, there is no role for this procedure in the obesity prevention arena. Bariatric surgery is considered appropriate in well-defined clinical situations such as morbid obesity where non-operative methods (such as behavioural interventions) have failed. Appropriate protocols for this procedure, covering guidelines on patient selection, assessment (medical and psychological) and post-operative monitoring, should be followed.\(162\)

The Taskforce also notes that the lack of access to high quality publicly funded behavioural approaches to obesity management is potentially distorting choices in favour of surgery.
### Summary Tables

#### OBESITY: IMPLEMENTATION PLAN

Summary of action required and how progress will be measured

<table>
<thead>
<tr>
<th>KEY ACTION AREAS</th>
<th>RESPONSIBILITY</th>
<th>STAGED IMPLEMENTATION</th>
<th>MEASUREMENT</th>
</tr>
</thead>
</table>
| **Key action area 1: Drive environmental changes throughout the community which increase levels of physical activity and reduce sedentary behaviour** | Lead agency: All governments (Australian/ state/ territory/local). Partners: Industry peak bodies; professional groups (e.g. planners and developers); building industry, developers transport groups; active living consumer and advocacy (e.g. cycling organisations); Australian Sports Commission, sporting bodies, health groups. | Years 1–4
Establish a Prime Minister’s Council for Active Living to provide high level leadership and oversee the development of the National Framework for Active Living. A National Framework for Active Living will identify key impediments and enablers of physical activity in relation to the built environment, transport and social engagement. This will include reviewing: Built environment – relevant Australian and state government legislation (including building codes), planning guidelines including examples of good practice that incorporate healthy living (e.g. Healthy Spaces and Places, Healthy by Design). Transport – relevant transport policy and guidelines including examples of good practice in active transport (e.g. TravelSmart, national cycling strategy). Social engagement – strategies and initiatives to promote social engagement in active living and sport. | Prime Minister’s Council for Active Living established. National Framework developed and implementation commenced in agreed timelines. Population measures of physical activity for adults and children. Population measures of participation in sports and active recreation including cycling and walking. Infrastructure funding programs that include a focus on active transport and recreation. |

| | | Years 5–8
Implement the National Framework. | |
| | | Years 8–10
Monitor and report on progress with the implementation. |
### Key Action Areas

<table>
<thead>
<tr>
<th>Action Area</th>
<th>Responsibility</th>
<th>Staged Implementation</th>
<th>Measurement</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.2</td>
<td>Develop business case for a new COAG National Partnership Agreement on Active Living.</td>
<td>Lead agency: All governments (Australian/state/territory/local). Partners: Expert groups; NPA; community groups; sporting associations; non-government organisations. The Framework for Active Living will inform the development of the business case for consideration by COAG. Years 1–4 The business case will be developed in tandem with the development of the Framework for Active Living described above. Implement the national partnership agreement if approved by COAG.</td>
<td>The business case for a new COAG National Partnership Agreement on Active Living is developed within three years.</td>
</tr>
<tr>
<td>1.3</td>
<td>Australian and state governments to consider the introduction of health impact assessments in all policy development (including urban planning, school education, transport), using partnership models such as the Health in All Policies (HiAP) approach in South Australia.</td>
<td>Lead agency: Australian, state and territory governments. Years 1–4 Examine existing approaches in Australia including the Health in All Policies (HiAP) approach in South Australia and overseas. Implement a trial of appropriate approaches across a range of priority policies and portfolios. Monitor and evaluate effectiveness of approaches. Implement the system.</td>
<td>Health Impact assessment process trialled. Health Impact assessment process adopted. Health Impacts associated with policies are explicitly identified and considered at an early stage.</td>
</tr>
<tr>
<td>1.4</td>
<td>Commission a review of economic policies and taxation systems, and develop methods for using taxation, grants, pricing incentives and/or subsidies to:</td>
<td>Promote active living and greater levels of physical activity. Decrease sedentary behaviour.</td>
<td>Lead agency: Expert group in consultation with Treasury. Partners: Australian/state/territory/local governments; NPA; planners, developers, building industry; workplace/employer groups; private health insurance industry; sporting, public health and non-government organisations. Years 1–4 Independent review commissioned and completed. Baseline measures collected. Implement review recommendations and develop strategies to overcome existing barriers and maximise opportunities. Implement monitoring system to measure impact of changes. Years 5–8 Review progress and consider need for additional measures.</td>
</tr>
</tbody>
</table>
### Key Action Areas

<table>
<thead>
<tr>
<th>Key Action Area 2: Drive change within the food supply to increase the availability and demand for healthier food products, and decrease the availability and demand for unhealthy food products</th>
</tr>
</thead>
</table>

#### 2.1 Develop and implement a comprehensive National Food and Nutrition Framework for the Australian food supply covering:
- Price, choice and access to food and food security through open and competitive markets
- Achieving healthier diets
- Food safety
- Issues related to food production and agricultural policy that ensure a safe and environmentally sustainable food chain and food supply

**Lead agency:** Australian Government. Partners: Whole-of-government; industry (including food, agriculture, horticulture, transport, planning and development, retailers, manufacturers, primary producers, restaurants); consumer groups; professional and public health organisations.

**Years 1–4**
- Development of the National Food and Nutrition Framework that articulates a policy framework and key actions for government, industry and other partner organisations to achieve a safer, healthier and more sustainable food supply. It will:
  - Ensure that issues relating to healthy eating and nutrition are considered appropriately within the same policy context as food safety, food supply and environmental issues
  - Provide an opportunity to strengthen partnerships
  - Include development of a Healthy Food Code of Practice where companies in the food sector commit to the promotion of healthy eating
  - Identify and implement strategies by which affordable, healthy, fresh, good-quality foods are available to all Australians
  - Target population groups at particular risk
- Commence implementation.

**National food supply framework developed.**
- Relevant stakeholders engaged and participating.
- Public sector agencies adopting standards for healthier food in their workplace.
- Other workplaces adopting standards for healthier food in their workplace.
- Code of Good Practice for Food established and implemented. Compliance with the code.
- Price, quality, availability and source of fresh food.
- Healthy food basket surveys: prices of fresh foods in regional, remote and disadvantaged areas.
## Key Action Areas

### 2.2 Commission a review of economic policies and taxation systems, and develop methods for using taxation, grants, pricing, incentives and/or subsidies to:

- Promote the production of healthier food and beverage products, including reformulation of existing products
- Increase the consumption of healthier food and beverage products
- Decrease the production, promotion and consumption of unhealthy food and beverage products
- Promote healthy weight

**Lead agency:** Expert group in consultation with Treasury.

**Partners:** Australian/state/territory/local governments; NPA; food industry (retail sector; food service; manufacturers; marketing and promotions; primary producers; horticulture); transport sector; workplace/employer groups; public health organisations.

**Years 1–4**

- Independent review commissioned and completed. Baseline measures collected.
- Implement review recommendations including any new measures.
- Develop strategies to overcome existing barriers and maximise opportunities.
- Implement monitoring and evaluation system.

**Years 5–8**

- Review progress and consider need for additional measures.

**Measurement**

- Review completed within 12 months.
- Introduction of new measures.
- Impact of measures on behaviour (particularly for disadvantaged populations).
- Trends in pricing of food and beverage products and related services (transport, storage, infrastructure).
- Production, availability, price and promotion of healthier food products (requires assessment of 'healthiness' of food products).
- Sales and consumption data (e.g. supermarket sales data; population surveys).
- Long-term nutrition-related population health outcomes.
- Impact of taxes on unhealthy foods on low-income earners (e.g. proportion of income spent on food; purchase and consumption patterns).

### 2.3 Examine and develop systems and subsidies that increase the availability of high-quality, fresh food for regional and remote areas, focusing on:

- Regional and remote transport
- Increasing the production of high-quality, locally grown fresh foods that are available to the local community

**Lead agency:** Australian Government.

**Partners:** State/territory and local governments; industry (transport, food, agriculture and horticulture industry); NPA; community groups; health groups.

**Years 1–2**

- Consultation and development of best practice approach. Review existing transport and marketing systems and subsidies related to fresh food in regional/remote areas. Develop or revise systems to increase fresh food availability. Collection of baseline measures on price, quality and source of fresh foods.
- Implement approach in selected regional and remote communities and refine as necessary.

**Years 3–4**

- Implement best practice approaches across regional and remote Australia. Monitor impact of changes and introduce amendments as necessary.

**Measurement**

- Price, quality, availability and source of fresh food.
- Healthy food basket surveys: prices of fresh foods in regional and remote areas.
- Consumer expectations, attitude awareness, intention and behaviour for fresh food.
- Availability, quality and proportion of food grown locally.
- Retail outlet purchase/ordering/sales data and transport/manufacturer data: measure of proportion of fresh foods from local source versus transported.
- Promotion of fresh food in local area.
<table>
<thead>
<tr>
<th>KEY ACTION AREAS</th>
<th>RESPONSIBILITY</th>
<th>STAGED IMPLEMENTATION</th>
<th>MEASUREMENT</th>
</tr>
</thead>
</table>
| 2.4 Drive change within the Australian food supply by establishing a Healthy Food Compact between governments, industry and nongovernment organisations to reduce the production and promotion of foods and beverages that are energy dense and nutrient poor, are high in sugar, fats, saturated fats and salt, and which contain trans fats, by setting targets for these nutrients. | Lead agency: Australian Government. Partners: Food industry; professional organisations; relevant public health and consumer organisations. | Years 1–4
Establish the Healthy Food Compact.
Examine the feasibility of providing incentives to the food industry to reformulate existing products or develop new ones to produce healthier alternatives. Examine successful approaches to date within Australia and internationally.
Develop voluntary targets with the food industry (e.g., targets to reduce levels of energy, sugar, saturated fat, salt and trans fat; and standard portion sizes).
Collect baseline measures.
Implement reporting, monitoring and surveillance system.
Implement strategies in partnership with the food industry to reformulate existing products or develop new ones.
Review uptake and effectiveness of voluntary targets. If voluntary reformulation is ineffective, introduce government regulation to decrease levels of saturated fats, sugar and salt in foods and remove trans fats. | Uptake of voluntary targets by industry. Products reformulated and/or new products developed. Compliance with targets. Consumer knowledge, attitude and awareness. Consumption of foods and beverages that are energy dense and nutrient poor, are high in sugar, fats, saturated fats and salt, and which contain trans fats. Uptake of incentives by industry. |
### Key Action Areas

<table>
<thead>
<tr>
<th>Key Action Area</th>
<th>Responsibility</th>
<th>Staged Implementation</th>
<th>Measurement</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>2.5 Introduce food labelling on front of pack and menus to support healthier food choices with easy to understand information on energy, sugar, fat, saturated fats, salt and trans fats, and a standard serve/portion size within three years in partnership with industry, health and consumer groups.</strong></td>
<td>Lead agency: Australian Government/state/territory governments (AHMC). Partners: Food industry; public health organisations; consumer organisations; NPA.</td>
<td>New food labelling system commences within three years. Years 1–2: Implement a national trial of appropriate approaches across a sample of products. Review international experience with food labelling. Monitor and evaluate effectiveness of approaches. Year 3: Implement a national system with appropriate information, monitoring and enforcement systems.</td>
<td>Consumer knowledge, awareness and understanding of food labelling and amount of energy, sugar, fat, saturated fats, salt and trans fat in food. Consumer understanding of portion sizes. Consumer ability to use food labelling system to assist them in making healthier food choices. Consumer purchase behaviour and sales data. Consumer choices in quick service restaurants. Changes in the nutrient composition or availability of individual products or portion size.</td>
</tr>
</tbody>
</table>

### Key action area 3: Embed physical activity and healthy eating in everyday life

<p>| 3.1 Fund, implement and promote school programs that encourage physical activity and enable healthy eating. | Lead agency: Australian Government. Partners: State/territory and local governments; education sector; NPA; school community including families, parents and teaching staff. | Years 1–4: Build on existing approaches at state and territory level and enhance partnerships with the education sector. Ensure a curriculum entitlement to HPE for all Australian children by incorporating HPE into the second stage of National Curriculum development. Australian and state governments to establish a national program to support implementation of the new curriculum, including teacher curriculum guidance and professional development opportunities. Education sector to encourage all schools to develop, implement and evaluate health, nutrition and physical activity policies. Ensure implementation of the policy requirement of at least two hours of physical activity per week for all students K–10. Expand coverage of out of school care health programs such as Active After School, Eat Smart, Play Smart. Improved access to school-based recreational facilities by the community, especially after hours and in neighbourhoods that lack park and recreational facilities. | Number of schools with food and nutrition policies. Number of schools with physical activity policies, including school travel and active transport. Number of schools implementing the National Healthy School Canteens Project. Proportion of children meeting physical activity guideline recommendations. Proportion of children undertaking at least two hours of physical activity in schools per week. Proportion of children using active transport to and from school. Number of hours per week school children are participating in sport and recreation. |</p>
<table>
<thead>
<tr>
<th>KEY ACTION AREAS</th>
<th>RESPONSIBILITY</th>
<th>STAGED IMPLEMENTATION</th>
<th>MEASUREMENT</th>
</tr>
</thead>
</table>
| 3.1 Fund, implement and promote school programs that encourage physical activity and enable healthy eating. | - Promotion and support through state and territory governments for the National Healthy School Canteens Project, ensuring a nationally consistent approach.  
- A comprehensive national approach to phasing out soft drinks in school canteens and vending machines.  
- Ensure key policy elements are appropriately reflected within the National Prevention Agreements. |  
Years 5–8  
- National implementation of the Health and Physical Education (HPE) curriculum for all Australian children as part of the second stage of the National Curriculum development.  
- Monitor policy requirement of at least two hours of physical activity per week for all students K–10.  
- Monitor and evaluate impact. |  
Years 9–11  
- Scale up most effective approaches. |
### Key Action Areas

<table>
<thead>
<tr>
<th>Lead agency: Australian Government. Partners: State/territory governments; local government; workplace health program providers; employer groups and unions; workplace insurers.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>3.2 Fund, implement and promote comprehensive programs for workplaces that support healthy eating, promote physical activity and reduce sedentary behaviour.</strong></td>
</tr>
</tbody>
</table>

### Staged Implementation

<table>
<thead>
<tr>
<th>Years 1–4 Fund, implement and promote comprehensive workplace programs through the COAG Healthy Workers initiative including:</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Development of a national accord to establish best practice principles for workplace programs including protecting the privacy of employees, workplace risk monitoring, risk assessment or risk modification programs.</td>
</tr>
<tr>
<td>- Development of a voluntary industry scorecard, benchmarking and award scheme for workplace health.</td>
</tr>
<tr>
<td>- Development of nationally agreed accreditation standards for providers of workplace health programs.</td>
</tr>
<tr>
<td>- Development of a national action research project to strengthen evidence of effective workplace health promotion programs in the Australian context.</td>
</tr>
<tr>
<td>- Establish a national workplace health leadership program and a series of resources, tools and best practice guidelines.</td>
</tr>
<tr>
<td>- A review of potential legislative changes to promote take up of workplace health programs, for example changes to Fringe Benefits Tax Assessment Act, reforms to the Private Health Insurance Act and/or employer commitment to a percentage of annual payroll allocated to workplace health programs (similar to the former Training Guarantee Levy).</td>
</tr>
<tr>
<td>- Investigation of the feasibility of rewarding employers – through grants or tax incentives – for achieving and sustaining benchmark risk factor profiles in their workforce.</td>
</tr>
</tbody>
</table>

### Measurement

<table>
<thead>
<tr>
<th>National accord developed. Voluntary industry scorecard and benchmark developed and adopted by industry. Uptake of voluntary scorecard and benchmark by industry. Accreditation standards developed. National action research program commenced. Increased number of workplaces implementing health policies with a focus on food and nutrition and physical activity. Increased number of workplaces with health programs. Number of employees with access to healthy programs in the workplace and the proportion who use them. Uptake of workplace policies and programs by public sector agencies at the Australian/state/territory/local government level. Active transport to and from work, level of physical activity and healthy eating by employees. Uptake of incentives by the private sector.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Increased number of workplaces implementing health policies with a focus on food and nutrition and physical activity. Number of employees with access to healthy programs in the workplace and the proportion who use them. Active transport to and from work, level of physical activity and healthy eating by employees. Uptake of incentives by the private sector.</td>
</tr>
<tr>
<td>KEY ACTION AREAS</td>
</tr>
<tr>
<td>---------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>3.2  Fund, implement and promote comprehensive programs for workplaces that support healthy eating, promote physical activity and reduce sedentary behaviour.</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>3.3  Fund, implement and promote comprehensive community-based interventions that encourage people to improve their levels of physical activity and healthy eating, particularly in areas of disadvantage and among groups at high risk of overweight and obesity.</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>
### Key Action Areas

3.3 Fund, implement and promote comprehensive community-based interventions that encourage people to improve their levels of physical activity and healthy eating, particularly in areas of disadvantage and among groups at high risk of overweight and obesity.

<table>
<thead>
<tr>
<th>KEY ACTION AREAS</th>
<th>RESPONSIBILITY</th>
<th>STAGED IMPLEMENTATION</th>
<th>MEASUREMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Develop, pilot and implement a new Healthy and Active Families initiative as an additional intervention to the activities proposed for Healthy Communities sites. This may include:</td>
<td>Limitations: Impact and effectiveness to determine most effective approaches.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Provision of education that encourages parents to be positive role models for their children.</td>
<td>Scale up intervention across Australia according to results of national trials.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Locally targeted information on family-oriented physical activity opportunities.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Development of programs in sporting and community clubs.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Offering free/subsidised physical activity and nutrition programs in public spaces such as parks, beaches and recreation centres.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Allocation of funding to local governments and community organisations to support development of programs that aim to get families healthy and active and include a focus on existing infrastructure.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Years 5–8 Implement programs. Monitor and evaluate impact and effectiveness to determine most effective approaches.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Years 9–11 Scale up community interventions across Australia according to results of national trials.</td>
<td></td>
</tr>
<tr>
<td>KEY ACTION AREAS</td>
<td>RESPONSIBILITY</td>
<td>STAGED IMPLEMENTATION</td>
<td>MEASUREMENT</td>
</tr>
<tr>
<td>------------------</td>
<td>----------------</td>
<td>-----------------------</td>
<td>-------------</td>
</tr>
<tr>
<td>Key action area 4: Encourage people to improve their levels of physical activity and healthy eating through comprehensive and effective social marketing</td>
<td>Lead agency: NPA. Partners: All governments (Australian/state/territory/local); non-government organisations; local communities; health professional organisations.</td>
<td>Years 1–4: Identify effective campaign messages through qualitative research and review of other campaigns. Build on effective campaigns to date (e.g. Go for 2&amp;5). Ensure sufficient reach and frequency of campaigns. Place media for maximum reach among low SES groups and others at high risk. Strengthen partnerships with NGOs and industry to appropriately support the campaigns. Implement the new campaigns. Ongoing – evaluation and campaign tracking.</td>
<td>Population measures of nutrition and physical activity behaviours (by SES and LGA). Change in measures such as knowledge, attitudes, awareness, intention and behaviour relating to physical activity, healthy eating and sedentary behaviour. Understanding and recall of key campaign messages.</td>
</tr>
<tr>
<td>4.1 Fund effective national social marketing campaigns to increase physical activity and healthy eating and reduce sedentary behaviour; and support people to make informed choices about their health:</td>
<td>Ensure that funding is sustained and at a sufficient level to allow adequate reach and frequency</td>
<td>Years 5–8: Implement new phases of a comprehensive, sustained social marketing strategy to increase healthy eating and physical activity.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Choose messages most likely to reduce prevalence in socially disadvantaged groups and provide extra reach to these groups</td>
<td>Years 9–11: Report on progress with the social marketing strategy to increase healthy eating and physical activity and develop new phases as required.</td>
<td></td>
</tr>
</tbody>
</table>
### Key Action Area 5: Reduce exposure of children and others to marketing, advertising, promotion and sponsorship of energy-dense nutrient-poor foods and beverages

#### Key Action Area 5.1

**Lead agency:** Australian Government.  
**Partners:** Industry (food, marketing); ACMA; health and consumer groups; broadcasting and media groups; retailers.

<table>
<thead>
<tr>
<th>Stage</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Years 1–3</td>
<td>Monitor and evaluate the effectiveness of the industry voluntary approach. Develop and adopt an appropriate set of definitions and criteria for determining EDNP food and drink.</td>
</tr>
<tr>
<td>Year 4</td>
<td>Introduce a co-regulatory approach to address any identified shortfalls in the voluntary approach and other issues. Monitor and evaluate the effectiveness of the co-regulatory approach.</td>
</tr>
<tr>
<td>Years 5–8</td>
<td>Continue to phase out food and beverage marketing to which children are exposed if self-regulation and co-regulation are demonstrated to be ineffective.</td>
</tr>
</tbody>
</table>

**Measurement:**  
- Level of industry compliance with the restrictions.  
- Level and type of public complaints.  
- Children’s and adults’ exposure to food marketing – healthy food and beverages and EDNP food and beverages as determined by nutrient profiling.  
- Sales data for specific products and product types.  
- Use of persuasive techniques such as licensed characters and celebrities.  
- Overall levels of advertising across all media.  
- Advertising spending.  
- Population surveys to monitor community attitudes towards restrictions over time.
### Key Action Areas

#### Key action area 6: Strengthen, upskill and support the primary healthcare and public health workforce to support people in making healthy choices

<table>
<thead>
<tr>
<th>Key Action Area</th>
<th>Responsibility</th>
<th>Staged Implementation</th>
<th>Measurement</th>
</tr>
</thead>
<tbody>
<tr>
<td>6.1</td>
<td>Contribute to relevant national policies (for example, the National Primary Health Care Strategy) to ensure key actions to improve preventative health are considered and implemented in the primary care setting. These may include:</td>
<td>Lead agency: Australian Government. Partners: State/territory government; National Primary Health Care Strategy External Reference Group; healthcare professionals and associations; health insurers; educational institutions.</td>
<td>Contribute to relevant national policies (e.g. The National Primary Health Care Strategy) to ensure that key actions that would improve preventative health are considered and implemented in the primary healthcare setting.</td>
</tr>
</tbody>
</table>

- Expanding the supply of relevant allied health workforce and number of funded positions
- Ensuring all individuals have easy access to health services that provide physical activity, weight loss and healthy nutrition advice and support
- Funding, implementing and promoting evidence-based clinical guidelines and other multidisciplinary training packages for health and community workers

#### Key action area 7: Address maternal and child health, enhancing early life and growth patterns

<table>
<thead>
<tr>
<th>Key Action Area</th>
<th>Responsibility</th>
<th>Staged Implementation</th>
<th>Measurement</th>
</tr>
</thead>
<tbody>
<tr>
<td>7.1</td>
<td>Establish and implement a national program to alert pregnant women and those planning pregnancy to the 'lifestyle' risks of excessive weight, insufficient physical activity, poor nutrition, smoking and excessive alcohol consumption, and assist them to address these risks.</td>
<td>Lead agency: Australian Government. Partners: Maternity services (states and territories).</td>
<td>Years 1–4 Develop strategies to ensure women who are pregnant or planning a pregnancy receive appropriate information, advice and support from a range of sources (community based, GP primary care, antenatal and health services) to reduce their risk associated with unhealthy weight poor nutrition, lack of physical activity, alcohol use and smoking. Implement strategies and evaluate and monitor the impact.</td>
</tr>
</tbody>
</table>

- Support the development and implementation of a National Breastfeeding Strategy in collaboration with the state and territory governments.

<table>
<thead>
<tr>
<th>Key Action Area</th>
<th>Responsibility</th>
<th>Staged Implementation</th>
<th>Measurement</th>
</tr>
</thead>
<tbody>
<tr>
<td>7.2</td>
<td>Support the development and implementation of a National Breastfeeding Strategy in collaboration with the state and territory governments.</td>
<td>Lead agency: Australian Government. Partners: NHMRC; maternity services (states and territories).</td>
<td>Contribute to the development of a National Breastfeeding Strategy to ensure appropriate consideration of obesity prevention issues and broader health benefits. Ensure key leadership roles and responsibilities at state/territory and Australian Government level are clearly articulated.</td>
</tr>
</tbody>
</table>
Key action area 8: Support low-income communities to improve their levels of physical activity and healthy eating

8.1 Fund, implement and promote effective and relevant strategies and programs to address specific issues experienced by people in low-income communities, such as lack of access to affordable, high-quality fresh food.

**Lead agency:** Australian/state and territory governments.

**Partners:** NPA.

**Staged Implementation:**
- Ensure that all programs implemented under the strategy specifically target low SES (e.g. social marketing campaigns, community-based and school programs including the community trials).
- Primary care services located in disadvantaged areas will be supported to appropriately address behavioural risk factors. Other strategies will include provision of food vouchers with accompanying incentives to purchase healthy fresh foods; improvements to infrastructure and facilities to encourage and increase opportunities for incidental activity and organised sport.

**Measurement:**
- Population measures and trends in physical activity, active living and sedentary behaviour for adults and children (low SES).
- Changes in community knowledge, attitude, awareness, intention and behaviour. Population measures of car use, public transport, walking and cycling to work and schools among low SES.
- Consumption of foods and beverages that are energy dense and nutrient poor, are high in sugar, saturated fats and salt, and which contain trans fats by low SES populations.

8.2 Fund, implement and promote multi-component community-based programs in low SES communities.

**Refer to action 3.3.**

8.3 Provide resources for brief interventions from the primary healthcare setting.

**Refer to key area 6 and relevant actions.**

Key action area 9: Reduce obesity prevalence and burden in Indigenous communities and contribute to ‘Close the Gap’

9.1 Fund, implement and promote multi-component community-based programs in Indigenous communities.

**Lead agency:** Aboriginal Community Controlled Health Services (ACCHS).

**Partners:** National Aboriginal Community Controlled Health Organisation (NACCHO); NACCHO affiliates; Australian, state and territory governments; Menzies School of Health Research; Cooperative Research Centre for Aboriginal Health; other relevant academic institutions and public health groups.

**Staged Implementation:**
- Years 1–4: Project sites identified. Baseline measures collected and evaluation strategy developed. Projects to be developed and led by local Indigenous communities. Organisation(s) with main responsibility for the projects depends on the location and nature of the projects, but may include local Indigenous health services, state/territory NACCHO affiliates, or regionally based associations of Indigenous health services. Projects may involve partnerships with Indigenous organisations from other sectors. These programs are linked with those listed under action 3.3.
- Projects funded and implementation commenced.
- Years 5–8: Continue to implement programs. Monitor and evaluate to determine most effective approaches.
- Years 9–11: Scale up community interventions across Australia according to results of evaluation and national trials.

**Measurement:**
- Percentage of Indigenous people aware of project activities.
- Changes in knowledge, attitudes, awareness, intention and behaviour in targeted compared to non-targeted communities in regard to nutrition and physical activity and sedentary behaviour.
<table>
<thead>
<tr>
<th>Key Action Areas</th>
<th>Responsibility</th>
<th>Staged Implementation</th>
<th>Measurement</th>
</tr>
</thead>
<tbody>
<tr>
<td>9.2 Strengthen antenatal, maternal and child health systems for Indigenous communities.</td>
<td>Lead agency: ACCHS. Partners: NACCHO and NACCHO affiliates; Royal Australian College of General Practitioners; Australian College of Rural and Remote Medicine; Australian General Practice Network; Australian Breastfeeding Association; Maternity Coalition; Australian College of Midwives; Council of Remote Area Nurses of Australia.</td>
<td>Years 1–4 Development of evidence strategies to strengthen antenatal, maternal and child health services for Indigenous communities. Implementation of strategies. Ongoing – evaluation.</td>
<td>Proportion of low birth weight infants &lt;2500 g. Proportion of children breast-fed to six months, 12 months and two years. Proportion of pregnant women presenting in first trimester for antenatal care.</td>
</tr>
<tr>
<td>9.3 Fund, implement and promote effective and relevant strategies and programs to address specific issues experienced by people in Indigenous communities such as lack of access to affordable high-quality fresh food.</td>
<td>Lead agency: Australian Government. Partners: State/territory and local government; social, welfare and community support organisations (e.g. ACOSS; public health and health promotion organisations); physical activity providers (e.g. gyms; swimming, tennis facilities) and cycling organisations.</td>
<td>Ensure that all programs implemented under the strategy specifically consider Indigenous communities. In particular, social marketing campaigns, community-based and school programs. Strategies to improve access to fresh food will also be particularly relevant. Additional specific strategies will be developed and implemented in consultation with Indigenous communities, building the evidence from the community-based programs.</td>
<td>Population surveys (physical activity levels, nutrition behaviours, overweight and obesity prevalence) and other specifically targeted surveys/data collection (e.g. qualitative data collection; specifically targeted respondent groups) for Indigenous people. Rigorous evaluation of trial programs.</td>
</tr>
</tbody>
</table>

**Key action area 10: Build the evidence base, monitor and evaluate effectiveness of actions**

<p>| 10.1 NPA to develop a national research agenda for overweight and obesity, with a strong focus on public health, population and interventional research. | Lead agency: NPA. Partners: Australian Government/state and territory Health Governments; ABS and AIHW; organisations/groups involved in public health research; NHMRC, CSIRO; NGOs and consumer groups. | Year 1 Development of a national research agenda. Development of links between researchers and policy makers and the field to enhance exchange of relevant information. Years 2–3 Funding and implementation. Year 4 Dissemination of key findings. | National research agenda completed within 12 months. Increase in funding provided for public health, population and interventional research into overweight and obesity. Knowledge of research findings among policy makers and the field. |
| 10.2 Expand the National Health Risk Survey Program to cover adults and the Indigenous population. | Lead agency: Department of Health and Ageing. Partners: ABS and AIHW; organisations/groups involved in public health research; NHMRC, CSIRO. | Year 1 Survey to commence in 2010. The surveys are to include regular national data collection of comprehensive, up-to-date and representative health status and risk data for Australian adults and Indigenous people, including nutrition and physical activity behaviours, anthropometric measurements and biomedical data, with survey methods allowing comparison with other national surveys as well as the potential to develop a longitudinal dataset. | A national biomedical risk factor prevalence survey for adults and Indigenous Australians established and conducted in 2010 and then on a five-yearly basis. |</p>
<table>
<thead>
<tr>
<th>KEY ACTION AREAS</th>
<th>RESPONSIBILITY</th>
<th>STAGED IMPLEMENTATION</th>
<th>MEASUREMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>10.3 Ensure that the National Children’s Nutrition and physical activity survey is repeated on a regular basis to allow for the ongoing collection of national data on children.</td>
<td>Lead agency: Department of Health and Ageing, Partners: ABS and AIHW; organisations/groups involved in public health research; NHMRC, CSIRO,</td>
<td>Years 1–4  The survey to be repeated in 2012 and at regular intervals will include regular national data collection of comprehensive, up-to-date and representative health status and risk data for Australian children allowing comparison with other national surveys as well as the potential to develop a longitudinal dataset.</td>
<td>Australian National Children’s Nutrition and Physical Activity Survey (2007) repeated in 2012 and to include biomedical risk factor data.</td>
</tr>
<tr>
<td>10.4 Support ongoing research on effective strategies to address social determinants of obesity in Indigenous communities.</td>
<td>Lead agency: Australian Government, Partners: State/territory and local government; National Indigenous Health Equality Council; Aboriginal Community Controlled Health Organisations; Indigenous health staff and medical services; research/academic groups; health promotion organisations.</td>
<td>Commence within 12 months and ensure coverage within the national research agenda.</td>
<td>Research commenced and reported.</td>
</tr>
</tbody>
</table>
References


49. National Heart Foundation, Blueprint for an active Australia. 2009, National Heart Foundation: Canberra.


53. UK Department for Culture Media and Sport, Free swimming programme. Media release. 31 March 2009.


108. Executive summaries of the June and December 2008 Progress Reports for the Evaluation of the Stephanie Alexander Kitchen Garden Project. 2008, The McCaughey Centre, VicHealth Centre for the Promotion of Mental Health and


120. National Heart Foundation of Australia, Overweight & Obesity Project 2003. Detailed review of intervention studies; how do we best address the issues of overweight, obesity and cardiovascular disease? 2004, National Heart Foundation of Australia.


166. Gluckman P and Hanson M, Mismatch – Why our world no longer fits our bodies. 2007, USA: Oxford University Press.


208. Menzies School of Health Research, Nutrition improvement for Aboriginal people in remote townships. 2008, Menzies School of Health Research.


211. Centre for Overweight and Obesity, A literature review of the evidence for interventions to address overweight and obesity in adults and older Australians (with special reference to people living in rural and remote Australia and Aboriginal and Torres Strait Islanders) undertaken for the Department of Health and Ageing National Obesity Taskforce. 2005, University of Sydney: Canberra.


