

The Senate

Select Committee into the
Obesity Epidemic in Australia

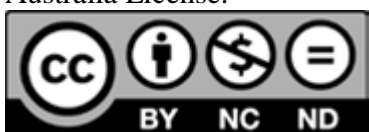
Final report

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TABLE OF CONTENTS

Committee Membership	iii
Abbreviations	ix
Recommendations	xi
Executive summary	xv
Chapter 1	1
Introduction	1
Referral of inquiry and terms of reference	1
Conduct of the inquiry	2
Acknowledgments	2
Note on terminology and references.....	2
Definitions	2
Background information.....	4
Childhood Obesity.....	7
Chapter 2	11
Language, Stigma	11
Terminology	11
Chapter 3	17
Obesity Strategy	17
National Obesity Strategy.....	17
Chapter 4	23
Food labelling	23
Front-of-pack labelling (FoPL)	23
Chapter 5	41

Reformulation	41
Chapter 6.....	45
Tax on sugary drinks.....	45
Chapter 7.....	51
Marketing and advertising of discretionary foods	51
Link to obesity	51
Self-regulatory system.....	52
Chapter 8.....	59
Education campaigns	59
Chapter 9.....	63
Health care interventions.....	63
Interventions aimed at preventing childhood obesity.....	63
Primary care interventions.....	70
Chapter 10	77
Community-based multi-strategy interventions.....	77
Dissenting Report from the LP and PHON Senators.....	83
National Obesity Taskforce	83
Health Star rating System.....	83
Tax on sugar-sweetened beverages	84
Marketing and advertising of discretionary food	88
Labor Senators' Dissenting Report.....	91
Appendix 1	95
Submissions, additional information, answers to questions on notice and tabled documents.....	95
Submissions	95
Additional information	100

Answers to Questions on notice	100
Tabled documents.....	101
Appendix 2.....	103
Public hearing and witnesses	103

Abbreviations

AANA	Australian Association of National Advertisers
ABC	Australian Beverages Council
ABS	Australian Bureau of Statistics
ACCHO	Aboriginal Community Controlled Health Organisation
ACMA	Australian Communications and Media Authority
ADG	<i>Australian Dietary Guidelines</i>
AFGC	Australia Food and Grocery Council
AMA	Australian Medical Association
ANZMOSS	Australian and New Zealand Metabolic and Obesity Surgery Society
APDs	Accredited Practicing Dietitians
BMI	Body Mass Index
CDM	Chronic Disease Management
CEO	Chief Executive Officer
CHF	Consumers Health Forum of Australia
COAG	Council of Australian Governments
CREEPOC	Centre for Research Excellence in the Prevention of Obesity in Childhood
DAA	Dietitians Association Australia
Dialogue	Food and Health Dialogue
DIG	Daily Intake Guide
DoH	Australian Government Department of Health
FoPL	Front-of-pack labelling
Free TV Code	Commercial Television Industry Code of Practice

GLOBE	Global Obesity Centre, Deakin University
GP	General Practitioner
HFP	Healthy Food Partnership
HSR	Health Star Rating
HSRAC	Health Star Rating Advisory Committee
IPAN	Institute for Physical Activity and Nutrition
kJ	Kilojoule
MBS	Medicare Benefits Schedule
NACCHO	National Aboriginal Community Controlled Health Organisation
NCEPH	National Centre for Epidemiology and Population Health
NGO	Non-Government Organisation
NIP	Nutrition Information Panel
OPC	Obesity Policy Coalition
PBS	Pharmaceutical Benefits Scheme
PHAA	Public Health Association of Australia
QLD	Queensland
QSRI	Quick Service Restaurant Initiative for Responsible Advertising and Marketing to Children
RCMI	Responsible Children's Marketing Initiative
SSB	Sugar-sweetened beverage
UK	United Kingdom
USA	United States of America
WHO	World Health Organisation

Recommendations

Recommendation 1

2.25 The committee recommends that Commonwealth funding for overweight and obesity prevention efforts and treatment programs should be contingent on the appropriate use of language to avoid stigma and blame in all aspects of public health campaigns, program design and delivery.

Recommendation 2

2.26 The committee recommends that the Commonwealth Department of Health work with organisations responsible for training medical and allied health professionals to incorporate modules specifically aimed at increasing the understanding and awareness of stigma and blame in medical, psychological and public health interventions of overweight and obesity.

Recommendation 3

3.27 The committee recommends the establishment of a National Obesity Taskforce, comprising representatives across all knowledge sectors from federal, state, and local government, and alongside stakeholders from the NGO, private sectors and community members. The Taskforce should sit within the Commonwealth Department of Health and be responsible for all aspects of government policy direction, implementation and the management of funding.

Recommendation 4

3.28 The committee recommends that the newly established National Obesity Taskforce develop a National Obesity Strategy, in consultation with all key stakeholders across government, the NGO and private sectors.

Recommendation 5

3.29 The committee recommends that the Australian Dietary Guidelines are updated every five years.

Recommendation 6

4.98 The committee recommends the Minister for Rural Health promote to the Australia and New Zealand Ministerial Forum on Food Regulation the adoption of the following changes to the current Health Star Rating system:

- The Health Star Rating Calculator be modified to address inconsistencies in the calculation of ratings in relation to:
 - foods high in sugar, sodium and saturated fat;
 - the current treatment of added sugar;
 - the current treatment of fruit juices;

- the current treatment of unprocessed fruit and vegetables; and
- the 'as prepared' rules.
- Representatives of the food and beverage industry sectors may be consulted for technical advice but no longer sit on the HSR Calculator Technical Advisory Group.
- The Health Star Rating system be made mandatory by 2020.

Recommendation 7

4.100 The committee recommends Food Standards Australia New Zealand undertake a review of voluntary front-of-pack labelling schemes to ensure they are fit-for-purpose and adequately represent the nutritional value of foods and beverages.

Recommendation 8

4.102 The committee recommends the Minister for Rural Health promote to the Australia and New Zealand Ministerial Forum on Food Regulation the adoption of mandatory labelling of added sugar on packaged foods and drinks.

Recommendation 9

4.104 The committee recommends that the Council of Australian Governments (COAG) Health Council work with the Department of Health to develop a nutritional information label for fast food menus with the goal of achieving national consistency and making it mandatory in all jurisdictions.

Recommendation 10

6.32 The committee recommends the Australian Government introduce a tax on sugar-sweetened beverages, with the objectives of reducing consumption, improving public health and accelerating the reformulation of products.

Recommendation 11

7.44 The committee recommends that, as part of the 2019 annual review of the Commercial Television Industry Code of Practice, Free TV Australia introduce restrictions on discretionary food and drink advertising on free-to-air television until 9.00pm.

Recommendation 12

7.45 The committee recommends that the Australian Government consider introducing legislation to restrict discretionary food and drink advertising on free-to-air television until 9.00pm if these restrictions are not voluntarily introduced by Free TV Australia by 2020.

Recommendation 13

7.47 The committee recommends the Australian Government make mandatory the display of the Health Star Rating for food and beverage products advertised on all forms of media.

Recommendation 14

8.22 The committee recommends the proposed National Obesity Taskforce is funded to develop and oversee the implementation of a range of National Education Campaigns with different sectors of the Australian community. Educational campaigns will be context dependent and aimed at supporting individuals, families and communities to build on cultural practices and improve nutrition literacy and behaviours around diet, physical activity and well-being.

Recommendation 15

9.37 The committee recommends that the National Obesity Taskforce, when established, form a sub-committee directly responsible for the development and management of a National Childhood Obesity Strategy.

Recommendation 16

9.71 The committee recommends the Medical Services Advisory Committee (MSAC) consider adding obesity to the list of medical conditions eligible for the Chronic Disease Management scheme.

Recommendation 17

9.75 The committee recommends the Australian Medical Association, the Royal Australian College of General Practitioners and other college of professional bodies educate their members about the benefits of bariatric surgical interventions for some patients.

Recommendation 18

10.34 The committee recommends the proposed National Obesity Taskforce commission evaluations informed by multiple methods of past and current multi-strategy prevention programs with the view of designing future programs.

Recommendation 19

10.35 The committee recommends the proposed National Obesity Taskforce is funded to develop and oversee the implementation of multi-strategy, community based prevention programs in partnership with communities.

Recommendation 20

10.36 The committee recommends the proposed National Obesity Taskforce develop a National Physical Activity Strategy.

Recommendation 21

10.38 The committee recommends the proposed National Obesity Taskforce is funded to develop and oversee culturally appropriate prevention and intervention programs for Aboriginal and Torres Strait Islander communities.

Recommendation 22

10.39 The committee recommends the Commonwealth develop additional initiatives and incentives aimed at increasing access, affordability and consumption of fresh foods in remote Aboriginal and Torres Strait Islander communities.

Executive summary

In Australia, rates of overweight and obesity have risen dramatically in recent decades in all age groups. The link between obesity and poor health outcomes is well established. As a result Australia is seeing an increase in diseases stemming from risk factors associated with obesity. This includes type 2 diabetes, cardiovascular disease and cancers. The causes of obesity are myriad and complex, as are the impacts and the potential prevention and treatment solutions.

Terminology

The importance of language when describing the problem or developing programs that attempt to tackle obesity was highlighted throughout the inquiry. Indeed, a high degree of stigma is associated with the term obesity. As a result, the committee supports a move away from using the term obesity in prevention and intervention programs and public information campaigns, and move the focus from weight to health. However the committee accepts that in medical and overarching policy settings, there is no current agreed alternative to the term, and as such it will continue to be used.

National Obesity Strategy

At present, Australia does not have an overarching strategy to tackle obesity. The committee heard compelling evidence around the need for a wide ranging array of multi-strategies to address obesity. The committee is of the view that a whole-of-government approach at the federal level is required to develop, resource and deliver a comprehensive National Obesity Strategy. The committee believes that key to the success of a national strategy is the establishment of a National Obesity Taskforce, which would comprise representatives from all levels of government alongside stakeholders from the NGO and private sectors. The inclusion of all stakeholders is critical to the taskforce adopting a coordinated response to improve diets and lifestyles, and reduce the burden of chronic disease in Australia.

Food labelling

While it is true that the causes of the rise in overweight and obesity can be attributed to multiple systemic factors, there is no doubt that a major contributor is poor diet and in particular the increased consumption of processed and discretionary foods. Inquiry participants identified several strategies to improve provision of healthier food choices, including better food labelling. A simple and consistent front-of-pack labelling system is essential for enabling consumers to make informed and healthier food choices. The committee heard that the Health Star Rating (HSR) system has the potential to empower consumers to effectively compare the nutritional value of foods. However, the committee was made aware of a number of significant problems with the current HSR. The committee is supportive of making the HSR system mandatory and recommends the adoption of some significant changes to address inconsistencies in the system. Importantly, the committee is of the view that making it mandatory will drive food companies to reformulate more of their products in order to achieve higher HSR ratings.

Food reformulation

Food reformulation initiatives can improve the availability of healthier products, and can contribute to improve diet at a population level. The committee received compelling evidence that reformulation works, especially around salt and sugar. The committee is of the view that reformulation of food and products must be accelerated to enable increased access to healthier food options.

Tax on sugary drinks

The committee is of the view that the introduction of a tax on sugar-sweetened beverages should be considered as it would have a significant impact on reformulation. It will compel the food industry to reformulate more of their products. This will drive food and drink companies to focus on producing and marketing much healthier products.

Advertising of discretionary foods

The committee heard compelling evidence supporting the introduction of stricter rules aimed at reducing children's exposure and influence of discretionary food marketing on children. The committee believes that there is a need to review the current rules around advertising on free-to-air television and recommends introducing restrictions on discretionary food and drink advertising on free-to-air television until 9.00pm. Additionally, the committee believe that children and their parents need to be better informed about the nutritional value of the foods and drinks advertised on all forms of media.

Education campaigns

The committee heard that there is a clear need for governments' leadership to establish and resource comprehensive education campaigns. The committee is of the view that public education campaigns are effective and play an important role in improving attitudes and behaviours around diet and physical activity. The committee agrees with submitters that there is a critical need for developing a suite of publicly funded education campaigns.

Health care interventions

Health interventions are essential for treating those already living with obesity. Prevention programs and early clinical interventions to reduce the prevalence of childhood obesity are also important. Inquiry participants identified that many factors influence whether children will become overweight or obese in their early years, pointing to the need to develop and implement a range of strategies to prevent and treat childhood obesity. The committee therefore proposes that there should be a subset of the National Obesity Taskforce created which would be responsible for the development, design, implementation, and management of funding for a National Childhood Obesity Strategy. Issues around access, availability, appropriateness and affordability of treatments are currently impeding the delivery of effective health interventions. In order to accelerate access to treatment options, the committee recommends that obesity is recognised as a complex and chronic disease and added to the list of medical conditions eligible for the Chronic Disease Management scheme. The committee received compelling evidence about the benefits of bariatric surgical

interventions for some patients. However, access to bariatric surgery services remains limited. Too few hospitals offer these services and many health professionals continue to be reluctant to offer this treatment option. Campaigns to educate the medical profession about the cost effectiveness and health benefits of bariatric surgical interventions should be considered.

Community-based multi-strategy interventions

The committee noted the success of multi-strategy, community-based and led prevention programs. Submitters identified that a whole-of-government approach combined with a whole-of-community approach is required for such prevention programs to be successful. The committee is of the view that a multi-pronged approach involving all sectors of the community work well to address the structural causes of obesity and is an effective driver to achieve systemic changes. The committee recommends that funding is directed toward the development and implementation of such programs.

Conclusion

The committee received a wealth of information and evidence throughout the inquiry and thanks all those who participated. As a result, the committee has made 22 recommendations, which aim at addressing in a holistic way the complex causes of obesity.

Chapter 1

Introduction

Referral of inquiry and terms of reference

1.1 The Select Committee into the Obesity Epidemic in Australia was established on 16 May 2018. The committee is composed of seven Senators.

1.2 The committee is tasked with inquiring into and reporting on the following terms of reference:

- a. The prevalence of overweight and obesity among children in Australia and changes in these rates over time;
- b. The causes of the rise in overweight and obesity in Australia;
- c. The short and long-term harm to health associated with obesity, particularly in children in Australia;
- d. The short and long-term economic burden of obesity, particularly related to obesity in children in Australia;
- e. The effectiveness of existing policies and programs introduced by Australian governments to improve diets and prevent childhood obesity;
- f. Evidence-based measures and interventions to prevent and reverse childhood obesity, including experiences from overseas jurisdictions;
- g. The role of the food industry in contributing to poor diets and childhood obesity in Australia; and
- h. any other related matters.

1.3 This report is comprised of 10 chapters, as follows:

- This chapter (Chapter 1) provides some background information around the prevalence of obesity, and defines some key terms;
- Chapter 2 discusses the importance of language and the high degree of stigma attached to the term 'obesity';
- Chapter 3 examines strategic policy directions which could help tackling obesity;
- Chapter 4 discusses the issue of food labelling;
- Chapter 5 focuses on the critical role of reformulation to improve the availability of healthier products;
- Chapter 6 examines the benefits of introducing a tax on sugary drinks;
- Chapter 7 focuses on the issues associated with the marketing and advertising of discretionary foods;
- Chapter 8 discusses the importance of education campaigns;
- Chapter 9 looks at the benefits of health care interventions; and

- Chapter 10 discusses promising multi-strategy prevention programs to prevent and address the prevalence of obesity at community level.

Conduct of the inquiry

1.4 The committee received 150 submissions to the inquiry from individuals and organisations. These submissions are listed in Appendix 1.

1.5 The committee also conducted four public hearings:

- 06 August 2018 in Sydney;
- 07 August 2018 in Melbourne;
- 04 September 2018 in Melbourne; and
- 05 September 2018 in Melbourne.

1.6 Transcripts from these hearings, together with submissions and answers to questions on notice are available on the committee's website. Witnesses who appeared at the hearings are listed in Appendix 2.

Acknowledgments

1.7 The committee would like to thank the individuals and organisations that made written submissions to the inquiry, as well as those who gave evidence at the four public hearings. We are grateful for their time and expertise.

Note on terminology and references

1.8 References to submissions in this report are to individual submissions received by the committee and published on the committee's website. References to *Committee Hansard* are to official transcripts.

Definitions

1.9 The committee received evidence from a number of submitters on how to define some of the terms used across the spectrum of issues covered by the committee's terms of reference. Reaching an agreed definition on some of these terms underpins an understanding of the problems faced, and helps focus potential solutions.

1.10 The terms range from the technical definition of particular types of food, to how overweight and obesity themselves are defined, right through to how children are defined in relation to areas such as advertising.

Food

1.11 Discretionary foods were the subject of much discussion in evidence to the inquiry. The Australian Beverages Council describes discretionary foods as:

...foods and drinks [that] are not necessary for a healthy diet and are high in saturated fat and/or added sugars, added salt or alcohol and low in fibre (22), e.g. alcohol, cakes, biscuits, confectionery, chocolate and some non-alcoholic beverages.¹

1 Australian Beverages Council Ltd., *Submission 22*, p. 10.

1.12 The Australian Bureau of Statistics (ABS) similarly cites the Australian Dietary Guidelines' description of these foods as being non-essential, although they may add variety and can still be consumed safely in small quantities depending on one's lifestyle:

...foods and drinks not necessary to provide the nutrients the body needs, but that may add variety. However, many of these are high in saturated fats, sugars, salt and/or alcohol, and are therefore described as energy dense. They can be included sometimes in small amounts by those who are physically active, but are not a necessary part of the diet.²

1.13 While all sugar is processed by the body in the same way, sources of that sugar determine how that sugar is treated in regard to dietary guidelines and food preparation. Free sugars are those naturally present in food substances such as honey and fruit juice, while 'added sugars' are those added during the manufacture of food, and include 'sucrose, fructose, dextrose, lactose and sugar syrups such as glucose syrup'.³

Body Mass Index (BMI)

1.14 The ABS describes the BMI as 'a simple index of weight-for-height that is commonly used to classify underweight, normal weight, overweight and obesity. It is calculated from height and weight information, using the formula weight (kg) divided by the square of height (m)'.⁴

1.15 The limitations of BMI as the sole indicator of a healthy weight, particularly in relation to children, were discussed by submitters throughout the inquiry.⁵

Overweight and obesity

1.16 Overweight and obesity are defined as abnormal or excessive fat accumulation that may impair health. For adults, the World Health Organisation

2 Australian Bureau of Statistics, 4364.0.55.007 - *Australian Health Survey: Nutrition First Results - Foods and Nutrients, 2011-12*, available at: <http://www.abs.gov.au/ausstats/abs@.nsf/Lookup/by%20Subject/4364.0.55.007~2011-12~Main%20Features~Discretionary%20foods~700>, accessed 22 November 2018.

3 Australian Bureau of Statistics, 4364.0.55.011 - *Australian Health Survey: Consumption of added sugars, 2011-12*, available at: <http://www.abs.gov.au/ausstats/abs@.nsf/Lookup/by%20Subject/4364.0.55.011~2011-12~Main%20Features~Added%20Sugars%20and%20Free%20Sugars~7>, accessed 22 November 2018.

4 Australian Bureau of Statistics, 4364.0.55.003 - *Australian Health Survey: Updated Results, 2011-2012*, available at: <http://www.abs.gov.au/ausstats/abs@.nsf/Lookup/4364.0.55.003Glossary402011-2012>, accessed 22 November 2018.

5 See: Australian Taxpayers' Alliance, *Submission 123*, p. 2; The Grattan Institute, *Submission 50*, p. 8; Monash Centre for Health Research and Implementation, *Submission 16, Supplementary Submission*, p. 9; The Royal Children's Hospital Melbourne, *Submission 17, Attachment 1*; Obesity Policy Coalition, *Submission 135*, p. 25.

defines overweight as a BMI greater than or equal to 25; and obesity as a BMI greater than or equal to 30.⁶

Children

1.17 For the purposes of this inquiry the definition of children is important not only in terms of how to measure and assess a healthy weight, but it is crucial in relation to how particular foods are marketed and advertised.

1.18 A number of perspectives around advertising and marketing aimed at children were explored throughout the inquiry. TV advertising in particular categorises its audience in terms of age, so how children are defined is important in this context. This is further discussed in Chapter 2.

Background information

1.19 In Australia, rates of overweight and obesity have risen dramatically in recent decades in all age groups, with the increase most marked among obese adults.⁷

1.20 Overweight and obesity in adults and children is associated with significant health impacts. Poor diets and high BMI are the major risk factors contributing to Australia's disease burden, ahead of smoking-related illness.⁸

Prevalence of overweight and obesity in Australian adults

1.21 In 2014–15, 63 per cent of Australian adults were overweight or obese. Seventy-one per cent of men were overweight or obese, compared with 56 per cent of women.⁹

1.22 Prevalence of overweight and obesity is higher for adults living outside major cities. Sixty per cent of Australians in major cities are overweight or obese, compared to 69 per cent in inner regional Australia and 70 per cent in outer regional and remote Australia.¹⁰

1.23 For women, the prevalence of overweight and obesity varies according to socioeconomic group. In 2014–15, about three in five women in the lowest socioeconomic group were overweight or obese, compared with less than half of those in the highest socioeconomic group. However, for men, prevalence of overweight or obesity was similar across socioeconomic groups.¹¹

6 World Health Organization, 'Obesity and overweight', available at: <http://www.who.int/news-room/fact-sheets/detail/obesity-and-overweight>, accessed 22 November 2018.

7 Obesity Policy Coalition, *Overweight, obesity and chronic diseases in Australia*, January 2018, p. 1.

8 Obesity Policy Coalition, *Overweight, obesity and chronic diseases in Australia*, January 2018, p. 2.

9 Australian Institute of Health and Welfare, *A picture of overweight and obesity in Australia*, 2017, p. vi.

10 Obesity Australia, *Obesity: A national epidemic and its impact on Australia*, 2014, p. 10.

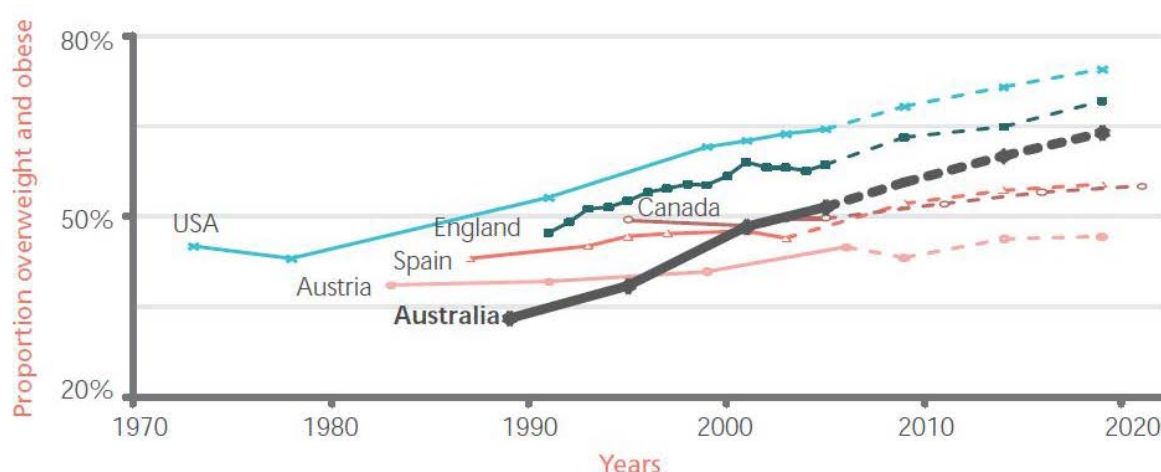
11 Obesity Australia, *Obesity: A national epidemic and its impact on Australia*, 2014, p. 10.

1.24 In 2012–13, after adjusting for differences in age structure, Aboriginal and Torres Strait Islander adults were 1.2 times as likely to be overweight or obese as non-Indigenous adults, and 1.6 times as likely to be obese.¹²

International comparisons

1.25 Among 22 Organisation for Economic Co-operation and Development countries, more than half (57 per cent) of people aged 15 and over are overweight or obese (based on data for 2016 or the closest available year). Of those countries, Australia's obesity rate (28 per cent of the population aged 15 and over) was the 5th highest, behind the United States of America (38 per cent), Mexico (33 per cent), New Zealand (32 per cent), and Hungary (30 per cent), and was higher than the 23 per cent average rate.¹³

Graph 1.1—Proportion of overweight and obese by country



Source: Obesity Australia, *Obesity: A national epidemic and its impact on Australia*, 2014, p. 7.

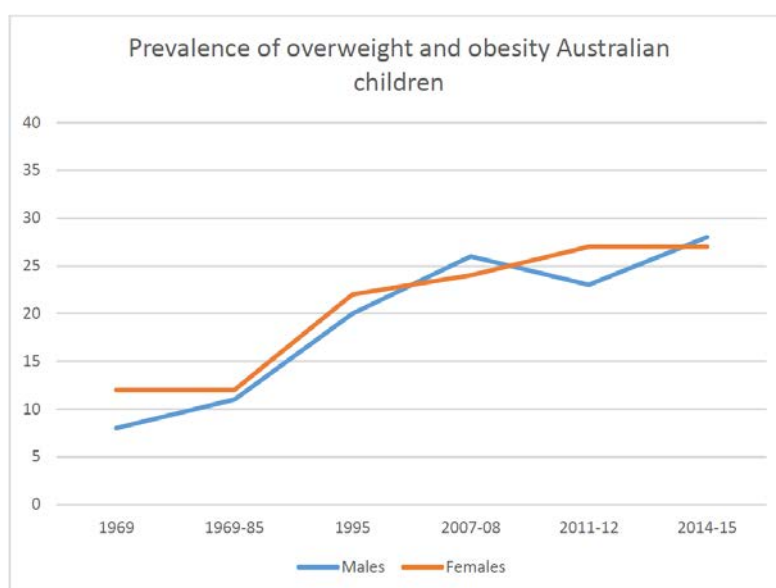
Prevalence of overweight and obesity in children

1.26 Over the past 40 years, the prevalence of overweight and obesity among Australian children increased at an alarming rate (see graph 1.2).

12 Australian Institute of Health and Welfare, *A picture of overweight and obesity in Australia*, 2017, p. vii.

13 Australian Institute of Health and Welfare, *A picture of overweight and obesity in Australia*, 2017, p. 24.

Graph 1.2—Prevalence of overweight and obesity among Australian children from 1969 to 2014-2015



Source: Australian Health Policy Collaboration, *Submission 59*, p. 6.

1.27 There are currently over one million children in Australia who are overweight or obese.¹⁴

1.28 In 2014–15, 20 per cent of children aged 2–4 were overweight or obese—11 per cent were overweight, and 9 per cent were obese. Twenty-seven per cent of children and adolescents aged 5–17 were overweight or obese—20 per cent were overweight, and 7 per cent were obese. For both children aged 2–4 and 5–17 years, similar proportions of girls and boys were obese.¹⁵

1.29 Aboriginal and Torres Strait Islander children and adolescents are more likely to be overweight or obese than non-Indigenous children and adolescents. In 2012–13, 30 per cent of Aboriginal And Torres Strait Islander children and adolescents aged 2–14 were overweight or obese, compared with 25 per cent of their non-Indigenous counterparts.¹⁶

International comparisons

1.30 The prevalence of infant, childhood and adolescent obesity is rising around the world. Although rates may be plateauing in some settings, in absolute numbers

14 Obesity Policy Coalition, *Submission 135*, p. 6.

15 Australian Institute of Health and Welfare, *A picture of overweight and obesity in Australia*, 2017, p. vi.

16 Australian Institute of Health and Welfare, *A picture of overweight and obesity in Australia*, 2017, p. 14.

there are more children who are overweight and obese in low and middle-income countries than in high-income countries.¹⁷

Short and long-term harm to health associated with obesity

1.31 The link between obesity and poor health outcomes is well established. Overweight and obesity lead to heightened risk of developing chronic diseases, including cardiovascular disease and type 2 diabetes. In particular, visceral fat, which is stored around the body's vital organs, has been associated with increased risk of heart disease and metabolic disorders.¹⁸ Being overweight or obese also increases risk for at least 13 types of cancer, including breast and colon cancer.¹⁹

Childhood Obesity

1.32 Overall, children with overweight and obesity are more likely to experience poorer health status and lower emotional functioning.²⁰

1.33 Children's and adolescents' short-term health impacts include chronic conditions such as breathing difficulties, fractures, hypertension, insulin resistance and early markers of cardiovascular disease.

1.34 The most significant long-term health impacts of childhood obesity that manifest in adulthood are cardiovascular disease, diabetes, musculoskeletal disorders (osteoarthritis), and certain types of cancer (endometrial, breast and colon).²¹

1.35 Many submitters and witnesses focussed strongly on how childhood obesity can be prevented, given the serious implications all through life that being overweight or obese in childhood brings.

1.36 In purely economic terms, the committee heard that early intervention is the key to preventing higher healthcare costs. Dr Shirley Alexander from The Children's Hospital Westmead told the committee:

[R]aising the issue to enable early intervention for greater success. Research indicates that healthcare costs for children with obesity, even as young as between two and five years of age, are much higher than those for children of a healthy weight. Interventions using family-centred behavioural change in diet and activity have been shown to be effective.²²

1.37 In health terms, the picture is similarly bleak:

17 World Health Organisation, *Ending Childhood Obesity*, 2016, p. vi.

18 Swinburne University of Technology, *Submission 75, Supplementary Submission*, p. 15.

19 Obesity Policy Coalition, *Overweight, obesity and chronic diseases in Australia*, January 2018, p. 2.

20 Australian Health Policy Collaboration, *Submission 59*, p. 8.

21 World Health Organisation, 'Why does childhood overweight and obesity matter?', http://www.who.int/dietphysicalactivity/childhood_consequences/en/, accessed 24 July 2018.

22 Dr Shirley Alexander, Staff Specialist and Head of Weight Management Services, The Children's Hospital, Westmead, *Committee Hansard*, Sydney, 6 August 2018, p. 2.

Worryingly, the prevalence of severe obesity in the paediatric population has increased significantly, to the point that we [are] now see children as young as eight years old with type 2 diabetes.²³

1.38 The overall impact of obesity on a person's life course was also discussed by a number of witnesses. Dr Nicole Black from the Centre for Health Economics at Monash University cited research showing the pervasive reach of the obesity:

There's been quite a lot of research looking at the health consequences of childhood obesity as well as the psychosocial and developmental consequences during childhood. We know that these consequences can affect children over their whole life course. There's evidence suggesting that, for example, obesity in children is likely to lead to more emotional problems and it's likely to lead to more social problems during school. Other research has shown that these problems can lead to problems in academic achievement, it can affect their educational attainment and it can affect their employment prospects later in life. We've also got evidence from studies that look at the social and economic impacts of adolescent obesity. As these adolescents enter adulthood, if they were obese during adolescence they're less likely to be married, for example, and they're less likely to have a high household income than adolescents who were of normal weight.²⁴

1.39 The grave concerns are supported by Mrs Belinda Smith from The Root Cause, an organisation that focuses on children making healthier food choices. Mrs Smith outlined the misconceptions around what children will eat, and the consequences of this lack of understanding:

There's also a frightening lack of understanding amongst many parents and children about the impact these foods are having on health, behaviour, concentration and academic results. Sadly, we are growing a generation of children who are likely to go into adulthood with expensive chronic illness such as fatty liver disease, type 2 diabetes, heart disease and obesity, and neurological disorders like dementia and mental illness.²⁵

1.40 Dr Seema Miharshahi from the Centre of Research Excellence in the Early Prevention of Obesity in Childhood outlined many of the factors that influence whether children will become overweight or obese in their early years:

So it's not just caused by the imbalance of intake and expenditure; there are a multiple levels of influence. With little children it's also the family level influences: the availability of healthy food; mothers breastfeeding; parents' preferences and modelling; physical activity; and the knowledge, education and skills of the parents. Then there are the community level influences,

23 Dr Shirley Alexander, Staff Specialist and Head of Weight Management Services, The Children's Hospital, Westmead, *Committee Hansard*, Sydney, 6 August 2018, p. 2.

24 Dr Nicole Black, Senior Research Fellow, Centre for Health Economics, Monash University, *Committee Hansard*, Melbourne, 7 August 2018, p. 45.

25 Mrs Belinda Smith, Founder/Director, The Root Cause, *Committee Hansard*, Sydney, 6 August 2018, p.41.

such as parks and green space around for parents to take their children to, and cycle ways and cycle paths. Then there are the government and societal influences: government policies, marketing of unhealthy foods to children and so forth. So it's those societal influences that have really changed over the last 20 years.²⁶

26 Dr Seema Mirshahi, Research Translation Coordinator and Senior Research Fellow, Centre of Research Excellence in the Early Prevention of Obesity in Childhood, *Committee Hansard*, Sydney, 6 August 2018, p. 5.

Chapter 2

Language, Stigma

Terminology

Use of the term 'obesity'

2.1 The importance of language when describing the problem, or developing programs that attempt to tackle overweight and obesity, was highlighted throughout the inquiry. Even the language used for this inquiry was questioned as it potentially generates fear among individuals. These descriptions then permeate to the level of the individual with negative connotations.¹

2.2 The committee deliberated on whether the term 'obesity' itself should be used in any context. It is a medical term meaning excess weight that is likely to be detrimental to health. The general usage of the term covers all aspects of the condition from description, to prevention, to intervention. It is a term understood and used universally among stakeholders.

2.3 However, the committee agreed that in certain circumstances the term is not helpful. As discussed throughout this chapter, there is a high degree of stigma associated with the term, which can cause those most in need of assistance to shy away from accessing help, or being influenced by messaging that contains it. The example cited below, of the Nepean Family Metabolic Health Service changing its name from the Family Obesity Service, highlights the difficulty the term creates. The same difficulties apply to public information campaigns where the messaging needs to be focused on positive behavioural change, with a focus on health rather than weight.

2.4 The committee therefore is of the view that the term should not be used for intervention and prevention programs. These programs should emphasise healthy weight; good nutrition; increased physical activity and appropriate public and community infrastructure. This is discussed in the rest of this chapter.

2.5 However, in medical and high level policy settings, there is no current alternative to the term. The efforts to tackle obesity are multipronged, and require coordinated efforts from across all levels of government and public agencies. Obesity is the single catch-all term that covers all elements that need to go into prevention and intervention efforts, and as such, brings all of those programs under one policy. The committee therefore accepts that until an alternative is available, the term needs to remain attached to government efforts and bodies charged with implementing change.

1 School of Social Sciences, University of Adelaide, *Submission 52*, p. 5.

Focus on health, not weight

2.6 Food Fairness Illawarra recommended that programs to address the problem should ensure that they do not attribute the blame for a person's weight solely to the individual:

Education or campaign approaches need to demonstrate that they will not have an unfavourable impact, such as stigmatisation, blaming and misconceptions about the importance of physical activity and good diet as protective factors for disease prevention irrespective of weight.²

2.7 The National Centre for Epidemiology and Population Health (NCEPH), Research School of Population Health at the Australian National University, also pointed to evidence which suggests that the focus on body size, rather than health, is detrimental to people's mental health:

Campaigns tend to target obesity using a bio-medical focus on individual bodies and weight contributing to the stigmatization of fat people and potentially contributing further to unhealthy food consumption practices (Kinmonth 2016) and mental health issues. If the focus was shifted to directly addressing chronic diseases such as Type 2 diabetes, hypertension, cardio-vascular disease and cancers associated with obesity this might reduce the obsession with body size.³

2.8 As did the Royal Australian and New Zealand College of Psychiatrists in its submission:

Research has established an association between increased body weight and mental health disorders, with increased odds for mood disorders or anxiety disorders (Scott et al., 2008; Simon et al., 2006). People with obesity are also at increased risk of exposure to bullying, social stigma and weight bias in employment, education and health care. This can have a significant impact on mental health, and exacerbate psychological issues around diet and healthy eating. In addition, stigma can often form a barrier to seeking help. It is important that these factors are considered when designing services to meet the growing need for obesity-related interventions.⁴

2.9 The focus on health rather than weight was raised by a number of witnesses, including Ms Sarah Harry from Health at Every Size Australia:

It is taking the things that we know stigmatise like BMI and weight, measuring those things in research and putting the focus on health and wellbeing. I do keep coming back to This Girl Can because it worked so well...It worked because it was stigma free, weight loss free and number

2 Food Fairness Illawarra, *Submission 27*, Attachment 1, p. 12.

3 National Centre for Epidemiology and Population Health, Research School of Population Health, Australian National University, *Submission 29*, p. 3.

4 Royal Australian and New Zealand College of Psychiatrists, *Submission 30*, p. 2.

free, and the focus was entirely on getting out, having fun and being healthy.⁵

2.10 The committee was also told of health services that no longer use the term obesity, for fear of stigmatizing those who are most in need of treatment. The Nepean Family Metabolic Health Service (formerly known as the 'Nepean Family Obesity Service') changed its name to remove any barriers for people accessing the service, particularly pregnant women:

We had several clients tell us that they had problems sitting underneath the Nepean Family Obesity Service tag and they didn't like taking referrals for various investigations saying 'obesity service'; they felt judged. It's already hard enough for them to attend our clinic. In the first clinic appointment they're usually very anxious and they don't want to be there. It's our job to make them feel very comfortable, and we want to remove every single barrier that there is. One area that we found particularly difficult was the obstetrics services. Even midwives and other healthcare professionals had problems referring pregnant mothers to our service because they themselves felt uncomfortable with the concept of obesity and, indeed, their own weight.⁶

Psychological impact of stigma around weight

2.11 The psychological impact of obesity on those affected can be profound. The committee received evidence from the Nepean Family Obesity Service, whose region has one of the highest levels of childhood overweight and obesity in Australia, explaining how children in particular are affected by obesity:

The typical paediatric patient engaging with our tertiary service tends to live a stressful life. One or both parents of this child are obese, often living on minimal incomes, and have high stress and/or medical co-morbidities. Children suffer psychological illness due to bullying and weight stigma and feel excluded from school and peer interactions. These children can also have multiple medical conditions including diabetes, sleep disorders and joint and mobility limitations.⁷

2.12 The International Health Economics Association's Economics of Obesity Special Interest Group echoed findings citing the psychological effects of obesity on children:

Children with obesity suffer from weight stigma and bullying. After accounting for confounding and selection bias, compared to healthy weight children, obesity among 6 to 13 year olds in Australia causes substantially

5 Ms Sarah Harry, Board Member, Health at Every Size Australia, *Committee Hansard*, Melbourne, 7 August 2018, p. 42.

6 Dr Kathryn Williams, Clinical Lead and Manager, Nepean Family Metabolic Health Service, *Committee Hansard*, Sydney, 6 August 2018, p. 46.

7 Nepean Family Obesity Service, *Submission 18*, p. 3.

more **emotional problems** (both genders) and **peer problems** (especially for boys). Similar findings have been reported in the United States.⁸

2.13 The committee also heard that one of the reasons previous measures to tackle childhood obesity have failed is because they have focused on weight, rather than health, and this results in stigmatization which has many unintended consequences:

There is strong evidence that weight focused anti-obesity interventions have significant unintended harmful consequences through stigmatization of people of higher weight. This causes psychological harm including anxiety, depression, body dissatisfaction and disordered eating; that promotes adolescent dieting which predisposes and leads to eating disorders and weight gain. Weight focus and stigmatization result in reduced participation in health related physical activities.⁹

2.14 This view was shared by Professor Susan Sawyer from the Centre for Adolescent Health at The Royal Children's Hospital Melbourne:

This is where it's also important to recognise the intersection between obesity and eating disorders... I'm just highlighting that we need to be very careful, particularly with children and adolescents. We know, absolutely, from the studies that at the age of three and five they are already highly aware of the stigma of being overweight. That then leads to the risk of very abnormal behaviours and the entry into anorexia nervosa and bulimia nervosa.¹⁰

2.15 The real life effects of this stigma on a child's life choices were illustrated by the Clinical Dietician from the Nepean Family Metabolic Health Service, Ms Sally Badorrek, who explained:

They find every opportunity to get out of sport at school. They will choose to do art at high school instead of sport because often there are art classes that can be used as sport. That's an issue. Or they'll say that they're unwell, and they're often unwell, and they'll go and sit in the sick bay to miss out on sport. Often they feel a lot of stigma. They're not going to be chosen to be on a team sport, and that makes them feel even worse about themselves. So they grow to hate sport.¹¹

2.16 The committee heard that stigmatisation has far-reaching health consequences beyond any conditions related to weight. Health at Every Size Australia provided the take up of pap smears as an example:

We see time and time again that people in bigger bodies aren't presenting to primary care until it's way too late. They're putting off pap smears. They're

8 International Health Economics Association, Economics of Obesity Special Interest Group, *Submission 26*, p. 6.

9 The Victorian Centre of Excellence in Eating Disorders, *Submission 21*, p. 3.

10 Professor Susan Sawyer, Director, Centre for Adolescent Health, The Royal Children's Hospital Melbourne, *Committee Hansard*, Melbourne, 7 August 2018, p. 20.

11 Ms Sally Badorrek, Clinical Dietician, Nepean Family Metabolic Health Service, *Committee Hansard*, Sydney, 6 August 2018, pp. 45-46.

putting off treatment and they're coming in with illnesses way too late, because they're afraid of the stigma that's associated with weight when they come to primary care.¹²

Stigma in the medical profession

2.17 This sensitivity of treating obesity and weight-related conditions among health professionals was also evident for doctors. Dr Alexander, Staff Specialist and Head of Weight Management Services at The Children's Hospital Westmead, told the committee that there is a reluctance by general practitioners (GPs) to raise the issue, particularly in the case of children:

Because it's such a sensitive thing, particularly general practitioners don't want to raise it because they think it's going to upset the family. Whereas the research suggests that, in fact, parents want you to raise any health issues, including weight management, but many GPs won't raise it because of their own barriers of feeling uncomfortable about raising it.¹³

2.18 This is an issue which is widely recognised in the medical profession and health sector. Professor Boyle, Deputy Director and Obstetrician from the Monash Centre for Health Research and Implementation, told the committee of the training for health professionals to overcome the stigma attached to the issue:

There are a number of difficulties that health providers experience. One is time—training people to undertake these sorts of brief interventions in a short time, and understanding that it can be delivered by a health promotion officer; it doesn't actually have to be the doctor or the midwife. I think that a lot of health providers worry about talking to women about their weight. There is the stigma. How do they go about it? We need to train people at undergraduate and postgraduate levels about how to do that.¹⁴

2.19 Mr Ahmad Aly, a bariatric surgeon, told of the stigma and prejudice around surgical treatment to treat obesity, which includes from hospital administrators:

Obesity has this stigma and prejudice. Further than that, surgery has a stigma as well, because people say: 'No, you should be able to do it yourself. You shouldn't need surgery; that's too drastic.' So that has a stigma as well...So, yes, prejudice is part of it. That probably is what happens at a local hospital level. If a surgeon went to their administrators and said, 'We'd like to start a bariatric surgical service,' one of the main reasons that that may not go ahead is that concept of stigma and perception.¹⁵

12 Ms Sarah Harry, Board Member, Health at Every Size Australia, *Committee Hansard*, Melbourne, 7 August 2018, p. 42.

13 Dr Shirley Alexander, The Children's Hospital Westmead, *Committee Hansard*, Sydney, 6 August 2018, p. 4.

14 Associate Professor Jacqueline Boyle, Deputy Director and Obstetrician, Monash Centre for Health Research and Implementation, *Committee Hansard*, Melbourne, 7 August 2018, p. 19.

15 Mr Ahmad Aly, President, Australian and New Zealand Metabolic and Obesity Surgery Society, *Committee Hansard*, Melbourne, 7 August 2018, p. 26.

Committee view

2.20 A fundamental and highly damaging feature of the obesity problem is the stigma associated with weight, and weight-related health conditions. The stigma is endemic, in that it impacts all aspects of how society thinks about overweight and obesity, how it describes it, how it attributes blame for the condition, and how it is treated.

2.21 The committee unsurprisingly received extensive evidence on the impact of stigma, and importantly and pertinently, how to avoid stigmatising the issue further, even to the point of the naming this inquiry differently. The overwhelming message in the evidence is that this goes far beyond a simple language issue.

2.22 How program and treatments are named impacts on how people will access them, which in turn impacts on their effectiveness. The psychological impacts from childhood onward have significant tangible effects, and exacerbate the health impacts of overweight and obesity. The attitude and understanding of the condition, and treatment options by health professionals, including doctors, and health administrators, again impacts hugely on clinical and medical outcomes.

2.23 The committee heard useful suggestions on how to best address stigma at all junctures. Care should be taken in naming programs and treatments, and funding for programs should be conditional on them being appropriately named. Health professionals at all levels should receive adequate training on how to ensure that recipients of care and treatment are best identified and encouraged to access services.

2.24 As discussed at the start of this chapter, the committee supports a move away from using the term 'obesity' in all prevention and intervention programs and public information campaigns, and move the focus from weight on to health. However the committee accepts that in medical and overarching policy settings, there is no current agreed alternative to the term, and as such it will continue to be used.

Recommendation 1

2.25 The committee recommends that Commonwealth funding for overweight and obesity prevention efforts and treatment programs should be contingent on the appropriate use of language to avoid stigma and blame in all aspects of public health campaigns, program design and delivery.

Recommendation 2

2.26 The committee recommends that the Commonwealth Department of Health work with organisations responsible for training medical and allied health professionals to incorporate modules specifically aimed at increasing the understanding and awareness of stigma and blame in medical, psychological and public health interventions of overweight and obesity.

Chapter 3

Obesity Strategy

3.1 The causes of obesity are myriad, as are the impacts, and the potential solutions. The committee heard extensive evidence around the importance of bringing all factors in the obesity policy debate under one roof.

National Obesity Strategy

3.2 Australia does not have an overarching strategy to combat obesity. Many of the policy areas required to identify the causes, impacts and potential solutions to the obesity problem span every level of government. There was broad support across the spectrum of evidence received for a whole-of-government strategy to be put in place.

3.3 Submitters highlighted the need for coordination to ensure that policy drivers are in place across social, education, economic and health policy fields. Professor Steve Allender from the Global Obesity Centre at Deakin University proposed a 'comprehensive national obesity strategy with high-impact and sustained public education campaigns around diet, physical activity and sedentary behaviour.'¹ This was a view supported by the Australian Medical Association among others.²

3.4 The Charles Perkins Centre at the University of Sydney also emphasised the broad policy reach that is required from a national strategy, and the levers necessary to ensure it is being implemented and evaluated effectively:

If Australia is to make significant progress on halting and reversing the rise in childhood obesity, there is a need for a much stronger regulatory approach on issues such as the marketing, labelling, content, and pricing of unhealthy foods and beverages. This must take place within a comprehensive policy approach that addresses the social, economic and cultural drivers of unhealthy diets, and is underpinned by a national obesity strategy, accompanied by appropriate federal government infrastructure, monitoring and surveillance of food, nutrition, physical activity, and obesity, and substantial, sustained funding.³

3.5 The Queensland Nurses and Midwives' Union concurred and recommended that a strategy be developed involving 'business, communities, schools, childcare and healthcare facilities'.⁴

1 Professor Steve Allender, Director, Global Obesity Centre, World Health Collaborating Centre for Obesity Prevention, Deakin University, *Committee Hansard*, Melbourne, 7 August 2018, p. 1.

2 Dr Tony Bartone, President, Australian Medical Association, *Committee Hansard*, Melbourne, 4 September 2018, p. 40.

3 Charles Perkins Centre, University of Sydney, *Submission 58*, p. 12.

4 Queensland Nurses and Midwives' Union, *Submission 55*, p. 3.

3.6 Others cited international examples of national strategies to tackle obesity such as those in the United Kingdom (UK), Canada, and New Zealand.⁵

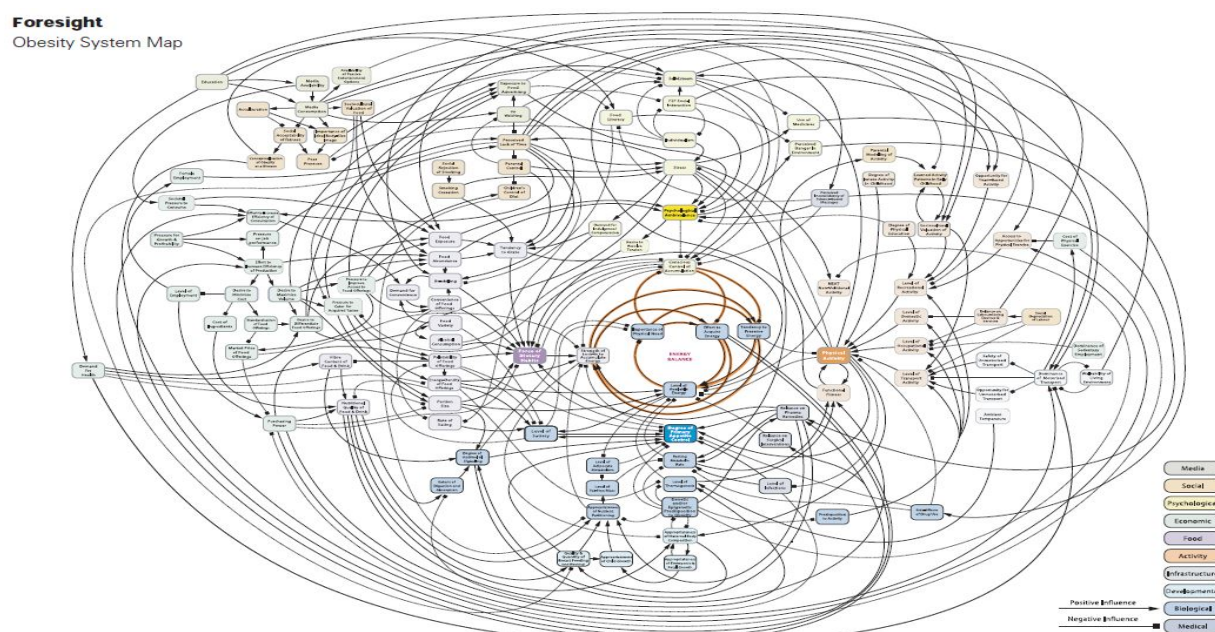
3.7 The Consumers Health Forum of Australia (CHF) stressed that a strategy was needed because education campaigns focussing solely on the role of the individual to arrest or reduce obesity have failed:

CHF has consistently advocated for a national, whole-of-society obesity strategy. This is because recent reports show that years of public education campaigns have failed to reverse the rise in obesity, showing that it is well past time for individual-oriented prevention to become a priority. Most alarming is the rising rate of childhood obesity, which indicates a future where health levels and life expectancy will decline.⁶

3.8 The committee explored reasons why such a strategy has not been developed to date. The Public Health Association of Australia (PHAA) suggested that the complexity of such a strategy, and the necessity for it to align with other broader public policy goals, such as increased physical activity and healthy nutrition, was a significant barrier.⁷

3.9 Dr Alan Barclay, a practicing dietician, provided the committee with an illustration of the complexity of all the factors that influence obesity:

Figure 3.1—Obesity System Map



5 Council of Presidents of Medical Colleges, *Submission 3*, p. 2; Ms Jennifer Thompson, *Submission 4*, p. 5.

6 Consumers Health Forum of Australia, *Submission 129*, p. 4.

7 Mr Terry Slevin, Chief Executive Officer, Public Health Association of Australia, *Committee Hansard*, Melbourne, 4 September 2018, p. 21.

3.10 Largely impenetrable, the map, originally devised by the UK Government Office for Science as part of its Foresight Programme, was provided by a number of submitters⁸ to show how many variables impact the propensity of obesity, and the measures required to address it.

3.11 In addition to a national strategy, NCDCFREE (Non-Communicable Diseases) proposed that governments of all levels have their own obesity strategies:

[W]e understand and emphasise the importance of local action for global health – that is, states, cities, local governments and individual communities should be supported and encouraged to develop their own obesity strategies and obesity prevention projects.⁹

National Obesity Taskforce

3.12 In April 2008, the Australian Government established the National Preventative Health Taskforce to develop a National Preventative Health Strategy by June 2009. The strategy was to provide a blueprint for tackling the burden of chronic disease caused by obesity, tobacco and excessive consumption of alcohol.¹⁰ The agency responsible for the taskforce and strategy, the Australian National Preventative Health Agency, ceased operations on 30 June 2014.¹¹

3.13 Many submitters proposed the establishment of a new national obesity taskforce, tasked with the responsibility of developing and managing a national obesity strategy. The Heart Foundation proposed the taskforce due to the complexity of the issue, and the requirement for a coordinated, whole-of-government response:

Existing dietary and physical inactivity patterns are a result of the lack of health supportive policies across a broad range of government portfolios such as health, agriculture, transport, urban planning, environment, food processing, distribution, marketing, and education. In the Australian context this responsibility is also spread across all levels of government.

These complex contributing factors and policy settings highlight the need for a centrally coordinated national obesity taskforce to drive programs across government portfolios and promote cooperation across all levels of government.¹²

8 See for example: Australian Beverages Council, *Submission 22*, p. 52; Alan Barclay, *Submission 36*, p. 2; Australian Medical Association, *Submission 126*, p. 11.

9 NCDFREE, *Submission 82*, p. 2.

10 Medical Journal of Australia, *Australia: the healthiest country by 2020*, 17 November 2008, available at: <https://www.mja.com.au/journal/2008/189/10/australia-healthiest-country-2020>, accessed 22 November 2018.

11 Australian Government, 'Australian National Preventive Health Agency', 17 May 2018, <https://www.directory.gov.au/portfolios/health/australian-national-preventive-health-agency>, accessed 22 November 2018.

12 Heart Foundation, *Submission 139*, p. 7.

3.14 This was a view espoused by the Obesity Policy Coalition (OPC),¹³ and shared with a number of other submitters.¹⁴

3.15 The role of the taskforce and its various responsibilities is discussed throughout the report. The driving theme when the taskforce was discussed was that it should be responsible for providing a whole-of-government strategic direction to tackle obesity. For this to occur, submitters stressed the importance of a consistent funding stream to support the taskforce, and for membership from all levels of government, and all key stakeholders. The taskforce would be responsible for the management and distribution of funding.

3.16 Many submitters cited the OPC's eight recommendations, as outlined in its *Tipping the Scales* report, as being the responsibility of a taskforce to implement:

1. Toughen restrictions on junk food advertising
2. Set food reformulation targets
3. Make Health Star Ratings mandatory
4. Develop an active transport strategy
5. Fund public health education campaigns
6. Add a 20 per cent health levy to sugary drinks
7. Establish a national obesity taskforce
8. Monitor diet, physical activity, and weight guidelines¹⁵

The role of the food industry in a national obesity strategy

3.17 The membership of a taskforce was subject to some commentary during the inquiry. The central point was how much of a role the food industry should have in driving the policy agenda. This is a point that was repeated in the context of national dietary guidelines and healthy food partnerships.

3.18 The issue of undue influence from the food manufacturing sector concerned a number of submitters, and is discussed in greater detail in the context of the health star rating system in Chapter 4. The PHAA pointed to the inherent conflict of interest of the food industry and efforts to curtail overweight and obesity:

[T]here are various industry forces that see it as a threat to their market share. It may be the sugar industry in Australia and the concerns with the prospect of being able to sell that sugar. The majority of sugar that's grown in Australia, as I understand, is exported, but if, for example, there's a levy

13 Obesity Policy Coalition, *Submission 135*, p. 14.

14 Council of Presidents of Medical Colleges, *Submission 3*, p. 2; Western Australian Cancer Prevention Research Unit, *Submission 8*, p. 2; Centre of Research Excellence in the Early Prevention of Obesity in Childhood, *Submission 10*, p. 9.

15 Obesity Policy Coalition, *Tipping the Scales: Australian Obesity Prevention Consensus*, September 2017, available at: <http://www.opc.org.au/what-we-do/tipping-the-scales>, accessed 22 November 2018.

on sugar-sweetened beverages, and that means less sugar in that product nationally, that means a reduction in the sale of sugar. That is one example. We've got junk food industries. We've got industries that essentially promote and sell food that is unhealthy, and we're seeing a pushback from those industries, absolutely unquestionably, in trying to stop whatever policies might influence their market share.¹⁶

3.19 As discussed in Chapter 4, the industry needs to be involved in many aspects of a comprehensive strategy, and in particular how that strategy is implemented, however the committee heard that this role should be limited given the impact of previous steps to increase healthy food and lifestyle choices:

[T]here has been evidence, where industry has been involved, of watering down of strategy—for example, front-of-package labelling shifting from a mandatory approach to a voluntary approach. So I think it's important to recognise that industry does have an impact on how policies are generated and how they're regulated.¹⁷

National Dietary Guidelines

3.20 The Australian Dietary Guidelines (ADG) are developed by the National Health and Medical Research Council with advice from experts on the Dietary Guidelines Working Committee and funding from the Australian Government Department of Health.¹⁸ The current version was released in 2013, and is the fourth iteration since first developed in 1982.¹⁹

3.21 The frequency of the guidelines being reviewed was raised by the committee, in response to concerns around ensuring they are underpinned by the best available scientific knowledge. This point was addressed by Dr Barclay who suggested that the guidelines be updated every five years rather than the current 10 years:

Dietary guidelines are fairly conservative. They need to be updated, though, and they need to be updated every five years, as they are in the [United States]. Getting back to Senator Di Natale's question about what we can do, one thing is to have a five-year rolling update of dietary guidelines, like North America has. That way we keep on top of the science, and we don't still promote what was the best science of the day because now new science has proven that that maybe wasn't as accurate as we would have liked it to be.²⁰

16 Mr Terry Slevin, Chief Executive Officer, Public Health Association of Australia, *Committee Hansard*, Melbourne, 4 September 2018, p. 21.

17 Ms Katherine Silk, Integration and Innovation Manager, Australian Healthcare and Hospitals Association, *Committee Hansard*, Melbourne, 4 September 2018, p. 23.

18 EatforHealth.gov.au, *Australian Dietary Guidelines*, available at: <https://www.eatforhealth.gov.au/>, accessed 22 November 2018.

19 Food and Agriculture Organization of the United Nations, 'Food-based dietary guidelines – Australia', available at: <http://www.fao.org/nutrition/education/food-based-dietary-guidelines/regions/countries/australia/en/>, accessed 22 November 2018.

20 Dr Alan Barclay, private capacity, *Committee Hansard*, Sydney, 6 August 2018, p. 57.

Committee view

3.22 While many of the elements that would constitute a strategy are being undertaken at various levels, this fragmented approach has not been able to deliver the necessary impetus to alter the trajectory of the obesity problem in Australia.

3.23 The committee is therefore strongly of the view that what is required is a whole-of-government approach at the federal level, a coherent and committed Council of Australian Governments' position, both underpinned by the inclusion in a taskforce of key stakeholders from all sectors. There is an excellent and so far under-utilised research and evidence base for what works in different jurisdictions, and locally around Australia. The committee wants to see all of this evidence utilised in the development of the strategy.

3.24 Key to the success of a strategy is the composition, role and responsibilities of the Taskforce. The inclusion of all stakeholders from all sectors is critical to the taskforce adopting a comprehensive and coordinated response to the obesity problem. The committee's view is that the taskforce should be the single authority responsible for the national obesity strategy, and it should be managed by the Commonwealth Department of Health and furnished with the requisite authority and budget to drive the agenda forward.

3.25 The ADG are a crucial benchmark in terms of recommended nutrition for the population. They appear to be generally uncontroversial and supported by all stakeholders. However, given the ongoing advances in nutritional science, the committee was convinced of the value of updating the guidelines more regularly than they are currently.

3.26 The membership of the taskforce, and in particular the inclusion of the food manufacturing sector, was raised by several submitters. Public health advocates maintain that while the sector should be key stakeholders, their contribution should be limited to a consultancy role, but should not take any part of the decision-making of the taskforce. The committee concurs with this view.

Recommendation 3

3.27 The committee recommends the establishment of a National Obesity Taskforce, comprising representatives across all knowledge sectors from federal, state, and local government, and alongside stakeholders from the NGO, private sectors and community members. The Taskforce should sit within the Commonwealth Department of Health and be responsible for all aspects of government policy direction, implementation and the management of funding.

Recommendation 4

3.28 The committee recommends that the newly established National Obesity Taskforce develop a National Obesity Strategy, in consultation with all key stakeholders across government, the NGO and private sectors.

Recommendation 5

3.29 The committee recommends that the Australian Dietary Guidelines are updated every five years.

Chapter 4

Food labelling

4.1 While it is true that the causes of the rise in overweight and obesity can be attributed to multiple systemic factors, there is no doubt that a major contributor is poor diet and in particular the increased consumption of processed foods.¹

4.2 Australians spend more than 58 per cent of their food dollar on discretionary foods, and the average Australian household spends 27 per cent of their weekly household budget on dining out and fast food, much of which is high in fat, salt and sugar.²

4.3 Australian adults are deriving 35 per cent of their daily energy intake from discretionary foods. They are consuming 60g of added sugar per day, of which 81 per cent comes from discretionary foods and drinks.³ This is well above the World Health Organisation (WHO) recommended daily intakes of added sugars, which is no more than 25g.⁴

4.4 Improving the Australian food supply and the provision of healthier food options outside the home environment are recommended interventions to facilitate population-wide improvement in diet.⁵

4.5 Several strategies have been identified to improve provision of healthier food choices, including better food labelling, reformulation of food products and the introduction of a tax on sugary drinks.⁶

4.6 To date, in Australia, the majority of activities around the development of interpretative front-of-pack labelling systems have been voluntary.

4.7 The objective of this chapter is to determine the strategies, policies and regulations that could be introduced around food labelling.

Front-of-pack labelling (FoPL)

4.8 At present, it is mandatory in Australia for products to feature a Nutrition Information Panel (NIP). The NIP states the amount of energy and macronutrients per serve size and per 100g. However, serving sizes are not standardised, resulting in a

1 See for example: Sugar By Half, *Submission 48*, p. 2; Nutrition Australia, *Submission 61*, p. 2.

2 Obesity Policy Coalition, *Submission 135*, p. 13.

3 Heart Foundation, *Submission 139*, p. 9.

4 Sugar By Half, *Submission 48*, p. 4.

5 Heart Foundation, *Submission 139*, p. 9.

6 See for example: Heart Foundation, *Submission 139*, p. 9; The Obesity Collective, *Submission 70*, pp. 7-8; Obesity Policy Coalition, *Submission 135*, pp.12-17.

lack of consistency that reduces the ability for consumers to easily interpret information and compare products.⁷

4.9 All other labelling information schemes are voluntary. This includes the Health Star Rating (HSR) system, the Daily Intake Guide label, portion information labels designed by food companies and warning labels such as *Be Treatwise*. Kilojoule menu labelling in fast food restaurants are mandatory in only some jurisdictions.

4.10 Current food labels outlining the nutritional content of foods are difficult to read and interpret. Submitters overwhelmingly suggested that there is a need for clearer nutritional information panels that are legible and easily understood by the general public and called for more transparent and easy to understand food labelling.⁸

4.11 Professor Greg Johnson, Chief Executive Officer of Diabetes Australia, illustrated the need for better labelling of foods by describing to the committee his experience of trying to read the nutrient label on the packaged aeroplane food he was served on his way to the committee hearing and concluded 'I couldn't even read it, let alone comprehend it'.⁹

Health Star Rating system

4.12 The HSR is a FoPL system that rates the overall nutritional profile of packaged food and assigns it a rating from half a star to five stars. It provides a quick, easy, standard way to compare similar packaged foods. The more stars, the healthier the choice.¹⁰

4.13 The HSR system has been jointly funded by Australian, state and territory governments and was developed in collaboration with industry, public health and consumer groups. Organisations involved in the development of the system, including technical design, Style Guide and implementation framework were:

- Australian Beverages Council;
- Australian Chronic Disease Prevention Alliance;
- Australian Food and Grocery Council;
- Australian Industry Group;

7 Heart Foundation, *Submission 139*, p. 8.

8 See for example: Nepean Blue Mountains Family Obesity Service, *Submission 18*, p. 9; Ms Jennifer Thompson, *Submission 4*, p. 7; National Centre for Epidemiology and Population Health at the ANU, *Submission 29*, p. 4; Sugar Free Smiles, *Submission 31*, p. 1; National Centre for Epidemiology and Population Health, The Research School of Population Health, Australian National University, *Submission 29*, p. 4.

9 Professor Greg Johnson, Chief Executive Officer, Diabetes Australia, *Committee Hansard*, Sydney, 6 August 2018, p. 20.

10 Health Star Rating System, 'About Health Star Ratings', <http://healthstarrating.gov.au/internet/healthstarrating/publishing.nsf/Content/About-health-stars>, accessed 22 November 2018.

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- Australian Medical Association;
 - Australian National Retail Association;
 - CHOICE;
 - Obesity Policy Coalition (OPC); and
 - Public Health Association of Australia (PHAA).¹¹

4.14 Since its establishment in June 2014, a number of committees have been involved in overseeing the implementation of the HSR, including: the Australia and New Zealand Ministerial Forum on Food Regulation; Front-of-Pack Labelling Steering Committee; and HSR Advisory Committee (HSRAC). These committees are comprised of government ministers, industry players, public health professionals and consumer groups.¹²

How it works

4.15 HSR is a voluntary scheme that rates the nutritional profile of packaged food and assigns a rating within six broad categories of food: dairy beverages, non-dairy beverages, core dairy (soft cheeses and yoghurts), core dairy (hard cheese), fats and oils, and general foods. It is designed to compare food within a category, for example, yoghurts with yoghurts, or cereals with cereals.¹³

4.16 The Heart Foundation monitors the implementation of the system using data on uptake of HSR by industry. As at April 2018, 165 companies had adopted the HSR system with over 10 300 products displaying the HSR graphic.¹⁴

4.17 However, The George Institute reported that at the end of 2017, HSR was only on 28 per cent of all eligible products in major supermarkets.¹⁵

Calculation of Health Star Ratings

4.18 The number of stars is determined using a calculator designed to assess positive and risk nutrients in food (the HSR Calculator). The algorithm that drives the calculator was developed in consultation with Food Standards Australia New Zealand and other technical and nutrition experts.¹⁶

4.19 The algorithm awards a star rating based on the nutrient profile of a food, taking into account components linked to risk of diet-related chronic disease (energy,

11 Health Star Rating System, 'Acknowledgements', 6 December 2014, <http://healthstarrating.gov.au/internet/healthstarrating/publishing.nsf/Content/Acknowledgements>, accessed 22 November 2018.

12 Australian Beverages Council, *Submission 22*, p. 14.

13 Health Star Rating Advisory Committee, *Submission 65*, p. 1.

14 Health Star Rating Advisory Committee, *Submission 65*, p. 2.

15 The George Institute, *Submission 104*, Attachment 1, p. 3.

16 Health Star Rating System, 'About Health Star Ratings', <http://healthstarrating.gov.au/internet/healthstarrating/publishing.nsf/Content/About-health-stars>, accessed 22 November 2018.

sodium, saturated fat, and total sugars) and components with health benefits (fibre, protein and fruit, vegetable, nut and legume content). In some cases, protein acts as a proxy for micronutrients such as calcium or iron, or is used to offset naturally occurring sugars in dairy (lactose).¹⁷

4.20 Some submitters criticised the algorithm, saying that some foods that are high in risk-nutrients score quite well.¹⁸

4.21 The Institute for Physical Activity and Nutrition (IPAN) at Deakin University and other inquiry participants submitted that recent research indicates that the HSR is undermining the Australian Dietary Guidelines.¹⁹

4.22 For example, an IPAN study indicated that 57 per cent of new discretionary foods entering the marketplace are displaying 2.5 or more stars.²⁰

Added sugar and the algorithm

4.23 Several submitters are concerned with how the HSR calculator treats added sugar.²¹ The current HSR calculator is based on total sugars in a product and makes no distinction between products with high levels of added sugar and those with intrinsic sugars, which are not considered dangerous to health, making it difficult to determine the relative healthiness of a product.²²

4.24 At a public hearing, Ms Jane Martin, Executive Manager at the OPC, further explained the issue around how the HSR calculator treats added sugars:

We're particularly concerned about added sugar not being adjusted appropriately in the algorithm. Also, the added sugar that's derived from fruit is considered a positive rather than a negative. The algorithm benefits from that ingredient, and we know that added sugar from fruit is the same as added sugar from sugar cane or corn syrup—that it's problematic to health and doesn't mean that the product is healthier.²³

4.25 Professor Kevin Buckett, Chair of the HSRAC, explained that there are a number of reasons why added sugar is not included in the algorithm:

17 Health Star Rating Advisory Committee, *Submission 65*, p. 2.

18 See for example: CHOICE, *Submission 90, Supplementary Submission*, p. 6; Cancer Council Australia, *Submission 39*, p. 4; Institute for Physical Activity and Nutrition, Deakin University, *Submission 46*, p. 5; Obesity Policy Coalition, *Submission 135*, p. 11.

19 See for example: Institute for Physical Activity and Nutrition at Deakin University, *Submission 46*, p. 5; Food Governance Node, *Submission 58*, p. 8; Mark Lawrence, Institute for Physical Activity and Nutrition and School of Exercise and Nutrition Sciences, Deakin University, *Submission 95*, p. 2; Australian Chronic Disease Prevention Alliance, *Submission 106*, p. 10.

20 Institute for Physical Activity and Nutrition, Deakin University, *Submission 46*, p. 5.

21 See for example: Obesity Policy Coalition, *Submission 135*, p. 11; The George Institute, *Submission 104*, Attachment 1, p. 2.

22 Obesity Policy Coalition, *Submission 135*, p. 11.

23 Ms Jane Martin, Executive Manager, Obesity Policy Coalition, *Committee Hansard*, Melbourne, 4 September 2018, p. 29.

The major reason that it was total sugar is because that's what the body recognises; the body doesn't really care whether the sugar is added or natural or endogenous in a product. Where there's natural sugar, there's usually other good nutritional elements to the food—vitamins and minerals and so on—that are important as well. Added sugar is just empty calories, as you've heard previously, but the body accepts it in the same way. So you can have products that are completely natural sugars still making 60 per cent of the product, and that's not a healthy product.²⁴

4.26 CHOICE recommended that added sugar should be incorporated into the HSR calculation.²⁵ Similarly, The George Institute is of the view that including added sugar into the HSR algorithm would greatly improve the HSR.²⁶

4.27 Professor Buckett noted that the HSR is under review and that there have been plenty of submissions saying added sugar should be added to the algorithm.²⁷

Issues with the 'as prepared' rules in the HSR calculator

4.28 Submitters raised the issue of the 'as prepared' rules for the calculation of the HSR on products such as packet soups or powdered chocolate drinks.²⁸

4.29 Ms Alexandra Jones from The George Institute explained that the rule was created 'so you could show the health star of the product as the manufacturer says it should be consumed'. She told the committee that companies took advantage of this rule:

What we saw happen was that companies realised that this could be a good advantage to them, and Milo was the most visible example, because they said that Milo obtained 4.5 health stars on the basis that you prepared it with three teaspoons of Milo and a cup of skim milk. The problem was that everybody smirked when they heard that and they went out very hard on the promotion of that. The result was that people didn't trust health stars and said that health stars must be a bad system if Milo can get 4.5.²⁹

4.30 Ms Jones added that 'to their credit, Nestlé have taken that off their product'.³⁰

24 Associate Professor Kevin Buckett, Deputy Chief Public Health Officer, SA Health, *Committee Hansard*, Melbourne, 7 August 2018, p. 65.

25 CHOICE, *Submission 90*, p. 3.

26 The George Institute, *Submission 104*, p. 1.

27 Associate Professor Kevin Buckett, Deputy Chief Public Health Officer, SA Health, *Committee Hansard*, Melbourne, 7 August 2018, p. 65.

28 See for example: Mr Steve Pratt, Nutrition and Physical Activity Manager, Cancer Council Western Australia, *Committee Hansard*, Sydney, 6 August 2018, p. 11; Ms Alexandra Jones, Research Fellow, Food Policy Division, The George Institute, *Committee Hansard*, Sydney, 6 August 2018, p. 24; Obesity Policy Coalition, *Submission 135*, p. 11.

29 Ms Alexandra Jones, Research Fellow, Food Policy Division, The George Institute, *Committee Hansard*, Sydney, 6 August 2018, p. 24.

30 Ms Alexandra Jones, Research Fellow, Food Policy Division, The George Institute, *Committee Hansard*, Sydney, 6 August 2018, p. 24.

4.31 Ms Margaret Stuart, Corporate and External Relations Manager at Nestlé Australia, raised the question of the HSR on Milo and explained the company's actions:

Nestle feels the Health Star Rating system is useful, which is why we were one of the first to implement it. When we came to put it on Milo, we simply followed the guidance and used the online calculator and applied the resulting 4.5 on the pack. We never anticipated the criticism of Nestle and Milo that came more than a year later. In fact, we thought we'd done the right thing by applying the Health Star Rating early. As the committee will know, to avoid confusing consumers and eroding confidence in a system that we think is fundamentally sound, we have now removed the rating from Milo powder.³¹

4.32 Ms Katinka Day, Campaigns and Policy Team Leader at CHOICE, told the committee that the 'as prepared' loophole needs to be fixed, and provided the example of another type of product that uses the 'as prepared' loophole:

This is salt mix – and it claims a four-star rating on the basis of being mixed with lean meat, wholemeal buns, baby spinach, tomato and onion. This product by itself gets ½ star.³²

4.33 The OPC recommended that the current 'as prepared' rules be replaced by a new option whereby the HSR of products would be calculated on the basis of products 'as sold', apart from products that are required to be drained or reconstituted with water prior to consumption.³³

Other concerns with the algorithm

4.34 The Grains and Legumes Nutrition Council reported that whole grain is not included in the algorithm. As a result, the current algorithm shows little difference between refined and whole grain products. The Grains and Legumes Nutrition Council recommended including whole grain in the HSR as it would lead to greater HSR differences between white and whole grain bread, pasta and rice, creating a greater incentive to choose more nutritious whole grain products.³⁴

4.35 The Root Cause is concerned that the HSR algorithm does not consider additives and preservatives, which are especially designed to get children to want more.³⁵

31 Ms Margaret Stuart, Corporate and External Relations Manager, Nestlé Australia, *Committee Hansard*, Melbourne, 4 September 2018, p. 65.

32 Ms Katinka Day, Campaigns and Policy Team Lead, CHOICE, *Committee Hansard*, Sydney, 6 August 2018, p. 35.

33 Obesity Policy Coalition, *Submission 135*, p. 11.

34 Grains and Legumes Nutrition Council, *Submission 72*, p. 2.

35 The Root Cause, *Submission 108*, p. 6.

4.36 The OPC recommended modifying the HSR algorithm to correct inappropriately high ratings for some foods with relatively high levels of added sugar, sodium and saturated fat.³⁶

4.37 For example, a selection of nutrient poor, energy dense discretionary foods, such as cakes, biscuits, chips, jelly and icy poles are scoring relatively high ratings of 3 to 5 stars whilst some core foods, such as plain full fat dairy foods, are at the lower end of the rating scale. This is contrary to the Australian Dietary Guidelines and can mislead consumers.³⁷

Influence from industry groups

4.38 CHOICE contended that the involvement of industry players in the Technical Advisory Group that developed the algorithm has influenced the scoring of foods. For example, CHOICE said Sanitarium plays a significant technical role regarding the algorithm, and many Sanitarium products that are high in risk-nutrients score quite well.³⁸

4.39 CHOICE recommended that conflicted companies are removed from policy decisions that impact their products.³⁹

4.40 Sugar By Half also expressed the view that the HSR is subject to the influence of the food manufacturers.⁴⁰

4.41 Dr Rosemary Stanton OAM pointed out that companies are now using the HSR system as a marketing tool with many instances of energy dense and/or nutrient poor products bearing star ratings that may make them appear healthier than they are.⁴¹

Effect on consumers' dietary choices

4.42 According to the WA Cancer Prevention Research Unit at Curtin University, the HSR is more effective in influencing food choices than the Daily Intake Guide and Traffic Light food labelling systems.⁴²

4.43 In April 2018, the Heart Foundation presented findings from their consumer awareness survey on the HSR and found that 67 per cent of respondents reported being influenced by the HSR in their purchasing decision, with 35 per cent buying a product with more stars.⁴³

36 Obesity Policy Coalition, *Submission 135*, p. 4.

37 Obesity Policy Coalition, *Submission 135*, p. 11.

38 CHOICE, *Submission 90, Supplementary Submission*, p. 6.

39 CHOICE, *Submission 90, Supplementary Submission*, p. 7.

40 Sugar By Half, *Submission 48*, p. 4.

41 Dr Rosemary Stanton OAM, *Submission 112*, p. 11.

42 WA Cancer Prevention Research Unit, *Submission 8*, p. 3.

43 Australian Beverages Council, *Submission 22*, p. 15.

4.44 CHOICE is of the view that the HSR has the potential to be a leading FoPL initiative to help people make informed and healthy choices.⁴⁴

4.45 Professor Bruce Neal, Executive Director at The George Institute, told the committee that people find the HSR useful and easy to understand: 'health star ratings came out a firm favourite with consumers in terms of, 'We like this, we understand it, we think it's helpful'.⁴⁵

4.46 However, some submitters argued that HSR is poorly understood and not always trusted by consumers.⁴⁶ For example, the OPC noted that despite the HSR's positive impact on consumers, a large number of consumers do not have, or have lost, confidence in the HSR.⁴⁷

Effect on food manufacturers

4.47 In addition to raising consumer awareness, interpretative FoPL systems have also been identified as a driver for food companies to reformulate some of their products.⁴⁸

4.48 According to recently published research, implementation of the HSR has driven food manufacturers and retailers to reformulate products to reduce negative and increase positive nutritive components.⁴⁹

4.49 As described by the Australian Medical Association, the HSR has led some food producers to reformulate their products to achieve a higher HSR rating.⁵⁰

4.50 The Australian Government Department of Health says:

There are numerous anecdotal reports of reformulation where companies have reformulated products to achieve higher HSRs by reducing sugar, fat and / or salt and increasing fibre content.⁵¹

4.51 Nestlé Australia submitted it was an early adopter of the HSR and has reformulated some of its products to improve the HSR. For example, Nestlé Australia has reformulated Milo cereal and reduced its sugar content by 12 per cent, halved saturated fat and doubled whole grain and fibre.⁵²

44 CHOICE, *Submission 90*, p. 2.

45 Professor Bruce Neal, Executive Director, The George Institute, *Committee Hansard*, Sydney, 6 August 2018, p. 30.

46 See for example: Nepean Blue Mountains Family Obesity Service, *Submission 18*, p. 9; Obesity Policy Coalition, *Submission 135*, p. 10.

47 Obesity Policy Coalition, *Submission 135*, p. 10.

48 Heart Foundation, *Submission 139*, p. 8.

49 Health Star Rating Advisory Committee, *Submission 65*, p. 3.

50 Australian Medical Association, *Submission 125*, p. 7.

51 Australian Government Department of Health, *Submission 142*, p. 3.

52 Nestlé Australia, *Submission 78*, p. 11.

4.52 Professor Buckett told the committee that reformulation was actively happening but 'it is largely anecdotal, because companies tell us that but they don't want to talk about it too much'.⁵³

4.53 Professor Buckett gave the examples of reformulation of muesli bars and breakfast cereals to improve their star ratings without mentioning brand names.⁵⁴

Should it be mandatory?

4.54 Submitters, with the exception of the food and beverage industry sectors, are overwhelmingly of the view that the system should be made mandatory.⁵⁵

4.55 Cancer Council Australia explained that the mandatory adoption of the HSR system would make it easier for consumers to make an informed decision about processed foods.⁵⁶

4.56 According to the OPC, at present, the capacity of consumers to successfully make comparisons between products is hampered by the voluntary nature and limited uptake of the HSR system.⁵⁷

4.57 The Food Governance Node stressed to the committee that HSR must be made mandatory to enable consumers to receive the full benefit of the system across the food supply.⁵⁸

4.58 Mr Kirkland, Chief Executive Officer of CHOICE, also pointed out to the committee that making HSR mandatory would stop manufacturers from being selective about which products they put the HSR on. He provided the example of Milo:

Nestlé is a good example. Having fought the claim about Milo for several years, they now say they're going to take health stars off Milo, so that's an example of manufacturers getting around the voluntary nature of the system.⁵⁹

53 Associate Professor Kevin Buckett, Deputy Chief Public Health Officer, SA Health, *Committee Hansard*, 7 August 2018, p. 65.

54 Associate Professor Kevin Buckett, Deputy Chief Public Health Officer, SA Health, *Committee Hansard*, 7 August 2018, p. 65.

55 See for example: WA Cancer Prevention Research Unit, *Submission 8*, p. 3; Centre for Research Excellence in the Early Prevention of Obesity in Childhood, *Submission 10*, p. 8; The Royal Children's Hospital Melbourne, *Submission 17*, p. 2; Food Fairness Illawarra, *Submission 27*, p. 4; Cancer Council Australia, *Submission 39*, p. 4; Food Governance Node, *Submission 58*, p. 8; Public Health Association Australia, *Submission 73*, p. 17; CHOICE, *Submission 90*, p. 3; Obesity Policy Coalition, *Submission 135*, p. 4.

56 Cancer Council Australia, *Submission 39*, p. 6.

57 Obesity Policy Coalition, *Submission 135*, p. 10.

58 Food Governance Node, *Submission 58*, p. 8.

59 Mr Alan Kirkland, Chief Executive Officer, CHOICE, *Committee Hansard*, 6 August 2018, p. 36.

4.59 However, Ms Stuart from Nestlé Australia argued that 'making it mandatory is going to have implications that would be quite significant for imported products, for shared labels'.⁶⁰

4.60 Professor Buckett told the committee that adding the HSR label on imported products is not an issue:

There is a style guide which has the label available, so people can easily download the label...and put the label on the product that they're importing, in the same way as they do for nutrition information panel now. Nutrition information panels aren't required in all countries overseas, and we do get some imports from those countries.⁶¹

Five-year review

4.61 The HSR is currently being reviewed in line with the Australia and New Zealand Ministerial Forum on Food Regulation's decision that the system be reviewed after five years of implementation. The review is being undertaken by an independent consultant (MP Consulting), with a final report due in 2019.⁶²

4.62 The review broadly considers: the impact of the system; whether the system has successfully met its objectives; and if necessary, how the system could be improved.⁶³

4.63 The HSRAC made the initial call for public submissions. A total of 483 submissions were received and MP Consulting has been analysing those submissions and identifying the themes that they need to consult further on.⁶⁴

4.64 Further consultations are now planned and there will further public consultations starting in November 2018.⁶⁵

Other voluntary FoPL schemes

4.65 Other voluntary FoPL schemes have been introduced by food and beverage companies. These include the *Daily Intake Guide* and portion control communications.

The Daily Intake Guide (DIG) label

4.66 Introduced in 2006, the DIG is a voluntary FoPL program run by the Australian Food and Grocery Council (AFGC), which provides contextual information

60 Ms Margaret Stuart, Corporate and External Relations Manager, Nestlé Australia, *Committee Hansard*, 4 September 2018, p. 70.

61 Associate Professor Kevin Buckett, Deputy Chief Public Health Officer, SA Health, *Committee Hansard*, 7 August 2018, p. 71.

62 Health Star Rating Advisory Committee, *Submission 65*, p. 4.

63 Australian Beverages Council, *Submission 22*, p. 15.

64 Ms Elizabeth Flynn, Assistant Secretary, Preventive Health Policy Branch, Population Health and Sport Division, Department of Health, *Committee Hansard*, 5 September 2018, p. 18.

65 Associate Professor Kevin Buckett, Deputy Chief Public Health Officer, SA Health, *Committee Hansard*, 7 August 2018, p. 68.

about energy and nutrients. It also provides information on both the number of kilojoules per serve and what this represents as a percentage of an adult's total daily energy intake.

4.67 According to AFGC, in 2014, DIG appeared on over 7200 products in all major food categories.⁶⁶

4.68 The Australian Beverages Council informed the committee that the DIG label was introduced on beverage packs by most of the Australian Beverages Council Members in 2006.⁶⁷

4.69 The OPC is of the view that DIG is not effective in guiding consumers to healthier food choices, pointing to research that found that the scheme is confusing for consumers with low literacy and from lower socio-economic groups.⁶⁸

4.70 The OPC contended that the scheme is not based on current recommended energy and nutrients intake and may be misleading, particularly when used on children's products, and does not provide consumers with interpretative guidance about the healthiness of products.⁶⁹

Portion communication

4.71 Some food companies have also introduced their own portion guidance communication and labelling. For example, in 2014, Nestlé Australia introduced portion guidance icons on packs to help guide consumers toward recognising and choosing appropriate portion sizes.⁷⁰

4.72 In February 2017, Coca-Cola Australia introduced new serves per pack labelling on large multi-serve bottles.⁷¹

Advisory labels regarding nutrients of concern

Advisory labels regarding added sugar

4.73 In 2016, the Food and Drug Authority in the United States of America updated its nutrition information panel to require added sugars in grams and as a percent of Daily Value to be included on labels.⁷²

4.74 However, this is not mandatory in Australia. Live Lighter WA and the OPC pointed out to the committee that Australian consumers are currently unable to ascertain the amount of added sugar in a product.⁷³

66 Australian Food and Grocery Council, *Submission 88*, p. 7.

67 Australian Beverages Council, *Submission 22*, p. 32.

68 Obesity Policy Coalition, *Problems with DIG food labelling scheme*, Policy Brief, p. 1.

69 Obesity Policy Coalition, *Problems with DIG food labelling scheme*, Policy Brief, p. 1.

70 Nestlé Australia, *Submission 78*, p. 12.

71 Coca-Cola Australia, *Submission 114*, p. 7.

72 Obesity Policy Coalition, *Submission 135*, p. 15.

73 Live Lighter WA, *Submission 88*, p. 12.

4.75 Nutrition Australia reported that 67 per cent of parents find it hard to know how much added sugar is in the food products they buy for their children.⁷⁴

4.76 Ms Day from CHOICE also shared concerns with the current lack of labelling of added sugar on products which makes it impossible for consumers to reduce their intake of added sugar:

Current dietary advice from the Australian Dietary Guidelines and the WHO say we need to reduce our amount of added sugar. Currently, looking at the food labels, there's no way for an individual to follow that advice. Food companies use over 40 different words for sugar in ingredient lists, so it's really difficult for consumers.⁷⁵

4.77 Some inquiry participants recommended the introduction of clearer food labelling that makes the disclosure of added sugar content mandatory.⁷⁶ The PHAA recommended nutrition information panels include a separate line for added sugars.⁷⁷

Be Treatwise

4.78 *Be Treatwise* is a confectionery industry initiative launched in 2006 to help consumers recognise the role of confectionery as a treat within a consumer's diet. The confectionery industry uses *Be Treatwise* in conjunction with energy per serve labelling such as DIG labelling.⁷⁸

4.79 According to Nestlé Australia, independent research conducted by Nielsen Australia shows that 79 per cent of Australians aged 18 years and over interpret the *Be Treatwise* message as 'a food that can be eaten occasionally' or 'a food that can be eaten rarely'.⁷⁹

4.80 *Be Treatwise* is also used in New Zealand and in the United Kingdom.⁸⁰

Warning labels

4.81 According to the OPC, there is a growing body of research demonstrating that graphic health messages, similar to those used on cigarette packets, could be an effective way of helping people to make healthier food choices.⁸¹

74 Nutrition Australia, *Submission 61*, p. 4; Obesity Policy Coalition, *Submission 135*, p. 15.

75 Ms Katinka Day, Campaigns and Policy Team Lead, CHOICE, *Committee Hansard*, 6 August 2018, p. 35.

76 See for example: That Sugar Movement, *Submission 115*, p. 2; Obesity Policy Coalition, *Submission 135*, p. 16.

77 Public Health Association of Australia, *Submission 73*, p. 17.

78 Robern Menz, *Submission 80*, Attachment 2, p. 1.

79 Nestlé Australia, *Submission 78*, p. 14.

80 Australian Industry Group, *Submission 117*, p. 14.

81 Obesity Policy Coalition, *Submission 135*, p. 16.

4.82 Professor Neal explained that its randomised trials on the effect of different types of food labelling on consumer behaviours found that warning labels are very effective:

In terms of what actually changed what people bought, the most effective was the warning labels. Warning labels are probably most effective because they basically just go, 'Don't buy that, it's really bad for you.'⁸²

4.83 The OPC noted that health advisory labels on food are beginning to be introduced internationally. For example, in Chile processed foods that exceed predetermined levels of key nutrients are required to have warning labels.⁸³

4.84 The OPC recommended introducing advisory labels on foods that are high in unhealthy ingredients, such as sugary drinks.⁸⁴

Nutrition labelling at fast food restaurants

4.85 In 2012, New South Wales (NSW) was the first state to legislate mandatory kilojoule (kJ) menu labelling to encourage healthier food and drink choices at major fast food outlets.⁸⁵ Since then, Victoria, Queensland, South Australia and the Australian Capital Territory have also implemented a kJ Menu Labelling Scheme.⁸⁶

4.86 Whilst the kJ Menu Labelling Scheme is not mandatory in Tasmania, the Northern Territory and Western Australia, some fast food companies such as Kentucky Fried Chicken have introduced a kJ menu board in all their restaurants.⁸⁷

4.87 An evaluation of NSW's kJ Menu Labelling Scheme found that it was noticed by consumers, there was a shift toward better understanding of daily energy intake, and there was some reduction in kilojoules purchased.⁸⁸

4.88 There is also a strong body of international research supporting implementation of energy information as a means of empowering consumers to make healthier choices. For example, the provision of calorie information on fast food menus in New York City resulted in customers purchasing food with fewer calories.⁸⁹

4.89 The OPC says there is strong public support for the display of nutrition information in fast food outlets, pointing to a recent Cancer Council and Heart

82 Professor Bruce Neal, Executive Director, The George Institute, *Committee Hansard*, Sydney, 6 August 2018, p. 30.

83 Obesity Policy Coalition, *Submission 135*, p. 16.

84 Obesity Policy Coalition, *Submission 135*, p. 17.

85 NSW Health, *Submission 145*, p. 5.

86 Kentucky Fried Chicken Pty Limited, *Submission 53*, p. 2.

87 Kentucky Fried Chicken Pty Limited, *Submission 53*, p. 1.

88 Swinburne University of Technology, *Submission 75, Supplementary Submission*, p. 13.

89 Obesity Policy Coalition, *Menu Kilojoule Labelling in chain food outlets in Australia*, Policy Brief, p. 2.

Foundation survey, which found that more than eight in 10 consumers surveyed want kilojoule information in fast food and snack chains.⁹⁰

4.90 The Centre for Research Excellence in the Early Prevention of Obesity in Childhood recommended mandatory nutrition labelling in restaurant foods.⁹¹ Similarly, the PHAA and the OPC recommended extending mandatory kilojoule menu labelling in chain food outlets across all Australia.⁹²

Committee view

4.91 Given that the high consumption of energy-dense processed foods is a key contributing factor to rising rates of overweight and obesity, the committee is of the view that a clear, simple and consistent FoPL system is essential for enabling consumers to make informed and healthier food choices.

Health Star Rating

4.92 The committee was particularly interested to hear the views of inquiry participants on the HSR, which is currently under review. Indeed, the HSR has potential to empower consumers to effectively compare the nutritional value of foods within a particular product range. As described by some submitters, the HSR is more effective in influencing food choices than other labelling systems, such as the DIG. However, the committee was made aware of a number of significant problems with the current HSR.

HSR algorithm

4.93 In particular, the committee heard that the algorithm used to award stars needs to be recalibrated, as it can lead to discretionary foods such as cakes and chips scoring ratings of 3 to 5 stars. The committee understands that the current modelling allows products that are relatively high in sugar, sodium or saturated fat to score well through the addition of fibre or protein, which attracts positive points in the calculation of the HSR.

Treatment of added sugar and fruit juices

4.94 The committee heard that the problem is especially significant in relation to added sugar. Indeed, the current HSR is based on total sugar and does not make the distinction between products with high levels of added sugars and those with intrinsic sugars. Modifying the treatment of added sugar in the HSR calculator may become particularly important in the context of making the HSR mandatory as it may drive food companies to reduce the amount of added sugar in their products to achieve higher HSR ratings. The committee is also concerned that the HSR treats fruit juice as

90 Obesity Policy Coalition, *Menu Kilojoule Labelling in chain food outlets in Australia*, Policy Brief, p. 3.

91 Centre for Research Excellence in the Early Prevention of Obesity in Childhood, *Submission 10*, p. 10.

92 Public Health Association of Australia, *Submission 73*, p. 17.

equal to whole fruit resulting in some fruit juices scoring 5 stars and some whole fruits not.

'As prepared' rules

4.95 The committee also believes that the 'as prepared' rules need to be replaced. As a result, the committee is of the view that the HSR calculator should be modified to ensure the HSR does not mislead consumers and is in line with the Australian Dietary Guidelines.

Conflict of interest

4.96 Additionally, in order to avoid potential conflicts of interest, representatives of food and beverage companies should no longer provide input and technical support to the development of the HSR calculator. The Technical Advisory Group should no longer comprise members from the food and beverage industry.

Making it a mandatory scheme

4.97 The other key problem with the HSR is that it is a voluntary scheme. As a result, the capacity of consumers to successfully make comparisons between products is reduced. Alarmingly, the committee heard that food companies use the HSR as a marketing tool, choosing to put the HSR only on products that attract high ratings. The committee agrees with submitters that the mandatory adoption of the HSR would make it easier for consumers to make an informed decision about the food products they purchase. Making it mandatory will also stop food companies using the HSR as a marketing tool. Importantly, the committee is of the view that making it mandatory will drive food companies to reformulate more of their products in order to achieve higher HSR ratings. The committee also believes that, once the HSR is made mandatory, the HSR calculator could be regularly adjusted to make it harder to achieve a 5 star rating. This would further drive reformulation activities and greatly increase availability of healthy food options.

Recommendation 6

4.98 The committee recommends the Minister for Rural Health promote to the Australia and New Zealand Ministerial Forum on Food Regulation the adoption of the following changes to the current Health Star Rating system:

- **The Health Star Rating Calculator be modified to address inconsistencies in the calculation of ratings in relation to:**
 - **foods high in sugar, sodium and saturated fat;**
 - **the current treatment of added sugar;**
 - **the current treatment of fruit juices;**
 - **the current treatment of unprocessed fruit and vegetables; and**
 - **the 'as prepared' rules.**
- **Representatives of the food and beverage industry sectors may be consulted for technical advice but no longer sit on the HSR Calculator Technical Advisory Group.**

- **The Health Star Rating system be made mandatory by 2020.**

Other FoPL initiatives

4.99 The committee heard that research conducted since the introduction of the HSR, which compares different FoPL options, has shown that consumers prefer the HSR. The HSR is simple to understand and effective. As a result, the committee does not see any value in keeping other existing voluntary FoPLs or introducing new ones. In particular, the committee is of the view that the DIG label is confusing, difficult to interpret and, at times, misleading. Indeed, the committee is concerned that the DIG reference values are based on an average adult's daily energy intake, which is not suitable for *all* persons and children in particular. This can lead to parents underestimating how much energy a product contributes to their child's needs, resulting in their child consuming more energy than he or she requires. This is of serious concern for the committee as childhood obesity continues to rise in Australia. The committee acknowledges the findings and recommendations of the last independent review of food labelling law and policy (Blewett review) which was commissioned by the Australian and New Zealand food regulations ministers in 2009. As this work predates the introduction of the HSR, it would be timely to consider undertaking another review to ensure FoPL schemes provide adequate information and do not mislead consumers. Additionally, the review should look into the benefits of introducing regulation to limit the number of nutrition information labels allowed on food and drink packaging.

Recommendation 7

4.100 The committee recommends Food Standards Australia New Zealand undertake a review of voluntary front-of-pack labelling schemes to ensure they are fit-for-purpose and adequately represent the nutritional value of foods and beverages.

Advisory labels regarding nutrients of concern

4.101 The committee understands that the Australia and New Zealand Ministerial Forum on Food Regulation is currently investigating labelling approaches for providing information on sugars to consumers and that public consultations are underway.⁹³ Given the current difficulty for consumers to ascertain the amount of added sugar in the products they purchase and consume, the committee is of the view that clearer labelling making the disclosure of added sugar mandatory on packaged foods and drinks should be introduced. The committee also noted the growing evidence around the effectiveness of health warning labels on food products high in unhealthy ingredients.

93 Food regulation, *Labelling of sugars on packaged foods and drinks*, <http://foodregulation.gov.au/internet/fr/publishing.nsf/Content/labelling-of-sugars-on-packaged-foods-and-drinks>, accessed 22 November 2018.

Recommendation 8

4.102 The committee recommends the Minister for Rural Health promote to the Australia and New Zealand Ministerial Forum on Food Regulation the adoption of mandatory labelling of added sugar on packaged foods and drinks.

Nutrition labelling in restaurants

4.103 The committee is aware that the Australia and New Zealand Ministerial Forum on Food Regulation has recently conducted a review of fast food menu labelling schemes in Australia. The results of the consultation have been provided to the Forum and Council of Australian Governments (COAG) Health Council. In June 2018, the Forum agreed that further targeted consultation is to be undertaken to develop policy options that aim to improve and strengthen fast food menu labelling in Australia. Overall, the review found that there is stakeholder support for menu labelling schemes in fast food chains. The committee received similar evidence and heard that the provision of nutritional information on fast food menus has resulted in customers purchasing food with fewer kilojoules. The committee believes that a consistent, accessible, legible and recognisable nutrition information label on fast food menus should be introduced and made mandatory nationally.

Recommendation 9

4.104 The committee recommends that the COAG Health Council work with the Department of Health to develop a nutritional information label for fast food menus with the goal of achieving national consistency and making it mandatory in all jurisdictions.

Chapter 5

Reformulation

5.1 Food reformulation can greatly improve the availability of healthier products and therefore improve diet at a population level.¹ Reformulation of food products has been identified as one of the most effective obesity reduction strategies in terms of cost and impact.²

5.2 Mr Ben Harris, Manager of National Policy Strategy at the Australian Health Policy Collaboration, explained to the committee that reformulation works, particularly around salt and sugar, especially if the aim is to make gradual changes to products.³

5.3 One parent, a member of Parents' Voice (a network of over 11 000 parents from across Australia), pointed out that reformulation provides an opportunity to make healthy choices much easier for consumers:

The emphasis needs to be placed on making the healthy choices the easy choices – i.e. the default option – which means strategies which don't rely on millions of people making the right conscious decisions...Food reformulation is a no-brainer.⁴

5.4 The Obesity Policy Coalition (OPC) pointed out that reformulating processed food products to make them healthier has the potential to impact palatability and consumer expectations of a product. Therefore, food manufacturers are likely to face a conflict of interest when encouraged to make these changes, which is an argument for regulation applied equally to all manufacturers in order to create a level playing field.⁵

Healthy Food Partnership Reformulation Working Group

5.5 The Healthy Food Partnership (HFP) provides a mechanism for collective, voluntary action between government, the public health sector and the food industry, to improve the dietary habits of Australians.

5.6 One of the focus areas of the HFP is reformulation. In August 2016, the HFP established a Reformulation Working Group with the aim of setting priorities for food reformulation.

5.7 The Reformulation Working Group has focused its efforts on identifying nutrients and food categories to target for reformulation. Food categories identified for

1 See for example: Cancer Council Australia, *Submission 39*, p. 4; Parents' Voice, *Submission 43*, p. 3.

2 Heart Foundation, *Submission 139*, p. 9.

3 Mr Ben Harris, Manager, National Policy Strategy, Australian Health Policy Collaboration, *Committee Hansard*, Melbourne, 7 August 2018, pp. 53-54.

4 Parents' Voice, *Submission 43*, p. 3.

5 Obesity Policy Coalition, *Submission 135*, p. 13.

nutrient reformulation targets include bread, breakfast cereal, cheese, flavoured milk, gravies and sauces, muesli bars, pizza, processed meat, ready meals, biscuits, snacks, soft drinks and energy drinks, soups and yoghurt.⁶

5.8 Reformulation targets are currently still under development and an extended period of public consultation on the draft targets has commenced.⁷

5.9 In essence, the HFP follows a similar format to a product reformulation initiative introduced under the prior Federal Labor Government, the Food and Health Dialogue (Dialogue). The Dialogue acted as a non-regulatory platform for government, public health and food industry actors to collaborate on a set of voluntary targets for sodium reduction in twelve product categories.

5.10 The Dialogue achieved some success in reducing the salt content of some products, but there was substantial variation in what was achieved by the participant food companies. Researchers also identified significant limitations in the design and implementation of the Dialogue, including its voluntary nature, the small number of product reformulation targets, and the lack of mechanisms to enhance its transparency and accountability.⁸

5.11 The Food Governance Node pointed out that the HFP is similar to the Dialogue and that there has been little visible progress since the HFP commenced.⁹ This view was shared by other inquiry participants who submitted that the HFP has had limited success to date with food reformulation.¹⁰

5.12 The Food Governance Node submitted:

This lack of progress suggests that without real government leadership, the HFP is unlikely to achieve any meaningful results, instead acting as a façade to give the appearance of action.¹¹

5.13 Sugar By Half submitted that the program relies on industry cooperation and is subject to the influence of the food industry, whose priority is profit rather than health.¹² Other submitters raised the issue of the influence from food manufacturing interests and pointed to a lack of information regarding how potential conflicts of interests are assessed or managed.¹³

6 Australian Government Department of Health, *Submission 142*, p. 9.

7 Australian Government Department of Health, *Submission 142*, p. 6.

8 Food Governance Node, *Submission 58*, p. 8.

9 Food Governance Node, *Submission 58*, p. 8.

10 See for example: Cancer Council Australia, *Submission 39*, p. 4.

11 Food Governance Node, *Submission 58*, pp. 8-9.

12 Sugar By Half, *Submission 48*, p. 4.

13 See for example: Mark Lawrence, Institute for Physical Activity and Nutrition and School of Exercise and Nutrition Sciences, Deakin University, *Submission 95*, p. 4.

5.14 The Cancer Council Australia recommended improving the program by setting clear timeframes and introducing penalties if manufacturers fail to meet targets.¹⁴

5.15 Similarly, many submitters called for food reformulation targets with established time periods and penalties if compliance is not met.¹⁵

Food and beverage industry sector initiatives

5.16 The Australian Beverages Council (ABC) has pledged to reduce its sugar contribution from the food supply across the non-alcoholic beverage industry portfolio by 10 per cent by 2020 and 20 per cent by 2025. The pledge is voluntary and will be measured only for those companies who sign up.¹⁶

5.17 These commitments are based on data from 2016, and all drinks represented by the ABC are included in the commitment. The pledge will be achieved by a range of initiatives, including reformulation of higher sugar beverages, increased innovation of low and no-sugar beverages and promoting the consumption of more bottled water by young Australians.¹⁷

5.18 Coca-Cola Australia is supportive of the work of the HFP and claimed it is 'proactively supporting the sugar target through a range of reformulation actions'.¹⁸ For example, Ms Christine Black, Director of Public Affairs at Coca-Cola Australia, told the committee about its voluntary commitments to reduce sugar:

Coca-Cola Australia together with Coca-Cola Amatil have made a commitment to reduce sugar across our portfolio sales by 10 per cent by 2020, as well as supporting the beverage industry pledge to reduce sugar by 20 per cent by 2025.¹⁹

5.19 According to the Australian and Food and Grocery Council, the Australian Quick Service Restaurant sector has engaged in reformulation activities across its portfolios to reduce levels of saturated fat and sodium.²⁰

14 Cancer Council Australia, *Submission 39*, p. 4.

15 See for example: WA Cancer Prevention Research Unit, *Submission 8*, p. 2; Centre for Research Excellence in the Early Prevention of Obesity in Childhood, *Submission 10*, p. 10; Global Obesity Centre, *Submission 13*, p. 7; Primary Care Partnership, *Submission 28*, p. 2; Live Lighter WA, *Submission 88*, p. 1; The Boden Institute, University of Sydney, *Submission 130*, p. 14; Heart Foundation, *Submission 139*, p. 2.

16 Australian Beverages Council, *Submission 22*, p. 38.

17 Australian Beverages Council, *Submission 22*, p. 38.

18 Coca-Cola Australia, *Submission 114*, p. 6.

19 Ms Christine Black, Director of Public Affairs, Coca-Cola Australia, *Committee Hansard*, Melbourne, 4 September 2018, p. 67.

20 Australian Food and Grocery Council, *Submission 88*, p. 14.

International experience

5.20 According to the OPC, international experience shows that when reformulation measures are strong and government-led, real change can be achieved.

5.21 For example, in 2000, the United Kingdom (UK) Food Standards Agency implemented a salt reduction strategy, providing the food industry with voluntary targets, which were reset every two years. This achieved a daily reduction in salt consumption by 0.9g per person between 2005 and 2014. This is now implemented in relation to other ingredients of concern, such as sugar in the UK.²¹

5.22 The committee also heard strong evidence on the effectiveness of introducing a tax on sugary drinks as a driver for the beverage industry to actively reformulate their products. This is discussed in Chapter 6.

Committee view

5.23 The committee agrees with submitters that food reformulation initiatives can improve the availability of healthier products, and can contribute to improve diet at a population level. The committee received compelling evidence that reformulation works, especially around salt and sugar. The committee is of the view that reformulation of food and products must be accelerated to enable increased access to healthier food options.

5.24 The committee notes that the Health Star Rating (HSR) system (discussed in Chapter 4) has been a driver for the reformulation of a number of products in order to attract better ratings. The committee also notes that the ABC has made a voluntary pledge to reduce its sugar contribution from the food supply, which will drive the reformulation of high sugar beverages. However, voluntary initiatives to date have not achieved any significant results.

5.25 Similarly, the HFP is a non-regulatory platform for government, public health organisations and food companies to collaborate on improving the dietary habits of Australians. One of its priorities is reformulation. However, since the establishment of the HFP Reformulation Working Group in 2016, little has been achieved. The committee understands that the voluntary reformulation targets are still under development. It is apparent that without strong government leadership, the HFP will achieve very little.

5.26 As discussed in Chapter 4, the committee believes that making the HSR mandatory will significantly increase reformulation as food and beverage companies. The committee notes that the introduction of a tax on sugary drinks has resulted in beverage companies accelerating their reformulation programs.

21 Obesity Policy Coalition, *Submission 135*, p. 14.

Chapter 6

Tax on sugary drinks

6.1 The World Health Organisation (WHO) *Global Action Plan for the Prevention and Control of Non-communicable Diseases 2013-2020* recommends that member states consider economic tools, including taxes and subsidies, to promote the consumption of healthier food products and discourage the consumption of less healthy options.¹

6.2 In particular, WHO recommends that governments tax sugary drinks to address type 2 diabetes, obesity and tooth decay.²

6.3 Over 30 countries and sub-national jurisdictions around the world have introduced taxes on sugar-sweetened beverages (SSBs), in line with the WHO recommendations.³

6.4 A few countries such as Hungary have also introduced tax on confectionery, salty snacks and other products.⁴

Sugar-sweetened beverage (SSB) tax

6.5 The vast majority of submitters, with the exception of the food and beverage industry, are of the view that a tax on SSBs is an important piece of the puzzle of multiple strategies required to address obesity.⁵ They all recommended the introduction of a SSBs tax.⁶

6.6 Parents' Voice recently conducted a survey which showed that a levy on sugary drinks had the support of 90 per cent of Australian parents who participated in the survey.⁷

6.7 However, many submitters also stressed to the committee that a tax on SSBs in isolation will not solve the high rate of overweight and obesity and that it has to be considered within a suite of strategies and programs.⁸

1 Food Fairness Illawarra, *Submission 27*, Attachment 1, p. 9.

2 Obesity Policy Coalition, *Submission 135*, p. 18.

3 Public Health Association of Australia, *Submission 73*, p. 14.

4 Australian Taxpayers' Alliance, *Submission 123*, p. 21.

5 See for example: Public Health Association of Australia, *Submission 73*, p. 15; The George Institute, *Submission 104*, p. 2; Dietitians Association of Australia, *Submission 107*, p. 11.

6 See for example: Australian Medical Association, *Submission 126*, p. 7; The Boden Institute, University of Sydney, *Submission 130*, p. 18; Dr Joanne Walker, Director, Policy and Strategy Development, National Rural Health Alliance, *Committee Hansard*, Melbourne, 4 September 2018, p. 42; Public Health Association of Australia, *Submission 73*, p. 14.

7 Parents' Voice, *Submission 43*, p. 3.

6.8 For example, the Grattan Institute stated:

We recognise that a tax on sugary drinks is not a 'silver bullet' solution to the obesity epidemic – that requires numerous interventions at an individual and population-wide level.⁹

Benefits of introducing a SSB tax

6.9 The committee heard that price signals influence consumer choice and therefore introducing a SSB tax should be supported in a bid to reduce consumption of these products.¹⁰

6.10 For example, Diabetes Australia said:

There is clear evidence, though, that a sugary drink tax discourages consumption. One study found a 20 percent levy could reduce consumption by around 12.6 percent. This could lead to 800 fewer people developing type 2 diabetes annually.¹¹

6.11 According to the Dietitians Association of Australia, introducing a SSB tax in Australia would trigger the food industry to reformulate more of their products.¹²

6.12 Dr Tony Bartone, President of the Australian Medical Association (AMA), told the committee:

What we also know is that where there have been jurisdictions where a tax has been introduced, there have been reformulations of those beverages to lower sugar-sweetened options, and that's part of the conversation that we need to have.¹³

6.13 The Royal Children's Hospital Melbourne provided an example from the United Kingdom (UK), where as soon as the government committed to introducing a sugar tax in 2016, companies elected to reformulate the sugar content of their drinks. Within months of the proposed tax, the amount of sugar was halved in the formulation of Sprite and the sugar content of Fanta fell from 7 to 4.5grams. The Royal Children's Hospital Melbourne concluded:

8 See for example: Dietitians Association of Australia, *Submission 107*, p. 11; Mr Terry Slevin, Chief Executive Officer, Public Health Association of Australia, *Committee Hansard*, Melbourne, 4 September 2018, p. 23.

9 Grattan Institute, *Submission 50*, p. 3.

10 See for example: Australian Medical Association, *Submission 126*, p. 1; Consumers Health Forum of Australia, *Submission 129*, p. 4; Obesity Policy Coalition, *Submission 135*, p. 18; Diabetes Australia, *Submission 67*, p. 4.

11 Diabetes Australia, *Submission 67*, p. 4.

12 Dietitians Association of Australia, *Submission 107*, p. 11.

13 Dr Tony Bartone, President, Australian Medical Association, *Committee Hansard*, Melbourne, 4 September 2018, p. 42.

These UK gains show that far quicker and greater sugar reductions can be achieved than what is proposed for Australia.¹⁴

6.14 Many submitters believe a SSB tax should be used to offset the cost of other elements of a comprehensive program to address obesity in Australia.¹⁵ For example, The George Institute considered that the funds generated from the tax could be used to make healthier foods cheaper, or to increase children's participation in physical activity.¹⁶

Level of tax

6.15 There are a number of different fiscal models that have been used internationally to increase the price of SSBs. For example, the UK introduced a volumetric tax in April 2018 that has two levels – one for more than 5g of sugar per 100ml and a higher one for drinks with more than 8g per 100ml.¹⁷

6.16 Other countries such as Nauru or Chile have introduced an *ad valorem* tax of between 10 and 30 per cent on all SSBs.¹⁸

6.17 In November 2016, the Grattan Institute published *Sugary drink tax – recovering the community costs of obesity*. The report called for an excise tax of 40 cents per 100 grams of sugar on non-alcoholic, water-based beverages that contain added sugar. The report says this would increase the price of a two-litre bottle of soft drink by about 80 cents. This tax would raise an estimated \$500 million a year and reduce by about 15 per cent the consumption of SSBs.¹⁹

6.18 The Grattan Institute recommended that SSBs subject to a tax include soft drinks, flavoured mineral waters, energy drinks, cordials and fruit juices with added sugar.²⁰

6.19 Ms Jane Martin, Executive Manager at the Obesity Policy Coalition (OPC), explained its recommendation for a 20 per cent tax was based on WHO analysis of fiscal policies on food, which said that, for the best health outcomes, a 20 per cent or more price increase is required.²¹

6.20 Dr Bartone from the AMA explained that a recent Australian study estimated that a 20 per cent tax on SSBs could result in a 12 per cent decline in consumption and

14 The Royal Children's Hospital Melbourne, *Submission 17*, p. 3.

15 See for example: Public Health Association of Australia, *Submission 73*, p. 15; Australian Healthcare and Hospitals Association, *Submission 101*, p. 3.

16 The George Institute, *Submission 104*, p. 2.

17 Heart Foundation, *Submission 139*, p. 14.

18 Grattan Institute, *Submission 50*, p. 26.

19 Grattan Institute, *Submission 50*, p. 3.

20 Grattan Institute, *Submission 50*, p. 4.

21 Ms Jane Martin, Executive Manager, Obesity Policy Coalition, *Committee Hansard*, Melbourne, 4 September 2018, p. 32.

would result, over a 25 year period, in as many as 16 000 fewer cases of type 2 diabetes and 4400 fewer cases of heart disease.²²

6.21 Most submitters endorsed the recommendation of the OPC's *Tipping the Scales* report, which supports a 20 per cent tax on sugary drinks.²³

Arguments against the introduction of a SSBs tax

6.22 In 2017, the Menzies Research Institute published *Fat chance: why sugar taxes won't work*. The report argues it reviewed a series of papers in favour of the introduction of a SSB tax and found that these papers failed to provide a comprehensive assessment of the overall costs and benefits that such a tax would impose on Australians. It further argued that SSBs tax proposals are not convincing because the logic of the connection between SSBs consumption and obesity is weak given SSBs are neither the sole source of sugar in foods nor even the main source.²⁴

6.23 Coca-Cola Amatil and other submitters also claimed there is very little evidence that taxes targeting SSBs actually work to reduce obesity rates.²⁵

6.24 For example, Dr Alan Barclay pointed out that while consumption of sugary drinks falls after a sugar tax is introduced, there is no evidence that obesity rates decline.²⁶

6.25 Professor Greg Johnson, Chief Executive Officer of Diabetes Australia, responded to this argument by explaining that it takes five to 10 years to see change and that you can only measure impacts in the long-term. Professor Johnson took the example of tobacco control:

You've heard about tobacco control and the measures. Many of these things take five to 10 years as an individual element in an overall package of things. Tobacco control has been going on for 40 years. It's 40 years since we started TV advertising against tobacco, against cigarettes—all of those things. These are long-term things. All the public policy instruments that we've recommended here are things that will have long-term impacts, but

22 Dr Tony Bartone, President, Australian Medical Association, *Committee Hansard*, Melbourne, 4 September 2018, p. 42.

23 See for example: Sugar Free Smiles, *Submission 31*, p. 2; Nutrition Australia, *Submission 61*, p. 4; Public Health Association of Australia, *Submission 73*, p. 17; Diabetes Australia, *Submission 67*, p. 4.

24 Menzies Research Institute, *Submission 119*, Attachment 1, p. 1.

25 See for example: Coca-Cola Amatil, *Submission 84*, p. 15; Australian Food and Grocery Council, *Submission 89*, p. 19; Mr Nick Cater, Executive Director, Menzies Research Centre, *Committee Hansard*, Sydney, 6 August 2018, p. 70; Australian Taxpayers' Alliance, *Submission 123*, p. 14; Australian Association of Convenience Stores Limited, *Submission 6*, p. 4.

26 Dr Alan Barclay, private capacity, *Committee Hansard*, Sydney, 6 August 2018, p. 56.

they're not things that you can necessarily measure in two years or three years.²⁷

Committee view

6.26 The committee believes that the introduction of a tax on sugary drinks (SSB tax) should be considered as part of a suite of strategies and programs within a national obesity strategy. The committee notes that WHO has recommended governments tax sugary drinks and that, at present, over 30 jurisdictions across the world have introduced a SSB tax as part of their effort and commitment toward preventing and controlling the rise of obesity.

6.27 Importantly, the committee is of the view that the introduction of a SSB tax will have a significant impact on reformulation. It will compel the food industry to reformulate more of their products. This will drive food and drink companies to focus on producing and marketing much healthier products. Indeed, the committee heard that as soon as the UK Government announced its commitment to the introduction of a sugar tax, beverage companies started to reformulate products. Within months, the amount of sugar was halved in the formulation of Sprite. The committee is confident that similar reformulation activities will actively occur if a SSB tax is introduced in Australia.

6.28 The committee also believes that a SSB tax will influence purchasing and consumption behaviour. Price signals do influence consumer choice and the introduction of a SSB tax will contribute to reduced consumption of SSB. Also, it is likely to influence demand for healthier alternatives such as water and low fat milk.

6.29 Additionally, the introduction of a SSB tax would firmly convey the message that the Australian Government is committed to discouraging the consumption of products that contribute to the rise of obesity as well as diseases such as type 2 diabetes and tooth decay. Finally, the committee received plenty of evidence showing there is strong support for a tax from Australian and international health experts.

6.30 Equally, the Committee noted analysis that a SSB tax would have a disproportionate impact on poorer Australians, as well as industry arguments that a SSB could have adverse consequences for employees and industry. The committee is of the view that the impact of a SSB tax would be mostly on manufacturers, not consumers. As seen in the UK, the food industry is likely to bring forward alternatives in order to avoid tax. The impacts of sugary drinks are borne most by those on low income and they will also reap the most benefits from measures that change the behaviour of manufacturers. Finally, the government has taken this approach tax other products, which may have an impact on public health. In particular, smoking and carbon pricing have successfully set price signals that changed corporate behaviours. And, in the case of carbon pricing, the impacts were offset through the tax and transfer system (raising the tax free threshold).

27 Professor Greg Johnson, Chief Executive Officer, Diabetes Australia, *Committee Hansard*, Sydney, 6 August 2018, p. 19.

6.31 The committee heard that there are a number of different fiscal models that have been used internationally to increase the price of SSBs. The committee notes that many submitters, in line with the WHO recommendation, were supportive of a 20 per cent tax on sugary drinks. The committee believes that the government should investigate what is the best fiscal model to achieve a price increase of at least 20 per cent on SSBs and whether a tiered volumetric tax or a 20 per cent *ad valorem* tax should be implemented to achieve optimal impacts on consumption behaviour and reformulation activities.

Recommendation 10

6.32 The committee recommends that the Australian Government introduce a tax on sugar-sweetened beverages, with the objectives of reducing consumption, improving public health and accelerating the reformulation of products.

Chapter 7

Marketing and advertising of discretionary foods

7.1 The World Health Organisation (WHO) reported that there is unequivocal evidence that the marketing of discretionary foods and sugar-sweetened beverages is linked to childhood obesity, and recommends reducing the exposure and influence of the marketing of discretionary foods as part of a comprehensive approach to addressing childhood obesity.¹

7.2 Submitters expressed deep concerns about the failure of the current self-regulatory system in reducing the exposure and influence of discretionary food marketing campaigns to children.²

Link to obesity

7.3 The Public Health Association of Australia described the marketing of discretionary food, including packaging and retail promotion, advertising, and sponsorship, as a major threat to child health because it encourages overconsumption and influences children's food preferences.³

7.4 Other submitters expressed similar concerns and pointed out that children are particularly vulnerable because they lack the cognitive ability to recognise the persuasive intent of advertising and cannot critically evaluate advertising content.⁴

7.5 Mr Steve Pratt from the Australian Chronic Disease Prevention Alliance stressed the link between exposure to food marketing and weight:

There is an absolute, demonstrated causative link between children's exposure to food marketing, the foods they choose and their subsequent weight.⁵

7.6 Professor Bridget Kelly from the University of Wollongong cited new research that establishes the link between food advertising and increased consumption of food:

1 Australian Chronic Disease Prevention Alliance, *Submission 106*, p. 13.

2 See for example: Food Fairness Illawarra, *Submission 27*, Attachment 1, p. 11; Obesity Policy Coalition, *Submission 135*, p. 20; WA Cancer Prevention Research Unit, *Submission 8*, p. 8; Food Governance Node, *Submission 58*, p. 4.

3 Public Health Association of Australia, *Submission 73*, p. 11.

4 See for example: Australian Chronic Disease Prevention Alliance, *Submission 106*, p. 13; Australian Medical Association, *Submission 126*, p. 2; The Boden Institute, University of Sydney, *Submission 130*, p. 18; Obesity Policy Coalition, *Submission 135, Supplementary Submission*, p. 7; Professor Greg Johnson, Chief Executive Officer, Diabetes Australia, *Committee Hansard*, Sydney, 6 August 2018, p. 20.

5 Mr Steve Pratt, Nutrition and Physical Activity Manager, Cancer Council Western Australia and Member, Australian Chronic Disease Prevention Alliance, *Committee Hansard*, Sydney, 6 August 2018, p. 15.

We found food advertising to be so powerful and persuasive that even children who had a better capacity to self-regulate their food consumption were overcome by the commercial messages and ate more after watching the food advertisements in our study. So simply teaching children to be more aware and critical of marketing will not work, given the power of that marketing over children.⁶

Self-regulatory system

7.7 Australia has in place a self-regulatory system, which sets the rules for food and beverage marketing to children.

7.8 The Australian Association of National Advertisers (AANA) has developed a series of codes, which is applicable to all food and beverage advertisers and to a wide range of media. This includes the AANA Food & Beverage Code and the AANA Code for Advertising and Marketing Communications to Children (AANA Children's Code).⁷

7.9 The Australian Food and Grocery Council (AFGC) has developed voluntary codes for the food and beverage and fast food restaurant industries in relation to advertising to children:

- the Responsible Children's Marketing Initiative (RCMI) for the Australian Food and Beverage Industry; and
- the Australian Quick Service Restaurant Initiative for Responsible Advertising and Marketing to Children (QSRI).⁸

7.10 The RCMI applies to advertising to children under 12 years, and limits marketing communications to children only when it is for healthier dietary choice products and where the message of the advertisement will promote healthy dietary choices and a healthy lifestyle.⁹

7.11 The QSRI applies to advertising to children under 14 years. It obliges signatories to ensure that only food and beverages that represent healthier choices are promoted directly to children, and that parents or guardians can make informed product choices for their children.¹⁰

7.12 There are currently seven signatories to the QSRI and 18 companies participating in the RCMI.¹¹

6 Associate Professor Bridget Kelly, Associate Professor of Public Health, Food and Movement research Theme, Early Start, University of Wollongong, *Committee Hansard*, Melbourne, 4 September 2018, p. 46.

7 Ad Standards, *Submission 19*, p. 18.

8 Ad Standards, *Submission 19*, pp. 3-4.

9 Ad Standards, *Submission 19*, p. 19.

10 Ad Standards, *Submission 19*, pp. 19-20.

11 Ad Standards, *Submission 19*, p. 20.

7.13 According to Ad Standards, which administers the complaint resolution component of the codes, the system is effective, with a record of nearly 100 per cent compliance by industry.¹²

7.14 The Australian Industry Group pointed out to the committee that there is broad compliance with the codes and that the confectionery industry is actively involved in the promotion of responsible advertising.¹³

Issues with the codes

7.15 The Food Governance Node is of the view that initiatives to regulate food marketing to children have failed to reduce children's exposure to the marketing of discretionary foods.¹⁴

7.16 Many submitters told the committee that the current system does not adequately protect children from the harmful effects of discretionary food advertising.¹⁵

7.17 The Obesity Policy Coalition (OPC) explained that the AANA codes contain extremely weak restrictions on the marketing of food to children.¹⁶

7.18 Submitters were critical of the RCMI and QSRI initiatives and identified the following issues:

- the codes apply only to marketing that is 'directed primarily to children' and those words are defined and interpreted extremely narrowly;
- the codes do not provide a clear definition and framework of what is considered 'healthier choices';
- the codes do not apply to all types of marketing;
- the codes have failed to keep pace with the changing media landscape and the rise of digital marketing;
- children over 12 (RCMI) or 14 years (QSRI and AANA Children's Code) are not protected by the codes;
- food companies can choose not to sign up to the voluntary industry codes;
- the codes are not independently monitored; and
- there are no effective enforcement mechanisms.¹⁷

12 Ad Standards, *Submission 19*, p. 2.

13 Australian Industry Group, *Submission 117*, p. 23.

14 Food Governance Node, *Submission 58*, p. 4;

15 See for example: Food Fairness Illawarra, *Submission 27*, Attachment 1, p. 11; Obesity Policy Coalition, *Submission 135*, p. 20; WA Cancer Prevention Research Unit, *Submission 8*, p. 8.

16 Obesity Policy Coalition, *Submission 135, Supplementary Submission*, p. 8.

Narrow interpretation of 'directed primarily to children'

7.19 Submitters raised issues around the narrow interpretation by the food and beverage industry of the term 'directed primarily to children'.¹⁸

7.20 The QSRI and RCMI define an advertisement to be 'directed primarily to children' by reference to either the placement or content of the advertisement.

7.21 To meet the test, the advertisement must be placed in a medium that is directed primarily to children such as a television program rated C or P, placed in a medium where children are 35 per cent or more of the audience, or be directed primarily to children, when considering the themes, visual and language of the advertisement.

7.22 The OPC argued that the rule around content directed primarily to children also rarely applies as food and beverage companies claim that their ads are aimed at both parents and children, not 'primarily to children'.¹⁹

No clear definition of 'healthier choices'

7.23 Submitters are concerned that the codes do not include a specific definition of unhealthy food. At present, nutrition criteria of 'healthier choices' are determined by the individual food companies themselves.²⁰

7.24 As a result, advertising of many discretionary foods and beverage items remains unrestricted.²¹

The codes do not cover all types of marketing

7.25 The RCMI and QSRI codes do not apply to sport sponsorship, product packaging, in-store promotions, competitions and giveaways. This means that a significant amount of marketing to children is not covered by the codes and that children are exposed to a variety of discretionary food marketing that greatly influence their food choices and preferences.

7.26 For example, the committee received compelling evidence that children's taste preferences are influenced by packaging.²² Food companies often display on

17 See for example: Obesity Policy Coalition, *Submission 135, Supplementary Submission*, pp.7-20; Dr Belinda Reeve, Co-Founder, Food Governance Node, *Committee Hansard*, Sydney, 6 August 2018, p. 22; Dr Joanne Walker, Director, Policy and Strategy Development, National Rural Health Alliance, *Committee Hansard*, Melbourne, 4 September 2018, p. 42.

18 See for example: Food Governance Node, *Submission 58*, p. 5; Obesity Policy Coalition, *Submission 135, Supplementary Submission*, p. 12.

19 Obesity Policy Coalition, *Submission 135, Supplementary Submission*, p. 12.

20 See for example: Food and Movement Research Team, Early Start, University of Wollongong, *Submission 69*, p. 13; Obesity Policy Coalition, *Submission 135*, p. 24.

21 Food and Movement Research Team, Early Start, University of Wollongong, *Submission 69*, p. 13.

22 See for example: Centre for Research Excellence in the Early Prevention of Obesity in Childhood, *Submission 10*, p. 8; Obesity Policy Coalition, *Submission 135, Supplementary Submission*, p. 9.

children's food products cartoon graphics or familiar characters to make them more attractive. Common products displaying child-targeted packaging include confectionery, sweet biscuits, chips, dairy snacks and ice cream.²³

Sport sponsorship

7.27 Submitters raised concerns about the prevalence of sponsorship of Australian sport by food and beverage companies producing discretionary foods and sugar-sweetened beverages.²⁴

7.28 The OPC explained to the committee that sport sponsorship has a strong influence on children because they consider sponsors 'cool' and often like to return the favour of sponsorship by buying the sponsor's products.²⁵

7.29 As the codes do not apply to sport sponsorship, children participating in sport are exposed to high-impact marketing through:

- the food brand forming part of the competition's name;
- the brand and logo displayed on sporting equipment, uniforms, drink bottles, hats and other items; and
- the prominent signage at children's weekly sporting events.²⁶

7.30 Research conducted in 2011 revealed that 63 per cent of food promoted by sponsors of children's sport did not meet healthy food criteria.²⁷

Codes do not apply to adolescents

7.31 Children over 12 (RCMI) or 14 years (QSRI and AANA Children's Code) are not protected by the codes. The OPC argued that children are vulnerable beyond these ages as their decision-making capacities are limited by their brain development, which is not complete until late adolescence.²⁸

7.32 Submitters are of the view that the codes should apply at least to children under 16 years of age, as there is evidence showing associations between market exposure and increased likelihood of poor dietary intake among adolescents.²⁹

23 Obesity Policy Coalition, *Submission 135*, p. 20.

24 See for example: Australian Chronic Disease Prevention Alliance, *Submission 106*, p. 15; Obesity Policy Coalition, *Submission 135, Supplementary Submission*, p. 9; Mr Steve Pratt, Nutrition and Physical Activity Manager, Cancer Council Western Australia and Member, Australian Chronic Disease Prevention Alliance, *Committee Hansard*, Sydney, 6 August 2018, p. 15.

25 Obesity Policy Coalition, *Submission 135*, p. 20.

26 Obesity Policy Coalition, *Submission 135, Supplementary Submission*, p. 9.

27 Obesity Policy Coalition, *Submission 135, Supplementary Submission*, p. 9.

28 Obesity Policy Coalition, *Submission 135, Supplementary Submission*, p. 18.

29 See for example: Obesity Policy Coalition, *Submission 135, Supplementary Submission*, p. 18; Food and Movement Research Team, Early Start, University of Wollongong, *Submission 69*, p. 14.

Advertising on free-to-air television

7.33 The content of commercial free-to-air television is regulated by the Commercial Television Industry Code of Practice (Free TV Code). The Free TV Code is reviewed annually by Free TV Australia in consultation with the public and then registered with the ACMA.³⁰

7.34 The ACMA is tasked to enforce the Free TV Code, with penalties for non-compliance.³¹

7.35 The Free TV Code requires advertisers to comply with the AANA Code of Ethics, the AANA Children's Code, the RCMI and QSRI.³²

7.36 As previously discussed, the QSRI and RCMI define an advertisement to be 'directed primarily to children' for ads placed in a medium where children make up at least 35 per cent of the audience.

7.37 In practice, this captures some TV programs designed specifically for young children but does not capture the programs seen by the highest number of children, such as sporting events, family movies and reality TV programs.³³

7.38 For example, popular TV watching times in the morning and evening are not covered by the codes because children never exceed 35 per cent of the audience.³⁴

7.39 The Food and Movement Research Team at Early Start, University of Wollongong, explained that the peak viewing time for 0-14 year olds on commercial free-to-air television is from 7.00am to 9.00am in the morning and in the evening between 7.00pm and 8.00pm. However, during peak viewing times adults are also watching, and in numbers large enough to push the child proportion to below 35 per cent. During peak viewing times, the average child audience rises to 435 000 persons, compared with just 80 000 during C and P rated programs.³⁵

7.40 Parents' Voice pointed out that 'children continue to be exposed to high levels of food advertising during peak TV viewing times' and is of the view that 'current regulations do not sufficiently cover the extent and impact of children's food marketing exposures'.³⁶

30 Free TV Australia, *Submission 91*, p. 7.

31 Free TV Australia, *Submission 91*, p. 7.

32 Free TV Australia, *Submission 91*, p. 7.

33 See for example: Food Governance Node, *Submission 58*, p. 5; Obesity Policy Coalition, *Submission 135*, p. 23.

34 Obesity Policy Coalition, *Submission 135*, p. 23.

35 Food and Movement Research Team, Early Start, University of Wollongong, *Submission 69*, p. 11.

36 Parents' Voice, *Submission 43*, p. 2.

7.41 The vast majority of inquiry participants recommended implementing time-based restrictions on exposure of children to discretionary food and drink marketing on free-to-air television up until at least 9.00pm.³⁷

Committee view

7.42 The committee is of the view that there are inadequacies with the current regulatory framework aimed at reducing the exposure and influence of discretionary food marketing on children. The committee is of the view that the current codes and initiatives, set by the AANA and administered by the Advertising Standards Bureau, as well as broadcasting codes of practice, need to be reviewed and strengthened to ensure children and adolescents are better protected from the harmful effects of discretionary food advertising. Community expectations around responsible advertising are evolving and the industry should respond accordingly and update the codes. In particular, the codes should apply to all forms of advertising, marketing and promotion, including sponsorship of children's sport and product packaging and should apply to all forms of media. The committee believes that a key weakness of the codes is their failure to define what are 'healthy food' and 'healthier choices'. The committee is of the view that the codes should use the Health Star Rating (HSR) system to define healthier choices, and apply restrictions to foods and drinks, that attract a rating of less than 3 stars. Finally, the codes should also apply to advertising aimed at children aged up to 16 years.

7.43 The Committee notes that it has been a decade since the ACMA reviewed the Children's Television Standards, including the relationship between advertising, children's food and drink preferences and obesity and that, since then, new evidence on children's viewing patterns, advertising and food preferences has emerged, along with new advice and recommendations on tackling childhood obesity. For example, the Committee is aware that children watch C and P programs on free to air television, and on many occasions, the committee heard that children watch TV programs until at least 9.00pm.

Recommendation 11

7.44 The committee recommends that, as part of the 2019 annual review of the Commercial Television Industry Code of Practice, Free TV Australia introduce restrictions on discretionary food and drink advertising on free-to-air television until 9.00pm.

Recommendation 12

7.45 The committee recommends that the Australian Government consider introducing legislation to restrict discretionary food and drink advertising on free-to-air television until 9.00pm if these restrictions are not voluntarily introduced by Free TV Australia by 2020.

37 See for example: Global Obesity Centre, *Submission 13*, p. 7; Parents' Voice, *Submission 43*, p. 2; Associate Professor Bridget Kelly, Associate Professor of Public Health, Food and Movement research Theme, Early Start, University of Wollongong, *Committee Hansard*, Melbourne, 4 September 2018, p. 50;

7.46 The committee is of the view that children and their parents need to be better informed about the nutritional value of the foods and drinks advertised on all forms of media. The committee believes applying the HSR system to all advertisements for food and drink products would help consumers make better informed choices about their food and drink purchases.

Recommendation 13

7.47 The committee recommends the Australian Government make mandatory the display of the Health Star Rating for food and beverage products advertised on all forms of media.

Chapter 8

Education campaigns

8.1 As part of a comprehensive approach to reduce obesity, public health campaigns are essential to raise awareness, improve nutrition literacy, attitudes and behaviours around diet and physical activity.¹

8.2 The World Health Organisation (WHO) has identified public education campaigns as an effective means of disseminating messages about obesity prevention at a population level, and can be a useful tool for population behaviour change and shifting social norms to preference healthy behaviours.²

Lack of leadership and investment

8.3 According to Mr Terry Slevin, Chief Executive Officer of the Public Health Association of Australia, the lack of high-profile education and prevention programs at a national level raises the question of government's commitment and investment in public health:

There seems to be...little appetite to boost investment in public health or prevention, even though we've got an enormous body of evidence that suggests this is one of the best buys we can make in health.³

8.4 Other submitters also noted the current lack of government leadership and investment in prevention programs and sustained initiatives.⁴

8.5 Many inquiry participants called for additional funding for public health campaigns to improve attitudes and behaviours around diet, physical activity and sedentary behaviour.⁵

8.6 For example, the Australian Chronic Disease Prevention Alliance recommended sustained, funded and well-researched mass-media campaigns to increase activity and improve nutrition.⁶

1 Heart Foundation, *Submission 139*, p. 11.

2 Obesity Policy Coalition, *Tipping the scales*, September 2017, p. 12; Obesity Policy Coalition, *Submission 135*, p. 27.

3 Mr Terry Slevin, Chief Executive Officer, Public Health Association of Australia, *Committee Hansard*, Melbourne, 4 September 2018, p. 16.

4 See for example: Food Fairness Illawarra, *Submission 27*, Attachment 1, p. 6; Food Governance Node, *Submission 58*, pp. 8-9; Live Lighter WA, *Submission 88*, p. 10.

5 See for example: WA Cancer Prevention Research Unit, *Submission 8*, p. 2; Global Obesity Centre, *Submission 13*, p. 7; Primary Care Partnership, *Submission 28*, p. 3; Ms Leanne Chambour, *Submission 32*, p. 2; Sugar By Half, *Submission 48*, p. 4; Queensland Country Women's Association, *Submission 56*, p. 2; Food Governance Node, *Submission 58*, p. 15; Public Health Association of Australia, *Submission 73*, p. 17; CHOICE, *Submission 90*, p. 4.

6 Australian Chronic Disease Prevention Alliance, *Submission 106*, p. 12.

Healthy Food Partnership

8.7 In November 2015, the Australian Government initiated the Healthy Food Partnership (HFP), a non-regulatory, collaboration between public health groups, food industry bodies and government.

8.8 The HFP is aimed at tackling obesity, encouraging healthy eating and the reformulation of products by food manufacturers.⁷

8.9 The HFP work to date has focused on the development and design process of key activities, including improving consumers' knowledge and awareness of healthier food choices, and educating consumers on appropriate portion and serve sizes, as well as supporting consumers to eat appropriate levels of core foods such as fruit and vegetables.⁸ Another focus of the HFP is to support the industry to reformulate their foods (see Chapter 5).

8.10 The Australian Government Department of Health informed the committee that some of these activities are expected to start from late 2018 / early 2019.⁹

8.11 Inquiry participants commented that they support the HFP but noted its lack of progress to date.¹⁰ For example, Ms Alexandra Jones, Research Fellow at The George Institute, told the committee:

The Healthy Food Partnership is a good start and it could be effective, but right now it's totally under resourced and it's moving slowly.¹¹

8.12 Other submitters were concerned about the capacity for the HFP to operate and deliver tangible outcomes because of the undue influence of food companies within HFP governance, and the apparent lack of monitoring and accountability mechanisms.¹²

8.13 For example, the Tasmanian Government noted in its submission that the food industry should be a key stakeholder in the development of initiatives such as the HFP, but 'there is a risk of undue commercial influence on the development of policy and guidelines, and this requires careful consideration'.¹³

7 Australian Government Department of Health, *Submission 142*, p. 5.

8 Australian Government Department of Health, *Submission 142*, p. 6.

9 Australian Government Department of Health, *Submission 142*, p. 6.

10 See for example: Heart Foundation, *Submission 139*, pp. 9-10; Australian Industry Group, *Submission 117*, p. 11; Obesity Policy Coalition, *Submission 135*, p. 12.

11 Ms Alexandra Jones, Research Fellow, Food Policy Division, The George Institute, *Committee Hansard*, Sydney, 6 August 2018, p. 23.

12 See for example: School of Social Sciences, The University of Adelaide, *Submission 52*, p. 5; Food Governance Node, *Submission 58*, pp. 8-9; Mark Lawrence, Institute for Physical Activity and Nutrition and School of Exercise and Nutrition Sciences, Deakin University, *Submission 95*, p. 4; Sugar By Half, *Submission 48*, p. 3; The George Institute, *Submission 104*, p. 1.

13 Tasmanian Government, *Submission 144*, p. 14.

8.14 The School of Social Sciences at the University of Adelaide is of the view that there has been a substantial disinvestment in obesity prevention by the Australian Government, and it made the following assessment of the HFP:

We are sceptical about the capacity for the Partnership to deliver meaningful outputs due to failure to manage conflicts of interest, lack of accountability mechanisms, and commitment to describing obesity as a matter of individual responsibility and choices.¹⁴

LiveLighter

8.15 The Western Australian Government has funded the *LiveLighter* campaign since 2012.¹⁵ The campaign was extended to Victoria and the Australian Capital Territory in 2014 and to the Northern Territory in 2015.¹⁶

8.16 *LiveLighter* is a public education program, which aims to encourage people to eat well, be physically active and maintain a healthy weight via a variety of initiatives including mass-media and social media campaigns, community engagement activities and the production of tools and resources.¹⁷

8.17 For example, in 2015, *LiveLighter* ran a mass-media campaign in Victoria around the contribution of sugar-sweetened beverages (SSBs) to the development of visceral toxic fat around vital organs. An evaluation of the campaign showed that it resulted in a significant reduction in consumption of SSBs and an increased knowledge of the health effects of SSB consumption.¹⁸

8.18 Submitters noted the effectiveness of the *LiveLighter* campaigns and are of the view that more funding should be directed towards mass-media education campaigns.¹⁹

8.19 However, Swinburne University of Technology was critical of these types of campaigns, arguing they can further contribute to the stigma associated with weight and body shapes:

Media campaigns, especially those directed at adults (i.e. *LiveLighter*) disempowers people by focusing too heavily on the weight and shape of the body at the expense of health behaviours that are within their control, and upstream action on social, cultural, environmental, and commercial determinants of health. Furthermore focusing efforts on obesity prevention

14 School of Social Sciences, The University of Adelaide, *Submission 52*, p. 5

15 Government of Western Australia, *Submission 120*, p. 4.

16 *LiveLighter*, 'Background', <https://livelighter.com.au/About/Background>, accessed 22 November 2018.

17 *Live Lighter WA*, *Submission 88*, p. 1.

18 Heart Foundation, *Submission 139*, p. 11.

19 See for example: Obesity Policy Coalition, *Submission 135*, p. 27; Heart Foundation, *Submission 139*, p. 11; Dietitians Association of Australia, *Submission 107*, p. 8; Tasmanian Government, *Submission 144*, p. 12.

pathologises larger bodies, creating an environment that entrenches weight stigma.²⁰

Committee view

National Education Campaign

8.20 The committee is of the view that public education campaigns are effective and play an important role in improving attitudes and behaviours around diet and physical activity. The committee agrees with submitters that there is a critical need for developing a suite of publicly funded education campaigns.

8.21 Overall, the committee heard that there is a clear need for government leadership to establish and resource comprehensive education campaigns. At present, the Australian Government is doing too little in this area. The HFP has made no tangible progress since its establishment. There is no overall strategy around the development and implementation of education campaigns and programs that take a holistic approach to improve behaviours around diet and physical activity. This reflects a lack of government leadership and absence of a national obesity strategy.

Recommendation 14

8.22 The committee recommends the proposed National Obesity Taskforce is funded to develop and oversee the implementation of a range of National Education Campaigns with different sectors of the Australian community. Educational campaigns will be context dependent and aimed at supporting individuals, families and communities to build on cultural practices and improve nutrition literacy and behaviours around diet, physical activity and well-being.

20 Swinburne University of Technology, *Submission 75*, p. 10.

Chapter 9

Health care interventions

9.1 Health interventions are essential for treating those already living with obesity. As described by Dr Shirley Alexander, Staff Specialist and Head of Weight Management Services at The Children's Hospital at Westmead, 'you need prevention and you need clinical intervention for those that are affected'.¹

9.2 Prevention programs and early clinical and allied health interventions to reduce the prevalence of childhood obesity are also important. Indeed, the World Health Organisation (WHO) pointed out that without intervention, obese infants and young children will likely continue to be obese during childhood, adolescence and adulthood.²

9.3 Health practitioners play a significant role in identifying, supporting and treating people who are overweight and obese. However, issues around access, availability, appropriateness and affordability of treatments are impeding the delivery of effective health interventions.

Interventions aimed at preventing childhood obesity

9.4 To mitigate the negative influences facing children, many submitters stressed the importance of prevention programs, early interventions and providing guidance to parents as obesity is completely preventable in early life.³

9.5 In terms of actions to prevent both childhood obesity itself, as well as interventions to prevent associated health issues, Dr Alexander cited clinical and allied health interventions known to be effective:

Interventions using family-centred behavioural change in diet and activity have been shown to be effective...

We recommend, amongst other things, that all states and territories provide dedicated training for health professionals as well as services to clinically manage childhood obesity. At a federal level, we would recommend a review of Medicare rebates associated with accredited allied health professional consultations for children with obesity to encourage and enable

1 Dr Shirley Alexander, Staff Specialist and Head of Weight Management Services, Children's Hospital at Westmead, *Committee Hansard*, Sydney, 6 August 2018, p. 3.

2 World Health Organisation, 'Commission on Ending Childhood Obesity', <http://www.who.int/end-childhood-obesity/facts/en/>, accessed 22 November 2018.

3 See for example: Dr Seema Mhrshahi, Research Translation Coordinator and Senior Research Fellow, Centre of Research Excellence in the Early Prevention of Obesity in Childhood, *Committee Hansard*, Sydney, 6 August 2018, p. 1; The Boden Institute, University of Sydney, *Submission 130*, p. 3; Centre for Research Excellence in the Early Prevention of Obesity in Childhood, *Submission 10*, p. 8.

greater support in healthcare intervention, including an increased number of sessions for families of children and adolescents with obesity.⁴

9.6 Professor Anna Peeters from the Global Obesity Centre at Deakin University (GLOBE) discussed the integrated approach adopted in Amsterdam, and its success in reducing the prevalence of childhood obesity:

In essence, what they've done in Amsterdam—and they've seen a three percentage point drop in childhood obesity over the last four years, so you do need a long time frame—is they've had quite a concentrated effort in schools around nutrition, activity and standards around the schools, but then also around the cities—things like removing unhealthy food and drink advertising from public transport, and sponsorship of sports. So they've done quite a wide range of things across the city, but they've made really intensive efforts in schools.⁵

9.7 Ms Alexandra Jones from The George Institute emphasised the need for a whole-of-government approach to addressing the problem, pointing to the experience in New South Wales:

New South Wales have a Premier's priority on childhood obesity, and they've recognised that this can't just be the responsibility of the health ministry. A lot of these policies engage with transport, education and a whole range of things. So having a task force or a body at a national level that could coordinate action is absolutely necessary, and we can't just leave it up to the health department.⁶

9.8 Similarly, the ACT government suggested that, to be effective, a national framework would need to be coordinated across all levels of government and across diverse portfolios. It also stressed the importance of considering the social determinants of health:

In addition, it is important to consider social determinants of health as key factors, along with physical activity, active travel, consideration of the structure of workplaces in terms of work/life balance and the role urban design plays in creating and maintaining accessible public spaces and natural environments to support healthy connected communities.⁷

9.9 The Menzies School of Health Research highlighted the importance of a cohesive strategy to tackle obesity, starting in pregnancy and continuing throughout a person's life:

4 Dr Shirley Alexander, Staff Specialist and Head of Weight Management Services, The Children's Hospital, Westmead, *Committee Hansard*, Sydney, 6 August 2018, p. 2.

5 Professor Anna Peeters, Associate Director, Global Obesity Centre, Deakin University, *Committee Hansard*, Melbourne, 7 August 2018, p. 1.

6 Ms Alexandra Jones, Research Fellow, Food Policy Division, The George Institute, *Committee Hansard*, Sydney, 6 August 2018, p. 24.

7 ACT Government, *Submission 87*, p. 3.

First, effective policies are needed across the life span, from maternal health to infancy, childhood and youth and through to adulthood. Children are an integral part of families, and their diets are formed and influenced by family behaviours.⁸

9.10 Professor Steve Allender from GLOBE emphasised the need for comprehensive data and an evidence base to assess whether specific interventions are successful:

What we also need to discuss with you is Australia's obesity evidence base or, in fact, the lack of an evidence base. There is a need for rigorous monitoring of childhood obesity, using a legislated opt-out consent approach, to give us meaningful and timely data.⁹

First 1000 days

9.11 There is strong evidence that the first 1000 days of life—from conception to age two—is a critical period influencing the likelihood of obesity in infancy, childhood and late in life.¹⁰

9.12 The focus on maternal and early childhood, running through a person's life course, was expanded on by Professor Susan Sawyer from the Royal Children's Hospital in Melbourne. Professor Sawyer discussed the concept of the first 1000 days of a person's life, and went further to look at it in terms of the first 1000 weeks:

[T]hat life course perspective tells us that the most effective interventions are going to be those that take place during what we would refer to as the developmental years of zero to 24—that is the notion of the first 1,000 days from preconception—and that it continues through. Many of us are referring to the importance of the first 1,000 weeks and not just the first 1,000 days.¹¹

9.13 Professor Peter Davies, Chairperson of The Early Life Nutrition Coalition, explained to the committee that there are five key elements in the 1000 days, which have a profound effect on the chances of a child becoming overweight and obese:

- high pregnancy body mass index in the mother;
- inappropriate maternal weight gain;
- an increased birth weight;

8 Dr Frances Cunningham, Senior Research Fellow, Menzies School of Health Research, *Committee Hansard*, Sydney, 6 August 2018, p. 40.

9 Professor Steve Allender, Director, Global Obesity Centre, Deakin University, *Committee Hansard*, Melbourne, 7 August 2018, p. 1.

10 See for example: Centre for Research Excellence in the Early Prevention of Obesity in Childhood, *Submission 10*, p. 3; Queensland Nurses and Midwives Union, *Submission 55*, p. 5; Professor Peter Davies, Chairperson, The Early Life Nutrition Coalition, *Committee Hansard*, Melbourne, 7 August 2018, p. 15.

11 Professor Susan Sawyer, Director, Centre for Adolescent Health, The Royal Children's Hospital, Melbourne, *Committee Hansard*, Melbourne, 7 August 2018, p. 16.

- rapid growth during infancy; and
- prenatal tobacco exposure.¹²

9.14 A recent study found that infants experiencing rapid weight gain between birth and two years had nearly four times greater odds of being overweight or obese later in life.¹³

Preconception and pregnancy risk factors

9.15 The committee heard that maternal weight prior to and during pregnancy is important in terms of the future child health outcomes and weight.¹⁴

9.16 Professor Jacqueline Boyle from the Monash Centre for Health Research and Implementation explained that maternal obesity affects oocytes, early embryo development, and a baby's weight.¹⁵

9.17 Professor Sawyer pointed out that the issue of preconception weight is relevant for both parents as evidence would suggest that there are also male epigenetic factors in terms of sperm in relationship to obesity.¹⁶

9.18 The Boden Institute at the University of Sydney stressed the importance of monitoring and managing appropriate gestational weight gain as part of antenatal care.¹⁷

Early life nutrition

9.19 There is a growing body of evidence linking the nutritional environment in early life to an increased risk of obesity.¹⁸

9.20 The *Australian Dietary Guidelines* (ADG) recommend that children receive breast milk, and where that is not possible, suitable formula, until 12 months of age. The ADG also state that children do not require formula beyond 12 months of age.¹⁹

12 Professor Peter Davies, Chairperson, The Early Life Nutrition Coalition, *Committee Hansard*, Melbourne, 7 August 2018, p. 16.

13 Centre for Research Excellence in the Early Prevention of Obesity in Childhood, *Submission 10*, p. 3.

14 See for example: Professor Susan Sawyer, Director, Centre for Adolescent Health, Royal Children's Hospital Melbourne, *Committee Hansard*, Melbourne, 7 August 2018, p. 16; Professor Peter Davies, Chairperson, The Early Life Nutrition Coalition, *Committee Hansard*, Melbourne, 7 August 2018, p. 16; Mr Ahmad Aly, President, Australian and New Zealand Metabolic and Obesity Surgery Society, *Committee Hansard*, Melbourne, 7 August 2018, p. 27.

15 Professor Jacqueline Boyle, Deputy Director and Obstetrician, Monash Centre for Health Research and Implementation, *Committee Hansard*, Melbourne, 7 August 2018, p. 15.

16 Professor Susan Sawyer, Director, Centre for Adolescent Health, The Royal Children's Hospital Melbourne, *Committee Hansard*, Melbourne, 7 August 2018, p. 16.

17 The Boden Institute, University of Sydney, *Submission 130*, p. 3.

18 See for example: The Early Life Nutrition Coalition, *Submission 2*, p. 1; Centre for Research Excellence in the Early Prevention of Obesity in Childhood, *Submission 10*, p. 3; Public Health Association of Australia, *Submission 73*, p. 7.

9.21 Professor Sawyer stressed the importance of breastfeeding:

All the evidence is that, long-term, any breastfeeding is beneficial and protective against overweight and obesity in children.²⁰

9.22 However, although 96 per cent of women start breastfeeding, there is a rapid decline in breastfeeding rates with each month after birth. The proportion of infants receiving any breastmilk in the age group seven to 12 months drops to 42 per cent.²¹

9.23 Professor Sawyer outlined other factors such as socioeconomic trends in breastfeeding, which can impact the weight and overall health of both mothers and children:

[T]he importance of promoting breastfeeding, for example, as one of those elements that is healthiest for the infant and also healthiest for the mother in terms of reducing rates of overweight. Yet we know that we see socioeconomic trends in terms of rates of breastfeeding.²²

Infant food products

9.24 Research undertaken by the Centre for Research Excellence in the Early Prevention of Obesity in Childhood (CREEPOC) shows compliance with the infant feeding guidelines from the ADG is low.²³

9.25 Indeed, the early introduction of solids and inappropriate infant formula feeding practices are significantly increasing the likelihood of obesity in infancy and childhood.²⁴

9.26 For example, Professor Elizabeth Denney-Wilson described to the committee how inappropriate use of formula can lead to overfeeding babies:

Now what we see is people over concentrating infant formula, which gives babies more calories, in the belief that might help babies to sleep a bit better.²⁵

19 Centre for Research Excellence in the Early Prevention of Obesity in Childhood, *Submission 10*, p. 7.

20 Professor Susan Sawyer, Director, Centre for Adolescent Health, The Royal Children's Hospital Melbourne, *Committee Hansard*, Melbourne, 7 August 2018, p. 16.

21 Breastfeeding Coalition Tasmania, *Submission 102*, p. 3.

22 Professor Susan Sawyer, Director, Centre for Adolescent Health, The Royal Children's Hospital, Melbourne, *Committee Hansard*, Melbourne, 7 August 2018, p. 16.

23 Centre for Research Excellence in the Early Prevention of Obesity in Childhood, *Submission 10*, p. 5.

24 See for example: Centre for Research Excellence in the Early Prevention of Obesity in Childhood, *Submission 10*, p. 3; Breastfeeding Coalition Tasmania, *Submission 102*, p. 3; Institute for Physical Activity and Nutrition, Deakin University, *Submission 46*, p. 4.

25 Professor Elizabeth Denney-Wilson, Professor of Nursing, Centre for Research Excellence in the Early Prevention of Obesity in Childhood, *Committee Hansard*, Sydney, 6 August 2018, p. 5.

9.27 Food companies have developed a range of products aimed at young children, including toddler formula, junior milks and infant foods, which undermine optimal infant and young child feeding.²⁶

9.28 These infant foods are heavily promoted by food companies and often contain a lot of sugar and unnecessary ingredients.²⁷

9.29 CREEPOC pointed out that the use of concentrated juices and trans-fats in ready to eat foods for infants and young children greatly contribute to poor diets and obesity in young Australian children.²⁸

Recommended initiatives and programs

9.30 Inquiry participants recommended the development of programs and campaigns to support, protect and promote breastfeeding for the first year of life and beyond.²⁹

9.31 CREEPOC recommended the development and/or continuation of obesity prevention programs which provide:

- support to parents using home visiting or parents' groups;
- detailed advice related to nutrition, including the promotion and support of breastfeeding and appropriate infant feeding, guidance on when to introduce solids;
- advice on parenting that includes recognition of a child's hunger and satiety clues; and
- advice on promoting child sleep and active play.³⁰

9.32 The Early Life Nutrition Coalition recommended expanding the Medicare rebate to include early life nutrition advice during stages of pregnancy and childhood to equip expectant and new parents with an understanding of the right type of nutrition needed to benefit the long-term health of their child.³¹

26 See for example: Breastfeeding Coalition Tasmania, *Submission 102*, p. 3; Centre for Research Excellence in the Early Prevention of Obesity in Childhood, *Submission 10*, p. 8.

27 Dr Seema Mhrshahi, Research Translation Coordinator and Senior Research Fellow, Centre of Research Excellence in the Early Prevention of Obesity in Childhood, *Committee Hansard*, Sydney, 6 August 2018, p. 5; Professor Elizabeth Denney-Wilson, Professor of Nursing, Centre for Research Excellence in the Early Prevention of Obesity in Childhood, *Committee Hansard*, Sydney, 6 August 2018, p. 5.

28 Centre for Research Excellence in the Early Prevention of Obesity in Childhood, *Submission 10*, p. 8.

29 See for example: Centre for Research Excellence in the Early Prevention of Obesity in Childhood, *Submission 10*, p. 9; Food Fairness Illawarra, *Submission 27*, Attachment 1, p. 4.

30 Centre for Research Excellence in the Early Prevention of Obesity in Childhood, *Submission 10*, p. 8.

31 The Early Life Nutrition Coalition, *Submission 2*, p. 3.

Committee view

9.33 The importance of preventing childhood obesity is paramount to preventing the onset of chronic disease as people move through their lives. The health, economic, and social impacts of an unhealthy start in life are endemic which is why there is so much focus on addressing the problem as early as possible.

9.34 All submitters and witnesses for the inquiry agreed that childhood obesity is a complex condition, with multiple factors influencing its prevalence. With children in particular, almost all of the factors regarding their diet and lifestyle are external. As Dr Seema Mhrshahi outlined in Chapter 1, they range from their mother's breastfeeding behaviours, to access to green space, to how much advertising they are exposed to.

9.35 The need for a comprehensive coordinated response is obvious. Because of the plethora of factors, many of the actions and interventions to arrest the trends are currently under the auspices of not only different government departments, but different governments and different levels of government. Even in a single state, such as New South Wales, they realised quite quickly that an intervention went far beyond just the Health Department.

9.36 The committee notes and welcomes the recent communique from the Council of Australian Governments Health Council on the creation of a national strategy on obesity, which includes a strong focus on early childhood. The committee therefore proposes that there should be a subset of the National Obesity Taskforce created which would be responsible for the development and management of a National Childhood Obesity Strategy.

Recommendation 15

9.37 The committee recommends that the National Obesity Taskforce, when established, form a sub-committee directly responsible for the development and management of a National Childhood Obesity Strategy.

9.38 The focus on a child's first 1000 days is a coherent, multi-pronged and evidence based intervention strategy. Research by many eminent academic and clinical research centres has found solid evidence around how low levels of breast feeding, poor pre-conception and pre-natal health, and the low nutritional value of some infant foods and formulas, can all contribute to childhood obesity.

9.39 The committee is therefore of the view that a focus on educating parents, rigid guidelines regulating infant foods and readily available advice on a child's activities should all be integral to deliberations of the body responsible for the development of the National Childhood Obesity Strategy.

Primary care interventions

Role of general practitioners (GPs)

9.40 Over 80 per cent of Australians visit their GP at least once a year and therefore GPs have a significant role in identifying and supporting patients who are overweight and obese.³²

9.41 However, many GPs are not comfortable to raise weight related matters with their patients. As discussed in Chapter 2, talking about weight can be a very sensitive issue for medical practitioners.

9.42 Professor Lauren Williams, a Fellow Member of the Dietitians Association Australia, explained that some GPs may also be hesitant to raise the issue of weight with their patients because of their own personal circumstances:

Some GPs are reluctant to start the conversation because not all GPs are in a healthy weight range themselves. I often get patients referred to me saying, 'I was really surprised when the GP told me, because I'm thinner than they are.' There's a lot of work that needs to be done.³³

9.43 The committee also heard that many GPs and clinicians are not equipped to support their patients because they lack expertise and experience in treating people who are overweight and obese:

It's a 21st century chronic disorder that many clinicians haven't had enough education and training and overt experience in.³⁴

9.44 Many inquiry participants identified a need for training and recommended the development of education programs for medical practitioners.³⁵

9.45 The Australian Medical Association (AMA) recommended the development of practical material for GPs so they can support their patients.³⁶

Allied health services

9.46 At present, the current Chronic Disease Management (CDM) scheme is for patients who are referred by GPs and who have a chronic and complex illness. Under the CDM scheme, patients get five rebated visits per year to see allied health professionals.

32 Australian Medical Association, *Submission 126*, p. 8.

33 Professor Lauren Williams, Fellow Member, Dietitians Association Australia, *Committee Hansard*, Melbourne, 4 September 2018, p. 11.

34 Dr Shirley Alexander, Staff Specialist and Head of Weight Management Services, Children's Hospital at Westmead, *Committee Hansard*, Sydney, 6 August 2018, p. 3.

35 See for example: Professor Elizabeth Denney-Wilson, Professor of Nursing, Centre of Research Excellence in the Early Prevention of Obesity in Childhood, *Committee Hansard*, Melbourne, 6 August 2018, p. 3; Ms Ingrid Ozols, *Submission 37*, p. 3; Australian Medical Association, *Submission 126*, p. 8; Professor Peter Davies, Chairperson, The Early Life Nutrition Coalition, *Committee Hansard*, Melbourne, 7 August 2018, p. 21.

36 Australian Medical Association, *Submission 126*, p. 8.

9.47 Obesity alone does not qualify them for that service. Overweight and obese patients can only access the CDM scheme to see allied health professionals such as dietitians when there is already a co-morbidity.³⁷

Expand access to Chronic Disease Management scheme

9.48 Nepean Blue Mountains Family Obesity Service argued that patients should have access to the CDM scheme for obesity alone. This would enable GPs to co-manage their patients with appropriate allied health specialists, including dietitians, clinical psychologists and physiotherapists.³⁸

9.49 Similarly, Dr Alexander and Professor Williams are of the view that obesity needs to be treated as a chronic disease.³⁹

9.50 The Council of Presidents of Medical Colleges also recommended recognising obesity as a chronic disease because this would facilitate access to early interventions:

This will provide the framework for giving proper consideration to early and better access to health care services and effective treatments for people with obesity.⁴⁰

Increase number of visits under CDM scheme

9.51 The committee heard that the current limit of five visits a year to see allied health professionals under the CDM scheme is inadequate to meet people's needs.⁴¹

9.52 Access to allied health services, especially Accredited Practising Dietitians (APDs) to support dietary and physical activity interventions should be increased.⁴²

9.53 Professor Williams stated that 'five visits in a year is not best practice' for managing an obese patient with a co-morbidity.⁴³

9.54 She also pointed out that the five visits are shared across all allied health professionals, which means that a patient may end up with only one or two consultations with an APD:

37 Professor Lauren Williams, Fellow Member, Dietitians Association Australia, *Committee Hansard*, Melbourne, 4 September 2018, p. 8.

38 Nepean Blue Mountains Family Obesity Service, *Submission 18*, p. 11.

39 Dr Shirley Alexander, Staff Specialist and Head of Weight Management Services, Children's Hospital at Westmead, *Committee Hansard*, Sydney, 6 August 2018, p. 2.

40 Council of Presidents of Medical Colleges, *Submission 3*, p. 2.

41 Dietitians Association of Australia, *Submission 107*, p. 10.

42 See for example: Dietitians Association of Australia, *Submission 107*, p. 10; Early Life Nutrition Coalition, *Submission 2*, p. 2; Dr Alan Barclay, *Submission 37*, p. 10; Children's Hospital at Westmead, *Submission 44*, p. 13.

43 Professor Lauren Williams, Fellow Member, Dietitians Association Australia, *Committee Hansard*, Melbourne, 4 September 2018, p. 8.

When you've got someone with type 2 diabetes, as dietitian you are sharing those five visits across a year with a podiatrist usually and maybe an exercise physiologist.⁴⁴

Surgical interventions

9.55 Bariatric surgery is currently recommended for patients with a Body Mass Index (BMI) of 35 or more and with at least one obesity related medical condition, such as fatty liver disease or hypertension, or in patients with a BMI of 40 with no obesity related medical conditions. Bariatric surgery is also recommended in patients with a BMI over 30 with Type 2 Diabetes Mellitus which is poorly controlled with medication.⁴⁵

9.56 All bariatric procedures are designed to reduce appetite and enhance satiety. Professor Michael Talbot, an Executive Member of the Australian and New Zealand Metabolic and Obesity Surgery Society (ANZMOSS), explained how the surgery works:

It basically alters the physiology of appetite, hunger and eating and changes patients' biological drive to eat so they become disinterested in food so you switch off the hunger that's been driving them to eat and then you train them to avoid food triggers that might create their metabolic or obesity problem again.⁴⁶

Benefits of bariatric surgery

9.57 According to Mr Ahmad Aly, President of ANZMOSS, 'bariatric surgery is the single most effective treatment modality that exists for obesity, not only in terms of weight loss but in reversing or improving the obesity related diseases'.⁴⁷

9.58 ANZMOSS submitted that bariatric surgery saves lives and is the best therapy for Australians with type-2 diabetes and class I and II obesity.⁴⁸

9.59 The Swedish Obese Subjects study, the longest running longitudinal cohort study available, has demonstrated that obese patients treated with bariatric surgery gained a 38 per cent reduction in cancer mortality and a 48 per cent reduction in cardiovascular death compared to the non-surgically treated cohort.⁴⁹

9.60 ANZMOSS reported that while most non-surgical treatment programs often result in weight loss, maintenance of weight is virtually never achieved. In contrast,

44 Professor Lauren Williams, Fellow Member, Dietitians Association Australia, *Committee Hansard*, Melbourne, 4 September 2018, p. 9.

45 Australian and New Zealand Metabolic and Obesity Surgery Society, *Submission 94*, p. 17.

46 Professor Michael Talbot, Executive Member, Australian and New Zealand Metabolic and Obesity Surgery Society, *Committee Hansard*, Melbourne, 7 August 2018, p. 25.

47 Mr Ahmad Aly, President, Australian and New Zealand Metabolic and Obesity Surgery Society, *Committee Hansard*, Melbourne, 7 August 2018, p. 22.

48 Australian and New Zealand Metabolic and Obesity Surgery Society, *Submission 94*, p. 9.

49 Australian and New Zealand Metabolic and Obesity Surgery Society, *Submission 94*, p. 15.

bariatric surgery results in longer term maintenance of weight loss in the majority of patients.⁵⁰

9.61 However, some inquiry participants believe that bariatric surgery has a very high rate of complication and failure.⁵¹ For example, the Butterfly Foundation stated that 'bariatric surgery resulted in improvements in eating behaviour and body image that were not sustained over the long-term'.⁵²

Access to bariatric surgery

9.62 Mr Aly explained to the committee that there are about 1.5 million Australians that, on broad criteria, would be eligible for bariatric surgery. However, only about 23 000 procedures are performed annually.⁵³

9.63 The Australian Government Department of Health explained that bariatric surgery is available to public patients in some public hospitals; however waiting lists can be long.⁵⁴

9.64 At a public hearing, Mr Aly stressed the lack of available public services in bariatric surgery:

More alarmingly, of...about 23 000 procedures a year, only 10 percent are performed in public hospitals and only 4 percent are fully publicly funded.⁵⁵

9.65 Similarly, Dr Tony Bartone, President of the AMA, told the committee that access to bariatric surgery in public hospitals is problematic:

There are significant waiting lists and significant difficulties in obtaining and accessing this in a public hospital space.⁵⁶

9.66 As a result, some people resort to access their superannuation early or go into debts in order to pay for surgery in the private sector.⁵⁷

50 Australian and New Zealand Metabolic and Obesity Surgery Society, answers to question on notice, 7 August 2018, p. 1.

51 See for example: Ms Sarah Harry, Board Member, Health at Every Size Australia, *Committee Hansard*, Melbourne, 7 August 2018, p. 40; Dr Carolynne White, Lecturer, Health Promotion, Swinburne University of Technology, *Committee Hansard*, Melbourne, 7 August 2018, p. 41.

52 Butterfly Foundation, *Submission 99*, p. 10.

53 Mr Ahmad Aly, President, Australian and New Zealand Metabolic and Obesity Surgery Society, *Committee Hansard*, Melbourne, 7 August 2018, p. 22.

54 Australian Government Department of Health, *Submission 142*, Attachment 3, p. 28.

55 Mr Ahmad Aly, President, Australian and New Zealand Metabolic and Obesity Surgery Society, *Committee Hansard*, Melbourne, 7 August 2018, p. 22.

56 Dr Tony Bartone, President, Australian Medical Association, *Committee Hansard*, Melbourne, 4 September 2018, p. 42.

57 Mr Ahmad Aly, President, Australian and New Zealand Metabolic and Obesity Surgery Society, *Committee Hansard*, Melbourne, 7 August 2018, p. 23.

9.67 The AMA and ANZMOSS recommended that access to bariatric procedures be increased in public hospitals.⁵⁸

9.68 Dr Stephen Duckett, Director, Health Program at the Grattan Institute, also pointed out that 'the evidence now is that obesity bariatric surgery is cost effective, and it is unfortunate that the public sector hasn't responded by making access more available'.⁵⁹

Committee view

General Practitioners

9.69 The committee believes GPs have a key role in identifying and supporting patients who are overweight and obese. As discussed in Chapter 2, because of the stigma associated with obesity, GPs are not always equipped to discuss with their patients weight management and health issues related to obesity. The committee reiterates the recommendation made in Chapter 2 around the training of the medical profession and sees value in also developing practical materials for GPs aimed at supporting patients who undertake treatment for obesity and weight related conditions.

Chronic Disease Management scheme

9.70 The committee understands GPs are responsible for referring patients to allied health services under the CDM scheme. However, at present, they cannot refer patients for obesity alone as it is not recognised as a complex and chronic disease. The committee is of the view that overweight and obese patients should be able to access allied health services, especially APDs and exercise physiologists, without a co-morbidity. This would provide early and better access to health care services and effective treatments.

Recommendation 16

9.71 The committee recommends the Medical Services Advisory Committee (MSAC) consider adding obesity to the list of medical conditions eligible for the Chronic Disease Management scheme.

Bariatric surgery

9.72 The committee heard that bariatric surgery is a cost effective intervention, which saves lives and improve obesity related diseases. The committee noted that bariatric surgery items are on the Medicare Benefits Schedule and that bariatric surgery is available through the public hospital system. However, access to bariatric surgery services remains limited.

9.73 Firstly, too few hospitals offer bariatric surgery services. Indeed, the committee heard that only 15 public hospitals in Australia have a specialised obesity

58 Australian Medical Association, *Submission 126*, p. 9.

59 Dr Stephen Duckett, Director, Health Program, Grattan Institute, *Committee Hansard*, Melbourne, 7 August 2018, p. 35.

service that involves surgery.⁶⁰ Secondly, many health professionals continue to be reluctant to offer this treatment option.

9.74 The committee believes that the lack of access and availability of bariatric surgery services is partly due to the stigma attached to this type of surgery. As discussed in Chapter 2, the stigma and prejudice around surgical intervention to treat obesity cannot be underestimated. Attitudes and perceptions need to change within the medical profession. At present, it is resulting in some health professionals not offering this treatment option to patients. Furthermore, given the higher prevalence of obesity in lower socio-economic groups, it is imperative that affordable options are available to all those who could benefit from surgical intervention. Finally, it impedes the creation of new bariatric surgery services.

Recommendation 17

9.75 The committee recommends the Australian Medical Association, the Royal Australian College of General Practitioners and other colleges or professional bodies educate their members about the benefits of bariatric surgical interventions for some patients.

60 Mr Ahmad Aly, President, Australian and New Zealand Metabolic and Obesity Surgery Society, *Committee Hansard*, Melbourne, 7 August 2018, p. 23.

Chapter 10

Community-based multi-strategy interventions

10.1 Submitters stressed the importance of multi-strategy prevention and intervention programs and identified a number of promising approaches to deliver effective programs at a community level.¹

10.2 Ms Alexandra Jones from The George Institute is of the view that some state governments have developed more initiatives and shown greater leadership in addressing obesity compared to the Australian Government.²

10.3 Submitters reported that there have been a number of effective programs at state and territory levels, including the OPAL and *Healthy Together* programs, which are aimed at preventing childhood obesity.³

10.4 Most of these programs were locally specific and are not ongoing, making it difficult to fully evaluate their effectiveness and potential application more broadly.

10.5 Inquiry participants also provided some examples of successful international prevention programs driven by governments, which demonstrate that initiatives that work have both a whole-of-government approach, as well as a whole-of-community approach. This includes EPODE in France, which the South Australian Government used as a model for the development of the OPAL program and the *Amsterdam Healthy Weight Program* in the Netherlands.⁴

OPAL program

10.6 Between 2008 and 2015, the South Australian Government ran the OPAL program in 20 communities.⁵

10.7 OPAL was an adaptation of the French program EPODE, a multi-strategy, community-based obesity prevention initiative that brings together healthy eating and physical activity programs available through schools, local government, health services and community organisations.⁶

1 See for example: Sugar By Half, *Submission 48*, p. 4; The Obesity Collective, *Submission 70*, p. 9; Council of Presidents of Medical Colleges, *Submission 3*, p. 2; Northern Territory Government, *Submission 124*, p. 9; The Boden Institute, University of Sydney, *Submission 130*, p. 15.

2 Ms Alexandra Jones, Research Fellow, Food Policy Division, The George Institute, *Committee Hansard*, Sydney, 6 August 2018, p. 24.

3 See for example: Sugar By Half, *Submission 48*, p. 4; The Obesity Collective, *Submission 70*, p. 9.

4 See for example: Council of Presidents of Medical Colleges, *Submission 3*, p. 2; Australian Beverages Council, *Submission 22*, pp. 27-28; Northern Territory Government, *Submission 124*, p. 9; The Boden Institute, University of Sydney, *Submission 130*, p. 15.

5 Flinders University, *Submission 38*, p. 4.

6 Northern Territory Government, *Submission 124*, pp. 7 and 9.

10.8 The program was coordinated through local governments, which engaged with communities to tailor interventions.⁷

10.9 Professor Megan Warin from the University of Adelaide commented positively on the program because of its whole-of-community approach:

The terrific thing about the OPAL program was that it did attempt to take a socio-ecological approach, a whole-of-community approach...It did have a large social marketing platform, but it has good community political buy-in through leadership of local councils and community organisations.⁸

10.10 Flinders University of South Australia reported that as a result of the OPAL program there were significant changes in the environments in which children spent most of their time, namely home and school. At the community level, changes included:

- more parents receiving nutrition and physical activity information;
- reductions in discretionary food intake;
- greater use of physical activity items in the home;
- greater use of community gardens;
- more rules at home resulting in children spending less time watching TV;
- primary caregivers being more active; and
- more children rating their teachers as good role models for activity.⁹

10.11 However, due to budget cuts to the program, the full evaluation of the program could not be completed.¹⁰

10.12 The National Rural Health Alliance expressed support for the program and described it as an effective prevention program model that should be reinstated and implemented across Australia.¹¹

Healthy Together

10.13 The Victorian Government invested in the *Healthy Together* initiative with the allocation of significant resources for 14 councils across Victoria between 2011 and 2015, as part of the National Partnership on Preventive Health.¹²

7 School of Social Sciences, University of Adelaide, *Submission 52*, p. 4.

8 Professor Megan Warin, Australian Research Council Future Fellow, School of Sciences, University of Adelaide, *Committee Hansard*, Melbourne, 7 August 2018, p. 9.

9 Flinders University, *Submission 38*, pp. 4-5.

10 Flinders University, *Submission 38*, p. 5; Swinburne University of Technology, *Submission 75*, p. 10.

11 National Rural Health Alliance, *Submission 138*, p. 18.

12 Ms Jan Black, Senior Policy Adviser, Municipal Association of Victoria, *Committee Hansard*, Melbourne, 5 September 2018, p. 7.

10.14 Similar to the OPAL program, *Healthy Together* was based on a whole-of-community approach with council and community health partners working with early childhood services, school and workplaces, and in parks and leisure facilities.¹³

10.15 In 2015, the program was terminated prematurely due to the abolition of the National Partnership Agreement on Preventive Health in 2014.¹⁴

10.16 Submitters are of the view that this program was effective and based on the best evidence of what works as a whole-of-community approach.¹⁵

Amsterdam Healthy Weight Program

10.17 In 2012, Amsterdam City Council in conjunction with the Dutch Health Department developed the *Amsterdam Healthy Weight Program*.

10.18 The program is based on the view that a healthy social and physical environment for children is not just the responsibility of the parents, but a responsibility shared by everyone including the food industry, schools and government.¹⁶

10.19 The program seeks to address structural causes of obesity, such as lifestyle, calorie dense food and the social and physical environment that makes it difficult for parents to ensure their children eat healthily and exercise adequately.¹⁷

10.20 The program focuses on both prevention and treatment interventions. It includes:

- community based interventions such as cooking classes;
- school based programs;
- working with the food industry, including supermarket chains and local snack bars to provide healthier food options;
- banning marketing of unhealthy food products to children at sports events; and
- working with paediatric nurses and other health care professionals.¹⁸

13 Ms Jan Black, Senior Policy Adviser, Municipal Association of Victoria, *Committee Hansard*, Melbourne, 5 September 2018, p. 7.

14 Food Governance Node, *Submission 58*, p. 10.

15 See for example: Ms Jan Black, Senior Policy Adviser, Municipal Association of Victoria, *Committee Hansard*, Melbourne, 5 September 2018, p. 7; SugarByHalf, *Submission 48*, p. 4; The Obesity Collective, *Submission 70*, p. 9; National Rural Health Alliance, *Submission 138*, p. 18.

16 Joep Lange Institute, *Submission 143*, p. 2.

17 Joep Lange Institute, *Submission 143*, p. 4.

18 Joep Lange Institute, *Submission 143*, p. 3; Dr Nicholas Manuelpillai, Medical Doctor, Joep Lange Institute, *Committee Hansard*, Melbourne, 4 September 2018, p. 78.

10.21 So far, the program has been very successful with a 12 per cent reduction in overweight or obese children. The City of Amsterdam continues to build and develop on this program.¹⁹

10.22 Miss Karen Den Hertog, Program Manager of the Amsterdam Healthy Weight Program, told the committee that key elements in its success have been political leadership and leadership at a program management level.²⁰

10.23 The Boden Institute at the University of Sydney commended this program for achieving significant drop in childhood obesity, especially in children from low and very low socio-economic backgrounds.²¹

Programs in Aboriginal and Torres Strait Islander communities

10.24 The committee heard that Aboriginal Community Controlled Health Organisations (ACCHOs) run effective programs aimed at preventing and addressing the high prevalence of obesity in Aboriginal and Torres Strait Islander communities.²²

10.25 Ms Pat Turner, Chief Executive Officer of National Aboriginal Community Controlled Health Organisation (NACCHO), gave the example of the *Deadly Choices* program, which is about organised sports and activities for young people. She explained that to participate in the program, prospective participants need to have a health check covered by Medicare, which is an opportunity to assess their current state of health and map out a treatment plan if necessary.²³

10.26 However, NACCHO is of the view that ACCHOs need to be better resourced to promote healthy nutrition and physical activity.²⁴

Access to healthy and fresh foods in remote Australia

10.27 Ms Turner also pointed out that 'the supply of fresh foods to remote communities and regional communities is a constant problem'.²⁵

10.28 Similarly, Ms Salli Cohen, Executive Director, Strategic Policy and Planning at the Northern Territory Department of Health, told the committee that food

19 Joep Lange Institute, *Submission 143*, p. 4.

20 Miss Karen Den Hertog, Program Manager, Amsterdam Healthy Weight Program, City of Amsterdam, *Committee Hansard*, Melbourne, 4 September 2018, p. 78.

21 The Boden Institute, University of Sydney, *Submission 130*, p. 15.

22 Ms Patricia Turner, Chief Executive Officer, National Aboriginal Community Controlled Health Organisation, *Committee Hansard*, Melbourne, 4 September 2018, p. 34.

23 Ms Patricia Turner, Chief Executive Officer, National Aboriginal Community Controlled Health Organisation, *Committee Hansard*, Melbourne, 4 September 2018, p. 34.

24 Ms Patricia Turner, Chief Executive Officer, National Aboriginal Community Controlled Health Organisation, *Committee Hansard*, Melbourne, 4 September 2018, p. 34.

25 Ms Patricia Turner, Chief Executive Officer, National Aboriginal Community Controlled Health Organisation, *Committee Hansard*, Melbourne, 4 September 2018, p. 36.

insecurity is a significant problem for Territorians, particularly for those living in remote and regional areas.²⁶

10.29 Given that healthy food is more expensive in remote Australia, the National Rural Health Alliance believes that incentives to provide fresh foods to remote communities should be provided to grocers and transport operators servicing these areas.²⁷

10.30 Ms Cohen noted that the Australian Government's community store licencing initiative has increased access to a healthier food range in remote communities and called for the continuation and expansion of this program:

We would really welcome an ongoing commitment from the Commonwealth government to the outback stores through the community store licencing. We would welcome an ability for those stores to be able to purchase foods at the same wholesale rates that the big retail stores have.²⁸

10.31 NACCHO is of the view that the government should be proactive in working with community stores to increase the consumption of healthy food choices.²⁹

Committee view

Multi-strategy prevention programs

10.32 The committee noted the success of multi-strategy, community-based and led prevention programs. This includes the OPAL and *Healthy Together* programs initiated by state and territory governments. Importantly, submitters identified that a whole-of-government approach combined with a whole-of-community approach is required for prevention programs to be successful. The Amsterdam Healthy Weight Program demonstrates that a multi-pronged approach involving all sectors of the community work well to address the structural causes of obesity and is an effective driver to achieve systemic changes. Developing pilot programs based on this approach should be considered.

10.33 The committee noted the importance of promoting physical activity within multi-strategy programs, including encouraging the use of active transport such as walking and cycling. The committee is aware that one in six adults and eight in ten children do not meet national physical activity requirements. A national strategy to encourage regular physical activity should be considered to support a culture and environment that promotes active travel, encourage physical activity and sport participation and influence sporting environments to be more inclusive.

26 Ms Salli Cohen, Executive Director, Strategic Policy and Planning, NT Department of Health, *Committee Hansard*, Melbourne, 5 September 2018, p. 1.

27 National Rural Health Alliance, *Submission 138*, p. 8.

28 Ms Salli Cohen, Executive Director, Strategic Policy and Planning, NT Department of Health, *Committee Hansard*, Melbourne, 5 September 2018, pp. 1-2.

29 Ms Patricia Turner, Chief Executive Officer, National Aboriginal Community Controlled Health Organisation, *Committee Hansard*, Melbourne, 4 September 2018, p. 34.

Recommendation 18

10.34 The committee recommends the proposed National Obesity Taskforce commission evaluations informed by multiple methods of past and current multi-strategy prevention programs with the view of designing future programs.

Recommendation 19

10.35 The committee recommends the proposed National Obesity Taskforce is funded to develop and oversee the implementation of multi-strategy, community based prevention programs in partnership with communities.

Recommendation 20

10.36 The committee recommends the proposed National Obesity Taskforce develop a National Physical Activity Strategy.

Aboriginal and Torres Strait Islander communities

10.37 As discussed in Chapter 1, there is an increased prevalence of obesity in the Aboriginal and Torres Strait Islander population and in regional and remote Australia. The committee was told that, after tobacco, obesity contributes most heavily to the disease burden affecting Aboriginal and Torres Strait Islander Australians.³⁰ The committee is also cognisant that access to fresh foods in remote communities is an ongoing challenge due to high costs of freight and distribution. Therefore, developing and resourcing targeted culturally appropriate prevention and intervention programs is a key priority. Importantly, initiatives such as the Department of Prime Minister and Cabinet's Community Stores Licensing Scheme, which requires community stores to stock a minimum range of health foods must continue and be strengthened.

Recommendation 21

10.38 The committee recommends the proposed National Obesity Taskforce is funded to develop and oversee culturally appropriate prevention and intervention programs for Aboriginal and Torres Strait Islander communities.

Recommendation 22

10.39 The committee recommends the Commonwealth develop additional initiatives and incentives aimed at increasing access, affordability and consumption of fresh foods in remote Aboriginal and Torres Strait Islander communities.

Senator Richard Di Natale
Chair

Dissenting Report from the LP and PHON Senators

National Obesity Taskforce

Recommendation 3

3.27 The committee recommends the establishment of a National Obesity Taskforce, comprising representatives across all knowledge sectors from federal, state, and local government, and alongside stakeholders from the NGO, private sectors and community members. The Taskforce should sit within the Commonwealth Department of Health and be responsible for all aspects of government policy direction, implementation and the management of funding

1.2 The Senators oppose the establishment of a National Obesity Taskforce within the Commonwealth Department of Health. The Chair's report recommends the establishment and operation of a National Obesity Taskforce in a number of its recommendations (3, 4, 14, 15, 18, 19, 20), within the Department of Health. This is a structural solution rather than a strategic one and it is unclear how adding another layer of bureaucracy will lead to better addressing obesity policy issues. The report could have recommended a review of the current administrative arrangements applying to identify if existing arrangements can be improved to make them more effective and efficient.

1.3 The Senators support a broad, multi-strategy approach to tackling obesity, but they do not support the establishment of a taskforce to sit within the Commonwealth Department of Health.

1.4 At the COAG Health Council (CHC) meeting of 12 October 2018, Senator the Hon Bridget McKenzie, the then Minister for Rural Health, sought agreement from members for the Commonwealth to lead the development of a National Obesity Strategy through the Australian Health Minister's Advisory Council (AHMAC), and proposed that an Obesity Summit be held as the first phase of its development. This summit will take place in 2019.

Health Star rating System

Recommendation 6

4.98 The committee recommends the Minister for Rural Health promote to the Australia and New Zealand Ministerial Forum on Food Regulation the adoption of the following changes to the current Health Star Rating system:

- **The Health Star Rating Calculator be modified to address inconsistencies in the calculation of ratings in relation to:**
- **foods high in sugar, sodium and saturated fat;**
- **the current treatment of added sugar;**
- **the current treatment of fruit juices;**
- **the current treatment of unprocessed fruit and vegetables; and**

- **the 'as prepared' rules.**
- **Representatives of the food and beverage industry sectors may be consulted for technical advice but no longer sit on the HSR Calculator Technical Advisory Group.**
- **The Health Star Rating system be made mandatory by 2020.**

1.5 The Senators oppose Recommendation 6. The Health Star Rating system (HSR) is currently undergoing a comprehensive review process conducted by MP Consulting. This review is ongoing with submissions closing 7 December 2018. It is not advisable to speculate on certain aspects of the calculator while that review is underway. The Senators further note that the food and beverage industry has played an important role in developing the HSR system and is well placed to provide technical input into the HSR.

1.6 The Senators also oppose making the HSR system a mandatory scheme. The voluntary uptake of the HSR by industry has been strong. The HSR is featured on over 10 000 products and the system is internationally renowned.¹ Currently, the HSR is undergoing its largest review since its inception, and it is important that the review proceeds without political interference. The HSR should not be made mandatory until all calculations involved in the operations of the HSR have been thoroughly assessed and further consultations undertaken. Moreover, any changes to make a 5 star rating increasingly harder to achieve represents a constant shifting of the goal posts, discouraging industry from important reformulation progress and sending confusing messages to consumers. This may undermine the HSR system by decreasing consumer trust.

Tax on sugar-sweetened beverages

Recommendation 10

6.31 The committee recommends the Australian Government introduce a tax on sugar-sweetened beverages, with the objectives of reducing consumption, improving public health and accelerating the reformulation of products.

1.7 The Senators do not support the introduction of a tax on sugar-sweetened beverages. There is insufficient evidence that sugar-sweetened beverage taxes are effective in reducing obesity. No witnesses who appeared before the inquiry could point to any jurisdiction in the world where the introduction of a sugar tax led to a fall in obesity rates. Research by the McKinsey Global Institute undertaken in 2014 in the United Kingdom examined 16 popularised options for obesity prevention and found that portion control, product reformulation and consumer education were consistently in the top five for effectiveness (see Graph 1). Graph 1 shows that the tax on sugar ranked 13 on the list and was found to be one of the least effective options for obesity prevention.²

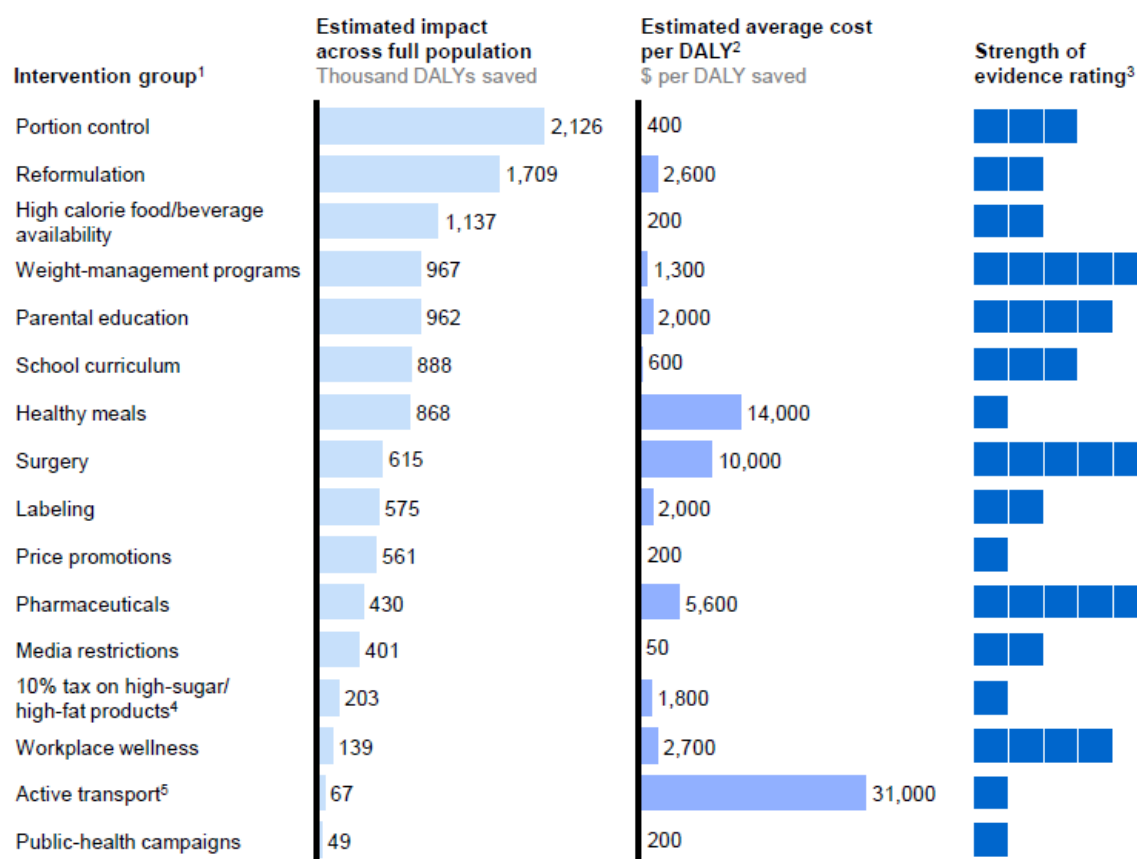
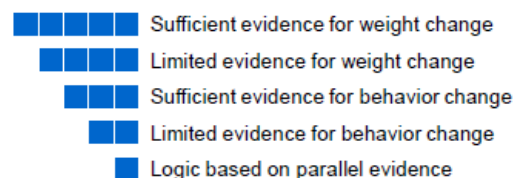
1 Professor Kevin Buckett, *Committee Hansard*, 7 August 2018, p. 64.

2 Coca-Cola Amatil, *Submission 84*, p. 15.

Graph 1: Cost-effectiveness and impact of obesity levers, United Kingdom

There is considerable scope to have high impact on obesity in a cost-effective way

Cost-effectiveness and impact of obesity levers, United Kingdom



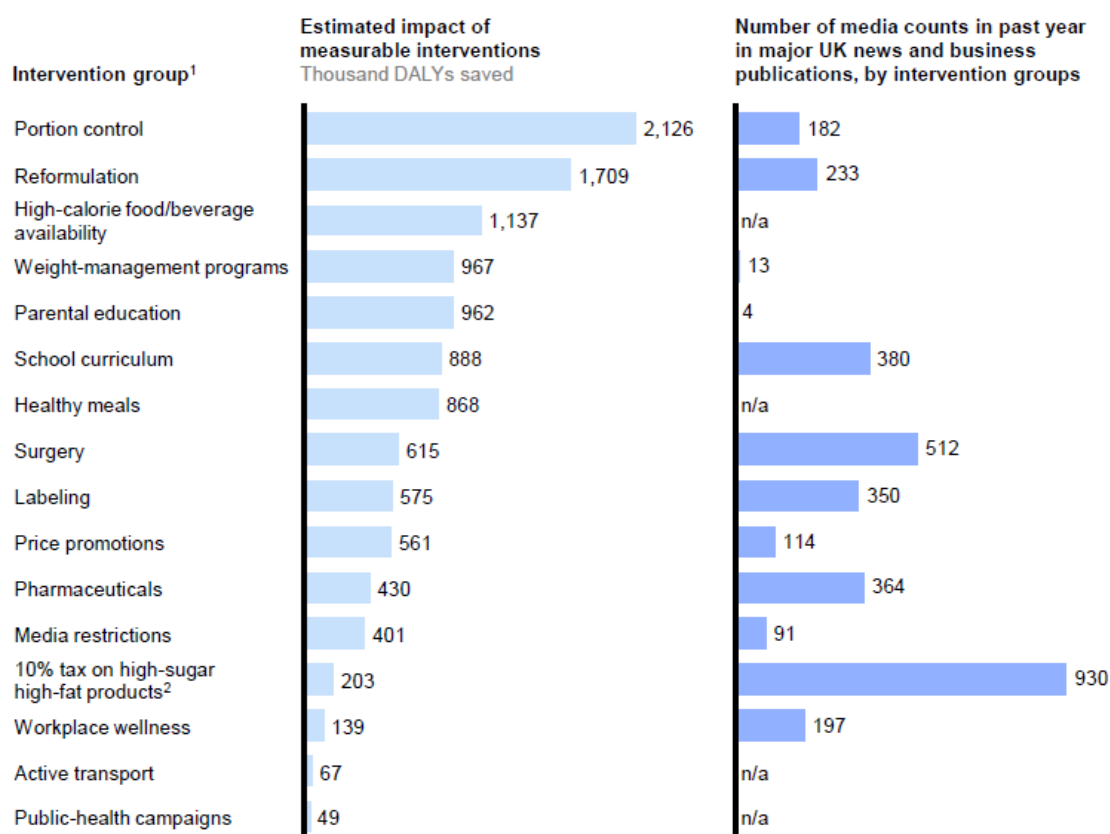
Source: McKinsey&Company, *Overcoming obesity: An initial economic analysis*, 2014

1.8 The research undertaken by the McKinsey Global Institute also shows that a sugar tax attracts disproportionate amount of media attention despite ranking poorly as a mechanism to counter or improve obesity rates (See Graph 2). This demonstrates that the continued focus on a sugar tax is political, rather than policy based on evidence. This skewed focus detracts from interventions that have a measurable impact demonstrated by the McKinsey report such as portion control, balanced access to discretionary foods and education programs.

Graph 2: High-impact intervention areas are receiving less media and public focus, United Kingdom

Some high-impact intervention areas are receiving less media and public focus

Impact and media count of intervention groups, United Kingdom



Source: McKinsey&Company, *Overcoming obesity: An initial economic analysis*, 2014

1.9 More recently, in 2017, both the Menzies Research Centre and the New Zealand Institute of Economic Research conducted a review of a series of papers in favour of the introduction of a tax on sugary drinks to see if a case could be made for a sugar tax. Both reviews concluded that a tax on sugar-sweetened beverages lacks evidence for reducing obesity levels and improving health outcomes.³ The Menzies Research Centre report also pointed out that a sugar tax is likely to be regressive as it would disproportionately affect low-income households. This is because low-income households spend relatively more on soft drinks as a share of their average weekly expenditure.⁴

1.10 Furthermore, a New Zealand Treasury paper published in 2016 noted that numerous studies found highly price sensitive consumers are more likely to switch to

3 Australian Beverages Council, *Submission 22*, p. 40.

4 Menzies Research Centre, *Submission 119*, Attachment 1, p. 2.

non-taxed and unhealthy substitute products, negating any potential health improvements from a soft drink tax.⁵

1.11 The Senators also note the recent United Nations General Assembly Declaration on Non-communicable diseases, adopted on 10 October 2018 that does not endorse taxes on discretionary foods as a means by which to tackle non-communicable diseases caused by tobacco use, harmful use of alcohol, unhealthy diets and physical inactivity. The Declaration supports the implementation of cost-effective and evidence-based interventions to halt the rise of overweight and obesity.⁶

1.12 The Senators note that the committee received compelling evidence about the ineffectiveness and the negative impacts of the taxes on sugar and unhealthy foods that have been introduced in other countries.⁷ For example, in 2011, Denmark introduced a 'fat tax' in an attempt to limit population's intake of unhealthy foods. The tax was scrapped twelve months later and the Danish government quickly cancelled its plans to introduce a sugar tax. According to the Danish government, the tax was abolished because of increased prices for consumers, increased administrative costs for producers and retailers, and because it put jobs at risk. Additionally, the tax failed in reducing consumption of unhealthy foods.⁸ Mexico introduced a soft drink tax in 2014 and the results have been similarly counterproductive. Indeed, sales of taxed products declined initially when the tax was introduced, only to rebound to pre-tax levels and show growth thereafter. The tax had no effect on reducing consumption or reducing obesity.⁹ Lastly, the Mexico experience demonstrates that the burden of taxation is mostly carried by those who can least afford the financial impost. Indeed, in 2014, 63.7 percent of the tax was collected from the lowest socio-economic group.¹⁰

1.13 As described in Chapter 3 of the report, the causes of obesity are myriad, as are the impacts, and the potential solutions. Therefore, we must approach obesity through a multifaceted approach. The Senators believe that introducing a tax or other

5 New Zealand Treasury Working Paper 16/09, *Implications of a sugar tax in New Zealand: Incidence and Effectiveness*, November 2016, <https://treasury.govt.nz/publications/wp/implications-sugar-tax-new-zealand-incidence-and-effectiveness-wp-16-09#formats> (accessed 3 December 2018)

6 United Nations General Assembly, *Resolution adopted by the General Assembly on 10 October 2018 -73.2 Political declaration of the third high-level meeting of the General Assembly on the prevention and control of non-communicable diseases*, 10 October 2018, http://www.un.org/en/ga/search/view_doc.asp?symbol=A/RES/73/2 (accessed 4 December 2018)

7 See for example: Australian Association of Convenience Stores Limited, *Submission 6*, p. 5; Terry Barnes, *Submission 83*, pp.7-8; Australian Food and Grocery's, *Submission 89*, p. 18; Australian Taxpayers' Alliance, *Submission 123*, pp. 18-22.

8 Terry Barnes, *Submission 83*, p. 7.

9 Australian Association of Convenience Stores Limited, *Submission 6*, p. 5.

10 Australian Beverages Council, *Submission 22.1*, p. 4.

punitive measures are paternalistic as it implies that people cannot be trusted to make healthier food choices by themselves.

1.14 The established narrative also oversimplifies and obfuscates the causes of obesity. The Senators further note that international experts are becoming increasingly frustrated with “siloes” approaches to tackling obesity related health issues in the community. In the October 2018 Edition of *The Lancet*, 18 experts from across the globe stated:

The continued temptation to chase easy wins and focus on single policies in silos, such as school programs or taxes, rather than addressing the wider obesogenic environment and other drivers of obesity will mean countries continue to fail to protect their citizens from the harm caused by obesity.¹¹

1.15 We also must be careful about not further stigmatising people who are overweight and obese (see Chapter 2 of the report). The Senators believes that introducing a tax or other punitive measures contribute directly to reinforcing the stigma of obesity as it implies that people cannot be trusted to make healthier food choices by themselves.

1.16 Based on the evidence, the Senators are of the view that the case for government intervention is extremely weak. Regressive taxes that stigmatise and patronise individuals, harm businesses and risk jobs are not the solution to tackle obesity.

Marketing and advertising of discretionary food

Recommendations 11

7.44 The committee recommends that, as part of the 2019 annual review of the Commercial Television Industry Code of Practice, Free TV Australia introduce restrictions on discretionary food and drink advertising on free-to-air television until 9.00pm.

Recommendation 12

7.45 The committee recommends that the Australian Government consider introducing legislation to restrict discretionary food and drink advertising on free-to-air television until 9.00pm if these restrictions are not voluntary introduced by Free TV Australia by 2020.

1.17 The Senators do not support introducing legislation to restrict discretionary food and drink advertising on free-to-air television until 9.00pm. Australia currently has in place a stringent and effective self-regulatory system for regulating the content of food and non-alcoholic beverage advertising, including advertising to children.¹² The Senators believes that self-regulation provides a robust, transparent and effective

11 Ralston J. et al, *Time for a new obesity narrative*, *The Lancet*, Vol 392, 20 October 2018, p. 1385.

12 Ad Standard, *Submission 19*, pp. 7-20.

way for advertisers to engage with consumers and to respond to consumer's concerns about advertising. There is no need for government to intervene or legislate.

1.18 The Senators note that the research undertaken by the McKinsey Global Institute has found that there is limited evidence for behaviour change through media restrictions. Graph 1 shows that introducing media restrictions would have a negligible impact on obesity prevention.

1.19 Furthermore, research shows that there is no causal relationship between responsible advertising and harmful consumption of food and beverage products.¹³ Work undertaken by the Australian Communications and Media Authority (ACMA) also found the contribution of television advertising to obesity appears inconclusive and that public health literature points to a range of multi-factorial contributors to obesity, including hereditary, environmental, social and cultural factors.¹⁴

1.20 Finally, the Senators are of the view that restricting advertising on free-to-air television disproportionately impacts this platform as other platforms, including paid platforms and YouTube, would not be impacted by such restrictions. With children now predominantly watching content on platforms like YouTube, further regulating free-to-air television, would not only reduce the revenue available to fund Australian services, but would also fail to achieve the policy intent.¹⁵

Senator James Paterson

Senator for Victoria

Senator Amanda Stoker

Senator for Queensland

Senator Peter Georgiou

Senator for Western Australia

13 Australian Association of National Advertisers, *Submission 49*, p. 2.

14 Free TV Australia, *Submission 91*, p. 14.

15 Free TV Australia, *Submission 91*, p. 5.

Labor Senators' Dissenting Report

1.1 The Select Committee into the Obesity Epidemic in Australia was tasked with inquiring into and reporting on the prevalence and cause as well as health and economic impacts of overweight and obesity in Australia, particularly related to children. Further, the Committee was tasked with inquiring into and reporting on the effectiveness of existing policies and programs to address childhood obesity, with a focus on evidence-based measures and interventions, among other things.

1.2 Labor Senators acknowledge the high health and economic impacts of obesity and are pleased this inquiry recognises the complex challenges confronting Australia in tackling the epidemic. We take this opportunity to reiterate Labor's commitment to tackling obesity and the record of the last Labor Government, including the establishment of the Australian National Preventive Health Agency and substantial investment through the National Partnership Agreement on Preventive Health – both abolished by the current Government.

1.3 It is clear that all stakeholders, including Government, need an ongoing focus on these issues and that a comprehensive, multi-layered and outcomes-focussed approach must be adopted to ensure progress is made.

Sugar tax

1.4 Chapter 6 of the report addresses a possible tax on sugary drinks.

1.5 Recommendation 10 calls for the Australian Government to introduce a tax on sugar-sweetened beverages.

1.6 Labor Senators do not support Recommendation 10.

1.7 Labor Senators note that evidence on the impact of sugar-sweetened beverage (SSB) taxes in other jurisdictions is still emerging, particularly in relation to obesity rates.

1.8 Labor Senators are particularly concerned that an Australian SSB would likely be regressive, meaning that it would impact lower-income households disproportionately. For example, while supporting a SSB tax the Grattan Institute submitted that:

Low-income households spend a higher proportion of their disposable income on drinks (but less in absolute terms), so an SSB tax will likely be regressive – they will pay a higher proportion of their income in tax ... Modelling of the suggested sugar content tax (at the rate of 40 cents per 100 grams) indicates the financial burden is modest because spending on beverages accounts for a small share of household income ... but will be slightly higher for people from lower socio-economic areas, meaning lower socioeconomic households will pay a higher proportion of their disposable income in tax. A recent analysis of SSB tax studies also found that an SSB tax will likely result in a slightly larger tax burden for lower socioeconomic groups (in dollar terms).

1.9 While Labor Senators accept the logic that a SSB tax is likely to reduce consumption and accelerate reformulation efforts, the Committee received substantial evidence that a SSB tax is only one option amongst many to address overweight and obesity and would not be effective without other measures. Labor Senators note that other interventions – including those introduced by the former Labor Government and abolished by the Abbott-Turnbull-Morrison Government – would have the same effect without a regressive impact, and without risking unintended employment and industry consequences.

1.10 Labor Senators will continue to monitor the international evidence on SSB taxes.

Marketing and advertising of discretionary foods

1.11 Chapter 7 of the report addresses marketing and advertising of discretionary foods.

1.12 Labor Senators acknowledge the report of the World Health Organisation (WHO) on Ending Childhood Obesity which recommends reducing the exposure and influence of the marketing of discretionary foods as part of a comprehensive approach to addressing childhood obesity. We note that Australia is a jurisdiction that has a multi-layered regulatory framework in place to reduce such exposure and influence. For this reason, we note that the Committee report is simply not correct to state that the current system fails to reduce such exposure and influence.

1.13 Labor Senators acknowledge the strong concerns expressed by submitters about the inadequacies of the current regulatory system in reducing the exposure and influence of discretionary food advertising and marketing campaigns to children.

1.14 Labor Senators note that it has been a decade since the Australian Communications and Media Authority (ACMA) conducted an evidence-based review of the Children’s Television Standards, which had a key focus on the relationship between advertising, children’s food and drink preferences and obesity.

1.15 Labor Senators note that in its Final Report of the Review, the ACMA noted that ‘the relative contribution of advertising to childhood obesity and overweight can be difficult to quantify’ and that ‘a causal relationship between these may not be possible to determine’.¹ The ACMA noted that factors influencing childhood obesity and overweight are complex and that public health literature had identified a range of factors, including hereditary, social, cultural and environmental factors.² Further, the ACMA noted evidence that ‘there are various nutrient profiling tools currently available in Australia, which seem to vary in terms of the criteria and/or method used

¹ ACMA, Review of the Children’s Television Standards 2005: Final Report of the Review, August 2009, pp. 5 and 9.

² ACMA, Review of the Children’s Television Standards 2005: Final Report of the Review, August 2009, p. 5.

to identify certain food categories' and that 'there is a lack of consensus on the definition of 'unhealthy' food'.³

1.16 Labor Senators note that, in the time since the ACMA Review, new codes and initiatives have been introduced by the advertising industry to restrict food and drink advertising and marketing to children, and that new evidence has emerged on children's viewing patterns, advertising and food preferences and obesity, along with new advice and recommendations on tackling childhood obesity.

1.17 Recommendations 11 and 12 call for the introduction of restrictions on discretionary food and drink advertising on free-to-air television until 9.00pm, either as part of the review of the Commercial Television Industry Code of Practice or by direct regulation by the Australian Government.

1.18 Recommendation 13 calls for the Australian Government make mandatory the display of the Health Star Rating for food and beverage products advertised on all forms of media.

1.19 Labor Senators note that Recommendations 11 and 12 focus on commercial free-to-air television to the exclusion of other platforms where children are increasingly viewing content, fails to address the definitional issue around 'discretionary food and drink' and fails to address the linkage between the Free TV Code of Practice and the AANA Codes of Practice which may also require review and updating to address latest evidence and advice, including changing patterns of child viewing.

1.20 Labor Senators note that commercial free-to-air television is a free advertiser-funded service to the public and that the ACMA, which administers the Children's Television Standards and registers broadcast industry codes of practice, is guided by the regulatory policy set out in section 4 of the *Broadcasting Services Act 1992* which provides that:

The Parliament also intends that broadcasting services ... be regulated in a manner than, in the opinion of the ACMA, enables public interest considerations to be addressed in a way that does not impose unnecessary financial and administration burdens on providers of broadcasting services.

1.21 Without an agreed and implemented food and drink identification standard to identify discretionary food and drink, it is challenging for the ACMA or the media, advertising and marketing industries to implement a uniform approach, or to undertake economic modelling to estimate the costs or benefits to the prevalence of overweight and obesity, to broadcasters' revenue, to media audiences (associated with potential change in program quality), the advertising sector and to food and drink manufacturers.

1.22 For these reasons, Labor Senators do not support Recommendations 11, 12 and 13 and, as an alternative, recommend that the newly established National Obesity

³ ACMA, Review of the Children's Television Standards 2005: Final Report of the Review, August 2009, p. 6.

Taskforce conduct a comprehensive review of the regulatory framework for food and drink advertising and marketing to children, in conjunction with relevant health, media and advertising bodies, to ensure the framework is fit for purpose in the contemporary media environment and recommends that a food-identification standard be agreed to inform such review and facilitate uniform implementation. Such review would be undertaken in conjunction with the ACMA, the AANA and advertising industry, the broadcasting industry and relevant health authorities to:

- ensure that advertising restrictions are based on an agreed and implemented food and drink identification standard in Australia;
- ensure that children and their parents are better informed about the nutritional value of foods and drinks advertised on all forms of media, including through the Health Star Rating system;
- take account of latest evidence and advice on tackling obesity;
- take account of changing patterns of child viewing habits across platforms; and
- take account of the administrative and financial burden of any restrictions on the broadcasting sector.

Senator Lisa Singh
Senator for Tasmania

Senator Kimberley Kitching
Senator for Victoria

Appendix 1

Submissions, additional information, answers to questions on notice and tabled documents

Submissions

- 1 Lance Payne
- 2 Early Life Nutrition Coalition
- 3 Council of Presidents of Medical Colleges
- 4 Jennifer Thompson
- 5 Mr Robert Lowndes
- 6 Australian Association of Convenience Stores Limited
- 7 Centre for Research Excellence in Integrated Quality Improvement
- 8 WA Cancer Prevention Research Unit
- 9 David Roberts
- 10 Centre for Research Excellence in the Early Prevention of Obesity in Childhood
- 11 Jonathan Pincus
- 12 David Hale
- 13 Global Obesity Centre
- 14 Amanda Atkins
- 15 YMCA Victoria
- 16 Monash Centre for Health Research and Implementation
- 17 The Royal Children's Hospital Melbourne
- 18 Nepean Blue Mountains Family Obesity Service
- 19 Ad Standards
- 20 Australian College of Nursing
- 21 Victorian Centre of Excellence in Eating Disorders
- 22 Australian Beverages Council
- 23 Brenda Janschek
- 24 Eating Disorders Victoria
- 25 Lactation Consultants of Australia and New Zealand
- 26 International Health Economics Association, Economics of Obesity Special Interest Group

- 27 Food Fairness Illawarra
- 28 Primary Care Partnership
- 29 National Centre for Epidemiology and Population Health, The Research School of Population Health, at The Australian National University
- 30 Royal Australian and New Zealand College of Psychiatrists
- 31 Sugar Free Smiles
- 32 Leanne Chambour
- 33 Name Withheld
- 34 Baker Heart and Diabetes Institute
- 35 Greg Stewart
- 36 Dr Alan Barclay
- 37 Ingrid Ozols
- 38 Flinders University
- 39 Cancer Council Australia
- 40 Metabolic Health Solutions
- 41 David Gillespie
- 42 Dr Narelle Story
- 43 Parents' Voice
- 44 Children's Hospital at Westmead Sydney
- 45 Dairy Australia
- 46 Institute for Physical Activity and Nutrition at Deakin University
- 47 Marcea Klein
- 48 Sugar By Half
- 49 Australian Association of National Advertisers
- 50 Grattan Institute
- 51 Australian Institute of Health and Welfare
- 52 School of Social Sciences, The University of Adelaide
- 53 Kentucky Fried Chicken Pty. Limited
- 54 Queensland Child and Youth Clinical Network
- 55 Queensland Nurses and Midwives Union
- 56 Queensland Country Women's Association
- 57 Priority Research Centre for Physical Activity and Nutrition, Nutrition and Dietetics
- 58 Food Governance Node

- 59 Australian Health Policy Collaboration
- 60 Filter Your Future
- 61 Nutrition Australia
- 62 Fonterra Australia
- 63 Federation of Parents and Citizens Associations of NSW
- 64 Dr Edward Cliff
- 65 Health Star Rating Advisory Committee
- 66 Dr Shannon Sahlqvist and Alfred Deakin Professor Anna Timperio
- 67 Diabetes Australia
- 68 Catholic Women's League Australia Inc
- 69 Food and Movement Research Team at Early Start, University of Wollongong
- 70 The Obesity Collective
- 71 Australian Sugar Alliance
- 72 Grains and Legumes Nutrition Council
- 73 Public Health Association of Australia
- 74 Stephanie Alexander Kitchen Garden Foundation
- 75 Swinburne University of Technology
- 76 The Australian Prevention Partnership Centre
- 77 Menzies School of Health Research
- 78 Nestle Australia
- 79 Exercise and Sports Science Australia
- 80 Robern Menz
- 81 World Breastfeeding Trends Initiative
- 82 NCDFREE
- 83 Terry Barnes
- 84 Coca-Cola Amatil
- 85 Dr Nicholas Brayshaw
- 86 Haigh's Chocolate
- 87 ACT Government
- 88 Live Lighter WA
- 89 Australian Food and Grocery Council
- 90 Choice
- 91 Free TV Australia

- 92 Reconnect Nutrition
- 93 Associate Professor Caroline Miller and Ms Aimee Brownbill
- 94 Australian and New Zealand Metabolic and Obesity Surgery Society
- 95 Mark Lawrence, Institute for Physical Activity and Nutrition and School of Exercise and Nutrition Sciences, Deakin University
- 96 Dr Rahul Barmanray
- 97 City of Greater Bendigo
- 98 South Australian Nutrition Network
- 99 Butterfly Foundation
- 100 Menzies Institute for Medical Research
- 101 Australian Healthcare and Hospitals Association
- 102 Breastfeeding Coalition Tasmania
- 103 Mars Australia
- 104 The George Institute
- 105 Partners in Prevention Geelong
- 106 Australian Chronic Disease Prevention Alliance
- 107 Dietitians Association of Australia
- 108 The Root Cause
- 109 Professor Wendy Brown
- 110 Leonie Elizabeth
- 111 Dollar Sweets
- 112 Rosemary Stanton
- 113 Australian Council of Social Services
- 114 Coca-Cola Australia
- 115 That Sugar Movement
- 116 The National Health and Medical Research Council
- 117 Australian Industry Group
- 118 Jim Donovan
- 119 Menzies Research Centre
- 120 Government of Western Australia
- 121 Australian Local Government Association
- 122 Mashblox
- 123 Australian Taxpayers' Alliance

124	Northern Territory Government
125	City of Cockburn
126	Australian Medical Association
127	Sunshine Sugar
128	Rory Robertson
129	Consumers Health Forum of Australia
130	The Boden Institute University of Sydney
131	Johnson and Johnson Medical
132	Outdoor Media Association
133	Services for Australian Rural and Remote Allied Health
134	Medtronic
135	Obesity Policy Coalition
136	National Aboriginal Community Controlled Health Organisation
137	Gold Coast Health and Wellbeing Working Group
138	National Rural Health Alliance
139	Heart Foundation
140	Australian Longitudinal Study on Women's Health
141	Novo Nordisk Pharmaceuticals Pty. Ltd.
142	Australian Government Department of Health
143	Joep Lange Institute
144	Tasmanian Government
145	NSW Health
146	Cockburn Integrated Health
147	Rob Rees
148	Arthritis Australia
149	Confidential
150	Confidential
151	Gary Fettke
152	Professor Luigi Fontana MD, PhD
153	Melinda Stratton
154	

Additional information

- 1 Additional Information from Swinburne University, arising from a Public hearing in Melbourne on 7 August 2018, received 10 August 2018
- 2 Additional Information from Swinburne University, arising from a Public hearing in Melbourne on 7 August 2018, received 10 August 2018
- 3 Additional Information from Swinburne University, arising from a Public hearing in Melbourne on 7 August 2018, received 10 August 2018
- 4 Additional Information from Swinburne University, arising from a Public hearing in Melbourne on 7 August 2018, received 10 August 2018
- 5 Additional Information from Australian Association of National Advertisers, arising from a Public hearing in Sydney on 6 August 2018, received 15 August 2018
- 6 Additional Information from Australian Health Policy Collaboration, arising from a Public hearing in Melbourne on 7 August 2018, received 15 August 2018
- 7 Additional Information from Australian Health Policy Collaboration, arising from a Public hearing in Melbourne on 7 August 2018, received 15 August 2018
- 8 Additional Information from Australian Beverages, arising from a Public hearing in Melbourne on 4 September 2018, received 2 October 2018

Answers to Questions on notice

- 1 Answers to questions taken on notice by Swinburne University at a public hearing in Melbourne on 7 August 2018
- 2 Answers to questions taken on notice by University of Adelaide at a public hearing in Melbourne on 7 August 2018
- 3 Answers to questions taken on notice by Australian Association of National Advertisers at a public hearing in Sydney on 6 August 2018
- 4 Answers to questions taken on notice by ANZMOSS at a public hearing in Melbourne on 7 August 2018
- 5 Answers to questions taken on notice by Department of Health at a public hearing in Melbourne on 5 September 2018
- 6 Answers to questions taken on notice by Northern Territory Department of Health at a public hearing in Melbourne on 5 September 2018
- 7 Answers to questions taken on notice by National Health and Medical Research Council at a public hearing in Melbourne on 4 September 2018
- 8 Answers to questions taken on notice by Australian Institute of Health and Welfare at a public hearing in Melbourne on 4 September 2018
- 9 Answers to questions taken on notice by Australian Medical Association at a public hearing in Melbourne on 4 September 2018

Tabled documents

- 1 Tabled documents from a public hearing held in Melbourne on 7 August 2018, received from Terry Barnes on 7 August 2018
- 2 Tabled documents from a public hearing held in Melbourne on 4 September 2018, received from Dietitians Association of Australia on 4 September 2018
- 3 Tabled documents from a public hearing held in Melbourne on 5 September 2018, received from the Department of Health on 5 September 2018

Appendix 2

Public hearing and witnesses

6 August 2018–Sydney

Members in attendance: Senators Colbeck, Di Natale, Paterson, Singh, Storer.

Witnesses:

ALEXANDER, Dr Shirley, Staff Specialist and Head of Weight Management Services, The Children's Hospital at Westmead

ANNISON, Dr Geoffrey, Deputy Chief Executive Officer, and Director, Health, Nutrition and Scientific Affairs, Australian Food & Grocery Council

ARANDA, Professor Sanchia, Chief Executive Officer, Cancer Council Australia; and Chair, Australian Chronic Disease Prevention Alliance

BADORREK, Ms Sally, Clinical Dietician, Nepean Family Metabolic Health Service

BARCLAY, Dr Alan, Private capacity

BARDEN, Ms Tanya, Chief Executive Officer, Australian Food & Grocery Council

BOYD, Ms Susan, President, Federation of Parents and Citizens Associations of New South Wales

BROOME, Mr John, Chief Executive Officer, Australian Association of National Advertisers

CATER, Mr Nick, Executive Director, Menzies Research Centre

CUNNINGHAM, Dr Frances Clare, Senior Research Fellow, Menzies School of Health Research

DAY, Ms Katinka, Campaigns and Policy Team Lead, CHOICE

DENNEY-WILSON, Professor Elizabeth, Professor of Nursing, Centre of Research Excellence in the Early Prevention of Obesity in Childhood

DOUMANI, Mr Patrick, Member Support Officer, Federation of Parents and Citizens Associations of New South Wales

FAIR, Ms Bridget, Chief Executive Officer, Free TV Australia

GOW, Dr Megan, Project Officer, The Children's Hospital at Westmead

JOHNSON, Professor Greg, Chief Executive Officer, Diabetes Australia

JOLLY, Ms Fiona, Chief Executive Officer, Ad Standards

JONES, Ms Alexandra, Research Fellow (Food Policy and Law), Food Policy Division, The George Institute for Global Health

JONES, Ms Alexandra, Research Fellow, Food Policy Division, The George Institute for Global Health

KIRKLAND, Mr Alan, Chief Executive Officer, CHOICE

LAM, Ms Sarah, Clinical Psychologist, Nepean Family Metabolic Health Service

LEE, Professor Amanda, Senior Adviser, Australian Prevention Partnership Centre

MIHRSHAHI, Dr Seema, Research Translation Coordinator and Senior Research Fellow, Centre of Research Excellence in the Early Prevention of Obesity in Childhood

MITCHELL, Mr Ross, Director of Broadcasting Policy, Free TV Australia MITCHELL, Ms Julie Anne, Director of Prevention, Heart Foundation; and Member, Australian Chronic Disease Prevention Alliance

NEAL, Prof. Bruce, Deputy Executive Director, The George Institute for Global Health

PARKER, Mr Geoff, Chief Executive Officer, Australian Beverages Council

PRATT, Mr Steve, Nutrition and Physical Activity Manager, Cancer Council Western Australia; and Member, Australian Chronic Disease Prevention Alliance

REEVE, Dr Belinda, Co-Founder, Food Governance Node

ROGUT, Mr Jeff, Chief Executive Officer, Australasian Association of Convenience Stores

SMITH, Mrs Belinda, Founder/Director, The Root Cause

WILLIAMS, Dr Kathryn, Clinical Lead and Manager, Nepean Family Metabolic Health Service

WILSON, Professor Andrew, Director, Australian Prevention Partnership Centre

7 August 2018–Melbourne

Members in attendance: Senators Colbeck, Di Natale, Singh, Storer.

Witnesses:

ALLENDER, Professor Steve, Director, Global Obesity Centre, World Health Collaborating Centre for Obesity Prevention, Deakin University

ALY, Mr Ahmad, President, Australian and New Zealand Metabolic and Obesity Surgery Society

BARNES, Mr Terry, Principal, Cormorant Policy Advice; and Fellow, Institute of Economic Affairs, United Kingdom

BLACK, Dr Nicole, Senior Research Fellow, Centre for Health Economics, Monash University; International Health Economics Association Special Interest Group on the Economics of Obesity

BOYLE, Associate Professor Jacqueline, Deputy Director and Obstetrician, Monash Centre for Health Research and Implementation

BROWN, Dr Vicki, Research Fellow, Deakin University; International Health Economics Association Special Interest Group on the Economics of Obesity

BRUKNER, Professor Peter, OAM , SugarByHalf

BUCKETT, Associate Professor Kevin, Deputy Chief Public Health Officer, SA Health

BUTERA, Ms Rita, Chief Executive Officer, Women's Health Victoria

DAVIES, Professor Peter, Chairperson, The Early Life Nutrition Coalition

DUCKETT, Dr Stephen, Director, Health Program, Grattan Institute

FARQUHARSON, Mrs Yvonne, Managing Director and Education Consultant, Filter Your Future

FARRELL, Dr Lucy, Research Assistant, School of Social Sciences, University of Adelaide

FRENCH, Ms Nicole, Steering Committee Member, Parents' Voice

HARRIS, Mr Ben, Manager, National Policy Strategy, Australian Health Policy Collaboration, Victoria University

HARRISON, Dr Cheryce, Research Fellow, Monash Centre for Health Research and Implementation

HARRY, Ms Sarah, Board Member, Health at Every Size Australia

JOVANOVSKI, Dr Natalie, Research Fellow, Swinburne University of Technology

KURZEME, Ms Ariana, Chair, Parents' Voice

LOWE, Mrs Janette, Executive Officer, Southern Grampians Glenelg Primary Care Partnership

MacKENZIE, Mrs Annabel, Biochemist, Nutritionist and Dietitian (Consultant), That Sugar Movement

MOORE, Prof. Vivienne, Professor, School of Public Health, University of Adelaide

PEETERS, Professor Anna, Associate Director, Global Obesity Centre, World Health Collaborating Centre for Obesity Prevention, Deakin University

PINCUS, Professor Jonathan James, Private capacity

PRYOR, Ms Alice, Campaigns Manager, Parents' Voice

SAWYER, Professor Susan, Director, Centre for Adolescent Health, The Royal Children's Hospital Melbourne

SKOCIC, Ms Vera, General Manager, and Co-Founder, That Sugar Movement

SKOUTERIS, Professor Helen, Monash Warwick Professor in Healthcare Improvement and Implementation Science, Monash Centre for Health Research and Implementation

TALBOT, Associate Professor Michael, Executive Member, Australian and New Zealand Metabolic and Obesity Surgery Society

WARIN, Prof. Megan, Australian Research Council Future Fellow, School of Social Sciences, University of Adelaide

WHITE, Dr Carolynne, Lecturer, Health Promotion, Swinburne University of Technology

4 September 2018–Melbourne

Members in attendance: Senators Di Natale, Paterson, Singh, Storer.

Witnesses:

BARTONE, Dr Tony, President, Australian Medical Association

BLACK, Christine, Director of Public Affairs, Communications and Sustainability, Coca-Cola Australia

BLOOM, Ms Kathryn, Legal Policy Adviser, Obesity Policy Coalition

BYRON, Ms Annette, Executive Manager, Policy and Advocacy, Dietitians Association of Australia

CAMERON, Ms Melissa, Human Health and Nutrition Policy Manager, Dairy Australia

CONNORS, Ms Cathy, Director, National Health and Medical Research Council

DAVEY, Dr Maureen, Public Health Medical Adviser, National Aboriginal Community Controlled Health Organisation

DEN HERTOOG, Miss Karen, Program Manager, Amsterdam Healthy Weight Program, City of Amsterdam

DIAMOND, Mr Mark, Chief Executive Officer, National Rural Health Alliance

GALLIGAN, Mr Dan, Chief Executive Officer, Australian CANEGROWERS Limited

GIBBONS, Prof. Kay, Fellow Member, Dietitians Association of Australia

HICKEY, Ms Katarnya, Legal Policy Adviser, Obesity Policy Coalition

JOHNSTON, Dr Ingrid, Senior Policy Officer, Public Health Association of Australia

KELLY, Associate Professor Bridget, Associate Professor of Public Health, Food and Movement Research Theme, Early Start, University of Wollongong

MANUELPILLAI, Dr Nicholas, Medical Doctor, Joep Lange Institute

MARAR, Mr Satyajeet, Director of Policy, Australian Taxpayers Alliance

MARTIN, Ms Jane Elizabeth, Executive Manager, Obesity Policy Coalition

NORMAN, Mrs Jenny, PhD Candidate, Public Health, Food and Movement Research Theme, Early Start, University of Wollongong; Accredited Practising Dietitian

PIETSCH, Mr David, CEO, Australian Sugar Milling Council

SANDISON, Mr Barry, Director, Australian Institute of Health and Welfare

SILK, Ms Katharine, Integration and Innovation Manager, Australian Healthcare and Hospitals Association

SINGH, Mr Alan, Executive Director, National Health and Medical Research Council

SLEVIN, Mr Terry, Chief Executive Officer, Public Health Association of Australia

SPARKE, Ms Claire, Head, Population Health Unit, Australian Institute of Health and Welfare

STAHLE, Dr Peter, Executive Director, Australian Dairy Products Federation

STUART, Ms Margaret, Corporate and External Relations Manager, Nestle Australia Ltd

THOMPSON, Ms Jennifer, Technical and Regulatory Manager, Ai Group Confectionery Sector, Australian Industry Group

THURECHT, Dr Linc, Senior Research Director, Australian Healthcare and Hospitals Association

TURNER, Ms Patricia, Chief Executive Officer, National Aboriginal Community Controlled Health Organisation

WALKER, Dr Joanne, Director, Policy and Strategy Development, National Rural Health Alliance

WATKINS, Ms Alison, Group Managing Director, Coca-Cola Amatil Ltd

WILLIAMS, Prof. Lauren, Fellow Member, Dietitians Association of Australia

YEATMAN, Professor Heather, Professor of Public Health, School of Health and Society, University of Wollongong

5 September 2018–Melbourne

Members in attendance: Senators Di Natale, Paterson, Singh.

Witnesses:

BLACK, Ms Jan, Senior Policy Adviser, Municipal Association of Victoria

COHEN, Ms Salli, Executive Director, Strategic Policy and Planning, NT Department of Health

de CHASTEL, Ms Liz, Senior Policy Adviser, Australian Local Government Association

FLYNN, Ms Elizabeth, Assistant Secretary, Preventive Health Policy Branch, Population Health and Sport Division, Department of Health

KELLY, Dr Paul, Chief Health Officer, Population Health Protection and Prevention, ACT Government

STUDDERT, Dr Lisa, Acting Deputy Secretary, Department of Health

