



Senate Select Committee into Obesity Epidemic in Australia

Inquiry into the obesity epidemic in Australia from the Aboriginal community controlled health sector, comprising:

National Aboriginal Community Controlled Health Organisation (NACCHO);

Winnunga Nimmityjah Aboriginal Health and Community Services (WNAH&CS);

Aboriginal Health and Medical Research Council (AH&MRC);

Aboriginal Medical Services Alliance Northern Territory (AMSANT);

Queensland Aboriginal and Islander Health Council (QAIHC);

Aboriginal Health Council of South Australia (AHCSA);

Tasmanian Aboriginal Corporation (TAC);

Victorian Aboriginal Community Controlled Health Organisation (VACCHO); and

Aboriginal Health Council of Western Australia (AHCWA).

The Aboriginal Community Controlled Health Sector

The National Aboriginal Community Controlled Health Organisation (NACCHO) is the peak body representing 143 Aboriginal Community Controlled Health Services (ACCHSs) across Australia. ACCHSs provide comprehensive primary health care to Aboriginal and Torres Strait Islander people through over 300 Aboriginal medical clinics throughout Australia. ACCHSs deliver three million episodes of care to around 350,000 people each year, servicing over 47% of the Aboriginal population, with about one million episodes of care delivered in remote areas.

The Aboriginal Community Controlled Health Service (ACCHS) sector is the largest single employer of Indigenous people in the country, employing 6,000 staff, the majority of whom are Aboriginal or Torres Strait Islander.

The evidence that the ACCHS model of comprehensive primary health care delivers better outcomes than mainstream services for Aboriginal people is well established. Without exception, where Aboriginal people and communities lead, define, design, control and deliver services and programs to their communities, they achieve improved outcomes.ⁱ The ACCHS model of care has its genesis in Aboriginal people's right to self-determination, and is predicated on principles that incorporate a holistic, person-centred, whole-of-life, culturally secure approach. The ACCHS principles of self-determination and community control remain central to wellbeing and sovereignty of Aboriginal people. Equipped with inequitable levels of funding and resourcesⁱⁱ, ACCHSs continue to meet the ongoing challenges of addressing the burden of disease in Aboriginal communities.

Executive Summary

The National Aboriginal Community Controlled Health Organisation (NACCHO) welcomes the opportunity to provide input into the ***Inquiry into the Obesity epidemic in Australia***.

Aboriginal and Torres Strait Islander people represent approximately 3% of the Australian population yet are disproportionately over-represented on almost every indicium of social, health and wellbeing determinant.ⁱⁱⁱ Social determinants and historical factors such as intergenerational trauma, racism, social exclusion, and loss of land and culture are commonly recognised as causative factors for these disparities.

In 2008 the Council of Australian Governments (COAG) committed to addressing the health disparity between Aboriginal and Torres Strait Islander peoples and non-Indigenous Australians by adopting the *Closing the Gap* initiative. Whilst gaining some success in achieving convergence for some health indicators, wide health and wellbeing disparity still remains for both children and adults. The life expectancy gap between Indigenous and non-Indigenous Australians remains 10.6 years for males and 9.5 years for females.^{iv} As a major contributor to morbidity and mortality among Indigenous Australians, obesity is estimated to account for 16% of the health gap between Aboriginal and Torres Strait Islander peoples and the total Australian population.^v

The 2012-13 Health Survey identified that Indigenous adults were 1.6 times as likely to be obese as non-Indigenous Australians, with the prevalence increasing more rapidly in Aboriginal school-aged children.^{vi} Overweight and obesity in childhood are important predictors of adult adiposity, increasing the risk of developing a range of medical conditions, each of which is a major cause of morbidity, mortality and health expenditure. While it is surprisingly clear what needs to be done to improve the health of Indigenous children, recent cuts to Indigenous preventative workforce and nutrition programs throughout Australia have severely reduced the capacity to respond.

Comprehensive primary health care is a key strategy for improving the health of Indigenous Australians and is an important platform from which to address complex health and social issues associated with obesity. Closing the Gap, including the gap attributable to obesity, requires ensuring the ACCHS sector is resourced to deliver the full range of core services required under a comprehensive and culturally safe model of primary health care. The effectiveness of ACCHSs has long been recognised, with many able to document better health outcomes than mainstream services for the communities they serve.

Combating the burden of obesity and its health effects for Indigenous Australians demands a strategic and coordinated whole-of-society approach at a national level by the Federal Government. Without coordinated, sustained national action, efforts to improve the health status of Aboriginal children are likely to fail. In recognising the need to seriously address this critical and increasing gap in Indigenous health, NACCHO welcomes this inquiry and proposes the following recommendations:

- Government to work in partnership with NACCHO and the ACCHS sector to develop policies and plans that are responsive to the needs of Aboriginal communities
- A commitment to increase the understanding of Aboriginal and Torres Strait Islander peoples of the health significance of overweight and obesity, and facilitating access for these communities to resources which support healthy eating and physical activity
- Additional investment to build organisational capacity within the ACCHS sector and to increase the capacity of Aboriginal Health Promotion Officers to maintain a focus on public health initiatives

- Government to encourage professional support systems for, and assist Aboriginal Health Worker's and other primary care workers to provide advice to adults and children about weight management as part of existing health checks and screening programs – this may be achieved by encouraging the MBS Aboriginal Health Check item to communicate more effectively the importance of physical activity, nutrition and weight management
- Fund the development of Aboriginal and Torres Strait Islander cultural awareness training for health care professionals covering care, education and information relating to food, physical activity, lifestyle choices and health service arrangements
- In understanding that health promotion is more difficult in regional and rural Australia, targeted funding should be dedicated to these areas to overcome the pervasive problems associated with distance
- A commitment to ongoing consultation with Aboriginal communities on what can be achieved at a local level to effectively promote healthy eating and physical activity for children
- Facilitate access for Aboriginal and Torres Strait Islander communities to resources which support lifestyle changes, including access to information, physical activity opportunities, and healthy food choices
- The prevalence of childhood obesity and the absence of culturally specific programs for Aboriginal and Torres Strait Islander people warrants further work in the development of culturally appropriate programs and tailored communication strategies alongside mainstream campaigns and messages
- Given the paucity of studies on Indigenous children, there is a need for further research on effective obesity prevention interventions for Indigenous families. This requires commitment to more detailed monitoring of young Indigenous children's diets and their physical activity
- Government to work with the food industry and community stores to implement retail intervention strategies to positively influence access to and consumption of healthy food choices for Aboriginal and Torres Strait Islander communities
- Consider mechanisms to sustain programs on physical activity, nutrition and weight management that have proven effective
- Ensure significant participation of Aboriginal and Torres Strait Islander people in national surveys and evaluations by enhancing the sampling frame and applying culturally appropriate recruitment strategies

Prevalence of overweight and obesity among Aboriginal and Torres Strait Islander children in Australia and changes in these rates over time

The increasing prevalence of childhood obesity is considered a major epidemic in many industrialised countries of the world today. In recognising that the number of obese children and adolescents has increased tenfold in the last 40 years, the World Health Organization established the *Commission on Ending Childhood Obesity* to identify effective approaches and interventions to tackle childhood and adolescent obesity in different contexts around the world. Obesity has been steadily increasing in Australia for the past 30 years, with the occurrence amongst children one of the highest in the world.

Until recently there has been a paucity of data on the prevalence of obesity in Indigenous Australian children, with national data only recently becoming available. Childhood is a critical

period in which inequalities in health determinants emerge, with research indicating that rates of overweight and obesity have increased more rapidly in Aboriginal than non-Aboriginal school-aged children,^{vii} suggesting a disparity in health status and health outcomes.

In 2012–13, nearly one-third of Aboriginal and Torres Strait Islander children between 2 and 14 years were more likely than non-Indigenous children to be overweight or obese (30% compared with 25%). Obesity rates for Indigenous children increased from the age of 5, with the highest rates at 10-14 years (12%).^{viii} A disparity in rates is also evident in adolescence, with two-thirds of Aboriginal and Torres Strait Islander people aged 15 and over being overweight or obese.^{ix} Alarming, in a large representative sample of Australian children aged 4–5 years, Aboriginal and Torres Strait Islander children were estimated to be 50% more likely to be overweight or obese compared to non-Indigenous children.^x

The gap in weight status between Indigenous and non-Indigenous children has widened over time. A recently published study of weight trends of children in NSW shows that from 1997 to 2010 rates of excess weight and obesity rose 22.4% in Aboriginal children, compared with 11.8% in non-Aboriginal children.^{xi} These rates vary geographically, with the highest rates in inner regional areas (40%) and the lowest in very remote areas (32%). By jurisdiction, obesity rates ranged from 41% in NSW to 29% in the NT.

Various other studies have documented the increased prevalence of obesity in Indigenous children, including a 2010 study conducted in an urban Aboriginal medical service finding that 36% of children who underwent an Aboriginal and Torres Strait Islander health check were overweight or obese.^{xii} Similarly, health checks performed on children in remote Aboriginal communities in Central Australia showed that 21.4% of children were overweight and 5.4% obese.^{xiii}

A study in the ACT demonstrated a statistically significantly higher prevalence of overweight and obesity in Indigenous kindergarten children compared to non-Indigenous children.^{xiv} The reliability of the data was assisted by the high response rate with the proportion of Indigenous people in the study (1.8%) being similar to that of the Australian population. The findings were consistent with previous research, mirroring a broader national trend of increased burden of disease among Indigenous Australian children.

Evidence is mounting that early intervention is critical. A study of urban Australian Aboriginal infants has shown that 37% were overweight or obese at two years of age, and those experiencing rapid weight gain in the first year of life were more likely to be overweight and obese.^{xv} Consistent with this data is evidence that other Indigenous populations, including Native Americans and Alaskan Natives also experience higher rates of obesity and excessive weight gain in the first two years of life.^{xvi xvii}

While less is known about the relationship between Indigenous status and obesity in children, predictors of child obesity including poorer diets and sedentary behaviours are more prevalent in Indigenous children. With a higher exposure to obesogenic environments, it is imperative there are effective healthy behaviour interventions early in life for Indigenous children and families.

The causes of the rise in overweight and obesity in Indigenous Australians

The factors contributing to overweight and obesity among Indigenous peoples are varied and complex. As with many other aspects of Indigenous health, geographical, social, historical and economic factors are likely to be major contributors, though it has been suggested that genetic factors also contribute.^{xviii}

Overweight and obesity is generally caused by an energy imbalance over a sustained period of time.^{xxix} A lack of physical activity and poor nutrition are major contributing factors, increasing the risk of the burden of disease in the Aboriginal and Torres Strait Islander population.

Evidence suggests that predictors of childhood obesity early in life, such as unhealthy infant feeding practices, poorer diet, and sedentary behaviours are more prevalent in Indigenous families.^{xx} Poor nutrition in the first five years of life and low birth weight are critical to the development of obesity and chronic disease. As core components of comprehensive primary health care, well-resourced antenatal, maternal and child health services have the ability to encourage and support programs to monitor infant growth and development and provide support and advice to parents about child nutrition, growth, and healthy family initiatives. In recognising the ACCHS sector as best placed to provide comprehensive primary care to Indigenous people, all ACCHSs should be resourced to deliver such services as a critical investment in future health.

Since European occupation of Australia, Indigenous people have experienced many lifestyle, dietary and physical changes. Once high in nutrient density and low in energy density, Indigenous diets today are high in refined carbohydrates and saturated fats,^{xxi} increasing the risk of developing nutrition-related diseases such as heart disease, Type-2 diabetes and renal diseases. Arguably, the transition from a hunter-gatherer lifestyle to a Westernised lifestyle is a major contributing factor.

A recent NSW study found that compared with other children, Aboriginal children have significantly lower odds of eating breakfast. They were also more likely to drink one cup of soft drink a day, eat dinner in front of the TV, and watch excessive amounts of TV during the week.^{xxii} Additionally, studies of exercise levels in non-remote areas have shown that three in five (62%) Aboriginal and Torres Strait Islander people aged 18 and over reported that they were physically inactive in the previous week; less than half (43%) aged 15 and over reported eating an adequate amount of fruit each day; and only 5% reported eating an adequate amount of vegetables each day.^{xxiii}

The relationship of remoteness to health and accessing nutritional food is particularly important for Indigenous Australians, as they are more likely than non-Indigenous Australians to live outside metropolitan areas.^{xxiv} In 2011, only 1.7% of non-Indigenous Australians lived in remote or very remote areas, compared with almost one-fifth of Indigenous Australians. Of consequence, Indigenous people are disproportionately affected by a 'deprivation amplification',^{xxv} contributing to a higher rate of food insecurity. Food prices tend to be high and choices limited. In the Northern Territory, for example, the cost of a standard food basket is 45% higher in remote communities than it is in the capital, Darwin.^{xxvi} If available, fresh healthy foods are often prohibitively expensive, which encourages people to consume cheaper, energy-dense foods which contribute to the increasing prevalence of obesity.

The short and long-term harm to health associated with obesity, particularly in Australian Indigenous children

The burden of ill-health among Indigenous Australians is far greater than that of the general population, particularly with regard to nutrition-related chronic disease.^{xxvii} As a major contributor to morbidity and mortality, obesity is estimated to account for 16% of the health gap between Aboriginal and Torres Strait Islander peoples and the total non-Indigenous Australian population. If this trend of increasing rates of obesity and chronic disease continues, particularly among Indigenous children, the gap in life expectancy is set to widen, not close.

The effects of obesity on health outcomes has been recognised within the broader international discourse, with Governments endorsing nine global voluntary targets to reduce

premature death from the four major non-communicable diseases by 25% by 2025. A target to halve the rise in diabetes and obesity was recognised as vital, in conjunction with targets to reduce the overall mortality from particular obesogenic-related diseases, including cardiovascular disease and diabetes, as well as a reduction in the relative decreased levels of physical activity.

Overweight and obese children are more likely to become overweight and obese as adults, with risk factors such as poor diet and lack of physical activity established in childhood often persisting in adulthood. Obese children today are increasingly affected by disease and health problems previously observed only in adults. Chronic illnesses like diabetes and heart disease have an earlier onset and prolonged course in children, with more severe complications and shorter lifespans.^{xxviii}

Obesity is causative for many chronic diseases including diabetes, cardiovascular disease, hypertension, osteoporosis, ischaemic heart disease, stroke, asthma and polycystic ovarian syndrome^{xxix}, with Aboriginal and Torres Strait Islander children at higher risk. These health issues have lowered life expectancy for Aboriginal Australians to 17 years below the national life expectancy, a gap that continues to grow. The observed increase in Type-2 diabetes among Indigenous Australian children in particular is estimated to decrease a child's life expectancy by up to 27 years.^{xxx}

Professor Paul Zimmet of Monash University released figures at a 2006 *Diabetes in Indigenous People Forum* in Melbourne, estimating the rate of diabetes from poor diet to be 24% of all Aboriginal and Torres Strait Islanders, and remarked that without urgent action, there is a 'real risk' that Aboriginal and Torres Strait Islander people would die out by the end of the century.

In weakening a child's quality of life, obesity also has many psychosocial consequences that contribute to a delay in academic and social functioning, as well as poor self-esteem and depression. Obesity often exposes children to teasing, discrimination, social exclusion and victimisation, and is linked with school absenteeism and poor school performance.^{xxxi xxxii}

The short and long-term economic burden of obesity

Beyond the individual risks and quality of life associated with obesity, there is a vast societal and economic burden through the associated direct and indirect costs. Recent studies and reviews have indicated that a gradient exists between increasing body mass index (BMI) and costs attributable to obesity.^{xxxiii} Significant economic consequences include increased health-care costs and a higher demand on health-care services, carers costs, lost productivity and forgone taxation revenue.^{xxxiv}

Data from the Australian Diabetes, Obesity and Lifestyle (AusDiab) study indicate that the total direct cost for overweight and obesity in 2005 was \$21 billion (\$6.5 billion for overweight and \$14.5 billion for obesity), with the annual cost of government subsidies for the overweight and obese estimated to be \$3917 per person. The same study estimated indirect costs of \$35.6 billion per year, resulting in a total annual cost of \$56.6 billion. In 2008 this total annual cost, including health system costs, lost productivity and carers' costs, was estimated by the Australian Bureau of Statistics to be around \$58 billion.^{xxxv}

A recent evidence-based report from Obesity Australia in partnership with PwC looked ahead to 2025 and costed a number of interventions including parental education, school curriculum, food labelling, tax on unhealthy foods and bariatric surgery – which is estimated to cost \$1.3 billion, and lead to savings of \$2.1 billion.^{xxxvi} The increase in the consumption of fruit and vegetables in the Australian population by one serve per day has been estimated to save the health system \$157 million annually, in relation to heart disease alone.^{xxxvii}

Undeniably the prevalence of obesity among Australians, particularly Indigenous Australians, is dire, with hospitals around the country struggling to manage the ever-increasing intake of obese patients. To reduce the economic burden associated with obesity, importance should be placed on pursuing and intensifying current measures aimed at promoting healthy lifestyles and altering the environments in which we live so they become more conducive to healthy eating and physical activity. Indeed, international recommendations stress the importance of working to change not only individual behaviour, but also the physical, economic, political and socio-cultural environments that shape our everyday habits.^{xxxviii} Long-term efforts will be required for the creation of living environments that make healthy choices the easiest ones.

Policies and programs introduced by Australian governments to improve diets and prevent childhood obesity

In recent years, the body of literature on childhood obesity interventions has increased considerably, however a 2014 systematic review identified that evidence for programs that have been adapted to better suit Indigenous children are lacking and of a low quality.^{xxxix} Data gaps compromise our ability to devise appropriate interventions to prevent children becoming overweight and provide treatment to children who are already overweight or obese. Given the tendency for Aboriginal people to exhibit central adiposity and their increased risk of cardiovascular disease and diabetes, it would appear that effective strategies to support healthy eating and physical activity in Indigenous Australian children should be a priority if the gap in life expectancy between Indigenous and non-Indigenous people is to be closed.

Although causes of obesity remain complex, prevention still offers a less expensive approach as opposed to treatment.^{xl} To date, there has been a limited evidence base to guide the development of programs and policies for prevention strategies. Although the National Preventative Health Taskforce have provided some key approaches, Australian Governments have, on the whole, been slow to act in designing policies specifically aimed at supporting the Indigenous population.^{xli}

There are programs in existence that have targeted Indigenous adults who are already overweight or obese, an early example being the 'Healthy Weight Program' which began in Queensland in 1996, where a majority of participants were able to lose weight and decrease waist and hip measurements. Most programs to address obesity amongst Indigenous people have focused on adults, with those focused on children predominantly delivered in and by schools.^{xlii}

There is a long history of effort to improve diet, nutrition and food security among Aboriginal and Torres Strait Islander people, however since the expiry of the *National Aboriginal and Torres Strait Islander nutrition strategy and action plan 2000–2010 (NATSINSAP)* there has been no specific food or nutrition policy targeting these issues. An evaluation of NATSINSAP found there has been very little action in the areas of household food security or nutrition issues, and that governance issues and inadequate resource allocation compromised the necessary operational capacity to drive implementation.^{xliii xliiv} The evaluation recommended that the strategy and action plan be revised and updated '*through a consultative process, and that it be adequately funded and embedded in emergency policy frameworks with clear accountability and reporting requirements*', however this has not eventuated and coordinated implementation of the NATSINSAP has ceased.

The ACT Government have demonstrated that childhood obesity remains an important policy issue, investing \$2.2 million in Healthy Canberra Grants to fund programs targeting childhood obesity.^{xlv} Campaigns such as the 'Go for 2 & 5', 'Get Moving', and 'Get Set 4 Life – Habits for Healthy Kids' have all focused on encouraging good nutrition and regular physical activity amongst children. Such initiatives, however, are general and not targeted to, or culturally

appropriate for Aboriginal and Torres Strait Islander children. The more specific and tailored Australian Government's *Indigenous Australians' Health Programme* (IAHP) was established to actively promote healthier lifestyle choices with culturally secure community education, health promotion and social marketing activities.

The NSW Government have committed to reduce overweight and obesity rates of children by 5% by 2025. So far, their programs have stabilised overweight and obesity rates in children in NSW to 21.4% in 2016.^{xlvi} As part of this commitment, the *Active Kids* initiative plans to involve more NSW children and young people in physical activity, and the healthy school canteen strategy focuses on the availability of healthy food and drink options in schools. Additionally, the *Go4Fun* community-based program for Aboriginal families will deliver an adapted program to regional and remote communities through face-to-face group discussions, online and over the phone. As this is a relatively new initiative, evaluation of success has not been completed.

In 2014 the Australian Government launched the *Healthy Bodies Need Healthy Drinks* resource package, encouraging school-aged children, their families and communities to choose water instead of high-sugar drinks. National evidence exists for the consumption of sugar-sweetened drinks leading to weight gain. This is particularly important for Aboriginal and Torres Strait Islander children who consume higher quantities of sugary-drinks.^{xlvii}

Overall, more than 100 nutrition projects alone have commenced in Indigenous communities, but many have failed because of poor levels of resourcing and evaluation. Programs that have proven successful in Indigenous families and communities have been consistently-delivered, inclusive, flexible, strengths-focused and holistic.^{xlviii} Initiatives targeting obesity in Indigenous children need to be championed by Aboriginal and Torres Strait Islander community members and through the ACCHS sector, who are best placed to deliver culturally appropriate care. Genuine partnerships should also be formed for the design of Indigenous specific healthy lifestyle programs; community-based projects that have been evaluated are found to be more effective when initiated and managed by the community, with technical and financial support from both Government and external organisations.^{xlix}

Evidence-based measures and interventions to prevent and reverse childhood obesity, including experiences from overseas jurisdictions

Evidence-based profiling of obesity and overweight in Indigenous Australian children has been poor, with very little known about the effectiveness of culturally adapted children's interventions. Given the impact on health, finances and community, the need for better strategies and interventions to manage obesity are now being recognised by the entire health system.

Historically, initiatives have focused on nutrition or physical activity as separate entities and have shown modest effects. In recent years, global interventions considering the wider 'obesogenic environment' have been recommended, with policymakers and public health practitioners increasingly turning to evidence-based strategies to discover effective interventions to childhood obesity. It is important to note, however, that the rapidly growing body of literature has meant many recommendations for childhood obesity have often relied on research that has not been systematically reviewed and focused more on assessing the internal validity of study results than on evaluating the external validity, feasibility or sustainability of intervention effects.ⁱ

Experience in several countries has shown that successful obesity prevention during childhood can be achieved through a combination of population-based initiatives.ⁱⁱ There is strong evidence for the effectiveness of school-based strategies, acting as an ideal setting for interventions to support healthy behaviours, and can also potentially reach most school age

children of diverse ethnic and socioeconomic groups. The Centre for Disease Control and Prevention (CDC) recommends a curriculum that is culturally appropriate and a school environment that reflects the culture within the community by demonstrating cultural awareness in healthy eating and physical activity practices.ⁱⁱⁱ

Examples of school-based strategies include policies that limit student access to foods and beverages that are high in fats and sugar, contributing to decreased consumption during the school dayⁱⁱⁱ, and efforts to increase physical activity leading to a lowered body mass index^{iv} and improved cognitive abilities,^{iv} especially in younger children. An evaluation of a school-based health education program for urban Indigenous youth found compromising results in physical activity, breakfast intake and fruit and vegetable consumption, all of which are core components of healthy weight management.^{vi}

Studies have examined the effectiveness of culturally specific versions of programs to tackle obesity, including a US study comparing a mainstream program with a culturally adapted version. Findings were that cultural adaptations improved recruitment and retention numbers, with the authors recommending that to improve program design, ethnic communities and organisations should be approached to collaborate with researchers in design, modifications, recruitment techniques, implementation, evaluation and interpretation of results.^{vii}

A 2013 Canadian pilot evaluation of a whole-school health promotion program, *Healthy Buddies*, involved researchers consulting Aboriginal community members about how the program could be more effective, sustainable and culturally appropriate, resulting in a new version called *Healthy Buddies – First Nations*. Prior to implementation, communities were able to review the program and tailor its cultural appropriateness. Lesson content and visual aids were amended to resemble Aboriginal children, as well as Aboriginal food and activities.^{viii} In promoting social responsibility through the buddy system, the program showed a significant lowering in BMI and waist circumference and was considered particularly important for remote communities.

Systematic and evidence-based reviews have suggested promise in tailoring programs to be more culturally appropriate for specific ethnic and culturally diverse groups. The 2014 Global Nutrition Report, which examined the limited access to supermarkets and a reliance on fast-food as contributing to the growing prevalence of obesity in American Indian communities, recommended that interventions need to be multi-faceted, culturally sensitive, grounded in cultural traditions, and developed with full participation of American Indian communities.^{lix} Similar recommendations were made in a review by Toronto Public Health, identifying that interventions targeting children from low socioeconomic or culturally diverse backgrounds can positively impact on physical activity levels and dietary intake. This highlights the need to consider focusing on specific cultural backgrounds, like Indigenous Australians, when planning obesity prevention interventions to achieve better outcomes.

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

Improving the access to and availability of nutritious food is a vital step to combating the prevalence of obesity. Indigenous people living in rural and remote areas in particular face significant barriers in accessing nutritious and affordable food.^{lx} The level and composition of food intake is influenced by socio-economic status, high prices, poor quality fruit and vegetables in community stores, and unavailability of many nutritious foods.^{lxi} This is indeed exacerbated by the exposure to high levels of unhealthy food marketing across a range of media.

The ubiquitous marketing of unhealthy food creates a negative food culture, undermining nutrition recommendations. Substantial research documents the extensiveness and persuasive nature of food marketing in Australia; importantly, the vast majority of all food and drink marketing, regardless of medium or setting, is for food and drinks high in fat, sugar and/or salt.^{lxii} Australian children are exposed to high levels of unhealthy food marketing through a range of mediums, including sponsorship arrangements with children's sport. With research identifying a logical sequence of effects linking food promotion to individual-level weight outcomes,^{lxiii} it is clear that food marketing influences children's attitudes and subsequent food consumption.

Australia's National Preventative Health Taskforce has highlighted the importance of restricting inappropriate marketing of unhealthy food and beverages to children as a cost-effective obesity prevention strategy.^{lxiv} Clear affirmative action in Australia to such marketing has been lacking to date, compounding the need for Government to explore options for regulating the production, marketing and sale of energy-dense and nutrient-poor products to reduce consumption.

Research has shown that the prevalence of obesity increases and consumption of fruit and vegetables decreases with increasing distance to grocery stores and supermarkets^{lxv} and a higher density of convenience stores and take-away food outlets.^{lxvi} Cost is also a major issue, with the price of basic healthy foods increased by 50% or more in rural and remote areas where there is a higher proportion of Indigenous residents compared to non-Indigenous residents than in urban areas.^{lxvii} The purchasing behaviour of children is particularly sensitive to price, and can have significant effects over time.

Foods of better nutritional choice, including fresh fruits and vegetables, are often expensive due to transportation and overhead costs, or only minimally available.^{lxviii} Comparatively, takeaway and convenience food, often energy-dense and high in fat or sugar, are less affected by cost and availability.^{lxix}

A study of intake of six remote Aboriginal communities, based on store turnover, found that intake of energy, fat and sugar was excessive, with fatty meats making the largest contribution to fat intake.^{lxx} Compared with national data, intake of sweet and carbonated beverages and sugar was much higher in these communities, with the proportion of energy derived from refined sugars approximately four times the recommended intake.

Recent evidence from Mexico indicates that implementing health-related taxes on sugary drinks and on 'junk' food can decrease purchase of these foods and drinks.^{lxxi} A recent Australian study predicted that increasing the price of sugary drinks by 20% could reduce consumption by 12.6%.^{lxxii} Revenue raised by such a measure could be directed to an evaluation of effectiveness and in the longer term be used to subsidise and market healthy food choices as well as promotion of physical activity.

It is imperative that all of these interventions to promote healthy eating should have community-ownership and not undermine the cultural importance of family social events, the role of Elders, or traditional preferences for some food. Food supply in Indigenous communities needs to ensure healthy, good quality foods are available at affordable prices.

In Summary

It is widely understood that many Aboriginal and Torres Strait Islander people, predominantly children, are at high-risk of ill-health due to overweight and obesity. This is likely to lead to a widening gap in health outcomes for Indigenous Australians if prevention efforts are not improved. Despite the identified health and economic gains which can be achieved by using

a social determinants and culturally appropriate approach, Australia is yet to embed such thinking in health policy.^{lxxiii}

Policy in isolation will not solve the epidemic of childhood obesity for Indigenous children. What is required, is urgent action to address poverty, education, unemployment and housing, all of which are factors that shape a child's ability to engage with healthy behaviours. There also needs to be close ongoing national monitoring through the collection of comparable data; more detailed monitoring of the composition of young Indigenous children's diets and physical activity is necessary to determine whether patterns are changing in response to interventions.

Undeniably, strategic investment is needed to implement population-based childhood obesity prevention programs which are effective and also culturally appropriate, evidence-based, easily understood, action-oriented and motivating. Interventions must be positioned within broad strategies addressing the continuing social and economic disadvantages that many Indigenous people experience and need to have an emphasis on training community-based health workers, particularly in the ACCHS sector who are best placed to respond to the increasing rates of obesity and associated health concerns for Aboriginal and Torres Strait Islander people.

The ACCH sector has a central role in promoting and improving health outcomes for Indigenous people yet requires additional targeted funding and resources to implement new initiatives, including intervention, education, and research to encourage physical activity and healthy nutrition. Indeed, multifaceted strategies involving the public, private and ACCHS sector, along with community participation and government support, are required to gradually reverse this trend.

NACCHO and its Affiliates in each State and Territory appreciate the opportunity to make this submission on behalf of our member services. With circumstances unimproved after years of policy approaches, the need remains to overturn the prevalence of overweight and obesity of Indigenous people. There needs to be a commitment at all levels of government in terms of funding, policy development, and support for the implementation of culturally appropriate programs and services. There must be a recognition that self-determination of Aboriginal and Torres Strait Islander people will be the foundation of true progress.

NACCHO strongly recommend that Government engage in meaningful dialogue with NACCHO, NACCHO's Affiliates in each State and Territory and ACCHSs in relation to the proposals canvassed in this response; and work in partnership to address the significant prevalence of obesity in Aboriginal and Torres Strait Islander people, especially children.

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