Submission No 28

REVIEW OF ROAD SAFETY ISSUES FOR FUTURE INQUIRY

Organisation: Australian Medical Association (NSW)

Date Received: 20 September 2018

From the President's Office
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17 September 2018

AMA (NSW): Review of road safety issues for future inquiry

Dear Mr Hale,

Thank you for the opportunity to provide a submission to StaySafe's review of road safety issues for future inquiry.

AMA (NSW) is a medico-political organisation that represents more than 9,000 doctors-in-training, career medical officers, staff specialists, visiting medical officers and specialists and general practitioners in private practice in NSW.

AMA (NSW) collaborated with the NSW Centre for Road Safety on its hard-hitting 'Don't Rush' campaign. Based on the experiences of medical professionals, this jointly-badged initiative featured Professor Brian Owler and highlighted the human and emotional costs associated with unsafe driving behaviour.

The campaign focused on speeding and driver fatigue, but it also emphasised that there are consequences for speeding, and that unsafe driving impacts on more than the individuals involved in the crash. Other messages included, speeding is socially unacceptable, slowing down to suit road conditions will reduce your chances of a crash and the motto 'Stop. Revive. Survive.'

The campaign was extremely effective. An evaluation revealed that since it was launched in 2010, more than 80% of people surveyed reported that they recall seeing the 'Don't Rush' and its related 'Multiple Choices' and 'Testimonials' campaigns.

Campaign Benchmark testing results found 90% of people thought the campaign was credible, believable, informative and showed important information. The results remained consistent over time.

Importantly, more than half of respondents were motivated to change their driving behaviour and indicated they would take more care in sticking to the speed limit.

Crash and casualty statistics reveal that total number of NSW road fatalities dropped from 405 in 2010 to 307 in 2014. That number has since started to climb back up, with 391 fatalities recorded in 2017.

The positive impact of the 'Don't Rush' campaign highlights that strong investment in prevention campaigns is worthwhile, and that effective advertising can influence behaviour.

It also highlights the importance of making public health a prominent part of road safety discussions.

Obesity is a national crisis and deserves a response that is commensurate with its prevalence and impact on individuals and society. Overweight and obesity was responsible for 7% of the total health burden in Australia in 2011, 63% of which was fatal burden.

Medical professionals have an important role to play in tackling this health crisis, which is why AMA (NSW) has made obesity one of its key advocacy campaigns.

AMA (NSW) supports the development of built environments that contribute to healthier, more active lifestyles. The adoption of Health Impact Assessments would help Government assess transport policies, programs and projects as to potential effects on the health of the population, and the distribution of those effects within the population.

Research indicates more people would cycle, walk, and exercise outside if their physical environment was safer. The connection between road safety, exercise and obesity means there is significant opportunity to create an impactful campaign that focuses on both prevention awareness and public health.

(Please find attachments: Obesity-2016-AMA-Position-Statement and Road Safety-2018-AMA-position-statement)

Yours sincerely,

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Road Safety
2018

Introduction
Every day, on average, three people die on Australian roads and a further 90 are seriously injured – two permanently.

According to the research, since data on the road toll began in 1925, there have been more than 189,000 deaths on Australia's roads.[1] The cost of road trauma to the Australian community is tragic and widespread. The annual economic cost of road crashes in Australia is estimated at $27 billion per annum[2], and the social impacts are overwhelming.

Road accidents are predominantly the result of:

- speeding;
- fatigue;
- driver distractions;
- disobeying road rules;
- reckless driving;
- alcohol and substance abuse;
- non-use of seat-belts, restraints and helmets;
- unsafe roads;
- unsafe vehicles;
- inexperienced driving; and
- inadequate law enforcement.[3]

Risk-taking behaviours also account for too many lives lost and harmed on Australian roads. Medical practitioners, along with paramedics, ambulance officers and nurses, frequently witness the tragic consequences of road trauma. They see when road safety is ignored and when avoidable accidents occur – accidents that take lives and cause horrific injuries.

The Australian Medical Association (AMA) is committed to advocating for improvements in the way Australians drive, the cars they drive, and the roads they drive on.

In Australia, we have managed to substantially reduce road trauma, especially in the past few decades with the introduction of preventive measures such as random breath tests, seat belts, and improved automobile technology. The AMA supports measures that change driver behaviour and change the culture and mentality about speeding and driver distraction, especially with mobile devices. There needs to be far greater emphasis on driver fatigue and tougher enforcement of the laws governing road use, including for pedestrians.

The AMA also supports new technologies that make cars safer and reduce road accidents, and wants to see more investment in improving the safety of Australian roads.

By making drivers more responsible, more aware and more conscious of their behaviour and its consequences, and by providing safer vehicles on our roads, the AMA believes we will see further reductions in preventable road fatalities and injuries.

AMA Position

- The AMA supports the *National Road Safety Strategy 2011-2020*, which aims to reduce the annual numbers of deaths and serious injuries by at least 30 per cent by 2020.[4]
- Australians should be driving the safest cars on the safest roads.
- Reducing road accidents and road trauma requires investment by governments, industry, and the community.

- A driver's licence is a privilege, not a right, and drivers who breach road rules should face meaningful sanctions, restrictions or licence suspension.
- The use of mobile telephones and electronic devices, including navigational devices, by drivers is a distraction and a major cause of accidents, trauma and death. Laws must be strictly enforced and meaningful sanctions must apply to drivers who text or use mobile devices.
- Zero tolerance of P-plate and L-plate drivers who use mobile or electronic devices, or breach any road rules, should be enforced, including loss of licence for up to one year.
- Greater controls need to be applied to L-plate drivers to ensure they meet their supervised driver training requirements, are supervised by a competent and experienced driver, and comply with log book regulations.[5]
- Pedestrians and cyclists using headphones and earpieces, or using mobile devices, pose a serious safety risk and are a factor in motor vehicle accidents.
- Fundamentals of road rules, including responsibility of pedestrians, must be formally instilled from a very young age through nationwide standards of education to young people about road rules.
- Preventive measures, such as random breath and drug tests, seat belts, and speed cameras, will substantially reduce road trauma in Australia.
- Enforcement of speed limits and greater compliance, especially around school zones and hospitals, is needed to reduce road accidents and road trauma.
- Driver fatigue is one of the top three contributors to Australia's road toll, and governments and stakeholders need to reinforce the dangers of driver fatigue. With drink driving, Australia has laws and systems in place to stop and apprehend those over the limit, and licences are cancelled as a result. The development of legislation regarding driver fatigue is desirable and consideration needs to be given to how this could occur.
- New automobile technologies, such as vehicle safety assist technologies (SAT), Autonomous Emergency Braking (AEB), which reduces rear-end accidents, and lane keep assist (LKA) can prevent car accidents or minimise the effects and subsequent injuries and associated costs of car accidents. These sophisticated technologies will lead the way in reducing road trauma and should be incorporated into new cars[6].
- Mandatory use of approved helmets for motorcycle and bicycle riders, and the wearing of appropriate protective clothing, will save lives and reduce road trauma.
- The growing popularity of e-bikes (bicycles fitted with an electric motor to provide power-assistance) requires both increased education and training and also appropriate regulations for their use and interaction on public roads.[7]
- Motor vehicles should be separated from cyclists through dedicated bicycle lanes for cyclists.
- Community-led road safety initiatives, such as Black Spot programs, and identification of local traffic issues have the potential to reduce road fatalities and injuries.
- The AMA endorses *Assessing Fitness to Drive: medical standards for licensing and clinical management guidelines*. *A resource for health professionals in Australia (October 2016).*[8]
- All States and Territories must adopt uniform criteria for assessing the functional ability of older drivers, as the discrepancies between jurisdictions are problematic.
- Medical practitioners should assist older drivers in assessing their ability and confidence to drive, and provide advice on when to retire from driving. This may require medical examinations or assessments of drivers beyond a specified age.

- Road safety public information campaigns encouraging older drivers to liaise with their medical practitioners about their fitness to drive will assist in encouraging older people to recognise when they are no longer safe to be driving a vehicle or motorcycle.

- Medical practitioners are encouraged to inform and advise patients if prescribed medication, drugs or treatments, or their medical conditions, makes them unsafe and/or unfit to drive. Doctors should document this advice and clearly inform patients that the responsibility lies with them if they choose to drive.

- Investment in safer roads is critical. This includes sealing dirt roads and reducing speed limits on rural and undivided roads to reduce accidents.

- Roads with unrestricted speed limits pose serious risks to all road users. Speed limits play an important role in reducing injuries and fatalities on our roads.

- Heavy vehicles, trucks and buses make up only three per cent of the vehicle fleet but are over-represented in accident statistics.[9] The AMA supports measures to improve heavy vehicle roadworthiness, including advanced braking requirements and other safety technologies to improve the safety of heavy vehicle drivers.

- Regulation of heavy vehicles (and their drivers) has been implemented overseas, and Australia may benefit from increased regulation of heavy vehicles and their drivers, particularly long distance drivers.

- Autonomous vehicles potentially offer greater safety for road users, however, no technology will prevent road accidents completely. Automated vehicle programming and technology should not remove the responsibility for decision-making from the driver.

- Every person who drives a vehicle, regardless of the technology and level of automation, must be a validated licence holder, and legally qualified to drive that class of vehicle.

- The AMA supports the establishment of a national advisory body, with appropriate expertise, to provide ongoing advice to governments about the important and complex issues of driverless automobiles, including road safety, infrastructure, data collection and privacy, intellectual property, standards, legal responsibility, and their impact on existing laws and legislation.

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[5] http://www.heraldsun.com.au/news/national/learners-admit-to-cheating-on-their-required-75-hours-of-supervised-driving/news-story/a18273da73f1be27d384f4ef38cefb15

[6] See: 'Study confirms effectiveness of Autonomous Emergency Braking', https://www.ancap.com.au/media-and-gallery/releases/study-confirms-effectiveness-of-autonomous-emergency-braking

[7] For further information, see: http://monash.edu/research/explore/files/33966117/24939805.pdf

[8] See: http://www.austroads.com.au/drivers-vehicles/assessing-fitness-to-drive

[9] http://roadsafety.gov.au/nrss/files/NRSS_2011_2020.pdf

Obesity
2016

1. The management of the obesity crisis in Australia is a national and economic priority, and Australia's response to it must be commensurate with the breadth of its prevalence, the speed of its growth, and major impacts on individuals and society.
2. Combating obesity demands a whole-of-society approach, requiring the participation of governments, non-government organisations, the health and food industries, the media, employers, schools, and community organisations.
3. Accurate data on the prevalence of obesity, as well as monitoring of body weight trends is a vital component of understanding the extent of the problem. Such efforts must recognise and account for potential bias such as low response rates and differences in sampling.
4. A whole of society response should incorporate measures for the prevention and reduction of excess weight in the population, including treatments for individuals.
5. Limitations in current knowledge about which obesity interventions are effective should not be a reason for inaction, or for adopting only tentative and short-term measures.
6. A whole of society response to obesity should be strategic, and coordinated at a national level by the Federal Government, which must commit to specific national goals for reducing obesity and its health effects in Australia.
7. Governments at all levels should employ the full range of policy, regulatory, and financial instruments available to them to modify the behaviours and social practices that promote and sustain obesity.
8. The major focus and effort in preventing obesity should be on children and adolescents. Prevention and early intervention should start with the pregnant mother and foetus, and continue throughout infancy and childhood.
9. National dietary, physical activity, and weight management guidelines must be kept up to date and evidence based. This material should be complemented by national comprehensive and effective social marketing campaigns.[1]

The AMA considers the following measures to promote appropriate dietary behaviour and greater physical activity, and to treat obesity, should be adopted as part of a whole of society approach.

Physical activity

10. Creating healthy communities should be the goal of town planning. Planning regulations governing housing, urban development, and transport infrastructure should mandate the incorporation of measures to promote and facilitate physical activity.
11. School and early learning settings curricula, the physical environment and community relationships must be modelled to promote physical activity and other health related behaviours, outcomes and skills.

Nutritional measures

12. The AMA reaffirms its position that all Australian mothers should be encouraged and supported to solely breastfeed their babies for the first six months of life (unless there are medical contraindications).
13. It is vitally important to increase nutritional literacy among mothers to be and new mothers to support good nutrition for infants and toddlers.

14. Whole of school and early learning settings curriculum programs around nutrition, with the provision of only healthy food choices in the school context, should be promoted so that children have a greater capacity for nutritional literacy, and for making healthy choices later in life.

15. The marketing of energy dense/nutrient poor food to children should be prohibited in all settings.

16. Nutrition labelling for packaged foods that is easy to interpret assists people to make healthy choices about packaged and processed foods.

17. Significantly higher taxes, and therefore higher prices, should apply to products known to significantly contribute to obesity, especially in children (for example, sugary soft drinks).

18. Healthy foods, such as fruit and vegetables, should be subsidised by governments to ensure their prices become and remain very low, particularly in remote areas.

19. The food industry and retail food outlets must adopt measures that aim to reduce the production, sale, and consumption of energy dense and nutrient poor products.

20. Urban planning regulations should ensure that new housing developments make provision for local access to retail outlets for fruit and vegetables (i.e. local grocery stores and supermarkets), and limit the density of convenience and take-away food stores.

Targeted interventions, community-based programs, research, and monitoring

21. Specific measures should be prioritised to high risk or vulnerable groups, especially Aboriginal and Torres Strait Islander peoples, and those from lower income groups.

22. There is need for a greater and more sustained investment in research, monitoring, and evidence collection to determine which individual and population measures are successful, which are not, and which may be promising.

23. Community-based pilot programs and initiatives should be established to address obesity in local communities, and best practice knowledge translation and exchange platforms supported[2] for the collection and sharing of information about their successes and challenges.

Treatment and management

24. Medical professionals have a particular role to play in prevention and early intervention. Opportunities need to be extended for doctors to spend time with patients who are at risk of being overweight, and to have ready sources of current information on interventions, counselling, and local facilities. A role also exists for doctors to provide translation of latest evidence for prevention to the broader community.

25. The AMA considers bariatric surgery an effective measure for long-term reductions in weight and improved health outcomes, primarily for obese adults and, in exceptional cases, for obese adolescents with significant co-morbidities and for whom all other measures have not been successful.

26. The AMA believes there is only a very limited role for pharmacological treatments for obesity, and such treatments need to be provided in conjunction with counselling, monitoring, and behavioural change interventions.

An increasing number of Australians are obese. Obesity substantially contributes to preventable, non-communicable diseases, shortened life-expectancy, and impaired quality of life. The impacts of obesity are significant and warrant considerable and sustained attention.

More than half of Australian adults have a body weight that puts their health at risk. In 2011-12, 62% of adults were overweight or obese (35 per cent overweight, and 27 per cent obese).[3] The proportion of adults who are Obese Class 2[4] or severely obese, increased from 5 per cent in 1995 to almost 10 per cent in 2014.[5]

Obesity may run in families, with research showing that children of obese parents are more than twice as likely to be obese themselves.[6] A quarter of Australian children and adolescents are overweight or obese (18 per cent overweight and 7 per cent obese). [7] More recent estimates applying opt out monitoring methods have achieved far higher participation rates, and suggest the data of 2014 and earlier may underestimate the true childhood prevalence. Accurate data and monitoring around the prevalence of obesity among children and adults are vital.

Obesity is a major risk factor for chronic and preventable conditions such as type 2 diabetes, heart disease, hypertension, stroke, musculoskeletal disorders and impaired psychosocial functioning. About 70 per cent of people who are obese have at least one established morbidity, resulting in medical costs that are about 30 per cent greater than those of their healthy weight peers.[8] Many more have serious health conditions that they are unaware of, for example, it has been estimated that for every five cases of diabetes there are four undiagnosed cases.[9]

Evidence that obesity is overtaking smoking as the major cause of preventable death in Australia is growing.[10] The exact cost of obesity is difficult to determine. In 2011-12, a conservative estimate placed the cost of obesity at $8.6 billion.[11] An older, but a more expansive estimate of overweight and obesity, including both direct and indirect costs indicated the annual cost of obesity in Australia at $56.6 billion.[12] The costs of obesity are significant and are likely increasing every year alongside increasing prevalence. The increased health care costs associated with obesity are observable early in life, with recent Australian research indicating that obese children (aged between two and five years) incurring health care costs that were 60 per cent more than children of healthy weight.[13]

Specialised and costly hospital and ambulance equipment is required for the medical care and transport of obese patients. Health care professionals may be at increased risk of manual handling injuries in providing care to obese patients.

At a very basic level, the obesity crisis can generally be explained in terms of individuals' dietary and physical behaviours – individuals either consuming too many calories or being insufficiently physically active.[14] However, individuals' dietary choices and behaviours and their levels of physical activity are influenced by a broad array of factors. The UK Foresight[15] project created the 'obesity systems map', which presents a causal model that begins with energy balance at an individual level, and builds a peripheral set of 108 variables that directly or indirectly influence energy balance including:

- Breastfeeding;
- Birth weight;
- Childhood weight gain;
- Parental weight;
- Maternal smoking;
- Television watching;
- Food availability and affordability;
- Accessibility and affordability of active transport; and
- Socioeconomic status and social networks.

Evidence is emerging that the following factors may also influence obesity: being overweight in adolescence; consuming takeaway foods; childhood smoking; increased price of fruit and vegetables; low self-esteem and depression; low locus of control scores; stressful family life; food insecurity; self-reported dieting (particularly among girls); inadequate sleep; and low rates of breakfast consumption.[16]

Along with environmental contributors to obesity, genetic factors may also play a limited role in the development of obesity. Early research suggests epigenetic influences on susceptibility to obesity.[17]

This is not to suggest that individuals are never responsible for their behaviour - only that an effective response to the obesity crisis will need to be as comprehensive and multi-faceted as the factors that generate and sustain it.[18] A 'whole of society' approach engages stakeholders and agencies in all sectors of society who have the potential to diminish the factors that promote excess weight, and reinforce the factors that protect against it, or reduce it.

It makes sense to seek to prevent people from becoming obese. It is important to adopt population-based measures and individual treatments to reduce current levels of obesity and its health effects.

There is a body of evidence that engaging in regular, moderate to large amounts of physical activity, and reducing intake of energy-dense/nutrient poor foods can prevent weight gain.[19] The available evidence does not point to any single type or set of interventions that will definitely induce those protective behaviours on a population-scale.[20] The evidence is also variable as to which interventions will produce weight loss on a population-scale.[21]

There is some debate in Australia about whether or not obesity should be recognised as a disease. Those who support conceptualising obesity as a disease cite the World Health Organisation position that medicalising obesity will improve treatment. Others argue that obesity does not meet the definition of disease.

There is strong indirect evidence that population-based health interventions can be effective in changing deeply entrenched behaviours. Population health interventions are not always based on incontrovertible evidence of assured outcomes, but on an assessment of the potential risks and opportunities involved, compared with the potential costs of not intervening.[22] In the case of the obesity crisis, the costs of inaction are proving to be disastrously high.

Obesity is recognised as a National Health Priority Area. Efforts must be strategic in the approach to obesity, and adopt clear and measurable targets to reduce the levels of obesity in the community. The Federal Government has an important role in coordinating and supporting the efforts of other governments, local communities, businesses, health professionals, and individuals in achieving this goal. The Federal Government is well-placed also to monitor and evaluate these collective efforts, and to redirect action and resources where they are needed.

Governments are unique in their capacity to influence and regulate people's behaviour on a large scale. The full range of government instruments, such as taxation, financial penalties and incentives, subsidies and market interventions, policy and legislation should be applied to make it easier for people to make healthier choices.[23] In applying these instruments, governments should recognise that those sections of the food industry that market and profit from energy dense and nutrient poor food products are not bearing the full costs of their activity, but are shifting costs onto the public sector and general community.

Ongoing research into the most effective measures for maintained weight loss is required. This research should recognise that some interventions may be better suited to certain population groups. For example, there is strong evidence that school-based interventions may help prevent childhood obesity in school aged children. [24]Research must also recognise that health benefits are observed in modest weight loss, i.e. loss of 5 per cent of weight, but that it can be difficult to maintain weight loss in the longer term.

Current clinical guidelines recommend that health professionals encourage overweight and obese patients to work towards a 2500 kj (just under 600 calorie) deficit per day with an appropriate dietary intervention, as well as engaging in 300 minutes of moderate intensity physical activity per week (or 150 minutes of vigorous activity, or a combination of both).[25] Government policies must recognise that (sustained) reductions in energy intake, and increases in physical activity, are particularly relevant for well over half of Australia adults.

There is evidence that obesity and excess weight in childhood and adolescence is a strong predictor of obesity or health problems in adulthood.[26] Foetal development and dispositions toward obesity may also be affected by the weight of the mother during pregnancy.[27] Interventions to prevent excessive weight gain during pregnancy (including physical and nutritional programs) are effective.[28] There is a role for the medical profession in providing counselling to women of child bearing age who are

considering having children on the importance of healthy weight, before, during and after pregnancy. There is also preliminary evidence that obese fathers may pass along predispositions to metabolic conditions to their sons and grandsons including diabetes and heart disease.[29]

Physical activity measures

There is evidence that the nature of people's habitual physical environment can influence their levels of physical activity.[30] [31] There is also evidence that particular urban engineering measures can promote increased activity. Measures recommended for this purpose include development of neighbourhoods with accessible walking paths, cycle paths, parks and recreational facilities, local and accessible shops, facilities and services, and greater street connectivity.[32] Provision of active transport networks for walking and cycling may also be very cost effective in terms of reducing future costs of cardiovascular disease.[33]

Employers, particularly in the health sector, can contribute by developing healthy work environments. Such environments might facilitate cycling to work, for example, through provision of secure bike parking, showers, and change rooms.

There is evidence that whole-of-school approaches to health can be effective in promoting physical activity and healthy eating.[34] A multifactorial approach would encompass the classroom teaching of health skills and knowledge, changes to the physical school environment, cultivation of health-relevant links to the local community, and aspects of the 'hidden curriculum', such as teacher behaviour and modelling, and school culture. There would be opportunity within this approach to reinforce with parents the importance of creating active households for their children, and of families eating together.

Nutritional measures

Efforts must be directed at improving the nutritional literacy of the population, with specific efforts targeting women of child-bearing age, as well as toddlers and children. Dietary education should be included as a standard component of all antenatal care.

There is an overwhelming amount of non-evidence-based nutrition advice and associated products that are promoted to the public. Most of the advice and associated products are endorsed by celebrities, which may appear to give them legitimacy. Many, if not all, of these arrangements are based on generating revenue, and do not provide sustainable advice about healthy eating.

There is evidence that school nutrition programs and policies, including gardening and food preparation activities, can have a positive impact on children's dietary behaviour and weight.[35] These are likely to be particularly effective if they connect to the broader community and their families.

Food marketing to children occurs through a number of media (e.g., television, internet, food packaging, product placement in films), and is typically for highly processed, energy dense foods. There is considerable evidence that this marketing affects children's consumption and diet-related behaviour.[36] One study has argued that restricting television marketing would be very cost-effective, at $3.70 per disability adjusted life year saved.[37]

Labelling of packaged food items must facilitate healthy food choices by enabling consumers, from all socio-economic and cultural backgrounds, to easily recognise and compare food items in terms of their effects on weight and health. Research shows that consumers make choices on the basis of nutritional information, and prefer 'at a glance' information.[38]

The Health Star Rating System is a simplified and uniform 'front of pack' labelling system that has been developed in partnership between the health sector, the food industry, and governments in Australia. There is a grace period for uptake of the system, but uptake will need to be monitored and if insufficient, the labelling will need to be mandated. It is important that the System is supported by ongoing research to evaluate effectiveness and support evolution to ensure maximum utility for healthy food choices.

The price of food and drink influences people's consumption choices. The purchasing behaviour of children is particularly sensitive to price. Modest changes in eating behaviour can have significant effects over time. For example, increasing 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.[39] Governments need to explore options for regulating the production and sale of energy dense and nutrient poor food products to reduce consumption.

Price signals are one tool that governments have available to them that encourage the consumption of healthier foods. Currently, poorer food choices are typically cheaper than more nutritious options, and the discrepancy increases for people living in regional and remote areas. Caution should be exercised around any national policies, such as the GST, that may inadvertently increase the price of healthier foods.

Recent evidence from Mexico indicates that implementing health-related taxes on sugary drinks and on 'junk' food can decrease purchase of the intended food and drinks without affecting purchase of other food and drink items.[40] A recent Australian study predicted that increasing the price of sugary drinks by 20 per cent could reduce consumption by 12.6 per cent.[41] Further, a recent systematic review indicated that, in addition to being effective, a sugary drinks tax is also likely to reduce inequalities in purchase and consumption of sugary drinks.[42] Revenue raised by such a measure should initially be directed to an evaluation of effectiveness. In the longer term, revenue may be used to subsidise and market healthy food choices, as well as the promotion of physical activity.

Food manufacturers and retailers should also be encouraged to engage in more socially responsible activities, including the display, placement and pricing of products in supermarkets; the portion-controlled packaging of energy dense products; and, the gradual altering of existing products in modest ways to reduce calorie density. Where there is a failure on the part of manufacturers and retailers to voluntarily adopt such practices, governments should apply penalties.[43]

Research from the US shows that the prevalence of obesity increases and consumption of fruit and vegetables decreases, with increasing distance to grocery stores and supermarkets in metropolitan areas.[44] There is also evidence indicating that people living in neighbourhoods with a higher density of convenience stores and take away-food outlets also have reduced fruit and vegetable consumption.[45]

Targeted Interventions, Community-based programs, Research and Monitoring

There is substantial evidence showing an association between risk factors for excess weight and socio-economic and educational status. Other priority groups for whom interventions may need to be tailored or targeted include the elderly, those from culturally and linguistically diverse backgrounds, and those with certain disabilities. The greater risk of obesity with disadvantaged status (in developed countries) may suggest that, to reduce obesity, inequality should also be minimised.

Obesity is estimated to contribute to 16 per cent of the health gap between Aboriginal and Torres Strait Islander people and the total Australian population.[46] Obesity is associated with risk factors for the main causes of morbidity and mortality among Aboriginal and Torres Strait Islander peoples through health conditions such as diabetes and ischaemic heart disease. Targeted, culturally appropriate programs, services and support are an essential aspect of reducing the impacts of obesity in the health of Aboriginal and Torres Strait Islander peoples.

There continue to be gaps in the evidence about what contributes to, protects against, and reduces overweight and obesity, particularly with respect to certain population groups (e.g., Aboriginal and Torres Strait Islander peoples, those with disabilities, those from culturally and linguistically diverse backgrounds). There is also a strong need to closely monitor and evaluate the effectiveness of the measures and treatments that are implemented to address obesity.

Local action should be a central component of a whole of society approach to obesity. There is evidence that well-resourced, informed, and coordinated community-based initiatives can impact on unhealthy weight gain.[47] Such initiatives can provide information about experiences and outcomes that could be added to an evidence bank for other communities to use in their planning.

Primary Health Networks (PHNs) are currently being established to support access to medical services at a local level. Given the significant impacts of obesity on many communities throughout Australia, it is likely that PHNs will play a key role in supporting prevention and treatment efforts. This may include facilitating access to programs including those that seek to improve dietary patterns, or increase participation in physical activity. PHNs also play a role in identifying and addressing gaps in the health workforce. If this is done effectively, when it comes to managing patient obesity, GPs should be confident that their patients are able to access referred services in a coordinated and timely manner.

Individual Treatment and Management

The goal should be to provide patients with skills and motivations to help manage their condition. Research indicates that advice provided by general practitioners is highly regarded by the public, and can be effective in bringing about behavioural change.[48]

General practice is well suited to the initiation and coordination for weight management of individuals. Evidence suggests that interventions (or combinations of interventions) delivered via multidisciplinary care arrangements may be more effective, particularly when the usual healthcare provider is also involved.[49] General practitioner-led multidisciplinary care for weight management may also be informed by dieticians, exercise physiologists, psychologists, diabetes educators, nurses, physiotherapists, occupational therapists, and social workers.

Moderate evidence supports the use of weight loss medication, in addition to lifestyle changes. However, as with all medicines, there is a risk of adverse effects (which will influence prescribing decisions). Prior to medication, a very low calorie diet is recommended as an initial step in any intensive obesity treatment program. [50] For some patients, more intensive and coordinated intervention will be required.

In Australia, bariatric surgery is recommended for adults with a BMI > 40 or with a BMI > 35 combined with serious medical co-morbidities, who have not successfully reduced weight by other means.[51] The AMA believes that bariatric surgery is not appropriate for children, but older adolescents (15-18 years) may be considered in circumstances involving appropriate pre-operative education and post-operative follow-up, long-term multidisciplinary care, and adequate engagement of the young person and the family. For suitable patients, access to bariatric surgery should be available publicly and privately. Monitoring the immediate and longer-term outcomes of patients who have had bariatric surgery is vitally important.

This position statement was developed by the AMA's Obesity Working Group. The Working Group would like to acknowledge the contribution of Prof Steven Allender.

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