Submission No 20

INQUIRY INTO INQUIRY INTO CHILDHOOD OVERWEIGHT AND OBESITY

Organisation: Australian Taxpayers' Alliance and MyChoice Australia

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Standing Committee on Social Issues

Inquiry into Childhood Overweight and Obesity

Joint Submission by

the Australian Taxpayers' Alliance

and

MyChoice Australia

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Executive Summary

1. The Australian Taxpayers' Alliance (ATA) and MyChoice Australia (MCA) recognise the consequences of childhood obesity, and commend the Committee's concern.
2. Prevalence of overweight and obesity is currently plateauing internationally. This trend is especially pronounced among Australian children.
3. Childhood overweight and obesity is half as prevalent as adult overweight and obesity.
4. In 2008, the federal financial cost of obesity was estimated at $8.3 billion AUD. The same study found that only 5.1% of this cost was borne by state governments.

Recommendations

5. The relatively low cost of overweight and obesity, particularly in childhood, to state budgets does not justify new spending initiatives.
6. Costings of obesity which are endorsed by the Standing Committee should not include disingenuous estimates of lost utility in their fiscal modelling.
7. Existing strategies are having some success. Review existing strategies to identify efficiencies.
8. To develop a stronger understanding of successful influences on behaviour, future interactive programs should take multi-factorial measurements including body composition measurements (such as BMI, waist circumference, and percentage of body fat), physical activity levels and physical fitness, dietary habits and decisions, knowledge and attitudes, sedentary behaviour, potential for unintended consequences (such as injuries or substitution behaviours), and long term follow up and evaluations.
9. Identify and eliminate existing strategies which are known to be ineffective or inefficient.
10. Apply the preventative health toolkit devised by senior policy analyst Helen Andrews.

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Introduction

> ***"The considerable uncertainty about the causes of obesity suggests that hard interventions, such as taxes or subsidies on specific goods and services, would be difficult to justify. Further, the practical challenges of designing taxes on specific goods and services limit the likelihood of them being effective in addressing obesity (and may lead to perverse outcomes). Softer interventions, targeted at addressing information failure and education, appear to be on stronger ground. The complex nature of obesity suggests that multi-pronged strategies addressing multiple risk factors may be more effective than other strategies that focus on a single risk factor."***

Crowle, J. and Turner, E. (2010), Productivity Commission Working Paper

11. The Australian Taxpayers' Alliance (ATA) and MyChoice Australia (MCA) thank the Standing Committee on Social Issues for the opportunity to make a submission to the Inquiry into Childhood Overweight and Obesity.
12. The Australian Taxpayers' Alliance (ATA) is a grass-roots free-market advocacy group of over 25,000 members. The ATA stands for the principles of limited government, personal responsibility, federalism and rolling back the regulatory state.
13. MyChoice Australia is a grass-roots activist group which unifies diverse groups to jointly advocate against the restriction of individual rights by regulation.
14. Definitions of obesity
    a. Weight categories are most commonly defined in relation to Body Mass Index (BMI). The bounds of these categories are different for adults (18 years and over) and children (under 18 years). Childhood and adolescent weight categories are adjusted to meet normal developmental ranges according to age and gender. [1]
    b. Weight categories can also be measured by Waist Circumference (WC) but are less useful when dealing with children, although WC measurement tracking can help to identify high risk populations for diabetes and cardiovascular disease. [2]
    c. Studies tend to account for both definitions, as well as for a synthesis of the two.
    d. Statistical evidence is gathered using these data points and analysed to identify core problem areas for targeting through policy. Studies sometimes compound rates of childhood overweight and obesity levels, complicating attempts to accurately determine the number of children affected by adverse health risks, and the magnitude of those risks.
15. Historical trends in child overweight and obesity
    a. Child overweight and obesity is noticeably plateauing in Australia. There is some evidence to suggest that adult overweight and obesity may also be plateauing international evidence. [3]
16. Difference between child and adult obesity [4]
    a. Child overweight and obesity is **half as prevalent** as adult overweight and obesity.
    b. Child underweight is **four times as prevalent** as adult underweight.
    c. **Children are almost twice as likely as adults to be at a 'normal' weight,** by Body Mass Index.

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[1] ABS (2013), 'Appendix 4: Classification of BMI for children', *Australian Health Survey: Users' Guide, 2011-13*. [online]
[2] Bassali, R. (2010) 'Utility of waist circumference percentile for risk evaluation in obese children', Int J Pediatr Obes. 2010; 5(1): 97–101. [online]
[3] ANPHA, (2014) 'Evidence Brief - Obesity: Prevalence trends in Australia' Australian National Preventative Health Agency, April 2014, page 15 [online - PDF]
[4] ABS (2015) 'National Health Survey: First Results, Australia, 2014-15' [Online - pdf]

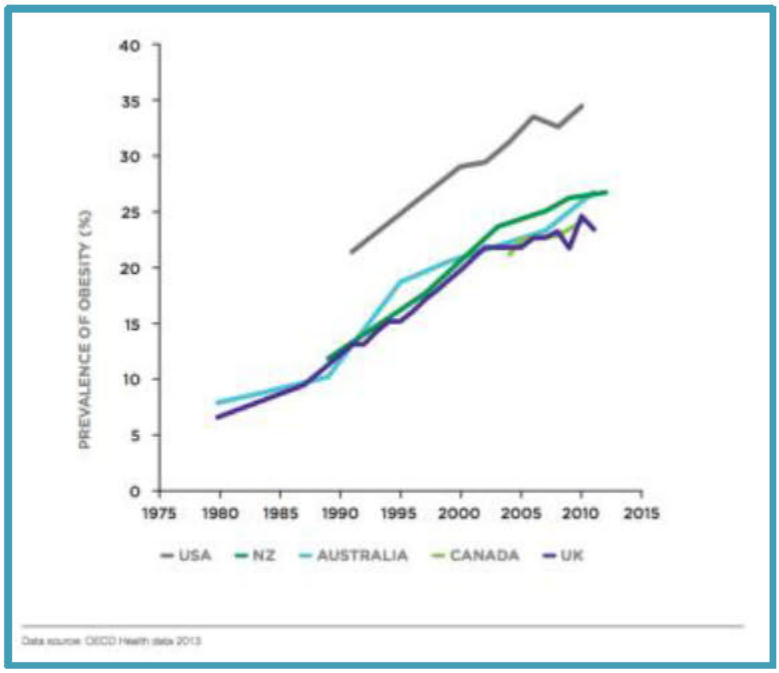

Figure 11.1: Screenshot of graph showing prevalence of obesity in five OECD countries [5]

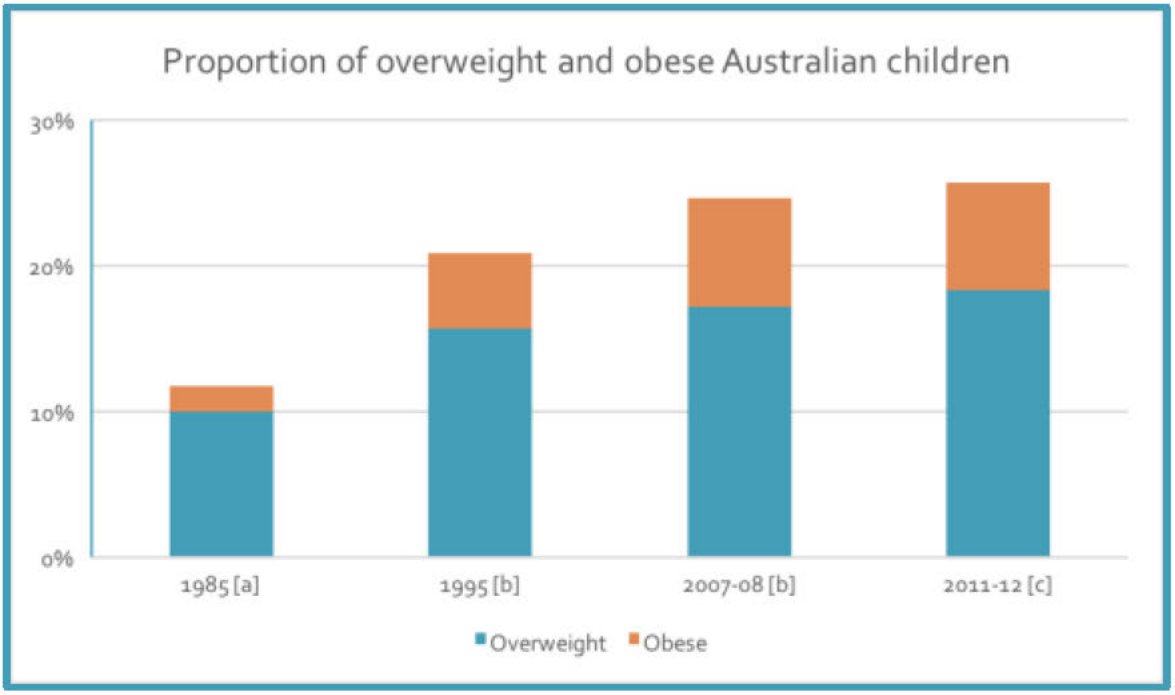

Figure 11.2: Prevalence of overweight and obesity in Australian children, 1985 – present[6]

[5] ANPHA (2014)

[6] Obesity Australia (2014) 'No time to weight: Obesity: A national epidemic and its impact on Australia', page 8 [PDF]
[a] 7-15 year olds - Magarey AM, Daniels LA, and Boulton TJ (2001). Prevalence of overweight and obesity in Australian children and adolescents: reassessment of 1985 and 1995 data against new standard international definitions. Med J Aust. 174(11): 561-564.
[b] 5-17 year olds - Australian Bureau of Statistics (2009). National Health Survey: Summary of results, 2007-2008. Cat no. 4364.0.

17. Costs
    a. In 2008, the federal financial cost of obesity was estimated to be $8.3 billion AUD. The study, by Access Economics, found that only 5.1% of this cost – some $423 million - was borne by state governments. [7]
        i. A Productivity Commission working paper notes that values for "loss of wellbeing" – a non-financial 'cost' – are derived in dollar terms, and included in highly exaggerated calculations of the cost of obesity in Australia. [8] These 'costs' are a disutility that is borne by the individuals themself.
        ii. ATA and MCA strongly recommend that any calculations of the cost of obesity which are endorsed by the Standing Committee should not include disingenuous estimates of lost utility in its fiscal modelling.
    b. The archetypal bottom-up study of the costs of obesity in Australia is Colagiuri's study, *The cost of overweight and obesity in Australia*, which puts the federal financial cost of obesity in 2010 at $10.7 billion AUD.
    c. "*The main contributions to direct health care costs in those with BMI- and WC-defined overweight were prescription medication, hospitalisation and ambulatory services, each accounting for about 32%. For obesity, hospitalisation accounted for 36% of cost, prescription medication for 33%, and ambulatory services for 25%.*" [9]
    d. ATA and MCA further recognise that, "*unlike alcohol and tobacco consumption, the externalities (spillovers on unrelated third parties) associated with obesity are probably minor*". [10]

Current approaches

Current approaches to reduce childhood overweight and obesity in NSW

18. The Productivity Commission conducted an extensive literature review in 2010[11], determining that the following strategies are **ineffective** in influencing BMI:
    a. Short term dietary and physical activity intervention programs which are not targeted to at-risk or already-diagnosed populations
    b. Food taxes and subsidies
    c. Sales restrictions at school canteens
19. Australian intervention-education programs that measured body composition results show mixed results, and failed to collect appropriate data to assess effectiveness. The programs which demonstrated clear short term behaviour or weight change targeted at-risk and already-diagnosed participants. There has been limited long-term follow-up to assess the sustainability of short-term outcomes. There is a lack of consistent data needed to fully understand childhood obesity prevalence in Australia and data on obesity among Indigenous children is especially limited. Consistent data is not always collected at the intervention level, precluding proper assessment of the effectiveness of the intervention. Long-term follow-up evidence is necessary to understand the sustainability of any interventions and data from randomised trials without long-term follow-up data may have limited use. These problems with experimental design preclude these studies forming a strong enough evidence base for policy programs to be built on.
20. The NSW Healthy Eating and Active Living Strategy has been in effect since 2013.

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[c] 5-17 year olds - Australian Bureau of Statistics (2013). Australian Health Survey: Updated Results 2011-2012. Cat no. 4364.0.55.003.

[7] Access Economics (2008). 'The growing cost of obesity in 2008: 3 years on. Canberra: Diabetes Australia'. As cited in ANPHA (2014)

[8] Crowle, J. and Turner, E. 2010, Childhood Obesity: An Economic Perspective, Productivity Commission Staff Working Paper, Melbourne. [online - PDF]

[9] Stephen Colagiuri, Crystal M Y Lee, Ruth Colagiuri, Dianna Magliano, Jonathan E Shaw, Paul Z Zimmet and Ian D Caterson (2010), 'The cost of overweight and obesity in Australia', Med J Aust 2010; 192 (5): 260-264 [online]

[10] Crowle, J. and Turner, E. (2010)

[11] Crowle, J. and Turner, E. (2010)

21. Fresh Tastes @ School - The strategy aims to encourage students to eat healthier foods, and is a mandatory set of rules regarding what NSW Government school canteens can sell. It has been in operation since 2005. It uses the traffic light colours of red, amber and green to categorise different canteen foods. Green foods are 'fill the menu' foods, which should make up the majority of the canteen menu and be promoted to students as the best choice, amber foods are 'select carefully' foods, which should only be offered for sale on certain days of the week, and red foods are 'occasional' foods, which cannot be sold on more than two occasions in a school term.

Strategies for parents and carers

Strategies to assist parents and carers in enabling their children to make healthier food and beverage choices and be active, including by participating in sport

22. Parents are the most effective influence on childhood activity.[12]
23. A proposal of the Productivity Commission is government intervention into a market failure by ensuring the provision of certain information. However, "obesity-related information on nutrition and exercise already available suggests that information gaps alone may not be 'the' problem."[13]
24. The Productivity Commission, however, warns against an introduction of bans or taxes as it can cause a blanket-effect and have perverse results. It also recommends evaluating current and proposed programs, and building the data and effectiveness from there, rather than rolling out high-cost, low-result programs.
25. Food or sugar taxes are ineffective and costly, both towards the consumer and the government and may have unintended side effects. Those of low socio-economic backgrounds may be at a significant disadvantage, especially given the current government definition of 'obese inducing foods'. Subsidies are also a problem as they skew the market and make sectors and inefficient industries dependent.
26. The ineffectiveness of these taxes extends to specific foods. A recent study noted that a 10% tax specifically on soft drinks would reduce consumption levels only by 4% or the equivalent of walking 3-4 minutes per consumer per day. This change is lessened further by the inclination of consumers to substitute different food or beverage items. In return for this miniscule change, consumers are hit with higher grocery bills and businesses are also hurt.[14]
27. Regulations will often induce higher cost and unnecessary red tape while disregarding personal and parental responsibility. Regulation introduced to restrict sales of certain foods, costs to business would include loss of profit from lower sales despite some offsetting gains from the sale of healthier alternatives.
28. A strategy that allows individual childcare and preschool providers to enforce their own guidelines would be more flexible than one prescribed by government and would allow different providers to tailor strategies specific to their particular target group (such as children from different cultural backgrounds), and respond to changes that may impact the strategy's effectiveness.
29. "If, as the evidence suggests, the link between television viewing and childhood obesity is tenuous, or at most small in magnitude, it is unlikely that banning the advertising of energy-dense food would significantly address childhood obesity prevalence (Carter 2006)."[15]
30. Interventionist policies that target groups with a disproportionately high level of obesity may make sense but there is a risk of stigmatisation and marginalisation.

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12 M.J, L., G, S., J, M., & L, A. (2015, June 1). Parents' concerns and family environment are associated with overweight children's physical activity levels. The ACORDA project. Appetite, p. 312.

13 Crowle, J. and Turner, E. (2010)

14 Wang, E. Y. (2015). The impact of soda taxes on consumer welfare: implications of storability and taste heterogeneity. *The RAND Journal of Economics*, *46*(2), 409-441.

15 Crowle, J. and Turner, E. (2010)

Strategies for young people

Measures to support 13 to 18 year olds to make healthier food and beverage choices and be active, including by participating in sport

31. In his first speech to the National Press Club as the new head of the Australian Medical Association, Doctor Michael Gannon talked down a sugar tax or soft drink tax, instead recommending a holistic, responsibility based approach [16]
32. Studies have shown that counselling and consultation is effective in assisting teenagers to develop healthier lifestyles and to make responsible choices on their own. [17] Most schools already employ counsellors and/or physical educators who could provide this service. Studies have also shown that moderate or limited consumption of 'unhealthy' foods can be consistent with a holistically healthy diet and lifestyle.[18]
33. We recommend strategies focused on enabling and facilitating responsible decision-making by teenagers rather than denial-of-access strategies such as taxes or bans on food products which have proven ineffective, hurt businesses and lead to the development of black markets.
34. Empowering teenagers to make their own consumption choices has the long-term benefit of serving them throughout their lives. By contrast, prohibition-based strategies have only temporary application and do nothing to address underlying issues such as fostering a sense of personal responsibility for one's own health and development of long-term personal discipline.
35. Individual schools are best placed to implement this strategy and ought to have freedom in developing the guidelines underpinning it. This will allow the tailoring of education programs to individual communities which are subject to different health risks, unhealthy habit prevalence and socio-economic conditions all of which can be accounted for without a centralised, one-size-fits-all approach by governments or government agencies.
36. Moreover, parents and families continue to bear primary responsibility for fostering a healthy lifestyle for their children and ultimately have the greatest influence in their children's lives in lieu of which government programs offer only limited effectiveness.

Strategies for health professionals

Strategies to support health professionals to identify and address childhood overweight and obesity

37. Excessive government regulations of school canteens drive up costs for food. This causes the healthier foods to be more expensive and inaccessible. The children from low socio-economic families have the most elastic canteen budget and are the most price sensitive to these prices. Children from low socio-economic families have less healthy dietary patterns and are the worst affected from these regulations. [19]
38. Reducing regulations with school sport would increase the willingness of teachers and student to take part in physical activity. Reducing the 284 page "Guideline for the Safe Conduct of Sports and Physical Activity in School" would directly benefit childhood obesity. [20] We believe the 284 page guidelines harms students more than it helps and the safe sport guidelines should be based around common sense.

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[16] Vickery, K., August 17 2016, 'AMA chief Michael Gannon backs junk food retailers' news.com.au [online]

[17] Walker, Z., Townsend, J., Oakley, L., Donovan, C., Smith, H., Hurst, Z. & Marshall, S. (2002). Health promotion for adolescents in primary care: randomised controlled trial. *bmj*, *325*(7363), 524.

[18] Aranceta, J., & Serra-Majem, L. (2001). Dietary guidelines for the Spanish population. Public health nutrition, 4(6a), 1403.

[19] http://www.growingupinaustralia.gov.au/pubs/asr/2013/asr2013f.html

[20] https://www.det.nsw.edu.au/policies/student_serv/...**sport**/pd02_12_safe_**sport**.pdf

Strategies for policy makers and departments

Coordination between NSW Government agencies to reduce childhood overweight and obesity

39. Public policy metrics should be used to accurately measure the performance of governmental action tackling childhood obesity. The Australian Taxpayers' Alliance recommends the adoption of the Preventative health toolkit developed by Helen Andrews when deciding a course of action. [21]
40. Respect for individual privacy should be paramount at all stages.
41. Coordinating different government agencies would increase the effectiveness of taxpayers' money tackling this issue. Economies of scale from coordinating the agencies will be an advantageous approach as opposed to many small disjointed governmental efforts.
42. Coordination of different governmental agencies should not add to the already large bureaucracy to help facilitate this coordination. Rather, existing resources should be redirected.
43. "*Mandated changes that seek to reduce individual risk can have adverse consequences if they result in reduced consumer vigilance. For example, Viscusi (1984) found that the 'lulling' effect of child-resistant safety caps on aspirin and other drugs negated the otherwise desirable effect of reduced child poisonings, and may have lead to additional poisonings*" [22]

Private-public collaboration

The potential for collaboration on strategies to reduce childhood overweight and obesity with the non-government and private sectors

44. Identify and support successful private programs which incentivise sustained behaviour or attitudinal change: eg Pokemon Go
45. The private sector has contributed large sums of money advertising for the Olympics which promotes athleticism and physical activity. Through private fundraising efforts, the Australian Olympic Committee has raised over $23 Million. Only $100,000 came from taxpayers. This private sector involvement has promoted a healthy lifestyle for children and parents to aspire to. [23]
46. Corporate social responsibility efforts make corporate sponsorship available for programs that represent the shared values of the organisation. There is significant room for partnership here.

[21] http://apo.org.au/files/Resource/pm143.pdf

[22] Crowle, J. and Turner, E. (2010)

[23] http://aoc-cdn.s3.amazonaws.com/corporate/live/files/dmfile/Rio-2016-Funding-Guidelines_8-June-20165.pdf