Submission to the National Preventative Health Taskforce on 'Obesity'

A response to the Discussion Paper
> *Australia: The Healthiest Country by 2020* (October 2008)

and to the supporting Technical Paper
> *Obesity in Australia: a need for urgent action*

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Overview

I welcome the invitation to comment on the discussion paper *Australia: The Healthiest Country by 2020* and one of its supporting technical papers on Obesity.

In making this submission, my intent is to assist the Taskforce fulfill its remit to develop a comprehensive and lasting Preventative Health Strategy by mid-2009 sought by the Minister for Health and Ageing, Nicola Roxon according to its terms of reference to which this submission refers (see Appendix 1).

The Taskforce's terms of reference direct attention in the first instance to areas of injury and disease and health services practice - namely 'evidence base', 'preventative health', clinical practice, the Medicare schedule – picking up on references 1,3, 4 and 5. On reference 2 – 'provide advice for policy makers on what strategies work best at a population level, and on the best buys for government investment in primary prevention ' – I suggest that to be effective for healthy weight (the obverse of obesity), the notion of population is its spatial distribution rather than treatment or target-setting at the aggregate, national level. Fifteen years ago one of the elders in public health, Professor Morris (1994), wrote about physical activity, such as health-promoting travel as one of the 'best buys' for heart health. And since then, if anything the case has since been strengthened, at least for cancer, another chronic disease associated with overweight and obesity (World Cancer Research Fund/American Institute for Cancer Research 2007). Similarly, physical activity is invaluable for reducing anxiety, alleviating stress, and for assisting people with depression.

The task of reducing overweight and obesity, at almost half the population, is far too big and complex to be tackled by clinicians and the preventative health/public health/population health sector. The American text *Urban Sprawl and Public Health. Designing, planning and building for healthy communities* (Frumkin, Frank, and Jackson) explains this well – including the need to retrofit existing urban settlements where most people live.

This submission addresses obesity, and in particular physical activity and its potential for contributing to healthy weight and well-being. It does not address alcohol or tobacco, the Medicare Schedule (reference 5), inter-governmental and public-private partnerships (reference 6) or such programs mentioned in the discussion paper such as 'physical activity by prescription', 'walking school buses' or social marketing (and its overemphasis).

The proposal for a National Prevention Agency in Chapter 5 calls for further reading of the background paper by Moodie et al and other recent discussion (e.g. Menadue and Doggett), so I shall prepare a supplementary submission. It is likely that the proposed agency would be over-stretched in working much outside the health sector given the health-centric content of the Discussion Paper and the tentative support for built environment and transport initiatives given in the Obesity Technical paper.

The emphasis of my submission is on how to address obesity, Discussion Paper, (p.xiv) – the burning question for members of the Taskforce in formulating a draft national Strategy. Of the material on obesity, the Discussion Paper and the Technical Paper, most weight (sic) is given to food – indeed, the Technical Paper proposes a National Food Strategy but no strategy for physical activity. Presumably, the DP is the later, key document.

Given that the physical environment in which people live – their houses, the footpaths, roadways, shopping centres, local parks – and where it is hoped that

they can and do engage in healthy eating and getting about by healthy, active travel, it is of considerably more importance than the weight given to it in the Discussion Paper. Indeed, my concern is that the Discussion Paper makes these issues less apparent by the way in which it accepted the compression or conflation of urban settlements to the 'natural environment' and the 'built environment' as shown in the AIHW figure. My concern was such that I participated in the Taskforce's Roundtable on The Built Environment held in Melbourne, 15 December 2008 to help develop the working concept of the 'built environment' as places where people live and move about and where 'obesity prevention' is to occur. Actions supported through the Draft Strategy will need to be geographically distributed and integrated into the governance structures and processes that operate across geographic areas.

I would be happy to provide examples, copies of references and for this submission to be put on the Taskforce's website.

Policy-framing aspects

I understand the Taskforce's next steps are:

- To produce a draft National Preventive Health Strategy ('draft Strategy') encompassing the three topics of obesity, alcohol and tobacco

- To produce a paper on the "obeso-genic" environment (hoping that this is given a plain English title). [Thinking of possible audiences in local government for example, it is likely that many urban settlements could be described as 'obesogenic' - Business-As-Usual (BAU) - on the criteria of transit-oriented development that's walkable and cyclable and the processes for managing and maintenance would continue BAU unless transitional steps were identified (e.g. changes to asset management plans) to work toward transformation into an active living environment, conducive to active travel. In other words, both milieux, the obeso-genic and the non-obeso-genic environment need description as well as processes for transformation.

Before responding to the questions raised in the Discussion Paper, I deal with a number of aspects that affect how policy and the corresponding draft Strategy is framed.

Policy-framing is essential because where it is not framed effectively it leads to policy failure and a waste of money.

Naming the problem – promoting healthy weight rather than 'obesity prevention'?

As a medical condition 'Obesity' is a risk factor for metabolic disease, the subject of much tertiary and secondary prevention (DP p.2)[1]. Technically, the risks are

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[1] Institute for Obesity, Nutrition and Exercise (IONE)(2008) *Obesity reality check,* Seminar, 28 October, University of Sydney. www.usyd.edu.au/news/84.html?newsstoryid=2762

undoubtedly higher for people who have reached the status of being 'morbidly obese' to develop chronic disease than for people who are merely 'overweight', or people of 'healthy weight'.

The Discussion Paper deals with 'obesity' as a risk factor, although it often refers to 'obesity and overweight'. 'Obesity' is at the tip of the iceberg with an ominous trend for almost half of the population becoming 'overweight'. Early intervention to promote future health is a principle applicable to 'obesity' prevention[2].

The upstream conditions that result in people no longer being of 'healthy weight' and becoming 'overweight' and 'obese' are principally sedentariness and energy-rich diets. The physiology of body weight is more complex, of course, being governed by genetic triggers, and interacting with biological factors such as elevated levels of the stress hormone cortisol (and its triggers (exposure to noise, sleep deprivation, trauma, poor diet & depression[3] etc).

Effective prevention (DP p.4) can reduce the burden of disease, injury and disability but also enable the determinants of health to be addressed (e.g. air quality). In the Obesity Technical Paper, the Taskforce seeks to plan for and implement a 'comprehensive approach to obesity prevention' (O p.52).

It appears desirable to deal with nutrition/energy intake and physical activity as the upstream precursors to healthy weight, overweight, and obesity.
Nutrition and physical activity are conjoint risk factors. As Jain (2004)'s review of clinical and community studies found:

> *In both clinical and community settings, there was strong evidence to support the effectiveness of combined dietary and physical activity interventions to prevent and control obesity.*

Beyond the concern for 'obesity prevention', a holistic health perspective acknowledges that people need to consume a healthy diet and be physically active. Human bodies need to grow and be maintained over the human life cycle, and on a daily basis for neuro-genesis and well-being.

In my view, such an approach would lead to a national strategy that aims for a higher proportion of the population with 'healthy weight' – not merely for halting the rise in the levels of 'obesity'.

Would it be more effective to focus on 'healthy weight' – and ingredients of nutrition and physical activity - from a policy perspective?

Also, would it be more effective to **name the issue** as 'healthy weight' as it is the goal, rather than 'obesity prevention'? Surely, the notion to convey is that for healthy eating and physical activity are both essential for health, and enable healthy weight. A number of my colleagues have concurred and observed that the term 'obesity' is very much the language of the health sector whereas 'healthy weight' would be picked up more readily by other sectors, as well as people (for whom 'evidence' is strongly showing under-estimation/denial).

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[2] E.g. Professor Clyde Hertzman, Director of Population Health, University of British Columbia reported in BMJ 1999: 319:1592.

[3] Nicole Vogelzangs (2008) Arch Gen Psychiatry. 2008;65:1386-1393.

> There are two points to make here:
> - First, the policy would be better framed as being <u>for</u> healthy weight rather than preventing obesity
> - Second, the policy would be better to emphasise healthy eating and physical activity because both are not only needed to achieve and maintain healthy weight/prevent obesity but also for general health (as implied by Technical paper on Obesity, p.52).

It could be counter-productive for a preventive health strategy to emphasise 'obesity' because of its visual character.

In 2000, Peter Kopelman of the Royal London School of Medicine summarised the thinking of the medical community:

> *"Obesity should no longer be regarded simply as a cosmetic problem affecting certain individuals, but [as] an epidemic that threatens global well being."*

In 2002, the NSW Minister for Health convened a 'State Summit To Tackle New Epidemic: Childhood Obesity' (July 11, 2002) – a residual approach to a population-wide issue. Again, the focus was on childhood obesity and food advertising aimed at children, and the Summit achieved a lot of media coverage.

Nonetheless, many non-medical people will tune out at the mention of obesity, and much Australian research shows that many parents do not recognise that their children are overweight (see References).

Many people who are not currently 'obese' are likely not to recognise that they are on track as they are possibly 'overweight' <u>and</u> because their current level of physical activity and nutrition is causing them to accumulate weight as well as being sub-optimal for their general health.

Owing in part to the victim-blaming or stereotyping of people by behavioural studies, such as much health promotion, people who are obese and overweight are gaining a certain social solidarity and proud identity, and even part of bogan culture. Thus, in response to problems about the rising level of obesity, we hear claims of 'discrimination'.

This social reaction was acknowledged by Caterson & others at the beginning of 2007.

Therefore, the draft Strategy does need to take a universal rather than residual approach to healthy body weight, and to deal with the societal conditions that enable people to eat more healthily and to live more actively. Two brief examples of people's concerns:
- The loss of fertile farmland in the Hawkesbury-Nepean River catchment that surrounds Sydney for housing development (and not transit-oriented development) as planned in the flawed Sydney Metropolitan Strategy
- The State Government's failure to invest in bike infrastructure and Sydney's car-friendly design, resulting in the lowest level of cycling to work in any Australia capital city[4].

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[4] Wendy Frew Urban Affairs Editor, *Sydney Morning Herald*, December 29, 2008.

Active Travel – why it's vital for inclusion

A misconception has arisen that 'active travel' describes people's journeys for instrumental purposes rather than merely the pleasure of getting about or moving around.

As background, the term 'active transport' was coined in the UK. It refers to walking, cycling and in combination with public transport on account of the human physical activity expended in contrast to car use (see Rissel on sedentary car travel). Car dependency/reliance is associated with weight gain, as 'evidenced' in studies of the uptake of car ownership among young men in China.

It is a collective term and has been named 'active travel' since that better describes what people do rather than conjuring up the image of a vehicle to carry people and users of public transport usually walk or cycle on some legs of the journey from home and back again, often with more than one destination. For the urban planning sector and transport sector where efforts for integration have been given much support, if less practice, recognition is for inter-modal travel rather than uni-modal travel (a welcome example is the terms of reference of a new Senate Inquiry into investment of government funds in public passenger transport www.aph.gov.au/senate/committee/rrat_ctte/public_transport/tor.htm)

It is is now used in Australia to denote what road authorities called 'non-motorised transport' or 'alternative transport' to motorised transport, the dominant form of land transport, described by the British Medical Association as 'health-damaging' (Mason 2000).

The Social Determinants of Health, the British Medical Association and the WHO (1999) Charter have recognised the value of contrasting human-powered travel with car travel (for references see Mason 2000).

Why is it vital for inclusion? For health, people need to be physically active everyday. Active travel is an obvious, socially acceptable opportunity as most people go out everyday, and some young people merely wait to be driven out by their parents. Also travel data from Sydney, for example, shows that almost 50% of car trips are less than 5 km (cyclable) and 30% trips are less than 3 km (some walkable) – were these to displaced, even in part, it would make a difference to environmental quality, risk of road trauma, and local traffic congestion.

Unless they own and care for a dog, many people do not achieve the desirable 'dose' of 30 accumulated minutes on most days of the week and the level of participation in sport over the life cycle is inadequate to meet this desired goal. In fact, I had thought the recognition of low participation in organised sport or even gymnasiums resulted in a shift of language from physical exercise (as in the old Canadian Air Force XBX days) to physical activity.

Active travel, substituting for car journeys, contributes not only to personal health and but to environmental quality by reducing pollution of the urban environment in the particular locality. This is often referred to as a double, or co-benefit.

To address active travel, it is necessary to get into the nitty-gritty of place management as this is divided territory – legally, professionally and organisationally. And needless to say, people notably Access Committees of

Councils report problems in crossing any of these boundaries and change from BAU to sustainable, livable environments is harder to organise because of the multiplicity of players (barely touched upon in the Discussion Paper, and probably not appropriate at this early stage).

Comments on Chapter 1 & 6: models of prevention & governance

This is a valuable chapter setting forth the conceptual basis and recognising governance as a key to change, particularly for societal problems such as physical inactivity[5]. Further detail is given in Chapter 6, pp. 50.

It seems anomalous, however, that the Taskforce has made much of the WHO's Social Determinants of Health yet has not strongly taken up the need for **intersectoral-action for health** or **healthy public policy** – one of the five actions for health promotion listed in the WHO Ottawa Charter (cited, but not applied in the Discussion Paper).

> I RECOMMEND greater recognition of the need for inter-sectoral action with respect to making urban areas more walkable and cyclable. Mention of health promotion across sectors (DP p.45) is insufficient.

Under governance principles, the Chapter appropriately recognises localised approaches within a broadly-based **universal prevention strategy** – but it is contradictory, then to 'target' people who are described as 'high risk groups'.

Therefore, the draft NPH strategy needs to address governance from the Federal level and its geographic distribution to effective local, context-sensitive governance – not only through the health sector but other government departments. , e.g. consider changing the function of the Australian Bicycle Council to fund regional cycleways and local cycleways to link into the regional cycleways; such link funding occurs in the UK.

The Discussion Paper notes some common frameworks, including a **'life-course' approach** highlighting the needs of different groups as they move through different stages of their lives. I note that people not only move through **time but also place and space**. This point is exceptionally well explained in Barton & Tsourou (2000) who refer to an ecosystem approach, 'creating settlements that provide a healthy human habitat' (pp. 83-141). The urban settlement, the local area, is governed and a considerable land area is in the public domain (not only parks, but the road reservation and car parking land).

Such **habitat or place-based thinking** helps to reveal that people need to get from home to some where else, such as a pre-school, a workplace – such facilities/ organised places are typically described as **'settings'** within the health promotion literature – or, as significantly merely to get around for social and recreational purposes their local neighbourhood (administered by local government). Getting to

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[5] Bauman & others (2002) p. 137.

or getting there represents a risk or opportunity for health as it may be either health-promoting or health-damaging[6].

Such place-based thinking, as a foundation for organisations/settings is applicable to considering the environmental aspects of physical activity and nutrition for healthy weight. Recognition that 'settings' are embedded in physical places, governed by local government, elevates the potential for addressing how people get about, get to and from, the 'settings'/facilities as well as how the 'settings'/facilities themselves deal with access, mobility and trip-making. Some organisations already deal with 'trip generation' to reduce greenhouse gas emissions because emissions from such trips are treated as an indirect responsibility of the facility[7].

Place-based approaches are also useful as a context for facilities/'settings' because facilities may be/can be **co-located** and thereby make trip-making more efficient by members of the same household. The consequence of preceding this conceptual layer prior to facilities/settings needs expression in the DP's priorities for action, set out in Table 1 – for comment see below.

Other areas of governments[8] are promoting **'transit-oriented development'** where mixed uses (types of facilities/'settings') are co-located within 10 minutes walk of a mass/public transport stops such as bus-rail interchanges.

To the 'settings'/facilities mentioned (DP p.7,16, 48), it would be valuable to add tertiary education facilities, campuses of colleges and universities for three reasons.
- First, unlike school children, tertiary students trip-making is independent of parents' journeys[9]. Tertiary students are generally undertaking a major life-cycle transition, a point known to be amenable to learning about personal travel to reach new places/settings[10].
- Second, campuses of colleges and universities tend to be quite large. As major trip generators, public transport services and the local management of the physical fabric of routes to the public transport stops, footpaths and crossing points, and cycleways and end-of-trip facilities need to be geared to users (encouraging use of physical activity). Legislation and guidelines already exist to support such user-friendly services, although their application may be geographically uneven and not strong.
- Third, many campus facility managers already have active programs for environmental sustainability, often with considerable faculty and student support. Federal government grants have been allocated for local, context-sensitive activities and programs – a substrate potentially for preventive health actions. There is a well-established network that could be engaged in developing the Draft Strategy and in subsequent actions.

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[6] Mason C (2000) citing British Medical Association's Road transport and health.
[7] See World Business Council for Sustainable Development & Gray v Minister for Planning & Ors (No 2) [2007] NSWLEC 91
[8] Infrastructure Australia and National Transport Commission. This integration between landuse and transport has been on the national agenda for a long time, at least since the 1991 National Greenhouse Strategy.
[9] Wen L-M, Rissel C, Fry F (2006?)
[10] NB Wetherill Park College of TAFE in western Sydney – project funded through the Federal Area Assisstance Scheme to produce Transport Access Guides for distribution in high schools and on enrolment days.

> I RECOMMEND that the draft NPH strategy refer directly to urban settlements/local areas(whether as local areas/localities) within which facilities/settings, such as schools, workplaces, shops, parks are located. The de novo planning or retrofitting of urban settlements, in terms of access and mobility, is pre-eminent structurally to actions that can be undertaken by the facilities (settings) themselves to reduce physical inactivity/promote physical activity. This is an issue for conceptual foundation for the Draft Strategy including the extent to which inter-sectoral action is envisaged and incorporated into governance options, and capacity-building for the staff of the draft NPH strategy and any subsequent National Prevention Agency.
>
> I ALSO RECOMMEND that tertiary campuses of colleges and universities be given higher prominence in the Draft Strategy.

As an important **principle of monitoring**, Chapter 6 lists 'capacity-building at regional and local levels'.

> I RECOMMEND that rather than as principle for monitoring, greater attention be given to building capacity at the local level, such as local government, in 'action research' for enabling and promotion increases in physical activity.

The Discussion Paper appears to give more attention to monitoring than to governance of the funds to increase physical activity, or actions to support whether led by health or other sectors, and this may vary from one region to another. Also, monitoring needs to include learning!

A strong case can be made for **performance measures** to encompass inputs, particularly inter-sectoral inputs/'specific service item' (DP p.50) (such as signage on new sections of safe cycling routes).

> Therefore, I strongly SUPPORT the use of National Partnership Payments to regions/localities rather than to States, and the development of data systems related to preventive activities for physical activity, including active travel, in the particular region.

A National Prevention Agency refers to development of a **national workforce** with developed capabilities (DP, p. xv) but omits the urban environment, inter-sectoral action, and critical thinking. It implies that such a workforce would be within the health sector.

> I RECOMMEND that capabilities for effective prevention of physical inactivity require understanding about the urban environment, inter-sectoral action, and critical thinking and that these areas be added to the list (DP p. xv).

Response to questions set out in the Discussion Paper: Chapters 2, 5 and 6

As noted in the Overview, I have not addressed the proposal in Chapter 5 for a national prevention agency but I expect to produce a short separate supplement.

Chapter 2

Q1. What is a realistic target for 2020? (page 18)

A target is proposed:

> *2020 target: halt and reverse the rise in overweight and obesity prevalence.*

Casting the target in this form seems not supportable from the discussion in the Technical Paper on Obesity.

The Technical Paper (p.13) makes a number of prudent observations and statues that the health goal should also address the disproportionate distribution of obesity, notably among people described as being in disadvantaged socio-economic groups.

> It is RECOMMENDED that the Taskforce consider a <u>composite</u> target – not only halting the increase but also increasing the level of physical activity.

Research from many jurisdictions, including NSW, that the geographic areas in which people in disadvantaged socio-economic groups predominant are also disadvantaged in urban form, being low density and inaccessible with poor transport services (McIntyre; Baum; Rissel; the VAMPIRE model, Dodson & Sipe).

Given this problem I suggest that the Discussion Paper is getting ahead of itself to be serious in thinking of claiming 'healthiest nation by 2020' – just let's not go there!

In this context, then, the use of modelling studies from the Netherlands (O p.13) for example has limited transferability to Australian urban settlements where the physical infrastructure is car-friendly rather than active travel-friendly.

Also, the Technical Paper has drawn extensively from the British <u>literature</u> and risks transplanting policy from a different societal and legal context that affects practice, for example at the local government level. In 1999, for example, the UK adopted a 'green tax' reform package reforming the subsidies to car ownership and use that still in Australia shape travel patterns and prestige at the workplace (O p.23), and most damagingly in local government. Also, many local government authorities had replaced the old-style road safety officer with mobility or 'active travel' advisers.

To know whether this target is achievable, the Technical Paper considers 'what is required' (section 3.2 pp. 15-19). This section is followed by a section "potential initiatives" and this documents most international experience in promoting active living, probably because much 'on-the ground' work in Australia is not published or known to the health sector[11]. It is likely this is the result of the different way of operating in the environment sector which has been a major source of funding for innovative active travel programs.

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[11] Reports commissioned by the RTA on the status of local government bicycle plans (through the NSW LGSA), on air quality management that resulted in trip generators within an area producing and using 'transport access guides'.

> It is RECOMMENDED that 'what is required' be re-formulated to achieve:
> - Links between primary health care and the local community for opportunities for active living
> - Situate 'multi-faceted, multi-sectoral response' (O p.15) within a geographic area, with clear governance responsibility such as a local government area and/or area/regional health service so that healthy choices are available everywhere
> - Incorporation of some actions currently identified as 'potential initiatives' and others needing identification for the Taskforce, such as in response to the forthcoming paper on the 'obesogenic environment' and hopefully the transition from this BAU toward an active living, active travel, healthy eating environment.
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> It is ALSO RECOMMENDED that section 3.2.8 be developed in detail relevant to the legal, organisational and professional arrangements in Australia.

The Draft Strategy would need to articulate its 'program logic' and how it would be applied in geographic areas.

Q2. How can key players (for example, individuals, communities, health services, industry and governments) be engaged from the outset?

> I RECOMMEND the draft Strategy strengthen its conceptual framework, indicated by Figure 1.2 (DP p.5) to more strongly represent governance and responsibility – its legal basis and geographic governance. Further, 'environmental factors' need to be unpacked to delineate the 'built environment' as overly abstract language is obscuring the legal responsibility for managing land and managing it in ways to increase physical activity levels everyday. This further analysis is likely to result in a clearer picture of who the key players are and ways in which they can be engaged in working collaboratively to achieve better health outcomes.

Given the geographical character of obesity, it will be necessary to create the organizational space and capacity to act effectively on health.

In *Closing the Gap* the WHO Commission (2008) recommended that:

> *6.3. Local government and civil society plan and design urban areas to promote physical activity through investment in active transport; encourage healthy eating through retail planning to manage the availability of and access to food; and reduce violence and crime through good environmental design and regulatory controls, including control of the number of alcohol outlets* (see Rec 12.3). (p.66) [emphasis added]

Also, within local government lie legally and structurally separate responsibilities for planning and managing private and public land, public land mostly comprising parks, roads and car parks. The professional groups planning parks tend to be separate from the planning of surround roadways and thus it can be difficult to

align the goals of safe and easy access to the parklands. In addition to professional boundaries, roads and park boundaries are often used to delineate jurisdictional boundaries between councils, other land managers including the state roads authority. These overlapping problems can lead to issues raised by Council Access Committees, typically crossing points, becoming seemingly intractable and neglected.

It is also helpful in developing a draft Strategy to acknowledge the efforts of many key players who have been engaged, sometimes as volunteers, for a very long time in creating supportive environments for health and in pioneering activities and programs.

Re-orientation of health toward prevention[12] is not only needed for obesity prevention, but also re-orientation of traffic and transport planning and management[13]. It has often been suggested that provision of walking and cycling need to be treated as **a form of affirmative action** given the many decades to prioritising the use of urban land for cars.

In practical terms, in expressing priorities it is helpful to show the directions to move in for more healthy eating and active living. Good examples are in the 2007 report World Cancer Research Fund – at least for expressing goals for public health and at the personal level. It's the players with the middle – between the individuals and the national public health aggregate – that need engagement, and on a geographically distributed basis. A good example of moving toward more environmentally sustainable neighbourhoods was set out in the WA Living Neighbourhoods guide contrasting BAU urban development with sustainable urban development.

It is RECOMMENDED that the Taskforce be asked to consider the feasibility of establishing an Ombudsman for Active Living as a protection against urban planning that fails to integrate provisions for connections by walking, cycling in combination with public transport.

Q3. What is the best combination of 'learning by doing' and, at the same time, building the evidence base?

The readymade phrase such as 'building the evidence base' contains some presumptions that need to be outlined particularly in the context of locally-based programs that connect the inter-personal, people engagement with the macro issues of institutions, organisations and physical conditions.

The Discussion Paper embraces the discourse of evidence-based policy making and building the evidence base as if this is unproblematic, or at least left unexamined. Given the span of work being considered from clinical nutrition to the built

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[12] For example, see Kaplan (1997).
[13] For example, Buis J speaking at seminar on walking and cycling, Metropolis Congress, Sydney 2008.

environment and human efforts to retrofit it, it is not useful to expect a one-size fits all approach to evidence.

Its curious too that heart health protection in the early 1990s had twigged to the value of investing in physical activity, particularly active travel rather than only more clinically-based interventions – the best buy for public health (Morris 1996). Indeed, the NHS Heart Health Policy required all NHS health services to adopt Travel Plans to encourage the use of active travel and reduce car use of staff, visitors and ambulatory patients and most of these Travel Plans liaised with the local authorities to assist in improved physical and service access. Is it ironic that in Australia cycling events donate to the Heart Foundation rather than the Heart Foundation lobby for local, connected cycleways to be built in towns and cities?

Australian writers Marston & Watts (2003)[14] undertake a critical appraisal of evidence-based policy-making as a diffusion from bio-medical thinking. It is germane to the Taskforce's challenge to develop a Draft Strategy because it stimulates thinking about the 'how' where it is more distant from clinical settings, such as action research on healthy weight.

Their aim, it seems, is to persuade would-be policymakers, such as the Taskforce, from treating evidence base as one reduced to the technical calculation of effectiveness and costing of well-defined policy options.

Fundamentally, to reduce the trend of growing obesity and overweight, actions from a proposed strategy – the 'how' – will have to engage with people; for example, people deemed 'at risk', people wishing to ride to work to manage their weight, and people offering cycling proficiency training. A problem with the managerial challenge of setting a national target and the risk discourse is that the writing transforms people who are 'at risk' of overweight into docile or even silent subjects. A strategy designed from this vantage point risks being unduly top down, hierarchical in knowledge claims and spatially blind whereas engaging with people where they live will entail dealing with their circumstances.

Many of the subjects express annoyance at the lack of footpaths constructed in new housing estates or the longstanding failure of governments to invest in cycling networks despite espousing the value of 'safe cycling' for clean air. Thus the subjects, in many geographic areas, already know[15] that governments and their traffic technicians have been remiss in their abject failure to invest in social and physical infrastructure such as safe, connected cycleways in neighbourhoods and regions. Prudently, some politicians have now publicly acknowledged the need to pick up their game; notably, the NSW Minister for Roads, jolted by the projected rise in the State health budget, spoke strongly of the need to provide cycleways so that people can ride the many short trips rather than driving. (SydneyCBD Mobility Forum, October 2008).

A further aspect of learning by doing is the use of appropriate scale geographic denominators and conversely avoiding aggregation that loses meaning. This is a particular challenge for a national strategy, but nonetheless important. Interest in the growth of cycling in inner Sydney (where the urban form and density is most

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[14] 'Tampering with the evidence: a critical appraisal of evidence-based policy-making' *The Drawing Board: An Australian Review of Public Affairs,* volume 3, number 3, march, 2003, 143-163. Published by School of Economics and Political Science, University of Sydney.
[15] Editorial, Sydney Morning Herald, 3 January 2009.

conducive), for example, had been masked by the use of a metropolitan-wide denominator.

As a lot of learning by doing entails capacity building, I RECOMMEND engaging Professor Penny Hawe & Lesley King and Marilyn Wise to update the supportive materials – *Capacity Building for Health* etc produced by NSW Health.

Q4. What can individuals and families do to be physically active, eat well and maintain healthy body weights?

Lots of things! The Draft Strategy needs to refer to the many consultations with young people, children, women and Access Committees about what they think would help them in how they live!

In addition to engaging them in programs, their neighbourhoods are likely to need some physical retrofitting and this will take time. Households will need the social support to do so – like the State and council-run household schemes for energy reduction. Other council initiatives such as setting aside land for community gardens is laudable, like the interest generated in fresh food available from farmer's/grower's markets and both are useful to encourage. But so too does the big question, where Commonwealth government comes in very obviously - about zoning and appeal to State governments of building on city fringes on arable farmland where urban density is low, public transport can function economically and people are deprived for the long-term by short-term thinking of design.

Enable people, both young people and adults to undertake cycling proficiency training – therefore, expansion of train-the-trainer programs. Support family-based cycling tourism, e.g. Mudgee Bike Muster Easter 2009.

The physical and social infrastructure needs to be adequate to cope too.
Caution is needed here: societal barriers are significant (Bauman & others 2002) and are not geographically uniform.

Aside from the physical barriers of deficient infrastructure, the soft infrastructure of capacity-building is also deficient or aggressively supportive of sedentariness (think rewards for car ownership, for subsidies for car parking etc). For example, Cycling Proficiency Training and Bicycle Maintenance programs need to be offered to secondary school students and on tertiary campuses.

It seems opportune to offer courses for trainers to provide programs jointly in healthy eating, active living whereas much current formal education is split between nutrition and physical activity, e.g the Deakin University programs. To cope with the needed increase in trainers, geographically spread, it would be useful to offer certificate level courses with competency-based advanced standing provisions and by distance learning.

Programs such as Gosford's 'Rebycycle' – a youth training program – has great potential for expanding to many other geographic areas, through the TAFE network, for example; other such piloted, successful programs could be extended too, e.g. Cycling in the City, and the Bike Bus program. None of these are Health programs, but have a health co-benefit.

Some web-based resources could be useful too. I note the US site Calorie Counter, claiming over a million registered users, that has interactive, record-keeping tools so it draws upon cognitive behaviour therapy, provides information about eating and physical activity, plus tools to connect people electronically and, potentially to groups in their neighbourhood.
http://caloriecount.about.com/

Some Australian sites are useful of course, such as the CSIRO, Australian Nutrition Foundation etc but the above site is far more comprehensive for individuals wishing to reduce or manage their weight. The Australian Fairfax website provides a useful source of recipes for vegetables in season, and allows the user to search for recipes that are 'healthy'.
http://www.cuisine.com.au/home

Some other actions:
- People, whether in adult-only households or households with children, could get around more without using a car. Some families have the resources to chose their residential location to be within walking distance of the local primary school. The Commonwealth Government could offer households program assistance rather than cash assistance for reducing its ecological footprint including its car use.

- In NSW take advantage of council-funded programs for capacity building such as cycling proficiency training and bicycle maintenance.

- The WHO Charter on Transport, Environment and Health (1999) addresses ways to reduce the reliance on private motor vehicles that would be in the common interests of each of these three sectors of society and the economy. From a health and safety perspective, the goal is for communities to use more health-promoting forms of transport, such as walking, cycling and public transport.

- The Taskforce could recommend that the Health and Hospitals Reform Commission have a brief for inter-sectoral matters, say with Infrastructure Australia.

- Signficant costs and impediments to improving footpaths arise from the powers of federal utilities and corporations to open the road reservation and locate services in the 'continuous path of travel'.

Q5. In what ways can high-risk groups be supported?

First, focus on where people at high-risk live and promote conditions that would enable more active living.

Second, provide resources, e.g. South West Sydney Area Health Service worked with aboriginal groups to produce a Transport Access Guide.

Third, provide a fund for supportive programs to be administered geographically. E.g. young people in Gosford area,

Fourth, utilise the knowledge about parental concerns and their children.

Writing from Western Australia, Lampard (2008) and colleagues studied parental concerns – or really, lack of concern about their **children** being overweight and concluded:

> *Interventions targeting childhood obesity should aim to optimise parental concern by reducing parents' underestimation of child body size and increasing their awareness of the effects of overweight and obesity on children's health and quality of life.*

- From a study of "Parental perceptions of overweight in 3-5 y olds" , Wake & others (2005) reported:

> *CONCLUSIONS: Parents were more likely to report poorer health and well-being for overweight and obese children (particularly obese boys). Parental concern about their child's weight was strongly associated with their child's actual BMI. Despite this, most parents of overweight and obese children did not report poor health or well-being, and a high proportion did not report concern. This has implications for the early identification of such children and the success of prevention and intervention efforts.*
> DOI:10.1038/sj/ijo/0801974

- I think it was a study by Carnell & others, University College London, in the UK on finding that only 1.9% of parents of overweight children and 17.1% of parents of obese children described their child as overweight concluded:

> *These findings suggest that parents of 3-5 y olds show poor awareness of their child's current weight status. Reframing discussions in terms of preventing future overweight may be an effective way to engage parents.*

Fifth, utilise the material set out in Getting Australia Active (Bauman & others 2002) – Part 3 Promoting Physical Activity with defined Population Groups, pp.102-127.

Sixth, consider extract on 'transport' prepared by Adrian Davis for the UK Acheson Inquiry into Health Inequalities – see Attachment 2.

Is this question of 'high-risk' or social disadvantage an issue of social class, highlighted by the VAMPIRE model (Dodson & Sipe)? However, uncomfortable the question and answers are here, its important to raise – a reading of Marston & Watts policy research study on juvenile crime is stimulating to read in this regard.

Also, see material prepared by Adrian Davis for the British Acheson report attached at Appendix 2.

Q6. Are the priorities for action appropriate? If you do not think they are appropriate, or have other suggestions, what would you

propose we do as a nation to halt the toll of early deaths and disease caused by overweight and obesity?

These seem to be priorities for the health sector, understandably for the Taskforce reporting to the Minister for Health and Aging.

> In addition I RECOMMEND that the Commission be advised of the value of the need for **inter-sectoral action** to achieve the turn around in the rise of chronic diseases associated with obesity, as argued in *Getting Australia Active*.

Furthermore, on obesity and overweight the emphasis appears to be on food whereas the evidence for **physical activity everyday** is widely regarded equally or even more convincing that for food. For example, the 2007 Panel on food, nutrition and physical activity for cancer prevention concluded that:

> *Sedentary living is causative.*
>
> *….Environmental factors (physical, economic, political, and sociocultural) are extremely important in determining health behaviour, including that which affects body fatness. (* World Cancer Research Fund/American Institute for Cancer Research, 2007p.322).

The Discussion Paper seeks comment on priorities set out in Chapter 2 Table 1 although the Obesity paper contains observations and proposed actions that do not seem to have been incorporated as priorities for action.

The Obesity paper (p.41) observes that increasing the environmental sustainability of an area is usually health-promoting. Societal change by inter-sectoral action – both within tiers of government and between tiers of government is required – not only as observed in the UK citing the 2007 Foresight publication – but in Australia too. For the Draft Strategy to be holistic for health, it makes practical sense to deal jointly with actions that have co-benefits, e.g. the substitution of car trips by active travel protects urban air quality (local, regional and global), reduces risk of road trauma, increases physical activity – yet without the availability of safe infrastructure (road crossings and safe cycleways) and communications (signage, maps etc) people are constrained to a car-dependent physical milieu.

Ch 2 Table 1 priorities – pp. 15-18

<u>Priority 3</u> – improve public education and information – only generally relates to increasing the levels of physical activity (or PAL).

The 2002 report *Getting Australia Active*[16] contained a section on 'next steps', noting that there is an over emphasis on programs relying heavily on enhancing knowledge, whereas what is needed is more systematic research; and, I would add, application of interventions in field settings (p.137).

Effective programs are often designed and piloted as the result of funding by State and Federal agencies, such as environment agencies, through Local Governments. Yet, there is no funding or mechanism to facilitate uptake of such programs in neighbouring council areas or in similar council areas in other States. For example,

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[16] Bauman A, Bellew B, Vita P, Brown W, Owen N, Melbourne, ISBN 0-9580326-2-9 www.nphp.gov.au/sigpah

the Cycling in the City program – a capacity-building program for workplaces and their staff within the local government area – was funded and rewarded in 2006 with prizes[17] but no dissemination program has been developed.

In local areas, public education and information could include practical aids such as funding for signposting. For example, Bike Bus Leaders recently requested[18] that signage for bicycle routes need to be erected, particularly on sections where physical improvements had recently been made. This project also highlighted the absence of adequate maps of safe cycling routes.

At a more structural level, the activities undertaken by Sydney South West Area Health Service on physical activity, particularly on active travel, could be considered for adaptation in other Area Health Service Areas, with the constituent local governments and equivalent community groups, such as Bicycle User Groups.

> Therefore, rather than national broad scale media, I RECOMMEND funding to support geographically-based communications and capacity-building (with small fund for physical repairs) to support people undertaken more physical activity.

Priority 4 – embed in everyday life + re-shape urban environments

These two priorities need to be reversed – settings/facilities operate within a locality and wider region, as argued above.

See discussion above.

> I RECOMMEND that the priority (reviewing and where necessary) re-shaping urban environments (DP p.17) should precede the priority to 'embed' in everyday life (DP p.16)because the urban environment is often the enabling/constraining milieu for people as householders or travelling to, or interacting in 'settings'/facilities.
>
> I ALSO RECOMMEND the inclusion of tertiary colleges and universities as an identified 'setting'/facility throughout the Draft Strategy.

On page 17, the Discussion Paper proposes an Action 'to promote and support re-orientation of urban obesity-promoting environments' and an associated Benefit. This topic is of great importance to ensuring and retrofitting urban areas so that they are walk-friendly, cycle-friendly and are connected by public transport.

> I RECOMMEND that the topic of re-orienting urban environments to support obesity prevention (by being walk- and cycle- friendly and connected by public transport – 'active travel') needs considerable development for the Draft Strategy, particularly the content in Table 1 Priorities Action, Benefit.
>
> As a consequence, I ALSO RECOMMEND that the package of reform, entertained in Chapter 5.1 and Chapter 5.2 , needs to include this topic of a re-oriented urban environment and the drivers for funding at the local, regional, state and federal levels – so far, Chapter 5 does not admit of the need for physical changes. It could

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[17] The Heart Health in Priority Groups award category; and a 'silver' from Environs Australia Local Government Sustainability Leaders Awards.
[18] Supplementary Report Environment, Water, Heritage & the Arts

be wasteful to embark on social marketing unless it is highly related to the physical and social reality that people face in the places where they live, work and play.

Considerable work in the area of re-orienting the public domain for sustainable mobility is already available for a Draft Strategy to draw upon.

At a more structural level, the Draft Strategy needs to note the growing support by local governments for re-orienting the public domain for a smarter use of space for people to use active travel (walking, cycling and in combination with public transport) from serving cars to serving people better. Two examples: the Melbourne Transport Forum[19] (19 Melbourne metropolitan councils) and the Inner Sydney Cycling Plan (15 councils)

Chapter 6 (page 52)

Q1. Are these measurements appropriate?

On PA, what would that entail?
See formulation in World Cancer Research Fund (2007) publication as preferable.

What data sets already exist that could be used?
Depends what 'data sets' mean? In context of urban settlements, suggest metropolitan and urban plans and integration of 'active travel'.

Transport Data; Census data; caution about limited meaning of conventional data, e.g. length of roadways with painted cycling logos in 'dooring' zone as and improved composite indicators expressed as a percentage increase of people cycling over a known baseline.

Q2. If not, what would you propose?

Avoid risk of over-investing in monitoring at the expense of locally-based implementation of programs.

First, start in the health sector's own backyard: what are Australian hospital standards doing? For example, work with the Australian Council on Healthcare Standards to more clearly specify the promotion of active travel under its standard for physical access to health care (2002 ed).

Second, collaborate with Sydney South West Area Health Service to consider the possibilities and cost of other health areas undertaking physical activity and healthy eating programs with their communities and with councils.

Third, consider more status reviews of local government e.g. on their progress with bicycle plans that connect up with State-based regional networks, through State-based local government associations in concert with cycling organisations (to improve level of community trust).

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[19] http://www.pt4me2.org.au/downloads/mtf_plan.pdf

Consider creating expectations of trip generators about their support for active travel for health, e.g. produce transport access guides, refurbish to include end-of-trip facilities as in guidelines and on Your Development website etc etc etc

Comment on the three levels proposed

> In Ch 6 Performance indicators, I recommend another tier, Tier 4 – Inter-sectoral action for health. Part of the problem has been the collapsing of the determinants of health plus the omission of the spatial organisation of urban settlements.

There's an undue emphasis on individual behaviour whereas much change is needed to organisational behaviour, such as local governments, the tertiary education sector and the transport sector. The use of determinants of health has somehow dropped out these sectoral relationships.

Other relevant information

(for example any technical, economic or business information, research-based evidence supporting the view being expressed)

Yes, the great opportunity for enabling and encouraging active travel.
More information is available on request.

Omissions in the Discussion Paper or alternative approaches

Risk arising from change -

- Responding to continuing challenges – a good example is the research/development program of Australian Bicycle Council

- Recognise the value of the Standards Australia guidelines on managing risk in sport and recreation (2002) in response to liability and insurance concerns taken up by the Standing Committee on Recreation and Sport of the Ministers Council (SCORS). Seek support from the Australian Transport Council and the Australian Bicycle Council to respond to the legal advice provided by Slater & Gordon, in the public domain, on shared footpaths.

Consider the 2007 report from World Cancer Research Fund/American Institute for Cancer Research with particular respect to:
- The use of quantified physical activity levels (PALs)
- The use of advisory statements for health policy and for the general public.

Inter-sectoral action [20]

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[20] The rationale for 'inter-sectoral action for health' and healthy public policy, WHO strategies in the WHO Ottawa Charter for Health; the basis for the social determinants of health, and what is known as the McKeown thesis.

Further considerable economic and other benefits would arise from a population that is of healthy weight/not obese, including to health status and health equity (such as reduced disabilities from motor vehicle collisions and road noise), reduced greenhouse gas emissions, and greater social inclusion.

In early 2006, Paul Gross, Institute Health Economics and Technology Assessment noted that the costs of health care and to employers of people becoming obese, overweight and sedentary had outstripped the NSW health budget at over $10.8 billion. The orientation at that time was on services provided through health insurance or as Dr Tim Gill supported urgent intervention, suggesting employer-based programs through tax breaks. More recent research shows that workplaces with end-of-trip facilities would help people who would ride to work. It is appropriate that the Discussion Paper as a pre-eminent step supports the Henry review of the FBT concession for motor vehicle purchase and use, monies saved could be spent on improved urban infrastructure for integrated, multi-modal active travel.

The Taskforce refers to the 2004 report from the Australian Chronic Disease Prevention Alliance estimating that for every 1% increase in the proportion of the adult population that is physically active there would be a saving of $8 million annually (O p.52). A question – is this estimate a saving to the healthcare system? Or indirect savings from other sectors as well? (noting Gross' estimate that the productivity impact would be a 2.5 factor higher than health costs).

In a recent policy discussion of inner city traffic congestion, for example, Sydney's Lord Mayor referred to an analysis of motor traffic on Sydney's Anzac Bridge that found by diverting 10 per cent of car occupants to bicycles - or about 730 cyclists an hour - the life of the current bridge would be extended by about eight years, a saving of $46 million based on present-day construction costs (Sydney CBD Mobility Forum, convened by NSW Department Premier & Cabinet, November 2008; page 15 www.infrastructureaustralia.gov.au/public_submissions/published/files/471_cityof sydney_SUB.pdf)

Towards a national strategy for both food <u>and</u> physical activity levels (PALs)

In the Obesity Technical Paper (O p.52), the Taskforce concludes on the health and cost benefits in meeting the challenges of obesity by improvements in nutrition and physical activity levels. It then proceeds to argue for a <u>national food strategy</u> in the context of preventative health, and specifically for its role in the prevention and reduction of rates of obesity and overweight.

But the conclusion does not refer to an equivalent role for a national physical activity strategy. It is silent on this possibility. So, I raise several questions:

- Does a national physical activity strategy already exist?
- Would it not be necessary for a proposed national food strategy to deal with (a) the conjoint relationship between diet and physical activity as risk factors for obesity and overweight in engaging with people across Australia?
- At a decentralised level of practice – at the area health level, or local government level – would it not be more meaningful and feasible to have a strategy combining tiers of interventions relevant to diet and physical activity levels? Such a strategy would necessarily address the 'creating supportive environments' and capacity-building for both factors.

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Promotion of exercise in primary care
Concerted efforts can improve patients' health

Effective promotion of exercise could result in substantial healthcare savings, but this is hampered by our limited knowledge of how to achieve sustained increases in physical activity.

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pdf/obesityresponse.pdf

NSW Health
Capacity building resources
Capacity building is an approach to development that builds independence. Capacity building increases the range of people, organisations and communities who are able to address problems, and in particular, problems that arise out of social inequity and social exclusion. This area focuses on capacity building in health promotion
http://www.health.nsw.gov.au/public-health/health-promotion/capacity-building/index.html

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Appendix 1 – Taskforce terms of reference

1. support the further development of the evidence base on preventative health, to inform what works and what doesn't;
2. provide advice for policy makers on what strategies work best at a population level, and on the best buys for government investment in primary prevention;
3. provide advice on the most effective strategies for targeting prevention in high risk sub-populations including Aboriginal and Torres Strait Islander peoples and people living in rural and remote locations;
4. provide guidance and support for clinicians, particularly in primary care settings to play a more effective role in preventative health care;
5. provide advice to Government on options for better integration of preventative health practice into the Medicare Schedule and other existing government programs; and
6. support the development of inter-governmental and public-private partnerships on preventative health.

Appendix 2 – Extract from UK Acheson Report on inequalities in health

Inequalities - Davis 1998

9.1   The key aim of any recommendations must be to improve access for all in order to reduce inequalities. The most equitable mode of road transport is walking and the least is the car. Most measures targeted to reduce car use will improve access for those without access or with only limited access to cars. This can only be achieved, however, if walking, cycling and public transport are seen as more attractive to car users than use of these vehicles for most journeys. This will require an unprecedented level of support for alternative modes of transport to the car backed up by vigorous traffic restraint measures and removal of fiscal incentives which engender habitual car use.

9.2   An over-riding goal will be, therefore, for the DETR to establish motor traffic reduction targets (as proposed in the Road Traffic Reduction (UK Targets) Bill and to develop complimentary targets for increases in walking and public transport. DETR should establish a Traffic Reduction Unit, headed by a senior civil servant, reporting directly to the Secretary of State, to co-ordinate action to achieve the traffic reduction targets.

1. Policy. Decentralise funding and responsibility for local transport from central government while providing an overall policy framework and monitoring of local authority policies. At present over 80% of local transport funding is controlled by central government.

Benefits. Greater autonomy for local authorities to develop integrated transport strategies which meet local access needs within national policy framework.

Evidence. European countries with the best records regarding provision for and use of alternative modes to the car have the most decentralised systems of government in the world. Denmark and the Netherlands are examples, having had major decentralisation programmes beginning in the 1970s.