COMMONWEALTH OF AUSTRALIA

Proof Committee Hansard

SENATE

OBESITY EPIDEMIC IN AUSTRALIA

Issues related to the rise in obesity among children in Australia

(Public)

MONDAY, 6 AUGUST 2018

SYDNEY

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SENATE

OBESITY EPIDEMIC IN AUSTRALIA

Monday, 6 August 2018

Members in attendance: Senators Colbeck, Di Natale, Paterson, Singh, Storer.

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

ALEXANDER, Dr Shirley, Staff Specialist and Head of Weight Management Services, The Children’s Hospital at Westmead ................................................................. 1

ANNISON, Dr Geoffrey, Deputy Chief Executive Officer, and Director, Health, Nutrition and Scientific Affairs, Australian Food & Grocery Council ............................................. 52

ARANDA, Professor Sanchia, Chief Executive Officer, Cancer Council Australia; and Chair, Australian Chronic Disease Prevention Alliance ........................................ 59

BARCLAY, Dr Alan, Private capacity ........................................................................ 22

BARDEN, Ms Tanya, Chief Executive Officer, Australian Food & Grocery Council ................................................................. 39

BOYD, Ms Susan, President, Federation of Parents and Citizens Associations of New South Wales ......................................................... 39

BROOME, Mr John, Chief Executive Officer, Australian Association of National Advertisers ................................................................. 16

CATOR, Dr Megan, Project Officer, The Children’s Hospital at Westmead ................. 16

CUNNINGHAM, Dr Frances Clare, Senior Research Fellow, Menzies School of Health Research ................................................................................................. 39

DAY, Mr Ross, Director of Broadcasti ........................................................................ 39

DENNEY-WILSON, Professor Elizabeth, Professor of Nursing, Centre of Research Excellence in the Early Prevention of Obesity in Childhood ........................................ 22

DOUMANI, Mr Patrick, Member Support Officer, Federation of Parents and Citizens Associations of New South Wales ......................................................... 39

FAIR, Ms Bridget, Chief Executive Officer, Free TV Australia ........................................ 33

GOW, Dr Megan, Project Officer, The Children’s Hospital at Westmead ................. 39

JOHNSON, Professor Greg, Chief Executive Officer, Diabetes Australia ..................... 16

JOLLY, Ms Fiona, Chief Executive Officer, Ad Standards ........................................... 16

JONES, Ms Alexandra, Research Fellow (Food Policy and Law), Food Policy Division, The George Institute for Global Health ................................................................. 22

KIRKLAND, Mr Alan, Chief Executive Officer, CHOICE ........................................... 39

LAM, Ms Sarah, Clinical Psychologist, Nepean Family Metabolic Health Service .......... 39

LEE, Professor Amanda, Senior Adviser, Australian Prevention Partnership Centre ................................................................................................................. 1

MIHRSHAHI, Dr Seema, Research Translation Coordinator and Senior Research Fellow, Centre of Research Excellence in the Early Prevention of Obesity in Childhood ................................................................. 1

MITCHELL, Ms Julie Anne, Director of Prevention, Heart Foundation; and Member, Australian Chronic Disease Prevention Alliance ........................................... 1

NEAL, Prof. Bruce, Deputy Executive Director, The George Institute for Global Health ................................................................. 1

PARKER, Mr Geoff, Chief Executive Officer, Australian Beverages Council ................. 27

PRATT, Mr Steve, Nutrition and Physical Activity Manager, Cancer Council Western Australia; and Member, Australian Chronic Disease Prevention Alliance ................................................................. 1

REEVE, Dr Belinda, Co-Founder, Food Governance Node ........................................... 22

ROGUT, Mr Jeff, Chief Executive Officer, Australasian Association of Convenience Stores ................................................................. 39

SMITH, Mrs Belinda, Founder/Director, The Root Cause ........................................... 39

WILLIAMS, Dr Kathryn, Clinical Lead and Manager, Nepean Family Metabolic Health Service ................................................................. 39
WITNESSES—continuing

WILSON, Professor Andrew, Director, Australian Prevention Partnership Centre ............................................. 9
ALEXANDER, Dr Shirley, Staff Specialist and Head of Weight Management Services, The Children's Hospital at Westmead

DENNEY-WILSON, Professor Elizabeth, Professor of Nursing, Centre of Research Excellence in the Early Prevention of Obesity in Childhood

GOW, Dr Megan, Project Officer, The Children's Hospital at Westmead

MIHRSHAHI, Dr Seema, Research Translation Coordinator and Senior Research Fellow, Centre of Research Excellence in the Early Prevention of Obesity in Childhood

Committee met at 08:32

CHAIR (Senator Di Natale): I declare open this hearing of the Senate Select Committee into the Obesity Epidemic in Australia. These are public proceedings, although the committee may determine or agree to a request to have evidence heard in camera. I remind all witnesses that in giving evidence to the committee they are protected by parliamentary privilege. It's unlawful for anyone to threaten or disadvantage a witness on account of evidence given to a committee, and such action may be treated by the Senate as a contempt. It's also a contempt to give false or misleading evidence to a committee. If a witness objects to answering a question, the witness should state the ground upon which the objection is taken, and the committee will determine whether it will insist on an answer, having regard to the ground which is claimed. If the committee determines to insist on an answer, a witness may request that the answer be given in camera. Such a request may also be made at any other time. Could I please remind those contributing that you cannot divulge confidential, personal or identifying information when you speak. If you wish to supplement your evidence with written information, please forward it to the secretariat after this hearing.

Let me now welcome a representative from the Centre of Research Excellence in the Early Prevention of Obesity in Childhood and the Children's Hospital at Westmead, Sydney. Thank you for appearing before the committee today. I'll invite you to make a brief opening statement if you've got one—you don't have to. I'll hand it over to you, if you've got a particular word in which you'd like to go.

Dr Mihrshahi: Thank you for giving us the opportunity to appear as witnesses to the inquiry. I'm Dr Seema Mihrshahi. I'm a research fellow at the University of Sydney's School of Public Health. I'm here with my colleague, Professor Elizabeth Denney-Wilson, who's also from the University of Sydney. We're very pleased to be here representing the Centre of Research Excellence in the Early Prevention of Obesity in Childhood, or CRE EPOCH. Our research is focused on developing and trialling interventions to prevent obesity in the early years, from birth to five years. Our centre has been funded by the National Health and Medical Research Council and includes researchers from seven universities within Australia and overseas. The main aim of our work is to reduce the prevalence of obesity and obesity-related behaviours in the first five years of life in order to transform the health trajectories of the next generation. We know that's an ambitious aim.

The main point we'd like to make is that obesity is completely preventable in early life, and one in five Australian children are already affected by overweight and obesity at the time of school entry. If we wait until school age to intervene, it's too late. Many obesity-related behaviours—poor diet quality, decreased physical activity, screen time and poor sleep behaviour—are established in and track from early childhood, so our research focuses on providing anticipatory guidance to parents to help them as their babies grow and develop. Our research suggests that children who are obese experience higher total healthcare costs than healthy-weight children. If we can prevent obesity in early life, there will be cost savings to the health system.

Our submission covered a number of the terms of reference, and we've also made a number of specific recommendations around early childhood. But we also recognise the need for interventions in later childhood and across the life course as well as interventions influencing the broader environment of children—where they play, eat and live—so we also recommended a number of more general strategies.

In summary, obesity in the early years is completely preventable. Our work provides evidence of effective prevention strategies that can be incorporated into routine health care and will hopefully ultimately result in cost savings to the health system.

Dr Alexander: I'm Shirley Alexander, a senior paediatrician at the Sydney Children's Hospitals Network's Westmead campus and head of weight management services there, and this is my colleague, Dr Megan Gow, who's an experienced dietitian and researcher in the field of paediatric obesity. Thank you for this opportunity to address the committee on behalf of The Children's Hospital at Westmead, Weight Management Services, and the Child and Adolescent Weight Management Pathways Study team.
Obesity in children and adolescents, as with adults, needs to be treated as a chronic disease. Clinical intervention to treat immediate and longer-term obesity-related complications is as important as implementing preventative public health measures. Worryingly, the prevalence of severe obesity in the paediatric population has increased significantly and with this a greater degree of complications, such that, for example, we now see children as young as eight years old with type 2 diabetes, secondary to obesity. Type 2 diabetes was a disease that used to only be seen in the adult population.

Childhood obesity is a stigmatised and sensitive issue, and often the presence of obesity and its potential serious implications are not recognised by either the parents or the clinicians. We work to increase recognition and overcome barriers, raising the issue to enable early intervention for greater success. Research indicates that healthcare costs for children with obesity, even as young as between two and five years of age, are much higher than those for children of a healthy weight. Interventions using family-centred behavioural change in diet and activity have been shown to be effective. Currently, the demand for clinical intervention services far outweighs available resources, and there is a significant resource gap for treating adolescents between 16 and 18 years of age.

We recommend, amongst other things, that all states and territories provide dedicated training for health professionals as well as services to clinically manage childhood obesity. At a federal level, we would recommend a review of Medicare rebates associated with accredited-allied-health-professional consultations for children with obesity to encourage and enable greater support in healthcare intervention, including an increased number of sessions for families of children and adolescents with obesity.

CHAIR: Thank you very much.

Senator SINGH: Thank you to all of you for appearing today for this first hearing of this committee's inquiry into the obesity epidemic in Australia. I want to first draw down on some of the points that Dr Alexander has made in relation to family based care—or community based care, I think it's often called—or programs. This goes to both sides. Where do you see the current gaps are in relation to that sort of early intervention through community based or family focused, or based, programs?

Dr Alexander: From a clinical perspective, within New South Wales Health or the New South Wales state, the only community intervention program is the Go4Fun program, which is for ages seven to 13. For anything outside of that age—younger or older—there is no community based intervention. For hospital or healthcare intervention, you have your primary, secondary and tertiary level carers; however, there is a dearth of multidisciplinary teams to provide clinical intervention at that level. There is only one well-established multidisciplinary team, and that's the Weight Management Services at the Children's Hospital at Westmead within NSW Health. However, since the 2015 Premier's Priority tackling childhood obesity, there have been a number of LHDs working together as a collaborative working party, and through sharing information and resources there are a number of additional clinical services that are developing in other LHDs. There are a couple of secondary-level services in John Hunter Children's Hospital, for example, and the Northern Sydney LHD, so we now have about five services within NSW Health at a secondary and tertiary level for clinical intervention.

My understanding is that we are ahead of other states. There are some states and territories within Australia that don't even have a tertiary multidisciplinary team, and some of them only have the one service—for example, in Perth there's one at the children's hospital there. There are some services down in Melbourne. There's a fledgling service in Adelaide and in Queensland—I've just started. There is definitely a gap between demand and resources at a clinical intervention level.

Prof. Denney-Wilson: One of the things that are really important is the real challenge in the early childhood years. Young children tend to see their general practitioner, their practice nurse and their child and family health nurses. There are very few services to support those young families with young children who are identified as having rapid weight gain in those early years, or who might be above a healthy weight, where we really need our whole-of-family approach to the issue. There are a number of preventive programs available for the nought-to-two-year-old children in New South Wales, and certainly our centre has trialled and is upscaling some of those programs around prevention, but for children who are identified with rapid weight gain—which we know is associated with being overweight and with obesity, and children with rapid weight gain in the first year of life up are about four times more likely to be overweight or obese as children—there's very little available for those children. So what do we do to try and reverse that or to try and get that growth trajectory back to a healthy trajectory? That is a real gap.
Dr Alexander: At the end of the day, the primary healthcare physician—the general practitioner—is the main point of contact for the majority of children. However, we know that there are a number of barriers that general practitioners see as preventing them from either recognising the issue or addressing the issue, including: they don't feel there's enough time to address the issue; remuneration is an issue; lack of education and the experience or confidence to address the issue—

Senator SINGH: By the GPs themselves?

Dr Alexander: GPs in the primary healthcare sector. There are studies to show that paediatricians don't feel trained enough. As a medical student many years ago, this never even came up. This wasn't an issue. Whereas now we are looking to provide specific education for medical students at university to highlight the issue that early intervention and prevention is—as I said, you need both. You need prevention and you need clinical intervention for those that are affected. However, it's a 21st century chronic disorder that many clinicians haven't had enough education and training and overt experience in, and we are aiming to change that by highlighting the issues. NSW Health, for example, along with us and the working party have put together a website called HealthyKids. It is basically a resource website giving you health pathways and guiding people through what to do once you've recognised and raised the issue. There are resources for the health professional to hand out to families. We've made them available in several different languages. There are BMI charts that you can use to start talking about the issue. We've done video vignettes of how to raise the issue. Four years ago our group put together an online e-module program called Weight for Kids to help with health professional education and training. That's on the website as well to make it readily available for clinicians and healthcare professionals to undertake to improve their knowledge.

Prof. Denney-Wilson: Regarding the BMI-for-age charts, one of the issues we know in general practice is that, just like the rest of the population, we can no longer really recognise by just looking at children which children are at risk or which children are above a healthy weight, because, as the weight of the population has shifted upwards, our interpretation of what an unhealthy or above-healthy-weight child looks like has also changed. So using BMI-for-age charts is a really important first step in terms of being able to identify a child who is above a healthy weight. All of the resources that Shirley has mentioned are designed to get primary healthcare providers using those charts as a way of identifying kids at risk and also as a way of raising the issue with parents about children being above a healthy weight. But if you don't use those BMI-for-age charts then it's unlikely you're going to be able to recognise that a child is above a healthy weight. At the extremes it will be obvious, but if you show a group of health practitioners photographs of children who are below a healthy weight, above a healthy weight, and well above a healthy weight, many will identify the children above a healthy weight. All of the resources that Shirley has mentioned are designed to get primary healthcare providers using those charts as a way of identifying kids at risk and also as a way of raising the issue with parents about children being above a healthy weight. But if you don't use those BMI-for-age charts then it's unlikely you're going to be able to recognise that a child is above a healthy weight. At the extremes it will be obvious, but if you show a group of health practitioners photographs of children who are below a healthy weight, above a healthy weight, and well above a healthy weight, many will identify the children above a healthy weight. All of the resources that Shirley has mentioned are designed to get primary healthcare providers using those charts as a way of identifying kids at risk and also as a way of raising the issue with parents about children being above a healthy weight. But if you don't use those BMI-for-age charts then it's unlikely you're going to be able to recognise that a child is above a healthy weight. At the extremes it will be obvious, but if you show a group of health practitioners photographs of children who are below a healthy weight, above a healthy weight, and well above a healthy weight, many will identify the children above a healthy weight. All of the resources that Shirley has mentioned are designed to get primary healthcare providers using those charts as a way of identifying kids at risk and also as a way of raising the issue with parents about children being above a healthy weight. But if you don't use those BMI-for-age charts then it's unlikely you're going to be able to recognise that a child is above a healthy weight. At the extremes it will be obvious, but if you show a group of health practitioners photographs of children who are below a healthy weight, above a healthy weight, and well above a healthy weight, many will identify the children above a healthy weight.

Senator COLBECK: I know plenty of people in the medical profession who spend a lot of their time upgrading or updating their qualifications and their skills because of new drugs, new understandings of different conditions and all those sorts of things. I understand your comment, Professor Denney-Wilson, about what you're seeing in the community and what you accept as the norm, because I'd make the same observation myself. Given this is obviously a recognised problem, an issue, I'd probably agree that, in the last decade or decade and a half, there's been a lot more focus on it, just going back through some of the historical data and information. But to suggest that medical practitioners don't have the skills, broadly, or the confidence to deal with it I find a bit hard to come to grips with, given I know people that I associate with in the medical profession spend a lot of time making sure they're on top of what's happening now. The institute that you're representing is only relatively new, from what I can see, which obviously concentrates the focus. But explain to me how the medical profession could be so far behind in this space? I find that hard to come to grips with, when there's been such a focus on it.

Prof. Denney-Wilson: I wouldn't suggest that they're a long way behind. I would suggest that most general practitioners and practice nurses are seeing perhaps 20 people in a day. They have numerous things that they need to deal with in a day, cradle-to-grave kind of issues. This is one issue, and it's an important issue, but one of the things that we know is that, once their attention is drawn to it, then their behaviour will change around weighing and measuring. For example, some research that I've done, and others have done similar research, shows that if you say to general practitioners and practice nurses, 'This is a really big issue. We'd like to work with you on this,' they'll say to you, 'We know it's a really important issue. Overweight and obesity is a really important issue. We just don't have many overweight kids in our practice.' And then, if you say to them, 'Well, would it be okay if you weighed and measured every child you see for the next week,' they'll do that, and they'll plot it on a BMI for age chart and, sure enough, they generally have the same prevalence of overweight and obesity in their practice as the
community does as a whole. And that realisation will stick, and that's a really simple intervention that we can do in general practice to get GPs and practice nurses weighing and measuring kids and saying, 'Right. Actually, we do have a problem. We've readjusted the way we look at kids, and this is one way we can do it.'

**Dr Gow:** As well as recognising the issue, the problem that general practitioners have is knowing how to address the issue, whether it be nutrition advice or physical activity recommendations, and I think that's what Shirley was talking about before. These online programs on upskilling clinicians to deal with this issue are really helpful but may need to be rolled out further to engage general practitioners in this area on how to really address the issue. It's also a sensitive issue, telling a parent that they have a child with obesity or overweight. Generally, a general practitioner may not feel comfortable telling a parent that, and I think that's another issue as well. The other issue is not knowing where to refer these kids, because, as Shirley has mentioned as well, there are limited services. Things are improving in New South Wales, but in other states there are limited services, so a general practitioner feels overwhelmed by this issue and doesn't have anywhere to send these kids. So I think there are a lot of barriers for general practitioners in properly addressing the issue of overweight and obesity in children and adolescents.

**Dr Alexander:** I think, overall, one of the things to maybe consider is: as clinicians, we've been very good at picking up weight loss in the well below a healthy weight or failure to thrive situation, because that has greater immediate implications—of potential sudden death, for example—in the paediatric population, whereas it's maybe different in the adult population, and I can't talk for them. But in the paediatric population, until more recently, and I think this is changing, there has been the perception that, if a child has overweight or obesity, it's puppy fat and they're going to grow out of it, so don't worry about it. Whereas, the research basically says that if you don't have any intervention—particularly in children who have obesity or severe obesity—the natural trajectory is for that obesity to continue. Because we don't see children dying immediately from severe obesity—although we have had a few deaths secondary to obesity complications in this state, and there are certainly many examples in America; they're ahead of us in that sense—there isn't necessarily that sense of urgency. As Elizabeth said, we're much better at picking up the more severe end for a number of different reasons.

What we're aiming to get across is that we need to be picking up these children earlier. Therefore, picking them up when their trajectory is beginning to go up and they're in the overweight or above a healthy-weight category and actually do something about it. Because, at the end of the day, it's not about weight per se, it's about health. It's about these children being healthy, optimising their energy and their opportunities for a long, healthy life. If we don't make those interventions at an earlier stage, we know that the likelihood is that they go on to have excess weight issues and all the complications that that come with that. I think because this is a newer problem, a little bit like allergy within the paediatric population, it's something that many clinicians, particularly older clinicians, haven't come across quite so much.

As I said, a lot of the research shows that many of the barriers include the feeling that they don't have the time to deal with this, because this is going to take a lot of time, so because of the time factor many people don't necessarily raise the issue or they have difficulty, as Megan said. Because it's such a sensitive thing, particularly general practitioners don't want to raise it because they think it's going to upset the family. Whereas the research suggests that, in fact, parents want you to raise any health issues, including weight management, but many GPs won't raise it because of their own barriers of feeling uncomfortable about raising it.

All our efforts are geared towards helping clinicians to recognise and raise the issue in a non-confronting, non-stigmatising way so that you can actually just start that journey. There's so much to show that if you don't say anything, nothing changes. Whereas, even if you do say something like, 'Did you realise that your child's above a healthy weight? Is that something that's been worrying you? If not, let's have a talk about it, maybe the next time when you come,' because most children present to health professionals not because the parents say I'm worried about my child's weight, they usually say they've got asthma, they've got multiple ear problems, they've got tummy aches or constipation or whatever, and obesity actually complicates and exacerbates all of these things. But unless the child has more severe obesity and is having psychosocial problems in terms of bullying and low self-esteem issues, most parents don't come to health professionals saying, 'I'm worried about my child's weight.'

**Senator COLBECK:** But you're not going to address it if you're not going to talk about it.

**Dr Alexander:** Exactly.

**Senator COLBECK:** I mean, I might not want to hear I'm going to have a heart attack, but someone's got to tell me otherwise it's—

**Dr Alexander:** Absolutely. As health professionals, just as ordinary people, we have our own barriers and our own stigmatisations and biases, and aiming to get over that in the health professionals is basically a lot of our
CHAIR: I just want to take a step back because we've sort of gone down the very important path of how it is that we respond at a clinical level. You're our first witnesses for the hearings, so I think it's worth just teasing out a little bit of context for us all and to get your perspectives on the burden of disease and the health impacts associated with obesity—I think you've already described some of them: diabetes, heart disease and so on. There's a great deal of evidence in your submissions and others about the economic costs associated with obesity. But something's happened over the last three decades or so—there's been a significant shift. This wasn't the case over three decades ago. The prevalence of obesity, and particularly childhood obesity, was nowhere near as high as it is now. I'm interested in your perspectives on what's actually changed. Why has that shift occurred? So can you perhaps just talk to that and give us a sense, from your perspective? It's not that suddenly doctors became bad at treating this, and that may be something that we need to explore in terms of our response. But why has it happened?

Dr Mihrshahi: There are multiple sectors of influence on obesity prevalence. It's a complex condition and there are genetic factors that are important, biological factors and societal factors—

CHAIR: But people's genetics haven't changed over 30 years.

Dr Mihrshahi: No, but the societal factors have. I'm coming to that. So it's not just caused by the imbalance of intake and expenditure; there are a multiple levels of influence. With little children it's also the family level influences: the availability of healthy food; mothers breastfeeding; parents' preferences and modelling; physical activity; and the knowledge, education and skills of the parents. Then there are the community level influences, such as parks and green space around for parents to take their children to, and cycle ways and cycle paths. Then there are the government and societal influences: government policies, marketing of unhealthy foods to children and so forth. So it's those societal influences that have really changed over the last 20 years.

CHAIR: Can you talk to that in more detail? You mentioned one aspect. You're saying those other things are relatively stable—the genetics and family influences—so the thing that's changed, in your view, is the societal influences?

Dr Mihrshahi: Yes, definitely.

CHAIR: Can you perhaps unpack that at bit?

Dr Mihrshahi: And also the food composition. Baby foods and so forth contain a lot of sugar and unnecessary ingredients, so that's changed as well.

Prof. Denney-Wilson: In terms of the nought-to-five space, since 20 or 30 years ago the breastfeeding rates have been reasonably stable. We have very high initiation rates of breastfeeding in this country, but there's quite a big drop-off in the first month, so a lot of people are using infant formula. It used to be the case, when I first started in this game, that we worried about women diluting formula because they were worried about the cost. But now what we see is people overconcentrating infant formula, which gives babies more calories, in the belief that that might help babies to sleep a bit better. There are other formula feeding practices that have possibly changed recently around not being cognisant of babies' hunger and satiety cues, and overfeeding babies with infant formula.

I guess one other thing that's changed in terms of babies slightly older than one is that it used to be the case that we transitioned young babies to family meals. Babies went from the breast or infant formula to the family meal. Whereas now a lot of products have turned up that are specific toddlers there that are really quite unnecessary in the diet if a child is eating a balanced family meal. One of these is toddler formula, which is advertised pretty heavily by the formula manufacturers. That's something that is completely unnecessary in a toddler's diet, but is advertised in such a way that suggests it is a necessary part of a toddler's diet. Those kinds of influences on families around what they should be feeding their kids, and that toddlers are somehow beings that need a particular product line of foods, are some things that have changed dramatically in the last 20 years and are completely unnecessary.

Dr Mihrshahi: The other things that have changed as well are screen time—putting children in front of screens—and marketing to children, like games that incorporate marketing factors. Children are always really
attracted to colourful characters—you've got cereal packets with colourful characters—and we know that children, when they're two, three and four, have a lot of influence within supermarket trips—pester power. That has changed substantially in the last 20 years as well.

**CHAIR:** You mentioned screen time. One of the things that often comes up in this is how much of this is about food and how much of it is about physical activity. Can you talk to the contribution that you think each of those factors makes, and how big a factor is the lack of physical activity with regards to screen time? Is there any evidence to show that kids— I suppose you're talking about a younger age group. Is there evidence to suggest that young children or toddlers are spending more time in front of screens than they were previously?

**Dr Mihrshahi:** Definitely; there's a lot of evidence to suggest that. Like I said, it's a whole level of influence. It's the food environment, as well as physical activity, that may be causing this problem.

**Dr Alexander:** The NSW Health submission gave a few numbers on things. Less than 10 per cent of children eat the recommended amount of vegetables a day. Only 50 per cent of children have the recommended amount of fruit a day. The amount of physical activity has decreased significantly—only 24 per cent of children do the recommended amount of physical activity. Many people think of physical activity as organised physical activity—playing sports after school or in school—whereas, actually, the incidental activity is the more important activity, and that's gone down too. We now no longer even get up to switch off our televisions. We don't get out of our cars to open our garages. We buy pre-prepared food that's chopped up. All these little things add up to mean that we move much less than we used to.

The other thing—it is almost like the forgotten factor—is that studies show that, on average, we sleep one hour less a night. We have children that go to bed at 11, 12, one, two or three o'clock in the morning, because they're on their screens and computers playing games or texting. Children have their phones by their bed and they're using Instagram in the middle of the night, so sleep is interrupted. Sleep is very important to get our hormones, particularly our eating and appetite hormones, back into balance. There's a huge amount of research going into how lack of or poor-quality sleep can influence weight gain. I think that's definitely one of the, I would say, 'new kids on the block' that's often forgotten about, and it goes across the board for adults and children.

Most of the research out there is on television screen time but there is more research on the small screens coming out—iPhones, computer gaming, iPads, that sort of thing. Basically it's excessive, and we all do it. Unfortunately I can't remember the data but there was a nice study from Melbourne that showed that, on average, adolescents and adults spend about 45 or 46 hours a week purely on screens.

I think the way we are living has changed markedly. We're much more sedentary. A third of our intake, in adults and children, is what's called empty calories. Those are high-energy dense foods such as chips, biscuits, sweets, lollies and non-nutritious foods. That's a third of our diet. Our diet's changed, and the way we conduct our lives has changed. There are also epigenetic changes, around switching genes on and off during pregnancy—I'm not as familiar with that but that certainly seems to be a factor. Another 'new kid on the block' is endocrine disruptor chemicals and influences—what's out there in the toxins in the environment that might also be causing some epigenetic or obesity-producing factors? It truly is multifactorial, and it's now all trending in the direction of the easier or the less healthy choices. Most of us human beings go for the easiest option. Most of us don't choose to climb a mountain every day to get fit. We choose the easier options. We're time poor. We spend a lot of time sitting busy doing things or sitting in traffic—it's just life. Our lives have changed markedly over the last 20 to 30 years.

**Prof. Denney-Wilson:** If I could add, the easy choices in terms of food and beverages are often the cheaper choices. The availability of energy-dense, nutrient-poor foods has exploded in the last 20 to 30 years.

**Dr Gow:** If I could add, going back to the initial question of what's changed in the last 30 years, another major factor which leads parents or families to go for the easier option as well. In the eighties a lot of mums went into the workforce, and I think that's created a lot of time-poor families as well. I'm not saying that's the cause of obesity; I'm just saying that that is also correlated with the time-poor family situations where families are needing easy quick options. We need to encourage these families to choose healthier quick options. It's very difficult, when they're coming home after picking up their kids from school, after school care or childcare and they drive past six or seven fast food chains on the way back to their house, to inspire them to go home and chop up the vegetables and cook a healthy dinner, because the availability of fast food is rife. That makes it hard for families to make the right choice, when those options are just so glaringly in their face on their way home from childcare.

**Senator PATERSON:** I have a basic medical question which might sound strange but bear with me: is obesity contagious or infectious?
Dr Alexander: That's a good question! You could say it's contagious in the sense that, if you are in an environment where there are obesity and obesogenic behaviours and factors, it's shown that those who move from an environment where obesity is low in prevalence to an environment where obesity is high in prevalence take on that community obesity risk and level. It's contagious in that sense, that you can develop obesity being within that environment. I'm not sure that it covers—it's not infectious.

Senator PATTERSON: It's not communicable. I'm not going to pick it up by sitting next to someone, am I?

Dr Alexander: No, you're not. However, if you sit beside someone who eats more, you will tend to eat more. If you sit beside or with people that have bigger plates and bigger cups, you'll eat more. If you sit with someone who's watching TV or a film, you'll eat more. If you get bigger containers, you'll eat more. One of the strategies that we use and suggest with families is: use smaller plates. Even though you might know it's a smaller plate, it's amazing how we will still eat less because it looks like it's more. That's all part and parcel of that. We're very poor at judging.

Can I go back to your question, Senator Colbeck, on clinicians not being trained in that. It is because, for growth patterns going upwards, most of the time people have relied on eyeballing a child and saying, 'That child looks okay.' We're trying to change that practice to say we can't say that anymore, because the average is shifting and we need to be doing measurements and plotting and starting to raise the issue at a much earlier stage. At the end of the day it's much easier to intervene. All the studies show that the earlier you intervene, the more successful your intervention is. I've been doing this for nine years now. When I first started we had a three-year-old child that weighed 10 times their age, so 33 kilograms. In the past 18 months we've had children three years old that are up to 56 kilos and 14-year-olds that are 240 kilos. Many of them have developmental disabilities or behavioural problems such as autism spectrum disorder. These children have real problems around texture, taste and colour. Often food has been used as a reward for good behaviour. That's not just in children with disabilities.

Food is part of our culture. It's often part of welcoming people, showing love and respect and that sort of thing. You need food to survive. We've developed an unhealthy relationship with food. Children don't know what it's like to be hungry anymore. Parents are worried that their child's going to be hungry, so they take things with them just in case. The snacks are energy dense and high in calories, which is evidenced by the fact that children don't eat vegetables. Many children don't even know what certain vegetables are. I'm losing my train of thought here.

Senator PATTERSON: I get the point.

Senator COLBECK: Socially communicable.

Dr Alexander: It's socially communicable, exactly.

Senator PATTERSON: The reason I asked is that often in public debate we refer to obesity as an epidemic. Even this committee is titled 'the Obesity Epidemic'. No-one's suggesting that it's not a very serious problem, but in your submissions, other than referring to our community title, I couldn't see either of you describe it as an epidemic. Is it medically correct to call it an epidemic? Is that the correct definition?

Dr Alexander: Actually I think pandemic is almost the correct definition, isn't it?

Senator PATTERSON: It's global.

Dr Alexander: So it's not just an epidemic, which is more over a short period in time; it's a pandemic, as it's occurring globally. We're in the top five in the world with overweight and obesity rates. The fact that a minority of adults are within the normal weight range is a sad state of affairs. Mostly it shows that it's very difficult not to be influenced by our environment. We eat more. We are less physically active than we used to be.

Prof. Denney-Wilson: I take your point, Senator Paterson, but our submission would suggest that it doesn't matter what you call it; it's a really important issue, and—

Senator PATTERSON: Terminology is important. Ebola is definitely an epidemic. Something that rapidly spreads over a couple of weeks is an epidemic.

Prof. Denney-Wilson: Absolutely.

Senator PATTERSON: Is obesity a problem we've been dealing with over generations, decades, an epidemic?

Prof. Denney-Wilson: I would suggest that it is reasonable to call it an epidemic, because it affects so many people. I'm an epidemiologist. I understand that from an epidemiological point of view it would not fit the traditional definition of epidemic, but it affects an enormous number of people. If calling it an epidemic gets the attention of policymakers like yourself then I think it's perfectly reasonable.

Senator PATTERSON: So it's a political tool, not a medical term?

Prof. Denney-Wilson: Okay.
Senator STORER: I am very interested in the opt-out consent process in height- and weight-monitoring surveys by GPs. Every GP reviewing children and parents would be undertaking BMI tests, they would be?

Prof. Denney-Wilson: I think opt-out consent has been suggested in monitoring and surveillance on a population basis. In clinical presentations it would be perfectly reasonable to weigh and measure every child.

Senator STORER: Even if the GPs aren't picking up that someone is overweight or obese, wouldn't there be numbers that guide them to have a discussion with the parents?

Prof. Denney-Wilson: Even though it is part of the recommendations for preventive care, we know that it's not done in most consultations. As Shirley mentioned before, there has been a big push to get GPs and practice nurses in New South Wales weighing and measuring every child and using a BMI-for-age chart. Weighing and measuring them is not enough; it needs to be plotted on a BMI-for-age chart to look at progress and trajectories.

Senator STORER: You're saying that's not mandatory.

Prof. Denney-Wilson: Nothing that happens in general practice is mandatory. It is highly recommended. It's part of the guidelines. We know it isn't done universally, but we're pushing to change that in New South Wales.

Dr Gow: Opt-out consent is in reference to population studies in schools. We want opt-out consent rather than opt-in because traditionally it was opt-out, and it has been changed to opt-in. That's why, in our epidemiological work, it might look like the prevalence of overweight and obese children is stabilising. We believe that parents who have overweight or obese children are not opting-in for those sorts of surveys, because they are not comfortable with their child being identified as overweight or obese. That's why we propose or recommend that it's changed back to opt-out, so that we capture a more realistic number for the prevalence of overweight and obese children and it's not underrepresented.

Senator COLBECK: We have gone through the issues around a couple of factors in the medical profession, but I want to ask a question about trusted sources of information to help with this. There is so much stuff out there—10 years ago you shouldn't drink high fat milk; now you can drink high fat milk—coming out of the dietary profession. How do we resolve this issue for people who are genuinely looking for trusted sources of information. The comment you made, Professor Denny-Wilson, about toddler or transitional foods—as part of your research work, which I hope is mapping some ways forward, how do we determine trusted sources of information in this information-rich era?

Dr Alexander: We've been working on that website with New South Wales Health. The feedback from parents, families and patients is that they get mixed information. They want the same message. I would say that one size doesn't fit all, in the sense that some families need different directions as to whether it's to do with eating, physical activity, screen time or sleep. However, if you look at the research, you find that communities with less processed food, a high intake of fruit and vegetables and a high intake of water, rather than sugar sweetened beverages, are much healthier.

Working with New South Wales Health, we put together all these resources on the website, and one of the resources is just an A4-size picture that's called '8 for a healthy weight'. It's actually nine, because the centre bit is a picture of a family sitting at a table together eating a meal. It's not talking about calories or a specific fat or sugar intake per se; it's just healthy measures for anyone. It doesn't matter what weight you are, what size you are or what gender you are. There are things like making water your main drink, eating the recommended fruit and vegetables, watching your portion sizes, doing the recommended physical activity of 60 minutes of moderate activity a day, getting enough sleep, reducing your screen time, and healthy snacks. So there are very general but sensible messages that we'd like to think health professionals can use and give to families as a sort of one-stop shop to say, 'Which of these areas could you start to look at to make it healthier for you and your family?'

CHAIR: Thank you so much for your time. With regard to that final question, if you've got any additional information, we're more than happy to take anything that you might want to provide us on notice. Thanks for helping to kick off our proceedings today and what should be, I think, a really stimulating and very important few days for this committee. Thanks again for your contribution.
ARANDA, Professor Sanchia, Chief Executive Officer, Cancer Council Australia; and Chair, Australian Chronic Disease Prevention Alliance

LEE, Professor Amanda, Senior Adviser, Australian Prevention Partnership Centre

MITCHELL, Ms Julie Anne, Director of Prevention, Heart Foundation; and Member, Australian Chronic Disease Prevention Alliance

PRATT, Mr Steve, Nutrition and Physical Activity Manager, Cancer Council Western Australia; and Member, Australian Chronic Disease Prevention Alliance

WILSON, Professor Andrew, Director, Australian Prevention Partnership Centre

[09:27]

CHAIR: I now welcome representatives from the Australian Prevention Partnership Centre and the Australian Chronic Disease Prevention Alliance. Thank you so much for appearing before the committee today. Before we do that, do you have anything to say about the capacity in which you appear today?

Prof. Lee: I'm the senior adviser for the Australian Prevention Partnership Centre, based at the Sax Institute. I was also the chair of the Australian Dietary Guidelines Committee for the NHMRC.

CHAIR: I now invite you to make an opening statement.

Prof. Wilson: Thank you. The Australian Prevention Partnership Centre was established to look at translation and implementation of research, bringing to it a systems perspective on the prevention of lifestyle related chronic disease. I emphasise that, from the start, there was a recognition that the problems of dealing with chronic disease are broader than just individual behaviour but that we had to think about it from a systems perspective. We had to think about the whole context in which those behaviours that lead to chronic disease arise.

Prof. Aranda: The Australian Chronic Disease Prevention Alliance consists of peak organisations in diabetes, kidney health, cancer, stroke and diabetes. Really our focus is on prevention and shared risk factors. We know that one in two Australians have chronic disease, that one in four have two of those conditions and that a third of that disease burden could be modified or prevented through these risk factors, particularly around physical activity and healthy diet. One of the critical factors that we're concerned with trying to snap the inertia around is obesity. I think that would be where our country sits at the moment. If everyone in Australia had a healthy weight, that would mean we would have 33 per cent less diabetes than we have now, 38 per cent less chronic kidney disease, 38 per cent less oesophageal cancer—and, in fact, 12 other cancers would be impacted—and 25 per cent less coronary heart disease; and we would reduce strokes by 22 per cent. If we could get Andrew's stats use down, when he's wearing his other hat, we would certainly fund a lot of things that we're talking about today.

I think it's important, and it was emphasised in the earlier session, to not see obesity as just a question of personal responsibility. It isn't a lifestyle choice and it isn't about a lack of willpower, although, obviously, personal behaviours are also important. It is a complex condition that has been normalised within our society, which undermines the fact that it has genetic, biological and social roots. We actually live in an obesogenic environment, and this environment means that we're in a situation where never before in our history have we been able to consume so many calories in such a short time. One drink can give us our daily cal-

So we think that it's time for Australia to have an actual plan, a national strategy, to address obesity and overweight, and it should be a whole-of-government plan, because it's not just about things that we think are important in terms of risk factors and some of the recommendations that are in our report but also about our physical environment—the way we get to and from work, everything about how we plan our urban environments and the way that we go about those things. We want to emphasise those things.

What we often hear is that there's no place to start and that people don't agree, but in fact 36 organisations agree with the recommendations in the Tipping the Scales report. The ones that are particularly emphasised by the Australian Chronic Disease Prevention Alliance are to protect children from the marketing of unhealthy foods—someone asked before, 'What's the trusted source'; let me say it's not the food industry. The other recommendations are to invest in nutrition programs; to fix up the health star rating system, which has seen so many loopholes that it's almost become a problem in and of itself, and make it mandatory; to support the food reformulation activities of the Healthy Food Partnership; and to then also invest in well-researched, sustained social marketing about the benefits of healthy diet and physical activity. We also support a sugary drinks levy—
not just to generate revenue for public health programs but also in recognition that elsewhere such a levy has reduced consumption.

CHAIR: Thank you very much. I might just kick things off, and I'm going to ask you the same question I asked the previous witnesses: what's changed over the last three decades? In your view, what has been the significant change that's occurred that has taken us from the position we were in more than 30 years ago, when our rates of overweight and obesity were a fraction of what they are today?

Prof. Wilson: I want to take a specific example, because I think it really illustrates the nature and size of this problem and the rapidity with which it can occur, and that is the farming population of Australia. A little over 10 years ago, the farming population of Australia had an average body weight which was reported as lower than that of the rest of the population. In a period of some 10 years, that has changed, and now the body weight in rural communities is actually higher than that in the rest of the Australian population. So you can see that these things change very rapidly. Well, ask yourself: what is it that's changed for farmers? It's been about the change in the nature of the work environment, and the change in the nature of all the other things that have happened in their lives is part of what's going on there.

The two elements I want you to take away from that is: one, this can occur very quickly; and, two, it's not a single thing that leads to this. It's a series, a whole range, of events that leads to these sorts of changes. So, if we think about that over the last 30 years, you had a very good description presented to you before about the range of things which have changed across that period of time in which obesity has become a major problem in the Australian population—and, in fact globally—as an issue.

Mr Pratt: The thing that I know that has changed most is the commercial determinants of health. Calories are far more available than they've ever been before. We're marketed to more than we've ever been before. I do a fair bit of community presenting, and the story that I tell is: I learnt to drive 25 years ago in Perth. If you wanted to get petrol on a Sunday in Perth 25 years ago, you had to go to a roster petrol station. So, you went to the nearest petrol station, and there was a sign that told you where to go. When you got there and went inside, the petrol station sold fanbelts, spark plugs, oil and those types of things. Contrast that with today where there's a petrol station on every corner. They're open 24 hours a day, seven days a week, and, when you go inside, they're effectively junk food outlets. That's a nice encapsulation of the change in our food environment over the last 25 or 30 years.

Prof. Lee: In terms of the food environment, the thing that's changed is this ubiquitous availability, affordability, accessibility and acceptability of what we call discretionary food—that is, foods and drinks that are not required for health that are high in added sugar, saturated fat, salt or alcohol that are actually displacing healthy food from our diet. So this environment is causing a double whammy. We've got less than one per cent of Australians consuming diets consistent with the Australian dietary guidelines, but we have got 35 per cent of energy of adults and 41 per cent of energy of vulnerable groups—I work a lot with Aboriginal and Torres Strait Islander groups—that are disproportionately affected by these environmental changes. Again, in only 20 years, working on the APY Lands in Central Australia, we've seen people go from hunter-gatherers who were fit and healthy to being obese, diabetic and on renal dialysis. It's just having a devastating impact for those communities.

Ms Mitchell: In relation to physical activity, we now live in an environment that has engineered effort out of our minds. We have an increasing reliance on cars, machines and technology—so much so that eight in 10 Australian children and over half of adults do not meet physical activity requirements. As a way of example, the most common way for children to get to school these days is by car—it's up from 46 per cent in 2011 to 54 per cent in 2015. I think we can all recall how we got to school and, for most of us, it would have either been walking or cycling to school. That picture has changed.

CHAIR: I'm going to one more and then I'm going to hand over. Professor Aranda, you mentioned the health star rating system. You said that it's become a problem rather than part of the solution. Can you explain that, and what needs to be done to address it?

Prof. Aranda: Certainly there are too many loopholes where foods that are not healthy can be labelled as healthy. I'm going to flick to Steve who's right on top of this one.

Mr Pratt: I am, and I would also suggest that that's a good question for the George Institute who are up after us—they're experts on this. It's a problem in as much as it's created debate. The system itself is not perfect, but it's okay. It incorrectly identified—close to 100 per cent—that around 97 per cent of foods are at the right end of the spectrum. That doesn't mean it can't be improved. To be completely effective, it needs to be mandatory. There are issues around added sugar—they're considering added sugar in the algorithm behind it.
The other one that comes up is: as prepared or as purchased—that's complicated and a specific issue. Probably a good example of that is tinned soup versus packet soup. Is it the way that you eat it at the end or is it the way that it's sold so you can compare those two things? We also know—and there's some really good evidence from a few groups, including Professor Simone Pettigrew—that it shows that it does improve healthy choices. If you have a system like that, an indicative system, people choose the healthier foods.

**CHAIR:** So the information is important.

**Senator SINGH:** I just wanted to ask you, Professor Lee, or Professor Wilson. The centre did this study into affordability of diets, healthy or unhealthy. I'm a little bit confused, because you talk in that about how current unhealthy diets cost more than healthy diets. But, at the same time, you go on to say that a healthy diet is already unaffordable for low-income families, costing up to 31 per cent of their disposable income. I want to challenge this issue of a healthy diet being more affordable and an unhealthy diet being unaffordable, because we know that, when the fast-food outlets offer a free sugary drink with a hamburger and package it all up at quite a low price, that can end up meaning unhealthy diets can actually be more affordable. So I just want to challenge that study and see how you came to the conclusion that a healthy diet is, in fact, more affordable.

**Prof. Lee:** We were surprised too—that's the first thing I'd like to say—because the rhetoric is that the cost of healthy foods is one of the factors that stands in the way of uptake and intake of basic healthy foods. So we did something that, surprisingly, had not been done before. We're now doing this globally, as part of a group called INFORMAS, which is benchmarking and monitoring all sorts of factors that contribute to food environments. I'm leading the food price and affordability domain of that group. What we did that was novel in our national health survey was actually to cost what Australians say they're eating. Now there are issues around underreporting etcetera, which you'll hear about, but we took at face value what Australians said they were eating and we compared that with the equivalent types of foods and dietary patterns that a family of four would need to eat to conform to the Australian Dietary Guidelines, which is actually quite a radical change. It means a lot more of those basic healthy foods and a lot less junk, the discretionary foods I discussed before.

We went into supermarkets. We've now done Queensland, Sydney and Canberra, and I'm doing work now on the APY lands in Central Australia. When we cost what Australian families say they're eating, the total amount is about 15 per cent more than basic healthy foods. Firstly, in Australia, where we have a GST exemption on basic healthy foods, that just shows how critically important that is, because if healthy diets are already cheaper we do not want to put any additional impediments in the way of encouraging Australians to eat healthily. It probably shows that there are other factors beyond price. The rhetoric is that it is price that's the dominant feature that determines choice, but our work is showing that it's convenience. It's that ubiquitous availability and it's the advertising and promotion of junk, because the other thing that we were surprised about in that study was that it showed that the Australian family of four, on average, would get 38 per cent of energy from discretionary food and drinks, or junk, but that is costing the Australian family 58 per cent of its food budget. So, with 58 per cent of Australians' food budget going on junk, it's no wonder we have the food industries that push those products trying to maintain the status quo. So it has given us incredible insights.

We had trouble getting that study published. It took me two years to get that study published because editors kept saying exactly what you're saying: 'This doesn't make sense to us.' So we were delighted when the Australian Bureau of Statistics looked at household food expenditure and the consumer price index of foods and change, and they came up with the figure of Australian families spending 58.2 per cent of the food budget on junk. Finally we had the validation of that study that we needed.

So what it shows is that on TV it looks like hamburgers and chicken nuggets, etcetera, are cheap, but when people go out and buy them for the whole family and have chips and soft drinks with that and have enough to fill up men—we know that most men don't stop at one Big Mac—it's actually much more expensive to feed a family on those junk takeaway foods than it is to take home basic healthy foods and cook. But in order to cook you need facilities, you need time and you need the skills. We've lost those skills as a society. We have kitchens being developed in high-rise apartments that don't even have cooking facilities in them anymore. We've got Deliveroo and others taking that place.

**Prof. Aranda:** Those skills are really important. Just to use an example, I have a two-year-old grandson who is in a group of 17 other kids, and he's the only healthy weight child in that group. He's the only one who has a mother who prepares all of his food herself; every one of those other mothers buys it prepackaged from the supermarket. It's normalised in our young people today.

**Prof. Lee:** You can get healthy prepackaged foods. I think there are opportunities to work together to develop those lines. But they're not they're not just reducing a little bit of added sugar, a little bit of saturated fat or a little bit of salt. We're really in danger here of the healthy cigarettes stage. Reformulation of junk food is going to
produce more junk food, but a little bit healthier. We really need a revolution to get back to basic, healthy food that's formulated on a very strong evidence that NHMRC has about what Australians should eat and the dietary patterns that are most aligned with optimum health outcomes that are also equitable and good for environmental sustainability.

Senator COLBECK: I was going to ask the same question Senator Singh did. I have to say, to me your research does make sense. I'm a bit bemused that it took you two years to get it published. It is a perception thing about price; it's not a reality thing, as your research shows. It's a bit like some of the other situations. I hate to confuse Senate inquiries and issues, but the marketing of milk at a dollar a litre gives the impression that the big supermarkets are cheaper, when quite often they're not, for example. So it's a created perception thing. Fast food, if you go and buy it, is not cheap when you compare it to the cost of buying the ingredients and putting something together. So it's not about price; it's about other social cultural perception issues that are that are driving this. So it's good that that fact can now be put out there, because I think it's a reality. Obviously it was something that struck me very much in your research as something that should be part of the broader discussion. It also shows that price is not necessarily the issue when it comes to diet. Professor Lee, your comment about blokes eating two Big Macs, for example, probably goes to the consumption issues. We had a conversation earlier around portion size, how much we should be taking in, and general knowledge of that or desire to actually accept that with the social norms and the scale of the human population—I don't mean necessarily the number of us, but the size of the shadow we cast instead.

Prof. Wilson: One of the earlier questions was around what's changed. Well, one of the things that we can point to that has changed over this period of time is the serving size. If you look at things like some of these takeaway foods, the actual serving size which is being sold for the same price has basically increased over that period of time, so you get a substantial effect from that.

Prof. Lee: The other thing I'd like to say about price is the issue is what people are buying with their dollar. What we're seeing is people are not just buying food; they're buying entertainment and they're buying appeasement of their children that are demanding this junk food. There are other values that are being attached to the food that go beyond food being used for health. It's really important to understand the social domain and all the pressures that are on people to use food in a completely novel way that humans didn't evolve to do.

Senator PATTERSON: I'd like to follow up on this issue of affordability. I've seen other research which confirms what you've said as well, Professor Lee. In March 2017 the Institute of Economic Affairs in London published a paper on comparing the cost of healthy and unhealthy food. I appreciate you haven't seen it, but I'd be interested in your comment on one of their findings. They said that one of the ways we've previously measured the affordability of food is on the cost per calorie. The example they have in the paper is a low calorie, low-fat yogurt and a high-fat yogurt. You would say that the low-fat yogurt is less affordable because you'll get fewer calories for your money, but, in a meaningful sense, for a human being, we're not struggling to get calories in a day. So it's not a useful comparison. Is that a fair assessment?

Prof. Lee: That's exactly right. Previous studies have looked at the cost per energy density. You have kilojoules on each side of the X-Y axis. The data is spurious. They have to be related to each other, and that's why we came out with the wrong idea, I think, originally. This is what's been so good about The Australian Prevention Partnership Centre. We work in partnership with policymakers and practitioners that are in touch with the community on the ground and know the most meaningful ways to frame research questions that will give us the answers we need to tackle real-world problems. Often, previous studies have been ivory-world, desktop studies. We need to bed research in this area in obesity in the real world.

CHAIR: Can I follow up on this question of price. What you're not factoring in is the convenience—the time it takes to prepare the meal. If we're talking about walking into a fast-food establishment versus a restaurant or any outlet that provides healthy food consistent with NHMRC guidelines, surely the fast food is cheaper.

Senator COLBECK: I don't agree.

CHAIR: Well, I'm going to ask that question. I'm keen to get an answer. If you're talking about the cost of the ingredients and to prepare the meal but not factoring in time, isn't that a factor here? And then there's the other aspect of going to a fast-food restaurant. If you go into Macca's or Hungry Jacks with the kids, there's an entertainment aspect to that visit that you might not get if you were sitting at home, with the kids in front of the telly while mum and dad are preparing a healthy meal. I just want to hear your thoughts on that.

Prof. Lee: The entertainment factor speaks to what I was talking about before with what people are buying with that dollar: they're also buying obesity for their kids, with that entertainment. The other issue around the costs of factoring in fuel, access to fast foods, the driving time et cetera—I have a PhD student in New Zealand,
Dr Sally Mackay, who I co-supervise with Boyd Swinburn and who I think has been mentioned in several submissions here. We did the work to cost in those various other inputs, even electricity prices et cetera. In New Zealand, because they do not get that GST exemption, factoring in those additional prices just pushed things over parity, and healthy diets are a little bit more expensive. That is definitely what we do not want to see. It was about eight per cent—the difference to factor in those additional costs. In Australia it's still cheaper, and we should be able to market that and promote that to families. Price can still be a barrier, particularly amongst the Aboriginal people that I'm working with, who are now spending 80 per cent of the their income on foods and drinks.

**Prof. Wilson:** In urban and rural areas.

**Prof. Lee:** Yes.

**CHAIR:** The corollary is that, if we were to increase price for unhealthy foods, it's not going to have an impact on consumption. That would be the conclusion some people may draw from that. I want to hear your view. You heard the opening statement about sugar-sweetened beverages. Can you perhaps again talk to that.

**Prof. Lee:** What we're dealing with at the moment is a balance situation. That's ground zero. Currently, our data is showing that Australian families are spending four per cent of their food budget, on average, on soft drinks. I presume that's what you're alluding to. If there were a change to increase the price of unhealthy foods, including soft drinks, the insight that we have from overseas study is that it would still have an effect. We're in a balance at the moment—an unhealthy balance.

**Mr Pratt:** I think the difference between cost and value has been captured well, and there's additional value that people place on fast food and entertainment. But the other thing is those foods themselves. What's changed in the last 30 years is that these multinational companies have teams of food scientists working to make their food delicious and so you come back and so you don't get fooled as quickly—all of those things. There's some really clever manipulation in those foods around the proportions of fat, salt and sugar—the bliss point—so that you come back, and that's why we eat more. The notion that we need to learn about portion size has some merit, but, in light of foods that don't trigger those normal satiety cues, it becomes a harder proposition.

**Senator COLBECK:** Mr Pratt, I want to explore some of your comments around the star rating system. I think it's been in place now for about five years. I'm interested in what evidence you have in the context of how it's working and if it's working. What data do you have that supports where your views are on it at the moment? I understand the difference in different types of foods as well as, during the development of the star rating system, some of the things that were going on around, for example, how you would rank dairy. A three- or four-star in dairy is not the same as a three- or four-star in a different prepackaged product. So stars don't equal stars across the system, which I think is one of the issues with it. But then I think perceptions around what you would now eat in dairy have changed from what they were four or five years ago. I come back to the comment I made before about quality information, trusted information and how those sorts of things work, but I'm interested in that data that sits behind where you see the utility of it and how many people are actually using it. I go shopping every week, and I have to say I've never looked at the star rating on anything I've bought. That's why we eat more. The notion that we need to learn about portion size has some merit, but, in light of foods that don't trigger those normal satiety cues, it becomes a harder proposition.

**Mr Pratt:** Let me start by saying food and classifying healthy and unhealthy foods—food is complicated, and I think we spoke to that, but that's also not a reason to do nothing. It's important; we have to do something. There are always going to be anomalies. One of the issues through the inception and development of the health star rating is that the committee that was involved with that had both public health and industry at the table and I think that, whenever we see industry at the policy development table, they have a vested interest—to sell more product. But whether that belongs at the policy development table is probably a key question. Some of the issues we've seen with health star rating down the track can be traced back to the influence of industry at that table. Industry should be at the implementation table because industry are the ones who are putting their labels on their foods and all of those sorts of things. In terms of uptake and that type of thing, that's a question that I might put on notice for the people behind me with the George Institute. They've done a lot of work around that. Rather than me blustering my way through that, talk to the experts about that.

I can provide some studies and evaluations that show that health star ratings are effective when compared to other front-of-pack labelling things. I don't have those papers with me, but I can certainly provide those.

**Senator COLBECK:** So it's based on the Australian experience?

**Mr Pratt:** Yes. There are some really nice studies. Professor Simone Pettigrew is the one that's done a lot of that work and I collaborated with other people from around Australia—and Mark Lawrence.
Senator COLBECK: Does it line up actual sales data with what people say?

Mr Pratt: No. I suspect that accessing the sales data might be a bit tricky. There's a degree of commercial-in-confidence around that.

Senator COLBECK: It wouldn't be hard to get there. I disagree with that as a statement because there's a lot of information about what products are actually sold and where. It is not difficult to line the two things up. My experience over a long period of time is that what people say they will do or they want to do is completely different from what they actually do. Take diet out of for a moment. Going back over a decade to my first experience around country-of-origin labelling, when you walked into a supermarket and you asked people what they wanted, 90 per cent of them would tell you they wanted to buy Australian product, but, when they went to the checkout, 90 per cent of them bought on price. So my question is about the value of the data when it doesn't have the actual sales data along with it, because we have a split personality. When you ask us what we want, we'll tell you what we want, but then what we do with our dollar is on the line is a different matter. And the data here in consumption around healthy food versus unhealthy food says another thing all over again. We will tell you we want a healthy diet, but we go and buy an unhealthy one. So that's why I asked the question about the diet and what sits behind it. It's important to actually understand it at the empirical level.

Mr Pratt: I think that's a legitimate research question and I suspect it's something that is being pursued. I think the other thing to bear in mind about health star rating is that it's not just about the consumer information. We've seen significant reformulation of foods because, if you're on the border of 3½ and four and you can tweak something to get four, we see companies doing that. You're right about the link between intention and behaviour: we generally see that to be consistent, but the degree to which that holds true is probably different.

Prof. Wilson: And we know you cannot depend on that alone. We know that from the smoking area. We put labels on cigarette packets a long time before we put a lot of the other restraints on them. We knew we had to get people aware of that, but it wasn't enough. To get to one of the lowest rates of smoking in the world, which we have in Australia today, we had to put in a whole range of other incentives for people to stop smoking. They were smoking an addictive substance. It might have been their best intention to stop, but, once we started to increase the price, once we started to make it more difficult for them to access tobacco, once we started to make it more difficult for them to smoke because they couldn't smoke in their workplace and had to go outside, we started to see the rates really start to plummet around it. You need the full configuration of things to achieve these sorts of changes. And we have to recognise that it took 40 years to get where we are at the moment. So we have to set out on a journey to control obesity and recognise that you have to have all these different strategies in place if we're going to achieve it. We have to persist at it. We have to recognise it's a problem, we have to persist at it and we have to keep on ramping up the things that we do to try and address it. And some of them won't work. We know that you know some of them may not work when we go along the line, but that's not a reason for not trying them.

Senator COLBECK: But my point was that, if you're doing something and then you go back to check on it, find out if it does work and have the evidence to demonstrate that.

Prof. Wilson: Absolutely. I fully agree with you.

Senator SINGH: Professor Wilson, are you saying, in comparing this issue to nicotine addiction, that Australians have become addicted to junk food?

Prof. Wilson: There are people who have argued that there is a form of feedback that you get which is similar to that. I don't think we need to go there. We don't have to take that position. What I'm saying about it is that if you want to tackle something like this then we have to have multiple strategies. We have to recognise that we have to persist at it over a period of time. We have to recognise that there may be some things that we'll try that won't work as well as we want, and then we'll have to find some other things to try and keep going at it in that way.

Prof. Aranda: Those efforts aren't just about how that influences the behaviour of people within the society; it's also about influencing industry. It's actually the same complexity. Some of the things that were done in tobacco weren't actually about reducing smoking behaviours by people; they were actually about controlling the industry, and those kinds of things all coming together in this. So we would absolutely support the statement from Andrew that it's the complexity of the interventions coming together and doing something, not expecting, as our society tends to do, that there's a quick fix any of these things. They are complex problems that need complex solutions.

CHAIR: One of the things that you raised and we heard from previous witnesses with regard to tobacco, Professor Wilson, is the question of advertising and promotion—particularly that directed at young children. Consistently we've heard through some of these submissions that some people will oppose that and argue it has
very little impact. I always find it strange that a company would choose to waste its money on advertising if it didn't work. To anybody who may have some expertise in this area: I'm interested in the contribution you believe that advertising and promotion of unhealthy foods makes when it comes to consumption of those foods.

**Mr Pratt**: There's an absolute, demonstrated causative link between children's exposure to food marketing, the foods they choose and their subsequent weight. There are not many examples from around the world of countries that have really tackled this and tackled this well. I think it's also worth remembering that food marketing isn't just the adverts you see on telly. I think that spend is decreasing. It's sports sponsorship which has massive loopholes. The big one is online social media advertising. Never before have we been able to get an advert served specifically for you to you that appears in your face.

Chile is one country that's implemented a very broad response to this with food labelling, front-of-pack labelling, restrictions on use of cartoon characters, restriction on offers of toys and these sorts of things. They do have an incredibly robust evaluation infrastructure in place, but with that hasn't reported yet. South Korea has had restrictions, and that's that has proven to show changes in people's behaviour. There are restrictions on marketing on television, radio and internet between five and seven, and incentives have been banned. The UK has a watershed, and that has proved to be rather ineffective because kids watch TV later than we've heard before. Kids are going to bed at 10, 11, 12, 1, 2 or 3, so this notion that, if you advertise after nine o'clock, kids won't see it—or even seven o'clock—is probably not true. And in Australia we've largely left up the industry. There's the old line about giving industry the test and then letting them market as well. So there is evidence to show that it should work and there is good evidence being generated that I suspect will show that it does work.

**CHAIR**: We've over time. Unless we've got any other questions, I want to thank you all very much for really interesting submissions and an opportunity to be able to interrogate you around some of those questions. Thank you so much.

**Ms Mitchell**: I would add, because active travel and physical activity has not got much of a say, that I would recommend to you and will make copies available of the Heart Foundation's 13 key actions to enhance physical activity and active travel in Australia.

**CHAIR**: Thank you.

**Prof. Lee**: I'd like to table some evidence briefs from the Australian Prevention Partnership Centre that provide more data about some of the questions you've asked.

**CHAIR**: Wonderful. We'd be happy to take anything on notice. Thank you for any additional information.

**Proceedings suspended from 10:08 to 10:24**
JOHNSON, Professor Greg, Chief Executive Officer, Diabetes Australia

ACTING CHAIR (Senator Singh): We will now resume, and I'm sure the chair will be here shortly. I would now like to welcome representatives from Diabetes Australia. Thank you for appearing before the committee today. I'll invite you, Professor Johnson, to make a brief opening statement, should you wish to do so.

Prof. Johnson: I very much appreciate the opportunity to speak to you. I want to start by acknowledging that Diabetes Australia is part of the Australian Chronic Disease Prevention Alliance, and you've just had a discussion with my colleagues in that alliance. We fully support the submission from the Chronic Disease Prevention Alliance. I did want the opportunity to speak to you to put, particularly, a diabetes slant and to put the issues here from a diabetes perspective. As you know, in our current society, when obesity appears in the newspapers and on the television at night, it is often synonymous with diabetes—particularly type 2 diabetes—in the public mind and in the media mind. They immediately go to a picture of a fat person walking around—or as many fat people as they can find—and there's a big headline. That all defaults to a single issue: that it's about what people stick in their mouths and the food they put in their mouths. And that defaults to blame; people get blamed for doing so. That is a big problem in this country, and I'll explain why in a moment, and we need to address that. So I think this inquiry is very important.

Notwithstanding the complexity of things that you'll hear from various people—I'm sure you'll hear lots and lots of complexity around obesity—in our view there's compelling and strong evidence and a strong need to implement some simple and effective public policy levers in this country that we know have worked in other countries and other jurisdictions. They're doable and they're the responsibility of government. Industry has a big part to play in this; people and communities have a big part to play—lots of things. But it's government that sets the public policy levers that are incredibly powerful here, and there are three or four of those that are very clear and compelling that I'll run through.

This inquiry is very important, and thanks for the opportunity to speak to you. Central to what I'll talk about is our need to move away from the personal responsibility mantra that's too often linked to obesity and type 2 diabetes. We need to stop thinking about this problem, this epidemic, as if it's about some informed individual choice. As you know and everyone knows—and there's no disagreement—two-thirds of Australians are overweight or obese. Australia's not alone; this is a worldwide problem in many and most societies. One in four of our children are overweight or obese. The cost to our nation, in terms of health and wellbeing and in terms of how people actually cope and live a productive life and in terms of the impact on workplaces and productivity, is enormous. Obesity is an epidemic; it's not a lifestyle choice or about a lack of willpower in people. There are complex factors here around biology, society, genetics and other things, but the evidence is compelling: if everyone in Australia was at a healthy weight right now, we could reduce diabetes by 53 per cent, chronic kidney disease by 38 per cent, oesophageal cancer by 38 per cent, coronary heart disease by a quarter and stroke by almost that. So that's our opportunity, if we can move towards a healthier weight for the Australian population.

As I said, many cost-effective levers are there, and they're in our submission, and they're in the Chronic Disease Prevention Alliance submission and many other submissions from public health organisations. And they're not new. Many of them have been around for a long time. But, at the moment, the overpromotion of personal choice and personal responsibility and those notions is doing great harm, and I just want to point out why. As I said before, for the media and many in our society the word 'obesity' is often synonymous with type 2 diabetes, with overeating, and this leads to blame and shame for people. It's often parents and children. It's our families. These are not anonymous people; these are real people who are getting blamed and shamed for developing very serious conditions.

We've done behavioural research. Around 30 per cent of all people with diabetes in this country—and I'll remind you that there are nearly 1.3 million Australians right now who know they've got diabetes, they've been diagnosed—report that they've been blamed by others for bringing it upon themselves. They get blamed. A similar number of people blame themselves. The result of that is that they internalise that, they feel shame and they blame themselves. This contributes to a high prevalence of, around 30 per cent, moderate to severe anxiety and depression amongst people with diabetes in this country. I'll point out, I don't think anyone here would blame a person who developed cancer or kidney disease, as a result of being overweight or obese, but we do blame people with diabetes in this country. We need to stop doing that and treat this as a serious medical and societal problem and stop blaming people.

The reality is that we all live in a complex obesogenic environment, and that's a terrible word but that's the world we live in. Never before has the industry been so good at producing such cheap food with added fat, added sugar and added salts. It's a great success story of the postindustrial world just how good we are at producing incredibly cheap packaged food with added stuff that goes all around the world and gets everywhere. We're very

SELECT COMMITTEE INTO THE OBESITY EPIDEMIC IN AUSTRALIA
good at it. We're very good at marketing and promoting that food, getting it to people and convincing them that it's something that they should overconsume. Never before have we had such high energy food that is readily available, cheap, well-marketed but also combined with low physical activity. It is reducing all of the time with sedentary lives, sedentary work, loss of physical activity opportunities, screen time and all of those things combining.

There is no single, simple one fix here and we should avoid that question. We do need a range of things to happen, and you heard from the previous group that there's not just one thing here. We shouldn't overly focus on one aspect, but if we put four or five public policy actions together then we could see a very serious and very positive impact on this serious problem. We've outlined those in our submission, which includes introducing a tax on sugary drinks. We have a position statement on that—dozens of organisations do. That in and of itself won't solve the problem, but we know that increasing the price reduces demand, and any money that's generated from that should be reinvested into childhood prevention programs and family assistance programs that can help with other aspects.

Protecting children by restricting marketing of unhealthy foods is an incredibly important thing to do. We've heard from many people I'm sure that in a contemporary society with social media there are so many aspects of what is happening here right now that parents of children could have no control over and no informed choice about. There are incredibly sophisticated tools being used. It's not to say that the people doing that are bad people; it's just business. It's just the modern world, but we need to recognise that that is what's happening and that there are things we can do about that.

We can fix the labelling of foods and make it better. We do have a health star rating system but it's not perfect. It needs to be made mandatory and it needs to be improved in various ways that have been set out. We do need well-researched, sustained social marketing and activities that help the community and people make the informed choices they can and better choices they can, but that in and of itself is not the only thing.

These are four or five things together that are clear, well-researched, well-evidenced, public policy things to do. They're not new. These things are that have been put into effect in many jurisdictions around the world. In Australia, we believe it's time that we took that seriously. It is government's responsibility to put the policy levers in place, and they're there in front of you.

We shouldn't be distracted by particular complexities in this thing, and we should recognise that everyone's in this. Industry is part of it. I sat on the committee that worked for two years to get the health star labelling in place with industry. There were lots and lots of debates about it, and we ended up with a pragmatic result in what's been implemented to date. But it's the time we moved on from that to something better and stronger. Industry plays a part and people in communities play a part, but I'm here talking to representatives of government, who need to play their part and set the policy. And we hope you will. So thank you.

CHAIR: Thanks, Professor Johnson. Can I just kick off, because I think it's worth just highlighting. We often talk about obesity and overweight and their impact on a number of conditions, but can you just talk us through the link? Some people will argue: 'Oh well, does it really matter if more Australians are overweight? A lot of those people are healthy and just carrying a little more weight. Why is that a public health problem?' Talk me through the link between overweight, obesity and diabetes and the consequences of diabetes.

Prof. Johnson: The link is fundamentally with type 2 diabetes but also gestational diabetes. What happens with weight gain—and we're still learning about this—is that it isn't just a bit of extra weight, an extra kilogram or an extra five kilograms, that we carry around. It's not just a physical thing. Fat cells are biologically active cells. When we develop overweight and obesity, fat cells accumulate in the body. They particularly accumulate as visceral fat. Visceral fat is bad fat. It accumulates in and around your vital organs that tend to reside around the liver and around the pancreas. What we're finding now, with more and more studies that are using imaging techniques, is that this is not just carrying an extra kilogram; this is fat cell accumulation in our vital organs that's disrupting them biochemically and is leading to fatty liver disease and its contribution to diabetes. It's affecting the pancreas. It's affecting other organs. So that is the connection. There's still emerging science around this, but that is the evidence: visceral fat is a particularly bad fat. And we see this in many, many high-risk populations here in Australia—Chinese people, people from all the Pacific island nations, the South Asian population.

For every kilogram of weight we put on, we are more predisposed to accumulate this bad fat and then get diabetes flowing from that. And that happens because then we get insulin resistance, and we get damage to the pancreas, which reduces production of insulin, and we see diabetes. In China there are 110 million people with diabetes. In India there are 73 million people with diabetes. In Indonesia there are 12½ million people with diabetes. It's happening everywhere. It's proven, and it's very directly related to weight gain, but it's not just around what we stick in our mouths.
CHAIR: Inside a minute: why is it bad that so many people have diabetes? Talk me through the complications.

Prof. Johnson: The flow-on from diabetes is that we see all the things that we campaign about, such as amputations of limbs. There are many countries that have been maimed by the high rates of amputation. Go to many Pacific island nations and see the number of people losing toes and feet and limbs as a result of diabetes. Diabetes is the biggest leading cause of blindness in this nation in working-age Australians. It's a major cause of kidney failure leading to dialysis. The main reason we have some of the biggest dialysis units in the world in Australia and in our Indigenous populations is because of type 2 diabetes causing kidney failure. And then of course it's a contributor to cardiovascular disease—the heart attacks and strokes. And I can go on. There are others.

If you add it up, about one in four to one in three of all of our hospital beds are occupied by people with diabetes related complications. It's directly contributing about $14 billion to $15 billion of cost per annum to the Australian economy.

CHAIR: Thank you.

Senator PATERSON: Professor Johnson, in your submission you note a number of jurisdictions that have introduced a tax on sugary drinks. I'm wondering in how many of those, following that introduction, that has led to a fall in either obesity or diabetes.

Prof. Johnson: You've got to take time and look at the time course. The interesting thing is that, when the UK government announced a sugary drinks tax, we saw a reaction before it even started. These things can have effects just with the announcements and the intent of governments. We saw changes to formulation of drinks and manufacturers changing the way they do things—all good things. So I don't think we should say that the perfect thing here is that we've got to wait and see something that happens with a long-term measure, when we've already got evidence that just the simple announcement of a government intention to make a policy can have a direct impact on the reformulation of some unhealthy foods, remembering that these are products that have no nutritional value to our children.

Senator PATERSON: That doesn't really answer my question. What I'm interested in is: has obesity fallen or has diabetes fallen?

Prof. Johnson: Yes. I think Mexico's shown evidence. Yes, there's evidence of—

Senator PATERSON: That obesity has fallen in Mexico?

Prof. Johnson: Sorry, I'm not here as an expert on that, so I'd need to go away and look at the evidence.

Senator PATERSON: Thank you for acknowledging that, but you're advocating a policy prescription.

Prof. Johnson: Yes.

Senator PATERSON: So I'm just asking you for what evidence there is that it's effective in meeting your stated objective. Your stated objective is to reduce obesity and diabetes. You note that it's been introduced in a number of jurisdictions. I'm asking you: in which, if any, of those jurisdictions has it had that impact?

Prof. Johnson: Well, it reduces consumption. It's been proven that a sugary drinks tax will reduce consumption. Reducing consumption of sugary drinks will reduce type 2 diabetes and obesity.

Senator PATERSON: Unless people substitute other products. So is there any evidence that people are not substituting other products?

Prof. Johnson: The studies have been done. I can send you the details.

Senator PATERSON: That would be helpful because I can't see any in your submissions. In fact, I haven't seen any in any of the submissions. There is evidence in some jurisdictions that consumption of sugary drinks falls after a sugar tax is introduced. That's not surprising. But there's no evidence in any jurisdiction that I've seen that obesity falls or that diabetes falls. If that's what we're trying to resolve and we're interested in evidence based policy, how do we know that this is going to get us there?

Prof. Johnson: Our policy is based on, as I said, not just one thing. If we go down that path and simplify to one thing, in part we support this because there's strong evidence from the dental perspective on the impact on dental care. There are multiple effects of sugary drinks. We take a broad view of public health policy. We're not here—I'm not here—saying that a tax on sugary drinks is the only thing that you should be considering. It's one of the things you should be considering. But the evidence from the many, many jurisdictions that have taken this is that there is sufficient evidence to warrant that public policy initiative from a number of different perspectives.
The measurement of overall impacts on obesity rates and type 2 diabetes rates is a long-term thing. It's not a short-term thing. Most of these things that have happened are still relatively short term.

Senator PATERSON: Well, Mexico have had their sugar tax since 2014, so that's four years.

Prof. Johnson: That's not long term, sorry.

Senator PATERSON: Not long term? So when would we expect to see the benefits?

Prof. Johnson: You need to see five to 10 years. You've heard about tobacco control and the measures. Many of these things take five to 10 years as an individual element in an overall package of things. Tobacco control has been going on for 40 years. It's 40 years since we started TV advertising against tobacco, against cigarettes—all of those things. These are long-term things. All the public policy instruments that we've recommended here are things that will have long-term impacts, but they're not things that you can necessarily measure in two years or three years.

CHAIR: Can I just continue with that example. Let's say we introduced an increase in the tobacco excise. You might expect to see decreasing consumption—fewer people smoking. You wouldn't expect to see any long-term impact on ischaemic heart disease, stroke or cancers within five years with increasing the tobacco excise, would you?

Prof. Johnson: No. In most of most of these things, five years is a short time frame. You need to be thinking five to 10 years to look at evaluating those sorts of bigger outcomes.

Senator PATERSON: You recommend a rate of 20 per cent for the tax. On what evidence base was that figure chosen? Why 20 per cent?

Prof. Johnson: Because of various experts who look at how hypothecated taxes have worked and the sorts of levels they need to be at.

Senator PATERSON: Is there a reference in your submission to why the 20 per cent figure is particularly beneficial and the right one, not 15 or 25?

Prof. Johnson: I'll send you our detailed position statement, which has that detail.

Senator PATERSON: Thank you, that would be helpful.

Senator SINGH: Just quickly because of the time, Professor Johnson: getting back to the tax on sugary drinks and the health star rating system, there are a number of recommendations that you've put to the committee to consider, all of which I guess are there because the status quo is not working. Is that correct?

Prof. Johnson: That's right.

Senator SINGH: In pulling out the recommendations you've put—are they specifically pertinent for an Australian obesity issue, or are they recommendations that have obviously been put in place in other countries? We heard earlier that this shouldn't be called an epidemic; it should be called a pandemic because it's across the world. Therefore you would think that in Western societies similar policy parameters would work across the board.

Prof. Johnson: Yes. All of these things are things that have been considered in other jurisdictions and that are either implemented in other jurisdictions or sometimes those one-off things. There's no jurisdiction that I'm aware of that's implemented all of the things that we've put in our submission. So, yes, we've looked at what's happening in Australia and what the problems are but also at what sorts of policy levers have been tried around the world. This package of things, we believe, is a good package.

Senator COLBECK: I just want to go back to the question of personal responsibility. It's all very well for people to put responsibility onto others, but at some point in time there has to be some personal responsibility around this. We are responsible for what we put in our mouths. I've made my own dietary choices, as difficult as they might be. A long time ago I made a decision around applying salt to my food, for example. It took a while to get used to it because it changed the taste of what I was eating. I stopped adding sugar to tea and coffee a number of years ago. It changed my tastebuds. I can't take up a glass of Coke now. I can't drink it. It's too sweet. That's because it changed my tastebuds, and I prefer a different taste.

At some point in time people have to make those choices. Physical activity—you can't wander around to people's places on a Saturday morning and troop them all out into the street and march them around the block five times. People have to make those choices, and government can't do it for you. Yes, we can make some policy decisions, and I accept your evidence in that context, but at some point in time people have to make their own decisions.
Prof. Johnson: Government can make the environment easier for people to make those choices, for a start. I think we need to recognise that—with all due respect—you're a very well educated, intelligent person—

Senator COLBECK: I'm a carpenter. I'm a chippie. I sat on a milk crate on a—

Prof. Johnson: At least I'm calling you an intelligent person. The point is that there are lots of people who don't have the capacity to make those decisions. 

Senator Singh interjecting—

Senator COLBECK: Thanks, Senator Singh! I'm just talking about my education levels, not my intelligence levels. 

Prof. Johnson: So firstly my response is: let's think about children as the starting point—

Senator COLBECK: Absolutely.

Prof. Johnson: because most of us here are saying that we know that there are intergenerational things here. If we can focus on children: most children can't make those informed choices. A lot of the marketing and promotion of food is very directly to kids who just don't have the capacity. Secondly, from the labelling of foods and the way they're presented, you have no idea what's in them, and even the most educated people couldn't work out what's in them. This morning I read a nutrient label on the back of the Qantas thing that was served up to me on the aeroplane. I couldn't even read it, let alone comprehend it.

Senator COLBECK: I don't eat aeroplane food anymore.

Prof. Johnson: So, while we can contend that some people can make informed choices, the problem is that far too many people can't make informed choices, because of the world we live in. We can change that. We don't need to change it totally, but, if we changed it five or 10 per cent by some of these public policy measures, we would make a big difference.

Senator COLBECK: It comes back to my question that I've asked a couple times now around trusted data sources, trusted information sources. What would your thoughts be around that? We talked about it with the early childhood health people earlier this morning. Getting good, clean information, in our job, is gold. Most people come to us with a perspective. One of the things that we learn to do as part of doing our job is to read through the perspective to find the clean information, the best information.

Prof. Johnson: From people?

Senator COLBECK: Absolutely. That's what comes to us. You have to learn to read through that to get clean information so that you can use that to inform your policy decisions. It's just part of the job. It's what happens. So how do we then, as part of building that environment, develop or identify quality, trusted data sources when there is just so much rubbish information out there these days? What do people believe? You don't just see it in this space. Look at the news.

Prof. Johnson: I think the Robert Wood Johnson Foundation, a big foundation in the US that funds hundreds of millions of dollars of obesity prevention and other initiatives, looked at these things a few years ago. Their conclusion was that, if all you do is keep focusing on just putting the good information in and having the trusted information sources, you fail.

Senator COLBECK: You're talking about a multiplicity of things, and I'm not arguing with that.

Prof. Johnson: Yes. There is a lot of that already. There are a lot of organisations, like Diabetes Australia, that are trusted and are trying to put out good information and are doing that as best they can. But the issue is that that's not enough and that's not a big enough response. So that would be my response.

CHAIR: Can I just follow up. I suspect, Senator Colbeck—tell me if I'm wrong in this assumption—that part of the difficulty is that we've had conflicting messages over a long period of time.

Senator COLBECK: Absolutely.

CHAIR: And the medical community is partly responsible. There's been the trend away from high-fat foods to low-fat foods, and there was the evidence that saturated fats were almost unequivocally bad for you. That advice has now shifted somewhat, and of course we know what happened with the move from high-fat to low-fat: sugar was used as a substitute in a lot of foods. So I suspect that's partly where Senator Colbeck's coming from. The concern is: is what we're hearing now just the latest version of what happens to be the fashion of the day in terms of healthy eating advice? How do we get confidence to know that what we're being told is actually sound, definitive advice not influenced by vested interests or what happens to be the medical fashion of the day? Is that a summary of it?

Senator COLBECK: It's pretty good, actually.
Prof. Johnson: The response to that is that most of the things we're talking about there are not based on one particular bit of science. They're things that over time will continue to be implemented. If you talk about the need for public education campaigns, they should be informed year by year with the latest evidence, not just a fad. It's the latest evidence, and evidence does change over time. But right now there's compelling evidence around the world that we have overconsumption of added fat, added sugar and added salt. We can do things to reduce that, and it isn't just about personal choice. That's a part of it, but it's about the public policy levers that we put around how those things are labelled, how they're marketed and promoted and who to. Particularly, we believe we've got a responsibility to think about children and families, particularly children where the ability to make those informed choices is much more limited.

CHAIR: Professor Johnson, thank you very much for your evidence today. We really appreciate it. If you've got anything more you want to add to—if you have any studies et cetera that you might want to submit to the inquiry—we're very happy to take any of that information on notice.
JONES, Ms Alexandra, Research Fellow (Food Policy and Law), Food Policy Division, The George Institute for Global Health

REEVE, Dr Belinda, Co-Founder, Food Governance Node

[10:53]

CHAIR: I now invite representatives from the Food Governance Node. Thank you for appearing before the committee today. I invite you to make a brief opening statement if you wish to do so. Do you have anything to say about the capacity in which you appear?

Dr Reeve: I am a senior lecturer at the University of Sydney Law School. I have conjoint Bachelor of Laws and Bachelor of Arts degrees and a PhD in law. I am appearing on behalf of the Food Governance Node.

Ms Jones: I am also a lawyer. I have a masters in global health law. I am currently a PhD candidate at the University of Sydney and a research fellow at the George Institute for Global Health, which is also speaking this morning. Today I represent the Food Governance Node. I should declare that I am a representative on the technical advisory group of the Health Star Rating Advisory Committee, but my comments today are based entirely on my own research in my PhD, and I do not represent the views of that committee.

CHAIR: Do you have an opening statement?

Dr Reeve: We do. As I mentioned, we appear as the co-founders of the food governance node at the Charles Perkins Centre. The node is a platform for interdisciplinary research involving more than 30 researchers from faculties across the university and from a range of other universities and organisations who share an interest in using law and policy to improve Australian diets. The Charles Perkins Centre is a multidisciplinary research institute within the University of Sydney. It brings together a range of different researchers and other smaller institutes and centres. The mission of the Charles Perkins Centre is to reduce the burden of diabetes, cardiovascular disease and obesity. I should also mention that both Alexandra and I are members of the Obesity Collective, which has recently been formed and includes the Charles Perkins Centre and members of other organisations and businesses and health advocates from across Australia who have pledged to take action on obesity.

Like many others who have appeared before you, we endorse the eight recommendations from the Tipping the scales report to address obesity from the federal level. Today we want to speak to the specific policies that lie within the node's expertise. Our submission to the committee focused on two matters: the effectiveness of existing policies and the role of the food industry in contributing to Australia's obesity epidemic. We discussed three initiatives in detail: self-regulation of unhealthy food marketing to children, the voluntary health star rating system and the Healthy Food Partnership reformulation program.

Each of these initiatives is an important step in the right direction, but we believe that in their current self-regulatory form they are failing to drive the population health outcomes that we need. For example, the food industry's two initiatives on responsible marketing to children do not cover times when the largest number of children watch television. They also exclude a range of marketing techniques, such as brand advertising and equity brand characters that are created and owned by food companies. They also lack independent monitoring and administration and meaningful sanctions for noncompliance.

Ms Jones: It's now four years since health stars were launched, and they're only on around 28 per cent of products. My work suggests that three-quarters of all stars are on products that score three or more, so basically they're the ones where it's a nice marketing tool. Our work suggests that health stars would get it right if it was on everything, but consumer trust has been jeopardised by anomalies like the Milo loophole, which remains unresolved. While reformulation does have potential to drive changes in salt and sugar intake across the population, it's taken three years to even begin consultation on targets for the Healthy Food Partnership. I know that Senator Paterson mentioned the Ebola crisis before, and I can't imagine us having such a slow response acting on an infectious disease if two-thirds of us were suffering from that condition.

The other main thing is that all of these initiatives are voluntary, which means that food companies can and often do choose to opt out when participation no longer suits their bottom line. Food might not be tobacco, but there is growing evidence that the food industry uses tactics similar to other health-harming industries to stall and oppose evidence-based health policy. Some policies like labelling and recipe improvements do require industry co-operation to implement, but the node takes a position that the appropriate role of industry is not to set public health policy. Government needs better and more transparent processes for identifying and managing real and perceived conflicts so that nutrition policy is protected from commercial interests. We will not see public health
progress if we continue to let industry set their own rules and then mark their own homework. It isn't the job of the food industry to fix our public health problems.

The good news is that we do know what works. We could start by applying government leadership to strengthen what we have already. Unhealthy marketing could be regulated, the health star could be made mandatory, and the partnership could get clear time lines and meaningful mechanisms so that it's accountable. If we had an overarching national obesity or nutrition strategy, we would cement obesity as a national priority and then ensure that action had appropriate resourcing attached. It should recognise that we need comprehensive policies, we need to address the social determinants of health, and we specifically need to address the needs of Aboriginal and Torres Strait Islanders, who continue to suffer disproportionately from diet-related disease.

Australia is proudly recognised for its leadership in using regulation effectively to reduce risks and save lives in areas like tobacco control and road safety. It's now time that we apply the same focus to obesity. We welcome questions from the committee.

CHAIR: Thank you. I'll kick off by asking you about the Healthy Food Partnership. For people who don't know what it is, just explain it. What is it? How does it work? What are the problems with it?

Ms Jones: The Healthy Food Partnership is a multistakeholder voluntary agreement between industry, public health organisations and the government. The idea of the partnership is to agree on targets—the main part of its work is to agree on targets to reduce salt intake in Australia. They've now started to set some targets for sugar.

We essentially had the same policy several years ago; in that form it was called the Food and Health Dialogue. These sorts of agreements are recommended by the WHO as one of the policies we need, and there is some evidence that they've worked. For example, in the UK there was a pretty effective partnership for a while with industry to reduce salt intake. But the key elements of those policies being effective—that is, strong government leadership, and in the UK's case the threat that this would become mandatory if they didn't comply—have been missing from the Australian one. So like the Food and Health Dialogue, it just fizzled out. Companies were saying, 'We actually want to do this, but no-one's checking on us or asking us to report in on what we're doing, so we've just moved on.' The Healthy Food Partnership is a good start and it could be effective, but right now it's totally underresourced and it's moving so slowly.

CHAIR: Are questions around marketing and promotion being discussed in any way through the Healthy Food Partnership?

Ms Jones: Not in the current terms of the Healthy Food Partnership. It's mainly on reformulation; it's looking a little bit at portion size, but very, very few targets have even seen that area.

CHAIR: It's voluntary participation from industry. Are industry peak groups represented, or is it individual companies represented?

Ms Jones: It's in a transition phase. There were some original committees formed, and there were representatives of several large companies. I was on one of the committees—many people in this space have been on one of the committees—and now they've started to set the targets. You will see the peak bodies at the table; you will see some of the retailers at the table. I don't know if you'll see the biggest contributors to poor dietary products in our marketplace at the table.

CHAIR: Surely it's a problem if one of your competitors says, 'We know people like salt, and we're going to continue to use it,' and you've got another group of people who are involved in this who know they're going to suffer a significant disadvantage.

Ms Jones: That's exactly what we've seen in the UK. Some of the retailers who really went out strong and did the work didn't really receive any rewards for it, while other people were dragging the chain. They've actually said: 'We're ready for regulation here, because at least that gives everyone a level playing field. The first mover isn't disadvantaged in the market.'

Senator SINGH: Where does Australia sit in relation to WHO guidelines on healthy diet and the like?

Ms Jones: The guidelines I'm most familiar are the recommended policy actions. You will see that the WHO has best diet policies. They're on tobacco control, diet, physical activity and alcohol. I'd say we're doing great on the tobacco ones. On diet—this is what we have: we do have labelling, but it's voluntary; we do have a partnership, but it's voluntary; we do have regulation regarding kids, but it's industry led. All of those types of policies are in the list, as are other ones like effective taxation of sugar-sweetened beverages. Doing work in schools and canteens is on the list, which at the state level we're doing quite well at. But globally, there are other countries who are taking a much stronger line compared to us.

Senator SINGH: So on a scale, where do we sit globally?
Ms Jones: A good start, but we could be—

Senator SINGH: Are we down the bottom, are we halfway?

Ms Jones: In terms of the policies we’ve implemented?

Senator SINGH: No, in terms of other OECD countries.

Ms Jones: Our obesity rates are very high and our response is fairly mediocre.

Senator STORER: I think you’ve spoken about a national task force for obesity prevention, you've made a call for that, and that you see a lack of progress in government leadership. Could you outline that versus many of the other industry led bodies and initiatives of the states and territories that are already in place? Could you explain it little bit more for me please?

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

Senator STORER: It's been put to me that cost, taste and competing priorities, not lack of knowledge, have really been the strongest influence on food consumption. Where do you sit in terms of the amount of knowledge in the populace about food choices and the actual choices that are being made?

Dr Reeve: I think we need to be really careful about stressing a lack of knowledge. There's been a lot of discussion this morning about the fact that people are perhaps making poor food choices because they don't have sufficient understanding about what's good for their health. I think we need to also think about the social determinants of health and the fact that our choices about what we eat are determined by our economic resources as well as our education. They're also determined by our physical access to food and to active forms of transport or recreation, which is something that we haven't discussed so far. So something that we have seen in a number of studies is that in Australia and other countries we have what are called food deserts, areas where it's more difficult to access healthy fresh food but there's often a proliferation of fast food outlets and alcohol outlets as well. Those areas tend to be concentrated in lower socioeconomic areas as well. So it's not simply a question of people having the knowledge to make healthy choices; it's actually ensuring that they have physical access to places where they can purchase fresh food as well. It's also a concern in some of our remote communities. That is why, when we talk about addressing obesity, we need a whole-of-government approach, because we need to think about how sectors such as planning and transport can also contribute to addressing those drivers of obesity.

Senator STORER: Could you also define the Milo loophole for us, please.

Ms Jones: That's what Stephen Pratt earlier called the 'as prepared' issue with health star rating. It affects a small number of products—we estimated maybe four per cent of the supermarket—but it was a rule created so that you could show the health star of the product as the manufacturer says it should be consumed. This makes sense with something like a powdered soup where you're just going to add water and make it equivalent to a canned soup. What we saw happen was that companies realised that this could be a good advantage to them, and Milo was the most visible example, because they said that Milo obtained 4.5 health stars on the basis that you prepared it with three teaspoons of Milo and a cup of skim milk. The problem was that everybody smirked when they heard that and they went out very hard on the promotion of that. The result was that people didn't trust health stars and health stars must be a bad system if Milo can get 4.5. They didn't see this as something that showed you can't trust the food industry if they exploit the rules. It's something that's been raised since the beginning, and we still don't have a clear answer. To their credit, Nestle have taken that off the product, because I think they realised it was no longer doing them any favours.

Senator SINGH: Can you to define equity brand characters?

Dr Reeve: 'Equity brand characters' is a term that's used to refer to characters that are created and owned by food companies, so that would include a character like Ronald McDonald. I mentioned those characters in the context of regulation of unhealthy food marketing to children. The two self-regulatory codes that we have that have been developed by the food industry don't apply to those characters, so companies are free to use those characters on unhealthy products.

Senator COLBECK: I'm interested in your evidence in the context of something we heard earlier about regional communities, particularly the rural communities, and the significant changes in those communities over recent decades—which you can understand, given some of the mechanisations that have gone on and the changes in work practices and things that have had a significant influence, particularly on the physical activity in those communities.
roles. But in some of those outlying communities the dietary availability is not necessarily the same as it might be, say, in a metropolitan circumstance. I was interested if you’ve done any research that lines those two things up, because it is a significant change in the status of that community. Health information, for a long period time, has shown worse health outcomes in regional areas because of proximity to major health facilities and health services. But I was interested if any of your research has shown any causalities in those spaces. It's just an interesting change that has come about in the last couple of decades, comparative to metropolitan areas.

Dr Reeve: That is not one of my areas of expertise, unfortunately. But I am aware of studies on remote parts of Australia, particularly with Aboriginal and Torres Strait Islander communities.

Senator COLBECK: I would classify those communities as very different to what I'd call a rural community. Having visited and had a look through some of those Indigenous communities before, and having looked at their co-ops and their marketing and the products that they have, I would see them as very different with a very different set of base issues and problems to a rural community. I'd classify them very differently.

Dr Reeve: Certainly. I can't comment off the top of my head on health differences between rural and urban centres. I'm happy to try to provide that information to the committee later.

Senator COLBECK: Diabetes Australia talked about the growth in diabetes attributable to obesity in countries like China, Indonesia and India. A lot of the information that has come through in the submissions leaves Japan out as being something quite different to a lot of the other countries. It suggests perhaps some underlying cultural element in the changes in the community. Have you done any work that looks at those sorts of things, and what you see in those communities versus China, Indonesia and India? It is also prevalent in Australia, USA and the UK, with the growth in issues around obesity.

Dr Reeve: I can't comment on cultural differences and diet. I am aware of the fact that Japan in the past has actually had quite high rates of cardiovascular disease, which were linked to salt intake. Then in the 1970s they had quite a successful program of salt reduction, which in turn led to reductions in cardiovascular disease. So, although they don't have the obesity rates that a country like Australia may have, that doesn't necessarily mean that they're completely free of any diet related health problems.

Senator COLBECK: I'm trying to look at the obesity element of it, which is what we're talking about. Japan does stand out comparative to others, and I was just interested to know if anyone had done any work to look at that.

CHAIR: We might ask some of the research bodies that we are going to be speaking to a little later on. I think that's probably more appropriate for them. Ms Jones, one of the things you said in your submission was that the food industry seems to be adopting some of the same tactics as other health-harming industries—the tobacco industry being the obvious example. I've heard people say that before. Can you speak to that. What do you mean by that?

Ms Jones: There are a number of tactics used, and people have produced research papers on this. I'm guessing that we cited them, but we can provide follow-up. Some of the things you see include: when government suggests something, they just oppose it and use selective statistics to say it won't make a difference. But you can tell that if it actually didn't make a difference they probably wouldn't oppose it so strongly, because it wouldn't affect their product. They will oppose anything that's likely to impact on the profits of their industry. In America, for example, right now you have a lot of local sugar-sweetened-beverage taxation trying to get up, and you just see litigation. That is obviously one tool that industry will use to stop health policy. More insidious is the stalling of it, which is what you see here. With something like the Healthy Food Partnership, there's just enough happening to say that there's something happening. But, actually, that's quite a risk, because if it's not achieving anything, if it's moving so slowly that nothing is happening, then we're not doing anything stronger. But while everyone is there and saying that they're at the table, that is a risk of inaction.

Dr Reeve: Certainly we see other tactics as well. It would be things like establishing relationships with politicians and decision-makers; other corporate social responsibility tactics, like messaging that shifts blame away from the industry and focuses on personal responsibility and the role of physical activity in promoting good health; and stressing the good traits of the industry, like the fact that the food industry provides safe products, and its role in obesity prevention—that it's undertaking initiatives like the Healthy Food Partnership or self-regulation of food marketing to children. So it is actually taking steps to solve the problem. There's no suggestion that these tactics are illegal in any way. They are often a part of companies' corporate social responsibilities and strategies. But the problem is that these tactics are likely to forestall or prevent the introduction of public health policies that are likely to be effective in preventing obesity. We have a number of modelling studies that show that mandatory schemes—mandatory product reformulation schemes, for example—are likely to be more effective than voluntary
schemes, yet the industry will promote voluntary schemes or promote self-regulatory initiatives, and in doing so they often forestall or prevent the introduction of government regulation, which is more likely to be effective in preventing obesity.

Senator COLBECK: I might just ask one question off the back of that. If you can get something to work without regulation, which costs money—it costs the economy money and costs people. It's not as if consumers don't pay for this. None of this happens for free. If you impose a regulation, you impose a cost on the economy and you impose a cost on people's access to food. It's not free. So shouldn't there be some reasonable scrutiny of those things and some evidence that they will actually work before they're implemented? Isn't that reasonable? It's not a crime and it's not bad to make a profit. If you don't make a profit, you're not in business. It's a pretty simple basis. Characterising the industry as bad because they make a profit is, quite frankly, counterproductive. I know it's a tactic. I know it's a way of positioning industry so that they look bad in the eyes of the community, but it's actually counterproductive in the overall scheme of things, because if they're not making a buck they're not in business.

For example, for a vegetable-processing company in Tasmania, whose viability was on the line a few years ago, it was going to cost them $2½ million a year to apply the star rating system to vegetables—frozen veg. They're competing in a global market, because that's where we live. You've got 500 or 600 farming families who rely on them and their viability, plus the community for getting access to Australian grown vegetables. There has to be a reasonable level of scrutiny in this process, and positioning a company as bad because they want to break even, because they want to make a buck, isn't the way to align it. You have to have a relationship with them, you have to be able to work with them, to actually get these things done. Simplot, which is the company I'm talking about, is the last vegetable processor in Australia. If they're not there, everything's imported. Characterising them as bad can't be a way to—

CHAIR: I don't believe that's what the witnesses were actually doing. They weren't characterising them as bad simply because they were profitable. I think they were making a different point, but I'll let them respond to that.

Dr Reeve: We're certainly not saying that the food industry is evil simply because it wants to make a profit, but I think what we need to recognise is that the industry's desire to make a profit is not always aligned with the public health goal of preventing obesity.

We're certainly not saying that we can't work with the food industry in any circumstances. We also need to recognise that there are different actors within the food industry. It comprises everything from a mum-and-dad corner store right through to multinational companies that work and operate in multiple jurisdictions. We need to be very careful though about managing conflicts of interest. We need to be realistic about the fact that the food industry does sell a huge range of products that undermine health so we need to question whether or not that same industry is going to accept forms of regulation that interfere with its ability to sell those products. So we need to look carefully at the kinds of actors within the food industry that we're working with, what relationships government have with them and whether those relationships are appropriate.

In terms of whether there's an evidence body that supports the measures that we're recommending, in some cases we will have to work ahead of the evidence. If you look at something like tobacco control, before we introduced advertising restrictions, how would we know that they were going to work? There might be some modelling studies that we could rely on but certainly there would have to be something of a leap of faith there. We do also have some evidence available for these measures. We can show that these kinds of product reformulation programs that we're recommending do in fact reduce people's consumption of salt. We can show that regulation of unhealthy food marketing to children does in fact change consumption patterns. So there is a growing body of evidence for many of these measures, the same with sugar taxes as well. So what we and others making submissions today have been recommending is that, taken together, a package of measures together are very likely to have an impact on rates of obesity.

CHAIR: Thanks again for your evidence today. It was very stimulating. If you have anything else you need to provide us, we're very happy to take that on notice.
JONES, Ms Alexandra, Research Fellow, Food Policy Division, The George Institute for Global Health

NEAL, Prof. Bruce, Deputy Executive Director, The George Institute for Global Health

[11:22]

CHAIR: Thank you for appearing before the committee today. I invite you to make a brief opening statement.

Prof. Neal: In case you're not aware, The George Institute is an independent medical research institute affiliated with UNSW Sydney, where I also hold an appointment as a professor of medicine. We were established in 1999 and we now have about 650 people working in about 50 countries around the world. Our research is focused on preventing and treating chronic diseases and injury, and we've got a strong interest and expertise in aspects of the obesity epidemic. I thank you very much for giving me the opportunity to speak to you today.

To start, like others, I'd like to endorse the Tipping the Scales report prepared by the Obesity Policy Coalition. We're one of 30-plus organisations behind this initiative and we strongly advocate its contents to government. Our own submission focused on a couple of overarching issues related to the causes of crisis and what we might do to ameliorate the problem.

As we've heard, in just a few decades, Australia has gone from being a country where obesity was a fairly uncommon thing to it being the most common health problem that many of us see day to day. Changes of this rapidity make for interesting and insightful research opportunities. What I'd like to do to start is just pick up on a few things that have not happened to cause this. Australians have not become sloths and gluttons in the last couple of decades. They've not lost all their willpower and they haven't chosen to become overweight or obese. Furthermore, they haven't changed their physiology to become prodigious manufacturers and storers of subcutaneous fat; evolution just doesn't work that quickly. In fact, the biological fundamentals and the psychological fundamentals of the Australian population are really pretty similar to what they were 50 years ago in many regards. Rather, what has changed is the environment that the population lives in, and, in particular, as we've heard, the food industry has transformed the way that we eat these days.

Now, the food industry, as has been highlighted, does an excellent job doing what it's required to do, which is to provide a low-cost, continuous supply of food and to maximise profits and shareholder value for its owners. But, while the food industry has become a very profitable and important part of the Australian industry sector, it's had some serious unintended consequences, particularly the obesity epidemic which we're here to speak about today.

Understanding this perspective has really important implications for how we think about resolving the problem, and again I'd like to start by highlighting a few things that we don't need to do. We don't have to make huge new discoveries about human physiology, we don't need a revolution in personalised medicine and we don't need a raft of new drug therapies to resolve the obesity crisis. We simply have to figure out how to reverse the adverse changes to the food environment that have caused the problem in the first instance. Of course, we have to continue to encourage people to make the right choices and to take personal responsibility. But we've done that for 20 years now, and it simply isn't working and it's not enough. We have to make the system changes that are going to make it progressively easier for people to make more effective choices, and we need the food industry to feed the nation what it actually needs to eat.

The Tipping the Scales report identified a number of specific actions, and I'm just going to pick up on four of those very briefly. The first was that we should set food reformulation targets, and, as we heard, the Healthy Food Partnership is doing that. But, in terms of obesity, the recent submission put out for consultation is sorely lacking in targets for portion size, energy density, saturated fat and sugar. It does a great job on salt, I should say. The third point made in the Tipping the Scales report is making health star ratings mandatory. I won't expand on that here; we've already heard about that from people who've come before me. Point 6 is the 20 per cent recommended levy on sugary drinks. Again, I'm happy to expand on that during questions but won't expand on that at this point. Finally, point 7 is to establish a national obesity taskforce. It is going to be vital, to get on top of this problem, for us to have bipartisan support for this issue.

To finish my opening statement, I'd just like to highlight the tractability of the obesity problem. We often hear how difficult and complex it is. But Australia has become one of the most obese nations in the world in just a few decades, and, while this is very depressing, it also — on the upside — shows you just how fast you can change obesity rates. If the right levers are pulled, there is no reason to believe that we could not equally rapidly reverse the situation. It's just going to require a collective willingness to act, and we're going to have to take some difficult decisions. Thanks very much for listening. I'm very happy to take questions.
CHAIR: Thank you very much. I might hand over to Senator Colbeck because I know he had some questions of the previous witnesses that perhaps you can answer, about putting Australia's obesity epidemic in a broader international context.

Senator COLBECK: I hope you heard the question I asked before: why does Japan stand out like it does? If you look at the graphs, the rates of change in Australia, the UK and the US are very similar, and there's a rapid rate of change in developing nations—China, Indonesia, India—over recent years as affluence and access to food and new food formulations, I suppose, have changed. But why does Japan sit so differently in those graphs? It shows some growth, but at a very different rate.

Prof. Neal: I'm afraid I haven't personally done research in Japan. Maybe I could speak to China, where we actually see a similar situation and where I've been working for the last 25 years. When I first went to China, we saw something very similar, where obesity was an incredibly infrequent problem. Now if we look at urban China we see obesity rates spiralling, and rural China is following, though a decade or two behind the urban areas. This is not something to do with the difference between where China is now, compared to Australia, and almost certainly not where Japan is now, compared to Australia. It's very unlikely to be anything to do with the physiology or the genetics of the people but much more likely to be due to environmental factors and, in particular, the way that the community eats, the way that foods are presented to the community and those sorts of issues.

Senator PATERSON: Just a quick follow-up: something has changed radically in China in the last 30 years, and that is that 660 million people have been lifted above the poverty line. Is prosperity a contributing factor?

Prof. Neal: Absolutely. As people become wealthier, they get access to a different set of foods and a different set of opportunities to buy things. In many ways that's an incredibly positive thing. You take people who were previously starving or suffering micronutrient deficiency disorders and put them in a position where they have an adequate diet, and that's tremendous. The government food industry should be commended on that. But we have to figure out a way to stop it going the other way. I know that's a big focus for the Chinese government at the moment.

Senator SINGH: Professor Neal, I'm kind of putting this out there but there is a situation with certain ethnic groups. They don't regard any urgency in relation to obesity because eating excessively is almost a sign of affluence. Taking the China example, where there's growing middle class and rises of obesity, do you think they don't regard it as important in that sense because it is like a sign of affluence?

Prof. Neal: There are certainly important cultural factors. I remember, when I went to China the first few times, I would sit down for a meal with a colleague and they would buy 20 dishes and encourage me to eat as much as I could because that was the culture—to show that you were affluent, to show that you could afford to do that—and I would have to restrain myself from overeating every time I went to China. Yes, there are cultural aspects to that but I think you will find that even in the Pacific Islands, where being big has been regarded in a similar sort of way, those governments are now absolutely focused on trying to address this problem. I know that the Chinese government is absolutely focused on trying to ameliorate the rise in obesity that it's observing.

Senator COLBECK: Where would I go to find information on the difference in Japan? It's a clear difference.

CHAIR: We might see if that can be taken on notice. I'm sure we've got lots of people paying attention and it will be provided.

Senator COLBECK: I'm broadcasting here; I want to get the message out! I'm interested to know.

CHAIR: Can I go to a couple of points you made in your submission. Firstly, you've established the FoodSwitch program. As I understand it, you've got a global database of nutrition and labelling information for about half a million restaurants and packaged foods, and it allows us to map over time what trends there are in terms of portion size, energy density and so on. How do we take that further? What needs to happen to expand that, because that obviously gives us an opportunity to not just gather the information that we need but monitor some of these trends over time and make policy changes?

Prof. Neal: There are a couple of things. The database does exactly what you described. It quantifies exactly what is in the food supply, in nauseating detail, for about a dozen countries at the moment, including Australia. Here in Australia, where it's most developed, we've been really encouraged by the opportunities that have presented. The first thing that happened was that we matched the dataset up with a smartphone app that let people scan barcodes and see a health star rating or a traffic light label describing that food, and then similar but healthier alternatives listed underneath. If I'm completely honest, we launched it to irritate the food industry for a week because they were really annoying us in terms of their willingness to display some of this information. We put it
out there and it became the most popular app in the App Store overnight, and we suddenly realised there was an enormous community interest to have this information.

CHAIR: Can you give us an explanation of it again and talk us through how that works?

Prof. Neal: You scan the barcode—

Senator SINGH: What's the name of the app?

Prof. Neal: The app is called FoodSwitch, and it's free. It scans the barcode and then matches that barcode to the nutrition information. We then use the algorithm that decides the health star rating to display the stars for that product. What it then does is searches the database, within similar foods that are in the same category, and it says what is the healthiest alternative food that we could've had and it just lists it underneath.

CHAIR: So people would do this in supermarkets, I imagine? You don't go to McDonald's and scan—

Prof. Neal: It's difficult to apply it to McDonald's because there are no barcodes on the food. They do it in supermarkets or they do it at home.

CHAIR: Your view is that there's a very strong appetite for that greater level of information?

Prof. Neal: A great community appetite. What also encouraged us a great deal was that as soon as the food industry realised we had this database, they were actually very positive. For example, we work with one of the big retailers and they've come forward and said, 'Look, we want to make our own brand products as good as or better than the competitor branded products, in terms of the healthiness.' They've come to us and said, 'Can you tell us how our foods stack up, and can you provide us with advice and information that will enable us to achieve that?' Health insurers have come to us and said, 'How can we work with you to get our lives insured buying healthier?' It's been a very positive experience.

CHAIR: That goes to what we heard earlier, which is that sometimes these interventions aren't targeted specifically at individuals.

Prof. Neal: Everyone thinks of our FoodSwitch program as a smartphone app for individuals, when, actually, we're much more focused on working with industry on providing data to government. We'll make a significant response to the Healthy Food Partnership targets that have been set at the moment and say whether we think they're right, how they might be improved and where we might add new ones.

CHAIR: With regards to the Healthy Food Partnership, the previous witnesses suggested that there were all sorts of problems. Firstly, the hard targets are around salt but not around fat, sugar, portion size or energy density. That seems to be a glaring omission. The second problem is that it's voluntary, and why would you participate in something like set targets and trying to meet those targets if the person you're competing with gets a free kick because they don't have to do any of that stuff. There's that question of the voluntary nature of it. Then there are issues around enforcing and monitoring. It seems to me that, while the concept might have some merit, there are some real problems with the way that this is rolling out. Can you speak to that, given you're actively involved with the partnership?

Prof. Neal: Absolutely. It is an incredibly good idea and it lacks implementation. As Alexandra described, before this there was the Food and Health Dialogue. We were very strongly involved with that, particularly around the salt space. I was delighted to hear Senator Colbeck say that he was eating less salt—I'm sure that's in part due to the work that we did on the Food and Health Dialogue.

Senator COLBECK: Can I ask a question about the app?

CHAIR: As long as it's not about Japan!

Senator COLBECK: No, it's not! I'm interested in the algorithm that you mentioned. Who designed the algorithm, and what was the basis for that?

Prof. Neal: The UK, when they first introduced restrictions on marketing to children, developed something called an Ofcom nutrient profiling model. Australia took that and made slight modifications, first of all, in regard to deciding which foods could carry health claims and then modified that to underpin the health star rating. It's basically the algorithm that underpins the health star rating.

CHAIR: That's a very strong appetite for that greater level of information?
opportunities are,' and to bring transparency and accountability to the system and have a way of trying to drive that voluntary program by saying, 'Look, if you don't do it, we've got lots of data that the media are really interested in or that we can show to other people.' The challenge for us is that we find it hard to fund that sort of work, which is very much advocacy work, when we're working at a research institute. We find it hard to get those sorts of dollars.

**CHAIR:** Can I go to the health star rating system. There seem to be two criticisms levelled at it. One is it is voluntary and the other is that there are some perverse results—there is the 'as prepared' Milo example, and many others. I think you were quoted by one of the earlier witnesses as somebody who's been very actively involved in the development of a health star rating system. Can you talk to, firstly, the evidence that it's actually doing something, and, secondly, the voluntary versus mandatory and the 'as prepared' issue?

**Prof. Neal:** We've actually done some randomised trials. We took 1,500 people and we gave them a smartphone app a bit like the FoodSwitch app, and they scanned barcodes in the real world for a month. It basically showed them traffic light labels, health star ratings, daily intake guides, warning labels or nothing. Then what we did is we recorded everything that they bought for the next six weeks. What we were able to do is look to see the average healthiness of the things that they bought. We also asked everyone, 'Which ones do you like and which ones do you find most useful?' Health star ratings came out a firm favourite with consumers in terms of, 'We like this, we understand it, we think it's helpful.' It was followed by traffic lights. In terms of what actually changed what people bought, the most effective was the warning labels. Warning labels are probably most effective because they basically just go, 'Don't buy that, it's really bad for you.'

**CHAIR:** Can you give an example of warning labels?

**Prof. Neal:** We literally just put a message that came up on the smartphone app that said, 'This is in the bottom 20 per cent, don't buy it,' or, 'This is in the top 20 per cent, this is a really good buy.' It's a very simple message.

**CHAIR:** But that's really only suited to an app. You're not going to get manufacturers saying, 'Don't buy it.'

**Prof. Neal:** In Chile, which we've heard about, we do have a government that has said, 'We will put black stop signs for sugar, salt and fat on products that hit a particular high level of those constituents.' So there are examples of where that is used in the real world.

**CHAIR:** Would that be more analogous to traffic light labelling, with the red?

**Prof. Neal:** Yes, to some extent, if you just had red and green and not the amber in between. It might be, yes.

**Senator SINGH:** On your app, what does grey mean? You've got red, green, amber and grey.

**Prof. Neal:** Grey is behind the energy density, so there are no specific targets or cut points that are set to say, 'This is a red energy density versus an amber one versus a green one.' That's why that appears grey. It's not neutral, it's just that there isn't an agreed international or national system for grading them. So we've tried to base the app very strongly in the evidence.

**CHAIR:** Can I just go back to that. Consumers like the health star ratings and they're very straightforward and obviously easy to put on the front of a packet. How much of a difference do they make? Sure, I get that they're not as effective as, 'Don't buy it,' but how effective are they in shaping choices?

**Prof. Neal:** As we've heard, there's a lot of research which says consumers like them and they're going to make better choices. In the research we did we saw strong trends in favour of, first, health star ratings. The traffic lights, after the warning labels, were the most effective, and the least effective was something called daily intake guides, which are little thumbnail things.

**CHAIR:** So there's strong evidence that they actually impact on healthy eating choices—obviously not as strong as other options, but stronger than some of the alternatives.

**Prof. Neal:** I come from a clinical background where 'strong evidence' means we do drug trials and they show that they stop people dying. It's not as strong as that. But it is very unlikely that putting health star ratings on products is not going to result in better food choices, and the likelihood that they would cause worse food choices is vanishingly small.

**Senator PATERSON:** Just quickly, on that last comment, I was aware of some research in the United States on putting kilojoules at fast food outlets. Some consumers saw the measure of greater kilojoules for the same price as better value, and so they were choosing the less healthy option because they thought, 'Gee, I'm going to get 1,000 kilojoules for five bucks instead of 800 kilojoules five bucks.' Isn't it a concern that people respond in unanticipated ways?
**Prof. Neal:** It is. We don't think the kilojoule labelling here in New South Wales is probably the best option. We would much rather see the health star rating presented to consumers on the menu boards just the same way as it is proposed to be on the packages. We've actually done some research which shows that that would be highly feasible.

**Senator PATERSON:** On the reformulation, there was a witness earlier this morning—we didn't get follow this up because of time—who made a comment about reformulation being akin to trying to market a healthier cigarette. That's clearly not your view; you think reformulation is a good thing.

**Prof. Neal:** I don't think that was probably the intended—

**CHAIR:** I think you're misrepresenting—

**Senator PATERSON:** That was my honest impression. I'm happy to be corrected if I'm wrong.

**CHAIR:** We might go back to the Hansard, but that's certainly not the impression I got from that answer.

**Prof. Neal:** Absolutely. The greatest opportunity, frankly, with the health star rating is that it will drive small changes to the average composition of many foods that will shift a product from being, say, three stars to 3½. The beauty of that is that as a consumer you don't have to make a more-informed, better choice. You just can't help but get a slightly healthier food, because everything just gets a little bit better. So, that is the public health gold.

**Senator PATERSON:** Yes, but I've certainly had people say—and not in this inquiry—that, for example, changing a sugary drink to a non-sugar-based product to achieve the same sweetness is not a desirable thing, because they're still going to be in the habit of drinking sweetened products, and we want to get people out of that.

**Prof. Neal:** In an ideal world we would have people switch from drinking sugary drinks to drinking water—absolutely. The reality is that you're unlikely to be able to achieve that. So, having people switch from a sugary drink to sugary drink that is a bit less sugary or that's artificially sweetened is almost certainly going to be better from a public health perspective.

**Senator PATERSON:** I would think so, yes. Thank you.

**Senator COLBECK:** What was the uptake on the food switch?

**Prof. Neal:** We've had about probably three-quarters of a million people download it in Australia. I mean, it's been around for four or five years. It's also up in about eight other countries around the world, and we have plans to launch it in many more.

**Senator COLBECK:** In my view, utilising things that people use every day to provide information, particularly when you're talking about real estate, on products is a good way to deal with some of those things, because as formulations change it's easier to change this than it necessarily is to change a physical package.

**Prof. Neal:** Yes. The challenge there, of course, is that you've actually got to take your phone out, you've got to download the app and you've got to turn it on, so it becomes a much less-effective intervention than having it on the packaging.

**Senator COLBECK:** It also goes, though, to the point I made earlier about what people actually do when they're in a supermarket, where there's a whole heap of things on the label. I used the example of country of origin so I didn't get mixed up in this argument. People tell you what they want, but then they have completely different criteria when it comes to their actual decision-making. It then comes down to getting enough people to make their decisions based on the criteria you're looking for.

**Prof. Neal:** Yes. There's no doubt that if we could have packaging that was just the health star rating and sort of covered the whole thing, it would almost certainly be very effective, or if we had labelling that was stop signs—'Don't buy this!'—or poison signs—

**Senator COLBECK:** Good luck with that!

**Prof. Neal:** I know, and I'm not proposing that in any way, but just to take it to an extreme, there are things you can imagine that would be incredibly effective. This is about finding a reasonable compromise. I should say, the quote of $2.5 million to implement the health star rating seems to me like a bit of an example of the food industry doing—

**Senator COLBECK:** This was a vegetable processor; it wasn't a processed-food processor—and I used the example deliberately so that I wouldn't get into this argument.

**CHAIR:** Yes. Perhaps what we can do is invite the people in question to maybe provide some evidence to the committee. That might be worth doing.

**Senator COLBECK:** I think I can find it on the public record for you.
CHAIR: So, in your view health star ratings should be mandatory for two reasons. One is that it obviously gives people an opportunity to compare all products when they're shopping. But, more importantly, it actually exerts significant influence on the industry to shift. Is that your view?

Prof. Neal: It is, yes.

CHAIR: And in terms of closing the loophole around 'as prepared'? Is there a simple solution to that?

Prof. Neal: We've submitted solutions that are pretty simple, yes.

CHAIR: Just quickly—

Prof. Neal: For example, either you just don't allow 'as prepared'—that's really simple—or you allow 'as prepared' only in the setting where you're adding water, and that provides, again, a pretty level playing field for all industry players.

Senator SINGH: With the health levy on sugary drinks, there have been a number of submissions that stick to this 20 per cent. How is that derived, the 20 per cent? Do you have any more evidence on the benefits of a health levy?

Prof. Neal: I'm afraid I'm not an expert in the magnitude of the taxes and the price elasticity issues, but no doubt there are data that point to that. There is no doubt, I think as was alluded to earlier, that people make their purchasing decisions first and foremost on price. Again, the likelihood that a 20 per cent levy would not reduce purchases and consumption and the likelihood that it would not in the longer term lead to a positive effect on obesity, diabetes and dental caries is, again, pretty vanishingly small.

CHAIR: Professor Neal, thank you very much for your time. Again if you've got any more information to provide to us, we are more than happy to take it on notice. Thank you so much.
DAY, Ms Katinka, Campaigns and Policy Team Lead, CHOICE

KIRKLAND, Mr Alan, Chief Executive Officer, CHOICE

[11:50]

CHAIR: I'd like to now welcome representatives from CHOICE. Thanks for appearing before the committee today. I'd like to invite you to make a brief opening statement.

Mr Kirkland: I will make a brief opening statement. CHOICE is, of course, Australia's largest consumer organisation. We're a not for profit; we're entirely independent, and we exist to advance the interests of consumers.

When we ask Australians about the issues that they would most like to see us work on, in their priorities as consumers, food labelling consistently comes out near the top of that list over many years. So for many years we've worked on issues particularly to do with food labelling. But of course we work across a broad range of industries, and that's a perspective that we bring to this debate. So when we look at food labelling, we think that, as with our work in other industries like banking, it's really about wanting to see people treated fairly, able to find products that meet their needs, easily able to compare products, able to understand what's in them and what the actual product is, and free from misleading or deceptive conduct or claims. We see significant problems in terms of people being able to enjoy that sort of experience when buying food products at the moment, which is why we take a continued interest in this area.

It's our view, based on that experience across a range of industries, that food purchasing environments are stacked against Australian consumers. Every day people are exposed to multimillion-dollar marketing campaigns, misleading labelling and manipulative advertising. Not only do food and beverage companies target individuals through advertising and at point of purchase, they also target the regulatory environment. It's increasingly clear to us that they play an overly influential role in food and health policy in Australia. As we commented in our supplementary submission to this inquiry, we see the tactics of big food companies mimicking those that we've seen over many years from the tobacco industry. We've got evidence of food and beverage companies discouraging research they don't agree with, funding their own research and developing voluntary self-regulatory schemes to avoid real regulation that deliver absolutely nothing by way of benefits to consumers. This set of tactics leads to regulation being delayed, initiatives being watered down and an overwhelming lack of progress in making it easier for consumers who want to make healthy choices to do so.

We think there are a number of actions the committee can recommend to address the situation. The first is to learn the lessons from tobacco regulation. It would be outrageous to invite tobacco companies to the table to help draft tobacco control laws, so why would we give food and beverage lobbyists a similar level of influence in debates about food and health policy? The WHO has clear guidelines to protect policy development from commercial and other vested interests when it comes to tobacco, and we think we need to take a similar approach when it comes to food, and that recommendation needs to be taken as part of an overall approach—a national strategy—to address obesity in Australia. As with some other organisations appearing before the inquiry, we support the recommendations made in the Tipping the scales report.

In summary, we urge the committee to develop a strong national coordinated approach to obesity that's based on the best evidence about measures to advance public health—including better labelling to help consumers to make choices that they want to make, and protecting the regulatory process from undue industry influence. Thank you.

Senator SINGH: Thank you Mr Kirkland and Ms Day. I'm interested in your submission going to this issue of manipulative marketing hype. Being at the forefront of all things CHOICE does product related, can you give us some examples of this type of manipulative marketing hype that is obviously contributing to misinformation for consumers?

Mr Kirkland: There are so many of them. If you wander down the aisle of a supermarket, you could pull almost any product off the shelf or watch the way it's advertised through other channels and you'd find something, I would say. The sorts of examples we see at a basic level are things like misleading serving sizes—we've called out in the past examples where a small individual portion of yoghurt is claimed to have two serving sizes in it. I don't know anybody who would ever eat half a yogurt. We've talked about manipulation of the health star rating scheme. So we've made a lot of noise about the Nestle approach to the health star rating for Milo using the 'as prepared' rule, which saw Milo get 4.5 stars I believe. The other common thing we see is products that are high in a particular nutrient that is not good for health being promoted on the basis that they happen to be high in another nutrient, while ignoring the fact they are in fact high sugar, salt or fat—whatever it may be.
Senator SINGH: So are these specifically discretionary foods when we're talking about manipulative marketing hype?

Ms Day: A couple of years ago we did a routine review of products that were targeting children and parents—they were children snacks. We were finding that a lot of these products had logos on them that were developed by the food manufacturers that said 'school canteen approved'.

CHAIR: School canteen approved? So is there a list of products that aren't approved by school canteens?

Ms Day: There is a requirement as to what can be sold in canteens. But these were voluntary logos that the companies had created themselves; they didn't adhere to any particular guidelines. They were on a whole range of different products and each logo was slightly different in terms of how it conveyed that it was appropriate for canteens.

CHAIR: Can I just be clear about the example you're using, because I've not heard this before, you're saying some companies design their own logo?

Ms Day: That's correct.

CHAIR: To give the impression that somehow this had been given the approval of an independent body—that is, good to be given to kids.

Ms Day: Exactly. They used green ticks; there was a whole range of different logos that were used, and we're happy to provide them to the committee. We called on the ACCC to look into this case, and they actually agreed that these logos were misleading and subsequently fined two of the companies. So it is an example of some of the tactics that the food industry will use. A lot of these products that were using these logos were discretionary products—so we're talking Tiny Teddies, Paddle Pops and a lot of other snack products—making it really difficult for parents to be able to identify what products are good to buy as snacks for their children.

Mr Kirkland: To go to your question some more, I would say we don't always see these sorts of tactics employed in relation to products that people would consider to be discretionary. Breakfast foods are a great example. We see lots of breakfast products, which people probably don't think about as being discretionary—they think they're an essential part of the day—but we see misleading claims all over them about how healthy they are effectively.

Senator SINGH: So if we take a supermarket in totality, what percentage of a supermarket has these discretionary foods in it?

Mr Kirkland: I couldn't comment, but—

Senator SINGH: I'm just trying to get a picture as to the scale of products in your average Australian supermarket that fit within this discretionary food category.

Ms Day: We don't have specific statistics; we're happy to look into it for you. But when you when you are speaking to a nutritionist, for example, they will say walk around the perimeter of a supermarket, because it's often individual aisles that contain a lot of the discretionary foods. And we know how many aisles there are in a supermarket, so there are a lot of foods that would fall into that discretionary category.

CHAIR: We've heard on a number of occasions comparisons to the tobacco industry, and I know some people feel that's an unfair comparison. I'm interested in one of the examples you gave about Coca-Cola funding the Global Energy Balance Network. Can you talk to that and just explain that to people who might not be aware of it?

Ms Day: I think it was two years ago that they actually nominated Coca-Cola for a Shonky. If you haven't heard, Shonkies are our annual awards for the worst behaving companies. It was nominated essentially because it was astroturfing behind an organisation called the Global Energy Balance Network, which was advocating for a notion of food being about energy in and energy out and it really being about physical activity. So it was fine to have a can of Coke for example as long as you did X amount of exercise. It really distracted the attention away from the real issue, which is that we're consuming a lot of discretionary foods and the solutions to that need to be at a regulatory level. It did come out in the end that it was Coca-Cola behind it, but it wasn't evident in the first instance that the Global Energy Balance Network, which doesn't necessarily seem like it is conflicted or is giving advice, is industry funded. I think it's the confusion that there are potentially front groups out there giving health and nutrition advice when really there is a conflicted basis behind it.

CHAIR: Just finally, given there's been a lot of focus on the healthy star rating, what needs to change in your view? We've heard from others, but what has to change with regard to our health star rating system?

Ms Day: We think there are five key changes—you've heard about it being mandatory; we think that's really important. Secondly, we think that foods that are high in sugar, salt and fat shouldn't receive a high star rating. We
believe that the 'as prepared' loophole needs to be fixed. Just to add to the Milo example: there is another product that uses 'as prepared' loopholes—essentially, this is a salt mix—and it claims a four-star rating on the basis of being mixed with lean meat, wholemeal buns, baby spinach, tomato and onion. This product by itself gets 0.5 stars.

Senator PATERSON: You wouldn't eat it by itself, though?

Ms Day: No.

Senator PATERSON: It wouldn't taste very nice.

Ms Day: You probably wouldn't eat a beef burger with this salt mix either. It's an example of health star ratings being more used as a marketing tool, rather than generally trying to help people choose healthier options.

In relation to the other changes for health star ratings, we think added sugar should be incorporated into the algorithm. There's some useful and interesting research by the George Institute that shows that added sugar being incorporated into the algorithm would actually improve some of the results and reduce the number of anomalies in the system.

CHAIR: I perhaps missed my chance—and I know Professor Neal is in the audience, and he might want to provide some more information on this on notice—but we didn't explore the way the algorithm actually works. At the moment, added sugar is not taken into consideration in the calculation of the rating system.

Ms Day: That's right. It takes into consideration total sugars. The issue with that is you have some products that contain both intrinsic and added sugars—yoghurt, for example, contains both. This leads us to another issue with our food labelling laws: food companies don't need to label added sugar on their products. Current dietary advice from the Australian Dietary Guidelines and the WHO say we need to reduce our amount of added sugar. Currently, looking at the food labels, there's no way for an individual to follow that advice. Food companies use over 40 different words for sugar in ingredient lists, so it's really difficult for consumers.

CHAIR: I'm just going to tell you about our breakfast table conversations with regard to the cereals that are available at the supermarkets—honestly, it's just so difficult. Obviously, there are lots of breakfast cereals that've got natural fruits—dried sultanas and dried fruits—and, unless you actually interrogate the pack in great detail, you don't know whether they've added sugar. As you say, it might not be called sugar; it might be called all sorts of other things. I'm surprised to hear that, and I'd assume that added sugar would have been factored into the algorithm. But what you're saying is it's not.

Ms Day: That's right. They're currently looking at sugar labelling at the moment on food labels, and they're also exploring it as part of the five-year review of health star ratings, so it is being explored. However, added sugar labelling on food products was a recommendation from 2011, so we're concerned at how long it takes for even basic labelling changes to occur in Australia.

Senator SINGH: Added sugar is one of the major causes of obesity.

Ms Day: Yes, the associations with dental issues and weight gain—a whole range of issues—have been well documented.

Senator SINGH: Can I just ask what happened after you gave the Shonky Award to Coca-Cola? Did they respond?

Mr Kirkland: We do often see good responses to our Shonkies. The school canteen logos was a great example of something we called out in a similar way, and we got action. The large global companies like Coke are perhaps slightly less likely to pay attention to a little old consumer organisation in Australia.

Senator COLBECK: I just want to follow on from Senator Di Natale's question on sugar and total sugars—does total sugar include the added sugar?

Ms Day: Yes.

Senator COLBECK: So added sugar is included as part of the total sugar?

Ms Day: Correct, yes.

Senator COLBECK: It's not differentiated. I'll just get that straight in my head. I also want to go back to the canteen approved, or tuckshop approved—whichever state's terminology you want to utilise—so you refer that to the ACCC?

Ms Day: Yes.

Senator COLBECK: The ACCC made a finding in respect of that?

Ms Day: Yes.
Senator COLBECK: The point that I want to make is that there are systems at the moment that deal with misleading claims on food products, so it's not necessarily a free rein circumstance that we have. If a company makes a misleading claim—and I won't use sugar as an example now—Maggie Beer, for example, presenting a product as being made in the Adelaide Hills when it wasn't. There was a finding made against that product—to clarification. It's not an open slather situation; it's one where if someone makes a misleading claim, and it's found to be a misleading claim, then there are mechanisms to deal with it.

Mr Kirkland: To an extent. The ACCC has limited resources and it tends to pick out the most egregious examples it finds. In a particular year it targets particular industries and not others, so there's a relatively small number of actions that the ACCC has undertaken in relation to misleading or deceptive conduct when it comes to food labelling. We're glad with the ones they have taken, but we wouldn't see that as a sign that all of the misleading claims are likely to be taken out of the system just because of that prioritisation of resources that it has to do.

Senator COLBECK: No. But there are systems in place that can deal with that?

Mr Kirkland: Yes.

Senator COLBECK: By some body like yourselves, or one of us or somebody taking it—

CHAIR: Perhaps we can ask that question in the reverse: how do we improve the situation? For example, you could claim the product's low in fat but it might be really unhealthy for you. That's not an ACCC issue. What would you see as some of the ways of improving health claims that are made by products?

Mr Kirkland: I would come back to health star ratings, because having a consistent system of labelling that people can apply without having to think and interpret information, and that's different in every context, is one of the best ways to help people. Bearing in mind that you're talking about people making 30 or 40 choices in the context of a 20 minute shop, maybe with kids in the trolley and it's busy, so these are often decisions that are made very, very quickly—so making health star ratings mandatory, so manufacturers can't be selective about which products that they put them on. Nestlé is a good example. Having fought the claim about MILO for several years, they now say they're going to take health stars off MILO, so that's an example of manufacturers getting around the voluntary nature of the system. Then the other key change is ensuring that food products that are high in sugar, fat or salt can't get a high-star rating. Those two changes alone would have a huge impact.

Senator COLBECK: The total sugars doesn't impact on the star rating?

Mr Kirkland: Total sugars do at the moment but the way the algorithm works, and I pray that you don't ask me a more detailed question about this, because we're certainly not the best people—

Senator COLBECK: I think Senator Di Natale has already put the George Institute on notice of that.

Mr Kirkland: In effect, because of the way the algorithm works at the moment it is sometimes possible for a food that is particularly high in one of sugar, fat or salt to actually get a relatively high rating because of the other components of the food. What we're saying is that it should effectively be a veto that if you're high in one of those dangerous nutrients—

CHAIR: It brings down the overall level—

Mr Kirkland: then you shouldn't be able to get a high—

Senator COLBECK: What are dangerous nutrients?

Mr Kirkland: Those that are accepted around the world to have an impact on health if consumed in excessive quantities.

Senator STORER: I'm interested in social marketing versus the points regarding time-based restrictions on exposure for children to free-to-air television. What is your opinion about the status of social marketing regulations versus advertising that's on television? Does CHOICE have an opinion on that?

Mr Kirkland: It's not an area where we do a lot of work. The only comment I would make is that I think that with social influence marketing the job of regulators is even harder. It is relatively easy for the ACCC to identify misleading claims where they're made on a label or made in broadcast advertising on TV. Where claims are advanced through influencers, who are perhaps paid something or given some sort of free product or holidays by a manufacturer in return for them making positive claims about a product, a lot of that happens through social channels where it's very hard to detect. I think that presents an additional challenge for regulation to try and pin down and knock out misleading and deceptive practices.

Senator STORER: Is CHOICE doing a lot of work in that area?
Mr Kirkland: It's not an area where we're doing a lot of work at the moment, no. It's really just a matter of trying to work out where to apply limited resources.

Senator STORER: I understand.

Senator PATERSON: Mr Kirkland, I have a background question first. Primarily, how is CHOICE funded? What's the structure?

Mr Kirkland: Through membership fees. That's our largest source of income by a long shot.

Senator PATERSON: I saw in your annual report that you had $18 million of revenue last year. Am I correct in saying that you have about 12,000 or 13,000 members?

Mr Kirkland: No, we've got over 180,000 memberships.

Senator PATERSON: All right. I was looking at the annual review. Is 'CHOICE community' different?

Mr Kirkland: Yes, that's an online community. That's free for anyone to join.

Senator PATERSON: Right. The reason I asked is that, as advocates of consumers, I'm surprised that you're supporting a sugar tax that those consumers will ultimately bear, particularly because the research shows that these sorts of taxes are highly regressive—they have a disproportionate impact on low-income people.

Mr Kirkland: We support a tax in the context of a package of measures. It wouldn't be something you would do on its own. It needs to be part of a broad range of measures to tackle obesity. In doing so, we are conscious of the socioeconomic impacts of a tax, just as we are about the socioeconomic impacts of obesity. People who buy sugary beverages and give them to their kids ultimately bear the costs of that in terms of the health impacts. This is a position that has sort of been taken by a number of consumer organisations around the world. We're heavily influenced by the experience of our counterpart in Mexico, who has reported the positive impacts of a sugar tax there. They were very involved in advancing that. One of the reasons they were involved in advancing that is the impact on essentially poorer consumers in Mexico of the consumption of sugary beverages. It's in that international context, seeing the evidence around it that it is working in Mexico and also seeing it as part of an overall package of measures that we support.

Senator PATERSON: So you do recognise that it has a regressive impact, but you just think it's a worthwhile evil I guess?

Mr Kirkland: We think there would be a net gain to people on lower incomes from sending a stronger price signal. Because the market for sugary beverages is so distorted at the moment by the sorts of tactics that are used by these companies we think ultimately people would be in a better situation if there were a stronger price signal, just as we have done with other things like tobacco.

Senator COLBECK: But it hasn't necessarily worked on, say, alcohol. We went through the process back in 2008 I suppose of significantly increasing the tax on a certain category of alcoholic drinks. I looked at some of the figures last night. There has been continued decline in consumption but it hasn't followed anything other than natural trends. It has switched products. I suppose in that context it took people off sugary alcoholic drinks to straight spirits. Perhaps there is some benefit in this current debate in that context, but it hasn't necessarily changed the overall scheme of things.

Mr Kirkland: I can't comment on the alcohol-labelling issues or the evidence around their impact.

Senator COLBECK: I just remember those Senate inquiries, that's all.

Senator SINGH: Are there any other comments CHOICE would like to make? Are you part of any of the partnerships or alliances that we heard about this morning?

Ms Day: We've joined the Tipping the scales report, which was 35 leading health, community and consumer organisations. We also have been interested in engagement of the Obesity Collective, which is being established at the moment.

Senator SINGH: Can you talk about that?

Ms Day: It's a relatively new initiative arising from the need to have a coordinated approach to addressing obesity in Australia and have a more united and single voice. This group is keen on bringing a whole range of different groups—academics, retailers and manufacturers—on board to ensure that we are able to talk about and progress this issue. Like I said, it's in its very early stages.

Senator SINGH: So it's the Obesity Collective. Who instigated it?

Ms Day: Charles Perkins Centre and Stephen Simpson.
Senator SINGH: And you say it's made up of people from the food industry as well as consumers?

Ms Day: I'm not sure exactly of the structure of the membership. There has been engagement with some retailers, but mainly public health groups, community groups and consumer groups. It is really to engage everyone working in this sector to progress issues related to obesity and to have a more united and unified approach in terms of how we address it.

Senator SINGH: Could you take on notice to provide to the committee the membership, if you are able to find that out?

Ms Day: Yes, sure.

CHAIR: There being no further questions, thanks again for a really interesting presentation. You have some homework to do. Please provide us with answers to the questions you've taken on notice and anything else you think might be relevant to some of the questions that were asked today. Thanks very much.

Proceedings suspended from 12:16 to 13:15
BADORREK, Ms Sally, Clinical Dietician, Nepean Family Metabolic Health Service

BOYD, Ms Susan, President, Federation of Parents and Citizens Associations of New South Wales

CUNNINGHAM, Dr Frances Clare, Senior Research Fellow, Menzies School of Health Research

DOUMANI, Mr Patrick, Member Support Officer, Federation of Parents and Citizens Associations of New South Wales

LAM, Ms Sarah, Clinical Psychologist, Nepean Family Metabolic Health Service

SMITH, Mrs Belinda, Founder/Director, The Root Cause

WILLIAMS, Dr Kathryn, Clinical Lead and Manager, Nepean Family Metabolic Health Service

CHAIR: I welcome representatives from the Nepean Blue Mountains family obesity service, the Menzies School of Health Research, the Federation of Parents and Citizens Associations of New South Wales, and The Root Cause. I want to thank you all for appearing before the committee today. We've got a few people presenting at the same time. I'm sure some of you have a brief opening statement you'd like to make, so can we try to keep those fairly truncated. In order, if we begin across the table, I'd like to invite you to make your opening statements.

Dr Williams: I'm an endocrinologist. I'm the clinical lead at the Nepean Family Metabolic Health Service, previously known as the Nepean Family Obesity Service, at the base of the Blue Mountains. We're a tertiary lifespan obesity service in Western Sydney. We also have links to the Charles Perkins Centre at the University of Sydney. We'd like to stress that the ideas expressed today are our own as clinicians and do not necessarily represent those of the organisations that we represent.

As my opening statement, I'd like to make the point that public, political and media discourse around obesity to date has been dominated by a persistent skew towards individual-level choices as the primary determinant. This is then reflected in policies and interventions that focus on individual-level behaviour change. These interventions can be considered downstream endeavours and should not be considered as negatives, as they have potential to do great good. However, action now should move beyond individuals and focus on reshaping the system itself.

Healthcare professionals, researchers and policy-makers should take into account the wider systemic drivers of the obesity epidemic and realise that the effect of downstream interventions may be attenuated by so-called upstream drivers.

Upstream drivers can be divided into physical, sociocultural, economic and political areas of influence. Physical factors of note include the development of urban sprawl, such as we see in Western Sydney, and the lower complexity of land-use mix. Sociocultural factors include, in wealthier countries, those of lower socioeconomic status and the influence of social networks. Interestingly, that relationship between SES and BMI is bidirectional, and this highlights the importance of tackling obesity stigma as a separate, important issue.

Economic determinants include the higher cost of healthy foods, and political determinants include the effectiveness and stability of government to ensure the enactment of quality policy and the degree of regulation by government.

To quote something in Obesity Facts 2017 that I found very interesting:

It can even be argued that obesity is, in principle, a simple problem and that obesity is only a complex problem because we make it a complex problem. Boldly speaking, if we want populations to live in free market economies and commercial environments in which they are constantly being challenged or even manipulated by food and other industries, have access to an abundance of places to sit and eat, while at the same time maintaining a normal weight, then things start to get complex. No single measure will be able to resolve the problem on its own, but a 'simplistic' view of the upstream causes of obesity may help us shape upstream solutions.

At some point, in an individual, obesity takes on a life of its own and perpetuates itself through direct adverse effects on an individual's physical, mental and social wellbeing. We see this at the pointy end in a tertiary obesity service. Our patients come to see us, as we are a complex rehabilitation service. Our patients will never be cured; however, their life trajectories can be significantly improved with our intervention. I urge all politicians not to use obesity as a political weapon or a finger-pointing exercise. There's a need for a collective, positive and multifaceted approach from all stakeholders to ensure the massive change that will minimise the effects of this tsunami that we have effectively only just noticed but which is already bearing down upon us.

Dr Cunningham: Menzies is one of Australia's leading research institutes. Its major mission is improving the health and wellbeing of Aboriginal and Torres Strait Islander Australians. At the outset I'd like to acknowledge
the Gadigal people of the Eora Nation as the traditional owners and custodians of the land on which we're meeting today.

Thank you for the opportunity to appear at today's public hearing. Our submission addresses the committee's term of reference (e), the effectiveness of existing policies and programs introduced by Australian governments to improve diets and prevent childhood obesity. It covers six key points. First, effective policies are needed across the life span, from maternal health to infancy, childhood and youth and through to adulthood. Children are an integral part of families, and their diets are formed and influenced by family behaviours. Second, we need to address the higher impact of the social determinants of health and health risk factors, including overweight and obesity, on disadvantaged populations, particularly the Aboriginal and Torres Strait Islander population. Social determinants account for 39 per cent of the gap between Indigenous and non-Indigenous Australians. Impacts on health of multiple unhealthy risks, including overweight and obesity, are reflected in the 10-year gap in life expectancy between non-Indigenous and Indigenous Australians. And here the incredible diversity of Aboriginal and Torres Strait Islander communities across Australia must be noted. Effective strategies need to address challenges that are relevant to the local context. What might work at Mount Druitt is likely to be very different from what might work in Maningrida or on Masig Island in the Torres Strait.

Third, we must develop healthy environments. We need supportive environments for health to assist people to make healthy choices. Fourth, we need to acknowledge the importance of developing and adopting policies and programs that address multiple behavioural risks. There is high co-occurrence of such risks, and they can have a synergistic impact on health. Addressing multiple unhealthy behaviours should prove more cost-effective for health services and result in more-positive health outcomes for the client, their families and government than addressing single unhealthy risks. And fifth, I'd like to draw to your attention the rationale for using brief interventions in health care. Importantly, brief interventions designed to fit into everyday clinical practice have been found to produce clinically meaningful changes in the population for a growing number of behavioural risk factors, including overweight and obesity. Hence it is necessary for all frontline staff who are attending to clients to be upskilled with the knowledge, confidence and skills to conduct brief behavioural interventions with their clients.

Lastly, I'd like to draw your attention to the example of the Queensland Health B.strong program. That stands for 'Be strong together respecting our next generation'. Menzies is responsible for developing and delivering the B.strong program across Queensland on behalf of Queensland Health, which is funding the program. It's an area where Queensland Health is really taking the lead in Australia, as it did previously with the SmokeCheck program. So, B.strong is upskilling Aboriginal and Torres Strait Islander health workers and other health and community professionals to deliver brief interventions. It's for three areas at present—smoking cessation, nutrition, and physical activity—for those with Indigenous clients, which will benefit the clients, their families and their communities. Thank you.

Ms Boyd: We echo a lot of the sentiments that have already been said here. A lot of our introduction is there, and a subsequent one that we've done for the state, which is that our response to this inquiry is guided by our belief that children will learn better if they have full tummies. That's basically it in layman's terms. If they're sitting there starving, they are not going to do well. But if they're overfull and they need exercise, which is what this is about—obesity—then that has to be addressed as well. There was some strange media on the weekend suggesting that we stop feeding our children or young people.

The cost of food and cost of exercise is extremely high. In New South Wales we have a $100 dollar kids rebate. This has been taken up massively across the state. We've been doing surveys, and we have families who have never put any children into sports previous to this, now going, 'Okay.' The mum of a family of four in Western Sydney said, 'Right, I will put all of my children into sport this year because I have this $400.' She feels she can do it and it's been life changing for that family. So if we take that and multiply it by the number of children we've got at school—roughly 780,000 in New South Wales—that's a lot of children out there. Even people who have been into sports already, their parents are taking it up. We would like the federal government to actually weigh in on this issue as well. We get rebates for professional development as working people, or those who are working; parents can be looked at too. People say money will not cure everything but it's a lot easier to deal with paying your bills and buying better food for your children if there is more money available. So mine's basically on money. Patrick's going to do the hard stuff.

Mr Doumani: I support most of what Susie has just said. The only more general point I'd add is that this is such a multifaceted problem that there's not going to be one single solution for everything. Some things the government may be able to have an influence on, others not. I mean it's particularly a problem, for example, for people from low-income backgrounds and people in regional areas so any strategy to address obesity has to make
sure that those groups are targeted. It is the same with students who go to schools in metropolitan areas. They would often have less room to run around and play, and that may become even more of a problem with the proposed increase of high-rise schools in metropolitan areas. We believe that many efforts to make sure that there are more classrooms for students is accompanied by more space for them to run around as well, because addressing the needs of students not only means giving them classrooms but addressing all their needs including the need for physical activity.

**Mrs Smith:** I'm the founder of The Root Cause. Our work empowers children to make better food choices and makes it easier for parents to get their kids to eat healthily. We've been tackling children's health at a grassroots level. We've visited over 100 schools around Australia and spoken to over 23,000 people directly. What I would like to report is nothing short of an extreme normalisation of discretionary foods, also known as junk foods, and these foods are being eaten in excessive amounts every single day at school.

Parents are falling prey to the convenience and also the pester power of children created by the marketing of these foods. Many parents and canteen managers believe children are fussy, will not eat healthy foods and that it's too expensive trying to feed them healthy foods. There's also a frightening lack of understanding amongst many parents and children about the impact these foods are having on health, behaviour, concentration and academic results. Sadly, we are growing a generation of children who are likely to go into adulthood with expensive chronic illness such as fatty liver disease, type 2 diabetes, heart disease and obesity, and neurological disorders like dementia and mental illness.

I'd like to table today a report as evidence of a lunchbox study that we've been involved in and also examples of lunchboxes from this particular study. These lunchboxes are consistent with what we've seen right around Australia. These lunchboxes are like party food. Discretionary foods are recommended to be eaten only sometimes and in small amounts. But most Australian children are eating two to four of them in their lunch box every single day. Our study shows that children will prioritise eating these discretionary foods at the expense of their sandwiches, fruits and vegetables. We know from the experience of our Mad Food Science Program that, when you educate children with the 'Why?' behind making better food choices, they ask their parents for more fruits and vegetables, they start reading packet labels and they up-educate their parents and start working with them to make better food choices. Of the teachers we have surveyed this year, 89 per cent believe our Mad Food Science Program needs to be taught in all schools.

Health professionals say that 80 per cent of our health comes from what we eat. Therefore, it makes absolute sense that we need to start focusing on creating sustained behavioural change in children around food choices. Using the knowledge we have gained on the ground, we have developed a blueprint for an aspirational Health Heroes schools program which we believe can create sustained behaviour change in the school environment for children around food. We are working with Associate Professor Gary Leong and his team from Sydney University. We have a number of specialist organisations involved. And we have principals from five states around Australia who have expressed an interest in participating in a two-year pilot of this program.

We believe in a lot of the recommendations that have been tabled today, including the ones from Tipping the Scales. But, importantly, we believe a primary method for curbing and preventing childhood obesity must include a grassroots approach addressing sustained behavioural change in children. After all, these children are the parents of the next generation of children. We need to break the cycle that exists today.

**CHAIR:** Thank you. Senator Singh.

**Senator SINGH:** I thank all of you for your submissions and also for presenting in front of us today. Mrs Smith, I want to go to some of the recommendations you have put forward—and you have just alluded to some of them in your opening address—to do with disrupting behaviour and empowering children to teach parents. In my home state of Tasmania, over the last five years or more, a number of schools—in particular, primary schools—have started kitchen gardens. Part of that has been the empowering of students to teach parents and, through growing food at school, learning not only where food comes from but also how to cook healthily. Do you think that has made any difference, and is that something that could be expanded to do with the Health Heroes program you have referred to?

**Mrs Smith:** The kitchen garden programs are fascinating in the fact that they do get children to really understand food and where it grows. You would be amazed at how disconnected from fruits and vegetables our children are. Many believe they come in cans. Many think celery is lettuce. So the kitchen garden programs are fabulous. In fact, they are an important part of our overall Health Heroes schools program. However, the big issue is that the ecosystem in the school is far-reaching and there are many avenues through which children are exposed to food. Our curriculum covers making healthy choices but, within the school environment, children get many mixed messages about food. For instance, we have teachers who resort to giving lollies as rewards. I understand
that. Being on the receiving end of 100 kids in a hall is a big deal, and I can see why teachers would do that. We have canteens which, despite policies, still offer foods that aren't great for our children. We have fundraisers which focus on cakes, lollies and things like that. So our children are getting mixed messages about foods, notwithstanding what is coming from home in the lunchbox. So we need to address all of those areas.

A researcher from Yale University said in a report recently that teaching children about nutrition at school is vital but when you give them lollies or other messages it is akin to actually teaching children not to smoke and then giving them an ashtray and a lighter for good listening. So in the school environment, we need all of those parts of the school ecosystem to be singing the same song about healthy food choices. That's the problem that we need to address.

**Senator SINGH:** So how can this issue of mixed messaging be resolved from a policy perspective? You've talked about a national school food policy. Obviously parents are still going to make their own choices?

**Mrs Smith:** The P&C people would probably also be able to comment on this. But what we know from talking to parents is that they are stressed and tired and that a lot of them just do not get the connection of food and how it makes their children feel. So subsequently we need to find a way of educating the parents. Right around Australia, schools will report it is difficult to get parents to come in to any kind of educational seminar the school puts on, even if it's free. The best opportunity they have is if there's free food to go with it. But we know from our own experiences that children do go home and they tell their parents about what they learnt, and then the parents are shocked at what they learnt. So the key is that we need the children to be educated, so they go home and up-educate the parents.

**Ms Boyd:** Which state are you from, Belinda?

**Mrs Smith:** I'm from New South Wales, but I've been travelling Australia for two years doing this.

**Ms Boyd:** Within the New South Wales Healthy Canteens Strategy that we implemented up there—not putting reps up there for New South Wales, but yes, go us!—lollies should be phased out as should drinks unless they have really very, very little sugar; I don't know what the limit is, but it's miniscule. That was put into practice last year, and it's rolling. It is a phase—canteens have a certain stage that they've got to get to by where we will be phasing that out. If we can do it in New South Wales, then other states should be able to do that as well.

Those drink dispensers that pop out Coke, V and Powerade should not be in schools; it is ridiculous. The problem is that schools have been using those dispensers to create revenue in order to pay for air conditioning, art supplies et cetera. It's a never-ending circle. They need the money. The kids will buy the Coke, the V, and the Powerade, and then we'll get whiteboards, widescreen TVs or 3D printers. Unfortunately, and I hate to harp on about it, it does roll back to the money situation. We don't have those vending machines in our state now; they were the first thing tipped. If you've got them in your states, they need to come out and they need to come out now. Maybe your state governments need to review where their education money is going, because they need to up that, so that those people are not relying on these sorts of situations where kids are paying for it. It's a nasty circle.

**Senator SINGH:** We've heard a lot today about how this is not about one individual being able to tackle the issues of healthy diet, obesity and the like, and how there are various players involved that need to be considered. I'm interested in your views on that, because obviously you're talking about parents. It kind of does hone back into an individual family, for example. But then again you're talking about a school environment, with the drink dispenser. Then you start broadening it out and realising it is beyond a parent's control if, obviously, students are then accessing things within the school that provide the sugary outcome.

**Ms Boyd:** The biggest thing is kids are in school, and we live in Australia—it's really hot—those dispensers, drinks pop out ice cold. They are going to take that option because it's an ice-cold drink. We've had some replaced with water. I think Neverfail was one of those organisations that put one in, and it's working great. Again, it is a bit of a money maker to fund the school from the children, but that's that community's issue—they decided to do that. However, we've even had some school's P&Cs do fundraisers, and they have a cold working bubbler popping out ice-cold water—kids are taking their water bottles and filling them up. There's been a huge decrease in the number of children bringing along the little popper. When my kids were in primary, that probably was in one of their lunchboxes, because I thought, 'Yes, that's healthy. There's a banana in it. There's an apple. There's a sandwich,' but we all know sandwiches go in the rubbish bin—if you've got naughty children like mine! Bubblers are a way to give them the cold water that they need at any time of day, and that's a major pick up, and that can go across the state.

You've also got Life Education's Happy Harold who's out there telling kids drugs are bad. Good chap—I think it's a chap. Good giraffe. Is there scope for a happy—what fruit are you going to name it?—one of those...
endeavours where they roll around the countryside and teach kids: Happy Harold is all about drugs; Happy Apple is all about fruit or something.

Mrs Smith: Can I just step in there because that's actually what we've been doing for the last 2½ years. We've been travelling Australia running and honing our Mad Food Science Program, addressing the different issues that are facing children, parents and teachers. You would be shocked to hear the stories from teachers about what they're dealing with in the classroom environment when half their kids come back with a stomach full of discretionary foods.

The interesting thing is that the school system—the curriculum—is so busy already that teachers tell you they can't possibly take on something else. So an incursion-type environment like the Healthy Harold situation and what we've been doing is what works in schools, but it is only short term. We go in there for a day. We know that children go home and talk to their parents, but then they go back into their school environment, where their peers are still eating the party food in their lunchbox every day, those kids don't feel normal. So they ask their parents to start buying more. It needs to be an approach that's addressed.

In the lunchbox study, which I'll leave with you, we showed what happens when you use positive peer pressure to get children to eat fruits and vegetables. Across an eight-week period, we showed that we were able to minimise processed packaged foods, change the results of behaviour in the classroom, and also change behaviour and attitudes towards fruits and vegetables at home.

Senator SINGH: I wanted to ask you—this is obviously not in Australia—in France, students go to school and they have a cooked lunch provided by the school.

CHAIR: That's in the UK as well.

Senator SINGH: Have you looked into that, and/or have any schools in Australia gone down that path?

Ms Boyd: We don't have the facilities. With hot food, you're going to want them sitting down eating that lunch. Generally, here, children sit on a bench and eat their lunch. There's no way you'd want them balancing a dinner plate on their knees trying to eat something hot. It's unfeasible for the fact that you'd need a canteen or some sort of arrangement like that and also for the cost. If the government was willing to stump up the fees, yes, it's something we would consider.

Senator SINGH: You would be supportive of something like that?

Ms Boyd: For our home state anyway, we're real estate conscious. I was in Parramatta this morning, and there a discussion about the newest high-rise. It's not going to have an oval, so the kids aren't going to be running around, and that's a bit of an issue. But, to add a canteen—we've got people in demountable buildings. I just don't know realistically where we're going to fit a canteen that would fit all of the students. We'll have 500 children, a thousand children, in a lot of our schools, and we're being told that a lot of our schools will blow out to a minimum of 1,000 students in the not too distant future. It'd be interesting. I'd like to see a proposal.

CHAIR: Your concern seems to be a practical one about where kids can sit down and eat. I'm interested that you say that schools are allocating a 10-minute window for eating lunch. It seems to me that we're encouraging unhealthy eating habits. On one hand, we've got a kitchen garden program—terrific—they learn about where their food comes from, how to cook it and so on. But then they have 10 minutes to sit down and scoff their lunch. The 10-minute thing is interesting, because it's cutting across that. The other thing I saw—I'm not sure if this is backed up by any evidence—is that canteens are now the largest takeaway food outlet for Australian kids.

Mrs Smith: That was reported on ABC's program Food For Thought, which is an education program for schools.

CHAIR: It's pretty remarkable.

Mrs Smith: It is.

CHAIR: That is where most kids go. I've got two young kids and luckily we don't confront that at our school, but it's where most kids are getting their junk food.

Mrs Smith: It's also a testament to the changing times. If we turn back the clock to 30 years ago a lot of two-family households had one parent who stayed at home predominantly, and now they don't. Just to cover the costs of living, particularly in New South Wales, most parents are going off to work for long hours.

CHAIR: And preparing lunches just takes up an extra bit of time in the morning when you're trying to rush kids off to school.

Mrs Smith: Exactly. And that's why the healthy canteen strategies are so important, and they do need to be adopted as a consistent approach across Australia, primarily from the point of view that we get so much more
leverage from a tipping point if we all adopt the same kind of philosophy. There is a national guideline for canteens, which I think was put out in 2013, but each of the states have chosen to take that strategy and make it their own. The biggest problem that we've got in all states is there are no real teeth to these systems. The health department say they help with the guidelines, but then they say it's not their responsibility to police it. Then the education department are dealing with a lot, because they have to deal with the flack they get from parents.

CHAIR: Can I also go to the question of cost. I'm interested in exploring this question from Senator Singh. If you've got a lot of kids who are buying their stuff from the canteen anyway, and if you actually have a look at the pictures that you showed us—a packet of chips, a packet of biscuits, bottled fruit juice—those things aren't cheap either. When you add it all up, there's a sandwich, but there's all the other stuff. As parents of two young kids, we go through this at the moment: the sandwich often comes back, and if you happen to put other stuff in the lunch box that tends to go. So you just don't put the other stuff in the lunch box. But, clearly, people are. And that's expensive. In terms of cost, one would have thought that a nutritious school lunch, as other countries are providing, does have some merit, if you could get through some of those issues around how you actually provide the space for this to happen. Do you at least broadly support the notion of something like that?

Ms Boyd: We'd definitely look at something. We would be interested.

Mr Doumani: Other countries that are even poorer than us have done the same thing. Brazil, I believe, has something in place that says that students are entitled to school meals, and a third of that, I believe, has to come from fresh food that's grown in the country. I don't see any reason why Australia wouldn't be capable of something like that too. We are a breadbasket country.

Ms Badorrek: From a clinical perspective, we work in Western Sydney and we see our children with chronic, very severe obesity, and a lot of our children that are turning up are going to school without breakfast. So I think a breakfast program might be something to possibly look at. Regarding the idea of having a cooked nutritious lunch—not a lunch like in a lot of parts of America, where they're serving up processed food again; that defeats the purpose—if they had a nice range of nutritious food served at lunchtime I think that that would be an excellent idea. Senator Colbeck, you were talking about Japan this morning. All of those schools pretty much have school lunches provided, and they have a dietitian working in almost every single school. So they are ensured to have a nutritious lunch.

Senator COLBECK: You remind me that I have had lunch at a school in Japan. They were fascinated that I was using chopsticks left-handed!

Ms Badorrek: I'm sure it was a nutritious lunch as well! So, I think that idea of having a cooked nutritious lunch has merit, very much.

Ms Lam: The breakfast programs in our area have been a godsend for some of our patients who've been put in touch with those, because the children also make themselves lunch as part of the breakfast program. So they can go in there, have their breakfast, make a sandwich and choose a piece of fruit to take to school. So it means they're going to school with food, rather than, previously, they were going to school without breakfast, taking no food and buying stuff from the canteen—discretionary food from the canteen.

Ms Badorrek: And then turning up at home after school, eating pots of noodles and then starting binge eating until they go to bed.

Ms Lam: Soft drink and burritos.

Ms Badorrek: That's right. And a lot of things breakfast programs are put on by not-for-profits, so they're not run by schools. They are not-for-profit organisations that come in to disadvantaged areas and provide nutritious breakfasts. That's sometimes the only breakfast those children get all week. And this is fuel for learning. Our children are already behind in some of their mental health issues. Definitely, they've got a whole range of society and community problems. A lot of them come from dysfunctional families that don't know what good nutrition is. At least they are getting one meal a day that usually covers off at least four of the five food groups.

CHAIR: You mentioned kids who are obese, but there's this question around whether they are actually malnourished—they might be. I am interested from a clinical perspective. If you can talk to us about the difference between obesity and appropriate nourishment. That sounds counterintuitive—

Ms Badorrek: No, it's not—and we see it in adults as well. In fact, we have in-patients come to us and doctors look at them and say, 'Oh, they're obese; they must be well-nourished.' No. Their bloods and their pathology show that they're quite malnourished. This definitely happens in the children. They're missing core food groups. They're missing fruits and vegetables and dairy foods, so they're running the risk of osteoporosis and vitamin deficiencies. Often, 80 per cent of their calories are coming from discretionary foods—treaty-treat foods like chocolates, lollies and chips and those sorts of foods.
Senator COLBECK: So it's not always what they do eat; it's also what they don't eat?

Ms Badorrek: They are displacing good, nutritious food with calories that are coming from foods that offer very little nutrition. It is a big risk. We're seeing it in our service, almost all the time.

Dr Cunningham: I'd just like to make the point that the issue of having healthy environments—vending machines and so on—is not just one for the educational sector. It's very important in the health sector itself—vending machines in hospitals, for example, with lots of soft drinks and unhealthy foods, with candy bars and so on. I know that in Queensland some of the hospital and health services are trying to address it. I don't know about New South Wales and other states, but it's certainly something that could—

Ms Badorrek: We've done it.

Dr Cunningham: Yes. So it's good to model that behaviour. It needs to be across sectors, not just the education sector, but reinforce it through health and give those healthy environments and healthy options.

Mrs Smith: I would like to raise a case study of a school in New South Wales, Tyalla Public School in Coffs Harbour. Their school used to be known for the police cars in the car park. It's a low socio-demographic. Their school is now one of the pilot schools for the New South Wales Healthy School Canteens strategy. That canteen has become the heart of the school. The children are going there for lessons. The children have recommended a whole lot of sustainability issues for the canteen. Again, through the canteen the school is providing food for the breakfast club. The children are getting fantastic fresh foods for lunch. Most importantly, because they have taken the model of the canteen differently, they're providing foods that parents can pick up on the way home if they're busy. So, the kids are getting nutritious meals at home as well. That whole approach of 'can we change the way we think of canteens and food in Australia' has a real lot of merit. Tyalla school shows that when you treat food as a unifier it has the potential to change all sorts of behaviours, like the fact that it's not now known for police cars in the carpark; it's known because these kids are getting nourishing foods and their behaviour is improving.

Ms Boyd: I just want to echo some of the statements. To get back-up evidence, check the school stats on children's attendance at school used to be known on breakfast days. I live in western Sydney. I have children who go, 'Oh, it's breakfast club.' More kids go to school on a breakfast school day and there are fewer fights. Children on the north coast—Banora Point and that area—actually identified that there were lots of fights early in the morning at their school. One young bright spark said, 'It's probably because nobody's getting breakfast.' So they started a breakfast club and aggression levels came down because these kids were eating. Also the whole community spirit—everybody was just nicer to one another. They were taught how to pop their dishes in the sink, do their dishes and take their turn. Space was set aside in the hall in a sort of makeshift canteen style until they actually got some funding together from the local community, who all pitched in, and came up with a seating arrangement. These children went from little ratbags who were fighting with one another first thing in the morning to kids who were grouping together, having breakfast, making their lunches so they had food for the day, and going to school happier. If they get there happier, they're going to learn better. These are our leaders of the future.

Senator STORER: It was also interested in physical activity. You mentioned the lack of an oval in the development as an example. I wonder, Mrs Smith and others, whether you have looked at sedentary behaviour with screens and activities for children to provide a healthier outlet rather than just the input of food.

Mrs Smith: To be honest, my focus has actually been around food because we've been working with an integrative GP on a couple of different projects. They've been quite clear that 80 per cent of our overall health comes from what we eat. There are a lot of good physical education programs already available in schools. So my focus has actually been around the ability to feed people properly and the knock-on impact it has. What we found in our lunchbox study was that the parents of the children who started to eat more fruits and vegetables reported that the children slept better, had more energy and were more prepared to do physical exercise. This might be something the ladies down the end can comment on more. But in an environment where children aren't nourished very well, there's less energy, per se, to really have the impetus to go and do something physical. Certainly these new high-rise schools that we're talking about are not going to do a great lot to encourage physical activity either. So I do believe we need to look at how we support the children in those schools.

Ms Badorrek: Can I make a comment about an obesity perspective from working with children that are in high weights. They find every opportunity to get out of sport at school. They will choose to do art at high school instead of sport because often there are art classes that can be used as sport. That's an issue. Or they'll say that they're unwell, and they're often unwell, and they'll go and sit in the sick bay to miss out on sport. Often they feel a lot of stigma. They're not going to be chosen to be on a team sport, and that makes them feel even worse about themselves. So they grow to hate sport. So I think there's real room to improve and maybe develop some
strategies around some exercise, classes or sport that's appropriate for young children that are living in bigger bodies.

CHAIR: Can I just follow on from that? You talk about stigma, and I couldn't help but notice your name change. The name of the organisation previously—I think in the submission it was referred to—

Ms Badorrek: The Family Obesity Service.

CHAIR: Yes, and you no longer call yourself that. What's your new name?

Dr Williams: The Nepean Family Metabolic Health Service.

CHAIR: I imagine there was lots of discussions around the boardroom about why you changed the name, and you just mentioned stigma. Can you talk to that?

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

CHAIR: Is there anything you'd say to us? Obviously this is an inquiry looking into obesity. Are there different ways to talk about it that help reduce that stigma?

Ms Badorrek: Yes, there is a lot of stigma around it, and it even comes down to the chairs that you've provided for us to sit on right now. If we were of larger size, we wouldn't be able to sit in these chairs. So it's everywhere. Our patients find it's everywhere. Wherever they go, they consider themselves looked at. When they attend a GP appointment, they're scared to talk about their weight. GPs aren't equipped to deal with the questions around their weight, where to refer them on to and help that's available for them. So they're affected by their weight, and they've got internalised stigma as well, so they put themselves down. They feel that the rest of the environment is not geared for them.

Dr Williams: I think the main comment is that we're not talking about obese people; we're talking about people with obesity. Don't ever forget that that's a person. In the same way, we don't talk about diabetics anymore; we talk about people with diabetes. It's very important to remember that.

Dr Cunningham: I would just like to reiterate that point about the need to upskill the whole range of health professionals and some of the skills that they need. The core skills are in the area of how they do motivational interviewing and making sure they have the subject knowledge across those different areas as well. In our B.strong program, we're training Aboriginal and Torres Strait Islander health workers and other healthcare professionals and a lot of community health professionals in the social and emotional wellbeing area, as well as nurses and GPs. But there is a real shortage of upskilling programs like that.

Ms Badorrek: Westmead Children's Hospital have a Weight4KIDS program. It's online. It upskills health professionals—allied health and doctors. I think that, if that were promoted a little more, that would be really useful as well, because it goes through how to address and how to talk about these issues, especially when dealing with children, because we find that a lot of parents don't view their children as having a weight issue, and they clearly have a weight issue and health issues. Often they just consider them big boned. So it's a really important concept, but it has to be treated with delicacy.

CHAIR: You're a specialist referral service. Is it fair to say, given the scale of the issue, that, while it's important to have specialist referral services, we also need to really look at primary care right across the board to be able to address it? Specialist referral services would only be, I imagine, a small part of the response here given how widespread the issue is.

Ms Badorrek: Yes, we have a very long wait list—I guess from a lot of GPs not knowing how to deal with this.

Dr Williams: I think what's clear is that doctors can't treat this alone, particularly someone with quite extreme obesity. Tertiary referral centres are really the only place that can do that adequately now. But if there were capacity for GPs to tap into clinical psychologists and dietitians, even in a group based environment, then GPs would be much more capable. We don't have the tools outside tertiary obesity services to deal with someone who's 160 kilograms. It's just not possible at the moment, but that can be improved.
**Dr Cunningham:** I think one of the members of the panel raised the issue of opportunities for physical activity. Our feedback from running our program across urban, regional and very remote areas of Queensland is that there are quite a lot of opportunities for physical activity through schools, but then there's a gap. Once they leave school, if they don't meet the criteria to get into some of the adult sports, there's a bit of a gap there. Then we also did a scoping study to look at the availability of a whole range of different options to do physical activity. The story in Queensland—and it's probably similar in the other states—is that there are quite a lot of walking groups and opportunities to do different types of physical activity in urban areas, and in regional areas it's not too bad up the coast and in the major towns, but on the other side of the Great Dividing Range there's a real paucity of different clubs or different opportunities to do physical activity.

**Dr Williams:** A common time when the women at our service report weight gain is around the time of puberty, at 15 or 16, and that's when they drop their sport. For men, it's in their 20s, when they go to work and do their desk jobs and drop their sport. So it is actually quite a strong thing. I mean, they're often overweight as children, but then they really accelerate at those times.

**Senator COLBECK:** It has become quite organic. I was going to ask some questions around the frontline staff issue that you, Dr Cunningham, and others also mentioned, because the conversation we had earlier this morning was about doctors not feeling confident to even discuss this as an issue. That is quite disturbing, from my perspective, given that they, at primary health care, are effectively the front line, but if they don't raise it because they don't want to create a confrontation, effectively, with their patient—or client or whatever you want to call them—then our system isn't giving them the skills to actually even have the conversation. And if you can't talk about it, you can't deal with it.

**Dr Williams:** Doctors like to fix problems—

**Senator COLBECK:** Don't we all!

**Dr Williams:** and, if we don't have the know-how and tools, we feel nervous about bringing up the problem. I feel very comfortable now talking about the problem because I have the tools, but a person in primary care who knows that the patient can't afford to access services is not necessarily going to want to deal with that problem. The other thing is: they have 15-minute consultations with these people. Obesity is an incredibly complex condition. I get a whole hour to assess someone, and I understand them from the time they were two through to that point in time and understand every little bit of the thing that's driving them, so I can treat them effectively because I have individualised their management. GPs don't have that opportunity because they have their 15-minute short consultations. That's why we need the support in the community from other services.

**Dr Cunningham:** And particularly from other health professionals, allied health professionals, as well.

**Dr Williams:** Absolutely. Yes.

**Ms Badorrek:** We don't know quite how to exit our patients now. We have a large waitlist, and we have no strategy to exit our patients who have done well, to feed them back into the community, because their GPs are not empowered. There is a high cost to accessing allied health, and there are no real community programs that we can feed them back into. Obesity is not something you just cure; it's something that's lifelong, so it has to be managed for a long period of time. That's where we're finding some issues now, in trying to feed our patients who are doing quite well back into the community, so that we can allow other patients into our service. How do we deal with these patients to feed them back in?

**Senator COLBECK:** You're asking people to make lifestyle changes—

**Ms Badorrek:** That's right, and we're not giving them support.

**Senator COLBECK:** and, without support, they often can't maintain it.

**Ms Badorrek:** That's right.

**CHAIR:** So, in your setting, you would get, say, a referral to a dietitian as well, within the centre—is that right?

**Ms Badorrek:** We have three dietitians in the centre.

**CHAIR:** And who pays for that?

**Dr Williams:** The state government.

**CHAIR:** We're getting to the nub of it. You're a specialist referral service. If somebody is referred to you, they get access to multidisciplinary care: they see a doctor, a dietitian, a psychologist—

**Ms Badorrek:** And physios, midwives—
CHAIR: all funded. If I'm a GP in private practice and I want to refer my patient to each of those services, outside of a specialist referral service, there's a cost for the dietician; there's a cost for the psychologist. The GP consult might be free, but, again, not to the degree that you're talking about, although, through care plans, there might be an opportunity to do a little more. But these things are really expensive.

Ms Badorrek: Very.

CHAIR: And we're asking people to pay for all of that.

Dr Williams: That's right, and they're usually the most disadvantaged as well.

Ms Boyd: I will make one last comment, just to close it off: what you guys do is awesome; it's great; it's fabulous. But it all boils down to education. If the kids learned about better eating habits from this end of the table—

CHAIR: Yes—it's the prevention.

Ms Boyd: Yes. If we do early prevention—although this is still going to happen; I'm not saying we're going to get rid of it—there will be less.

Dr Williams: I would agree about the education, but 100 per cent of our paediatric clients have obese parents, and there are so many other social drivers. You can't just educate without fixing some of those others: high stress; medical conditions in parents; social support services—

Ms Boyd: No, no, but then it rolls straight back to education—educating the parents—

Dr Williams: I think it's more than education, unfortunately; otherwise, we would have won by now.

Mrs Smith: I think there are two very different strategies. There's the group that you're clearly dealing with, that are already obese, and, at that stage—correct me if I'm wrong—it's no longer lifestyle related; it's not as simple as flicking a switch and changing the diet—

Ms Badorrek: It's almost never just lifestyle related. It has always got other drivers. It's not just lifestyle, because that becomes blame, then; that's just about blaming somebody about their lifestyle. And that's not true.

CHAIR: Like I said earlier, we didn't have this problem 30, 40 years ago. People didn't suddenly start making bad lifestyle decisions because we suddenly had a different way of making these decisions. Something else has changed. People haven't, but the social environment in which people live has changed.

Dr Williams: Change is an issue of social contagion as well. My children originally went to inner-west schools, and now they're going to Western Sydney schools. Parents in inner-west schools used to frown at each other for putting processed cheese in lunchboxes and things like that. In the outer west, teachers are carrying coke around. It's very normal for parents to eat the wrong foods in front of their children. The children will mirror that behaviour. There's a very different social set. It's not just about educating the kids; we've got to somehow tap into the parents—and the teachers. I don't know how you do that effectively, but you do need to do that and let them know that they're modelling that behaviour and that it is not normal. It's like driving down the strip in Penrith for the first time. My jaw dropped. The number of takeaway outlets that are there is unfathomable. Now I drive down there and go, 'Oh, yeah, this is normal,' because I've become used to it, and that's what's wrong.

CHAIR: I note, for a clinical service, a lot of your submission focuses on some of the broader social environmental factors—

Mrs Smith: Sorry, I just wanted to add that, as we've been travelling Australia, one of the things we have been finding has the most powerful effect on parents is showing them very visually the impacts of regularly making poor choices for their children. We have been using a YouTube clip created by an American health insurance company called 'Rewind the future'. I urge you all to take a minute and a half to watch it, because it shows parents, very visually, that if they continue, every single day, to make poor choices for their children, their children are going to end up in the hospital system, usually not in a very positive way. When we first started travelling, we showed that clip to parents, and even today there are still parents who have tears in their eyes when they get the full force of their actions. I had parents ask me if I could start showing that to children so children would start to understand, so we tested it and we found that children in year 5 and year 6 really get it. They get that, if every single day they keep treating their body with foods that are not helping them, they're not going to end up being very well.

I don't want to go into tobacco, because we've spoken about that a lot today, but I would say that this is equivalent to the very graphic programs that we have around tobacco—it's got to be behind a shelf to buy; it's got horrible pictures on the front. Even our road safety campaigns show the consequences of poor choices, and so—
Ms Badorrek: Sorry to interrupt—that's important to probably think about, but we also have to be mindful that there are eating disorders as well. Coming from a clinical dietetic background, eating disorders are rising, and it's something that we should be mindful of. Doing a blanket, almost terror, campaign on what food can do may trigger some disordered eating, so I think that it's really important to acknowledge that. I think more policies, promotion and support must come from within schools, and they should be mandatory across all schools—not just government schools that have to abide by school canteen rules but the independent and Catholic schools. My children went to Catholic schools; one's at a Catholic school still. They don't have a policy on nutrition. They don't have to. They're their own governing bodies. It's really important that it's across the board so that it's not just an opt in or opt out but something that's supported and encouraged.

Senator PATERSON: Mrs Smith, I'm interested in following up on your earlier comment about comparing these products to tobacco products and particularly your comment that tobacco products, for example, have to be behind a shelf. Is that what you are suggesting we should do for junk foods? Should they be behind a shelf?

Mrs Smith: No. The reality is that our world has become very fast paced, so these discretionary foods are a way of life. What we need to do is empower people to learn which ones are okay to let in the house. How does a parent make ground rules for their children and how do they have the strength to stick to them, given everything that is marketed towards us?

So I don't think that we can actually say 'no more junk food'. I just think we need to find better ways of getting people to be strong in the face of what they're dealing with. The analogy was used earlier on today about encouraging people to shop around the outside of the shopping centre because in the middle is typically the foods that end up on breakfast tables and in lunchboxes, and even to a large degree are getting used in dinners. I apologise if that came across like a terror campaign before. We need to encourage people to make better choices through teaching them the best ways to do that.

Senator PATERSON: In a similar vein, Dr Williams, you gave an example of a teacher walking around a school with a coke can. Is it your view that a teacher should never do that?

Dr Williams: It is my view, yes. I've become so extreme now, I'm afraid, because I've seen so many awful things with obesity. Obesity kills. I've got a 38-year-old in hospital with an ACAT package now because he's got short life expectancy. For children, it is as bad as having a glass of wine.

Senator PATERSON: I agree that is fairly extreme.

Dr Williams: Being in a school and carrying a coke can around is not okay, so I bought him a bottle of water.

Senator PATERSON: Do you think of these discretionary foods as something that's okay to consume in moderation?

Dr Williams: If we deal with the social drivers, we find that in the Inner West, in more affluent areas of Sydney, energy-dense foods are consumed in moderation. I don't think that occurs in Western Sydney. I'm not entirely sure what the drivers are behind that; there are a lot. But I think we need to denormalise energy-dense foods. I don't know how we do that specifically but that's what we need to do. We need to make it clear that it is not normal to consume energy-dense foods.

Senator PATERSON: Do you mean not even occasionally, even as a treat?

Dr Williams: As a treat, it's okay. But we need to denormalise them because they're now normal. People are having them every day. Most of our clients are actually addicted to sugar-sweetened beverages and that's the first thing we will remove from their diet, and they will be drinking four litres a day.

CHAIR: Dr Williams, if you've got a school canteen policy that says 'we're not going to sell Coke', and you've got teachers walking around the school with cans of coke in their hand, do you think that's consistent?

Dr Williams: No.

CHAIR: I don't think that's particularly extreme, by the way; I think that is actually common sense

Dr Williams: Even in the hospitals, they've taken away sugar-sweetened beverages but they replaced them with chocolate milk; it's got twice as many calories. Yes, it's got a few more star ratings but there's a problem there. So people get confused that chocolate milk is actually healthy for them and it's not so clients will be drinking chocolate milk for breakfast thinking it's healthy. It's fraught. If you don't understand about food then you're going to make mistakes with the way food is marketed at the moment.

Senator COLBECK: I was interested in your point on the city of Amsterdam health checks process.

Mr Doumani: That was really a general point to see if there are places in the world where obesity has been lowered. We could look at those to see what they actually did. When it comes to health checks in schools, it's
something that should certainly be considered. If it's ever implemented, it should be done with a lot of care and sensitivity. As alluded to before, obesity comes with a lot of mental health implications, especially for young people, high-school-age people. So if anything like that is ever implemented, care should be taken to make sure that any results of those healthcare check-ups are strictly confidential.

Senator COLBECK: It depends on what actually happens with the information. If it comes with a referral to a service, that provides an outcome so that's a different matter. It's something that's worked, obviously. The data says it has worked. They are some of the things that we're investigating. Why did it work? What made it work?

Mr Doumani: That's the thing that needs to be considered.

Senator SINGH: Can I add, submission No. 143 is from the Joep Lange Institute in Amsterdam, and it goes into detail of how it works.

Senator COLBECK: Let's not pursue that anymore. We will go back to the submission and check that.

Mr Doumani: Some of that may also involve making active lifestyles part of an integrated part of schools and children's lifestyle generally. That should come with healthy foods and schools allowing for regular physical activity—not just physical activity during sports classes but throughout the day as well. In terms of what exactly that program did in Amsterdam to reduce obesity, that's something we're not really sure of.

Senator COLBECK: We can go to the submission. That's fine, thanks. My final question, Ms Boyd, goes back to your comment very early in the hour about cost of sport. I'm interested to know what's happened, particularly here in New South Wales, around organised school sport. I'm very conscious of not trying to put too much onto the education system because, as Mrs Smith said, there's a fair bit piled on it already. For example, in my home state of Tasmania, organised school sport, intra school sport and things of that nature don't exist so much anymore. It's actually effectively outsourced to community organisations or sporting clubs, which does apply some of the cost that you talk about. It's a significant change in the way children interact with sport, particularly during their school years. I'm interested in broader perspectives on that, particularly here in New South Wales.

Ms Boyd: With the crowded curriculum that we've got at the moment—that's actually nationwide, not just in our state; we're reviewing ours—we need to pluck things out because there's too much in there. Adding additional recreation is nearly impossible to do. There are strict guidelines on how much exercise students should do each week, but with the establishment of all of these high-rise schools it's going to be harder and harder. You can run around and around a classroom or a floor. I've looked at the overview of one of the particular schools and there's a large room which will basically be a gymnasium. You're not going to get the same feeling that we all got as children running around an open, non-fenced-off oval. We're going more to these extracurriculars for what you've obviously got in Tasmania.

Senator COLBECK: I understand that.

Ms Boyd: That's where the price is coming up—all of these additional things that we are trying to get our children into. And your P&C parents have one child dancing and three swimming, and there's footy, netball and lots of sports. I was a stay-at-home mum for their younger years. It was okay. It was easy enough for me to manage and get them from this training, to that training, to the next training, to games. That is becoming more and more difficult for our parents out there. I've got primary school parents, and when their youngest gets to the age of eight they're back to work. It's when those parents are going to work that those children drop off their ability to go to school. That's what we had with our eldest. When I went back to work, he couldn't go to sports because we couldn't afford it. He would go to school and then go over to OOSH, the out of school hours thing, and did nothing until I had the other two and then I stopped work.

It's more rare that you're going to get a single parent staying home. With single parent families, that's even worse. The mum, again, is only home for a certain period. Once their kid gets to a certain age, if you're on that single parenting pension, that's cut off and you need to go back to work. Then that child's mum is going back to work and she or he is working 40 hours a week, so they're losing out on the opportunity to get to sport. There are walking groups. I've heard of some really, really great programs that they've got in Queensland. When you were talking about that I thought, 'Yes, I've heard about them.' But a lot of it is security for the parents: 'How am I going to get my child from school to that program and home again if I'm working odd hours, depending on what I'm doing? It's a nine-year-old child, am I to put them on a bus? How do we get them there without a cost involved?'

That's why the cost is so prohibitive.

Senator COLBECK: And, again, it goes to a change in the way our education system operates, the way our society operates. I was driving through a new suburb in Melbourne and I was looking at the block sizes versus the...
house sizes—no backyards, effectively; the complete change in our environment. I hadn't heard of high-rise schools before.

Ms Boyd: Come and visit one! We'll take you around.

Senator COLBECK: I'm happy living in Tassie, thanks! I suppose it just shows the breadth of the issues that we're trying to manage in dealing with this bigger picture.

Ms Boyd: I deal with your Tasmanian parent group down there quite a bit, and Phillip Spratt, who's the ACSSO president. He extols the virtues of Tasmanian schools quite well.

Senator COLBECK: Don't tell anyone!

CHAIR: I need to draw this session to a close. Thank you so much. It's been a really interesting and enlightening conversation. Thank you for your participation. If you have anything else you'd like to contribute, please feel free to do so.
BARCLAY, Dr Alan, Private capacity

CHAIR: Thank you for appearing before the committee today.

Dr Barclay: Thank you for having me.

CHAIR: I'd like to invite you to make a brief opening statement, if you have one.

Dr Barclay: Yes. I appreciate the opportunity. I'm an accredited practising dietitian, author, academic—chef. In terms of an opening statement, I think you've heard a lot this morning and this afternoon that rates of overweight and obesity have been increasing in Australia since the 1980s, and despite our best efforts to date they still appear to be rising. While we're ranked fifth in the OECD, behind the United States and New Zealand, we shouldn't lose sight of the fact that we're ranked 23rd globally, behind many Pacific Island and Arabic nations, where big is often seen as a marker of wealth, success and even beauty. For Polynesians, for example, big is beautiful. And of course in recent years we've had immigration from Pacific Island and Arabic nations. That is probably contributing in part to some of those increasing rates.

We also shouldn't overlook the fact that average life expectancy of Australians is at an all-time high. In 2015 it was 82.45 years, and it's increased by 8½ years since 1980, which of course is the same time that overweight and obesity rates have risen. So, there's some bad news but there's also some good news. Yes, diabetes rates continue to rise, due in part to the ageing population and increasing obesity rates. However, there's some data now coming out from the National Diabetes Services Scheme showing that diabetes incidence rates are actually plateauing. So, again, it's not all bad news.

There are many reasons obesity rates are increasing, and of course you've heard many stories so far, including the Foresight program from the UK. At the core of that model of course is energy intake and energy expenditure, and I think that certainly was discussed well in the previous session. Systematic reviews of randomised, controlled trials, which are the highest level of evidence—level 1 evidence—demonstrate the kilojoules are the primary nutrient of concern with respect to energy intake. But of course we don't eat kilojoules; we eat foods and we drink beverages. Those foods and beverages are made up of the macronutrients protein, fat and carbohydrate. And while not technically a nutrient, alcohol is also grouped in there. Of course, it's not essential for growth or reproduction, but it certainly provides energy. When minimally refined, these macronutrients also come packaged with vitamins and minerals and often dietary fibres. There's no single dietary pattern that provides optimal health for all people. Diets can be high or low in fat or carbohydrate. There's less of a range for protein, but there is nevertheless a range. There are many ways of eating well.

I guess we've already come to the conclusion about what has happened despite all our efforts—and there are many, and I described many of them, and I won't be going through them at least in this opening introduction.

There are many things that we are doing to address overweight and obesity in this country. What's missing, I think, at the moment is that we don't have an overarching strategy. The national obesity policy dates from 1996—a long time ago—and a lot has happened in this country and around the world in that time. It's time to sit together with all stakeholders and come up with a new plan and then maintain that. An underlying theme in my application to you was that we do things on an ad hoc basis. There doesn't seem to be a plan. We don't do nutrition surveys and we don't release dietary guidelines; we just do them on an ad hoc basis, and I think that's a problem. An overarching obesity strategy might help address that.

We're a science based culture, of course. These guidelines need to be based on 100 per cent scientific evidence, the best available at the time, and this includes the latest estimates of Australian food and nutrient consumption. It should respect the changing needs of the evolving Australian population. We are getting different ethnic groups coming in. It shouldn't be patronising. We forget that Australians have a 99 per cent literacy rate and they're also very educated as a population.

Finally, we should always remind ourselves that nutrition is a science, not a religion, and that food is not medicine; it is far more important than that. From the day we're born to the day we die, food not only nourishes us but provides pleasure. That came out in some of the previous discussions. There's social interaction; there's conviviality; it anchors us to our family from birth as part of our community, our culture, our religion and of course the point in time. These things all need to be considered in the overall process that you're going through. Thank you.

CHAIR: Thanks so much.

Senator SINGH: Thank you, Dr Barclay, for your submission. I was trying to make sense of the diagram in your submission—the obesity system map. Even with my glasses on, my eyesight is not good enough to be able...
Dr Barclay: Yes, it is indeed.

Senator SINGH: What is it actually saying as far as being some obesity system map?

Senator STORER: Is it tongue-in-cheek?

Senator SINGH: Yes, is it serious?

Dr Barclay: It actually is serious. Key stakeholders came together in the UK and looked at all of the factors. This is from the UK government; it's not a farce. It illustrates at face value how complicated it all is. But there's a large document behind it and I did include a reference to that. I don't have time to go through it with you, but I do encourage you to read it. Four most important facts come out of it. There are four main influencers, which you probably can't see. I can't even see them with my glasses on. This map is actually quite common. If you Google it, you'd find it quite readily, and you can zoom in on it. The four main factors include physiological factors. I think that goes without saying. There's our genetic makeup and our family history; there's obviously our age, our body composition and whether we have disabilities. Then we can throw other factors in, which I think have been raised in some of the submissions. I haven't read all of them, but there are things like sleep deprivation which affect physiological processes. Silly things like climate controlled air conditioning are mentioned. In fact, a paper was published within the last week that showed antibiotic use before the age of two had an influence on childhood obesity going forward. It was a systematic review with meta-analysis. So there are obviously many physiological factors at play.

Eating habits are probably the primary focus of this committee, from what I can gather. I'm sure I'll be discussing that a bit more later, and others have before me, and the activity levels. Lastly, there are the psychosocial issues or influences. This relates to—I've already mentioned some of these—culture, religion, personal preferences and our own psychological wellbeing. I think there was discussion about mental health and the like earlier. We must not forget education. People have to be able to afford the foods. There are many other things like convenience. I think that came into it, and time. I live in Sydney. There's a hell of a long commute time for people living out in the far west. It can be one to two hours in each direction, and that impacts on people's ability to go to the shops and buy whole ingredients and prepare food from scratch. Of course, there's no surprise that fast food restaurants line up along those main corridors to tempt people to go in and buy it because it's convenient, they're tired and the kids are yelling in the back of the car. We mustn't forget convenience and price.

There's also a desire to reduce stress. We do eat foods because they provide enjoyment. Some people find eating chocolate helps to reduce stress, as a simple example. There are many more choices available in our supermarkets. The food supply is rapidly expanding. There are many, many more different foods, and we all want to try them and enjoy them. I think that's probably a factor. And there's a desire for a short-term reward of enjoyment versus thinking about the long-term consequences, which, of course, we've talked about and we know are obesity as we get older and then the associated chronic conditions. That's a very brief summary of that spaghetti, but I do encourage you to read the document. Yes, it is real and serious. I think it's interesting that it has been done, and that was over 10 years ago.

Senator SINGH: I will zoom in online to digest it. I'm sure Barry Jones would be very proud of it. Getting back to the direction you're pointing us in as policymakers and what we should be focused on, you talk about the need to introduce serve size legislation, which has been done already in Europe and—

Dr Barclay: It has been done in a number of parts of the world, in particular, North America. So there are the Reference Amounts Customarily Consumed under the USFDA, and Canada's Food Inspection Agency has a similar system in place. They've got 22 categories in the US and 24 in Canada. In fact, these are not recommended serve sizes. They're what people actually eat based on their most recent nutrition survey, I believe. But the principle is that you define what a serve is of the food or the beverage, and then that's used. There is a little bit of leeway, of course. It's not set in concrete; there is a bit of variation allowed. If we look at similar research in Australia, in fact, there was some recent research into 10,070 packaged foods. The serve size ranged from 18 grams to 100 grams in some products, so there was almost a fivefold difference.

I know there are challenges. I have discussed this with various people at Food Standards Australia New Zealand and various other stakeholders. I don't think it's easy, but I think it can be done. It has been done in other jurisdictions. I know there have been some discussions within Australia, but nothing seems to have happened yet. I think it would be a good idea. I think the debate's about whether it's actual serving sizes versus recommended serving sizes. We do, of course, have recommended serving sizes in our Australian dietary guidelines which are
based around kilojoules, and there are dietary plans that support that. I think there are pros and cons with each model. I think it would be really useful to have a discussion about that in, perhaps, a national obesity plan.

Senator SINGH: Would that be for those discretionary food outlets, like fast-food places and/or restaurants? Who is it applying to?

Dr Barclay: It's applying to packaged, processed foods, I believe. I don't necessarily think it would preclude large chains of fast-food restaurants, but I don't think they have any particular policies or strategies in place. They're packing around, from what I understand, price and value for money and taste. It's not around kilojoules or calories. It would probably be easier to start with the packaged, processed food supply. I think that's better regulated overall. Fast-food restaurants are coming along. I think the menu board labelling has been a good initiative, but we still have further to go there, and I imagine standardising those sorts of things would be quite difficult in the real world.

CHAIR: Your general starting point is that the food industry is led by consumer choices, so really it's up to consumers to seek out healthier options. Is that a fair summary?

Dr Barclay: I think we have to be realistic that consumer demand is the primary thing. I've worked with both Coles and Woolworths in the past, when I was working with Diabetes Australia, and they're quite ruthless. If a product doesn't sell, they will get rid of it from the shelf quite quickly because, for them, it's just profit. The food industry, in my mind, doesn't really care. In the years that I've been working in this area, all they have been ultimately worried about is making money. Let's face it: it's a capitalist society. That was addressed, I think, in the beginning of the last session. Really, money is their primary concern. If consumers want it, they will produce it. I think a really good example that's not—

CHAIR: Do you think there's a role for governments, though, to—

Dr Barclay: I think there is, but can I just continue? It's not related directly to this, but a good example is that there's a whole craze about gluten-free diets, where about 20 per cent of the population are consuming them. That's not for weight or anything else; it's because it's perceived to be good. And the food industry, of course, has developed a lot of gluten-free products, when about one per cent of the population actually has coeliac disease. The food industry produces products that it thinks consumers will buy—

CHAIR: Sure, but a gluten-free diet is not bad for you, is it?

Dr Barclay: It can be.

CHAIR: For most people, based on existing patterns, a gluten-free diet's not going to make any difference.

Dr Barclay: No, there's actually some good observational data that was published last year that shows it increases the risk of type 2 diabetes because you're having more refined carbohydrates, instead of wheat, for example.

CHAIR: 'Good observational data'?

Dr Barclay: Yes, good observational data.

CHAIR: Right. I think that's an oxymoron, isn't it?

Dr Barclay: It could be, yes. But still—

CHAIR: There's no hard empirical data that says—

Dr Barclay: There are no randomised trials at this point in time, because it's fairly early in the piece.

CHAIR: So what is the role of government here?

Dr Barclay: I think food legislation is probably the primary role with respect to the food supply, and Australia does have some very good food standards. I think Food Standards Australia New Zealand is one of the best food standards agencies in the world. It is very highly respected globally. But I think we can go a bit further. I also think—

CHAIR: Where should we go further? What should we be changing?

Dr Barclay: I think at the moment the dietary villain is carbohydrates. Since the Atkins diet came back in the late 1990s, we've had a really strong focus on carbohydrates in general. Then it sort of slipped into a focus on sugar in the mid-noughties, and low carb, low sugar is really in vogue at the moment. But, when we look at the way we label foods, it's really quite poor for carbohydrates. We just have total carbohydrates and total sugars. We don't mandate fibre. For example, in the United States, you have to have dietary fibre on the nutrition information panel—nutrition facts, as it's called there. I think it would be useful because that's a good marker of carbohydrate quality.
CHAIR: Don't those products show fibre?

Dr Barclay: No, it's an optional thing. If you make a claim that it's, say, low in sugar, then you have to have fibre too. That's part of the requirement under the Food Standards Code, but it's not across the board—it's not mandatory.

The other area, which I noted in my submission, is the whole other kind of carbohydrate in food, and that's starch, which people don't really understand, and that's quite clear from Food Standards Australia New Zealand research and just anecdotally, from discussions with people. When we think about it, in the eighties and nineties, we were very fat focused, and we had people lobbying to have not just total fat but saturated fat, trans fat, monounsaturated and polyunsaturated fat on food labels. So we actually list four different types of fat under 'fats', whereas under 'carbohydrates' we just have total carbohydrates and sugars. What the FSANZ research shows is that people add sugars to total carbohydrates because they don't really know how it works. So I think, given carbohydrates are the current dietary demon, labelling them better might help cut through the confusion.

CHAIR: How many people do you think look at the nutrition label and make a calculation about what they're going to consume based on detailed knowledge of the carbohydrates in it?

Dr Barclay: At the moment I think they're just cutting it out. Low-carb diets are very, very popular.

CHAIR: Are more popular, yes. I suppose what I'm getting at is—and I take it from your opening presentation that you accept that there's an issue associated with obesity and the consequences of obesity—

Dr Barclay: Absolutely.

CHAIR: what is that government needs to do to address that singular problem?

Dr Barclay: I think better labelling is one component.

CHAIR: So you're a supporter of the health star labelling?

Dr Barclay: I am. I think the health star rating system has been excellent. Again, I think it's one of the best systems in the world, if not the best. I know it has some teething problems, but—

CHAIR: Should it be mandatory?

Dr Barclay: Maybe it should be. Originally, it was for packaged processed foods, and I think it has the potential to go beyond that. But in order to do that we probably have to give some exemptions to, say, some of the core foods. Not all fruits and vegies get five stars, for example, but of course as a dietitian I would like people to eat more fruits and vegies. If that's what it's going to become, then it needs to be adjusted to perhaps provide some exemptions, like they did for water. Water is given five stars. But there's definitely an opportunity there, and it is potentially a good system.

The other thing, I think, that was discussed in the previous session was in fact providing the services of allied health professionals at an affordable price to people who have significant needs. It's really a bit of a black hole. I read the Dietitians Association submission, and even it didn't really push it as hard as it could have—because I actually see patients; I'm a clinician as well. GPs are fairly good, I think, at trying to find reasons to refer people on under the Enhanced Primary Care Program, as it used to be called. But they can't refer on people that are just overweight, because they really have to have a comorbidity. So you're waiting until they get obese, and usually it's somebody that has a comorbidity along with that that gets referred on to see me, and I presume, my colleague as well. I've certainly discussed it with him anecdotally. So it's about making it easier, from the GP's perspective, to refer on to people like dieticians and exercise physiologists, who have the time. We spend about an hour going through people, and we get to know them and their eating habits—I spend about half an hour asking people what they eat and drink—and then we can provide tailor-made advice to them, not just some sort of handout about generalities. I think that's a real problem within the current health system. It's focused on the tail end of the problem, rather than the front end and how we approach that.

CHAIR: What about advertising and promotion? Do you see a role for restrictions around those?

Dr Barclay: I'm aware there are codes of practices. I haven't looked into it enough to judge whether they are acting effectively. I believe there are a number of loopholes, and I am aware of some of those. I imagine those loopholes could be tightened up. Sometimes moving codes of practices into legislation is a more effective way. We saw that with the code of practice on nutrient claims on foods, for example—there were a lot of loopholes, and it wasn't as well-managed as a lot of health professionals would have liked. Now that's all gone within the Food Standards Code, and I think it's a much more rigorous system. If it's not working as well as we intended it to, maybe we should shift it up a level into a tighter system.

Senator PATERSON: Dr Barclay, your submission addressed the evidence base for sugar taxes around the world. Did you want to expand on that a little bit for the committee?
Dr Barclay: I did a review of the systematic reviews that I could find and came up with the New Zealand one. I quoted ad verbatim from it. I imagine you have access to that. Although I read it, I only put in the executive summary. Overall I think it's pretty obvious that a sugar consumption tax would decrease consumption of sugar-sweetened beverages. What we don't know at this point in time is whether that will have the intended consequence, down the track, of reducing overweight rates and obesity rates. I personally think it would be ideal to wait and see what happens in some of these other territories before we jump in. That's my personal opinion.

Senator PATERSON: So there's not yet any evidence that you're aware of that links a sugar tax to a reduction in obesity anywhere in the world?

Dr Barclay: Correct. We don't have the outcome data. We have processed data, which is looking promising, and I think that's important, but we don't have the outcome data. When you look at the randomised controlled trials, you can see that the effect of sugar-sweetened beverages is not huge—these are, of course, averages. We might not expect a huge improvement from it but there are countries around the world that have introduced them. There's nothing to stop us from very closely watching what the outcomes of those studies are and then, if there is proof that they are effective, introducing a tax.

Senator PATERSON: You referred a couple of times to how carbohydrate is the current enemy of the dieticians or the public health industry. Of course, that's changed over time. We've previously recommended that people should eat more carbohydrates. Why is it that we are now recommending things that are diametrically opposed to what we used to recommend, where, at the time, we had a very high degree of certainty that that was the right way to go but now we don't?

Dr Barclay: Nutrition is a fashion statement, for starters. I think there's a 50-year cycle. I've been around long enough to experience the seventies, when, thanks to Robert Atkins at the time, low carbohydrate diets were previously in fashion. We only have three macronutrients. We have four if we include alcohol but I haven't seen 'I quit the booze' out there on the bestseller list yet, and I doubt I will. We've moved from demonising fat to demonising carbohydrate, and we're now moving towards the protein side of things. Veganism is really big in the United States and is starting to come over here.

I think there's a 15- to 20-year cycle where fad diets focus on one nutrient, then we realise that it's not really working and somebody comes up with a new idea that's not really new. The extreme low carb diets, the ketogenic diets, were actually invented in the 1920s, which is two times that 50-year cycle. We're rediscovering and reinventing. Luckily the volume of the research evidence now is increasing dramatically and its availability is much better. You can't find a lot of those research papers that were probably done in the 1920s—they're really hard to get hold of—so we're sort of reinventing the wheel. It's unfortunate.

My honest opinion of the literature at this point in time is that it doesn't really matter if it's low carb or low fat or high carb or high fat—with protein, there's a much narrower band. But, even then, we mustn't forget that if you have too much protein, it's converted to glucose, et cetera. So we have to be careful about what we're doing. We don't say that one size fits all, which was the point of my opening address. Focusing on a single nutrient hasn't produced the benefits that I think people thought it would. They were very sincere people. You may remember Nathan Pritikin and the Pritikin diet. In the eighties, it was very popular, and we had our own Australian equivalent. Nathan was an engineer. We had our Australian equivalent, Ross Horne, who was an airline pilot, who wrote The New Health Revolution. He was a follower of Pritikin. It was just enormous, and everybody went on these ultra-low-fat diets, for all the right reasons at the time. But, of course, we know from history that that didn't produce the benefits that we hoped it would. We now turn to carbohydrate. Some people are saying that that's the problem. But, if you look at the dietary guidelines of the day for Australians from the early 1980s, in fact, they said to limit sugar and also have low saturated fat. But they're not popular diets. They were in Australian government bookstores—probably one in each capital city. They weren't very popular. It's the popular diets that tend to drive people's perceptions, which then, in turn, are driving consumer demand, and food companies are producing foods to meet those demands. It's a simple—

Senator PATERSON: I agree with that, but there have also been times when there's been a very high degree of consensus within the profession, and very bad advice about cholesterol, for example, was given to people.

Dr Barclay: I think we went through a little bit of a cholesterol obsession back in the eighties in particular. We now know, of course, it's more importantly saturated fat and the balance of fats—not just saturated fat. I think that's a bit of a carryover that we have now. We should be recommending more mono- and polyunsaturated fats instead of saturated fat, rather than just focusing on saturated fat.

But that is part of the evolution of science, and it really has been going up exponentially. There's a lot more research in nutrition. Nutrition is a fairly new science. In fact, it was instituted under Winston Churchill during...
World War II. I think there will still be evolution of that, but we shouldn't throw the baby out with the bathwater.

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

CHAIR: It is an interesting area, and we touched on it earlier with Senator Colbeck. But no-one's contesting that a high-sugar, high-fat, high-salt, high-calorie diet contributes to obesity and is bad for you. Do you think that's a statement you can make?

Dr Barclay: I think what you're talking about is energy-dense foods. What's missing from that list is highly refined starch, and that's the thing that probably concerns me the most. When you think about a bag of potato chips, for example, it's not high in sugar. It's very low in sugar. The carbohydrate in it is starch. So what's missing from that equation that you read out to me is starch, and that is the hidden ingredient in food. Because we don't label it, people aren't aware of. How do we deal with it? The American dietary guidelines had a nice guideline. When we were doing ours, I strongly recommended to the people who were doing them that we have a guideline saying, 'Eat less refined grains,' like the Americans do. Somebody said, 'We cover it under fat,' but we don't, because that year somebody came out with Grain Waves, which, of course, is a less refined product, low in saturated fat, but, of course, it's still full of starch. So I think we've got to be careful. We've got to shore up some of these loopholes. That's a classic example of a loophole.

CHAIR: That's a loophole, but it doesn't disprove the—

Dr Barclay: Energy density is important—absolutely. But, if you add cornflower to a product—and some people, in the reformulation for health stars, have taken out the sugar and added in cornstarch—you don't get a better product. It's going to have the same energy density, it's going to have the same effect on your blood glucose levels and it's going to cause dental caries. I would not dispute what you're saying, but it's missing an important component.

CHAIR: That's right. The point is that, if we know some of those basics and agree that there is some nuance within that—and we've had a lot of evidence today about some of the interventions that we can make to reduce consumption of those things—then anything that allows us to address that broad statement is ultimately going to provide an overall health benefit?

Dr Barclay: I agree.

CHAIR: I imagine that's the basis of your clinical advice to patients, as well.

Dr Barclay: I spend about half an hour asking people what they're eating and drinking, and then we make very specific personal recommendations as to what they can change. Often, it is cutting out snack foods. People don't need to eat snacks often; they just need to stick to their main meals. But we found out earlier on that kids aren't even having breakfast or lunch, so I think those school initiatives are really good and I'm hoping that you can explore those, for example.

CHAIR: Finally, your contention on sugar, sweet and beverage taxes is not that, if we were to decrease the amount of sugar consumed, it wouldn't provide a health benefit; it's just simply we haven't got enough data to demonstrate that that end outcome—

Dr Barclay: And I think we don't know what the substitutions will be. As a parent of two adult boys now, but they were teenagers not long ago, they drink sugar sweetened soft drinks when they go out—they're drinking it at parties—and I'm worried if you put it up too much then they'll drink more beer or alcoholic beverages. I think we need to think through those substitutions. There is a modelling paper from the UK that suggests that they will substitute to alcoholic beverages, so I think we need to address alcoholic beverage taxes as well. There was the Henry tax review from I don't know how many years ago now—

CHAIR: Volumetric tax.

Dr Barclay: that said we needed to address that.

CHAIR: You're a supporter of doing—

Dr Barclay: If you do one, please do the other, so that we don't have any unintended consequences—because alcoholic beverages, of course, are the No. 1 source of liquid kilojoules in Australians' diets.

Senator SINGH: Dr Barclay, I want to know your opinion of the 5:2 diet.
Dr Barclay: There's evidence that it works, but it doesn't appear to be superior. There are many ways of eating well. It suits some people fine, but there's no evidence that it's superior to eating a lower kilojoule diet for the rest of the time. I think it's an option.

CHAIR: We've got one final question, and then—

Senator COLBECK: I didn't get the chance to ask this of the metabolism centre earlier. Prescription drugs can have an impact on this as well. Do you see that as part of this, and how prevalent is it?

Dr Barclay: I'm not an expert in that area, but I think we can't ignore—alcoholic beverages seem to get kicked between medical and nutrition and—

Senator COLBECK: I'm not talking alcohol; I'm talking about—

Dr Barclay: Pharmaceutical drugs?

Senator COLBECK: Psychotic drugs, for example, which can have a significant impact on your metabolism.

Dr Barclay: Yes. Some of the antipsychotics, I believe, stimulate appetite, for example, and there's a strong link between the use of those medications and weight gain and risk of type 2 diabetes, for example. So we can't overlook it. There's some really interesting randomised control data coming out of Victoria, showing that people who go on a healthy diet actually reduce some of their symptoms of depression—for example, when put on a Mediterranean diet. It's early research. We really need to replicate it. It needs to be much more thorough, but it's interesting.

Senator COLBECK: The increase in stress related mental health issues drives the use of antipsychotics or antidepressive type drugs. It's just an observation of mine, but it clearly does have an impact on capacity to maintain a healthy metabolism.

Dr Barclay: Those drugs do have various metabolic effects. I'm not an expert in that area by any means, but there certainly are various psychoactive drugs that affect your metabolism or your desire to eat and drink—and, of course, we mustn't overlook that fact. I mentioned at the beginning too about antibiotics in children and weight, so there are things that we're only just starting to learn about. I think we need to keep an open mind, and that's why we need to do five-year national obesity policies and five-year dietary guidelines to keep all these things up to date to make sure we're always doing the best that we can.

CHAIR: Dr Barclay, thanks so much for your contribution today. If you've got anything further you'd like to add, please feel free to send it along.

Dr Barclay: Will do. Thank you.
ANNISON, Dr Geoffrey, Deputy Chief Executive Officer, and Director, Health, Nutrition and Scientific Affairs, Australian Food & Grocery Council

BARDEN, Ms Tanya, Chief Executive Officer, Australian Food & Grocery Council

PARKER, Mr Geoff, Chief Executive Officer, Australian Beverages Council

ROGUT, Mr Jeff, Chief Executive Officer, Australasian Association of Convenience Stores

[14:59] CHAIR: Welcome. I thank you all for appearing before the committee today. I'm going to invite each of you to make a brief opening statement, if you wish to do so. Before we start, do any of you wish to make any comment about the capacity in which you appear today?

Dr Annison: The inquiry may be interested to know I was on the health star rating project committee that set the health star rating up. I'm now on the Health Star Rating Advisory Committee. I'm also on the executive committee of the Healthy Food Partnership, which has also been discussed today. But I'm not representing any of their views at this; I'm solely representing the views of the Food and Grocery Council.

Mr Parker: I'll kick-off with an opening statement, if I may. On behalf of the non-alcoholic beverage industry's peak body, thank you for the opportunity to participate in this very important process. The Australian Beverages Council represents a $7 billion non-alcoholic beverage sector across Australia, an industry which supports almost 50,000 full-time equivalent jobs and pays $1.2 billion in tax per annum along its supply chain.

Australia's beverage industry proudly produces thousands of products that help everyday Australians support their own lifestyle and dietary choices for both the individual and that of the family. As an industry, we advocate consumption of some drink categories every single day and other categories occasionally, in moderation as part of a varied diet. As an industry, we are proud of the proactive role we have taken in providing a diverse range of drinks to assist Australians make informed choices towards healthier diets and more active lifestyles.

Today, three of the four top selling soft drinks are no kilojoule, and over the last two decades there has been a fundamental shift in consumption towards low and no kilojoule alternatives. We are all acutely aware that the rates of overweight and obesity are rising and there is clearly more we can all do to support and encourage healthier diets and more active lifestyles, be that governments, communities, the health fraternity, academia and industry.

As an industry, we have long recognised our role in supporting our part in a multisectorial solutions framework to address a really complex problem like obesity. For nearly a decade, we have been inviting governments and health bodies to engage with the industry and discuss targeted evidence-based ways to collaborate to bring about meaningful solutions and influence long-term change.

In June of this year, after almost two years in the planning, the beverage industry took that step to do something when the industry's fiercest competitors—representing over 80 per cent of the non-alcoholic volume—united to commit to Australia's first category-specific pledge to reduce its use of sugar by 20 per cent by 2025. This pledge is a step in the right direction and builds on ABS data from the last Australian Health Survey in 2011-12 that tells us that: (1) water is by far and away the drink of choice for adults and children and that the mean intake of water and the amount of people drinking water has increased since the last survey in 1995, (2) the mean intake of soft drinks and the per cent of the population consuming soft drinks has decreased since the last survey and (3) soft drinks are ranked eighth and ninth, in adults and children respectively, in kilojoule contributions from the discretionary or treated part of the diet.

Our industry is unique in the choice it provides for consumers both in taste diversity and portion size options but more importantly choice in beverages with kilojoules to alternatives that taste almost identical but without kilojoules. We will continue to advocate for choice, and our recent sugar reduction pledge will increase the speed and scale of choice for consumers. Our industry will continue to seek out forums of collaboration and consensus, which implies some compromise, with other stakeholders including government, public health, NGOs and from the food and allied industries to bring about meaningful long-term solutions. Any assertion that industry should only be consulted at the implementation phase of policy is farcical and underlines what a real problem we have with trust between key players in this space in 2018.

On behalf of our members and the non-alcoholic beverage industry thank you for the opportunity to appear this afternoon.

Ms Barden: I'd like to make an opening address on behalf of the Australian Food and Grocery Council. Thank you for the opportunity to appear and contribute evidence before the committee today. The Australian Food and
Grocery Council is the peak body for food, beverage and grocery manufacturers. Our members range from agribusiness processors of meat, dairy, grains, fruit and vegetables to foods and beverages sold in supermarkets and other retail outlets domestically and internationally. These companies include Australian owned and multinational companies and range from small to large businesses. The sector is Australia's largest manufacturing sector, employing 320,000 people, with 40 per cent in regional areas.

The food and beverage industry takes the issue of public health seriously and is concerned with the high level of obesity and its associated impacts on communities and the health of individual Australians. That is why the industry is and will continue to play an active role in helping to address obesity: firstly, by giving consumers healthier choices through new and reformulated products that contain lower levels of sugar, salt and fat, and through smaller portion sizes; secondly, by providing clear nutritional information—for example, through the health star rating system, menu-board kilojoule labelling, as well as provision of digital information; and, thirdly, by restricting the advertising of discretionary foods to children.

However, as all stakeholders recognise, obesity is a multifactorial problem. The solution lies in the combined efforts of all stakeholders, including the food and beverage industry, public health groups, the community, sporting and exercise groups, and government, working together in an aligned systems approach that recognises the complexities and interactions of the issues. There is no simplistic, silver-bullet, single-nutrient answer. The way forward needs a well-considered evidence based approach where all players have a role in supporting a consistent and united strategy based not only on products but importantly on diets; education about the Australian Dietary Guidelines; physical activity; and improving the environments in which we live.

I'm pleased to say that the various stakeholders are in broad agreement on many of these approaches. However, where industry disagrees with certain regulatory interventions, such as taxes, it is because they are not supported by evidence of their effectiveness in reducing obesity and they are not without their costs—costs on consumers, leading to cost-of-living pressures, and costs on industry, leading to job losses. We also disagree with calls to exclude industry from the debate. The industry is instrumental to providing solutions and its views should not be limited to ensuring effective implementation. Many of the achievements industry is making, such as product reformulations and labelling changes, would be difficult if not impossible and risk consumer backlash if government were to directly control the food supply through mandatory approaches. As in all areas of policymaking there are multiple perspectives to any issue and the food industry has a lot it can contribute to help solve obesity.

Some people have spoken of the profit motives of companies as being in conflict with public health. However, this ignores the reality that companies that don't respond to the ever-growing consumer trends and societal expectations towards health and wellness will fall behind. The profit motive is one of the reasons why you'll see major companies offering a suite of healthier choice options in their portfolios.

Finally, I urge the committee, when examining various policy proposals, to consider their success, not according to whether they have been implemented elsewhere, but if and how their implementation has had a tangible impact on consumer behaviour, overall dietary intake, and, ultimately, whether they have led to reduced obesity or improved health outcomes. Thank you again for the opportunity for Dr Geoffrey Annison and I to appear before you today. We're here to assist the committee in answering questions and providing any follow-up information, if that is of assistance.

Mr Rogut: The Australian Association of Convenience Stores was established in 1990. We represent the organised convenience chains. We have about 6,000 stores as members and we generate about $8.4 billion in sales every year. Our industry employs well over 40,000. Convenience stores may well operate under some well-known brands, but in reality they are all small businesses—or the large majority are small businesses—that operate either under a license or a franchise. The owners actually rely on those businesses for their livelihoods.

When it comes to issues like obesity and certainly freedom of choice it's extremely difficult for the voice of these small businesses to be heard, certainly amongst the very vocal and powerful health lobbyists. Therefore, on behalf of their members I thank you again for the opportunity to address you this afternoon.

The purpose of our submission was really to highlight the implications to small businesses of any new regulations or legislation, without proper consideration of real-world economic consequences. In recent times, convenience stores have responded to changing consumer demands by innovating and improving the health profile of their products. Beverage companies have introduced low-sugar and no-sugar varieties, retailers promote these as a standard part of their range, and consumers are responding. In fact hot coffee, surprisingly, is the biggest beverage that we sell in our networks. Following that are things such as water and other functional beverages.
The shift to healthier products is also reflected in the performance of on-the-go food in our stores. That category grew over 13 per cent with an extra $63 million worth of sales, and that's largely made up of things such as fresh sandwiches, salads and sushi. Interestingly, in a number of cases, retailers have reduced their sale prices to make these products more attractive to their customers. Healthy snacks such as fruit, yogurt, protein bars are around 20 per cent of all snacking, and growth in that category is well over 20 per cent annually.

It would be interesting, I would suggest, for Senator Colbeck to hear about Japan. You were talking about this earlier during the day. Based on my experience with Japan, where there's over 70,000 convenience stores, the large majority of product that's sold in those stores are prepared meals, prepared foods and beverages. So given the Japanese lifestyle, which is very intense in terms of working—a lot of travel; start early, finish late—the convenience store is actually the lifeblood for many of those people.

I will use confectionary as another category that we sell. It is a treat. Years ago, manufacturers launched the 'Be Treatwise' initiative and that logo is on many packs of confectionary items. Manufacturers have reduced serve sizes. There are descriptions on packs. Fat-free claims were removed back in 2012, and the industry continues to address dietary concerns.

The point is the convenience industry, like many others in the food industry, is already responding to many changes. It's safe to assume that the committee has had many submissions on a sugar tax, and we've heard some of them during the day. The available evidence that we've seen—certainly I'm not a doctor, not a professor nor a health expert at all—suggests that such taxes would do anything but solve the immediate problem. I'd like to use the example of legal tobacco, because every time the excise is raised in that category, the criminals really run to the bank and they rejoice. What has happened is illicit tobacco, as an example, is now 15 per cent of the market, between $1.9 and $4 billion a year, depending on estimates.

From an economic and employment point of view, we should not make the same mistake of viewing taxation as the solution to a health issue. Other countries and jurisdictions have tried and, from the best evidence, they've really failed. Denmark, in 2011, tried a fat tax to limit intake of fatty foods. That was scrapped within 12 months, and they also scrapped a potential sugar tax. Mexico's been spoken about many times. And again, with the cursory information that we've seen, with the soft drink tax that was introduced in 2014, sales did drop then went back to normal levels. The WHO ranked sugar taxing of sweetened beverages as one of the weaker recommendations to reduce sugar consumption. In February 2018, it said:

Overall, the evidence indicates that if we are to reduce the risks of diet-related noncommunicable diseases it will be better altering overall diet rather than focusing on the consumption of individual food items.

The federal government has repeatedly stated that it has no plans to introduce a sugar tax, and our industry certainly has been thankful for that position. We need to protect and support those small businesses and the industry and not put upon them additional regulations that are unproven.

Small businesses in our industry do need support. As prices would potentially go up, there would be channel shift. Consumers would go along from our types of stores to the supermarkets that in fact would reduce their prices and take custom from small businesses. We made some recommendations based on a survey of 4,000 people we did back in 2016, and the two biggest components that came out of that were better education—I think we heard that during the day—and also restricting advertising of junk food products to children.

We believe the convenience stores can assist and can play a meaningful role in educating consumers but we also believe consumers should be empowered with all of the information they need to be able to be free to make those informed choices. Thank you again for the opportunity. I'm happy to address any questions.

Senator SINGH: Thank you for appearing before our committee today. I might start with you, Ms Barden. We had some evidence this morning from The Australian Prevention Partnership Centre which stated that 58.2 per cent of family food budgets are spent on junk. I noticed in some of the submissions received—it might be in the Beverages Council or yours. I think there's a pie chart showing how much is spent on discretionary food compared to other foods. How do you respond to that statistic?

Ms Barden: On the statistic, I'll ask Dr Geoffrey Annison to reply, but my broad comment would be that as an industry we're very supportive of the Australian Dietary Guidelines and encourage consumers to eat according to those.

Dr Annison: I'm not aware of this specific statistic that you mentioned, but I am aware that the ABS published information a couple of years ago that indicated that about 35 per cent of energy intake from foods is from discretionary foods. You have to remember that the Dietary Guidelines—and I was also on the working group of the Dietary Guidelines when they were last brought out in 2013—advised the reduction in discretionary foods, but it was really an indication that some foods are suitable for particular eating occasions. We used to refer to them as...
occasional foods or treat foods. The working group agreed to use the term 'discretionary foods' and did some work around modelling of diets in order to try and give some guidance around discretionary foods, or occasional foods, and treat foods and core foods. The ABS in their definition of discretionary foods brought in a definition that actually hasn't been peer reviewed and confirmed since. Australia is the only country in the world that actually uses the term 'discretionary foods'. Even though we share our food code with New Zealand, for example, they don't use that term over there.

Senator SINGH: What do they use?

Dr Annison: They don't attempt to classify foods as healthy and non-healthy, and that's one of the problems with the term 'discretionary foods'. We've tended to think of them as non-healthy foods or unhealthy foods. It's much better to look at systems like the health star rating, for example, that looks at foods and their contribution within a healthy diet. The current advice in the Dietary Guidelines is that we eat from the five major food groups, and, indeed, we have to keep pushing that message, because, as we heard earlier, there's certainly evidence that some people are not eating as much dairy as they should and not eating as much grain foods as they should. Discretionary foods, or occasional foods, are really for those treat occasions. In constructing a diet, the advice before the Dietary Guidelines came in, and the advice still, is everything in variety, moderation and balance. The current wisdom is, and has been for a long time, that there are healthy diets and unhealthy diets, but it's very difficult to put your finger on a food which is unhealthy. In fact, I'd remind the committee that we don't actually talk about food related diseases. We talk about dietary related diseases, about lifestyle related diseases and about diseases of affluence when we're talking about obesity, cardiovascular disease, diabetes, hypertension and so on. We do not focus on individual foods, and there is still no evidence that an individual food product is specifically linked through to a health outcome, and I think it's very important to remember that.

Senator SINGH: Right. I don't know where to start with that. I'd have to say, Dr Annison, that I think I could identify a healthy food and an unhealthy food, but if you can't that's fine.

Dr Annison: It's not only me that can't—others can't either.

Senator SINGH: Therein lies the problem when we talk about obesity and the fact that we now have a situation where, as we heard this morning, 58 per cent of a family food budget is going into discretionary foods. You have just said they should be regarded as a treat and something that are not part of the mainstay of Australian people's diets, but they seem to have become so, and we've got various reasons why we now have an obesity epidemic in the country. There have been a number of recommendations to the committee about the need to address advertising when it comes to discretionary foods, particularly when we're talking about children. The Australian Beverages Council's submission talks about responsible marketing. What is your position on that? Do you agree with the recommendation that there be enforced time-based restrictions on advertising unhealthy foods on free-to-air television during hours when children are most likely to be watching TV?

Ms Barden: You'll be aware from our submission and some of the other comments made today that the AFGC has a couple of codes in place for responsible children's marketing—the Responsible Children's Marketing Initiative and the equivalent Quick Service Restaurant Initiative for Responsible Advertising and Marketing to Children. Both of those have commitments from industry around not marketing directly to children the products that are deemed discretionary, less-healthy choices. Those codes have been in since 2009. It's not really disputable the fact that they have actually had a significant impact on the advertising that children see and have virtually eliminated all advertising of discretionary food during children's programming. What is in debate is, when you go beyond that into prime-time viewing, which I think is the point of your question. I know a lot of studies that have been around about advertising have really gone to the point of having watersheds or excluding advertising right up until nine o'clock or 10 o'clock at night. Our comment on that would be that when you start to make those sorts of regulatory interventions you can really end up with some perverse outcomes from extending into those sorts of family viewing times. It would be at odds that you could have a child watching a TV show like MasterChef where they are baking a chocolate brownie yet not be able to see an ad for a chocolate brownie.

CHAIR: I'm not sure. I don't understand the conflict.

Ms Barden: If a food is deemed to be unhealthy and you can't have an ad for a chocolate brownie during that prime viewing time—

CHAIR: I've just got the image of a seven-year-old going to the pantry, getting the ingredients, whipping them up and cooking themselves a chocolate brownie versus being in a supermarket and pestering their mum or dad.

Ms Barden: But it's not about that; it's about the food. So seeing a food that is deemed—

CHAIR: No, it's actually about the outcome.
Ms Barden: Seeing an ad for a chocolate brownie isn't necessarily making that child go down to the shop and buy a chocolate brownie straightaway either.

CHAIR: So why do they do it? Why is it done?

Ms Barden: They're not getting up from the lounge and going straight to the shop to buy—

CHAIR: No, but it's done to encourage the consumption of chocolate brownies.

Ms Barden: But my point being—

Senator PATERSON: To clarify your point: you're saying that there's an inconsistency. Either chocolate brownies are bad and should not be shown to children, whether it is in an advertisement or part of programming; is that the point?

Ms Barden: That is the point, exactly. Similarly a child can work in a McDonald's and flip a hamburger but is not able to see a hamburger on an ad in the evening. We respect parents' decisions in determining the dietary choices of their children, so that's why the codes we have in place are very focused around the times when parents aren't there, when children are watching television alone, and respect the parental guidance during the prime viewing times.

You did mention earlier about changes in media as well. TV is also one media. We know children are watching a lot less television. A lot of teenagers particularly are in their bedrooms watching Netflix and YouTube and are on social media and other forms of media. We are very keen to explore that. We have been in touch with the Communications and Media Authority to try to understand the dynamics and the changing patterns of entertainment viewing to make sure that our codes remain relevant.

Senator SINGH: Dr Annison, I want to go back to your point about it being difficult to determine what's healthy food and unhealthy food. You referred to the star rating system as a positive guide to determine that factor. Is that what you were saying?

Dr Annison: The health star rating system has been designed to help consumers choose between products.

Senator SINGH: Don't you think it has done that?

Dr Annison: There's no doubt that it has done that. For a start, the penetration into the market has been high. I think we have now over 10,000 products in the market. It went live, if you remember, in mid-2014, so we are at about the four-year mark in mid-2018. Each year the progress of the health star rating has been monitored by the National Heart Foundation, so this is an independent assessment of the market, what industry is doing and what the penetration is.

They've also been doing consumer research. The latest data from them shows a very high level of awareness of the health star rating by consumers—I think it's somewhere up around 60 or 65 per cent. Quite a large percentage of those consumers say that they have used the health star rating in order to make a choice, and a large subsection of those consumers have also indicated that once they've made the choice in one purchasing decision, they stick with that choice.

It's important to remember that it is to help people within categories. One of the misunderstandings of the health star rating system is that it's a measure of the healthiness of food products, rather than a guide to the construction of healthy diets. It's not designed to compare a breakfast cereal with a dairy product. It's designed to enable consumers, when they're in the dairy aisle of supermarkets, to select a dairy product that is higher up the health star rating than the other dairy products. When they're in the cereal aisle, it's to help them select cereal products that are higher up that line, and that really reflects the way shoppers shop. When they go to the dairy cabinet, they're looking for dairy products. They don't tend to look at it and then, if they don't find what they want, go around to the breakfast cereal aisle or down to the biscuit aisle or across to the fruit and veg aisle. People buy in category. The beauty of the health star rating system and why it has been so successful for consumers who follow it is that it reflects the way they shop.

Senator SINGH: Successful in what terms? We have an obesity epidemic, so it's clearly not addressing obesity. And we've heard today about a lot of flaws with this health star rating, particularly the algorithms that make it up.

Dr Annison: I can certainly address the flaws, but we've also heard today that the ship of obesity is going to take quite a while to turn around. We're certainly very sympathetic to that, and we recognise that it will require a multifaceted approach. However, there is no doubt at all that if the health star rating has a high degree of penetration into the market, which it has already secured, and if quite a lot of consumers quite a lot of the time take its advice—in other words, when they're looking in the dairy category or the cereal category, they select products that are higher in the health star rating—their diets will move in a direction recommended by the
Australian Dietary Guidelines. Their intakes of energy will tend to go down; their intakes of saturated fat will tend to go down; their intakes of sodium will tend to go down. They will tend to eat more dietary fibre and have higher levels of protein. That is exactly what the Australian Dietary Guidelines recommend. So as a public health intervention, aligning the dietary intakes of the population as a whole, this is a good system.

CHAIR: So why don't we make it mandatory?

Dr Annison: I'll tell you why we can't make it mandatory.

CHAIR: I'm sure you will!

Dr Annison: It's really very simple. You make it mandatory if you don't think the penetration is high enough. We're in a review period and the review will ultimately determine what the penetration is.

CHAIR: We heard earlier it is 28 per cent.

Dr Annison: I'll remind you that it's not just the penetration in the simple number of products. It's the number of products which are in mainstream categories and the volume and what the contribution is to the diet as a whole. That's what we need to find out from the review. However, to go back to why we wouldn't make it mandatory: once it's made mandatory, it will lock it in stone. The real beauty of the system at the moment is that it can be reviewed frequently.

CHAIR: What? Sorry, just explain that. Why will it lock it in stone?

Dr Annison: Because it's extremely difficult to get changes in the Food Standards Code through the system. One of the examples of that is that within the Food Standards Code they reference the NRVs, the nutrient reference values, from which a lot of the labelling requirements in the Food Standards Code are derived. The current ones were derived in 2006. They have changed twice since then, and the Food Standards Code hasn't kept up with it. So we don't have a regulatory system that is agile enough and flexible enough to keep—

CHAIR: But that's what the current system is based on. The current products that you've been saying are currently working very, very well are based on the system that you're now criticising.

Dr Annison: No.

Ms Barden: No, Senator; they're not incorporated in the Food Standards Code.

CHAIR: Just explain that.

Dr Annison: Let me let me explain that. The current health star rating is based on the Australian Dietary Guidelines and the recommendations that are out from that. Some of the requirements around food labelling of nutrients are based on Nutrient Reference Values that are from 2006. There have been some updates of those since 2006 that are still not reflected in the Food Standards Code. So my point—

CHAIR: Is that with products that have an existing rating?

Dr Annison: This is not to do with the health star rating, this the nutrient information panel labelling

CHAIR: But I'm talking about health star rating.

Dr Annison: Well, let well let me say again: the beauty of the health star rating system is that we can review it—

CHAIR: We can review it if it's mandatory for all products.

Dr Annison: Well, we could do it, but the experience, not only of the food industry but also of other stakeholders in the food regulatory system is that it's quite difficult to get changes through the Food Standards Code. The beauty of the health star rating system and voluntary self-regulatory or partnership arrangements like this—which has been conceded by the ACCC, for example, in their guidelines on self-regulation—is that they can be more flexible and they can set the bar higher than you would be able to do through regulation. That is essentially why the Food and Grocery Council has argued that we maintain it as—

CHAIR: Yes, but on one hand you're saying the existing health star rating system works—it works well, it's a great system and it's made a huge impact—but you can't expand it to all other foods—

Ms Barden: It's saying that the current health star rating system, being a voluntary system, does not sit within the Food Standards Code. So being able to change it is quite an easy process.

CHAIR: So why don't we mandate—

Ms Barden: Making it mandatory would mean bringing it within the Food Standards Code and going through the longer, complex process. It just makes it more difficult to keep it agile and responsive to—

CHAIR: So is there a policy solution to that? Why not keep it within the existing arrangements and make it mandatory. Why does it need to be linked? I'm—
Ms Barden: To be mandated it would need to be in some form of legislation.

CHAIR: We can have legislation that reflects the current situation, can't we?

Ms Barden: It would be unusual to have a labelling scheme that sat outside the Food Standards Code, because that's the body that regulates our food standards.

CHAIR: But that's what you've got now?

Senator SINGH: Some of the grocery items would never want to opt in voluntarily to the health star rating because they'd probably only get half a star or one star, which wouldn't be good for their advertising of that product. The idea that Senator Di Natale is talking about would reveal that

Ms Barden: The system gives an incentive to consumers to purchase products that are healthier. And then it gives an incentive to companies to reformulate to make those healthier. Even if you were seeing products at the healthier end of the spectrum having more stars, that's actually still really informative for consumers. Consumers can go and choose from the products that have higher star ratings on them.

Senator SINGH: Isn't it the case that the current algorithm for the health star rating doesn't include added sugar? Sugar is one of the main issues here.

Ms Barden: Can I just bring you back, Senator, to some advice from Food Standards Australia New Zealand, just so that we're not just honing in on sugar as being the primal link to obesity? I think it's really important to recognise that—

Senator STORER: It's not in the algorithm; that's the point.

Ms Barden: My point, though, is that sugar isn't the major determinant, in and of itself, of obesity and FSANZ's view is that experts generally agree that eating excess kilojoules or energy contributes to weight gain. Being overweight or obese increases the risk of chronic health problems, like high blood pressure, type 2 diabetes and heart disease. Sugar provides the same amount of energy or kilojoules per gram as other forms of digestible carbohydrates, such as the starch found in breads, rice and pasta. However, some foods have a lot of sugar. It's important to remember that eating too much of any food can contribute to weight gain. So the issue around added sugar—

Senator SINGH: Would the council agree to having added sugar added to the algorithm for the health star rating?

Ms Barden: At the moment we're looking at added sugars as being open to consultation through a process through the form of food regulation. We will look, consider and give our views through that process on all the options before it.

Senator SINGH: You don't have a view at the moment?

Ms Barden: No. At the moment we just look at the advice of the regulator, which is that added sugars have the same nutritional impact as total sugars. But we're in the process of going through and looking at all the options in that consultation process.

Senator STORER: Mr Rogut, I was interested in your point about snacking—snacking that is 20 per cent fruit. You're saying that's a healthy amount—that 20 per cent is a healthy amount?

Mr Rogut: It certainly is. If you go back a number of years, really, it was chips and chocolates.

Senator STORER: They were eating less than 20 per cent?

Mr Rogut: Far less, it was in the low single digits. Over recent years, as there has been more focus on it and supply chains have improved, you'll now go to convenience stores and find a box of bananas for a dollar each at the sales counter or things like that. So, certainly, fruit, nuts and smaller packs of those healthier snacks becoming available have pushed that number up, and that continues to be the case.

Senator STORER: And that would be in response to the market rather than—

Mr Rogut: Absolutely. As a retailer, you sell what customers want to buy. Every retailer does their research. We research what consumers want and we try to satisfy their needs. If we put into stores what I wanted, we would go broke very quickly. It is a matter of being in touch with the marketplace.

Senator STORER: What were you trying to say with your 15 per cent tobacco analogy?

Mr Rogut: The analogy there is about the potential for something like a sugar tax on beverages. I use the analogy of tobacco, where the excise and the taxes continue to go up. All that has happened is that, rather than maintain that constant decrease in smoking rates and purchase of tobacco, there is a huge black market for illicit tobacco. It is worth billions of dollars. I was talking to my colleagues in the UK as recently as two weeks back,
who have now looked at the sugar tax. One of their fears is contraband soft drinks coming into the UK as well. It is an unintended consequence. So let's not jump into that without looking at some of the other issues that have occurred.

Senator STORER: That's what you have heard from your friends. You are not saying there is any evidence of that?

Mr Rogut: Not as yet. It is only been in in the UK a few months. Certainly, illicit tobacco is something we live with every day. It has cost our industry millions of dollars.

Senator STORER: Is there evidence from Mexico of contraband soft drink given that they made the change in 2014 with a sugar tax?

Mr Parker: What the Mexico example has told us of the tax that which was introduced in 2014 is it there was an initial dip in sales—if we take that as a proxy for consumption, that was an initial dip in consumption. And then sales/consumption rose in year 2 and has continued to climb in subsequent years. We take that data from Mexican Treasury tax receipts, which have indicated an initial dip and then a rise back to pre-tax levels in the second year and then subsequent growth after that. There is one study out there that purports a decline, year after year, in sales as a proxy for consumption. That one particular study is a modelling study which looks at counterfactuals. It looks at sales after the tax and compares that to what sales would been had the tax not been brought in. If that counterfactual was to hold true in the real world, it showed that consumption dropped in the first year by around the equivalent of six calories per day. In the average Mexican diet of over 3,000 calories, that represents a bite of an apple. Again, we refer back to Mexican Treasury tax receipts. It is quite an easy calculation—one peso per litre. That shows a dip in year 1, a climb back to pre-tax levels in year 2 and a subsequent growth in sales in year 3.

Senator STORER: If you aren't making those arguments about the Mexican situation, why wouldn't you advocate to meet your pledge of decreasing sugar by 20 per cent by 2025? Why wouldn't you advocate for a taxation measure to bring that about?

Mr Parker: First of all, there is no real-world evidence—

Senator STORER: But it is a pledge that you have made, so why isn't the Australian Beverage Council behind it with full force?

Mr Parker: Because we are against discriminatory and regressive taxes that lack any evidence from anywhere in the world that they have any discernible impact on public health. What we believe our pledge is going to bring about is an increase in the speed and scale of choices for people to be able to look for low- and no-sugar alternatives. In regard to taxes, yes, they have been brought in in around 25 countries around the world. That leaves around 170 countries that haven't brought in such a tax. Yes, they have been brought in in seven cities within the US. Depending on your definition of a city, that leaves around 3,000 cities in the US that have not brought in a tax. In fact, some states within the US have legislated for no further soda taxes. Berkeley California, although probably not indicative of the rest of the world, brought in a tax a year ago, and calories per day from beverages have actually increased as a result of the tax because consumers are moving to untaxed beverages.

I will make a couple of extra points on a tax. We know that McKinsey Global Institute recently looked at a range of interventions to reduce obesity, and found tax to be one of the least effective. The World Health Organization, in 2016, released its list of best ways to address NCDs. An SSB tax failed the WHO's own internal choice analysis. We also know that the WHO NCD conference, colloquially known as the Montevideo roadmap, excluded sugar sweetened beverage taxation from its final report. We also know that in 2018 the WHO independent high-level commission's report on NCDs, referred to as Time to Deliver, excluded SSB taxation from the list of recommendations. Finally, the most recent WHO report, entitled Saving Lives, Spending Less, also excluded taxation of sugar sweetened beverages. So the evidence moving away from sugar sweetened beverages globally is increasing.

Two of the unintended consequences that we are forgetting about in looking to this simplistic solution to what is a really complex problem are health and diet, as referenced in the Berkeley example. Mexicans are not getting any thinner as a result of the introduction of a soda tax there. In fact, a 2016 health survey in Mexico found that the prevalence of overweight and obesity was continuing to rise, particularly in women. However one of the things we do admit in this debate—albeit a flawed debate—is the unintended consequences on jobs and the economy. The industry association in Mexico is reporting job losses of up to 10,000. But Oxford Economics, whom many sitting in this room would know of, has estimated that 4,000 jobs will be lost in the UK. South Africa
is looking at anywhere between 60,000 and 70,000 job losses. And the soft drink industry in Philadelphia has laid off 20 per cent of its workforce.

Finally, we are sure that the Menzies Research Centre, when they appear before you this afternoon, will go into their report which found that taxes on SSBs failed to reduce obesity. And the New Zealand Institute of Economic Research undertook a report commissioned by the New Zealand Ministry of Health. I will give you a couple of salient quotes from that: ‘No study based on actual experience with sugar taxes has identified an impact on health outcomes’ and ‘The evidence that sugar taxes improve health is weak’. So it is perplexing why in 2018 we are continuing to look to a simplistic solution that just lacks any credible evidence from anywhere around the world that it has any discernible impact on public health.

CHAIR: The sugar sweetened beverage tax is targeted not only at consumers but also at manufacturers. With regard to the introduction of the sugar sweetened beverage tax in the UK, Coca-Cola indicated it would change its formulation for Fanta. And San Pellegrino changed the formulation of its soft drinks—40 per cent less sugar—in response to the introduction of that tax. You are saying it has had no discernible impact. That is a significant impact—the reformulation of those products.

Mr Parker: Our pledge has not only crystallised the huge amount of reformulation that has already happened over the last two decades in this country but increased the speed and scale of that reformulation to bring that forward. It is about providing more choice—

CHAIR: This happened straightaway. As soon as they promised to introduce the tax, they decreased sugar in the products they were making. What you say you want to achieve voluntarily over the next five years, these companies did immediately in response to a sugar tax. You made a very long presentation outlining in great detail why you oppose this measure. Based on your own evidence, I am showing you precisely how a sugar sweetened beverage tax worked in the UK and the response of industry, which is consistent with your so-called voluntary pledge.

Mr Parker: We don't believe that a tax which is discriminatory, which focuses on a small and, in Australia, declining part of the diet and which is regressive—it will hit low-SES households the hardest—is the right way to go about addressing what is a really complex problem.

CHAIR: You said it was because it is not going to have an impact on consumption decisions, that people will be consuming the same amount of sugar. That was your primary argument. And here we have an example of manufacturers decreasing the amount of sugar in the products that they are making, consistent with your primary argument against the tax. How do you square those two things off?

Mr Parker: Here in Australia, our pledge is about increasing choice for consumers. That is around products which will continue to have sugar but also a growing number of products which will have less sugar or no sugar. That is what our pledge is doing. It is about speeding up the scale and speed of bringing those products to market in the absence of some sort of regressive and discriminatory tax that lacks any evidence from anywhere around the world.

CHAIR: I think we are going backwards and forwards here.

Ms Barden: May I provide some data to the committee that might be of use. This is a table of some Nielsen data which is based on Nielsen home scan service data for the soft drink category for the 52-week period ending 16 June 2018 for the Australian total grocery market. What it shows is a split between low- and no-kilojoule soft drinks and full-sugar soft drinks consumed in Australia—50.6 per cent of soft drinks were regular- or mid-kilojoule soft drinks and 49.4 per cent were low- or no-kilojoule. That is quite a different starting point from what you see in other countries, particularly a lot of the less-developed middle-income type countries that have implemented a sugar tax—

CHAIR: Like the UK?

Ms Barden: I don't have the data for the UK. But in Mexico, for example, the split is completely different. They are over 90 per cent—

CHAIR: Let's compare it to the UK.
Ms Barden: I'm happy to see if I can get the data. What I am trying to show is that, for the last three years, that split has increased and we have a growing share of low- and no-kilojoule soft drinks being sold. About 50 per cent of carbonated soft drinks sold in Australia are low- or no-kilojoule varieties.

CHAIR: Thank you. Senator Paterson.

Senator PATERSON: Thank you, Chair. Mr Parker, I'm interested in coming back to your opening comments about changing consumer tastes. Members of your organisation have to respond to that whether they like it or not, because they have to cater to the market. What has been the trend in Australia? What are consumers demanding from your member companies?

Mr Parker: Over the last two decades, there has been a fundamental shift towards low- and no-kilojoule varieties. That is not only anecdotal. If you walk in the door of any member of the Association of Convenience Stores, you will see a proliferation of low- and no-sugar varieties, and that includes bottled water. If you walk down any supermarket aisle, you will see a proliferation of low- and no-sugar alternatives. As outlined in our submission across pages 33 to 36, there has been a fundamental shift away from regular-sugar varieties in favour of low- and no-sugar varieties. Over that period, there has been a 26 per cent reduction in sugar per person from carbonated soft drinks and a 17 per cent reduction per person from sugar sweetened beverages generally. The last Australian Health Survey showed clearly that all of the graphs and all of the trend lines, from a public health perspective, must be heading in the right direction. There is only one graph that is increasing, and that is the number of people consuming water and the amount they are consuming.

Senator PATERSON: So, absent of any kind of government intervention or regulation, consumers have already changed their preferences and businesses have changed the products that they supply to meet those preferences?

Mr Parker: Yes.

Ms Barden: And that's not just true for soft drink. You see that trend happening across a lot of other categories. For example, we are seeing a rise in low-sugar biscuits. So that is a trend. We are happy to provide some further data around that.

Senator SINGH: If that's the case—you're saying there's been a reduction in the uptake of sugary drinks—why do they still have the same amount of shelf space in a supermarket, which is basically nearly an entire aisle?

Ms Barden: Shelf space in the supermarket is really about giving variety and choice to consumers. People talk about the amount of shelf space given to processed food, for example, relative to fresh. You don't have 10 or 20 different varieties of an orange like you might have 10 different varieties—

Senator SINGH: I'm talking about sugary drinks.

Ms Barden: That's right, and my point is that you will see multiple versions of a beverage. You'll see multiple versions of a biscuit and you don't see multiple versions of other categories of product.

Senator PATERSON: Ten years ago, there was no Coke Zero and all the new products that are now available that are taking up space on the shelf weren't there at all previously; it was just the traditional high-sugar variety.

Ms Barden: That's right. It's also about making sure consumers have choice. So it's not about the removal of all of the full-sugar varieties. It's about—

Senator SINGH: There's not a lot of choice there. Often Coca-Cola takes up quite a lot of shelf space.

Ms Barden: That's right. And the retailers—

Senator SINGH: There's no choice there.

Senator PATERSON: This is a really important point. It's the kind of Coca-Cola that's on offer now. Previously, it was just the traditional Coke, which is high sugar, and now it is Diet Coke, Coke Zero and all the other kinds of varieties under the sun. So, it might still be the same brand and the same company, but it's a much healthier product.

Senator COLBECK: And Coca-Cola produce water.

Senator SINGH: [inaudible] the word 'healthy'.

Ms Barden: That's right.

CHAIR: We will extend this session for another five minutes or so.

Senator PATERSON: In that case, I will finish my line of questioning. Do you have any comparative international data on how relatively health conscious Australians are compared to other countries? Are they demanding healthier products at the same or similar rate or a greater rate compared to other jurisdictions?
Ms Barden: I don't have data to hand, but I'm certainly happy to bring some data to the committee's attention in a follow-up.

Senator PATERSON: Yes, thank you. You can take that on notice.

Ms Barden: Certainly.

Senator COLBECK: Mr Parker, are there comparisons around the formulations in various countries, bearing in mind that different countries have different taste profiles?

Mr Parker: Yes, and they vary dramatically, even between what could be deemed to be like markets—for example, the US compared to Australia compared to the UK. There will certainly be different recipes for the same type of branded product that is available in the US compared to here in Australia or compared to the UK. Certainly, there's a product portfolio mix, if I could call it that. The different types of beverages within a particular type of market do vary greatly between more developed markets, like those that I just mentioned and, perhaps, a middling-income market, like many of our neighbours, particularly in Asia. Taste profiles do vary greatly. What all of our members represented by these associations are very good at doing is responding to consumer demands.

Senator COLBECK: The ultimate market test.

Senator SINGH: Dr Annison, or it might have been you, Ms Barden, said that sugar is not the only contributing factor to obesity. We're obviously focused on the reduction in sugary drinks, but yet we still obviously have an obesity issue in Australia. How much sugar is in the average can of Coke?

Ms Barden: That information would be publicly available. I don't have it in front of me, sorry.

Mr Parker: Approximately 10 per cent of that can will be sugar.

Senator SINGH: Does any other product have that much sugar in it?

Mr Parker: On a percentage basis, I'm sure that there are a number that would be over 10 per cent.

Senator SINGH: More than 10 teaspoons.

Mr Parker: I'm not talking about beverages. There will be more products that will have more than 10 per cent sugar.

Senator PATERSON: And smaller pack sizes.

CHAIR: I think we're all aware of that.

Ms Barden: We should also recognise that those sorts of products are the ones that are encouraged for occasional consumption, and that's why there are the low-joule varieties and no-sugar varieties available.

Senator PATERSON: I'm going to have to draw this to a conclusion because we've extended well beyond the finish time. I want to thank you again for your contribution and for presenting today. If you've got any more evidence, we'd be happy to take it. We obviously hope to hold further hearings, so we may request some more information from you over the journey. Thanks for the contribution today.
CATER, Mr Nick, Executive Director, Menzies Research Centre

[15:55]

CHAIR: Thank you for appearing before the committee today. I invite you to make a brief opening statement.

Mr Cater: First, can I congratulate the committee on looking at this important issue and spending as much time as you have been at looking at a sensible and measured public response to this issue of obesity. Our evidence is largely based on a report which we produced last year on the sugar tax. You should have a copy of this; if not, I could make other copies available to the committee. At the Menzies Research Centre our focus is on strong, empirically based policy and avoiding policy mistakes.

We commissioned Cadence Economics to have a look at five of the most frequently cited reports which advocate a sugar tax. Their finding was that none established a causal link between the tax on sugary drinks and a reduction in obesity. None of them measured the cost of the economic inefficiency in raising a tax of that nature. None of them had considered inequity or the complexity of their proposed solution. None had questioned whether taxing the majority of soft drink consumers was justified—that is, whether taxing people who control their weight was justified. None had calculated the impact on society more broadly. We found no evidence of market failure. Indeed, consumption patterns, as I think the committee has heard from other people, have tended quite the opposite. There is evidence that sugar consumption is declining markedly in the younger age groups. I think anecdotally we understand that from watching the behaviour of parents these days as compared to parents a generation ago.

Having established that, our conclusion is that it's problematic to jump to a sugar tax without clearer evidence that it works. There are problems with the fact that people can shift their consumption to other sugar products. If you have a sugar habit of some sort, then you can easily satiate yourself on cake or candies which don't attract the sugar tax. We also found that in many of the studies—in fact, I think, in all the studies we looked at—the measurement of soft drink consumption was on the amount of money spent on soft drink rather than the volume. Of course people could switch to cheaper brands or could get larger bottles where, in some countries, less sugar tax would apply per litre.

We argue that there are alternative approaches to dealing with obesity which have not been studied properly and will not be while there is a focus on one single solution. Self-management, we believe, should be the starting point for treating chronic diseases like obesity. Doctors need to be empowered to tell their patients frankly that they are obese and that it lies within their powers to do something about it. Attributing a lifestyle disease to social, cultural, environmental or market factors only erodes their sense of responsibility and the authority of the doctors to instruct them on how to improve their health literacy, their self-care and their self-management.

One further factor that we think deserves much further consideration on the question of obesity, particularly as it applies to young people, is the question of physical activity. I note that the Minister for Sport and the Sports Commission produced some papers looking towards a new policy on sporting activity, and I'd encourage the committee to look at the statistics there about the amount of time young people spend on screen time and the fact that a frighteningly large proportion of them don't meet the recommended average time for physical activity. So, in brief, that is our evidence to you.

CHAIR: Thank you. You said that it's unfair to blame societal and environmental factors for issues over which individuals have agency and that in fact it's disempowering. Why do you think Australia has become a more obese country? In fact, we're almost on the podium. That's a change that's occurred within the past 50 years, probably closer to the past 30 years. What do you think is responsible for that? Have Australian suddenly all just decided to start making bad choices?

Mr Cater: I think there are a number of factors in that. One is prosperity and affluence, quite frankly. We used to talk about the 'freedom from want'. We don't talk about that anymore. Most people, even the most vulnerable in our community, should have enough to fill themselves. Of course there is sugar, which is often the cheapest option for people. We see, for instance, that high sugar consumption and obesity are closely linked to disadvantage—closely linked to welfare, for instance. Those may be some of the reasons. But I'd also say that there is the question of activity, and I think there should be more research done into how much time children are now spending in physical exercise compared with on the screen. There are European studies—which I think we cite in here, but I can furnish that study if it would assist the committee—that demonstrate, for instance, that in Europe the highest sugar consumption or the highest consumption of sugary soft drinks is in Holland and the lowest consumption is in Greece. But if you look at the obesity rates, they are the opposite, and that's much attributed to the fact that children in Holland are much more active—they're able to cycle to school, for instance.

CHAIR: So you think it's largely physical activity, and you don't feel that nutrition or diet's a major factor?
Mr Cater: I think you're going beyond my level of expertise here. I'm not a doctor, and I know you are. So, I wouldn't presume to in any way rank the factors.

CHAIR: Well, we've heard evidence today that they're both part of the conversation.

Mr Cater: I think it's important to recognise, when we come to a policy solution on this, that there are multiple factors, and there'll be no silver bullet that'll fix everything.

CHAIR: Can I then go to this question of what we do about the nutrition side of the equation? Do you accept that there are significant health impacts as a consequence of obesity, significant impacts on the health system and significant economic costs?

Mr Cater: There are indeed health impacts. That's undeniable. You've heard from medical experts on that—type 2 diabetes, increased risk of heart disease and so forth.

CHAIR: The Menzies Institute has a particular perspective. I won't speak for you, but given the framework within which you operate, the notion of taxing externalities is not one that would be inconsistent with the perspective that you adopt in other areas. Isn't that a fair thing to say?

Mr Cater: Well, our basic position on tax is that we want less of it, and we certainly want fewer inefficient taxes—that is to say taxes that cost an awful lot to raise. Our evidence shows that this particular tax—or any tax on a specific type of goods rather than across the board—is inevitably going to be more expensive to raise than a more general tax, so we're against this on economic grounds more than anything.

CHAIR: To understand your philosophical perspective: if there were evidence that it did lead to a decrease in consumption of sugar sweetened beverages and, subsequently, in rates of obesity, would you still oppose it?

Mr Cater: No. Let me make this clear: we were looking for a clear link between sugar consumption and obesity. Even then, correlation is not causation, but that might at least give you more confidence.

CHAIR: You don't have an ideological objection to the notion of a sugar sweetened beverage tax regardless of whether it has an impact on obesity or not?

Mr Cater: Sin taxes broadly have been effective in smoking—that's to be encouraged, although there are signs now that we've reached the limits of how much we can change behaviour in that manner—and possibly alcohol.

CHAIR: It's interesting to tease out that perspective. You talked a lot about personal responsibility, empowering doctors and ensuring that those conversations are had, and I suspect you won't get disagreement from most people within the professional community and possibly this panel, but part of the response is ensuring that the primary healthcare system is able to respond adequately. Do you think we need to do more than that?

Mr Cater: We need to do more about physical activity.

CHAIR: How should policymakers and government improve nutrition and encourage physical activity?

Mr Cater: I think education has an enormous role with physical activity. As I said, the initiatives unveiled last week by the sports minister seem to me to be pointing in that direction. Beyond that we need active adults too. Whilst not a health expert I would note that type 2 diabetes in its most chronic form is a disease of the over 50s. That's where the vast majority of deaths from type 2 diabetes occur. One of the things we've been in danger of overlooking—and I'm sure the committee will be considering this—is that obesity is not just a disease of teenagers or young children; it's a considerable problem for the older population. I think we need to address that, given that cohort is most directly burdening the cost of health.

CHAIR: What about advertising and promotion?

Mr Cater: No, we don't generally support that. We want to see advertising that's age appropriate, but—

CHAIR: Just to be clear: you don't generally support restrictions on advertising and promotion?

Mr Cater: There are clear restrictions: decency, for instance—

CHAIR: Additional restrictions?

Mr Cater: No, no additional ones.

CHAIR: For what reason?

Mr Cater: The primary responsibility and challenge is for parents to encourage and assist their children to view advertising as what it is, the word of the marketer, and in a different light from, say, Playschool.

CHAIR: That goes against the whole notion of what advertising is and how it works. Billions of dollars are spent on advertising to encourage the consumption of a product, and it works. That's why companies whose
responsibility is to turn a profit spend a hell of a lot of money doing it. You're asking an individual to somehow work against the whole tide of a system that's coming down on them.

Mr Cater: I am indeed.

Senator COLBECK: You're asking them to understand what the system actually is.

Mr Cater: I think you're doing a disservice if you try to insulate children from advertising, because they're going to have to deal with advertising in their adult life, unless you're proposing to ban all forms of advertising all the time. It's right that children should learn and be taught to recognise what advertising is and how to respond to it. There is useful information in it, but it has to be viewed—

Senator COLBECK: That's a very good point.

CHAIR: Even if the consequence is that, rather than learning what the advertising is, it encourages and leads to behaviours that are very unhealthy for that individual, that's just the cost of trying to teach them a lesson?

Mr Cater: I don't recognise quite what your point is here.

CHAIR: My point is you're saying that we shouldn't do it, because they should learn that it's actually not in their interests to be swayed by the advertisers. The reality is that they are. You're saying it should continue to happen, because we should just make sure that they understand that they're being preyed on by companies who want to turn a buck off of them.

Mr Cater: My view is that we're engaging in a very dangerous social experiment by the cotton-wooling of children and the risk-averse nature of childhood and, indeed, adulthood more generally. I think risk is part of everyday life and children need to learn to deal with it. Adults should understand their role in helping their kids cope with the world as it is, not as they might want it to be, and the world as it is is one in which there is heavy advertising.

CHAIR: So you don't think it's a social experiment to have these incredibly powerful vested interests—very wealthy corporations—advertising directly to children to get them to engage in behaviours that are unhealthy?

Mr Cater: As you're aware, there are very firm rules around what can and cannot be shown to children.

CHAIR: We've heard evidence that they're ineffective.

Mr Cater: I'm not advocating that those rules be extended.

CHAIR: All right. Senator Paterson.

Senator PATERSON: We might come to this with the next panel as well, but is the power of advertising perhaps overstated sometimes? In my lifetime I've probably seen 10,000 ads for Ford motor vehicles, and I have never bought a Ford.

Mr Cater: Very wisely! If you want my personal view, yes, I'd love to see some empirical research on this, but I think that children are perfectly capable of distinguishing between levels of media at a very early age.

Senator PATERSON: One of the things we've talked about today is what's changed in the last 30 years, why this was not a problem in the early 1980s and why it is a problem today. Most of the evidence from the witnesses today has been that the main thing that's changed has been the availability of what they call discretionary foods: junk foods. Another thing that might have changed—I'm interested in your reflection on this, though I suppose it's hard to empirically quantify—is the thing you were hinting at in your previous answer, which is a decline in personal responsibility. Do you think that adults and children today take less personal responsibility for the decisions that they make than they once might have?

Mr Cater: I certainly do. I think the trend in parenting—and this is driven by a lot of things. It's driven by the increased number of women in the workforce, which is something to be welcomed but does bring a cost in terms of the time and attention they're able to spend raising their own children. There are many other factors. One may be the availability of junk food, but I seem to recall that in my childhood, which was half a century ago, there was plenty of junk food around, so I don't think that that would be a satisfactory explanation.

Senator PATERSON: There's also growing concern about the effect of, for want of a better term, helicopter parenting or overbearing parents—and not just parents but schools and other systems in our society—who have protected their children from risks and decision-making at a young age and what the long-term consequences of that are.

Mr Cater: There are. One of the problems with taking a risk-averse strategy to parenthood is that you're inclined not to let your children play outside or certainly not outside in the street. Again, I can only speak anecdotally on this—I haven't seen the research—but I think that it would be a good idea to see what research there is on the amount of time children spend playing outside.
Senator PATERSON: Speaking of research: one thing which is in your submission and is empirical is the link between the introduction of sugar taxes and the impact that that's had on obesity. Of the jurisdictions that have introduced a sugar tax, how many have reduced rates of obesity subsequently?

Mr Cater: None that we've seen in the five studies we looked at. I go back to your previous question if I may. There is another factor which we should take into account, and that is the ageing of the population. The average age of death from type-2 diabetes is in the 80s. I believe it's 84. So it could possibly be that, like dementia, it's a disease that is becoming more apparent simply because people are living longer.

Senator PATERSON: And a previous witness did point out that, although this increase in obesity over the last 30 years is regrettable, at the same time our life expectancy has also increased considerably, so in at least one fairly important measure of human health there have been positive trends.

Mr Cater: We should take great hope from that. Much of the evidence from the people who want to impose a sugar tax is that we are going to live shorter lives than our parents. I can't look into the future, but certainly, if you look at the ABS statistics, there is a steady and continual increase in the life expectancy of Australians.

Senator PATERSON: Thank you.

Senator COLBECK: Just quickly, on a specific sugar tax on drinks, is there any information or research data on substitution if you are hooked on sugar? I'm happy to concede that it's easy to be hooked on sugar. It gives you a range of responses, particularly a straight boost in energy straightaway. The sugar tax is driving a change in that consumption of that product, but there's plenty of other ways to get sugar.

Mr Cater: Indeed. None of the five reports we looked at had studied that at all. I will go back to what I said earlier: that they were looking, by and large, at the amount of money spent on soft drink, not the volume, which is quite significant. But you would expect substitution rates to be quite high. There's good evidence, for instance, in tobacco that the substitution—that is, the switch to illegal or non-taxed tobacco, contraband tobacco—at the moment is about 20 per cent, or near 20 per cent, of the market. So there are many, many more ways, and legal ways, to substitute sugar. So you would imagine that if sugar itself is the issue—an addiction to sugar, as some people describe it—then the substitution rate would be much higher.

Senator COLBECK: Did you have a look at any of the figures that showed a significant decrease in the consumption of sugary drinks over the recent period anyway? There was a comment made earlier that diet is a fashion statement.

Mr Cater: We did attempt to find this, and subsequently, since this report's come out, we have got some broad figures from the soft drink companies to the effect that the full-strength Coca-Cola, if I can call it that, was overtaken by low-sugar types of Coca-Cola within the last five to six years—that the trend is in an opposite direction. You know that from going to the service station and seeing the amount of shelf space that's taken up with Coke Zero, although it's slightly confusing now because the bottle is very similar. I'd also say, if I can throw in one more piece of anecdotal evidence, that my children are much stricter with my grandchildren than I was with them, and I think that that's more widespread in the community.

Senator COLBECK: Thanks.

CHAIR: Thanks, Mr Cater. I appreciate your time.
CHAIR: I welcome representatives from the Australian Association of National Advertisers, Free TV Australia and Ad Standards. I'd like to thank you for appearing before the committee today. Do you have anything say about the capacity in which you appear today? If you've got a brief opening statement, we're happy to hear it. Thanks very much.

Ms Jolly: I am appearing in my capacity as the CEO of the Advertising Standards Bureau and not in my capacity on the Classification Review Board.

CHAIR: Thank you. Who'd like to go first.

Mr Broome: Thank you very much for this opportunity to present to this inquiry. I'm here on behalf of the Australian Association of National Advertisers, the AANA. The AANA is the peak body for advertisers and has represented national advertisers for 90 years this year. The self-regulatory regime we maintain is a national system of restrictions which apply to all media including TV, outdoor, the internet and social media. The AANA codes apply to all advertisers. There is no opt-in system. Everyone is included.

I'd like to address three points very briefly. Firstly, there are existing standards regulating food and beverage advertising in Australia. The AANA standards prevent the promotion of unhealthy eating or drinking habits or inactive lifestyles to children and to adults. They also prevent advertising from encouraging excess consumption of food and beverages. Also, they prevent advertising to children in the sense of preventing pester power and undermining parental authority.

Secondly, the relationship between advertising and the harms associated with poor diet and obesity is misunderstood by many. We are not aware of any linear or causal relationship between advertising and the harmful consumption of food and beverages that have been identified and quantified by academic evidence. Reports that refer to the exposure of children to advertising incorporating any marketing a child may see do not reflect the important distinction between advertising directed to children and of course advertising directed to adults. Advertising targeting children through content or placement is already subject to a range of restrictions. Marketing to adults should not be subject to the same limitations.

Thirdly, many in the health lobby have called on restrictions to TV advertising, as happened in the UK recently. It's important to understand the volume of advertising in this category, which has decreased by a massive 59 per cent over the last 12 years. At the same time, the overweight and obesity trend has gone the opposite way so we've actually got two trends going in the opposite direction. It is true that digital advertising has increased yet, in food categories, it only represents five per cent of spend. The typical average across the industry of advertising is over 50 per cent going into digital today so it is much less. It is clear that food advertisers are not using digital as a primary channel.

The consumption of food and beverages is not of itself harmful. There is a misconception that obesity is attributable to bad foods rather than bad diets. Regulating the advertising of particular foods ignores the reality that there is a need to focus on diet and consumption along with encouraging people to be more active through reducing sedentary activity if there is to be a significant impact on this problem. The facts demonstrate that television and digital advertising are not driving the obesity crisis. The NNA calls for and supports full independent, quantified and objective research to be undertaken to identify the dominant drivers of obesity and commits to working with any findings to play a responsible role in solving the societal problem.

Ms Fair: Thank you for the opportunity to be here today. Free TV represents all of Australia's commercial free-to-air television broadcasters—Channel 7, Channel 9, Channel 10, Southern Cross Win, Prime and Imparja. At no cost to the public, we provide diverse channel offerings covering a broad range of genres including drama, news, current affairs, entertainment and sport. These programs are provided free of charge into 99 per cent of Australian households. We're proudly the largest producer and commissioner of Australian content, responsible for six out of every 10 dollars spent in the local production sector. In the 2017 financial year, we invested a record $1.6 billion into local content.

The economic value of our industry is significant. Over 15,000 people are employed both directly and indirectly by our members, and we make a contribution to the Australian economy equivalent of $2.8 billion...
every year. Importantly, all of this is only made possible because of advertising revenue. In fact, we're required under the Broadcasting Services Act to fund our activities by advertising revenue alone. Across all platforms, total advertising revenue in Australia is about $16 billion. While the size of the advertising market has not grown significantly in the last decade, we've seen unregulated digital players like Google and Facebook come in and gain a 50 per cent share in little over a decade.

I'd like to focus today on three key points. Firstly, commercial free-to-air television is the most heavily regulated and the safest platform to access content. We're regulated by numerous interrelated mutually reinforcing instrument—the Broadcasting Services Act, the Australian content and children's content standards, and the commercial television code of practice. Under the BSA, the industry code of practice must be registered by the ACMA and this may only occur after an extensive process of public consultation. The code is reviewed regularly and was last updated in March 2018. Before registering the free TV code, ACMA must be satisfied that it reflects community standards. The ACMA is then tasked with enforcing the free TV code with significant penalties for non-compliance.

In addition to our own code of practice, industry bodies such as the AANA and the AFGC also administer important industry codes. We support those codes through a cooperative arrangement with Ad Standards in order to remove advertisements from broadcasts that have been ruled to have breached these industry codes. Instruments such as the Children's Television Standards and our own code of practice also contain extensive rules around the type and amount of advertising that can be shown during designated children's viewing times. For example, during C programming broadcasters are limited to no more than five minutes advertising in any 30-minute period and may show an advertisement no more than twice in any 30-minute period. There are also stringent rules around the nature of advertisements shown during these times—for example, ads may not be designed to put undue pressure on children to ask their parents or another person to purchase advertised products. There are also rules around the use of popular characters.

Child audiences watching commercial television are, sadly, falling. Much of the concern around advertising and whether it plays a role in the current levels of obesity we see in the community relates to children. However, as a recent ACMA report highlighted, Australian children are watching less than 40 minutes of commercial television per day, and when they are watching they're predominantly doing so in the company of one or more trusted adults. In prime time the percentage of all children who are watching television is only nine per cent. That is, 91 per cent of children are not watching television during prime time. In children's viewing hours, the average child audience watching C programs designed specifically for them is now around 4,700 children. That's a 30 per cent drop from a year ago when this average audience was 6,800—even then it was alarmingly low.

A recent study by ACMA of parents and guardians showed that children today are more likely to watch children's programming on the internet, especially on YouTube, than free-to-air television of any kind. With children now predominantly watching content on these online platforms, applying simplistic policy solutions, like further regulating advertising on commercial television, would only have the result of making it even harder for Free TV broadcasters to continue to provide the quality Australian news, current affairs, drama, entertainment and live and free sport that Australians value and expect from their commercial television services. It would also contribute to regulatory bypass. That is, people will be driven to find content on other platforms that do not offer the same regulatory safeguards that are available on television.

Finally, we acknowledge that obesity is a multifaceted and important problem facing the community. However, we urge the committee to take an evidence based approach to forming policy responses to this important challenge. To date, very few studies have been undertaken in the Australian context that recognise the extensive controls that already exist on commercial television. There is no definitive evidence that further restrictions on food advertising to children will materially impact childhood obesity rates, as you've just heard from John Broome from the AANA. Exposure to television food and beverage advertising has actually fallen over the past 12 years, while at the same time the prevalence of obesity has been increasing. It seems that there are other factors at play and that increasing controls on television advertising is not likely to deliver the desired outcome.

Accordingly, rather than impose further restrictions on what is already the most heavily regulated platform, we believe it's time to focus on more holistic strategies that address the broad range of lifestyle factors that contribute to obesity. Commercial television broadcasters are willing to play a role in supporting those strategies.

Ms Jolly: Thank you for the opportunity to address this important inquiry into obesity. Ad Standards, formerly the Advertising Standards Bureau, runs the self-regulatory area in advertising to children and advertising content generally in Australia. The system that we run is an efficient complaint resolution service, which is meeting the needs of industry, consumers and government. The system that we run, Ad Standards, has been found by previous government inquiries at the Commonwealth and state level to effectively and adequately protect consumers and
meet community needs. More recently, we have had research completed by Deloitte Access Economics which confirmed what we have long said and believed, which is that the complaints resolution system run by Ad Standards achieves similar results as a government entity in the areas of compliance and effectiveness, and performs better, in terms of cost, efficiency and responsiveness. The report, which I'll hand over to you, concludes:

... self-regulation appears to be a better choice than direct regulation by government.

The current self-regulatory complaints handling system for community standards in advertising appears to be working effectively and in the best interests of Australian consumers.

I'll just hand over copies of the report and the summary when we finish.

So how do we do this? Ad Standards operates in accordance with, if not exceeding, international best practice in self-regulation, and we operate in a spirit of continuous improvement. Key elements of best practice include operational independence from the advertising industry in all complaints handling, and complaints about advertising being determined by an independent community panel. In addition, all of our work is designed around the principles of transparency, accessibility, timeliness and robust decision-making. Our role is to deal with complaints received from the community—either individuals or special interest groups—under a number of industry approved codes of practice and initiatives.

In the advertising to children space, Ad Standards considers complaints under the provisions of the AANA food and beverages marketing and advertising code, including part 3, which relates specifically to advertising food to children. We also administer complaints under the AANA advertising to children code, which covers advertising of all children's products, including food, toys, movies, et cetera. We administer both of the Australian Food and Grocery Council's initiatives relating to quick service restaurants and supermarket advertising.

Decisions about whether an ad meets the requirements of the initiatives are made by the Ad Standards Community Panel. This is a panel of 20 members of the community. Panel members do not represent any industry groups or any consumer groups. They are individually and collectively clearly independent of the industry. Panel members reflect a diverse knowledge and experience base. The panel is gender balanced, and members come from a broad range of age groups and backgrounds. It is diverse and as representative of the Australian society as it can be. Details of how the panel is recruited in terms of appointment are in our submission. I'll just hand over the latest composition of the board, which includes our first ever member from Tasmania, which we're very proud to have.

So our system is robust and works well. How do we know that? We know that because we do regular research. There are two ways that we can be sure that what we're doing is meeting the needs of consumers. One is through findings of research, which we conduct annually, and also through the level of community concern that's evidenced through complaint numbers.

Let me quickly talk about research. We're committed to undertaking regular, if not annual, research into whether the decisions of this panel of people align with the views of the broader community. Research findings help us in two ways: they assist the panel itself to calibrate its decisions; and also enable me, as the CEO of Ad Standards, to inform the code owners about any gaps in the codes. In 2007 we conducted a 10-year review of how community panel decisions have aligned with the broader community. We found that, over the 10 years, the community panel decisions either aligned or were not inconsistent with the majority of community opinion 78 per cent of the time. Decisions of our panel aligned directly 51 per cent of the time, with the remaining 27 per cent showing mixed opinion from the community. Of the 22 per cent of times when the community panel was out of odds with community opinion, the community panel was more conservative than the community nine per cent of the time. What this meant was that the community panel made stricter decisions about discrimination and vilification, and health and safety in particular, than the community would have made. On the other side, though, the community was more conservative with decisions in relation to sex, sexuality, nudity and language in advertising.

In 2015 our research focused on advertising to children specifically because we know that this is an issue which comes up. In my 13 years as the CEO, it has come up many times. Findings from our 2015 research report showed that the perceptions of the general public on whether ads complied with the codes were consistent with the board's decision 60 per cent of the time. The public's perception was borderline for two decisions and different from the board's determination for the remaining two. Where the broad community perception was different, the public generally believed that the ads were not directed primarily to children. In fact, where the community and the panel were out of line was generally where the board had actually taken a stricter view in deciding that things were directed to children and therefore had to meet a higher standard.
We also asked the community what they felt were the main factors when determining when an ad is directed primarily towards children or not. What we've found from the community was very much a reflection of the criteria that the community panel already uses. Respondents believed that an ad was more likely to be aimed at children if the ad contained animation, if it featured a child, if it had design elements which would appeal to children—so the colours and the music—or if it had themes which would appeal to children. All of these factors that we've found from the community research were factors that our community panel was already taking into account. So the research really gives us confidence that our community panel is interpreting the codes and the initiatives in the way that the broad community thinks that they should be.

Finally, our complaints statistics demonstrate a low level of community concern about the content of food advertising that children see. From 2013 to 2017, so in the last full five years, 11 per cent of complaints related to food and beverage products. 2,786 complaints related to food ads. Only 180 of those complaints related to the food code or the initiatives. So there was a very low level of concern. Although people may have found things in food ads problematic enough to make them make a complaint, very few of those complaints, 180 over five years, related to issues about the type of food that was being advertised or how it was being advertised to children. In 2017 we received 45 complaints relating to 42 cases under the food codes and the initiatives. Two cases were found to breach the Responsible Children's Marketing Initiative and there were no breaches of the Quick Service Restaurant Initiative or the food and beverage code. We have a record of 100 per cent compliance by food companies where an ad is found to have breached any of the food codes.

We constantly monitor the level of community awareness of our organisation to make sure that the low level of complaint is not an indicator of lack of awareness. In our research last year we found that the likelihood of people complaining to Ad Standards if they have a concern about advertising has increased from 31 per cent in 2006 up to 51 per cent in 2017. However we believe there is still room to improve in terms of understanding of the complaints body and also in terms of understanding the type of complaints that we deal with. So later this year we'll be starting work on a new advertising campaign raising awareness, which will cover all types of media. Our campaign will be appearing across all types of media—social media, online, outdoor, everywhere.

Our view is that the statistics demonstrate a low level of community concern in relation to food and non-alcoholic beverage advertising to children and also about the portrayal of the types of health and nutritional value of such products. It's our position that the dispute resolution mechanism for advertising to children is working effectively and meeting consumer and government needs and that government intervention in this area is not required nor justified. Thank you for your attention. I'm very happy to answer any questions and I will be giving you some interesting things to take away.

CHAIR: Thank you, Ms Jolly. We might start with Senator Singh.

Senator SINGH: I'll start with you, Mr Broome. I understand the AANA put out a press release on 14 May about your amalgamation with the ASB. What was the impetus behind the decision to amalgamate the AANA and the ASB boards? What's that going to achieve?

Mr Broome: That process is still underway. We are midstream at this point in time. I can't speak to exactly how it will end up because that's part of the due process. The reason why we made that announcement is that, as well as the system has worked effectively for the past 20 years since its formation in 1997, we've got to look forward to the next generation. We really are focusing on future-proofing the system for that next generation. As you're aware, the media market is changing fundamentally. We've got to think about being fit for purpose for that next generation, particularly when it comes to funding the system as well, because the funding base of the self-regulatory system is changing the whole time. It's also important for me to state that where independence counts in this system and why it works so well today—and, dare I say, it's best practice in the world; no other self-regulatory system in the world does this—is through the independence of the community panel within Ad Standards. We have members of the public adjudicating complaints given to them by other members of the public. No other place in the world does that.

Senator SINGH: I understand what you're going to there. That's why I wanted to know what will change as a result of the amalgamation.

Mr Broome: Nothing will change in that respect.

Senator SINGH: So code development and complaints administration—no change?

Mr Broome: Code development will remain as is. Administration of complaints will remain exactly as it is today.

Senator SINGH: What about the Advertising Standards Bureau? How will changes be effected there?
Mr Broome: As I said at the beginning, we're still midstream in some of the work that we're doing here. But the separate secretariat that the Ad Standards body is, in basically running the Ad Standards community panel, will still be a function that will exist.

Senator SINGH: So, in terms of the ongoing independence of Ad Standards, will that remain.

Mr Broome: I think it's important to point out that the AANA is the sole member of Ad Standards, and that will remain, going forward.

Senator SINGH: What about in terms of ongoing funding for Ad Standards?

Mr Broome: Ad Standards is funded by advertisers. Advertisers pay a levy on their media budgets, and that money is basically paying for the whole self-regulatory system, be it code administration or complaints resolution.

Senator SINGH: But, in relation to this amalgamation, will there be changes for their funding?

Mr Broome: Not in the sense that advertisers will still basically pay that levy. How we collect that levy, thinking about the media market, is changing over time. For example, a lot more advertisers are now going direct to new technology like Facebook and Google, and they wish to pay the levy through that system, so we're going to have to adapt to that changing environment.

Senator SINGH: Ms Jolly, do you want to comment on how health funding is going to change for Ad Standards under this amalgamation?

Mr Broome: As Mr Broome said, things are still being discussed. My input into the process, as CEO of the body, is that the two key things are that we maintain operations at arm's length of the industry, for the reasons of being able to carry out an impartial role, and also that our work is that the purse strings aren't tightened in a way that would affect the independence of what we think is important to spend money on.

Senator SINGH: Will that remain?

Ms Jolly: That's my input into the process, so I hope so.

Senator SINGH: Right. I just want to get clear, then, when we're talking about this inquiry, in relation to this amalgamation that's going on between these two bodies, how the changes will affect, let's say, the administration of junk food advertising.

Ms Jolly: Ideally, there will be no change. The way the system works is that the complaints come to me and to my team, and we make decisions on how those complaints are processed and we send them to our community panel.

Senator SINGH: But won't there be one board?

Mr Broome: At the end of the day, that's a decision that's got to be made by the boards that we report to. They're still in—

Senator SINGH: But you're amalgamating.

Mr Broome: They're still in the process of going through that. It's very, very difficult. There are two CEOs that are not party to all the conversations the two boards are having, to actually answer your question directly.

Senator SINGH: So, just to clarify, the same board that oversees the body that develops the codes will oversee the body that administers the complaints. Is that correct?

Mr Broome: It already does, to a certain degree, because the AANA is the sole member of Ad Standards. There are advertisers on the board of Ad Standards, alongside other board directors, so there is going to be no fundamental change in the fact that we are a very efficient self-regulatory system administered, paid for and run by advertisers on behalf of the community.

Senator SINGH: But when we're talking about something like junk food advertising, you've got one body that oversees code development and you've got another body that oversees complaints. Now you've got them amalgamating. I can't quite understand how there wouldn't be an effect.

Mr Broome: Specifically for fast-food advertising, the Quick Service Restaurant Initiative, for example, is actually owned by the AFGC. We administer complaints against that code on their behalf, so that won't change.

Senator SINGH: When will this all be decided?

Mr Broome: By the end of the year.

CHAIR: Five per cent of all advertising for food products is digital; is that right?

Mr Broome: Correct, yes.
CHAIR: Are you saying that, in general, in the advertising market, it's now a fifty-fifty split for most products? Is that what I heard from the submission?

Mr Broome: The total ad revenue market is roughly 50 per cent digital and 50 per cent non-digital.

CHAIR: What's going on there? Why is there such a skew towards other avenues as opposed to digital? Free TV, I imagine, is a big part of it.

Mr Broome: It's a huge topic in its own right, but I think one of the key drivers of digital advertising is small business. Large business is still investing in TV, and it's much harder for small business to access TV.

CHAIR: So it's those entry costs, to start with?

Mr Broome: Absolutely correct.

CHAIR: Do you think that's the major reason for it?

Mr Broome: There's a whole host of—

CHAIR: What are some of the other factors? I'm interested to know what's influencing their decision.

Mr Broome: I think, at the end of the day, food companies need to reach mass audiences. Digital, despite the fact that everyone has a mobile phone, is not proven yet to actually deliver mass audiences effectively in terms of a return on the investment. As a result, whereas TV advertising for food companies has definitely declined, we still see them investing in other channels, such as radio, outdoor or print, for example. But what we haven't seen, as we're often accused of, is a mass flight to digital. It's not the case.

CHAIR: But it's interesting that that's used as a defence by people who don't want to see any further restrictions on advertising of junk food. Their argument is, 'You can't regulate here and then have this whole area over in the digital space that's unregulated.' But it's only a very tiny proportion of the market.

Mr Broome: It is regulated because the AANA codes apply to any form of media, irrespective of whether it's digital, TV, outdoor or whatever.

Ms Jolly: In fact, I think nearly 10 per cent of our complaints now come from online and social media—not under these codes, but, generally, 10 per cent of complaints.

CHAIR: One of the witnesses raised earlier today that current restrictions are ineffective because they target a particular time, but, actually, we know that kids are watching programs all hours of the day and night and also through digital access and so on. That sounds to me like an argument to extend it within those times, rather than to defend the status quo, so I want to hear your response to that.

Mr Broome: I think the emphasis must be on having a robust set of codes that ensure responsible advertising and not advertising to children. Because the codes are media channel neutral, I think you can be reassured that, if somebody sees an ad that they believe is targeting children in an inappropriate way, they can make a complaint about it, and that complaint will be heard, irrespective of where that ad is seen.

CHAIR: I can't remember what the actual jargon was, but if they're using a cartoon character, like a fluffy dinosaur or whatever it might be, do you think that's an ad that targets kids?

Senator STORER: A brand equity character.

Ms Jolly: The board has to look at whether an ad is directed primarily to children. The use of a cartoon character can be used in a way that is directed to children or directed to adults or directed in a retro style to 50-year-olds who remember certain cartoon characters from their childhood. So what the community panel has consistently found is that it depends on how it's used in the totality of the ad.

CHAIR: So, there's a distinction—there is a primary audience and there might be a secondary audience here. Is the fact that kids are going to be influenced by that and that is going to have a significant impact on kids a factor in this?

Ms Jolly: I don't know if you can make the assumption that any ad that a kid sees is going to have a profound effect on them.

CHAIR: Well, the industry exists because it has an effect. We can argue the toss about how effective it is. People don't spend money advertising products, particularly through your channels, which are very, very expensive, unless they think they are going to get a decent return on it.

Ms Fair: It's important to remember that during specific children's viewing periods that are designated, and programs directed to children, there are specific rules around the use of such characters, and that at other times where the audience is broader, as I've pointed out in my opening comments, the child audience is actually quite small and they're also watching in the company of adults.
CHAIR: Theoretically.
Ms Fair: That's what the data tells us.
CHAIR: We know that there are going to be kids watching TV not with their parents, well into the night.
Ms Fair: As I've said, only nine per cent of children are watching television during prime time, and of those children the vast majority are watching with an adult. We know that through OzTAM data.
CHAIR: What's the corollary? They're still watching an ad that will influence them and when they're at the supermarket with my mum or dad they'll say, 'I want fluffy dinosaur eggs and the yummy goodies that come with it.' I'm not sure why watching it with a parent actually changes the impact it has on the child.
Ms Fair: Because parents have some responsibility in this whole equation about teaching their children about healthy choices.
CHAIR: I know there are lots of parents who watch TV. I sit down on Friday night and watch the footy with my two boys, who are seven and 10. The reality is that I don't sit down and have a conversation about every ad when there's a game of footy on. I just don't, and most parents don't either. I know we keep hearing—
Ms Fair: No, but when your kids ask for something in the supermarket, what do you say to them?
CHAIR: Okay. However, let's get to the issue of why you decide you're going to restrict it during kids' viewing times and not during other times when you're watching TV. That's the point. Your argument seems to be—and this is what I hear consistently—that you are watching it with a parent and somehow that makes that situation very different, when the reality is that that ad will come on—and mostly the child will be exposed to the ad—and it will have the same impact whether or not the adult is in the room; not always, but often. I'm not sure why we make that distinction. In fact we heard earlier that there are times when kids are watching it without adults and there are times with adults. The notion of a watershed is actually that they're not effective.
Mr Broome: I think it fundamentally goes down to whether you believe parents exercise a degree of control over what their kids consume. We know from our own research amongst parents that they do.
CHAIR: I don't want to be rude—of course they do. That's a separate argument to saying that we're going to put these restrictions on during this time and that we're going to allow them during another time, because the point at which the purchase happens and where that element of control happens—it doesn't matter. Those two things, whether they are watching them on their own or with their parents or with another adult in the room—it doesn't matter.
Mr Broome: I can only say that, judging by the number of complaints that the public are putting through to Ad Standards, which—correct me if I am wrong, Fiona—was something like 120 in the last four years, it is not an issue for the parent in the room.
CHAIR: Again, I know that was the substance of your presentation—and I understand that. But as a parent, if there is an ad that's promoting junk food and targeting children, my view will be it's not—the advertisers have a right to do that; it's the role of policymakers to prevent that. If there were an ad where the content of that ad was inappropriate for kids to be viewing, of course that would be a different question. The fact that people aren't responding to the ads through a complaints mechanism doesn't tell me that they're happy with the fact that kids are being bombarded with these ads. I can tell you—let's put the issue of junk food advertising aside—that, on the question of sports betting, poll after poll demonstrates that most people don't like it. That won't be reflected in specific complaints about individual ads. It's a broader—
Ms Jolly: I'd challenge you on that.
CHAIR: Maybe it will be.
Senator COLBECK: I suspect that it will and it has.
Ms Jolly: It has.
CHAIR: But my point is that you get similar data when you poll people on the question of whether they think there should be junk food ads that kids can watch. They say no. They're not going to put in specific complaints to the advertisers.
Ms Jolly: Can I just pick up on one point that you made. Let me explain that what the codes and initiatives do is provide that the content of ads that are available in core children's viewing time are quite different to the content of ads that appear in family viewing time. So they are different types of ads, and what you'll see in prime time is not ads that are directly targeting children.
CHAIR: I understand the point you're making. I suppose I'm making a slightly different but related point which is that, as a body, you're responsible for responding to a code. That's a separate question to: what impact is advertising having on children, and what is my view of that as a parent?

Mr Broome: I think that is where there is a void in the evidence trail that we need, in the sense that there is no proof of a causal relationship between advertising in the time period that you're talking about and obesity. Obviously, the purpose of advertising is to drive normal consumption, not excessive consumption or unhealthy outcomes.

CHAIR: But is there evidence of a causal link for advertising during children's viewing times?

Mr Broome: There is so little advertising going on in—

CHAIR: My point is: we've got a code that's not based on the fact that there's clear evidence of a causal link but based on, first, a response to a problem where we understand that that advertising is influencing behaviour.

Ms Fair: But there's already a raft of rules around children's viewing times which are about not encouraging unhealthy consumption of foods, around not using certain characters to promote foods, around frequency—

CHAIR: But not during adult viewing times, when children are being—

Ms Fair: I thought you just referred to children's viewing times. There is a difference between family viewing times, where most people would consider that you as a parent have some role in having a conversation with your children about what choices to make—because there's no point pretending in the home that these products don't exist, and everyone walks out onto the street and it's like, 'Wow, that's amazing.' There's a difference between a child being advertised to without any intermediating influence, where there are much stronger rules, and ads where there are parents in the room whose responsibility is bringing up their children in a healthy fashion. And, might I add, there are, unfortunately for us, a very small number of children doing it.

CHAIR: My point was a different one. It was just simply saying that we have a code. We've made a set of decisions not based on empirical evidence of a causation, and we can't use that as justification for not legislating or at least introducing a code in this space—just being consistent, that's all.

Mr Broome: I've got it. I think the only other thing I'd add to that is: are we chasing the wrong horse? If food and beverage advertising is declining by nearly 60 per cent over 12 years and obesity is going the other way, it says to me that there's something else at play here that's having a much, much bigger influence.

CHAIR: There are many factors. We've heard that today. We've heard about many factors.

Mr Broome: I think that, if we think about where the TV audience is going to be in five years time, it's very, very hard to actually imagine what that's going to be. If we legislate today, we could end up with an outcome which is redundant.

Senator PATERSON: Ms Fair, I want to come back to your opening statement and the actual evidence of where children get their entertainment from these days, because I feel as if some of the proposals we've had today about regulating advertising of junk food on free-to-air TV are like they're happening in the 1990s—they haven't realised the massive change in the way that children behave. If you've spent any time with young kids today, you know that primarily they're getting their entertainment from apps on products like iPads that are specifically designed for them. They're watching ABC iview, where there is no advertising at all. They're watching YouTube, where to some extent the advertising that they're supplied is outside the control of the Australian government. Let's just revisit this issue. How many young kids today—no doubt to the regret of your members—are still watching free-to-air TV?

Ms Fair: As I said, only nine per cent of children up to the age of 13 are watching television in prime time.

CHAIR: How many kids is that—how many hundreds of thousands?

Ms Fair: I would have to go and do the calculation, but 91 per cent of children are not watching, and the amount of television that children are watching is around an average of 40 minutes per day. So the studies that we've seen which seem to suggest that children are glued to a television screen from about 9 am to about 10 pm and are therefore exposed to a certain number of ad impressions every day is—I would love that to be the case. Certainly my members would be ecstatic.

Senator PATERSON: Of course, parents are now using streaming services, where you can have complete control over when it's showed, and there's not typically advertising in most of the streaming services that are provided.
Ms Fair: Correct. There's no advertising on Netflix and Stan and other platforms. And the evidence that I referred to in my opening statement comes not from our sector but from ACMA about children's changed viewing habits and their likelihood to be accessing content on the internet and primarily YouTube.

Senator PATERSON: Yes. I would understand this proposal better if it were regarding my childhood, where we did rush home from school to watch cartoons at 3.30, and we probably were exposed to this advertising. I think it worked out okay for us; I'm not too worried. But it just doesn't make any sense in the modern era, and these trends are only going to continue and accelerate, if anything.

Ms Fair: I think that's right. And the other thing is that one of the greatest determinants of your likelihood to be obese is your postcode. We run the same ads across the country, so that says that something else is happening than just the fact that people see ads and mindlessly go out and buy whatever it is that they've been exposed to.

Senator SINGH: But your free-to-air on-demand channels still have ads in the programs.

Ms Fair: The catch-up services?

Senator SINGH: Yes.

Ms Fair: Yes, they do, but very few children access them. As I said, even on our main service, the average child audience for programs directed towards children is now 4,800 people. I could mail them all a DVD and it would be cheaper than putting it on air.

Senator SINGH: But how do you know?

Ms Fair: How do I know?

Senator PATERSON: I guess that answers Senator Di Natale's question about how many kids are watching. It's not hundreds of thousands; it's 5,000.

Senator SINGH: How do you know the percentage of children that are watching the on-demand service?

Ms Fair: Because we measure it. It's less than—

Mr Mitchell: Just to be clear on that: the figure we're giving you on the catch-up of those children's programs is a total audience figure. We can't determine who is watching—

Senator SINGH: No, you can't.

Mr Mitchell: All we can tell you is that it's a six per cent bump on those numbers. So you're talking about 457, which was the average audience of the catch-up C and P programs in 2016.

Ms Fair: Even if all of them are children—

Mr Mitchell: Even if all of them are children, we're talking about 457.

CHAIR: So this is on—I missed it—the catch-up?

Mr Mitchell: The catch-up.

CHAIR: We're not talking free-to-air. We're not talking on free-to-air broadcasting.

Ms Fair: The average increase in audience on our catch-up of C and P programming is six per cent of the total audience.

CHAIR: Yes, but the vast majority of viewers will be watching free-to-air TV and will see their ads not through a catch-up service but live and broadcast through free-to-air.

Ms Fair: Correct.

CHAIR: So we're not talking 5,000.

Ms Fair: And for C and P programming, firstly, in P programming there is no advertising, and in C programming there are very strict rules about the amount, the frequency and the nature of the advertising that can be shown in those programs.

CHAIR: We've heard that. It's really those outside those times.

Ms Fair: I think we would feel very strongly that in family viewing times there should be less strict rules because there are other factors at play.

CHAIR: We've heard that loud and clear. We've also heard a contrary view, and I suppose it's up the committee to deliberate on that evidence.

Ms Fair: And also taking into account the fact that Mr Broome's evidence seems to suggest that something other than advertising is impacting this issue.
CHAIR: Absolutely, and I don't think anyone here would even begin to suggest that advertising is the sole factor or perhaps even the dominant factor. The question is: is it a factor? Is it within the domain of policymakers to influence the rate of obesity?

Senator COLBECK: We have heard a couple of times, Chair, that the big bad food industry businesses who are advertising to our children to take them down an evil path today—I think the quote would be—don't spend the money, because it doesn't work. So there is a bit of a push to try to suggest that. It's good to get some data around that, particularly in the specific categories of process.

My one question to Ms Jolly is around the results of the assessment that you've done. My adding up of what you've told us is that the way that the panel assesses the complaints or the advertisements is that they're agreed with or are more conservative, largely, than where the community would naturally have been.

Ms Jolly: Yes, except in the area of sexualised images.

Senator PATTERSON: There is just one final question from me that will probably need to be taken on notice. Ms Fair, do you have the ratings for children's programs on free-to-air TV?

Ms Fair: Well, I can give you the average audience of children watching children's programs on free-to-air television. It is 4,800.

Senator PATTERSON: 4,800?

Ms Fair: Yes.

Senator PATTERSON: Free-to-air broadcast around Australia, nationally?

Ms Fair: Yes. Eighty per cent of our C and P programs are broadcast to audiences of less than 10,000 children.

CHAIR: Can you define what you mean by 'children's programming'?

Ms Fair: Children's programming that is designated as C and P programming by the ACMA and which we're required to broadcast hundreds of hours of every year.

CHAIR: Well, perhaps we can have a conversation. We might request a little more information on that in terms of what that looks like, what actually sits outside of that and where we're seeing large numbers of ads that might be viewed by children outside those hours. We might come back to you for just a bit more granular information.

Ms Fair: We're happy to provide more data.

CHAIR: Great. Thank you so much for your contribution today. We appreciate it. I want to thank for their cooperation, on behalf of the committee, all of those people who made submissions and sent representatives here today.

Committee adjourned at 17:07