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National Obesity Prevention Strategy
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About this submission

The George Institute for Global Health is pleased to contribute to the public consultation of the National Obesity Preventive Strategy (NOPS).

We welcome the opportunity to further engage with the Working Group of the NOPS and the Department of Health on this important issue.

About The George Institute for Global Health

The George Institute is a leading independent global medical research institute established and headquartered in Sydney. It has major centres in China, India and the UK, and an international network of experts and collaborators. Our mission is to improve the health of millions of people worldwide by using innovative approaches to prevent and treat the world's biggest killers: non-communicable diseases (NCDs) and injury.

Our work aims to generate effective, evidence-based and affordable solutions to the world's biggest health challenges. We research the chronic and critical conditions that cause the greatest loss of life and quality of life, and the most substantial economic burden, particularly in resource-poor settings.

Our food policy team works in Australia and overseas to reduce death and disease caused by diets high in salt, harmful fats, added sugars and excess energy. The team conducts multi-disciplinary research with a focus on generating outputs that will help government and industry deliver a healthier food environment for all.

Acknowledgement of Country

The George Institute acknowledges the Gadigal People of the Eora Nation as the Traditional Custodians of the land on which our Australia office is built, and this submission was written.

We pay our respect to Elders past, present and emerging.

Section 3 – Overarching Concepts

8. Do you agree with the overall approach of the Strategy?

Agree.

The George Institute for Global Health strongly supports the overall approach of the National Obesity Preventive Strategy (NOPS). We are particularly supportive of the guiding principles, objectives, ambitions, and individual strategies in the draft NOPS, and the inclusion of:

- a strong focus on changes to the environment, in particular the food environment;
- strategies that address broader determinants of health, including strategies that address health inequity, and multisectoral actions beyond the health system.

The George Institute, however, believes there are several ways the NOPS could be improved to have greater impact on rates of overweight and obesity, and improve the health of Australians.

To ensure its objectives and ambitions are realised, the NOPS should be accompanied by:

- **Strong targets** that, at a minimum, align with the National Preventive Health Strategy (NPHS).
- A **national governance committee** to oversee implementation of the strategy, with representation from all governments, led by Health Ministers.
- A **national implementation plan** to be developed within six months of the strategy's release and including:
    - agreed evidence-based **actions** for each strategy, with responsibility for each action assigned to federal, state, and territory governments or both, as appropriate.
    - a **timeline** for implementation and reporting, with the strategy's 10-year timeframe divided into blocks at three, six, and nine years.
- A **funding** plan that identifies committed, ongoing, and adequate funding from all governments.
- A **monitoring and evaluation** framework, requiring regular reporting on implementation and outcomes from each jurisdiction and an independent evaluation of impact.
- A process **free from conflicts of interest.**

9. The current title is National Obesity Prevention Strategy. Does the title reflect the content of the Strategy?

Strongly Agree.

The George Institute supports the new title of the strategy, and in line with public health stakeholders, we support the strategy's focus on prevention.

10. The Strategy includes two Guiding Principles outlined on page 11 of the draft. Do you agree with the Guiding Principles?

Equity	Strongly Agree	Agree	Neither agree nor disagree	Disagree	Strongly Disagree	Not relevant to me
Sustainable Development	Strongly Agree	Agree	Neither agree nor disagree	Disagree	Strongly Disagree	Not relevant to me

The George Institute supports the Guiding Principles, with some important additions:

Equity

- Action must be taken to address the disproportionate rates of overweight and obesity within some population sub-groups. The NOPS acknowledges that the '*economic and social barriers that many Australians face make healthy options harder*'. It is important that the NOPS not only acknowledge this but that it includes specific strategies and actions to address it. Society-wide actions are also required across sectors to level the playing field and measures focused on environment and systems changes should be prioritised.

- The strategy and the implementation plan must prioritise strategies and actions that will have most impact on ensuring this guiding principle is honoured. Evidence outlined in the 2019 review informing the NOPS' development shows that:
    - actions that focus solely on education and behaviour change are likely to have a negative impact on equity, although these actions may play an important role in supporting systems and environment changes, and
    - policies that change the structural conditions and daily living conditions should be prioritised.

Sustainable development

The George Institute supports the objective of sustainable development, particularly in the context of environmental protection and social equity. It is important that short term economic growth is not be a barrier to evidence-based action that will improve long term public health and environmental outcomes.

Where economic impact is considered in a policy or regulatory context, this must be assessed broadly, and include assessment of the economic impact of poor diet, overweight, and obesity and the cost-effectiveness of intervention. Economic impacts of any interventions that affect the food industry must be considered across all sectors. For example:

- There is evidence that there will be no loss of jobs if sugary drinks taxes or/and marketing restrictions are introduced – just shifts in the types of jobs [1, 2, 3].

- Some interventions will have a positive economic effect on the food industry as well as benefiting health. For example, economic modelling suggests a $10 million marketing spend per year would deliver an increase in vegetable consumption of around 0.5 serves per person, per day within five years. This would confer significant economic benefits to growers and retailers, and reduce government expenditure on health by an estimated $100 million per year ($60.7 million to the Commonwealth Government and $39.2 million to the states and territories) [4].

The NOPS recognises the importance of sustainable development as a guiding principle of the Sustainable Development Goals (SDGs) but provides few actions to ensure this is prioritised throughout the strategy. The SDGs should be leveraged more explicitly throughout the NOPS and all 17 SDGs should be used to guide the NOPS strategies. For example, actions that address the food system can have multiple benefits for SDG health and environmental goals.

The NOPS must also explicitly identify climate change as having major implications for sustainable development. Its omission neglects a key pillar of sustainable development that will have impacts on rates of overweight and obesity in the near and long term, particularly in the context of a warming planet and strained health systems.

References:

[1] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4025719/
[2] https://www.sciencedirect.com/science/article/pii/S0091743517303249
[3] Parajea. G., Colchero. A., Wlasiukc. J.M., Sota. A.M., Popkin. B.M. The effects of the Chilean food policy package on aggregate employment and real wages. Food Policy. 2021;100
[4] Deloitte Access Economics, The impact of increasing vegetable consumption on health expenditure. 2016, Hort. Innovation Limited: Melbourne.

11. The Strategy includes a high-level Vision outlined on page 12 of the draft. Do you agree with the Vision?

Strongly Agree.

The George Institute strongly supports the Vision of the NOPS.

12. The Strategy includes a Target outlined on page 12 of the draft. Do you agree with the Target?

Disagree.

The George Institute recommends one target is not adequate and will not capture all relevant factors that contribute to the objectives and ambitions of the draft NOPS. Additional targets should be included and, at a minimum, should align with those listed on page 48 of draft NPHS in relation to improving access to and the consumption of a healthy diet and increasing physical activity, including changing the current NOPS target to not only halting the rise of obesity by 2030, but also reversing this trend by that date.

The George Institute recommends strengthening the NPHS targets further in some areas by:

- Including a sub-target for the NPHS target around reducing the proportion of total energy intake from discretionary foods: **Reduce the consumption of ultra-processed foods to <20% of total energy intake.** Ultra-processed foods should be defined in accordance with the NOVA food processing classification system. These foods are known to have harmful impacts on health, including an increased risk of obesity, and on the environment. See our response to question 14 for more detail.

- Amending the target for breastfeeding to be: **50% of babies are exclusively breastfed until around 6 months of age by 2025**. This would align this target with the National Breastfeeding Strategy [1] and international best practice guidance from the World Health Organization, both of which aim for exclusive breastfeeding until 'around 6 months of age'.

References:

[1] Australian National Breastfeeding Strategy: 2019 and Beyond. COAG Health Council 2019

13. The Strategy includes five Objectives outlined on page 12 of the draft. Do you agree with the Objectives?

More supportive and healthy environments	Strongly Agree	Agree	Neither agree nor disagree	Disagree	Strongly Disagree	Not relevant to me
More people eating healthy food and drinks	Strongly Agree	Agree	Neither agree nor disagree	Disagree	Strongly Disagree	Not relevant to me
More people being physically active	Strongly Agree	Agree	Neither agree nor disagree	Disagree	Strongly Disagree	Not relevant to me
More resilient systems, people, and communities	Strongly Agree	Agree	Neither agree nor disagree	Disagree	Strongly Disagree	Not relevant to me
More accessible and quality support for people	Strongly Agree	Agree	Neither agree nor disagree	Disagree	Strongly Disagree	Not relevant to me

The George Institute strongly supports these objectives, with some additional amendments:

- We recommend the detail of the first objective explicitly state that more supportive and healthy environments require reducing the availability of unhealthy foods and drinks in these environments, not only increasing healthier options.

- We recommend changing the second objective from 'more people eating healthy food and drinks' to 'more people having healthy eating patterns', as this will better capture the reduced consumption of unhealthy food and drink, as well as increased consumption of healthy food and drinks. It also better reflects the Australian Dietary Guidelines and their emphasis on a wide variety of foods, in their optimal serve size and number of serves.

- We recommend changing the third objective from 'more people being physically active' to 'more people being physically active and less sedentary' as this will capture the need for people to be both more physically active and less sedentary.

14. Are there any Objectives missing?

Yes. In line with other public health stakeholders, The George Institute recommends the inclusion of an additional objective: **More people reducing their consumption of unhealthy food and drinks.**

The NOPS notes that 'unhealthy food and drinks are convenient, can cost less, are aggressively promoted and are available almost everywhere'. To change population diets in any meaningful way, the NOPS must include an objective to reduce the availability and consumption of unhealthy foods and drinks.

A stand-alone objective is required to reduce the consumption of unhealthy food and drinks to give sufficient attention to the impact these unhealthy food and drinks have on rates of overweight and obesity, and poor health outcomes. A focus on increasing consumption of healthy food is not sufficient.

We note the definition of 'unhealthy food and drinks' in the NOPS states these are also called discretionary foods and are those foods that are not necessary for healthy diet and are too high in fat and/or added sugars, added salt, kilojoules, or alcohol or low in fibre, as described in the current Australian Dietary Guidelines (ADGs). The ADGs are currently under review, and The George Institute recommends that review consider and incorporate emerging evidence on the role that level of processing plays in the influence of food on health, particularly overweight and obesity.

The NOVA classification system is a food classification system that categorises foods by the nature, extent, and purpose of industrial food processing. Ultra-processed foods represent the highest level of food processing. These products are designed to be hyper-palatable, affordable, and convenient and are often marketed intensively [1]. Ultra-processed foods have known adverse health and environmental impacts, including increased risk of obesity [2,3], cardiovascular disease, cancer, type-two diabetes, and all-cause mortality [4-7], greenhouse gas emissions, deforestation, bio-diversity loss, food waste, increased land clearing, and water use [8,9].

The George Institute recommends the definition of unhealthy food and drinks in the NOPS include all ultra-processed foods and aligns with the ADGs as and when they are updated.

References:

[1] Monteiro CA, Cannon G, Levy RB, Moubarac J-C, Louzada ML, Rauber F, et al. Ultra processed foods: what they are and how to identify them. Public health nutrition. 2019;22(5):936-41.

[2] Machado PP, Steele EM, Levy RB, da Costa Louzada ML, Rangan A, Woods J, Gill T, Scrinis G, Monteiro CA. Ultra-processed food consumption and obesity in the Australian adult population. Nutrition & diabetes. 2020 Dec 5;10(1):1-1.

[3] Livingston, A.S., Cudhea, F., Wang, L., Steele, E.M., Du, M., Wang, Y.C., Pomeranz, J., Mozaffarian, D., Zhang, F.F., 2021. Effect of reducing ultraprocessed food consumption on obesity among US children and adolescents aged 7–18 years: evidence from a simulation model. BMJ Nutrition, Prevention & Health bmjnph-2021-000.. doi:10.1136/bmjnph-2021-000303

[5] Elizabeth L, Machado P, Zinöcker M, Baker P, Lawrence M. Ultra-Processed Foods and Health Outcomes: A Narrative Review. Nutrients. 2020;12(7):1955.

[6] Srour B, Fezeu LK, Kesse-Guyot E, Allès B, Méjean C, Andrianasolo RM, et al. Ultra-processed food intake and risk of cardiovascular disease: prospective cohort study (NutriNet-Santé). bmj. 2019;365.

[7] Rico-Campà A, Martínez-González MA, Alvarez-Alvarez I, de Deus Mendonça R, de la Fuente-Arrillaga C, Gómez-Donoso C, et al. Association between consumption of ultra-processed foods and all-cause mortality: SUN prospective cohort study. bmj. 2019;365.

[8] Chen X, Zhang Z, Yang H, Qiu P, Wang H, Wang F, et al. Consumption of ultra-processed foods and health outcomes: a systematic review of epidemiological studies. Nutrition journal. 2020;19(1):1-10.

[9] Nguyen H. Sustainable Food Systems Concept and Framework. Food and Agriculture Organization of the United Nations: Rome, Italy. 2018.

[10] Rockström J, Steffen W, Noone K, Persson Å, Chapin III FS, Lambin E, et al. Planetary boundaries: exploring the safe operating space for humanity. Ecology and society. 2009;14(2).

15. The Strategy includes three Ambitions outlined on page 12 of the draft. Do you agree with the Ambitions?

All Australians live, learn, work, and play in supportive and healthy environments.	Strongly Agree	Agree	Neither agree nor disagree	Disagree	Strongly Disagree	Not relevant to me
All Australians are empowered and skilled to stay as healthy as they can be.	Strongly Agree	Agree	Neither agree nor disagree	Disagree	Strongly Disagree	Not relevant to me

All Australians have access to early intervention and primary health care.	Strongly Agree	Agree	Neither agree nor disagree	Disagree	Strongly Disagree	Not relevant to me

The George Institute strongly supports these three ambitions. We strongly support the focus on creating environments that promote health, especially changes to food and social environments. We particularly support ambitions that have an overarching focus on health, rather than representing nutrition and physical activity as separate, distinct, and competing foci. This symbiotic relationship is key for those who will need to implement the actions. Nutrition and physical activity do not sit separately in most of the relevant systems targeted in this document and both are key for impacting obesity.

16. The Strategy includes three Enablers outlined on page 12 and pages 42-44 of the draft. Do you agree with the Enablers?

Lead the way	Strongly Agree	Agree	Neither agree nor disagree	Disagree	Strongly Disagree	Not relevant to me
Better use of evidence and data	Strongly Agree	Agree	Neither agree nor disagree	Disagree	Strongly Disagree	Not relevant to me
Invest for delivery	Strongly Agree	Agree	Neither agree nor disagree	Disagree	Strongly Disagree	Not relevant to me

The George Institute supports the Enablers, with some important additions:

Lead the way:

The George Institute strongly supports the need for 'strong national leadership and accountability'. The NOPS must recognise the importance of strong leadership from the Australian Government, including the Prime Minister and the Federal Minister for Health, as well as from state and territory governments. The Australian Government must visibly and strongly support and fund the strategy and preventive health more generally to enable meaningful change nationally. It is vital that all governments across Australia commit to the strategy and prioritise its implementation. To enable and oversee this, The George Institute recommends the establishment of a national governance committee, with membership from the Commonwealth and State and Territory Governments, led by Health Ministers. See our response to question 25 for more detail.

The George Institute strongly supports the need for 'collaborative government leadership across sectors' and recommends the adoption of a new stand-alone enabler of a 'health-in-all-policies approach' to reflect the importance of cross-sectoral, collaborative action. This enabler should be reflected throughout the NOPS and its implementation plan, ensuring that public health is considered when developing or implementing government policy in all areas. This is consistent with the NPHS – where one of the policy achievements is that "a health lens is applied to all policy through ongoing, cross-sectoral partnerships, led by the health sector, at all levels of governments, to address the determinants of health" by 2030.

The George Institute recommends the NOPS also ensure supporting documents, policies, and regulations are developed using a process free from conflicts of interest. The George Institute recommends the World Health Organization principles for safeguarding against actual, perceived, and potential conflicts of interests [1] should be used across all aspects of the NOPS implementation. Similar principles about the need for good governance in health policymaking are also reflected in the National Health and Medical Research Council Guidelines for Guidelines that provide steps to both declare and manage conflicts of interest in health policymaking in Australia [2].

References:

[1] Safeguarding against possible conflicts of interest in nutrition programmes: draft approach for the prevention and management of conflicts of interest in the policy development and implementation of nutrition programmes at country level: report by the Director-General (who.int)

[2]https://www.nhmrc.gov.au/guidelinesforguidelineshttps://www.nhmrc.gov.au/guidelinesforguidelines]

Better use of evidence and data

The George Institute strongly supports Enabler 2 and the investment in national co-ordination for sustained data collection and use. Specific targeted funding for Enabler 2 should be outlined in the implementation plan for the NOPS. The George Institute recommends Enabler 2 include data sovereignty as a key feature of this work.

There is also a need for accountability by food companies, including the need for companies to regularly share data (on their products and sales) to support mandatory reporting of key indicators related to health and environmental sustainability of food systems, enable analysis of trends over time, and evaluate the impact of policy measures.

The George Institute recommends a searchable database of evidenced-based, scalable programs and strategies is developed and made available for public health agencies, communities, and services (as has been done by the National Cancer Institute in US www.ebccp.cancercontrol.cancer.gov/index.do). Funding should be prioritised for the implementation of evidenced-based scalable approaches.

Invest for delivery

The George Institute strongly supports investment to deliver the NOPS, both in terms of financial investment and in building a skilled, well-resourced workforce.

In relation to funding, The George Institute recommends the NOPS be accompanied by an implementation plan developed within six months (from November 2021) by a National Governance Committee, with membership from the Commonwealth and each state and territory government, led by Health Ministers. This implementation plan must include a detailed funding plan that identifies committed, ongoing, and adequate funding from all governments. Funding commitments from each level of government need to be identified for each element of the strategy, and for monitoring and evaluation.

The George Institute strongly supports enablers 3.1 and 3.2, to explore new funding mechanisms and investigate ways of shifting economic policies, subsidies, investment, and taxation systems to more strongly benefit healthy eating and active living, positive health outcomes, communities, and the environment.

Evidence shows that population-level interventions to improve diet and reduce overweight and obesity are very cost-effective, with the vast majority being cost-saving in the longer term [1]. Investment in these cost-effective interventions represents an opportunity for governments to save costs as well as improve health outcomes [1].

The George Institute strongly recommends the introduction of a sugar-sweetened beverages levy (SSB levy) by the Australian Government, with revenue from the levy then used to supplement funding for evidence-based actions under the NOPS. A SSB levy would provide a significant revenue source for the Australian Government, estimated at between $400 and $642 million annually [1]. The SSB levy is also predicted to reduce healthcare spending. A 2018 analysis of cost-effective policies to tackle Australia's obesity epidemic by Deakin University identified that a health levy on sugary drinks would save the Australian Government $1.7bn in total healthcare cost offsets, whilst costing relatively little (~$11.8m) to implement [2].

References:

[1] Veerman JL, Sacks G, Antonopoulos N, Martin J, "The impact of a tax on sugar-sweetened beverages on health and health care costs; a modelling study", (2016) PloS One, 11(4), Duckett, S., Swerissen, H. and Wiltshire, T. 2016, A sugary drinks tax: recovering the community costs of obesity, Grattan Institute. Lal A Mantilla-Herrera AM, Veerman L. Backholer K, Sacks G, Moodie M, Siahpush M, Carter R, Peeters A. (2017) Modelled health benefits of a sugar sweetened beverage tax across different socioeconomic groups in Australia: a cost-effectiveness and equity analysis. PLOS Med 14(6).

[2] Ananthapavan J, Sacks G, Brown V, Moodie M, Nguyen P, Barendregt J, Veerman L, Mantilla Herrera A, Lal A, Peeters A, Carter R. Assessing cost-effectiveness of obesity prevention policies in Australia 2018 (ACE-Obesity Policy). Melbourne: Deakin University, 2018.

17. Are there any Enablers missing?

Yes. The George Institute recommends two additional enablers should be included:

- Policy to **safeguard against conflicts of interest -** we recommend the World Health Organization principles for safeguarding against actual, perceived, and potential conflicts of interests in nutrition policies [1] should be used across all aspects of the NOPS. Similar principles about the need for good governance in health policymaking

are also reflected in the National Health and Medical Research Council Guidelines for Guidelines that provide steps to both declare and manage conflicts of interest in health policymaking in Australia [2].

References:

[1] Safeguarding against possible conflicts of interest in nutrition programmes: draft approach for the prevention and management of conflicts of interest in the policy development and implementation of nutrition programmes at country level: report by the Director-General (who.int)]

[2] https://www.nhmrc.gov.au/guidelinesforguidelines

- **Health in all policies approach** – we recommend making sure public health is a consideration when developing government policy in all areas and at all levels of government (e.g. planning, transport, agriculture, education) and that workforce development supports the skills needed for successful multisectoral action. This is consistent with the NPHS, where one of the policy achievements is that “a health lens is applied to all policy through ongoing, cross-sectoral partnerships, led by the health sector, at all levels of governments, to address the determinants of health” by 2030.

Section 4 – Ambition 1 – All Australians live, learn, work and play in supportive and healthy environments

18. Ambition 1 Strategies are outlined on pages 15-28 of the draft. Do you agree with the Strategies in Ambition 1?

Strategy 1.1 Build a healthier and more resilient food system.	Strongly Agree	Agree	Neither agree nor disagree	Disagree	Strongly Disagree	Not relevant to me
Strategy 1.2 Make sustainable healthy food and drinks more locally available.	Strongly Agree	Agree	Neither agree nor disagree	Disagree	Strongly Disagree	Not relevant to me
Strategy 1.3 Explore use of economic tools to shift consumer purchases towards healthier food and drink options.	Strongly Agree	Agree	Neither agree nor disagree	Disagree	Strongly Disagree	Not relevant to me
Strategy 1.4 Make processed food and drinks healthier by supporting reformulation.	Strongly Agree	Agree	Neither agree nor disagree	Disagree	Strongly Disagree	Not relevant to me
Strategy 1.5 Make healthy food and drinks more available and accessible and improve nutrition information to help consumers.	Strongly Agree	Agree	Neither agree nor disagree	Disagree	Strongly Disagree	Not relevant to me
Strategy 1.6 Reduce exposure to unhealthy food and drink marketing, promotion and sponsorship especially for children.	Strongly Agree	Agree	Neither agree nor disagree	Disagree	Strongly Disagree	Not relevant to me
Strategy 1.7 Build more connected and safe community spaces that inspire people of all ages, abilities and cultures to engage in regular physical activity.	Strongly Agree	Agree	Neither agree nor disagree	Disagree	Strongly Disagree	Not relevant to me

Strategy 1.8 Grow participation in walking, cycling, public transport, active recreation and sport by minimising cost and access barriers.	Strongly Agree	Agree	Neither agree nor disagree	Disagree	Strongly Disagree	Not relevant to me
Strategy 1.9 Build the capacity and sustainability of the sport and active recreation industry.	Strongly Agree	Agree	Neither agree nor disagree	Disagree	Strongly Disagree	Not relevant to me
Strategy 1.10 Enable school and early childhood education and care settings to better support children and young people to build a positive lifelong relationship with healthy eating and physical activity.	Strongly Agree	Agree	Neither agree nor disagree	Disagree	Strongly Disagree	Not relevant to me
Strategy 1.11 Enable workplaces to better support the health and wellbeing of their workers.	Strongly Agree	Agree	Neither agree nor disagree	Disagree	Strongly Disagree	Not relevant to me
Strategy 1.12 Enable government agencies, care facilities, tertiary and training institutions, sporting and recreation facilities, and community organisations to lead the way by supporting breastfeeding, providing access to healthy food and drinks, and encouraging more physical activity.	Strongly Agree	Agree	Neither agree nor disagree	Disagree	Strongly Disagree	Not relevant to me

The George Institute recommends in all strategies the language is strengthened around the actions by calling them 'recommended actions' instead of 'example actions'.

Strategy 1.1 and Strategy 1.2

The George Institute strongly supports strategies 1.1 and 1.2, however we recommend they are combined and renamed: '*Build a healthier and more equitable and sustainable food system in Australia that promotes equitable local availability of healthy and sustainable foods and drinks*'.

This would reflect that 'making sustainable healthy food and drinks more locally available' (current strategy 1.2) is a function of 'building a healthier and more resilient food system'

(current strategy 1.1) and cannot be seen as an independent strategy. We also think the focus should be on the system being 'equitable' and 'sustainable' into the future rather than 'resilient' as this reflects the NOPS guiding principles.

This strategy would:

- favour the production, processing, and distribution of healthy and sustainable food and drinks
- improve food systems while protecting land, sea, and biodiversity and reducing waste
- implement land use planning and urban design, drive community agriculture initiatives, and strengthen Aboriginal and Torres Strait Islander traditional food systems.

We support the example actions from both strategies 1.1 and 1.2 and these should all be retained.

In particular, The George Institute strongly supports the following actions and recommends they are strengthened as follows:

- Funding and encouraging innovation to shift industries that produce and use unhealthy commodities towards healthy food uses and/or new non-food markets. We note this must not be about encouraging minimal reformulation of ultra-processed food.
- Increasing access to local healthy food and drinks in residential areas through land use planning and policy. This action should be amended to include reducing access to unhealthy food and drinks, as well as increasing access to healthy food. It should be focused on implementing changes to planning regulation and urban design to reduce the density and impact of unhealthy food and drink outlets. This should include consideration of proximity to schools and other children's settings.

The George Institute also supports the following additional actions in this strategy area:

- National Nutrition Strategy – The George Institute recommends the development of a contemporary framework that integrates current and new guidelines and programs, including the Australian Dietary Guidelines (under review), Nutrient Reference Values, and food labelling initiatives (including the Health Star Rating system), with relevant taxes, laws, and monitoring systems. This will address the cost and prevalence of diet-related chronic diseases, meet the nutritional needs of people experiencing inequities, and improve food and nutrition security, sustainability, social equity, and productivity [1].
- The George Institute recommends an increase in federal agricultural subsidies to whole fruit and vegetable producers. Evidence suggests that there could potentially be large health benefits for the Australian population and large benefits in reducing health sector spending on the treatment of non-communicable diseases as a result [2].
- The George Institute recommends the implementation of mandatory reporting (with associated indicators) for companies operating in the food system regarding their impact on population and planetary health, including their efforts to improve the nutritional quality and environmental sustainability of food systems.
- The George Institute recommends the strategy define the food system to specify that it includes the charitable food relief sector that redistributes food donations and food waste to people experiencing food insecurity who are at increased risk of obesity and experience a disproportionate health impact. Food system changes need to be

applied to the charitable food relief sector, with benchmarking of nutritional quality of food provision followed by building a healthier and more resilient sector that can support people in times of need with appropriate nutritious foods.

References:

[1] Public Health Association Australia, Dietitians Australia, Nutrition Australia, Heart Foundation. National Nutrition Strategy background paper. 2021. Available from: https://dietitiansaustralia.org.au/voice-of-daa/advocacy/call-for-a-new-national-nutrition-policy/

[2] Cobiac LJ, Tam K, Veerman L, Blakely T (2017) Taxes and Subsidies for Improving Diet and Population Health in Australia: A Cost-Effectiveness Modelling Study. PLoS Med 14(2): e1002232. https://doi.org/10.1371/journal.pmed.1002232

Strategy 1.3:

The George Institute strongly supports this objective. The George Institute recommends the word 'implement' is used in the strategy heading rather than 'explore' to reflect that there is now sufficient international and Australian evidence for the implementation of economic measures to curb intake of unhealthy foods and drinks [1, 2, 3, 4, 5]. It is also important that the focus is on reducing the affordability and consumption of unhealthy food and drinks and not just shifting purchases towards healthier food and drink options and making them more affordable.

In remote Aboriginal communities there is evidence and active examples of economic and marketing measures in place to shift consumers towards healthier food and drink purchases, including Healthy Stores 2020 policy actions, $1 dollar water initiatives and across store fruit and vegetables subsidisation. At their core, initiatives must be underpinned by self-determination and acknowledge Aboriginal and Torres Strait Islander understanding of food and water systems, allowing for safe and genuine two-way knowledge transfer.

Additional actions for this strategy should be added:

- An SSB levy to increase price by at least 20% should be specifically included as an additional action.
- Regulation of grocery pricing in regional and remote Australia to reduce the cost of fruit and vegetables and increase the cost of unhealthy food and drinks to support healthy eating.
- Restrict temporary price reductions (e.g., half-price, multi-buys) on unhealthy food and drink products.

In relation to the examples of actions listed in strategy 1.3 we note the following:

- We explicitly support retaining the GST exemption on healthy foods as noted in the examples of actions. The economic, social, and environmental payback to invest to lift Australia's low vegetable consumption is compelling. There is a strong evidence base for sustained, collaborative effort:
    - A 10% increase in vegetable consumption would reduce annual health expenditure in Australia on certain cancers and cardiovascular diseases alone by $100 million [6]
    - That is, 10% of national average 2.5 serves = 0.25 serve or 18.75g of vegetables

- The George Institute recommends strengthening wording around a sugary drinks tax to 'implement' rather than 'investigate' policy approaches. Policy options in this space are already very clear. We also suggest removing the words ‘while minimising impacts on disadvantaged Australians’ - evidence suggests the benefits are stronger for disadvantaged Australians (for both SSB and food taxes) [5].
- The George Institute recommends including an action that prohibits the use of price promotions, including multi-buy offers on unhealthy foods and beverages.

References:

[1] Cobiac, LJ, Tam, K, Veerman, L & Blakely, T 2017, ‘Taxes and Subsidies for Improving Diet and Population Health in Australia: A Cost-Effectiveness Modelling Study’, PLoS medicine, vol. 14, no. 2.
[2] Teng, A.M., Jones, A.C., Mizdrak, A., Signal, L., Genç, M. and Wilson, N., 2019. Impact of sugar-sweetened beverage taxes on purchases and dietary intake: Systematic review and meta-analysis. *Obesity Reviews*, *20*(9), pp.1187-1204.
[3] Brimblecombe, J., Ferguson, M., Chatfield, M.D., Liberato, S.C., Gunther, A., Ball, K., Moodie, M., Miles, E., Magnus, A., Mhurchu, C.N. and Leach, A.J., 2017. Effect of a price discount and consumer education strategy on food and beverage purchases in remote Indigenous Australia: a stepped-wedge randomised controlled trial. The Lancet Public Health, 2(2), pp.e82-e95.
[4] Passos, C. M. D., et al. (2020). "Association between the price of ultra-processed foods and obesity in Brazil." Nutrition, Metabolism and Cardiovascular Diseases 30(4): 589-598.
[5] https://journals.plos.org/plosmedicine/article/authors?id=10.1371/journal.pmed.1002326
[6] Deloitte Access Economics 2016.

Strategy 1.4:

Unhealthy food and drinks make up a disproportionate amount of the Australian diet [1]. Reformulation can be used as a tool to reduce the negative impact of processed food on our health. While efforts to reduce harmful nutrients in processed foods are necessary and have the potential to confer health benefits, they will also be insufficient to improve dietary health if overall dietary patterns remain high in unhealthy food and drinks, particularly ultra-processed foods. This is because epidemiological and experimental studies indicate that an ultra-processed diet may increase risks for obesity and related diseases in ways that extend beyond the nutritional composition of the foods consumed [2,3].

The George Institute supports mandatory reformulation and compositional limits to improve the nutrient profile and serving size of processed foods and reduce energy and nutrients of concern including salt and sugar.

Given lack of any demonstrable efficacy, we do not support ongoing investment in initiatives such as the Healthy Food Partnership that rely on voluntary buy-in from industry. Nearly six years after it was created, there is little evidence the Partnership is operating in accordance with best-practice recommendations [4]. Reformulation targets took more than five years to agree, apply to a narrow range of product categories, and are so weak that even if met by all manufacturers would not make a significant impact on population health [5,6,7,8]. Similar voluntary reformulation initiatives in the United Kingdom have also failed to show meaningful effects, except for a limited window between 2010-2013 when there was a credible political threat to make targets mandatory. It is now time that Australia adopted a mandatory approach.

We do NOT support the following example actions included in the draft NOPS:

- Working in partnership with industry on reformulation targets, for the reasons set out above that there is no evidence base for efficacy of this strategy.
- Increasing the nutrient density of unhealthy food and drinks through using vegetables, legumes or wholegrain cereals in food service and retail settings, for the reasons outlined in the opening paragraph that if these foods remain ultra-processed this effort is likely of limited utility to population health. Australians need to eat more of these foods from whole and minimally processed food sources.

We support the following example actions, with some amendments:

- Work with the food regulation system to set mandatory compositional limits for the amount of nutrients of concern (such as added sugar, salt, and harmful fats) that can be used in certain processed foods and drinks in both retail and food service settings. In the area of salt reduction, these limits could draw on recent publication by WHO of global sodium targets for a wide range of categories.
- Regulation to set maximum serving sizes of unhealthy food and drinks in food service and retail settings, particularly items designed for children.

We support the following additional actions:

- Regulation to set compositional limits for harmful sugar in packaged infant and toddler foods and for sodium in toddler foods.
- Development of a target to reduce ultra-processed foods as a proportion of the food supply as part of efforts to improve the nutritional quality of diets alongside reformulation efforts.

References:

[1] Australian Bureau of Statistics. 4364.0.55.012 - Australian Health Survey: Consumption of Food Groups from the Australian Dietary Guidelines, 2011-12. 2016. http://www.abs.gov.au/ausstats

[2] Machado, Priscila & Martinez Steele, Euridice & Levy, Renata & Louzada, Maria Laura & Rangan, Anna & Woods, Julie & Gill, Tim & Scrinis, Gyorgy & Monteiro, Carlos. (2020). Ultra-processed food consumption and obesity in the Australian adult population. Nutrition & Diabetes. 10. 1-11. 10.1038/s41387-020-00141-0.

[3] Elizabeth L, Machado P, Zinöcker M, Baker P, Lawrence M. Ultra-Processed Foods and Health Outcomes: A Narrative Review. Nutrients. 2020; 12(7):1955. https://doi.org/10.3390/nu12071955

[4] Jones, A., Magnusson, R., Swinburn, B. et al. Designing a Healthy Food Partnership: lessons from the Australian Food and Health Dialogue. BMC Public Health 16, 651 (2016). https://doi.org/10.1186/s12889-016-3302-8

[5] Rosewarne, E.; Huang, L.; Farrand, C.; Coyle, D.; Pettigrew, S.; Jones, A.; Moore, M.; Webster, J. Assessing the Healthy Food Partnership's Proposed Nutrient Reformulation Targets for Foods and Beverages in Australia. Nutrients 2020, 12, 1346. https://doi.org/10.3390/nu12051346

[6] Trieu, K., Coyle, D. H., Afshin, A., Neal, B., Marklund, M., & Wu, J. H. (2021). The estimated health impact of sodium reduction through food reformulation in Australia: A modeling study. PLoS Medicine, 18(10), e1003806.

[7] Coyle DH, Shahid M, Dunford EK, Ni Mhurchu C, Scapin T, Trieu K, Marklund M, Chun Yu Louie J, Neal B, Wu JHY. The Contribution of Major Food Categories and Companies

to Household Purchases of Added Sugar in Australia. J Acad Nutr Diet. 2021 Aug 20:S2212-2672(21)00413-5. doi: 10.1016/j.jand.2021.06.013. Epub ahead of print. PMID: 34446399.

[8] Coyle D, Shahid M, Dunford E, Ni Mhurchu C, Mckee S, Santos M, Popkin B, Trieu K, Marklund M, Neal B, Wu J. Estimating the potential impact of Australia's reformulation programme on households' sodium purchases. BMJ Nutr Prev Health. 2021 Jan 12;4(1):49-58. doi: 10.1136/bmjnph-2020-000173. PMID: 34308112; PMCID: PMC8258059.

Strategy 1.5:

Key barriers to healthy eating patterns are the overrepresentation of unhealthy food and drinks on supermarket shelves and the misleading marketing of these products as healthy options on product labels. It is essential that food and drink labelling accurately represents the healthiness of products. Accurate and transparent information on food labels is important in facilitating informed consumer choice. It also has potential to incentivize manufacturers to improve the formulation of their products and/or discontinue less healthy offerings.

The information and example actions under Strategy 1.5 currently reference nutrition information specifically. We believe it is important to extend information on healthiness of products beyond the current focus on specific nutrients to include information on the level of processing of foods. We anticipate that evidence in this area will be reviewed and incorporated into the updated Australian Dietary Guidelines.

Accessibility and availability of healthy food and drinks are core components of food security, which is an ongoing issue in regional and remote Australia [1], and a growing issue across the country in the midst of the COVID-19 pandemic [2,3]. Ensuring food security for all people in Australia is essential for health promotion and obesity prevention, and to meet Australia's international obligation to Sustainable Development Goal 2 [4].

The George Institute supports the following existing actions, with some amendments as follows:

- Actions related to implementing advisory labels for unhealthy ingredients such as added sugar, salt, harmful fats, and alcohol. We also suggest that beyond ingredients or nutrients, new health evidence shows that the degree of processing of the food could also be used as a basis for requiring an advisory label on the front of packaging, for example on ultra-processed foods.
- Increased prominence, promotion, and availability of healthy food and drinks in food retail, however this must be strengthened to also include reducing the prominence, promotion, and availability of unhealthy food and drinks in food retail. This can encompass measures including limiting the placement of unhealthy food and drinks in supermarkets (at checkouts, ends of aisle, etc.) and limits on promoting price promotions (for example, large signs and displays highlighting discounts on unhealthy food and drinks), as well as removing shelf-space allocation differences between socioeconomic areas. This action must also be government led and mandatory and should be amended to reflect this.
- Consistent national menu labelling regulation.

The George Institute recommends additional actions for Strategy 1.5:

- Mandatory adoption of the Health Star Rating, and continued commitment to further review of the Health Star Rating algorithm to ensure it remains up to date with evolving nutrition science. This should include the implementation of progressively stricter thresholds for ratings under the system.
- Strengthen regulation of nutrition content claims and health claims on food to extend nutrient profiling to products carrying nutrition content claims and replace industry self-substantiation and notification processes with an independent review process. Alcoholic products should also be prohibited from carrying any nutrition content claims.
- Review and update of the Nutrient Profiling Scoring Criteria (used to assess eligibility of products to display nutrition content and health claims) to consider level of processing.
- Regulation of infant formula and toddler milk marketing.
- Regulation for labelling and promotion of infant and toddler foods.
- Extend the remit of food labelling regulation to improve the display of product information in online settings including food retail and food services.
- Technological innovations, like drone delivery, will make food and alcohol delivery cheaper, faster, and more convenient. Appropriate regulatory approaches need to be implemented proactively prior to widescale use of new delivery methods.

References:

[1] Understanding food insecurity in Australia CFCA Paper No.55. Australian Institute of Family Studies. 2020 (aifs.gov.au)
[2] Food Bank Hunger Report 2020 FB-HR20.pdf (foodbank.org.au)
[3] Food Bank Hunger Report 2021 Foodbank Hunger Report 2021 - Foodbank Reports
[4] Goal 2 | Department of Economic and Social Affairs (un.org)

Strategy 1.6:

The George Institute strongly supports a strategy to protect children from unhealthy food marketing. The strategy and recommended actions must focus on government regulation to protect children from unhealthy food marketing in all areas of their lives. Industry codes in Australia have been shown on numerous occasions to be ineffective in achieving public health benefits. Government regulation at a federal level is needed, with an independent monitoring system and strong sanctions for breaches. We support a strengthening of language throughout this section, including ‘prohibiting’ rather than ‘reducing’ and ‘regulate’ rather than ‘work with’.

The following key actions must be included to implement this strategy effectively:

- Protect children from digital marketing by restricting all digital marketing of unhealthy food, including during sports broadcasts. User controls will not be effective.
- Ensure public spaces and events are free from unhealthy food marketing, including public transport, public outdoor spaces, education, healthcare, sporting and recreation facilities, cultural institutions, and sporting and other events (including sponsorship).
- Introduce time-based restrictions for television, radio, and cinema (including online/digital services) from 6am to 9.30pm.

- Prevent processed food companies targeting children, including through sending or displaying marketing directly to children, using techniques or features that appeal to children (prizes, games, characters etc., including on product packaging), or marketing in places or media that are primarily for children. This should include prohibiting promotions of unhealthy food and drinks when using devices that appeal to children like toys and games.
- Introduce a government-led regulatory approach to monitoring of advertising and marketing in all settings, including effective monitoring and enforcement systems and sanctions.

We strongly support the introduction of restrictions on temporary price reductions and promotions, and this should be extended to capture the placement of unhealthy food (such as at checkouts, ends of aisle) and the promotion of price promotions (for example, large signs and displays highlighting discounted unhealthy foods) within retail environments and equivalent online. We also support regulation to stop companies targeting particular individuals or population groups with more unhealthy food marketing.

We support some of the current example actions, subject to the following changes/comments:

- The first action should be amended to say: *Introduce government regulation to restrict unhealthy food and drink advertising during peak television viewing times for children by introducing a time-based restriction from 6am to 9.30pm.'*

- The second action should be amended to say: *'Restrict unhealthy food and drink marketing in public places and at public events, including on public transport and at sporting and other major events'*. The current framing of reducing prominence and visibility is not strong enough.

  We note there is an action under the 'adults' section that is framed around reducing unhealthy food marketing on publicly-owned or managed settings and promoting healthy lifestyles instead. We do not support that action, as marketing must be restricted, not reduced. Promoting healthy lifestyles is important, but the priority should be removing unhealthy food marketing. Similarly, we do not support the action to 'reduce unhealthy food and drink sponsorship and marketing at sport and major community events' -- this marketing must be restricted, not reduced.

- The third action should be amended to say: '*Restrict marketing and promotional activity that use any feature or technique that is likely to appeal to children, including toys, games, characters and prices*'. This must include brand marketing and apply to product packaging and promotional activity, as well as other forms of marketing.

- The fourth action around marketing of breastmilk substitutes should be strengthened to refer to implementing regulation, instead of policies. We note the National Breastfeeding Strategy's recommendation to 'review regulatory arrangements for restricting the marketing of breastmilk substitutes' [1].

- We do not support the introduction of user controls or parental controls to limit exposure to digital marketing of unhealthy food. This is not likely to be effective. Instead, what is needed is to restrict all digital marketing of unhealthy food.

References:

[1] Australian National Breastfeeding Strategy: 2019 and Beyond. COAG Health Council 2019

Strategy 1.7

The George Institute recommends this strategy be reframed to reflect that active transport networks, recreation/sport infrastructure, and natural environments are in fact all 'spaces'. This strategy should also enable the creation of conditions to facilitate active transport and the design of communities to ensure activities of daily living (e.g. shopping) are within walkable/cyclable distances.

Strategies 1.7-1.9

The George Institute recommends that these strategies reflect key agreed documents like the World Health Organization Global Action Plan on Physical Activity [1] and the Heart Foundation Blueprint for an Active Australia [2]. These documents provide specific and actionable strategies that have already been committed to and are well aligned with the objectives of the NOPS.

For example, the Global Action Plan on Physical Activity includes 20 policy actions across 4 strategic objectives (create active societies, create active environments, create active people, create active systems). Example policy actions include:

- Strengthen pre- and in-service training of professionals, within and outside the health sector, to increase knowledge and skills related to their roles and contributions in creating inclusive, equitable opportunities for an active society including, but not limited to, the sectors of: transport, urban planning, education, tourism and recreation, sports and fitness, as well as in grassroots community groups and civil society organisations.
- Improve the level of service provided by walking and cycling network infrastructure, to enable and promote walking, cycling, other forms of mobility involving the use of wheels (including wheelchairs, scooters, and skates), and the use of public transport, in urban, peri-urban, and rural communities, with due regard for the principles of safe, universal, and equitable access by people of all ages and abilities
- Enhance provision of, and opportunities for, more physical activity programmes and promotion in parks and other natural environments (such as beaches, rivers, and foreshores), as well as in private and public workplaces, community centres, recreation and sports facilities, and faith-based centres, to support participation in physical activity by all people of diverse abilities.

References:

[1] https://apps.who.int/iris/bitstream/handle/10665/272722/9789241514187-eng.pdf

[2] https://www.heartfoundation.org.au/getmedia/6c33122b-475c-4531-8c26-7e7a7b0eb7c1/Blueprint-For-An-Active-Australia.pdf

Strategy 1.10

There is strong evidence around the health and economic benefit of early intervention, particularly the first 2000 days, [1] yet this strategy focuses almost entirely on school-aged children and predominantly on education settings. The George Institute recommends evidence on the first 2000 days is incorporated and actions added to support this.

The following key actions must be included to implement this strategy effectively:

- implementation of evidence-based programs for families and early childhood education and care (ECEC) settings to promote healthy eating (including breastfeeding) and physical activity from the start of life
- training of ECEC and maternal and child health workforce
- regulations to ensure ECEC settings provide healthy and sustainable food and physical activity environments.

We strongly support the action to 'establish whole-of-school/facility policies and practices to support healthy behaviours and skills (for example, incorporating movement across the day, healthy school canteens and childcare menus, healthy fundraising)'. This must be government led and implemented through mandatory government policy or regulation, and effectively monitored and enforced.

References:

[1] Hayes, A., Chevalier, A., D'Souza, M., Baur, L., Wen, L.M. and Simpson, J. (2016), Early childhood obesity: Association with healthcare expenditure in Australia. Obesity, 24: 1752-1758. https://doi.org/10.1002/oby.21544

Strategy 1.11

The George Institute support this strategy and its example actions, however to have the most impact we recommend these measures must be government led so that workplaces are resourced and supported to take action that is monitored and evaluated.

Strategy 1.12

The George Institute supports this strategy but recommends it be strengthened to clearly include the reduction of unhealthy food and drinks as well as increasing availability of healthy food and drinks. As the NOPS notes, the majority of respondents to the 2019 community consultation survey wanted to reduce exposure of unhealthy options in the community.

The George Institute recommends this strategy be strengthened to clarify that these organisations must be required to reduce the availability and promotion of unhealthy food and drinks through mandatory government policy or regulation, and not only through voluntary measures.

19. Are there any Strategies missing in Ambition 1?

The George Institute supports all strategies under Ambition 1, however, they must also specifically call out the need to reduce the availability, affordability, and consumption of

unhealthy food and drinks. Both an increase in healthy food consumption and a decrease in unhealthy food consumption are needed for the draft NOPS objectives and ambitions to be met.

Section 5: Ambition 2 - All Australians are empowered and skilled to stay as healthy as they can be

20. Ambition 2 Strategies are outlined on pages 29-36 of the draft. Do you agree with the Strategies in Ambition 2?

Strategy 2.1 Improve people's knowledge, skills and confidence.	Strongly Agree	Agree	Neither agree nor disagree	Disagree	Strongly Disagree	Not relevant to me
Strategy 2.2 Use sustained social marketing.	Strongly Agree	Agree	Neither agree nor disagree	Disagree	Strongly Disagree	Not relevant to me
Strategy 2.3 Enable parents, carers and families to optimise healthy child development and lifelong healthy habits for children and adolescents.	Strongly Agree	Agree	Neither agree nor disagree	Disagree	Strongly Disagree	Not relevant to me
Strategy 2.4 Engage and support young people to embed healthy behaviours as they transition to adulthood.	Strongly Agree	Agree	Neither agree nor disagree	Disagree	Strongly Disagree	Not relevant to me
Strategy 2.5 Engage and support local communities and organisations to develop and lead their own healthy eating and physical activity initiatives.	Strongly Agree	Agree	Neither agree nor disagree	Disagree	Strongly Disagree	Not relevant to me

Strategy 2.6 Support targeted actions that enhances active living and healthy food and drink opportunities within priority populations.	Strongly Agree	Agree	Neither agree nor disagree	Disagree	Strongly Disagree	Not relevant to me
Strategy 2.7 Enable and empower priority populations to have the same opportunities as others by supporting relevant sectors to reduce the structural and social barriers.	Strongly Agree	Agree	Neither agree nor disagree	Disagree	Strongly Disagree	Not relevant to me

The George Institute recommends in all strategies the language is strengthened around the actions by calling them 'recommended actions' instead of 'example actions'.

Strategy 2.1

The George Institute supports the existing actions for this strategy. The George Institute recommends regular updating of the Australian Dietary Guidelines (ADGs), and that this process be completed free from commercially conflicted interests. The ADGs must be reviewed regularly to ensure they reflect the most current evidence on healthy eating patterns. The current review of the ADGs must consider and incorporate the emerging evidence on the role that level of processing plays in the influence of food on health, particularly in terms of overweight and obesity. It should also incorporate review of the evidence of environmental sustainability of different dietary patterns.

The George Institute recommends an additional action to support physical literacy. This should ensure provision of physical literacy programs for children commencing in the early childhood period and throughout the school years, as well as continued support for physical literacy throughout life. These should align with Sport Australia's Physical Literacy Statement and Framework [1].

The George Institute recommends in the second action, alcohol is included in the list of areas where guidelines need to be kept current, based on evidence and free from conflicts of interest.

It is important that strategies, approaches, and programs used to change people's knowledge, skills, and confidence are evidenced based and can be scaled up within existing service delivery systems. Criteria should be developed to define 'evidenced-based' and 'scalable' programs/strategies and these should be prioritised for implementation. Development of a database of evidenced-based scalable programs/strategies should be

made available for public health agencies, communities, and services (the National Cancer Institute in US has created a database like this which could be used as an example [2]).

References:

[1] https://www.sportaus.gov.au/__data/assets/pdf_file/0019/710173/35455_Physical-Literacy-Framework_access.pdf
[2] www.ebccp.cancercontrol.cancer.gov/index.do]

Strategy 2.2

We strongly support the development of comprehensive, effective, sustained social marketing campaigns to raise awareness and educate the community to support behaviour change. These campaigns should be well funded by governments to support sustained, comprehensive implementation and should be based on robust evaluation frameworks to evaluate campaign messaging and impact. The George Institute recommends the strategy be amended to reflect the capacity of social marketing campaigns to support and shift behaviour change, as well as facilitate and increase public support for changes made to the environment, such as food labelling reform.

Strategy 2.3

While the strategy recognises the benefits of investing in early intervention, government funding has not shifted towards greater investment in this area.

There is need for sustained investment in integrated early childhood services, designed and delivered in a way that promotes health equity. This is critical: while the prevalence of childhood obesity appears to have plateaued in the past decade or more, this has not occurred in those experiencing social disadvantage.

Strategy 2.4

The George Institute strongly supports this strategy to engage and support young people to embed healthy behaviours as they transition to adulthood. The George Institute recommends expanding upon the consideration of environmental sustainability to explicitly recognise the role of global warming on rates of overweight and obesity. As global temperatures rise, healthy behaviours including physical activity and healthy food consumption will be impacted. It is crucial the NOPS recognize the impacts of global warming and establish a commitment to developing future scenarios planning that incorporates addressing overweight and obesity within recommended actions.

Strategy 2.7

The George Institute strongly supports this strategy to reduce the structural and social barriers that create inequities in health and weight. Addressing these barriers through structural interventions that change people's daily living conditions are fundamental to prevent obesity across the socioeconomic gradient and for those experiencing social and/or economic deprivation.

A 2019 evidence review that informed the development of the NOPS highlighted key social determinants of health that are associated with healthy weight, including socioeconomic

status, support during the early years of life, access to green space and paths, working conditions, and social participation [1]. The evidence review identified many effective interventions that influence the structural environment, daily living conditions, and community and school settings that can improve physical activity and weight-related outcomes, stating: 'Evidence exists to support interventions that target improvements to welfare, education, early childhood development, transport access, community infrastructure, and community engagement.'

The George Institute recommends the adoption of key actions to address those key areas, in addition to the existing action related to affordable housing. Actions should include:

- Increasing length of time in school.
- Creating comprehensive early childhood education initiatives, including by providing long-term, sustainable funding for universal access to two years of early childhood education (ECE) and scaling up of evidence-based integrated models of ECE. Integrated ECE models provide a soft entry point to early intervention and needed services and reduce stigma.
- Improving the provision of food and rent subsidy programs.
- Strategies to promote community engagement and inclusivity to support social participation. These actions need to be designed, implemented, and evaluated collaboratively with communities and their leadership to ensure they are culturally centred and meet community needs.
- Introducing a health and wellbeing principle as part of local government decision-making when considering land use planning and zoning permissions.
- Improving provision of and access to public transport.
- Providing holistic school programs and parenting skills programs. These should focus on supporting parental, child, and adolescent mental and physical health by implementing and/or scaling up evidence-based home visiting and pre- and postnatal support programs for priority population families and equivalent programs available to families of older children in ECEs, schools, and other community settings.
- Adjusting minimum wage levels and social protection floor according to regularly costed healthy foods and diets.
- Taxation policy focused on reducing income inequality.
- Governments acknowledge, legitimise, and support Aboriginal and Torres Strait Islander peoples, in policy, legislation, and programs that support and prioritise autonomy and self-determination.
- Protections for remote and regional communities most at risk, including:
    - Adjustment of social security payments and remote area allowances
    - Energy security initiatives
    - Strengthening of The Australian Drinking Water Guidelines and State and Territory legislation for drinking water quality to ensure sufficient access to high quality, palatable drinking water.

References:

[1] 2020.01_Addressing-the-social-factors-behind-overweight-and-obesity_Sax-Institute-Evidence-Brief.pdf (saxinstitute.org.au)

21. Are there any Strategies missing in Ambition 2?

These strategies under Ambition 2 are all important but unless implemented alongside strategies in Ambition 1 will only have limited effect and widen inequities.

Section 6: Ambition 3 - All Australians have access to early intervention and primary health care

22. Ambition 3 Strategies are outlined on pages 37-41 of the draft. Do you agree with the Strategies in Ambition 3?

Strategy 3.1 Enable access to primary health care and community-based practitioners and services in the community and at home.	Strongly Agree	Agree	Neither agree nor disagree	Disagree	Strongly Disagree	Not relevant to me
Strategy 3.2 Increase clarity and uptake of models of care and referral pathways that focus on the individual.	Strongly Agree	Agree	Neither agree nor disagree	Disagree	Strongly Disagree	Not relevant to me
Strategy 3.3 Support health, social and other care services to enable positive discussion about weight.	Strongly Agree	Agree	Neither agree nor disagree	Disagree	Strongly Disagree	Not relevant to me
Strategy 3.4 Strengthen the confidence and competence of the primary health care workforce to prioritise the prevention of obesity.	Strongly Agree	Agree	Neither agree nor disagree	Disagree	Strongly Disagree	Not relevant to me

Comments on Ambition 3 Strategies

The George Institute recommends in all strategies the language is strengthened around the actions by calling them ‘recommended actions’ instead of ‘example actions.

Strategy 3.1

The George Institute recommends the inclusion of Aboriginal and Torres Strait Islander health workers in paragraph one and suggests the following wording: “Health professionals—including doctors, nurses, midwives, Aboriginal Health Workers, and allied health (such as dietitians, psychologists, physiotherapists, exercise physiologists)”.

A whole-of-health approach is the standard for other diseases and health conditions, including mental health and eating disorders; nothing less is required for obesity. An evidence-based and person-centred framework for obesity prevention, management, and treatment will allow healthcare services and healthcare professionals to do fulfil their functions effectively.

While it is appropriate to focus the current strategy on prevention, early intervention, and primary care, the strategy must be clear in not perpetuating false dichotomies between prevention and treatment that already undermine the delivery of health and support services to Australians in obesity care and beyond. The forthcoming treatment strategy will need to build on and be aligned with this prevention-focused document, with an implementation plan backed by sustained funding commitments.

Updating the National Clinical Guidelines is a critical step to support an integrated approach to obesity across the health system.

Strategy 3.2

The George Institute supports this strategy to enable risk assessment and management of risk factors as many Australians are unaware they are living with a high risk of chronic disease, including obesity. Much disease burden could be prevented by reducing and managing risk factors, including overweight and obesity, unhealthy diets, and physical inactivity through primary care, community programs, and referrals to allied health professionals. However, embedding prevention in the health system requires funding reform to proactively support health professionals to assess and manage risk, as well as evidence-based risk assessment tools, adequate training, and strong referral pathways to risk management programs and allied health professionals.

The strategy must prioritise person-centric, transdisciplinary, integrated, and effective models of care for children and adults living with overweight and obesity. Since no single approach to weight management will work for all, a suite of evidence-based, targeted, stepped-approach options to treat and support people with overweight and obesity must be made available.

Multidisciplinary management interventions led by teams spanning primary care, obstetrics, pediatrics, specialists, nursing, midwifery, nutrition and dietetics, psychology, and others should be designed and funded to work together to support integrated, effective, and cost-effective models of care.

Models of care and treatment pathways for people with overweight and obesity must consider opinions of Australians with lived experience of these conditions, including their experience of weight stigma, to ensure that all care is person-centered, appropriate, and implementable.

The George Institute support, the existing actions and recommend, the inclusion of the following additional actions:

- Introduce specific item numbers under the Medicare Benefits Schedule for obesity management. This should cover appropriate weight assessment and examination for

common complications as well as an item for chronic disease management that can cover both physical and psychological support.
- Increase the availability and intensity of services and referral pathways for population groups experiencing higher levels of overweight and obesity.
- Increase the availability and intensity of multi-disciplinary pediatric weight management services, including in rural and remote communities.
- Specialised referral and management pathways, such as these for children and adults with impaired glucose tolerance and type 2 diabetes, should also be considered.

Strategy 3.3

We support efforts to reduce stigma and weight bias across the health care system, and also across the entire community. It remains commonplace for people in the community and those working in healthcare to hold strongly negative views about people living with obesity that impact on people's perceptions, judgment, behaviour, and decision-making [1,2]. We agree that stigma can prevent people from seeking health care and it can impact on the quality of care they receive [2].

Health care providers are currently ill-equipped to prevent and manage obesity, presenting challenges for patients seeking assistance. One way to address the challenges of stigmatizing individuals living with overweight and obesity is to recognise the many complex drivers of obesity, such as underlying biological causes that are exacerbated by an obesogenic environment and social disadvantage that can accumulate across generations.

The George Institute recommends actions should include:

- Educating practitioners on the genetic, environmental, biological, psychological, and social contributors to weight gain and loss that have been shown to improve practitioners' attitudes about people with obesity. Education should include examination of the detrimental effects of weight stigma in health care [2, 3].
- Training practitioners to use respectful language and exhibit zero-tolerance for weight discrimination in clinical settings. This will include training practitioners to use communication that is person-centred and condition-focused rather than weight-focused [3].
- Incorporating competency assessments for health care practitioners to demonstrate stigma-free practice competency [4].
- Incorporating appropriate infrastructure for the care and management of people with obesity into all health care facilities [4].

References:

[1] Jackson SE. Obesity, weight stigma and discrimination. Journal of Obesity and Eating Disorders. 2016 Jun 20;2(3).

[2] Phelan SM, Burgess DJ, Yeazel MW, Hellerstedt WL, Griffin JM, van Ryn M. Impact of weight bias and stigma on quality of care and outcomes for patients with obesity. obesity reviews. 2015 Apr;16(4):319-26.

[3] Palad CJ, Yarlagadda S, Stanford FC. Weight stigma and its impact on paediatric care. Current opinion in endocrinology, diabetes, and obesity. 2019 Feb;26(1):19.

[4] Rubino F, Puhl RM, Cummings DE, Eckel RH, Ryan DH, Mechanick JI, Nadglowski J, Salas XR, Schauer PR, Twenefour D, Apovian CM. Joint international consensus statement for ending stigma of obesity. Nature medicine. 2020 Apr;26(4):485-97.

23. Are there any Strategies missing in Ambition 3?

The George Institute strongly supports all strategies under Ambition 3 which all contribute to the prevention of overweight and obesity. We also support the need for primary care to shift towards prevention, risk assessment, and management of risk to help people stay well for longer (and potentially halt and reverse disease progression). However, unless implemented alongside the strategies listed in Ambition 1, they will only have limited effect and potentially widen inequities.

24. What do you think are the 5 most important Strategies and the 5 least important Strategies, considering all Strategies across each of the 3 Ambitions, to address overweight and obesity? Please select 5 only in each column.

	5 most important strategies **# of organisations that have indicated they will include in TOP 5 as @ 27/10/2021**	**5 least important strategies**
Strategy 1.1 Build a healthier and more resilient food system.	**TOP 5** **9**	
Strategy 1.2 Make sustainable healthy food and drinks more locally available.	**TOP 5** **9**	
Strategy 1.3 Explore use of economic tools to shift consumer purchases towards healthier food and drink options.	**TOP 5** **13**	
Strategy 1.4 Make processed food and drinks healthier by supporting reformulation.	**1**	
Strategy 1.5 Make healthy food and drinks more available and accessible and improve nutrition information to help consumers.	**TOP 5** **8**	

Strategy 1.6 Reduce exposure to unhealthy food and drink marketing, promotion and sponsorship especially for children.	**TOP 5** **9**	
Strategy 1.7 Build more connected and safe community spaces that inspire people of all ages, abilities and cultures to engage in regular physical activity.	**2**	
Strategy 1.8 Grow participation in walking, cycling, public transport, active recreation and sport by minimising cost and access barriers.	**1**	
Strategy 1.9 Build the capacity and sustainability of the sport and active recreation industry.		
Strategy 1.10 Enable school and early childhood education and care settings to better support children and young people to build a positive lifelong relationship with healthy eating and physical activity.	**2**	
Strategy 1.11 Enable workplaces to better support the health and wellbeing of their workers.		
Strategy 1.12 Enable government agencies, care facilities, tertiary and training institutions, sporting and recreation facilities, and community organisations to lead the way by supporting breastfeeding, providing access to healthy food and drinks, and encouraging more physical activity.		
Strategy 2.1 Improve people's knowledge, skills and confidence.	**1**	
Strategy 2.2 Use sustained social marketing.	**2**	
Strategy 2.3 Enable parents, carers and families to optimise healthy child development and lifelong healthy habits for children and adolescents.	**1**	

Strategy 2.4 Engage and support young people to embed healthy behaviours as they transition to adulthood.		
Strategy 2.5 Engage and support local communities and organisations to develop and lead their own healthy eating and physical activity initiatives.	**1**	
Strategy 2.6 Support targeted actions that enhances active living and healthy food and drink opportunities within priority populations.		
Strategy 2.7 Enable and empower priority populations to have the same opportunities as others by supporting relevant sectors to reduce the structural and social barriers.	**TOP 5** **13**	
Strategy 3.1 Enable access to primary health care and community-based practitioners and services in the community and at home.	**2**	
Strategy 3.2 Increase clarity and uptake of models of care and referral pathways that focus on the individual.	**3**	
Strategy 3.3 Support health, social and other care services to enable positive discussion about weight.		
Strategy 3.4 Strengthen the confidence and competence of the primary health care workforce to prioritise the prevention of obesity.	**1**	

We have selected six strategies in our top 5. This is to reflect that we recommend that strategies 1.1 and 1.2 are combined into one (see our response to question 18).

The George Institute recommend the NOPS must prioritise the implementation and funding of those strategies and actions that are supported by the strongest evidence base. Those strategies and actions will have the most significant impact on reducing overweight and obesity and improving diets across the population. We know that the strategies and actions that will have the most significant impact are those that will create environment and systems change, addressing the food, physical, and health environments to bring meaningful change. Strategies must also address social and commercial determinants of health. This is supported by the evidence review completed in 2019 to inform the development of the

NOPS. It is also clear that interventions that change the environment are likely to have a positive impact on equity.

Although The George Institute strongly recommend a focus on policy and regulation to change the food system as the key priority of this strategy, we consider that all the included strategies have an important role to play as part of a comprehensive set of interventions and should remain in the final strategy. We do not support the removal of any strategy.

Section 7: Making it happen

25. Part 4 Making it happen is outlined on pages 45-46 of the draft. Do you have any comments on Part 4 Making it happen?

Along with public health colleagues, The George Institute is concerned the model of flexible implementation as outlined does not present a committed pathway to ensure the strategy is fully implemented at a national level. While we support the ability of governments to tailor implementation to the local context and to build on policies in place or under development, this must be done under a collaborative national approach to implementation that establishes agreed actions and commitments to timely implementation that will lead to significant change at a population level.

A collaborative national approach to implementation should involve:

- a **national governance committee** - established to oversee the implementation of the strategy (the Committee). The Committee must have representation from the Commonwealth and each State and Territory government and be led by Health Ministers to reflect the breadth of the ambitions of the NOPS.
- a **national implementation plan** to be put together by the Committee, in consultation with key stakeholder groups, and signed onto by each jurisdiction within 6 months of the strategy's release. The implementation plan must include:
    - agreed evidence-based **actions** for each strategy, with responsibility for each action assigned to federal, state, and territory governments or both, as appropriate.
    - a **timeline** for implementation and reporting, with the strategy's 10-year timeframe divided into blocks at 3, 6 and 9 years.
    - a **funding** plan that identifies committed, ongoing, and adequate funding from all governments. Funding commitments from each level of government need to be identified for each strategy and action and for monitoring and evaluation.
- a **monitoring and evaluation** framework, requiring regular reporting on implementation and outcomes from each jurisdiction and an independent evaluation of impact. The framework should allow for adjustments to the implementation plan(s) based on new evidence and advances in technology. The monitoring framework should include mandatory reporting of key indicators related to health outcomes, environmental sustainability of the food system, and food industry data.
- a process **free from conflicts of interest.** The George Institute recommends the World Health Organization principles for safeguarding against actual, perceived, and potential conflicts of interests [1] should be used across all aspects of the NOPS. Similar principles about the need for good governance in health policymaking are also reflected in the NHMRC Guidelines for Guidelines that provide steps to both declare and manage conflicts of interest in health policymaking in Australia [2].

The strategy must also aim to work with communities, particularly Aboriginal and Torres Strait Islander communities, to ensure successful implementation. The strategy must include measures to ensure it is meeting the Closing The Gap priority reforms working with communities, including working with communities, sharing relevant data and information to set and monitor the implementation of efforts.

The George Institute recommends the wording in paragraph four under 'monitoring progress' is adjusted to reflect Indigenous data sovereignty. Suggested wording: "Strategy achievements and progress will be monitored using change indicators from the AIHW's 'A framework for monitoring overweight and obesity in Australia' and will incorporate principles of Indigenous data sovereignty [3]".

The George Institute recommends the wording in the second last paragraph under 'monitoring progress' is modified to recognise cultural determinants. Suggested wording: "The AIHW framework also recognises the need to assess health inequalities and social and cultural determinants of health to inform policies, programs and services."

References:

[1] Safeguarding against possible conflicts of interest in nutrition programmes: draft approach for the prevention and management of conflicts of interest in the policy development and implementation of nutrition programmes at country level: report by the Director-General (who.int)

[2] https://www.nhmrc.gov.au/guidelinesforguidelines

[3] https://www.aigi.com.au/wp-content/uploads/2019/10/Communique-Indigenous-Data-Sovereignty-Summit-1.pdf

26. Do you have any additional comments on the draft Strategy?

The George Institute welcomes the development of the National Obesity Prevention Strategy. We believe it to be an important tool in reducing rates of overweight and obesity and improving the health of Australians. Key recommendations to improve the NOPS are:

- The Strategy must align with the NPHS as far as possible and must represent a position that is at least equal to, or stronger than, the actions, targets, outcomes, and funding mechanisms set out in the NPHS. These two important strategies must complement and support each other.

- The Strategy and the implementation plan must prioritise those strategies and actions that are supported by the strongest evidence. Interventions recommended by the evidence review must be given priority, with a focus on systems and environment change to achieve significant change at a population level, as well as actions to address social determinants of health and reduce health inequity. Given significant recent history of policies with laudable objectives but limited impact in their voluntary form, including the Healthy Food Partnership and Health Star Rating system, it is important that where evidence suggests that mandatory implementation is necessary for public health impact that this evidence is followed.

- The strategy overall is focused on increasing availability and consumption of healthy food, with limited focus on reducing availability and consumption of unhealthy food.

The strategy must be refocused to give equal or greater priority to reducing availability and consumption of unhealthy food. Both are important and although related, should be distinct goals.

- The definition of unhealthy food should be broader than the current NOPS definition linked to the 'discretionary food' definition in the Australian Dietary Guidelines. The Australian Dietary Guidelines are currently under review, with recent work by NHMRC already highlighting that this term is not 'fit-for-purpose'. We expect the current review to consider and incorporate the emerging evidence on the role that level of processing plays in the influence of food on health, particularly overweight and obesity. Outcomes, targets, strategies, and actions should be considered in terms of their application to ultra-processed foods.

- The language throughout the strategy should be strengthened, including a change from 'example actions' to 'recommended actions'. Many strategies and actions use language that does not indicate an intention or commitment to act, including words such as 'explore' or 'investigate'. This wording should be strengthened to 'implement' or similar. This is particularly the case where the strategy or action is already supported by a substantial evidence base.

The top level of the document does a good job of taking a broad health focus and recognising the importance of multiple influences in the prevention of obesity. This is less well reflected in the strategies, with many dichotomised into food-focused or physical activity-focused silos. Ensuring the implementation plan takes an inclusive health focus will be important to ensuring those tasked with implementation can most efficiently and effectively undertake the actions. For example, local communities will want to consider addressing active transport systems alongside local food systems.

- The glossary should include a definition of Indigenous data sovereignty to reflect the needs and community identified priorities of First Nations peoples. Indigenous Data Sovereignty is a global movement concerned with the right of Indigenous peoples to govern the creation, collection, ownership and application of their data [1].

References:

[1] Kukutai, T. and Taylor, J. eds. 2016. Indigenous Data Sovereignty: Towards an Agenda (Vol. 38) ANU Press

The George Institute congratulates the Working Group on the development of the National Obesity Prevention Strategy. We look forward to reviewing the next iteration of the NOPS and participating in the development of its implementation.

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