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**Submission from the Dietitians Association of Australia  
House of Representatives Standing Committee on Health and Ageing  
Inquiry into Obesity in Australia**

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The Dietitians Association of Australia (DAA) commends the Standing Committee for their inquiry into obesity in Australia and welcomes the opportunity to make a submission. DAA is Australia's largest professional nutrition organisation, representing over 3500 members. DAA is the leader in nutrition and has made addressing overweight and obesity a priority for the association.

DAA's role is to advocate for broad public health responses to the prevention and management of overweight and obesity, to provide accurate and practical information to Australians and support members in this area of their professional practice. This role reflects the DAA Mission: *supporting members, and advocating for better food, better health, better living for all.*

DAA manages the only credentialing program for dietitians in Australia, this is the Accredited Practising Dietitians Program (APD) with 93% of eligible DAA members being Accredited Practising Dietitians (APDs) who are recognised professionals with the qualifications and skills to provide expert nutrition and dietary advice. APDs have sound university qualifications accredited by DAA, undertake ongoing training and education and comply with the Associations guidelines for best practice. They are committed to the DAA *Code of Professional Conduct* and *Statement of Ethical Practice*, and to providing quality service.

DAA believes poor nutrition and physical inactivity are the risk factors for obesity that need to be better recognised as the fundamentals for obesity prevention. While it is appropriate that the Committee recognise that we have an obesity epidemic, we also have a major issue in Australia in relation to malnutrition. Therefore it is important to ensure that activities to address obesity are sufficiently sophisticated and evidence based so has not to have a detrimental effect on other nutrition issues in the population.

DAA argues that APDs have a strong role to play in both the prevention of overweight and obesity, across all age groups and effective management of overweight and obesity, across all

age groups. APDs are uniquely placed to comment on obesity issues as we work across the entire continuum of care. DAA members working in a range of practice areas including research and education, public health nutrition, clinical dietetics and private practice contributed to the development of this submission. DAA would welcome the opportunity to present in person to the committee at a public hearing.

## **Executive Summary**

**Accredited Practising Dietitians (APDs) are the recognised experts in nutrition, from the prevention of nutrition related illness to nutritional management of overweight and obesity, in all settings and across all age groups<sup>1,2</sup>.**

APD is the only national credential recognised by the Australian Government (for Medicare and Department of Veterans Affairs rebates) and most private health funds, providing a quality standard for nutrition and dietetics services in Australia. APDs provide a pivotal role in the management of overweight and obesity. They have unique skills in individualising a dietary assessment and plan, in demonstrating empathy and identifying practical strategies when addressing client motivation, goal setting and risk factor identification as well as in management, incorporating specific strategies to assist clients in achieving long term lifestyle change in liaison with GPs and other members of the multidisciplinary health care team<sup>2</sup>.

**DAA is advocating for better access to APDs for individuals and community groups and improved resourcing for effective public health level nutrition interventions.**

Access to APDs, in either a group or individual setting, for those who are overweight or obese is limited due to the current insufficient capacity of the public sector. There is capacity for growth in the private sector but further incentives are required. A recent survey conducted by researchers at Monash University<sup>3</sup> found dietitians believed the current scheduled rebate does not allow adequate time to manage chronic conditions under EPC.

**DAA strongly recommends that overweight and obesity are recognised as chronic diseases and that the EPC guidelines be changed so that treatment of obesity is made specific under the item and the maximum visits to an APD allowed is increased to 12 visits per annum.**

There is a structural issue for individual services in relation to the Enhanced Primary Care (EPC) Plan supported through Medicare Australia. Currently Medicare's EPC plan only allows up to 5 visits to allied health professionals per annum, including APDs. Overweight and obesity are not currently recognised as chronic diseases, so Australians without a co-morbidity cannot even access the relevant individual or group EPC items. Of particular concern, considering the new four year old checks, is that parents who are told their child is overweight or obese will currently not be able to receive a rebate under EPC for seeing an APD and public services, particularly specialised childhood obesity services which have very long waiting lists in most states.

**DAA strongly recommends that funding which allows for national, comprehensive, coordinated, sustainable, evidence-based approaches to tackling overweight and obesity especially for vulnerable and disadvantaged groups is allocated in the next budget. The ongoing National Tobacco Strategy is a good model to consider when looking at obesity. This strategy has had significant investment over many years and has thus demonstrated good outcomes.**

DAA calls for Commonwealth funding to support a collaborative approach to prevention engaging all stakeholders: government, non-government organisations, consumer groups, health, education and food service professionals, food industry, media, marketers and others.

**DAA calls for food security for Australians to be a central component of any national obesity strategy.**

Security of our national food system by ensuring equitable access to healthy foods for all Australians, especially those in rural areas, of low socioeconomic status, people with mental illness, people with disabilities and Aboriginal and Torres Strait Islander communities is fundamental to any national approach to improving nutrition in the population.

**DAA supports investment in Aboriginal and Torres Strait Islander Health Workers and Environmental Health Workers as outlined in the National Aboriginal and Torres Strait Islander Nutrition Strategy and Action Plan 2000-2010 and the National Nutrition Networks Conference 2008.**

DAA calls for funding of training and employment of Aboriginal and Torres Strait Islander Health Workers and Environmental Health Workers in Aboriginal and Torres Strait Islander communities to combat the high level of obesity in those communities.

**Key recommendations:**

DAA calls for the Federal government to *immediately* provide:

- Funding for national, comprehensive, coordinated, sustainable, evidence-based approaches to tackling overweight and obesity, especially for vulnerable and disadvantaged groups in the next budget.
- Ensure that nutrition initiatives addressing obesity involve/are led by APDs as the nutrition experts and best qualified to supply nutrition intervention strategies across all ages to manage obesity and are an essential component in strategies to prevent overweight and obesity.
- Enhancement of Medicare to allow overweight and obese children who will be identified in the 4 year old health check commencing 1 July 2008 to access appropriate nutrition care through APDs.

DAA calls for the Federal government *over the next 12 months* to provide:

- Establishment of a national preventative health agency which has a focus on improving nutrition and physical inactivity with an APD on the agency board.
- A commitment to regular revision of food composition databases, monitoring and surveillance of dietary intake and physical activity levels to inform regular updates of national dietary guidelines and food selection guides.
- The development of a new National Nutrition Policy, the development of a plan for its implementation and adequate resourcing to ensure its implementation. This should provide the underpinning for any obesity prevention strategy.
- Funding to support a widespread communication strategy regarding the NHMRC Clinical Practice Guidelines for the Management of Overweight and Obesity in Adults and the Clinical Practice Guidelines for the Management of Overweight and Obesity in Children and Adolescents<sup>6,7</sup>.
- Regulation to ensure responsible marketing of food and beverages to children
- Specific initiatives for families including the promotion of breastfeeding and establishing early healthy eating habits as priorities in prevention strategies. The recommendations from this committees recent report “The Best Start”, should be fully implemented and

funding to support group family-focussed weight management programs for childhood obesity, such as the PEACH programs in NSW and SA<sup>9</sup> and HIKCUPS in NSW<sup>10,11</sup>.

- Funding for national, comprehensive, coordinated, sustainable, evidence-based approaches to tackling overweight and obesity especially for vulnerable and disadvantaged groups.
- Greater funding to research effective obesity prevention, early intervention and obesity management strategies.
- An increase in the number of Commonwealth funded university positions and related clinical placements to increase the Australian dietetics workforce with an increase in funding provided to universities to train allied health professionals to allow sustainable, high quality professional education.
- Funding of training of Aboriginal and Torres Strait Islander Health Workers and Environmental Health Workers to support obesity prevention and management programs in their communities.
- Improved regulation to provide greater protection of the Australian public from harmful and unproven weight loss products and programs.

### **Background to key recommendations**

APDs are active across the continuum of care and all aspects related to the prevention and management of obesity in the Australian population. Overweight and obesity are multi-factorial in their development with nutrition, physical activity and psychosocial health being important in prevention and management. This includes, but is not limited to, prevention activities; treatment of the obese and overweight in hospitals, community, food industry and private practice; and research into determinants, prevention, treatment and health services requirements.

- 1) DAA requests that the Federal government improve access to dietetic services. Equity of access for all needs to be ensured, but access for disadvantaged groups (including ATSI, CALD and low SES) who suffer the greatest obesity-related burden is required as a matter of urgency. This may be achieved by:
  - Adding both adult and childhood obesity to the list of eligible chronic conditions under the current EPC Plans, for both individual and group services.
  - Education and incentives to facilitate both GPs and specialist medical practitioners to refer overweight or obese adults and children to APDs for early intervention. For example the four year old health checks could be used to identify those in need of APD intervention. In a similar vein, the 45 year old health checks could be used to identify adults requiring early intervention including APD services for the management of overweight and obesity. Access to Medicare rebates would strengthen this initiative.
  - Increasing access to APDs and enhancing patient outcomes via changes to the current EPC plans from 5 individual visits to 12 visits annually, through a new Medicare Item Number dedicated to APD services for overweight and obesity management. This would be similar to the current Medicare items currently available for 'Focussed Psychological Strategies' items and 'Psychological Therapy' items for psychologists. A recent survey of dietitians in private practice throughout Australia found that 70% indicated 5 visits provided insufficient time for successful treatment<sup>3</sup> and international research indicates patients maintain weight loss more successfully when they have monthly, personal contact with the interventionist<sup>8</sup>.

- Supporting multidisciplinary approaches in primary health care and similar models in the public and private sector. Specifically funding implementation of group family-focused weight management programs for childhood obesity, such as the PEACH programs in NSW and SA<sup>9</sup> and HIKCUPS in NSW<sup>10,11</sup>.
- 2) DAA urges the Federal Government to provide greater protection for the Australian public from harmful and scientifically unproven weight loss products and programs. Evidence based practice suggests that APDs should be involved with all clients using medical weight loss strategies such as energy restriction (low kilojoule diets), meal replacements, pharmacological agents and bariatric surgery. This is especially pertinent for those with medical conditions and co-morbidities. The Therapeutic Goods Code and the Therapeutic Goods Advertising Code require strengthening. The registration of weight management products should be required. The current voluntary weight management industry code of practice<sup>12</sup> is insufficient.

DAA calls for better regulation of weight loss products on pharmacy and supermarket shelves that are not proven to be safe and/or efficacious for use in the treatment of overweight and obesity. Better regulation is required to protect the consumer, especially those most vulnerable in society being children and adolescents, people with mental illness and the desperate obese wanting the advertised “magic bullet”.

- 3) Bariatric surgery (weight loss surgery) is a growing field and has been recognised to be an effective treatment for morbid obesity<sup>13</sup> for some people. Surgical therapy for morbid obesity is very effective in producing long-term weight loss and is also effective in ameliorating or resolving many of obesity’s co-morbidities, including diabetes, hypertension, dyslipidemia, sleep apnea, gastroesophageal reflux disease and many others<sup>14</sup>. Currently this type of surgery is only available to a limited number of public patients. Equity in access for those most in need (rather than just who can pay) is therefore an issue<sup>15</sup>. APDs are key in the treatment of patients using bariatric surgery. Access to APDs could be improved through Medicare item numbers, as previously suggested. There is a lack of clinical practice guidelines in this area which is concerning and thus DAA applauds the NHMRC on their overview study to gather evidence in efficacy and long term outcomes in bariatric surgery. However it is important that there is increased access to APDs for obese people to ensure that other treatment options are fully explored and that surgery is not seen as the first option.
- 4) Understanding what the population actually eats and how this changes over time is fundamental to any population health intervention to address obesity. Consequently, DAA calls on the Federal government to commit funds for regular revision of food composition databases and monitoring and surveillance of dietary intake and physical activity, in concert with National Health Surveys, to inform regular updates of national dietary guidelines and food selection guides. The last National Nutrition Survey was completed in 1995. Knowing what Australians eat and how physically active they are, is crucial information to inform health prevention strategies that a national preventative health agency could lead. DAA has demonstrated expertise in the management of these processes. DAA is involved in the revision of the 1994 Core Foods Groups and looks forward to ongoing involvement in this area. Furthermore, DAA is aware that the Dietary Guidelines for Australians are to be reviewed in the near future and supports regular updating of the Guidelines.

- 5) DAA supports the suggestion made at the 2020 Summit to establish a national preventative health agency. Such an agency should include an obesity prevention stream and representation from the DAA should be included in the board of such an agency.

DAA points to the important and relevant work already undertaken by health professionals through the National Obesity Taskforce<sup>16</sup> ('Healthy Weight 2008' which recommends actions across a range of settings such as child care, schools, primary care, maternal and infant health care, neighbourhoods, workplaces, food supply, family and community services, media and marketing), Public Health Partnerships<sup>17</sup> ('Eat Well Australia' and the 'National Aboriginal and Torres Strait Islander Nutrition Strategy and Action Plan') which was designed to provide government and other sectors with a strategic framework and an agenda for action on public health nutrition for the first decade of the twenty first century) and the NHMRC<sup>6,7</sup> (national clinical practice guidelines for overweight and obesity). DAA requests that currency of this work is validated and not discarded. The last National Nutrition Policy was developed in 1992 and is in need of an update to provide a framework in addressing the complex contemporary nutrition issues in Australia.

Integrating healthy lifestyle education into broader government strategies in early childhood/ childcare can promote practical action to improve food and nutrition literacy of families and establish lifelong habits, ultimately benefiting the individual and the community. DAA calls for a co-ordinated and adequately resourced strategic framework for national action that addresses the individual, group and family, physical environment and societal factors required to focus efforts on preventing obesity in children, effectively halting the progression of obesity into adulthood.

- 6) DAA advocates for responsible marketing of food products and government regulation of food marketing via all mediums including television, product placement and internet to children and other vulnerable groups. DAA also advocates for the removal of inducements for food purchasing by children, or for children. See the DAA submission to the Australian Communications and Media Authority August 2007 as Attachment 1.
- 7) DAA calls on the food industry to provide information and marketing that makes it easier for Australians to select healthier foods and to provide that information in a consistent format that meets government regulations. DAA advocates for consumer friendly food labelling to support appropriate food choices. Evaluation of various strategies is required to inform future developments in food labelling to ensure that any labelling system that is implemented (particularly if mandated by government) is actually making choices easier. It is also important to ensure that those most at risk, the poor and the vulnerable, benefit from these interventions.
- 8) DAA recognises that the family setting has the most influence on the development of nutrition behaviours in children and is the best vehicle for interventions and treatment<sup>10,11</sup>. DAA supports specific initiatives for families. One example of DAA's work in this respect has been the development and publication of a brochure resource titled 'Easy Family Eating for Healthy Kids'.
- 9) Breastfeeding must be a key feature in obesity prevention strategies<sup>18</sup>. See the DAA submission to House of Representatives Inquiry into Breastfeeding February 2007 given

as Attachment 2. The recommendations in the report from this inquiry should be full implemented.

- 10) DAA supports increased funding for research into the prevention and management of obesity via government agencies, non-government organisations and private industry. Practice-based research, translational research and health service delivery are under-resourced compared with basic science research. An example of DAA's contribution been the support to members to develop evidence based dietary guidelines for the management of overweight and obesity as well as communication and implementation plans.
- 11) The demand for dietitians in the health workforce continues to grow as the obesity epidemic worsens<sup>19,20</sup> and co-morbidities such as type 2 diabetes, osteoarthritis and cardiovascular disease increase. The Federal government should increase the number of Commonwealth funded university places to train dietitians. In particular initiatives to increase representation in the profession by groups such as Aboriginal and Torres Strait Islander peoples, using the successful initiatives used in the medical and nursing area, would be welcomed.

### **Additional Information**

The increasing prevalence of obesity in the Australian population is well recognised by the dietetics profession. The rates of prevalence and implications for Australia's health system, including costs, have recently been summarised in DAA's Overweight and Obesity Strategy, see Attachment 3.

This year DAA launched the inaugural Australia's Healthy Weight Week (AHWW) on January 20, 2008. AHWW is an initiative that forms part of the DAA's obesity strategy. AHWW aims to address Australia's health crisis due to the rising rates of overweight and obesity by encouraging Australians to take control of their health and achieve and maintain a healthy weight. In 2008 AHWW aimed to raise awareness of AHWW amongst all Australian adults. DAA plans to work with media partner Network Ten again next year to expand the project. For details on this initiative and outcomes please see Attachment 4.

### **References**

1. DAA. Overweight and Obesity Strategy. 2008. [Accessed 16/5/08 on [www.daa.asn.au](http://www.daa.asn.au) ]
2. DAA. *Best Practice Guidelines for the Treatment of Overweight and Obesity in Adults*. 2005. [Accessed 16/5/08 on [www.daa.asn.au](http://www.daa.asn.au) ]
3. Monash Institute of Health Services Research. Dietetics EPC survey. Monash University. March 2008.
4. Strategic Inter-Governmental Nutrition Alliance of the National Public Health Partnership 2001. *National Aboriginal and Torres Strait Islander Nutrition Strategy and Action Plan 2000-2010 and First Phase Activities 2000-2003*. National Public Health Partnership.
5. National Nutrition Networks Conference 2008. Recommendations arising from the National Nutrition Networks Conference. <http://ruralhealth.org.au/conferences/nann2008/NNNCrecommendations.pdf> Accessed 13 June 2008
6. NHMRC. *Guidelines for the Management of Overweight and Obesity in Adults*. Commonwealth of Australia. 2003.
7. NHMRC. *Clinical Practice Guidelines for the Management of Overweight and Obesity in Children and Adolescents*. Commonwealth of Australia. 2003.

8. Svetkey LP et al. Comparison of strategies for sustaining weight loss. *Journal of the American Medical Association*. 2008. 299:1139-1148
9. Golley RK, Perry RA, Magarey A and Daniels L. Family-focused weight management program for five-to nine- year-olds incorporating parenting skills training with healthy lifestyle information to support behaviour modification. *Nutrition & Dietetics*. 2007; 64:144-150
10. Collins CE, Okely AD, Morgan PJ, Jones RA, Warren RA, Cliff DP, Burrows T, Steele JR, Baur LA. Efficacy of HIKCUPS in reducing BMI z-score at 1 year: Results of a multi-site randomized trial for overweight 5-9 year olds. NASSO October 20-24th, New Orleans USA; *Obesity* 15(S) Sept 2007 Supplement 108-OR, A34.
11. Jones RA, Okely AD, Collins CE, Morgan PJ, Steele JR, Warren JM, Baur LA, Cliff DP, Burrows T, Cleary J. The HIKCUPS Trial: A multi-site randomized controlled trial of a combined physical activity skill-development and dietary modification program in overweight and obese children. *BMC Public Health* 2007, 7 (15) (31 Jan 2007) [www.biomedcentral.com/1471\\_2458/7/15](http://www.biomedcentral.com/1471_2458/7/15)
12. Weight Management Council of Australia Ltd. *Weight Management Industry Code of Practice*. Accessed 18 May 08 at <http://www.weightcouncil.org/>
13. Colquitt J, Clegg A, Loveman E, Royle P, Sidhu MK. Surgery for morbid obesity. *Cochrane Database of Systematic Reviews* 2005, Issue 4. Art. No.: CD003641. DOI: 10.1002/14651858.CD003641.pub2.
14. Bouldin MJ, Ross, LA, Sumrall, CD, Louctalot FV, Low AK, Land, KK. The Effect of Obesity Surgery on Obesity Comorbidity. *The American Journal of the Medical Sciences*. 2006, 33(4):183-193.
15. Talbot ML, Jorgensen JO and Loi KW. Difficulties in provision of bariatric surgical services to the morbidly obese. *Medical Journal of Australia*. 2005. 182(7):344-347.
16. National Obesity Task Force *Healthy Weight 2008 Australia's Future The National Action Agenda for Children and Young People and their Families*. Commonwealth of Australia. 2003.
17. SIGNAL. *Eat Well Australia: An agenda for Action for Public Health Nutrition 2000-2010*. National Public Health Partnership. 2001
18. Horta BL, Bahl, R, MArtines JC and Victora CJ. Evidence on the long- term effects of breastfeeding. *Systematic Reviews and Analyses*. WHO 2007.
19. Allman-Farinelli MA, King L, Bonfiglioli C, Bauman AE, Gill T. *The Weight of Time – men*. NSW Centre for Overweight and Obesity. Sydney ISBN 1-921186-02-X
20. Allman-Farinelli MA, King L, Bonfiglioli C, Bauman AE, Gill T. *The Weight of Time – women*. NSW Centre for Overweight and Obesity. Sydney ISBN 1-921186-01-1

## Attachments

- 1) DAA Submission to the Australian Communications and Media Authority August 2007
- 2) DAA Submission to House of Representatives Inquiry into Breastfeeding February 2007
- 3) DAA's Overweight and Obesity Strategy
- 4) Australia's Healthy Weight Week Evaluation Report