Healthy Eating Healthy Weight

DAA Statement on Overweight and Obesity

Our role
As Australia's largest professional nutrition organisation, the Dietitians Association of Australia (DAA) is the leader in nutrition and has made overweight and obesity a top priority.

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.*

Prevention and management
DAA believes overweight and obesity are multi-factorial in their development and both nutrition and physical activity are equally important in prevention and management.

Key priorities are to increase Australians' ability to select and prepare healthy foods, to understand nutrition, and to fight nutrition misinformation.

DAA supports a collaborative approach engaging all stakeholders: government; food industry; media; marketers; consumer groups; non-government organisations; health, education and food service professionals and others.

DAA supports comprehensive, coordinated, evidence-based approaches to tackling overweight and obesity, not piecemeal approaches.

DAA calls for the management of obesity as a chronic disease to be addressed across the continuum of care, including Medicare.

Accredited Practising Dietitians (APDs) are experts in nutrition, including the nutritional prevention and nutritional management of overweight and obesity across the continuum, in all settings and across all age groups. DAA is advocating for better access to APDs for individuals and community groups and improved nutrition capacity in public health planning, interventions and government.

DAA supports evidence-based best practice in obesity prevention and management and has endorsed the *Best Practice Guidelines for the Dietetic Treatment of Overweight and Obesity in Adults.* DAA will encourage development of standards for treatment of overweight and obesity in children.

Disadvantaged groups
DAA recognises that the greatest health burden related to overweight and obesity is borne by the more disadvantaged groups in Australia: lower socioeconomic groups; Indigenous and culturally and linguistically diverse communities and remote and other isolated communities. DAA supports and advocates that priority targeting of interventions be directed to areas and groups of greatest disadvantage.

DAA calls for all stakeholders to address food security - the ability of individuals, households and communities to acquire appropriate and nutritious food on a regular and reliable basis, using socially acceptable means – as a priority.

Children and families
DAA understands that early childhood is a critical time for growth, development and the establishment of lifelong eating patterns.

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. DAA supports specific initiatives for families.

DAA calls for the development and dissemination of national nutrition guidelines for children 0-5 years old and their application to early childhood services such as preschools and day care.

DAA calls on all organisations to support and promote breastfeeding.

Food industry and food service
DAA calls on the food industry to continue to improve the nutritional quality of products, control portion sizes, and ensure competitive pricing of healthier options.

DAA calls on the food industry to provide nutrition 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, and our members, will work in partnership with the food industry to develop and promote healthier food choices for Australians.

DAA calls for more responsible marketing of food products.

DAA calls for tighter government regulation of food marketing, especially to children and other vulnerable groups.

DAA calls for removal of inducements for food purchasing by children, or for children.

DAA calls for more healthy food choices to be readily available in all food service settings including early childhood services and educational facilities; sporting clubs; fast food outlets and workplaces.

Nutrition priorities for government

DAA calls on the Australian Government to coordinate consistent approaches to obesity prevention in all States and territories, across a range of settings including schools, workplaces and sporting venues.

DAA calls on the Australian Government and State and Territory governments to make nutrition a priority and commit more resources to advancing the nutritional health of Australians including:

- establishing comprehensive and ongoing regular nutrition monitoring and surveillance across the Australian population;
- revising the Australian Guide to Healthy Eating to be in line with the new Nutrient Reference Values;
- systematically expanding and upgrading the limited food composition database;
- resource and implement nationally coordinated nutrition plans;
- supporting nutrition education for all Australians; and
- improving community access to APDs.

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For further information please contact:

Dietitians Association of Australia
1/8 Phipps Close
Deakin ACT 2600
Ph: (02) 6163 5200
www.daa.asn.au

DAA Overweight and Obesity Strategy

DAA's Mission: *Supporting members, and advocating for better food better health, better living for all.*

Introduction
DAA as the professional body representing dietitians has a role to support members in this area of their professional practice, to advocate for the role of dietitians and to advocate for broad public health responses to the prevention and management of overweight and obesity. This strategy defines a coordinated approach to this important issue in keeping with the DAA Strategic Plan 2007-10

DAA has already developed and endorsed *Best Practice Guidelines for the Treatment of Overweight and Obesity in Adults* and has been engaged in advocating strongly on public health aspects of obesity and working with a range of stakeholders.

Most APDs have significant experience in this area of practice and a long history in advocating for prevention and treatment.

This strategy specifically emphasises targeting of families and disadvantaged groups as priority areas for intervention because:

- the family setting has the most influence on the development of nutrition behaviours in children and is the best vehicle for interventions; and
- disadvantaged groups, including Indigenous Australians, have the highest levels of overweight and obesity and carry the greatest burden of related chronic disease.

Advocacy for broad public health initiatives provides the opportunity to influence a broad range of groups but will also impact on these high priority areas.

The most recent study data available indicates that overweight and obesity are serious health issues affecting over 60% of Australian adults (67% men and 52% women) (1-4) and up to 25% of Australian children (5). The Diabetes, Obesity and Lifestyle Study (AusDiab) estimated that in 1999-2000 up to 7.5 million Australians aged over 24 years had a BMI of 25 or greater and that over 2.6 million of these were obese (3).

The National Obesity Taskforce reported in Healthy Weight 2008 (6) that excess weight was more common among lower socio-economic and socially disadvantaged groups. The issue of lack of food security defined as 'the ability of individuals, households and communities to acquire appropriate and nutritious food on a regular and reliable basis, and using socially acceptable means' is a major contributor to the problem in this segment of the population. Food security is determined by the food supply in a community and whether people have adequate resources and skills to acquire and use that food.

Aboriginal and Torres Strait Islander peoples have a markedly greater prevalence of obesity with 25% of men and 29% of women being obese (8). Indigenous young people 12% (12% males, 12% females) were obese (ABS 2006c) compared to 6% of all young Australians. Estimates from the 2004–05 National Health Survey (NHS) for adults aged 18 years or over showed that people in the most socioeconomically disadvantaged group had higher rates of overweight and obesity. Among adults in the first quintile (most disadvantaged), 50% were overweight or obese, compared with 45% of adults in the fifth quintile (least disadvantaged) (ABS 2006d). The gradient is more marked when considering obesity alone. Estimates from the 2001NHS for adults aged 20 years or over showed that females in the most disadvantaged socioeconomic group had nearly double the rate of obesity (23%) of those in the most advantaged group (12%). Males in the most disadvantaged group were also more likely to be obese than those in the most advantaged group (19% compared with 13%) (7).

Whilst the following data is self reported and has limitations it clearly demonstrates a trend. There have been major increases in the proportions of overweight or obese Australians over the last 20 years. For example, the most recent national data based on self-reported height and weight comes from the 2004–05 NHS. From this survey, 2.5 million Australian adults were estimated to be obese (19% of males and 17% of females aged 18 years or over). The highest levels of obesity were seen among males aged 45–54 years (23.2%) and females aged 55–64 years (21.7%) (ABS 2006d). A further 4.9 million Australian adults were estimated to be overweight but not obese (41% of males and 25% of females aged 18 years or over) (7).

The impact of overweight and obesity on the development of debilitating and life-threatening conditions such as stroke, coronary heart disease, Type 2 diabetes, cancers, osteo-arthritis, kidney and gall bladder disease, and respiratory and musculo-skeletal problems as well as social discrimination, reduced self-esteem and mental illness is a major health, social and economic concern (4).

The price Australian society pays for this epidemic is significant in terms of the impact on individual health and costs, to an already over-burdened health care system. Of the biomedical and behavioural risk factors measured in the Australian Burden of Disease study 2003, overweight is estimated to cause the most premature death and disability in Australia (8.6%), followed by tobacco smoking and high blood pressure (7).

The latest estimate of the true costs of obesity suggests that it may be as high as $1.3 billion per year and is rising fast (4). If obesity had been reduced in Australia by 20% during the years of 1992-2000, the potential cost saving to the health system was estimated to have been $59 million (1997 $Aust.) (4). Included in this estimate was the cost of obesity related to high blood pressure, coronary heart disease, diabetes, breast and colon cancers and gallstones. Potentially a saving of 2,300 years of life could also have been achieved (4).

To achieve healthy eating and a healthy weight for all we, as DAA members and as an association, play a pivotal leadership role in both the prevention and management of overweight and obesity. This document is a call to action to help members rise to this challenge. In all settings DAA seeks to support its members in delivering services to prevent and manage overweight and obesity. It also provides a roadmap on how we can work together and with partners to improve the health and wellbeing of all Australians; particularly those most disadvantaged who carry the greatest burden of this chronic condition

The strategy

This aligns with DAA's strategic priorities and reflects the DAA Mission of *supporting members, advocating for better, food better health, better living for all.*

The activities are grouped under three key result areas of Supporting Members, Advocacy and Consumer Communication. Within these key result areas actions are designed to address overweight and obesity across the spectrum from prevention to treatment in all age groups and in a variety of settings such as primary care, child and family, institutions, food supply and communities.

Supporting members

DAA objectives

1. To support development and communication of the evidence base for dietetic practice in overweight and obesity.
2. To support best practice in the primary care sector and to support members in delivering best practice obesity interventions in this context.
3. To increase access to APDs especially for disadvantaged groups.
4. To increase national recognition of the APD credential and DAA as the national body for provision of dietetic services for overweight and obesity.
5. To facilitate member access to DAA endorsed continuing professional development (CPD) and resources to support development of *Healthy Eating Healthy Weight* in a range of settings.

DAA actions

1. Advocating for dietetic services across a range of settings.
2. Facilitate continuing professional development (CPD) for members addressing overweight and obesity using both prevention and treatment models in variety of settings.
3. Endorse suitable resources that support members in service delivery and disseminate via the DAA website database, DINER - Dietetic Information and Nutrition Education Resources e.g. Guidelines for healthy canteens and other food service outlets, guidelines for healthy fundraising.
4. Increase member capacity via guidelines, educational tools, private practice promotion.
5. Facilitate member implementation of DAA endorsed evidence-based practice guidelines through CPD.
6. Encourage development of evidence-based dietetic best practice guidelines for childhood overweight and obesity for DAA endorsement.
7. Develop member capacity and promote the expertise of APDs to work with organisations such as Aboriginal Community Controlled Health Services and welfare organisations to address the increased prevalence and risk of obesity in disadvantaged groups.
8. Develop member capacity to support and up-skill other health professionals and workers in key settings to support the delivery of appropriate nutrition information and health promotion programs.
9. Where medications and bariatric surgery are used for weight loss, ensure dietetic intervention is incorporated as pivotal for successful outcomes.

Key Indicators for DAA Actions

1. CPD for members related to *Healthy Eating Healthy Weight*
2. Increased number of endorsed resources on DINER that support prevention and management of overweight and obesity
3. Increased numbers of weight management programs (primary prevention, public health, individual and group treatment programs) and primary prevention, public health intervention programs on DINER as a resource for dietitians and, potentially, other health professionals. CPD on line presentation developed on the implementation of the obesity guidelines.
4. Survey of members implemented and repeated post CPD online to provide trend data regarding practice in the area of obesity.
5. Best Practice Guidelines for treatment of childhood overweight and obesity developed and endorsement.

Advocacy

DAA Objectives

1. To develop effective partnerships to promote to *Healthy Eating Healthy Weight* especially for populations most at risk of obesity and food insecurity.
2. To influence government policy to achieve consistent approaches to preventing and managing overweight and obesity.
3. To achieve better and more affordable access for the public to APDs.
4. To support the development and access to a healthier and more affordable food supply.

DAA Actions

1. Advocate for emphasis on healthy lifestyle skills including the balance between both nutrition and physical activity in all settings.
2. Advocate for increased nutrition workforce capacity in the Australian Government.
3. Advocate for comprehensive and ongoing nutrition surveillance and monitoring at a national level including upgrade of the food composition database.
4. Advocate for the revision of the *Australian Guide to Healthy Eating* in line with the new Nutrient Reference Values (NRVs).
5. Advocate on food security issues.
6. Advocate for nutrition education programs and resources that address the needs of disadvantaged groups.
7. Support and encourage breastfeeding especially in disadvantaged communities.
8. Advocate for responsible marketing of food products and government regulation of food marketing in areas, such as product placement and TV advertising, especially to children and other vulnerable groups.
9. Advocate for the removal of inducements to purchase food by or for children.
10. Work through partnerships to encourage food manufacturers to promote healthy eating.
11. Advocate for affordable healthy choices.
12. Advocate for control of portion sizes to prevent over consumption of energy dense foods.
13. Advocate for consumer friendly food labelling to support appropriate food choices.
14. Advocate for development of national nutrition guidelines for children 0-5 years and their consistent application across all states and territories.
15. Advocate for food skills as part of parenting programs.
16. Advocate for a consistent approach to school nutrition curriculum development including practical food and cooking skills.

17. Advocate for consistency across all states and territories in healthy eating and food supply policies for childcare settings, schools and educational facilities, sporting venues (particularly those for children), workplaces and vending machines.
18. Advocate for healthy fund raising initiatives across a range of settings including schools, preschools, workplaces, sport and recreational clubs.
19. Advocate for broader application of Medicare to address issues around overweight and obesity and related risk factors.
20. Advocate for obesity to be recognised as a chronic condition.
21. Advocate for private health funds and the Department of Veterans' Affairs to include rebates which address a variety of treatment options.
22. Engage in alliances (according to DAA policy) to promote effective management and prevention strategies.
23. Advocate for national promotion of increased fruit and vegetable consumption.

Key Indicators for DAA Actions

1. A range of complementary and consistent guidelines/policies developed/endorsed.
2. National nutrition guidelines for 0-5 year olds developed.
3. Evidence of advocacy activity in a range of areas.
4. Number of alliances to promote effective management and prevention strategies increased.
5. Number of strategies to support and encourage breastfeeding increased.
6. Support acknowledged for initiatives targeting improvements to the food supply.
7. Evidence tabled showing advocacy for affordable healthy choices; increased fruit and vegetable consumption and initiatives which address food security.

Consumer Communication

DAA Objectives

1. To achieve consistent and appropriate information to improve the nutrition literacy of all segments of the population with particular emphasis on families and disadvantaged groups.

DAA Actions

1. Develop and disseminate key messages related to Healthy Eating Healthy Weight.
2. Maximise the value of the DAA website to provide accurate and practical information to professionals and Australians.
3. Work with corporate partners to promote healthy eating, especially to vulnerable groups.
4. Address misinformation vigorously and support members to do so at a local level.
5. Develop and promote healthy meetings policy for workplaces.
6. Develop healthy shopping list for consumers for Smart Eating.
7. Develop and disseminate education resources to improve nutritional literacy of families and disadvantaged groups.
8. Endorse and disseminate suitable resources that support Australians in preventing and managing overweight and obesity.
9. Support consistent messages on prevention and management of overweight and obesity to reduce consumer confusion.

Key Indicators for DAA Actions

1. Key *Healthy Eating Healthy Weight* messages developed and disseminated.
2. DAA website information related to obesity for professionals and consumers updated.
3. Healthy eating promotions developed with corporate partners.

4. Guidelines developed for healthy eating across a range of settings (including sporting facilities, educational facilities, food services, fundraising and meetings) endorsed and disseminated.
5. Healthy shopping lists and other resources for consumers developed and disseminated.

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