

## **Australia's domestic response to the World Health Organization's (WHO) Commission on Social Determinants of Health report "Closing the gap within a generation"**

### **Introduction**

Cancer Council Australia and the National Heart Foundation of Australia welcome the Senate Community Affairs References Committee's inquiry into Australia's domestic response to the WHO Commission on Social Determinants of Health report.

As discussed throughout this submission, Australia is a paradox in global terms in the context of the *Closing the gap* report. We are rightly recognised as a world leader in tobacco control, yet are among the five fattest nations in the OECD. If we are to close the widening gap in the burden of weight-related disease and lead by example in meeting WHO principles, we must urgently learn from tobacco in reversing trends in obesity/overweight.

### **Recommendations**

- That Australia's National Food Strategy prioritises improved population health outcomes as a core objective;
- That the Commonwealth supports a clear, interpretive front-of-pack food labelling system, working with state and territory governments on the system's introduction and continuous improvement;
- That restrictions to junk food advertising targeting children be identified as a key to improving population health, consistent with WHO principles referred to on page 118 of the report and supported by the global Non-communicable Disease Alliance;<sup>1</sup>
- That greater attention is given to addressing cardiovascular and cancer care inequities in relation to social gradients, in particular disparities in outcomes for Aboriginal and Torres Strait Islander people;
- That the Commonwealth vigorously support food reformulation through a strengthened and accelerated Food and Health Dialogue; and
- That the Commonwealth take action to address unacceptable levels of physical inactivity, which are more prevalent in socially disadvantaged population groups.

### **Rationale**

On the basis of current trends, the most alarming preventable determinant of cancer and cardiovascular disease in Australia on a population basis is the nation's unprecedented obesity/overweight crisis.

Obesity/overweight and the combined and individual effects of its main causes – poor nutrition and physical inactivity – are significantly more prevalent among Australians of lower socioeconomic status.<sup>2,3</sup>

Based on this evidence and the need for feasible responses, in our view the Committee should recommend achievable reforms in food policy to support reduced population-wide social inequities in future cancer and cardiovascular disease burden

Importantly, two of the recommendations are on the current Commonwealth policy agenda: the National Food Strategy and front-of-pack food labelling. Both represent a once-in-a-generation opportunities to improve public policy in an area where Australia is performing poorly.

We also highlight the need for restricting food advertising to the community's most vulnerable, as the weight of evidence shows that public policy measures aimed at fostering healthier communities can only reach their potential if commercial activities driving unhealthy behaviour are regulated.<sup>4</sup>

Australia's success in tobacco control shows the benefits of direct public policy responses to population health needs, using a range of policy levers including measures within the brief of non-health portfolio agencies and policy makers.<sup>5</sup>

A similar approach is urgently required if Australia is to reverse its trends in obesity/overweight. If not addressed, Australia's poor standing as one of the five fattest OECD nations will lead to increasingly unaffordable and inequitable rates of preventable chronic disease.

## *Addressing the terms of reference...*

### ***(a) Government's response to other relevant WHO reports and declarations***

It is the view of Cancer Council Australia and the National Heart Foundation that Australia's performance in addressing the social determinants of health should be evaluated on the basis of equitable health outcomes in Australia.

We acknowledge and appreciate Australia's endorsement of WHO declarations over many years, our nation's role in promoting the Millennium Development Goals and as one of the world's largest funders of the WHO.

In our view, as a relatively wealthy country Australia should lead domestically in reducing health inequities in the context of Australian demographics. Evaluating Australia's response to particular goals of WHO declarations and reports is instructive and highlights significant success and alarming underachievement.

Australia is well-placed as one of the wealthiest nations in the Western Pacific region to lead by example in addressing the social determinants of health. In responding to this inquiry, we address the terms of reference in relation to the two most important joint preventable risk factors for cancer and cardiovascular disease in Australia: tobacco use; and the combined and individual effects of overweight/obesity, poor nutrition and physical inactivity.

Whether tobacco use and overweight/obesity (and its underlying behavioural causes) are defined as social determinants of health themselves, or products of other social determinants, is a philosophical question that extends beyond the remit of our organisations.

What is important is that these risk factors lead to social inequities in health outcomes that can be addressed effectively through targeted policy responses. Therefore, the keys to reducing such inequities are direct policy interventions and programs that will reduce tobacco use and obesity/overweight and its causes.

## ***(b) impacts of the Government's response;***

It is well-documented that smoking, and the combined and individual effects of obesity/overweight, poor nutrition and physical inactivity, impact disproportionately on Australians who are socioeconomically disadvantaged.<sup>6</sup>

While it follows that greater social equity on a whole-of-population basis would reduce demographic disparities in health outcomes, in our view governments should prioritise targeted public policy measures that are shown to be effective in reducing the impact of disease risk factors.

In other words, while seeking to address the complex, multi-faceted social determinants of inequitable health outcomes, governments should not delay in investing directly in policy interventions with potential to reduce tobacco use and to improve nutrition and physical activity across the whole population.

Population-based public health interventions are beneficial to all segments of the community; measures can also be tailored and targeted to the needs of socially disadvantaged groups.

## ***(c) extent to which the Commonwealth is adopting a social determinants of health approach through:***

### ***(i) relevant Commonwealth programs and services,***

Commonwealth programs and services have, by international standards, a mixed record of success and lost opportunity in addressing the social determinants of health. Most importantly, the Commonwealth now faces an urgent need to learn from previous successes and failures if it is to address the nation's obesity/overweight crisis – which is on track to become the main primary cause for socioeconomic health disparity this century.

Australia's distinct experiences in tobacco control and in obesity/overweight management are instructive, and graphically highlight some of the best and least effective of Australian public policy. On one hand, we have among the world's lowest smoking rates<sup>7</sup> – and are rightly being commended by global health agencies for our leadership in plain packaging of tobacco. On the other hand, we are one of the five fattest nations in the OECD,<sup>8</sup> with the disease burden of obesity/overweight borne disproportionately by disadvantaged people.<sup>9</sup>

It took four decades for Australia to respond adequately to the tobacco epidemic; even now around 2.8 million Australians smoke daily,<sup>10</sup> most of them Australians of below average socioeconomic status.<sup>11</sup> While more must be done to reduce the inequity in tobacco disease burden, Australia's broad success in tobacco control should serve as a general guide for reducing the impact of other disease risk factors – without waiting another 40 years, by which time the social and economic cost of inaction on obesity will be irreversible.

We must learn from our successes, rather than wait for the crisis in obesity/overweight to impact fully on our hospital system – an outcome the whole community will pay for, given that the majority of the nation's overweight, poorly nourished and physically inactive people are likely to rely on the public hospital system.

While the broader debate about inequity and social determinants of health will continue, government has a responsibility to act now with targeted public policy measures that will improve population health for all demographic segments.

## Lessons from tobacco

By international benchmarks, Australia is a world leader in tobacco control. Smoking rates for Australian men and women dropped from 72% and 26% of the population respectively in 1945 to 16.4% and 13.9% in 2010.<sup>12,13,14</sup> (Note that while female smoking increased from the 1940s until the late 1970s, it has been declining steadily since 1980.<sup>15,16</sup>)

These gradual but substantial reductions in tobacco use did not occur serendipitously; they were the result of public policy measures driven by government and nongovernment health organisations over the past four decades.<sup>17</sup>

Decreases in smoking over this period are attributable for significant reductions in cardiovascular disease burden and lung cancer incidence rates<sup>18,19</sup> which, on a population basis, are gradually returning to levels that occurred before the 20<sup>th</sup> century tobacco epidemic. (Note that tobacco is still by far the main cause of preventable cancer death in Australia<sup>20</sup> and that lung cancer, around 80% of which is caused by smoking,<sup>21</sup> remains the largest cause of cancer death in Australia.<sup>22</sup>)

In our view, the key to whether tobacco control measures adopt a social determinants of health approach should be the measurable outcomes. In this context, Commonwealth tobacco control policies have been effective. While an integrated, comprehensive approach to tobacco control is best practice, two stand-out interventions should be highlighted: price control through tobacco tax; and restrictions to tobacco advertising.

It is important to note that, while this Inquiry's terms of reference focus on Commonwealth programs and services, the most effective tobacco control measure in Australia has been excise<sup>23</sup> – neither a program nor a service, but a regulatory price control. Evidence shows that of the many public policy responses to smoking, price control has had the most beneficial impact. It has also provided a revenue source to fund other tobacco control measures.

Tobacco tax has been particularly effective in reducing smoking rates among people on below average incomes.<sup>24,25,26</sup> On that basis, tobacco tax has directly addressed one of the key social determinants of health: smoking status.

Restricting tobacco advertising, again a regulatory rather than health-program response, has also been effective in reducing consumption.<sup>27</sup> In addition, advertising restrictions add impact to government and nongovernment media campaigns aimed at reducing tobacco use. (Public health messages have less impact when competing with big-budget advertising campaigns that encourage unhealthy behaviour.<sup>28</sup>)

It is therefore critical that, while exploring policy interventions relevant to this Inquiry, government is not restricted to programs, services and policies implemented by health agencies alone. Whole-of-government responses are critical to improved outcomes. Australia's National Food Strategy, food labelling agenda and food marketing policy are all important cases in point, as they involved several non-health agencies.

## Obesity

The social determinants of Australia's obesity/overweight crisis are complex. However, the direct behavioural causes of obesity/overweight on a population basis are simple: excess kilojoule intake and insufficient energy expenditure.

The escalation in obesity/overweight has coincided with unprecedented availability and promotion of high-kilojoule/low-nutrition food, and an increasingly sedentary lifestyle. Both of these causes of obesity/overweight predominate among socially disadvantaged groups,<sup>29,30</sup>

the long-term disease impacts are also expected to be borne disproportionately by these groups.

Given the timeliness of this Inquiry in relation to the current Commonwealth policy agenda, we will highlight the case for urgent food policy reforms with significant potential to address the social determinants of cancer and cardiovascular disease risk in Australia.

### ***(ii) the structures and activities of national health agencies, and***

In our view the structure of national health agencies is less problematic than the lack of a whole-of-government response to address obesity/overweight. Success in tobacco control required the involvement of portfolio agencies and ministers outside health – for example price control (Taxation Office), advertising restrictions (broadcasting authorities), point-of-sale (state licensing), smoke-free environments (transport, licensing and other agencies).

We will as a nation only address the social determinants of Australia's obesity/overweight crisis through an integrated, whole-of-government response involving multiple agencies. While we work towards an integrated approach, we must also make the most of immediate policy opportunities for individual responses, as follows.

#### **Inadequate response to government's own taskforce**

Appropriate policy responses have already been recommended by the government's Preventative Health Taskforce<sup>31</sup>. However, the government's response – while robust in relation to tobacco – has been tentative in relation to obesity/overweight<sup>32</sup>.

The core recommendations have been thoroughly researched by the nation's leaders in obesity control and are backed by well-documented evidence. These recommendations, supported by detailed programs, services and policy responses, are<sup>33</sup>:

- A national food strategy for Australia;
- Reshape the food supply towards lower risk products and encourage physical activity;
- Protect children and others from inappropriate marketing of unhealthy foods and beverages;
- Improve public education and information;
- Reshape urban environments towards healthy options;
- Strengthen, up-skill and support primary healthcare workers and the public health workforce to support people in making healthier choices;
- Targeted healthy eating programs for pregnant;
- Build the evidence base, monitor and evaluate effectiveness of actions; and
- Improved research and tailored responses to the close the gap in Indigenous health outcomes relating to obesity/overweight.

## Food strategy and labelling

The government has moved on the development of a national food strategy. However, the draft strategy released in July contains no meaningful recommendations for improving Australia's food system in relation to population health – only a passing acknowledgement that obesity/overweight and other problems caused by poor nutrition are on the increase.<sup>34</sup>

The food strategy itself should provide an ideal vehicle to act on the critical taskforce recommendation to reshape the food supply towards healthier products. This is a once-in-a-generation opportunity to ensure the quality and health benefits of the food supply are supported by a government that campaigned on shifting the focus of health policy to prevention.

It is also critical to note that one of two specific proposals under the broader taskforce recommendation of public information and education (the other being social marketing) is the introduction of a food labelling system that provides clear guidance for Australians wishing to make healthier purchasing choices.

Food labelling is currently subject to a review by the intergovernmental forum on food regulation, which is expected to announce a new labelling system in December 2012.<sup>35</sup> This is also a once-in-a-generation opportunity, to replace the confusing per cent daily intake guide with a system that provides clear purchasing guidance to Australians of all backgrounds – particularly those who are socially disadvantaged and bear an inequitable obesity/overweight disease burden.<sup>36,37</sup>

There is limited value in investing taxpayer funds into media campaigns encouraging healthier eating, if well-intentioned consumers cannot make informed purchasing choices. This is particularly relevant to disadvantaged groups who bear a higher obesity/overweight disease burden and would benefit from clearer consumer advice.<sup>38</sup>

We urge the Community Affairs References Committee to support the implementation of the taskforce's recommendations in its report, most urgently that the Commonwealth:

- Support a national food strategy that supports improved population health as well as commercial food industry interests; and
- Shows national leadership to help ensure the food labelling system introduced by the intergovernmental forum on food regulation is simple and interpretive enough to provide clear guidance to Australian consumers.

We also call on the Senate to identify the urgent need for food marketing reform as a pillar of Australia's much-needed response to reversing the obesity crisis according to WHO principles.

### ***(iii) appropriate Commonwealth data gathering and analysis; and***

#### **Role of ANPHA**

Cancer Council Australia and the National Heart Foundation support the establishment of the Australian National Preventive Health Agency (ANPHA).

While we will continue to engage with ANPHA in relation to its research and policy agenda, it is critical to note that compelling evidence already exists for policy reform in obesity control – as emphasised throughout this submission.

**(d) scope for improving awareness of social determinants of health:**  
**(i) in the community,**  
**(ii) within government programs, and**  
**(iii) amongst health and community service providers.**

The proposed work of ANPHA and the intergovernmental commitment to obesity-related social marketing and targets, underpinned by the national Preventive Health Partnerships, provides encouraging scope for improving awareness of the social determinants of health.

It must, however, be emphasised that awareness in increased isolation is not an adequate policy response. As shown by the experience of tobacco, the potential for increased awareness of the causes of disease burden can only be reached through an integrated policy response.

For example, we support measures to work across multiple sectors to raise awareness of how poor food choices among disadvantaged groups results in higher levels of obesity-related disease burden. However, the current daily intake guide on packaged foods, which is confusing to people in all groups, particularly disadvantaged groups, makes it highly difficult for increased awareness to translate to healthier behaviours and therefore improved outcomes.

On the same basis, a passing acknowledgement in the draft National Food Strategy that there are some concerns about diet-related risk factors and disease in Australia is no substitute for a robust policy response for addressing the problem.

**(iii) amongst health and community service providers.**

Stark disparities exist across the social gradient in relation to healthcare and health outcomes. Among the most stark examples are the disparities in inpatient cardiac care between Indigenous and non-Indigenous Australians<sup>39</sup> and inequities in cancer care outcomes, highlighted by data showing that Indigenous Australians are twice as likely as non-Indigenous Australians to die within five years of a cancer diagnosis.<sup>39</sup>

Indigenous communities have poor access to primary, secondary and tertiary healthcare, which compounds their poorer health outcomes. There is emerging evidence that disparities of care exists for other population subsets on the lower social scale.

As long as a “two step” health service system exists, there will be a continued reduction in the treatment outcomes of the health system. This issue requires a whole-of-system response; with attention to governance systems, accountability, performance monitoring for low SES populations, workforce enhancement, cultural awareness and standardisation of systems of care.

## **Conclusion**

In conclusion, we emphasise that the keys to reducing social inequities in preventable health outcomes in Australia are targeted policy responses. In relation to the most urgent need, and what is on the current policy agenda, we implore the Senate Community Affairs References Committee to recommend reforms in food strategy, labelling and marketing that will directly assist in making Australia a leader in obesity control, as we have been for years in tobacco, rather being among the most overweight nations in the OECD.

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