Response ID ANON-D6TS-MYRM-6

Submitted to Draft National Obesity Prevention Strategy
Submitted on 2021-11-02 14:11:50

Section 1: Privacy information

1 Do you consent to your submission being published on the Department's website, and accessible to the public, including persons overseas, in accordance with the following preference:

Publish entire response, including my name and organisation's name

2 Please read and agree to the below declarations:

I have read, understood and consent to the above statements.:
Yes

Section 2: Introduction

3 What is your name?

Name:
Emma Esdaile

4 What is your email address?

Email:
emma.esdaile@sydney.edu.au

5 What is the name of your organisation?

Organisation (if not representing an organisation you can enter 'member of community'):
NHMRC Centre for Research Excellence for the Early Prevention of Obesity in Childhood (CRE EPOCH)

6 Are you completing this survey on behalf of your organisation?

Yes

7 What sector do you represent? You may select more than one option.

Health professions, Academia or research, Health promotion

Section 3: Overarching concepts

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

Strongly agree

You can explain your selection or provide comments in the text box if you wish. (250 word limit):

The COVID19 pandemic has reminded us that our community's health – Australia's public health - is everyone's business. Obesity is one of the main drivers of disease and disability in Australia, and there is widespread recognition that more needs to be done to reduce this burden. A paradigm shift is needed to re-orient cross-portfolio responsibility for maintaining health and wellbeing as a high priority. We applaud many aspects of the draft National Obesity Prevention Strategy (NOPS), particularly those that focus on system level change, collective action, creating healthier environments, addressing social disadvantage and inequity and the need to reduce stigma.
However, we believe there are some implicit elements which rely too much on "eat better and move more" narratives. These excuse the commercial determinants of health (notably the processed food and beverage and advertising industries and property developers seeking monopoly of land use), reinforce stigma and blame across society, fail to provide governments with the social license to act, and perpetuate a false dichotomy between 'prevention' and 'treatment' that continues to impede effective action.
It is critical that people in general and particularly healthcare professionals understand that obesity is more than a failure of individual responsibility. Focus group work undertaken by The Obesity Collective has shown that if people do not understand the science of obesity, then asking them not to be judgmental will likely be ineffective and could backfire in some cases.

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

Strongly agree

You can explain your selection or provide comments in the text box if you wish. (250 word limit):

A few additional notes on ensuring an anti-stigma approach throughout. The introduction could include a definition of obesity that clarifies the focus is on health impacts from additional adiposity. Referring to just BMI would be an oversimplification. The link between trauma and obesity is relevant and missing. Please consistently use person first language e.g. check on the use of the word “obese” throughout and re-word as needed (see: https://www.obesityaction.org/action-through-advocacy/weight-bias/people-first-language/). Weight stigma is prevalent across the preconception, pregnancy and postpartum periods and needs to be specifically addressed.

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

Guiding Principles - Equity:
Strongly agree

Guiding Principles - Sustainable development:
Strongly agree

You can explain your selections or provide comments in the text box if you wish.:

While the prevalence of childhood overweight and obesity in Australia appears to have plateaued in the past decade or more (DOI: 10.1016/S0140-6736(17)32129-3), this has not occurred for those experiencing social disadvantage. Children from socio-economically disadvantaged and culturally and linguistically diverse households are at greater risk of developing overweight and obesity during childhood (DOI: 10.1038/s41366-021-00751-3). Existing programs may be relatively ineffective for priority population groups, as a result of limitations in access and suitability, and need to be tailored. Among adults, socio-economic inequalities in obesity are projected to grow in Australia, with greatest inequalities in severe obesity (DOI: 10.1136/bmjopen-2018-026525). While the guiding principle of equity speaks to the broader determinants of health (employment, income, housing, education) and their causes (distribution of resources, money and power), there are neither strategies contained within the NOPS, nor links to other national policies which face/address these issues. We suggest identifying how or where this Strategy links to existing or planned national policies (e.g. the National Partnership Agreement on Housing and Homelessness).
An additional guiding principle of ‘anti-stigma’ would be warranted and in line with the details outlined in the strategies, and as noted as a key theme from the first consultation.
We applaud the strategic links made between the NOPS and our international obligations under the UN Sustainable Development Goals noted in Appendix 1, we suggest a rephrasing on page 11 to make it clearer that the Strategy aligns with 15 of the 17 SDGs.

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

Agree

You can explain your selection or provide comments in the text box if you wish. (250 word limit):

Suggested re-phrasing: For an Australia that encourages healthy living for all and enables each person to be their healthiest weight

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

Disagree

You can explain your selection or provide comments in the text box if you wish. (250 word limit):

Whilst important to support the WHO global strategy, these targets are aspirational for Australia which has one of the highest rates of overweight and obesity in the world. These targets also do not address inequities in overweight and obesity and they do not acknowledge that severity of obesity is increasing in Australia. Modeling indicates that even under conservative assumptions, obesity prevalence will increase through to 2025 (and beyond) and that the prevalence of severe obesity will also grow increase (DOI: 10.1038/ijo.2016.165). It would be important therefore to have our Australian national targets, and state targets.
Additionally, many health improvements which can happen faster than reductions/stabilisation of population level BMI. Furthermore, in the interest of equity a halt in population-wide obesity may mask its higher prevalence among socially disadvantaged people.
We suggest adding other targets which align to the objectives. These include increased walkability and healthy food access and affordability, % increase of children and adults meeting dietary and physical activity guidelines, social cohesiveness and climate change preparedness as well as those noted in Enabler 2.1 on p.43. These targets would also be in keeping with the Strategy vision to both encourage – and more importantly enable – a healthy Australia which will require significant policy and environmental restructuring, to address the social and commercial determinants of health.

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

Do you agree with the Objectives? - More supportive and healthy environments:
Strongly agree

Do you agree with the Objectives? - More people eating healthy food and drinks:
Strongly agree

Do you agree with the Objectives? - More people being physically active:
Strongly agree

Do you agree with the Objectives? - More resilient systems, people, and communities:
Strongly agree

Do you agree with the Objectives? - More accessible and quality support for people:
Strongly agree

You can explain your selections or provide comments in the text box if you wish.:

14 Are there any Objectives missing?

You can provide comments in the text box if you wish.:

An objective which speaks to co-ordinated systems and services – taking a life course approach – would service the strategy well, particularly in the first 2000 days (from conception to the child's fifth birthday). That regardless of political, community or health system/service touch point, Australian families received continuity of care in a consistent manner and did not fall through the gaps between care transitions.

An additional objective: More people reducing their consumption of unhealthy food 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 which states that 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 Australian Dietary Guidelines (ADGs). The ADGs are currently under review, and we expect that 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. We note that all references to 'unhealthy food and drinks' in our submission assumes that all ultra-processed food and drinks (according to the NOVA classification system, DOI: 10.1017/S1368980018003762) are unhealthy foods and drinks. These products are designed to be hyper-palatable, affordable, convenient and are often marketed intensively.

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

Ambitions - All Australians live, learn, work, and play in supportive and healthy environments.:
Strongly agree

Ambitions - All Australians are empowered and skilled to stay as healthy as they can be.:
Strongly agree

Ambitions - All Australians have access to early intervention and primary health care.:
Strongly agree

You can explain your selections or provide comments in the text box if you wish.:

We strongly agree with the premise of Ambition 1 and its placement first in the Strategy. As written, however, it does not connect with broader determinants (housing, employment, income, education) as we mentioned earlier under Q10 (Guiding Principles). We have made several suggestions for the accompanying Examples for Action under Q18-19.
Ambition 2. Most Strategies focus on motivation via the attainment of skills and knowledge and broad messaging about how dangerous obesity is. Very few address the 'authority, opportunity and resources to apply' parts of empowerment directly. However, we applaud the inclusion of housing and health hardware in Strategy 2.7 and suggest it be moved to the position of 2.1. We also suggest commitments to funding community-led and co-designed initiatives in this space.
Ambition 3 is ambiguous and should make clear the roles and responsibilities for the different levels of government (see Q23 responses for more detail). The Examples of Action (which we will refer to as 'Actions' throughout) are "provided for governments… to consider for implementation in conjunction with their current approaches…" (p.12) which means no government is required to commit to implementing these Actions. Therefore, it is imperative that Actions are both wide reaching (i.e. all options are on the table) and explicit (rather than vague) to ensure public accountability and transparency when all jurisdictions report back on how they are contributing to each of these Ambitions. We have made additional comments on the Strategies and Actions below. We suggest they be re-named throughout as 'Recommendations for Action'.

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

Enablers - Lead the way:
Agree

Enablers - Better use of evidence and data:
Agree

Enablers - Invest for delivery:
Agree

You can explain your selections or provide comments in the text box if you wish.:

While we applaud the consideration of co-design, there is no detail about the structural support that would enable fostering partnerships and collaborative government in Enabler 1.
We note the following statement: "To ensure accountability and a coordinated national effort, a cross-jurisdictional governance mechanism will oversee the implementation of the Strategy. The governance mechanism is yet to be established but will consider alignment with the new National Federation Reform Council structure and the development of the National Preventive Health Strategy" (p.46).
Given the loss of COAG and revised intergovernmentalism since the Conran Review in 2020, it is even more important for an intergovernmental institution that can facilitate genuine learning and offer advice and knowledge for adaptation/implementation across the many governance contexts in

Australia. We call for a permanent, funded, genuine intergovernmental agency – such as a National Preventive Health Agency – and support alignment to the National Preventive Health Strategy.

Enabler 2: The agency that is required to support Enabler 1 would also play an important role in evidence synthesis and dissemination. We suggest a similar searchable database of evidence-based scalable programs as the USA National Cancer Institute, www.ebccp.cancercontrol.cancer.gov/index.do. Research funding should prioritise solution-focused public health intervention research that aligns with the NOPS (including environments). Funding should be prioritised for the implementation of evidenced-based and evidence-informed scalable approaches/programs.

Enabler 3: The Strategy assigns no responsibility for funding. Some traditional funding will be needed to support the Strategy, but we support the additional exploration of economic policies, subsidies, investment and taxation systems.

17 Are there any Enablers missing?

You can provide comments in the text box if you wish.:

Yes. The establishment of clear governance, funding and accountability frameworks. Although a national mechanism within the new National Federation Reform Council structure is mentioned ('Make it Happen'), such a mechanism is a key enabler for delivering economies of scale across jurisdictions (e.g. rural and remote projects across Australia will have multiple commonalities, even though each community will have unique needs). Based on past evidence there is a high risk that piecemeal smaller initiatives will not have scalable, sustainable impact unless actively considered within a broader systems approach with accountability. Coordinated and sustained action across society is required, including local communities, businesses, non-profits, health, academics and government. An intergovernmental agency could enable leadership across jurisdictions (Enabler 1), provide support for adaptation and implementation, contribute to the evidence base on what works in Australia and for whom (Enabler 2) and ensure investment for delivery (Enabler 3) is supported through expertise in adaptation and implementation.
We strongly support investment to deliver the NOPS, both in terms of financial investment and in building a skilled, well-resourced workforce. In relation to funding, we recommend the NOPS be accompanied by an implementation plan developed within 6 months 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 strategy, action and for monitoring and evaluation.

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?

Ambition 1 - Strategy 1.1 Build a healthier and more resilient food system.:
Strongly agree

Ambition 1 - Strategy 1.2 Make sustainable healthy food and drinks more locally available.:
Strongly agree

Ambition 1 - Strategy 1.3 Explore use of economic tools to shift consumer purchases towards healthier food and drink options.:
Strongly agree

Ambition 1 - Strategy 1.4 Make processed food and drinks healthier by supporting reformulation.:
Agree

Ambition 1 - Strategy 1.5 Make healthy food and drinks more available and accessible and improve nutrition information to help consumers.:
Strongly agree

Ambition 1 - Strategy 1.6 Reduce exposure to unhealthy food and drink marketing, promotion and sponsorship especially for children.:
Strongly agree

Ambition 1 - 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

Ambition 1 - Strategy 1.8 Grow participation in walking, cycling, public transport, active recreation and sport by minimising cost and access barriers.:
Strongly agree

Ambition 1 - Strategy 1.9 Build the capacity and sustainability of the sport and active recreation industry.:
Agree

Ambition 1 - 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

Ambition 1 - Strategy 1.11 Enable workplaces to better support the health and wellbeing of their workers.:
Agree

Ambition 1 - 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

You can explain your selections or provide comments in the text box if you wish.:

We strongly support strategies 1.1 and 1.2, and 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 (current) Strategy 1.2 is a function of (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.

1.1: new Action: Ensure the upcoming review of the Australian Dietary Guidelines incorporates 'farm to plate' considerations which support healthy food availability, accessibility and affordability. Align to the Lancet Global Syndemic of obesity, undernutrition, and climate change (DOI: 10.1016/S0140-6736(18)32822-8) and Sustainable Development Goals.
1.2: Action 1. Legislate to protect such land; Action 2. Enable local governments to support this through state-level planning and/or local government authority legislation; new Action: consider using existing government property for community gardens and local markets, such as schools/childcare with out of hours access (e.g. Monday afternoon markets or co-operative drop offs for the wider community, DOI: 10.3390/ijerph17114154).
Additional actions for 1.1/1.2 combined:
We recommend the development of a contemporary National Nutrition Strategy, which integrates the ADGs (under review), Nutrient Reference Values, food labelling initiatives (e.g. Health Star Rating), with relevant taxes, laws and monitoring systems, to cover from 'paddock to plate'. This will address the cost and prevalence of diet-related chronic diseases, the nutritional needs of vulnerable and disadvantaged Australians and improve food and nutrition security, sustainability, social equity and productivity (see https://dietitiansaustralia.org.au/voice-of-daa/advocacy/call-for-a-new-national-nutrition-policy/).
Trade agreements influence food environments (DOI: 10.1111/obr.12081). We recommend the Australian Government include ultra-processed food/drinks (UPF) and industrial ingredients in future global free trade agreements, including: industrial ingredient import volumes, actual/bound tariff rates and tariff-rate quotas for UPF and industrial ingredients and anti-dumping measures for these products.
Increase federal agricultural subsidies to whole fruit and vegetable producers. Evidence suggests potentially large health benefits for the Australian population in reducing health sector spending on the treatment of non-communicable diseases as a result (DOI: 10.1371/journal.pmed.1002232)

Strategy 1.3: Additionally use economic tools to motivate food producers, food retail (e.g. supermarkets) and food outlets (e.g. restaurants, etc) to produce and sell healthier options (both incentives and disincentives)
1.4 Action 1: voluntary partnerships do not work. This must be combined with fiscal incentives to motivate industry as was seen in the UK where the SSB levy (based on % sugar content) resulted in prominent reformulation while the concurrent 'Voluntary Reformulation Targets' with industry did not lead to consistent reductions in added sugar/salt/fat. (DOI: 10.1016/S2468-1253(20)30334-4, https://researchbriefings.files.parliament.uk/documents/POST-PN-0638/POST-PN-0638.pdf). Action 3: Use Food Code to protect complementary foods, toddler foods/snack and 'drinks' (e.g. toddler milks) composition to ensure children's first and early experiences of flavours are not overwhelmed by added sugars, fat, salt; new Action: Use the WHO definition of added sugars in all policies.
1.5: new Action: Food delivery apps are sites for advertising/push notifications of low nutrient quality food but hold potential for providing consumer information and healthier options (DOI: 10.3390/nu13030905, 10.3390/nu12103107); new Action: Require Ingredient Lists to group all added sugars (like Canada) and consider similar for added salt/fat.
1.6 Action 1: specify times (i.e. 6am to 9pm) on all platforms as the way children view content has changed (including broadcast, print media, online/streaming, digital/app-based, which link to Action 6); Action 4: MAIF is not enough, fully implement the WHO Code including WHA resolutions 63.14, 63.23, 69.9, with a regulatory framework. Action 5: extend to all out-of-home advertising assets e.g. billboards (leverage public safety legislation)
1.8: Ensure fiscal policy exemption for people who require private transport (e.g. disability) to avoid exacerbating any existing disadvantage; Action 3: Connect these fiscal policies to the existence of reliable and accessible public transport options, minimising burden on people experiencing social disadvantage; new Action: Fund the preservation of naturally and culturally significant sites (e.g. within and beyond Australia's national and state/territory parks)
1.10: new Action: invest in early childhood education and care leadership, initiatives and programs that mirror Actions 1-5 in schools.
1.11: Action 2: Paid parental leave and enabling flexible working options for all parents (regardless of gender) such as working from home and flexible working times is key to addressing gender inequity.
1.12: Link policy to support breastfeeding in all government facilities and workplaces, to gender equity and, in turn, family violence policies.

19 Are there any Strategies missing in Ambition 1?

You can provide comments in the text box if you wish.:

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?

Ambition 2 - Strategy 2.1 Improve people's knowledge, skills and confidence.:
Agree

Ambition 2 - Strategy 2.2 Use sustained social marketing.:
Agree

Ambition 2 - Strategy 2.3 Enable parents, carers and families to optimise healthy child development and lifelong healthy habits for children and adolescents.:
Strongly agree

Ambition 2 - Strategy 2.4 Engage and support young people to embed healthy behaviours as they transition to adulthood.:
Agree

Ambition 2 - Strategy 2.5 Engage and support local communities and organisations to develop and lead their own healthy eating and physical activity initiatives.:
Strongly agree

Ambition 2 - Strategy 2.6 Support targeted actions that enhances active living and healthy food and drink opportunities within priority populations.:
Strongly agree

Ambition 2 - 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

You can explain your selections or provide comments in the text box if you wish.:

2.1: Strategies, approaches and programs used to change people's knowledge, skills and confidence must be evidenced-based and scalable within existing service delivery systems. Criteria should define 'evidenced based scalable' programs/strategies and be prioritised for implementation. Action 2: ADGs should be free from vested influence and work across multiple sectors
2.2: new Action: use social media campaigns to highlight the influence of commercial interests on Australian diets, to change social norms (e.g. Harmful Industries work by VicHealth)
2.3: Infantprogram.org.au and HealthyBeginnings.net.au are Australian examples of evidenced-based scalable programs to support parents across the first 1000 days that can be embedded into existing health services.
2.4: Action 1: consider curricula/programs embedded in all Australian schools (see DOI: 10.1108/HE-06-2021-0098); new Action: school nurses as a health service (e.g. Victoria
https://www.education.vic.gov.au/Documents/school/teachers/health/Victorian%20School%20Nursing%20Program%20guidelines.pdf, Queensland
https://www.childrens.health.qld.gov.au/chq/our-services/community-health-services/school-based-youth-health-service/, Tasmania
https://www.education.tas.gov.au/parents-carers/programs-and-initiatives/school-health-nurse-program/)
2.5: Structural support, initiative design and implementation support and ongoing investment have real potential for empowering Australians. This Strategy has potential to enable the 'authority, opportunity and resources to apply' elements of empowerment. This is a key strategy, make it second.
2.7: We suggest moving this Strategy to the top of this section and especially link this to Enabler 1.4 'create genuine partnerships'; new Action: Invest in whole-of-community food and nutrition insecurity projects (e.g. see South West Sydney Local Health District). Building the capacity of health, social and other care providers to be responsive to diverse needs and strengths is a worthy aspiration but would take longer than the timeframe of this Strategy to be achieved effectively.

21 Are there any Strategies missing in Ambition 2?

You can provide comments in the text box if you wish.:

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?

Ambition 3 - Strategy 3.1 Enable access to primary health care and community-based practitioners and services in the community and at home.:
Agree

Ambition 3 - Strategy 3.2 Increase clarity and uptake of models of care and referral pathways that focus on the individual.:
Agree

Ambition 3 - Strategy 3.3 Support health, social and other care services to enable positive discussion about weight.:
Strongly agree

Ambition 3 - Strategy 3.4 Strengthen the confidence and competence of the primary health care workforce to prioritise the prevention of obesity.:
Agree

You can explain your selections or provide comments in the text box if you wish.:

3.1: A comprehensive update of the National Clinical Guidelines is a critical step to support an integrated approach to obesity across the health system, which is evidence-based, person-centred, non-stigmatising and supports positive relationships with food and body image. Urging people to lose weight without appropriate tools, evidence-based options and referral pathways, risks doing more harm than good.
3.2: Action 2: We assume practitioners here means GPs. If this is the case, they would be most clearly enabled by Medicare numbers which specifically cover 'assess, discuss, refer' for obesity prevention (this could involve practice nurses also). This Action could also include professional development opportunities, but it is unclear if that is what is meant. Meeting the needs of priority populations (such as culturally diverse groups) requires significant infrastructure support including time, specialised workforce, co-design, and multidisciplinary collaboration among different care providers (DOI: 10.1111/hsc.12950). Building the capacity of health, social and other care providers to be responsive to diverse needs and strengths is a worthy aspiration but would take longer than the timeframe of this Strategy to be achieved effectively. We suggest capitalising on existing bilingual/bicultural workers in health and other sectors to act as a bridge to assist culturally diverse communities receive appropriate care (DOI: 10.1186/s12905-021-01368-4).
Action 4: such services would be welcomed, but it is unclear what 'provide access' means. If it means 'fund services' then please use this.
3.4: Action 2: instead of 'and for people from at-risk population groups' consider 'and for people experiencing higher levels of disadvantage'

23 Are there any Strategies missing in Ambition 3?

You can provide comments in the text box if you wish.:

Additional comment: Make the roles for different levels of government clearer. For the Commonwealth i.e. GP Medicare rebates (where people initiate conversations about health concerns), and additional Medicare number funding options to support primary and secondary obesity prevention across the life cycle, e.g. Medicare numbers for use with private sector allied health, or assessment, discussion numbers with GPs or practice nurses. Additionally, articulate the roles and responsibilities for state/territory (and in some jurisdictions, local) governments in community and tertiary settings – such as the provision of programs that GPs can refer into and adequately funding allied health in outpatient/community settings for secondary prevention. Primary Health Networks also have a substantial role to play in this space, including service procurement and supporting continuity of care between health professionals who are responsible to different government authorities in public and private settings.
Funding structures needs to be reviewed within primary health care to enable the workforce to address obesity prevention, for example this needs to be embedded into Maternal and Child Health Service funding at the state level and appropriate rebates for practice nurses and GPs.

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/least important strategies - Strategy 1.1 Build a healthier and more resilient food system.:
5 most important Strategies

5 most/least important strategies - Strategy 1.2 Make sustainable healthy food and drinks more locally available.:
5 most important Strategies

5 most/least important strategies - Strategy 1.3 Explore use of economic tools to shift consumer purchases towards healthier food and drink options.:

5 most/least important strategies - Strategy 1.4 Make processed food and drinks healthier by supporting reformulation.:

5 most/least important strategies - Strategy 1.5 Make healthy food and drinks more available and accessible and improve nutrition information to help consumers.:

5 most/least important strategies - Strategy 1.6 Reduce exposure to unhealthy food and drink marketing, promotion and sponsorship especially for children.:
5 most important Strategies

5 most/least important strategies - 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.:
5 most important Strategies

5 most/least important strategies - Strategy 1.8 Grow participation in walking, cycling, public transport, active recreation and sport by minimising cost and access barriers.:

5 most/least important strategies - Strategy 1.9 Build the capacity and sustainability of the sport and active recreation industry.:

5 most/least important strategies - 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.:

5 most/least important strategies - Strategy 1.11 Enable workplaces to better support the health and wellbeing of their workers.:

5 most/least important strategies - 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.:

5 most/least important strategies - Strategy 2.1 Improve people's knowledge, skills and confidence.:

5 most/least important strategies - Strategy 2.2 Use sustained social marketing.:

5 most/least important strategies - Strategy 2.3 Enable parents, carers and families to optimise healthy child development and lifelong healthy habits for children and adolescents.:

5 most/least important strategies - Strategy 2.4 Engage and support young people to embed healthy behaviours as they transition to adulthood.:

5 most/least important strategies - Strategy 2.5 Engage and support local communities and organisations to develop and lead their own healthy eating and physical activity initiatives.:
5 most important Strategies

5 most/least important strategies - Strategy 2.6 Support targeted actions that enhances active living and healthy food and drink opportunities within priority populations.:

5 most/least important strategies - 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.:
5 most important Strategies

5 most/least important strategies - Strategy 3.1 Enable access to primary health care and community-based practitioners and services in the community and at home.:

5 most/least important strategies - Strategy 3.2 Increase clarity and uptake of models of care and referral pathways that focus on the individual.:

5 most/least important strategies - Strategy 3.3 Support health, social and other care services to enable positive discussion about weight.:

5 most/least important strategies - Strategy 3.4 Strengthen the confidence and competence of the primary health care workforce to prioritise the prevention of obesity.:

You can explain your selections or provide comments in the text box if you wish.:

We selected six items as we strongly support the combination of strategies 1.1 and 1.2 (see our response to Question 18).

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?

You can provide comments in the text box if you wish.:

Flexible implementation: a noted element for success includes multi-sectoral action, but it is not clear how likely such buy-in will be achieved from agencies beyond health. Without strong leadership, government-wide priorities (that include environments and broader determinants), and implementation support it is unlikely that the officials in those non-health agencies will have the imprimatur to implement such strategies, many of which are beyond their traditional organisational culture.

Ensuring accountability: linking to Enabler 2 (better use of evidence), ideally the reporting processes will use the same/comparable measures in each jurisdiction.

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

You can provide comments in the text box if you wish.:

We have some additional comments on overall implementation and technical considerations to add.

Implementation.
We support strong alignment between the NOPS and the NPHS. These two important strategies must complement and support each other and work together. While we are particularly supportive of the NOPS principles, objectives, ambitions and strategies, overall the NOPS does not represent a commitment to strong, sustained, best practice action. In its current form, is unlikely to reduce overweight and obesity and improve the health of Australians.

The promotion of a health in all policies approach (even if that language is not used), will enable local communities to consider environments for health, rather than focus on singular 'nutrition' or 'physical activity' actions alone.

We suggest strengthening the language throughout, starting with changing 'Examples of actions' to 'Recommended actions', and revising vague language such as 'explore' or 'investigate' to indicate intention to act, such as 'implement', 'trial' or similar.

We call for strong, resourced, and coordinated implementation plans with built in accountability at the federal and state/territory level, to be developed within six months of the NOPS release. This plan should be free from conflicts of interest and include:
Strong targets which (at a minimum) align with the NPHS;
An equal (intergovernmental) national prevention agency to oversee implementation of the strategy and support coordination and knowledge sharing
A clear timeline for implementation of the NOPS with public reporting at 3, 6, and 9 years of the 10-year plan, based on a monitoring and evaluation framework to report from all jurisdictions;
A funding plan that identifies committed, ongoing and adequate funding from all governments.

Technical.
Specific consideration should be given to the first 2000 days (i.e. from conception to about the child's fifth birthday) in any life cycle approach, given the influence on establishing lifelong habits and because one if four children are already above a healthy weight by the time they start school in Australia. Key actions include continuity of care for families across health services with multiple government (i.e. Commonwealth or state/territory or local government) oversight and settings children are likely to attend at this life stage such as early childhood education and care settings.

The NOPS should give equal priority to reducing availability and consumption of unhealthy food in addition to supporting the availability, affordability, accessibility and consumption of healthy food. Both are important and although related, should be distinct goals.

In line with the identified need for a review of the term 'discretionary choices' in addition to the upcoming review of the ADGs, we expect these reviews 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, and the application of a classification system (i.e. NOVA) should be applied to ensure clear indications for the food industry.

Under the Better Regulation paradigm, consideration of the economic impact of policy, regulation, or legislation must be addressed broadly and include assessment of the economic impacts of poor diet, excess weight and cost-effectiveness. Of note, there is evidence of no net loss of jobs with an introduction of marketing restrictions for unhealthy food or a tax/levy on sugary drinks – rather, just a shift in the types of jobs (DOI: 10.1016/j.foodpol.2020.102016, 10.1016/j.ypmed.2017.09.001, 10.2105/AJPH.2013.301630)

Actions should be evidence-based but the unavailability of evidence around a potentially useful strategy (as a result of novelty or limited current research)

should not be used as a reason for inaction. Policy experimentation should be encouraged, supported, and resourced.

There is a need for the strategy and related implementation plans to use person-first, non-stigmatising language throughout, e.g. the term ‘obese’ should not be used and avoid any reference to individual blame even as a myth-busting approach.