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Submitted to **Draft National Preventive Health Strategy**
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Introduction

1 What is your name?

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3 What is your organisation?

Organisation:
HAES Australia Inc.

VISION

4 Do you agree with the vision of the Strategy?Please explain your selection. (1000 word limit)

Agree

Vision Text:

Overall, the Strategy benefits from addressing the wider determinants of health in the vision section as this provides a holistic understanding of health, steering away from an individualistic focus. To achieve the vision, health must be defined, incorporating diverse cultural understandings of health and recognising that people differ in how they value health. We recommend the vision emphasises that it will address modifiable risk factors, that are related to what people do (behaviours and activities) and their environments (physical, social, cultural and institutional). If the vision is to improve health and wellbeing, the strategy needs to also focus on building protective factors such as social connection, education, employment and housing. For the purposes of prevention, proactively 'addressing the broader causes of poor health and wellbeing' is important to achieving the vision.

AIMS

5 Do you agree with the aims and their associated targets for the Strategy?Please explain your selection. (1000 word limit)

Disagree

Aims Text:

1. Australians have the best start to life.
It is unclear if the 'prevention of risk factors' is looking holistically at the wider determinants of health or biomedical preventative strategies as the targets are currently limited in scope and reflect biomedical and behavioural outcomes. This aim needs to ensure that preventive strategies for chronic conditions in later life do not negatively impact the growth, development, health and well-being of children and adolescents.

2. Australians live as long as possible in good health
We suggest the second aim could be rephrased to: "Australians are empowered and supported to optimise their health and wellbeing throughout the life stages." Consistent with secondary and tertiary prevention, the Strategy needs to provide effective care to those with disabilities and chronic conditions. Using terminology such as 'full health' in the aims is ableist and not inclusive of the diverse set of circumstances individuals face with their health. Supporting the strengths-based approach of the Strategy, health should not be defined as the absence of disease or infirmity but rather as a resource for life as described in The Ottawa Charter. In line with the World Health Organisation's definition of health, the targets must include physical, mental and social well being.

3. Health equity for target populations
A focus on supporting equitable outcomes for population groups who experience health inequalities and recognition of burden due to wider determinants of health is welcomed. It is good to see that specific populations are listed on page 17. However, not all of these populations are currently reflected in the targets. The targets for equity could be strengthened to include actual health outcomes and life expectancy targets for Aboriginal and Torres Strait Islander populations, and people with mental illness and disability and those from CALD and LGBTIQ groups. Given the ongoing gender inequalities evident in Australian society, e.g sexual abuse and violence against women, the limited exploration of gender as a social determinant of health is concerning especially as gender equity is one of the UNs Sustainable Development Goals. To demonstrate its commitment to equity, the Strategy must incorporate respectful images that reflect the diversity of the Australian population.

4. Investment in prevention is increased
Further investment in public health is welcomed however both health promotion and prevention is needed to achieve the vision of this strategy.

PRINCIPLES

6 Do you agree with the principles?Please explain your selection. (1000 word limit)

Agree

Principles Text:

Multi-sector collaboration: Consistent with the discussion of commercial determinants of health (pg. 17), it is recommended that accountability and transparency be incorporated into the principle.
Enabling the workforce: this section discusses mobilising the current workforce to improve health promotion. To achieve this principle rebuilding the public health workforce is necessary as it has historically been understaffed and overworked. Placing more responsibilities/training on remaining individuals may not produce the intended outcomes. Additional staffing with improved training in this area is required.
Community engagement: Community input will be a strength to the Strategy. We recommend the term community participation, which exists on a spectrum (see https://www.iap2.org.au/resources/spectrum/), rather than engagement which doesn't necessarily reflect true collaboration, as it is still health sector focussed, not community focussed. Funding must be allocated to enabling community participation to provide training and recognise and value their contributions, while guarding against undue influence from commercial vested interests.
Empowering and supporting Australians: Environmental factors are discussed in the Strategy however, the Strategy does not sufficiently address how the impacts of the social environment (stigma, racism, ableism, sexism etc) will affect the Strategy's ability to empower individuals.
The equity lens: Adopting an equity lens involves addressing the determinants of health and needs to be an explicit focus of this principle. Structural barriers within the healthcare system and related sectors need to be addressed to ensure these settings are providing safe and culturally sensitive practices.

ENABLERS

7 Do you agree with the enablers? Please explain your selection. (1000 word limit)

Agree

Enablers Text:

Leadership, governance and funding: It is a strength that the Strategy incorporates a multi-sectoral approach to leadership, governance and funding. It is important that leadership, governance and funding are interdisciplinary (rather than being medically led) to draw on these strengths of the wider public health workforce. Currently, leadership relies on 'expert-led' initiatives and does not speak to the strengths of engaging community leaders in governance processes. The Strategy would benefit from input from these diverse groups to ensure it delivers equitable outcomes for all.

Prevention in the health system: Due to cuts to public health budgets over many years, staff are often stretched and insufficiently resourced. It would be good to see this addressed. It is also promising to see recognition of the inherent preventive health capabilities of allied health professionals. Current fee-for service funding models are a barrier to allied health professionals participating in prevention and health promotion initiatives, which requires a long-term commitment to building partnerships that lead to meaningful and sustained change.

Partnerships and community engagement: Participation in decisions that affect one's life and more specifically their health is a fundamental human right. We welcome the commitment for partnerships and community engagement, which are free from vested commercial interests so that initiatives benefit population health rather than for profit motives.

Information and health literacy: Information must be clear, reliable, easily accessible and meaningful. Further attention to establishing an enabling health literacy environment through policies and processes that support people to access, understand and appraise and apply health-related information is needed. With the increasing reliance on digital technology to access health information, care and resources, this enabler also needs to address digital inclusion, as more that 2.5 million Australians are not online (see https://digitalinclusionindex.org.au/about/about-digital-inclusion/).

Research and evaluation: In the strategy, there is no mention of ethics. Complex challenges in public health, especially universal prevention strategies, require strong ethical oversight to ensure that they are fair, respect people's autonomy, have benefit and do no harm. Research and evaluation must consider both the benefits and harms of public health interventions. Research and evaluation must be guided by the values and priorities of people with relevant lived experience and free from vested commercial interests.

Monitoring and surveillance: HAES Australia would welcome a commitment to an ongoing National Nutrition and Physical Activity survey along with surveys that regularly monitor the mental health and wellbeing of Australians. We strongly advise against the routine use of anthropometric measures in public health. The body mass index is not a reliable indicator of health with the cardio-metabolic health of 1 in 3 adults being misclassified when using BMI (Tomiyama, A. J., Hunger, J. M., Nguyen-Cuu, J., & Wells, C. (2016). Misclassification of cardiometabolic health when using body mass index categories in NHANES 2005–2012. International Journal of Obesity, 40(5), 883.), In addition, healthy lifestyle habits are associated with reduced mortality risk, regardless of baseline BMI (Matheson, E. M., King, D. E., & Everett, C. J. (2012). Healthy lifestyle habits and mortality in overweight and obese individuals. The Journal of the American Board of Family Medicine, 25(1), 9-15.)

Preparedness: There needs to be a stronger focus on planetary health in the Strategy. Focusing efforts on preparing for the impacts of climate change is not upstream enough when looking at preventative health strategies. Human health will soon be inextricable from the health of our environment and planetary health needs to be implemented into all areas of the Strategy.

8 Do you agree with the policy achievements for the enablers? (1000 word limit)

Agree

Enablers - Policy Achievements Text:

1. Leadership, governance and funding: Independent governance is essential to reduce risks posed by vested commercial interests.
2. Prevention in the health system: Surge capacity within the public health workforce is needed as currently public health staff are under pressure as they are expected to perform business as usual roles alongside contributing to the COVID-19 response. Another policy achievement could be to implement the recommendation from the Senate Select Committee into the Obesity Epidemic in Australia (2018) that "Commonwealth Department of Health work with organisations responsible for training medical and allied health professionals to incorporate modules specifically aimed at increasing the understanding and awareness of stigma and blame in medical, psychological and public health interventions."
3. Partnerships and community engagement: Funding to support partnership development and community participation is needed to guard against conflicts of interest.
4. Information and health literacy: Greater focus on the health literacy environment is needed. The policy achievement could read "The health workforce and organisations are supported to create an environment that builds the health literacy capacity of themselves, communities, patients and clients." Another policy achievement would be to improve rates of digital inclusion.
5. Research and evaluation: Independent funding and mechanisms for ethical oversight of health promotion and prevention research is recommended.
6. Monitoring and surveillance: Due to the limitations of the BMI, we advise against routine monitoring and surveillance using anthropometric measures. Instead, reliable measures of dietary quality, physical activity, sleep, smoking and alcohol use should be routinely collected and made readily available to policy makers, researchers, practitioners and communities.
7. Preparedness: It was great to see climate change addressed as both an enabler and policy achievement. However, planetary health was not addressed in the policy achievement, despite its intersection between climate change and human health.

FOCUS AREAS

9 Do you agree with the seven focus areas? Please explain your selection. (1000 word limit)

Agree

Focus Areas Text:

HAES Australia broadly agrees with the seven focus areas. It is promising that none of them focus on body weight, shape or size in the title, as weight stigma and discrimination is a significant determinant of health (see Wu, Y. K., & Berry, D. C. (2018). Impact of weight stigma on physiological and psychological health outcomes for overweight and obese adults: a systematic review. Journal of advanced nursing, 74(5), 1030-1042.). Indeed references to higher body weight as an epidemic in public health discourse are inaccurate and harmful. (see O'Hara, L., & Taylor, J. (2018). What's wrong with the 'war on obesity?'A narrative review of the weight-centered health paradigm and development of the 3C framework to build critical competency for a paradigm shift. Sage Open, 8(2), 2158244018772888.)

To enhance the effectiveness of the strategy, we recommend ensuring that the focus areas are weight-inclusive (focus on supporting the health of people across the weight spectrum and challenge weight-stigma) by removing all references to weight in the rationale.
2. Healthy diet: All Australian adults across the weight spectrum consume a poor diet (Grech, A., Sui, Z., Siu, H. Y., Zheng, M., Allman-Farinelli, M., & Rangan, A. (2017, March). Socio-demographic determinants of diet quality in Australian adults using the validated Healthy Eating Index for Australian Adults (HEIFA-2013). In Healthcare (Vol. 5, No. 1, p. 7). Multidisciplinary Digital Publishing Institute.) and would benefit from improving the quality of their food intake.
3. Physical activity: Less than 50% of Australians across all BMI categories participate in sufficient physical activity. (see Chau, J., Chey, T., Burks■Young, S., Engelen, L., & Bauman, A. (2017). Trends in prevalence of leisure time physical activity and inactivity: results from Australian National Health Surveys 1989 to 2011. Australian and New Zealand journal of public health, 41(6), 617-624.) Focusing on weight or body composition change is a deterrent to regular, sustained participation in physical activity (Mailey, E. L., Dlugonski, D., Hsu, W. W., & Segar, M. (2018). Goals Matter: Exercising for Well-Being But Not Health or Appearance Predicts Future Exercise Among Parents. Journal of physical activity & health, 15(11), 857–865. https://doi.org/10.1123/jpah.2017-0469)
4. Increasing cancer screening: The correlations between weight and cancer are complex, especially for women, and weight stigma is a barrier to preventive screening (Lee, J. A., & Pausé, C. J. (2016). Stigma in practice: barriers to health for fat women. Frontiers in Psychology, 7, 2063.).

The additional focus area related to protecting mental health is welcomed. While the description mentions mental health conditions such as anxiety, depression and psychotic disorders, eating disorders are not mentioned despite having a high mortality rate and being a leading contributor to disability among young women (see Australian Institute of Health and Welfare, (2019). Australian Burden of Disease Study: impact and causes of illness and death in Australia 2015. Canberra, ACT: AIHW.).

We recommend that this oversight be amended as eating disorders are currently underrepresented in burden of disease statistics (see Santomauro, D. F., Melen, S., Mitchison, D., Vos, T., Whiteford, H., & Ferrari, A. J. (2021). The hidden burden of eating disorders: an extension of estimates from the Global Burden of Disease Study 2019. The Lancet Psychiatry, 8(4), 320-328.). Furthermore, during the COVID-19 pandemic, rates of disordered eating and compulsive exercise have increased. (see Phillipou, A., Meyer, D., Neill, E., Tan, E. J., Toh, W. L., Van Rheenen, T. E., & Rossell, S. L. (2020). Eating and exercise behaviors in eating disorders and the general population during the COVID-19 pandemic in Australia: Initial results from the COLLATE project. The International journal of eating disorders, 53(7), 1158–1165. https://doi.org/10.1002/eat.23317).

In light of this evidence, health and related policies should not increase the risk of disordered eating or eating disorders and campaigns and programs targeting nutrition and physical activity and other health-promoting behaviours should aim to do no harm. Protecting mental health must also be incorporated into the other focus areas, especially 'improving access to and the consumption of a healthy diet' and 'increasing physical activity'. To align with a compassionate and trauma-informed approach, we suggest that the strategy promote empowering messages about nutrition and physical activity, rather than stigmatising and counterproductive messages about changing people's weight, shape and size. Weight-neutral interventions that adopt a Health at Every Size approach have equal or better outcomes than weight-centred approaches, without causing harm (see Ulian, M. D., Aburad, L., da Silva Oliveira, M. S., Poppe, A. C. M., Sabatini, F., Perez, I., ... & Baeza Scagliusi, F. (2018). Effects of health at every size® interventions on health■related outcomes of people with overweight and obesity: a systematic review. Obesity Reviews, 19(12), 1659-1666.). The multiple benefits of eating well and being active for physical and mental health and social well-being, must be emphasised, without reference to body weight, shape or size.

10 Do you agree with the targets for the focus areas? (1000 word limit)

Not Answered

Focus Areas - Targets Text:

We agree with the targets with the exception of the focus on body size in the “improving access to and the consumption of a healthy diet” section.

In this section, we recommend removing targets that focus on changing body size, in the same way as for physical activity. A focus on BMI is problematic as it reinforces stereotypical views about an individuals’ ability to control their weight through nutrition. Body weight should be considered a non-modifiable risk factor (like age) as it is strongly influenced by genetic inheritance and a tightly regulated set of factors that are not within an individuals’ conscious control. Indeed, Level A evidence from the NHMRC (2013) “Clinical practice guidelines for the management of overweight and obesity in adults, adolescents and children” found that lifestyle modification does not achieve long-term weight loss (p. 160). The Strategy would benefit from focussing on behaviour-based outcomes that improve health and well-being and mortality, irrespective of weight.
There is good research to show that the effect of body weight on mortality is moderated by health behaviours such as improved nutrition, physical activity, limiting alcohol and not smoking (for example see Matheson, E. M., King, D. E., & Everett, C. J. (2012). Healthy lifestyle habits and mortality in overweight and obese individuals. The Journal of the American Board of Family Medicine, 25(1), 9-15.).

Furthermore, obesity and overweight are highly stigmatising terms (Meadows, A., & Daníelsdóttir, S. (2016). What's in a word? On weight stigma and terminology. Frontiers in psychology, 7, 1527.) and body weight is a poor predictor of health with the cardio-matabolic health of one in three people being misclassified using the body mass index (Tomiyama AJ, Hunger J, Nguyen-Cuu J, Wells C. Misclassification of cardiometabolic health when using body mass index categories in NHANES 2005–2012. International Journal of Obesity. 2016;40(5):883)

An additional target related to food insecurity would be beneficial given that rates of food insecurity have increased during the COVID-19 pandemic (Foodbank Hunger Report 2020).

Currently, the only target related to increasing physical activity reflects a deficit focus and addresses insufficient physical activity. We recommend including additional targets related to promoting equitable participation in sport and physical activity, for populations who currently face barriers to life-enhancing movement, such as women and people with mental ill-health and disability. In addition, targets related to increasing rates of active transport would be beneficial.

Similarly, there is only one target related to protecting mental health that also reflects a deficit focus. Additional targets related to reducing psychological distress as well as increasing well-being and social inclusion are recommended.

11 Do you agree with the policy achievements for the focus areas? (1000 word limit)

Agree

Focus Areas - Policy Achievements Text:

The policy achievements reflect each focus area and have a balance of actions that address determinants of health through upstream actions at a public policy and environmental level as well as downstream actions focused on community action and developing personal skills. Caution is warranted however, to avoid lifestyle drift and placing the emphasis on individual action through education or behaviour change, which is insufficient to address health inequities, and may even exacerbate them.

It is encouraging to see that eliminating stigma and discrimination is included in the focus areas for alcohol and other drugs and mental health. However, eliminating stigma and discrimination should be an aim of prevention policy across all focus areas, especially healthy diet and physical activity, as it presents a barrier to social inclusion and participation in health promoting activities and causes harm through psychological distress.

For physical activity, another policy achievement would be to incorporate universal design principles into the design of built environments to ensure that physical activity is accessible for people of all body shapes and sizes, abilities, and genders.

CONTINUING STRONG FOUNDATIONS

12 Do you agree with this section of the Strategy? Please explain your selection. (1000 word limit)

No Opinion

Continuing Strong Foundations Text:

This section is brief compared to the rest of the document. Throughout our response, we have emphasised the need for weight-inclusive public health policy. An example of prevention activity that adopts a weight-inclusive approach is VicHealth’s This Girl Can campaign (see https://thisgirlcan.com.au/). Rather than focusing on the weight, shape and size of women’s bodies in this campaign, VicHealth have foregrounded the importance of understanding women’s stories and, specifically, the factors that have prevented them from participating in sports and exercising. In doing so, the campaign effectively challenges the structural factors (e.g., sexism in sporting clubs) that often precipitate women’s negative experiences or potentially prevent women from engaging in sports and exercise. Successful campaigns such as This Girl Can provide an exemplar that can inform future public health strategies.

FEEDBACK

13 Please provide any additional comments you have on the draft Strategy. (No word limit)

Comments Text:

Thank you for the opportunity to provide input to the Draft National Preventive Health Strategy.

HAES Australia is the representative body for health and fitness professionals, researchers and academics working from a Health at Every Size® appraoch (www.HAESAustralia.org.au). The work of HAES Australia and its members is underpinned by an evidence-based, weight-neutral, size inclusive, and body positive perspective.

HAES Australia is an independent, member-based association that promotes equitable access to evidence-based healthcare and life-enhancing practices for people of every size, through information, resources, and advocacy. Our vision is for a just and compassionate community, where all bodies are respected and belong.

HAES Australia strongly advocates the use of weight-neutral and weight-inclusive paradigms in health policy (see Hunger, J. M., Smith, J. P., & Tomiyama, A. J. (2020). An Evidence■Based Rationale for Adopting Weight■Inclusive Health Policy. Social Issues and Policy Review, 14(1), 73-107.) and health care (see Tylka, T. L., Annunziato, R. A., Burgard, D., Daníelsdóttir, S., Shuman, E., Davis, C., & Calogero, R. M. (2014). The weight-inclusive versus weight-normative approach to health: Evaluating the evidence for prioritizing well-being over weight loss. Journal of Obesity) and particularly Health at Every Size (HAES)® approaches (www.asdah.org).

A weight-inclusive approach focuses on supporting the health of people across the weight spectrum and challenges weight-stigma, especially in health care policy and practice. Specifically, the HAES principles focus on accepting body diversity, supporting equitable policies that improve health, delivering respectful health care, and promoting eating for wellbeing and engagement in life enhancing movement. Such approaches are consistent with the Strategy's trauma-informed and compassionate approach to prevention, which is essential to address the health gap for Aboriginal and Torres Strait Islander people as well as those affected by mental ill-health.

The Select Committee into the Obesity Epidemic in Australia (The Senate, 2018) recommended that "Commonwealth funding for overweight and obesity prevention efforts and treatment programs should be contingent on the appropriate use of language to avoid stigma and blame in all aspects of public health campaigns, program design and delivery". Medicalised terms that pathologise body size, such as "overweight", "underweight", or "obese", are inherently stigmatizing and should be avoided. Using neutral descriptive terms such as "weight" or BMI range can reduce unintended harm for individuals across the BMI spectrum.

In line with the Select Committee's recommendation, the strategy must also recognise and challenge weight bias. For instance, on page 5 and 49 of the strategy, it is claimed that there is a link between "severe obesity" and severe illness from COVID-19. However, several studies refute this claim. An examination of risk factors for hospitalisation, mechanical ventilation and death found that BMI >35 vs 18.5-24.9 was not significantly associated with mortality. (see Ioannou GN, Locke E, Green P, et al. Risk Factors for Hospitalization, Mechanical Ventilation, or Death Among 10 131 US Veterans With SARS-CoV-2 Infection. JAMA Netw Open. 2020;3(9):e2022310. doi:10.1001/jamanetworkopen.2020.22310). Similarly, a study in Spain found that a BMI over 30 was not associated with mortality among patients hospitalised for COVID-19. (See Velasco-Rodríguez D, Alonso-Dominguez JM, Vidal Laso R, Lainez-González D, García-Raso A, et al. (2021) Development and validation of a predictive model of in-hospital mortality in COVID-19 patients. PLOS ONE 16(3): e0247676. https://doi.org/10.1371/journal.pone.0247676) A study conducted in the Netherlands found a higher BMI was not related to proposed mechanisms such as different immunological response, or unfavorable respiratory mechanics, or impaired outcome in COVID-19 patients receiving intensive care. (see Kooistra, E.J., de Nooijer, A.H., Claassen, W.J. et al. A higher BMI is not associated with a different immune response and disease course in critically ill COVID-19 patients. Int J Obes 45, 687–694 (2021). https://doi.org/10.1038/s41366-021-00747-z)

Quaternary prevention focuses on reducing harms caused by medical interventions for a disease or disorder (pg. 19) which must include preventing weight bias, stigma and discrimination in health care contexts. A focus on weight has been increasingly discouraged by several medical agencies, who are now advocating to help people optimise their health, regardless of weight status (see Royal Australian College of Physicians (2018). Action to prevent obesity and reduce its impact across the life course: RACP position statement on obesity. Sydney, NSW: RACP.) and focus on health gain rather than weight loss (see Royal Australian College of General Practitioners. (2019). Obesity prevention and management: Position statement. Melbourne, VIC: RACGP.)

We commend the strategy for recognising commercial determinants of health (p. 17) and pledging to protect public health policies and strategies from undue influence from vested commercial interests (pg. 36). Consistent with this commitment, we strongly recommend that reference to the PwC Australia (2015) report (p 21) be removed as this report was commissioned by Obesity Australia, who are funded by an unrestricted grant from Novo Nordisk, a pharmaceutical company with a vested commercial interest in pathologising high body weight (see PwC (2015) Weighing the cost of obesity: A case for action, pg 12.).