Submission No. 012

14 June 2017

To whom it may concern,

## RE: Proposed outcome measures for Healthy Futures Commission Queensland

We are a group of Queensland-based health and fitness professionals with an interest in assisting the aims of the Commission. We applaud the formation of the Healthy Futures Commission Queensland to 'support the capacity of children and families to adopt a healthy lifestyle' and 'contribute to reducing health inequity for children and families.' Every day in our work we see the power of the social determinants of health to influence the opportunities people have in participating in health promoting activities. It is indeed time to lead by innovation as a focus on weight loss as a proxy for health has regrettably resulted in little sustained benefit<sup>1</sup> and inequitable opportunities for health improvement in the populations at risk for lifestyle-related chronic disease.

We are making this submission because we have grave concerns about the prevalence of childhood obesity being used as the primary outcome measure of program success in this population, as stated in the press release and parliamentary documents. Positive changes to dietary patterns and physical activity are not automatically expressed in changes to weight, and BMI is not an accurate or adequate tool to assess lifestyle behaviours or health status in children or adults.

While body weight and growth patterns in children are certainly influenced by a multitude of factors including diet and physical activity, using BMI to assess the impact of the Commission is misguided. Note that the definition of overweight in childhood is a BMI between the 85<sup>th</sup> and 95<sup>th</sup> percentiles, and obesity is a BMI of greater than the 95<sup>th</sup> percentile on the CDC age adjusted growth charts<sup>2</sup>. This means that 10% of children will be classed as overweight and 5% will be classed as obese as a completely normal part of their growth pattern. The published prevalence of Queensland childhood obesity is 7% and of overweight children is 19%<sup>3</sup>. With this fact in mind, it is clear the proposed efforts directed towards 26% of Queensland children will be unnecessary for almost 60% of them; that's 150 000 children in real figures. Unnecessarily interrupting the normal growth and development for these children may well confer harm and this risk should not be disregarded. Contrast this with the 300 000 children (30%) who do not eat sufficient fruit, 960 000 children (96.3%) who do not eat sufficient vegetables, and 550 000 children (55%) who are not sufficiently active for health and it becomes clear that an undue focus on larger kids is inequitable.

Parliamentary documents<sup>4</sup> assert that 'the over-arching purpose of the commission is to support the capacity of children and families to adopt a healthy lifestyle through a focus on promoting physical activity and healthy eating'. It follows then that it is these factors that should be used as key outcome measures of change, not BMI. It is the exception rather than the rule that significant positive changes in these areas impacts upon BMI in children. Nourishing, health-supporting diets are not defined solely by their energy content. Children of all sizes can be sedentary and have poor diets, just as active well-nourished children come in all shapes too. Focussing efforts on and thus pathologising larger kids entrenches weight stigma<sup>5</sup> which is itself a predictor of poorer health in adulthood and the development of disordered eating and eating disorders<sup>6</sup> through adolescence and beyond.

We strongly encourage the commission to provide funding to projects that prioritise health related behaviour-based, quality of life, equity-impact-related outcomes or growth-velocity-based outcome measures rather than BMI. The Healthy Futures Commission Queensland could be a world leader in this space by incorporating weight-neutral policy into its objectives, activities and outcomes.

Our contact details are below and overleaf if you wish to discuss these factors further; we welcome consultation.

Sincerely,

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<sup>5</sup> Brewis A, 2014, *Stigma and the perpetuation of obesity*, Social Science and Medicine <u>http://www.sciencedirect.com/science/article/pii/S0277953614005206</u> <sup>6</sup> American Academy of Pediatrics, 2016, *Preventing Obesity and Eating Disorders in Adolescents* 

<sup>&</sup>lt;sup>1</sup> National Health and Medical Research Council (NHMRC), 2013, Clinical practice guidelines for the management of overweight and obesity in adults, adolescents and children in Australia, p161 <u>https://www.nhmrc.gov.au/\_files\_nhmrc/publications/attachments/n57\_obesity\_guidelines\_140630.pdf</u>

<sup>&</sup>lt;sup>2</sup> Royal Children's Hospital Melbourne <u>http://www.rch.org.au/childgrowth/Overweight\_and\_obesity/</u>

<sup>&</sup>lt;sup>3</sup> Queensland Government, 2016 Chief Health Officer Report, p75 <u>https://www.health.qld.gov.au/research-reports/reports/public-health/cho-report/2016/full#8</u> <sup>4</sup> Healthy Futures Queensland Commission Bill, presented 23 May 2017 by Hon. CR. Dick, transcript:

http://www.parliament.qld.gov.au/documents/tableOffice/BillMaterial/170523/Healthy.pdf

http://pediatrics.aappublications.org/content/early/2016/08/18/peds.2016-1649

Health Futures Commission Queensland Bill 2017	Submission No.012
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