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The nutrition problem – the magnitude of the issue and lack of policy response

Throughout Australia, poor diet is now the leading preventable risk factor contributing to disease and disability (Institute for Health Metrics and Evaluation, 2013). This is particularly the case in Aboriginal and Torres Strait Islander groups, whose rates of diet-related diseases are much higher than for non-Indigenous Australians (Australian Indigenous HealthInfoNet 2016). For example, the age-adjusted rates of diabetes and kidney disease are now three times higher and that of heart disease is 20% higher in Indigenous Australians than in other Australians. Many of these conditions are underscored by overweight and obesity, which affect 66% of Aboriginal and Torres Strait islander adults. At the same time, undernutrition is also common in some indigenous communities; for example the prevalence of anaemia is high among pregnant women, infants and young children (Boesler 2013). Growth failure, or failure-to-thrive, of Aboriginal infants and toddlers remains a serious problem, especially in remote communities; the main reason for this is insufficient intake of healthy foods between the ages of six months and two years (RACGP 2016).

Therefore, it is very surprising that a focus on nutrition has not been included in efforts to close the gap on Indigenous health and disadvantage (Browne et al, 2014). Indeed, this has been suggested as a key reason why, other than slightly reduced rates of cigarette smoking, efforts to improve Aboriginal and Torres Strait islander health under the Council of Australian Governments’ Closing the Gap strategy (Australian Government 2016) have showed little improvement (Browne et al 2014; Simpson 2016; Lee and Turner 2016).

The social determinants of poor nutrition and health - Why is poor diet such a problem in Aboriginal and Torres Strait Islander communities?

All available evidence confirms that Aboriginal and Torres Strait Islander Peoples were fit and healthy before European settlement of Australia. The positive characteristics of the traditional diet are summarised in contrast with the features of Aboriginal and Torres Strait Islander Australians’ current diet (ABS 2015) in Table 1.

Table 1. Selected characteristics of hunter-gatherer and contemporary Indigenous diet

<table>
<thead>
<tr>
<th>Traditional diet</th>
<th>Hunter-gatherer life</th>
<th>Contemporary life</th>
</tr>
</thead>
<tbody>
<tr>
<td>Energy intake</td>
<td>Adequate</td>
<td>Excessive</td>
</tr>
<tr>
<td>Animal food intake</td>
<td>High</td>
<td>Moderate</td>
</tr>
<tr>
<td>Plant food intake</td>
<td>Moderate</td>
<td>Low</td>
</tr>
<tr>
<td>Discretionary (junk) food</td>
<td>Not available</td>
<td>Available</td>
</tr>
<tr>
<td>Energy density of the diet</td>
<td>Low</td>
<td>High</td>
</tr>
<tr>
<td>Nutrient density of the diet</td>
<td>High</td>
<td>Low</td>
</tr>
<tr>
<td>Protein content of diet</td>
<td>High</td>
<td>Low-moderate</td>
</tr>
<tr>
<td>Carbohydrate intake</td>
<td>Moderate (slowly digested)</td>
<td>High (rapidly digested)</td>
</tr>
<tr>
<td>Sugars</td>
<td>Low</td>
<td>High</td>
</tr>
<tr>
<td>Dietary Fibre</td>
<td>High</td>
<td>Low</td>
</tr>
<tr>
<td>Fat</td>
<td>Low</td>
<td>High</td>
</tr>
<tr>
<td>Saturated fat</td>
<td>Low</td>
<td>High</td>
</tr>
<tr>
<td>Alcohol</td>
<td>Not available</td>
<td>Available</td>
</tr>
</tbody>
</table>
A very worrying statistic from the recent Australian Health Survey (ABS 2015a) is that over twenty percent of Aboriginal and Torres Strait Islander respondents reported running out of food during the last 12 months and not being able to afford to buy more.

This high proportion confirms that Aboriginal and Torres Strait Islander groups are vulnerable to food insecurity. The United National Food and Agricultural Organization defined food security as existing when all people, at all times, have physical and economic access to sufficient, safe and nutritious food that meets their dietary needs and food preferences for an active and healthy life (FAO 1996).

One of the rejected ‘Close the Gap’ equity targets in the area of food security was that, by 2018, 90% of Indigenous families could access a healthy food basket for less than 25% of their income (Lee et al 2009). Currently, healthy diets can cost over 50% of household’s disposable income, as highlighted in 2015 in the Torres Strait to then Prime Minister Abbott (Lee and Turner 2016).

What’s been tried- what worked and why?

Improving nutrition can be complex, but remarkable successes have been achieved.

For example, the people of Minjilang in Arnhem Land in the early 1990s showed in a robust intervention study- the Survival Tucker project- that rapid, marked and sustained improvement in objective measures of dietary intake, nutritional status and biomedical risk factors for chronic disease are possible (Lee et al 1994; 1995). The community worked with the store to improve food supply and, in just 12 months, achieved reductions in unhealthy cholesterol levels (by 12%), increases in red blood cell folate (by 234%) and plasma ascorbic acid (by 252%), lowering of blood pressure (by 8%) and normalization of weight status and glucose tolerance tests indicative of diabetes. The main reason for success was that the multi-strategy project was directed and controlled by the community. However, these positive results have not been replicated widely.

What’s been tried-what didn’t work and why not? What’s happening now?

The National Aboriginal and Torres Strait Islander Nutrition Strategy and Action Plan 2000-2010 provided a framework to address both food supply and demand. Evaluation showed some promising results, particularly in workforce development, but implementation was poorly resourced and hence patchy (Urbis 2010). In 2009, the Council of Australian Governments developed the National Strategy for Food Security in Remote Indigenous Communities; a subsequent audit also found that resourcing has been very poor so few outcomes have been achieved (Australian national Audit Office 2014).

Since 2010 there has been a nutrition policy vacuum in Australia. Aboriginal and Torres Strait Islander health services and community leaders persevere, but efforts tend to be opportunistic, fractured and ad hoc due to lack of resources, support and coordination. Current projects mainly focus on nutrition education of children and school-based activities, including gardening (Australian Indigenous HealthInfoNet 2016a). Most Indigenous nutrition work is currently centred on rural and remote communities; in urban areas there are even fewer projects underway. Nationally, there is little co-ordination and very little funding provided for initiatives to improve food supply and address the determinants of poor nutrition.

Remote community store groups, such as Arnhem Land Progress Association (ALPA 2016) and Retail Stores in Queensland (Queensland Government 2016) have confirmed the benefits of store nutrition policies. Outback Stores (Outback Stores 2016) was established in 2006 to improve diet-related health in remote Australia by addressing unreliable food supplies, poor store management and debt. This government funded venture provides little transparency around nutrition data, but in senate estimates in February 2016 admitted selling 1.1 million litres of sugar sweetened soft drink per year in its 36 stores (ABC News 2016).

Most recent nutrition research efforts focus on cutting high sugar intake or increasing intake of fruit and vegetables (for example, Brimblecombe et al 2013; Black et al 2013). But while these seem like obvious targets, it’s not that simple. Our recent study (Lee et al 2015) describes efforts to improve nutrition over the last 30 years in Central Australian communities now serviced by the Mai Wiru Regional Stores Council (Mai Wiru 2016). It shows that, despite some achievements including decreased sugar (from 30% to 22% of energy intake), increased availability and affordability of fruit and vegetables leading to a doubling of consumption, and consequent improvement in some nutrient intakes, the overall effect has been a decrease in total diet quality. This is characterized by a 3% increased intake of ‘junk’ foods and drinks, particularly sugar sweetened soft drinks,
convenience meals such as microwavable pizzas and unhealthy take-away foods. During this time Mai Wiru also lost funding for its nutritionist.

These results confirm that Aboriginal communities in remote areas can exert control over some aspects of their food supply. But the overall findings demonstrate that concerted action and more resources are required to help communities tackle the broader impacts of the current Australian food system on our health.

A major barrier is that community stores are seen as small businesses rather than as essential services and are subject to commercial pressures to sell cheap, unhealthy food at high profit margins. One worrying recent example is the advent of private-enterprise bakeries in Northern Territory communities. These are promoted as providing local employment opportunities and solutions to food insecurity - but mainly sell unhealthy options (Alice Springs News 2015).

What more needs to be done?

It is clear that systematic, widespread, sustained implementation of evidence-based nutrition programs is required urgently in both urban and rural/remote locations (Lee et al 2009). Based on past successes, the cost-effective mix must include structural and regulatory changes to improve availability, affordability, accessibility and promotion of healthy food. Increased community capacity to prepare, cook and store healthy foods is also essential, for example by improving housing. Evidence-based economic interventions such as freight-subsidies, cross-subsidisation of healthy food and “fat taxes” are really to be tested (Lee et al 2009). Effective primary care strategies for application in local health centres, such as brief interventions based on stages-of-behaviour change theory, “well person’s health checks”, breastfeeding promotion and infant growth assessment and action programs, are ready and waiting for funding to be implemented and expanded (Lee et al 2009).

But the major need to improve Aboriginal and Torres Strait Islander nutrition and health is for real community consultation, improved public governance and political will.
Student activities:

1. a. Why is there a concern about poor diet and nutrition in Aboriginal and Torres Strait Islander people?
   
   b. Are these dietary concerns and consequences shared among other population groups in Australia? Provide evidence for your response.

2. How have the diets of Aboriginal and Torres Strait Islander groups changed since European settlement?

3. Identify and describe the social determinants of nutritional health among Australians.

4. a. Identify and describe the major nutrition-based conditions that are prevalent among Aboriginal and Torres Strait Islander people.
   
   b. What are the major factors contributing to the poor nutrition of many Aboriginal and Torres Strait Islander people?

5. a. Define food security.
   
   b. How is food security threatened in Indigenous communities?

7. The Dietary Guidelines for Australians make recommendations for Indigenous people. Justify the inclusion of these recommendations.

8. Discuss the practical considerations to keep in mind when implementing dietary change among individuals, families and community groups.

Going further

9. a. What are the current government food and nutrition policies in Australia?
   
   b. Describe the role of government policy in improving the nutritional status and health of Australians.

10. Write a persuasive article that argues for the inclusion of food and nutrition initiatives in the Council of Australian Governments Close the Gap strategy to improve Indigenous disadvantage.
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SHOULD WE BE EATING FOOD THAT CONTAINS FAT?

Dr Rebecca Reynolds, lecturer and nutritionist, University of New South Wales

What is dietary fat?

Fat in foods and drinks, or dietary fat (fat that you eat and drink as part of your everyday diet), occur as triglyceride units. Triglycerides are three (‘tri’) fatty acids joined to one glycerol. The fatty acids of the triglycerides can be either saturated or unsaturated. See Figure 1 below.

![Figure 1. Triglyceride units that make up fat. The fatty acids can be saturated or unsaturated](image)

Saturated fatty acids are ‘saturated’ with hydrogen atoms, whereas unsaturated fatty acids are not because they have carbon-carbon double bonds. See Figure 2 below.

![Figure 2. Saturated fatty acids don’t have double bonds, whereas unsaturated fatty acids do](image)

There are several types of unsaturated fat: monounsaturated, polyunsaturated or trans-fat. Monounsaturated fats have one (‘mono’) double bond in the ‘cis’ arrangement (where the hydrogen atoms are on the same side), whereas polyunsaturated fats have more than one (‘poly’) double bond in the ‘cis’ arrangement. There are two types of polyunsaturated fat: omega-3 (also called n-3) and omega-6 (also called n-6). The numbers refer to the carbon atoms where the double bond occurs, i.e. omega-3 fatty acids have one of their double bonds at the 3rd carbon atom from the end of the carbon chain, while omega-6 at the 6th carbon atom from the end of the carbon chain. Lastly, trans-fats have double bond/s in the ‘trans’ arrangement (where the hydrogen atoms are on opposite sides).

These varying structures of the fatty acids cause the different types of dietary fat to behave differently, e.g. whether they are solid or liquid at room temperature (20°C), as well as how they affect human health.

What foods and drinks contain dietary fat?

Saturated fats are usually solid at room temperature and are mostly found in high amounts in animal foods. Just think of butter (although not on a hot day!) and the obvious fat bits on a steak. However, there are foods and drinks that are not solid at room temperature but contain high levels of saturated fat, like cream and milk. Saturated fat can also occur in plant foods, including coconut oil and margarine; and processed foods, like cakes and deep-fried takeaway foods.

In comparison, unsaturated fats are usually liquid at room temperature and are found in higher quantities in plant foods. Monounsaturated fats are high in olive oil, nuts and avocados. Omega-3 polyunsaturated fats are found in oily fish like salmon, eggs and flaxseeds. Omega-6 polyunsaturated fats are found in margarine, nuts, soy(bean) oil and sunflower seeds.
Table 1. The different types of dietary fat found in food and drinks

<table>
<thead>
<tr>
<th>Type of Fat</th>
<th>Structural Properties</th>
<th>Mainly Naturally-occurring or Commercially-produced?</th>
<th>Found in High Levels in What Foods and Drinks? See: <a href="http://daa.asn.au">Link</a> for more information</th>
<th>Likely/possible Effects on Human Health?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Saturated</td>
<td>No double bonds</td>
<td>Solid</td>
<td>Natural (animal foods)</td>
<td>Natural saturated fats</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Animal: butter, cream, milk*, cheese*, unprocessed meat* (e.g. steak) and processed meat (e.g. salami)</td>
<td>/ maybe saturated fats in dairy aren't as bad as most saturated fats</td>
</tr>
<tr>
<td>Unsaturated</td>
<td>All Double bond/s</td>
<td>Solid</td>
<td>Commercial (processed foods)</td>
<td>Natural unsaturated fats are healthier</td>
</tr>
<tr>
<td>Trans-Fats</td>
<td>1+ double bond/s in trans configuration/s</td>
<td>Solid</td>
<td>Processed, commercial (processed foods)</td>
<td></td>
</tr>
<tr>
<td>MUFA</td>
<td>1 double bond in cis configuration</td>
<td>Liquid</td>
<td>Natural (plant foods)</td>
<td>Natural (plant foods)</td>
</tr>
<tr>
<td>PUFA</td>
<td>All</td>
<td>Liquid</td>
<td>Olive oil, canola oil, peanut oil, nuts, avocados</td>
<td>Natural (plant foods)</td>
</tr>
</tbody>
</table>

Key: MUFA = monounsaturated fatty acids, PUFA = polyunsaturated fatty acids, likely mostly beneficial to human health, / more uncertainty with harms/benefits to human health, likely mostly harmful to human health
Trans-fats are unsaturated fats that have been commercially changed so that they act more like saturated fats, e.g. they are solid at room temperature, and therefore useful in making products like biscuits and cakes.

Common belief has been that all fat is bad and/or that saturated fat and trans-fats are ‘bad’ and/or that unsaturated fat is ‘good’. We will discuss this further below. See Table 1 for a summary of the different types of fat and their proposed effects on health.

What have we been advised to do about eating fat in the past?

In the early to mid-1900s, discoveries about the energy value of different macronutrients led to the establishment of ‘Atwater Factors’ (FAO, 2003). These are standardised values of how much energy, or kJ/kcal/calories, a nutrient such as fat or carbohydrate provides to the human body.

Fat was assigned the highest value of 37 kilojoules per gram, indicating it provides the most energy per weight unit (gram) to the human body out of all the macronutrients (more than carbohydrates, protein and alcohol). As it was the most energy-dense, this contributed to a belief that a high-fat diet would lead to weight gain.

Then, around the mid-1900s, various research studies were published about fat and human health, particularly regarding cardiovascular health. A scientist named Ancel Keys reported findings of the Seven Countries Study (The Online Scientist, 2016), highlighting a statistical association in population data from seven countries between eating saturated fat and trans-fat and an increased risk of coronary heart disease.

Even though the detrimental effects on heart health were not attributed to unsaturated fats in this example study, unfortunately a general feeling of malaise towards all types of fat mostly strengthened. There were some movements from around the 1970s onwards that advocated a high-fat, low-carb way of living — such as the Atkins Diet (Mayo Clinic, 2014).

What is the advice now?

Worldwide, there has been variation in when governments or organisations have issued dietary guidelines for their populations (FAO, 2016). The Australian Dietary Guidelines were first issued in 1982 (NHMRC, 2016), in the United States in 1980 (Office of Disease Prevention and Health Promotion, 2016) and in the United Kingdom in 1994 (British Nutrition Foundation, 2015).

Most of the advice has included care with total fat intake, avoidance of the ‘bad’ saturated and trans-fats and a mostly monitored consumption of ‘healthier/good’ unsaturated fats. It’s important to note that we need to consume fat in our diets, or else we would die! There are ‘essential fatty acids’ to our health: omega-3 and omega-6 fats (NHMRC, 2014a). If we don’t get enough of these, then we may develop rough, scaly skin or dermatitis (these fats are essential vital components of healthy skin). High fat foods can also provide other ‘good’ nutrients, like antioxidants in extra virgin olive oil that are beneficial for health (DAA, nd).

Current Australian Dietary Guidelines (NHMRC, 2013a) are similar to previous ones regarding fat, and mirror the current advice given by many countries across the globe. The main message is to be careful of overall fat intake due to its energy density and the current issue of excess weight and obesity (AIHW, 2016), but be particularly careful of saturated and trans-fat intake because of their detrimental effects on cardiovascular health.

They usually also recommend the more ‘pure’ unsaturated fats in moderation as there is evidence (Mozaffarian et al, 2010) unsaturated fats have health benefits, but again, there is the high energy-density issue.

This translates to eating high protein and dairy food options such as lean meats, fish, some nuts and reduced-fat dairy; eating high unsaturated fat foods such as nut butters and olive oil in small amounts; and avoiding foods high in saturated fats and trans-fats such as butter, coconut oil and processed foods like biscuits.

Fat into the future

The dietary advice at supermarket for fat measures are often misleading. These fat free products offers lots of processed carbohydrate options and are mostly low in fibre (fibre is a great thing for most bodies) (NHMRC, 2014b) and high in glycemic index (which is a bad thing for most bodies) (The University of Sydney, 2016).

For example, rice crackers are not a healthy choice, even though they may advertise 99% fat-free. Similarly, flakes made from corn are not healthy either, even though they may be low in fat. Reduced-fat yoghurt with grams and grams of added sugar is not the best yoghurt either. However, many of us see such fat claims and automatically assume the product is healthy (Mohr, 2012).
The Australian Dietary Guidelines are based on a thorough analysis of the best available evidence (NHMRC, 2013b). They advise what they should at this stage in nutrition science. However, there are problems with nutrition evidence. It is notoriously hard to measure what a person eats – diet is vastly more complex than whether a person smokes or doesn’t smoke, for example.

There is also bias in the reporting of research, over-ambitious conclusions of causation from association, and focus on single nutrients and foods instead of dietary patterns.

Perhaps nutrition evidence regarding fat will evolve in the future so that the guidelines become slightly modified. Some possibilities are listed below in the Summary.

**Summary**

Follow the Australian Dietary Guidelines in general (NHMRC, 2013a), but perhaps make some small tweaks in anticipation of a potentially new nutrition evidence future. Like:

- choosing lower GI carbohydrate foods, e.g. oats instead of wheat biscuits (The University of Sydney, 2016)
- eating some full-fat dairy, e.g. Greek yoghurt, instead of low-fat and sweetened yoghurt (Huth and Park, 2012) – but continuing to avoid most saturated fat and all trans-fat
- eating more extra virgin olive oil and nuts and seeds, i.e. increasing the fat content in your diet, but with foods high in ‘good’ fats (Estruch et al, 2016)
- avoiding (de Lorgeril and Salen, 2012) processed omega-6 polyunsaturated fats, such as vegetable oils like soybean oil (Blasbalg et al, 2011)
- focus on the actual foods and drinks that you mostly eat and drink, rather than focusing on particular nutrients - including fat. Mostly foods and drinks are often common sense, and include: fruits and vegetables; nuts and seeds; legumes like chickpeas; grainy bread; cereals like barley, oats and quinoa; eggs; unprocessed meat; fish; tofu; dairy; extra virgin olive oil; water; and black teas and coffees. It’s still ok to sometimes have rice crackers, sausages and biscuits, of course.

**Student activities:**

1. Discuss in small groups:
   a. what your definition of a ‘healthy food or drink’ is and then share your group’s ideas with the rest of the class
   b. what your family thinks about dietary fat
   c. what you have learned from your friends about dietary fat
   d. what you have taken from the media about dietary fat

2. Go to your local supermarket and:
   a. take some photos of some ingredients lists and nutrition information panels: [http://www.foodstandards.gov.au/consumer/labelling/panels/Pages/default.aspx](http://www.foodstandards.gov.au/consumer/labelling/panels/Pages/default.aspx) - how is fat listed?
   b. write down some of the food label nutrient content claims and health claims that you see: [http://www.foodstandards.gov.au/consumer/labelling/nutrition/Pages/default.aspx](http://www.foodstandards.gov.au/consumer/labelling/nutrition/Pages/default.aspx) - what products are these claims on? Do you think that the products that the claims are on are ‘healthy’?
   c. write down a selection of products have the ‘health star rating’: [http://healthstarrating.gov.au/internet/healthstarrating/publishing.nsf/content/home](http://healthstarrating.gov.au/internet/healthstarrating/publishing.nsf/content/home) - do you think that the products with the highest number of stars are ‘healthy’ products and those with the lowest number of stars ‘unhealthy’ products?
   d. write down a selection of products have the GI symbol: [http://www.gisymbol.com/](http://www.gisymbol.com/) - do you think that all of the products with this symbol are ‘healthy’?
References

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Further reading

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- http://www.thelancet.com/journals/landia/article/PIIS2213-8587(16)30085-7/abstract
Victorians have been subjected to a campaign of clandestine behaviour hacks to encourage us to consume healthier alternatives to the alcohol and sugar we seem to crave.

The campaign has included techniques such as hiding sugary drinks from view at the hospital, installing free drinking fountains at the footy and pushing pubs to promote water.

The program is detailed in a report to be released Thursday from behavioural psychologist David Halpern, head of the the Britain-based Behavioural Insights Team (BIT), following a period in residence with VicHealth.

The projects are experiments in methods to encourage healthier behaviour through suggestion, rather than prohibition.

“The fundamental objective is to make sure that at least in most of these cases there is an easy and attractive alternative,” he said. “If you want to change something, don’t say ‘Stop’, but offer a better alternative. The challenge is, coming out of a stadium for example, what can the healthier alternative be?”

**Behaviour hack 1: water at the footy**

Embattled Etihad Stadium, which last year responded to complaints that food and drinks were too expensive, began allowing punters to bring their own to the footy, contacted VicHealth to run a trial encouraging healthier habits.

The trial involved installing and promoting free water fountains at the grounds, and the results are still being analysed. Dr Halpern said it was contentious because of the risk people would choose to drink water for free rather than pay at the concession stands.

There is a problem throughout sport - whether at the local Auskick or the MCG - that the options on offer for food and drink tended to be unhealthy at any age.

“Sometimes it is an ingrained culture and sometimes it isn’t, it’s just what we fall into the habit of doing,” he said. “If you offer a healthier alternative, [sometimes] people are just as happy to engage in that.”

**Behaviour hack 2: hiding sugary drinks at the hospital**

At the Alfred Hospital, a trial began by simply moving sugary drinks out of a prominent position and replacing them with healthier alternatives.

“They are in the business of making people healthier and I think they thought it was a bit ironic that they were serving unhealthy foods,” Dr Halpern said.

Despite the concern of the proprietor in this case, drink sales overall didn’t tank. Rather, the sale of high-sugar drinks fell 12 per cent while the sale of the healthier alternatives increased by the same amount.

Next, the price of the sugary drinks was lifted by 20 per cent. Again, the sale of those dropped - from about half of all drinks sold to 44 per cent - without any drop in overall sales.

“This means that we were able to reduce the kilojoule content of people’s purchases without adversely impacting revenue for the suppliers,” the report says. “This is incredibly important for potential scaling of this intervention as suppliers would be reluctant to implement anything that...
might reduce their profits.”

Behaviour hack 3: drinking (water) at the pub
VicHealth convinced four pubs to join them in promoting water at their venue. Unsurprisingly, this was “complicated”, according to the report.

“Making sure that water is available is fundamental, but getting businesses on side to implement and actively promote drinking it is hard,” the report says. “You can legislate for water to be available, but you can’t make punters drink it.”

They tried three different approaches: putting water on the menu, creating an “oasis” cooler on site with water offered with every order between 8pm and 1am, and a “control” group that just had water available without promotion.

The results were inconclusive, but researchers found that, for every 100 people in a bar, only three glasses of water were seen. For every 100 drinks ordered, only two were water.

The experiment was repeated in February with better resources for capturing data, with results expected to be published later this year.

Dr Halpern praised Australia’s leadership in adopting behavioural insights to target particular health outcomes, for example, with plain packaging for cigarettes.

He said the experiments were novel for Victoria, but that their impact could be felt for a long time to come.

“Victorians didn’t choose it, but we are evolving into a world where it’s easier to make the unhealthy choice,” he said. Adopting suggestive techniques to make healthier alternatives more viable and available could have massive benefits.

“We should be thinking, well, this does affect our behaviour, it’s consequential, so why don’t we just tilt it a bit in our own favour?”

Student activities:
1. VicHealth is a Victorian Health Promotion Foundation.
   a. What is the aim of VicHealth?
   b. How does VicHealth promote healthy eating?
   c. Justify the promotion of healthy eating by VicHealth.
2. The author of the article suggests that a variety of methods are suggested by VicHealth are implemented to discourage unhealthy eating behaviours.
   a. Identify each of the methods and the places (settings) where they were used.
   b. What evidence is provided by the author to support the claims made?
3. Dr Halpern contends that “...it’s easier to make the unhealthy choice.”
   a. Write a letter to the editor that supports this contention.
   b. Conduct a class debate on this topic. At the conclusion of the debate, write a persuasive piece that refutes the contention.
4. Consider your school environment.
   a. Describe the structures and policies that both encourage and discourage health eating behaviours.
   b. Make and justify suggestions that may encourage healthy eating behaviours at school.