

Inequities in obesity: Indigenous, culturally and linguistically diverse, and disability perspectives

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Key points

- Higher rates of obesity are among the health inequities experienced by Indigenous Australians, people with disability and culturally and linguistically diverse (CALD) people in Australia
- Translational research that involves Indigenous communities at every stage of the research process is vital to reduce obesity and type 2 diabetes incidence among Indigenous Australians
- Investment in tailored, accessible, and codesigned early intervention and preventive care is needed to address entrenched disparities in obesity experienced by people with disability
- Creative solutions that address migration-related social determinants of health must be developed to address disparities in obesity experienced by CALD communities in Australia

Abstract

Population groups, including Aboriginal and Torres Strait Islander peoples, people with disability, and people from culturally and linguistically diverse communities (CALD) experience health inequity and resulting disparities in disease rates. These include higher rates of obesity and associated chronic diseases. This paper brings together three perspectives by researchers in the fields of Indigenous health, disability and CALD health to examine how overweight and obesity impact these populations in Australia and to put forward ways of addressing the problem. The authors urge investment in research co-designed with people from each of these communities and with lived experience of obesity to build valuable knowledge about what preventive actions and interventions will work to reduce obesity rates. They call for evidence-based, tailored obesity prevention programs to address these historical disparities and improve health outcomes among some of Australia's disadvantaged populations.

Improving health equity for Indigenous communities: obesity, chronic disease, and laying the foundation for closing the gap

By Ray Kelly

The rate of obesity in Aboriginal and Torres Strait Islander peoples in Australia (hereafter referred to as Indigenous Australians) has been increasing, rising from 40% of adults in 2012–13 to 45% in 2018–19.¹ Obesity and associated chronic conditions such as cardiovascular disease and type 2 diabetes are the greatest health issues experienced by Indigenous Australians across the lifespan.² The rates of obesity and associated conditions could be significantly reduced through improvements in the quality of food consumed, increased physical activity and maintaining a healthy weight.³

In 2008, the Australian Government renewed its focus on Indigenous health through its Closing the Gap framework, and while the annual report on its progress brings focus to the issues, we have fallen short on meeting several targets.⁴ Target 1 of the framework uses life expectancy as a measure of whether Indigenous Australians are experiencing long and healthy lives⁵, however, high prevalence of obesity and type 2 diabetes is associated with shorter lifespans.⁶ The 2022 *Closing the Gap – annual data compilation report* stated that “the national target of ‘no gap’ in life expectancy is not on track to be met for males or females”.⁷

A need for quality research

Quality research across Indigenous health has not been given the importance it deserves. A recent study by Kennedy et al. reviewed the health research completed since the initial *Closing the Gap* report was published in 2008.⁸ In total, 2150 Australian studies were assessed, with the majority being descriptive in design. Only 2.6% of all studies in Indigenous health since 2008 have been randomised controlled trials (RCTs), the type of research that can provide a greater understanding about the cause of health issues and the effectiveness of interventions. While other research designs can be useful in collecting knowledge, they are less likely to lead to a change in clinical practice required to achieve better outcomes.

Physical activity and diet have consistently been the first line of treatment for the prevention and management of type 2 diabetes.³ Yet, there have been limited studies on the impact of physical activity for Indigenous Australians diagnosed with type 2 diabetes. Even more surprisingly, no RCTs have been completed that investigate the combined impact of diet and physical activity interventions.

Despite this lack of research, the advice given by health professionals to Indigenous Australians for the management of weight and associated chronic diseases is often described as research-based, and is treated as if it has been proven to be effective through research. Many patients are not successful in managing weight through recommended interventions and wear the blame for overweight and obesity. However, I believe that we, as health professionals, need to take responsibility if outcomes are not achieved. We need to improve what we are doing. The focus needs to change from what should work to what does work.

The *Australian dietary guidelines* are the basis for dietary advice when it comes to obesity and related chronic diseases.⁹ However, given the scarcity of research performed with Indigenous Australian input that has contributed to the guidelines, it is questionable whether the guidelines are suitable for Indigenous Australians. In the most recent update of the guidelines in 2013, it was noted that any changes would be based on systematic reviews.¹⁰ However, guideline authors noted “there were

no reviews on dietary patterns amongst Indigenous Australians”, so a broader search to find individual studies was completed. Of those studies provided in the report, only one investigated type 2 diabetes.¹¹

So, if this dietary advice has not been truly tested with the Indigenous population, how can we be so confident that it is appropriate?

Is this just another ongoing aspect of colonisation, where the dominant cultural values are deemed more appropriate, even in the absence of research evidence?

The way forward

While research is lacking, we have seen some effective studies in Indigenous health that could give us a good foundation for moving forward.

In 1984, O’Dea showed that Indigenous Australians could reverse type 2 diabetes, reducing fasting blood sugars by 5.0 mmol/L and losing 8 kg in just 7 weeks by temporarily adopting a traditional lifestyle.¹² In a more recent study, Power et al. also reported an average weight loss of 7.46 kg and a reduction in HbA1c of 1.68% over a 10-week program.¹³ Both these studies took a strength-based approach and involved the Indigenous community in design and implementation. The meal plans were both high in protein and reduced daily calorie intake. Historically, the traditional Indigenous diet was high in protein, and it has been noted that type 2 diabetes and heart disease are virtually non-existent in communities that still live traditionally.¹⁴

It is easy to understand why many Indigenous people are disillusioned about the prospect of health equity when we hear many acknowledging the issues, but little is being achieved. In the first national report on Aboriginal health in 1979, the authors noted:

“When innumerable reports on the poor state of Aboriginal health are released, there are expressions of shock or surprise and outraged cries for immediate action. However, the reports appear to have no real impact and the appalling state of Aboriginal health is soon forgotten until another report is released.”¹⁴

It seems that 43 years on, we still have the same problem.

To reduce obesity and type 2 diabetes and improve health outcomes for Indigenous Australians, we need more translational research that involves Indigenous communities at every stage of the research process. Indigenous-led evidence, drawing on lived experience, will improve the quality of data analysis and, in turn, the addition of new knowledge. As the interventions informed by this research are implemented and evaluated, we can build new knowledge and provide Indigenous Australians with the health equity they deserve.

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Disability and obesity in Australia: current issues in health and social care equity and future directions for policy and practice

By Kostas Hatzikiriakidis

Obesity has been identified as a significant global health issue, particularly among populations that often experience disadvantages when it comes to equity in health and social care, including people with disability. People with disability have been recognised as a health disparity population and experience a disproportionate risk for poor health outcomes across the lifespan.¹⁵ In Australia, recent statistics estimate that approximately 4.4 million people have a disability; of this population, approximately 72% have either overweight or obesity, compared with 55% of people without disability.¹⁶ A higher risk of mortality and lower life expectancy has also been identified in people with disability, and overweight and obesity identified among the common contributors to potentially avoidable deaths.¹⁷ National research also suggests that obesity may be associated with an increased long-term risk of physical disability in later life.¹⁸

In understanding the health outcomes of this population, biomedical models attribute health disparities to disability itself, while social models challenge this perspective and argue that adversity results from barriers in the social, economic, and political environment.¹⁹ As an alternative understanding, the human rights model, values disability and impairment as a natural part of human diversity and highlights the responsibility of governing bodies to ensure that basic rights to accessible health and social care are maintained.¹⁹ The World Health Organization's *International classification of functioning, disability and health* (ICF)²⁰ is one of the most widely accepted frameworks used to conceptualise disability. The ICF recognises that disability and health are multifaceted constructs arising from the interaction between bodily functions and impairments, activity limitations and participation restrictions, and contextual factors.

Entrenched health disparities

Research has partly attributed the health disparities experienced by people with disability to health behaviours such as physical inactivity and unhealthy eating and inequalities across a broad range of social determinants, including higher unemployment rates, lower household income, inadequate transportation access, and an increased risk of exposure to violence, relative to individuals without disability.¹⁵ Although many factors contribute to the disproportionate risk for overweight and obesity, the health outcomes of this population are often perpetuated by inequalities in access to preventive healthcare and the unavailability of tailored health

promotion initiatives.¹⁵ From a healthcare perspective, this includes the lack of early referral to services such as dietitians, exercise physiologists and modified lifestyle programs, following the identification of overweight and obesity, and the sensitivity of these services in responding to individual needs.¹⁷ Further, the appropriateness of standard anthropometric screening assessments used for weight monitoring and the delivery of clinical interventions to treat obesity in people with disability have been queried, and strategies to manage the obesogenic side effects of medications prescribed to people with disability may be overlooked.²¹

Historically, inequalities across social care systems have similarly been reported, with reference to key determinants such as the knowledge and capacity of caregivers to create opportunities for healthy living. This sits alongside the need for staff training that supports the promotion of a healthy lifestyle and the presence of organisational policies that direct processes of care.²² Moreover, children with disability experience many barriers to accessible and developmentally appropriate health promotion interventions, despite early childhood being identified as a critical window for early intervention.²³ This may include support for parents and caregivers in creating a nurturing caregiving environment that meets the health promotion needs of children with disability, alongside tailored physical activity and nutrition programs and the accessibility of exercise facilities and affordable nutrient-rich foods.²³ In addition, addressing intersectionality is critical, as there is evidence to suggest that inequalities in access to health and social care services are exacerbated among other priority groups in Australia, such as people with disability who are Aboriginal and/or Torres Strait Islander.²⁴ These inequities are deeply entrenched in a long history of disadvantage, discrimination, segregation, isolation from society, adverse living conditions associated with institutionalisation, and exclusion from mainstream public healthcare.¹⁵

The development of policies and initiatives to provide support for people with disability has received increasing attention through the implementation of initiatives in Australia, such as the National Disability Insurance Scheme²⁵ and the Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability.²⁶ During the recent coronavirus disease 2019 (COVID-19) pandemic, governing bodies have been criticised for the inadequate prioritisation of people with disability in emergency response plans, and challenges in accessing health and social care services have exacerbated, despite their identification as an 'at-risk' population.²⁷ Now, more than ever, prioritising the health of people with disability is critical. Supporting the health and wellbeing of people with disability has been recognised as a growing priority under *Australia's disability strategy 2021–2031*.²⁸ The Strategy aims to promote societal inclusiveness for people with disability and recognises the need for working towards achieving

health equity through appropriate prevention and early intervention services. In addition, the recently released *National obesity strategy 2022–2032*²⁹ has outlined several priorities that are specific to people with disability, such as increasing the availability of health education programs designed to strengthen practical skills, upskilling the health and social care workforce in health promotion and obesity prevention, and ensuring that people with disability are included in the co-design of obesity prevention initiatives.

Addressing inequities experienced by people with disability

In the context of obesity prevention and management, there is a need for investment in tailored and accessible early intervention and preventive care for people with disability and investment in supporting people with disability to live a healthy lifestyle. Priorities include building health and social care systems by:

1. Addressing the barriers to health service access and upskilling the healthcare workforce through the development and implementation of policies and clinical practice guidelines for the prevention and management of obesity that are specific to people with disability
2. Investing in policies, guidelines, and training to support and empower disability service providers, staff, and caregivers in directing attention to the health needs of people with disability and creating an accessible living environment that is conducive to a healthy lifestyle
3. Breaking down silos and strengthening interdisciplinary coordination between healthcare systems and disability service providers to provide a holistic and integrated approach to health promotion for people with disability.

Importantly, the development of obesity prevention strategies in consultation with people with disability is warranted to ensure that the voice of lived experience is adequately represented. Overall, continued investment in the health of people with disability in Australia is needed to ensure that people with disability are protected and receive the accessible health and social care to which they are entitled and deserving.

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Obesity prevention from culturally and linguistically diverse perspectives

By Konsita Kuswara

Culturally and linguistically diverse (CALD) voluntary immigrants in Australia have been shown to have better health upon arrival than the Australian-born population.³⁰

Despite the initial health advantage, CALD immigrants are more susceptible to overweight and obesity than the Australian-born population due to assimilation to an 'obesogenic' environment characterised by the ubiquity of energy-dense foods and sedentary lifestyles in Australia.³⁰ Over time, CALD immigrants and their children experience a disproportionate health burden associated with obesity. For some immigrant groups (such as those from North Africa and the Middle East), the prevalence of overweight and obesity in adults is 40% higher than in the Australian-born population.³⁰ Similarly, children from CALD backgrounds, especially boys, are more likely to be affected by overweight and obesity compared to children from English-speaking backgrounds, even after controlling for socioeconomic factors.³¹

Migration as a determinant of health

Migration is recognised as a distinct social determinant of health that must be considered in obesity prevention interventions for CALD communities.³² Cultural differences, low health literacy and language difficulties, and resettlement experiences post-migration impact individuals' capacities to live active and healthy lives.³³ The term 'immigrants' in this paper broadly encompasses people who left their country to seek a better life, reunite with their family (skilled and family streams voluntary migrants), or escape persecution (refugee and asylum seeker). While specific discussions related to each group are outside the scope for this paper, it is important to note that reasons for migration confer differing implications on people's legal status, migration experiences, and health risks.

Migration and the conditions associated directly with migration impact working and living conditions and access to healthcare, which increases vulnerability to poor health. Compared the Australian-born population and/or immigrants born in English-speaking countries, CALD immigrants experience higher job insecurities, underemployment and discrimination in the job hiring process³⁴, and greater challenges in renting and owning a home.³⁵ CALD immigrants have reported difficulties finding suitable employment due to a lack of local experience, lack of suitable jobs and non-recognition of their qualifications or skills.³⁶ These challenges increase their socioeconomic vulnerabilities with flow-on effects for health. In addition, experiences of discrimination, racism, loneliness, family conflicts and concerns for family and friends in the home country are prevalent, and they too are strong predictors of overall health, including poor mental health and obesity.³⁷ The loss of family and social support networks may mean reduced resilience when facing challenges, especially because CALD immigrants experience greater psychological distress than the Australian-born population, even years post-migration.³⁸ For example, women who are unable to access emotional and practical support from family and friends during pregnancy and postpartum experience an increased

risk of ante- and postpartum depression.³⁹ Given the positive link between maternal poor mental health and both maternal and childhood obesity⁴⁰, and the link between mental health and obesity across all life stages⁴¹, the promotion of a healthy lifestyle is likely important in managing both obesity and mental illness.

Another challenge for obesity prevention is that CALD communities face multiple barriers in engaging with health services. These include: knowing which health services to engage and the logistics of accessing services; fear of – and stigma associated with – seeking help; language difficulties; cost of services; dissonance in treatment approach; and lack of cultural sensitivity in care.⁴² Many cultures do not consider obesity a problem and may even consider it desirable, particularly for children.⁴² Therefore, CALD immigrants may not feel the need to engage in obesity prevention programs or services. Similarly, seeking help for mental health problems is highly stigmatised among many CALD communities, leading to an additional barrier to the prevention of obesity and its co-morbidities.⁴³

The need for creative solutions

Tailoring obesity prevention interventions for CALD communities requires the acknowledgement of, and creative solutions to address migration-related social determinants of health as well as partnerships across researchers, clinicians, community, and policy makers for collective impact. Indeed, lessons from communicating COVID-19 information to CALD communities showed that partnering with communities is vital to effectively design and implement health interventions.⁴⁴ Hence, to meaningfully reduce the prevalence of obesity in CALD communities, public health research, policy, and practice should focus on:

1. Mitigating systemic discrimination by collaborating with sectors beyond health to facilitate CALD immigrants' social integration and improve their living conditions, employment opportunities, food security, and access to culturally safe health services.
2. Reorienting primary health services to proactively reach at-risk CALD groups which may have multiple barriers to engaging with health services. Universal home visiting programs, for example home visits from midwives after all hospital births, or technology-based primary interventions (e.g. telephone, digital, web) may increase the reach to CALD population groups.
3. Using strength-based, co-design approaches with CALD communities to design appropriate interventions and services. Many CALD communities have large informal support networks that can be leveraged to promote nonstigmatising and culturally appropriate healthy lifestyle interventions; for example, online forums for mothers with young children, ethnic community services, and faith-based organisations. This strategy was recommended by CALD community

leaders to support COVID-19 health promotion messages⁴⁴.

4. Build rigorous evaluation into all interventions to document learnings, which is important to advance knowledge in this field.

Given Australia's rapidly growing CALD population groups, the growing disparities in the prevalence of overweight and obesity can no longer be ignored. Obesity-related health inequalities and their associated costs will continue to widen if we do nothing.

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None declared.

Author contributions

RK conceptualised and wrote the perspective on Indigenous health.

KH is the sole author of the perspective on disability.

KK conceptualised the content, wrote, and revised the perspective on inequities experienced by culturally and linguistically diverse communities.

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