

## **Preventative Health Taskforce**

### **Consultations**

#### **Alice Springs**

**4 November 2008**

**Facilitator: Dr Christine Connors**

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29 participants attended the Preventative Health Taskforce Alice Springs general stakeholders consultation.

Christine Connors provided an overview of Taskforce terms of reference, roles and responsibilities and progress to date. Christine also provided some context on prevention from a Territory perspective noting in particular that tobacco smoking rates higher in the Territory than in other parts of the country; NT has a strong focus on inter-sectoral and collaborative work and that the suggestion in the discussion paper of a national prevention agency would allow a central broker to get buy in from health and other sectors to drive prevention effort.

### **Challenge 1**

#### **Omissions to the discussion paper and any other/innovative ideas?**

##### **General**

- Address social determinants of health
- If we remove current 'props' that people are using – foods, tobacco and drink what will they substitute?
- Address the influences that cause use
- Supportive environments – must be community driven
- Need changes to environmental structures to support change
- Mental health is a major issue that cant be separated from the three topics in paper
- Early childhood needs higher focus
- Community consultation is missing
- Community engagement – need to identify how this will happen.
- Take a life course approach – especially adolescent focus
- Ensure positive messages about what's good as well as what's bad
- Highlight benefits of healthy lifestyle (eg in Indigenous communities – message not that they will die young but that if healthy lifestyle will live long)
- Prevention- is it self limiting - can we change the underlying structures that influence social health rather than individual action?
- Social marketing – use positive reinforcers – provide reasons for change
- The rules we need to apply for social marketing change with different population groups
- Men's health – understated
- Define community or government responsibility v individual responsibility

- Show that it is the responsibility of communities and governments to facilitate individual + choices

### **Overweight and obesity**

2 messages:

- People don't eat well because they can't afford it or don't have access to healthy food
- Affluent overeating

Key players:

- increase health workforce:
  - o community based
  - o work phased screenings
  - o local engagement – local government/ communities

### *Barriers*

- Mental health - sweet food perceived to help, especially if depressed
- Young peoples inability to cook
- Access to food
- Lack of food security – overcrowding – buy food – someone else eats

### *Additional Targets*

- Reduce child obesity by 10% by 2020
- Adults - plateau rate by 2020
- Focus on exercise and nutrition not fatness

### *Suggestions*

- Need to substantially increase community based workforce
- Develop broader organisation-based health screenings (not just in GP surgery)
- Promote health promotion messages throughout workplaces
- Education of other organizations in and around communities
- Action research – more research
- More money for program research and evaluation
- Dedicated positions to capture evaluation and research
- Families and individuals – promote use of facilities in communities
- More sports and recreation officers
- Regulation of food industry
- Distribution of healthy foods
- Target food security at community level
- GST free food costs in rural/remote areas
- Incentives for healthy lifestyle choices
- Tax deduction for sports/vouchers
- Boundaries and guidelines for healthy choices
- Social marketing 2 and 5 – message not taken up in Indigenous communities
- Cost of insurance in sporting bodies – is a barrier
- Schools maybe not the only place – can't do everything – think wider than schools
- Employ phys ed workforce to work across sectors – eg part in school, part in community – use cross sectoral payment model
- How can high risk groups be supported? – more sport and rec officers
- Specific actions – banning advertising junk food

- Subsidise fruit and vegetables
- Introduce an accreditation system
- Legislate - use traffic light system as in UK
- Target school canteens
- Reinstate physical ed in all schools – mandatory
- Prioritise introduction of bike paths
- Work on urban design
- Introduce bicycle credit system
- Reduce costs of public transport
- Ban cars from CBDs
- Neighbourhood parks – design competition
- **Breastfeed** to age 2 – (this will need workplace changes etc )
- **Good antenatal and postnatal care**

## **Tobacco**

Agree with discussion document content

*Target for ETS needed* : measure of child ETS exposure in home – national outcome measure

### *Strategies*

- Invest higher than 1% from government
- Where does the current funding go?
- Decrease accessibility
- Ban vending machines
- ETS ban on smoking in cars nationwide – raise awareness of ETS on young lungs
- Risk of high cost tobacco on low income groups
- Improve enforcement of current legislation/measures
- Cessation support is not just NRT – include pharmaceutical and non pharmaceutical options.
- If new antagonist drugs proven to work then list on PBS
- Not only nicotine that's dangerous in cigarettes
- NRT free for disadvantaged /low income groups
- Stop children from taking up smoking. Messages are wrong – we are targeting them well before they think about living/illness /dying
- Role models – try to counter peer pressure
- Work on reversing negative aspects – eg low self esteem (especially if overweight)
- Kids – if you want to be good a sport don't smoke
- Training for health professionals needs to change
- Its about good food and fitness not fatness
- Early childhood important
- Legislating for foods in canteens
- Breast feeding promotion
- Equalising options for good/bad foods

## Alcohol

### *Targets*

- Alcohol target is difficult to measure

- Add others eg reduce regional pure alcohol consumption to *average levels across Australia*.
- Reduce *national average* of alcohol consumption to 30%

### *Suggestions*

- Volumetric tax -supported
- Drive cultural change - supported
- Promote safe drinking – reduction outlets and hours
- Focus on remote communities
- Coordinated approach across all three topics not silos
- Plan that is intersectoral and brings into play how cross sector workforce acts on these three issues.
- Separate sport from alcohol
- Focus on low risk drinking
- Cost impact of price rises on low income people
- Tie effort to indicators of social disadvantage
- Regulating alcohol – current doesn't always work
- Educate across settings – not just health professionals
- Advertising self regulation doesn't work
- Alcohol problems can be hidden (personal)
- Alcohol problems can be public (eg violence) – how to address
- Volumetric tax and floor price - supported
- Reduce hours of sales - supported
- Increase legal age to 21?
- Stop alcohol sales from 12mn everywhere
- Stop sports advertising and increase sales bans
- Add pictures on alcohol products (similar to tobacco health warnings)

### **Prevention Agency**

- Supported but broaden from preventative health to social equity and health /social determinants etc
- Set up as a statutory body so it can hold governments to account.
- A body that can put out evidence independent of government
- An entity that can provide global assessment - what it is to be healthy – what it is to be unhealthy – provide comparative lists – incarceration, education, level of income – explain and intervene on social determinants of health

### **Social marketing – across all three topics**

- Market behaviour change but also provide information on how price, legislation, etc work to consumers advantage + explain the reasons and strategies – it's not just about knowledge of products and standard drinks

### **Working Group**

- Needs to be regionally specific
- Workforce – diversity of workforce – upskill community members
- Social justice, social determinants important issues for inclusion

### **Challenge 2**

*Are there common public health approaches?*

*What other areas can we learn from?*

- Importance of data measurement and clear targets
- Lessons from tobacco control – remember where we come from
- Be ambitious
- Remember we are on right track
- Maybe radical for community – don't be afraid
- Multidisciplinary – multifaceted – lots of varied attributes and skills NOT just health professionals
- Silo versus health approach
- Tobacco has perhaps let side down by using people ONLY for tobacco reduction – not whole of health approach
- Lesson to be learned about broader reach
- *Think of Strategy as supporting a trajectory for individuals across a cluster of issues aiming towards a healthy life*
- Importance of community wide approach vital
- Make healthy decisions easier
- Disadvantaged groups need special messages
- Lessons from Tobacco - those who don't smoke don't want to be exposed to tobacco
- Drinkers are killing non drinkers - analogy
- Obesity is not part of this analogy
- Dram shop liability
- Alcohol – how much of a community health issue is it? Spell out in Strategy.
- Obesity – BMI issue – change emphasis to food security and nutrition not obesity and overweight – element of moralism in the language that may not be productive.
- Issues for people that don't smoke and drink
- Add equity targets across all three areas – Make clear that there are major differences by socio economic status – lead into focused strategies
- Bring down national targets to focused high risk groups
- Care this doesn't lead into blame scenarios (in other countries it has worked)
- Good information for political advocacy and change

### **Messages**

Message must appeal to Aust psyche

Targeted messages for specific issues/specific population groups

Meaningful messages but not punitive

Make healthy choice the easy choice

Think about mental health – don't send negative messages

### **Community engagement**

Buy in and sustain community action.

Community development officers

Importance of language in Indigenous communities – use community people

Identify the drivers/triggers for engagement – what was it that triggered change (Example -

Seat belts – legislation; Immunisation – financial incentives – good data, good track records).

Commercial concepts – meal deals – easy way to put together a healthy meal – include recipe

Fund healthy messages – level of?

Staffing – community trained staff – barriers to Indigenous students in gaining qualifications

**Build on what works**

- Tobacco control - whole package example
- Develop a broad strategy
- Use a quality assurance tick box approach
- Include cross over with other topics
- Learn from immunisation
- Include check lists – check monitors
- Work with families and groups
- Person and family centred care
- Move from medical model of care
- Introduce community action groups – three good ones across Australia – fund – organise (maybe one in each state?)
- Revive community development activity and streamline actions
- Provide leadership and organisation for same

**What are the next specific steps on obesity, tobacco and alcohol?**

- Sexual health
- Mental health
- Keep monitoring OTA – don't take foot of the accelerator
- Immunisation – its there
- Drug use /abuse in general
- Social determinants of chronic disease

Close 1.30