

Darwin Consultations

31 October 2008, 9 am to 12.30pm.

Facilitators: Professor Rob Moodie, Dr Christine Connors, Ms Kate Carnell

Sixty participants attended the Darwin consultations on the Preventative Health Taskforce's discussion paper:

CHALLENGE ONE

Gaps in the report identified by participants included:

Table 1

- Actions need to relate to states and territories – broad and vague more prescriptive
- The how to implement and time limits for actions, monitoring and evaluation are missing
- Social determinants of health – it is far too limiting to just focus on particular health issues such as obesity, tobacco and alcohol– social view of health could be linked more strongly throughout the report. There is also a need to look to recent international reports.
- There needs to be some thought given to provision of tax breaks for individuals who maintain a healthy lifestyle

Table 2

- There is a need for more community engagement such as community coalitions and greater focus on a social determinants model
- There is a need to look at existing case studies of what has worked well in Aust
- We need a national audit of existing programs from all levels of government and workforce within Australia – this could be a key role of the proposed National Preventative Health Agency
- There is a need for a different workforce model that contributes to what we already have rather than more of the same
- There is a lack of focus on Aboriginal disadvantage, particularly in remote areas
- There is a need to focus on positives and building health equity. For example, tax breaks for industries that do well in health promotion rather than enforcing legislation onto people
- Should be focussing on physical activity and nutrition not obesity
- There is a need to also look across the continuum – rehabilitation – look at the tertiary end of things
- There is a need to change the culture of alcohol consumption
- The linkages between climate change and health are underdone in the existing report. We need greater focus on physical activity and food miles being good for the environment as well as for health.
- There is a need to focus on a wellness workforce to set an example.

Table 3

- Remote focus at this table – applied NT wide
- The obesity targets should focus on exercise and nutrition

- There is a need for stronger emphasis on climate change – potential for suggestions to undermine the current agenda
- There is a need for education around portion size. For example, standard plate size for meals.
- With regard to obesity and alcohol, we need to learn from regulation of tobacco sales.
- There is a need for cultural change around food. For example, fast food vouchers are given out as prizes at sporting clubs. This message needs to change.
- There is a need for more targeted campaigns for specific remote communities as well as an increase in education and intervention
- Control and enforcement – not much going on here – those responsible need to be accountable – monitoring enforcement could be the role for a National prevention agency
- Supply major factor for alcohol – harm reduction and minimisation needs to be the focus rather than tax
- Regulatory framework needs to learn from tobacco - supply and marketing two areas that need control
- Capacity to manage community based intervention and prevention
- Primary prevention in field of alcohol and tobacco requires fulltime employment and education and housing
- National agency could be involved in working with other groups to improve this
- Universally in NT, the sense is that alcohol is a badge of honour – strong social marketing and effective regulation would be effective.
- Liquor commission used to reward the most profitable bars. We need a national agency that keeps an eye on this and coordinates the efforts of state/territory/fed govts.
- For remote communities food subsidies and food growing programs would be good
- Schools are central to physical activity. While it is recognised schools already have crowded curriculum, we need to start here to promote activity. We could build on strategies that are already in some schools. For example, promote riding bikes to school.
- Focus on older people – number of initiatives where people can gain access to exercise activities – GP program referral or join yourself – free access is over supplied and some need GP referral – look at how people gain access
- Alcohol – price taxation and tax reform – hypothecation – experience in NT was very effective
- So much of this stuff is outside the health sector need to involve all agencies – police, justice, welfare, education and health – need linkages between these and communicate across all areas – this requires structural reform
- Culture of alcohol in NT – all pervasive – kids exposed from early childhood – sporting clubs celebrate alcohol – experience in NT is alcohol program in 1990s led to reductions in consumption – has fallen over – now very difficult to get back to that – need a multi faceted approach to get back there

Table 4

- Tended to focus on obesity and overweight issues
- Current target isn't specific enough or strong enough to lead to good outcomes
- Need to identify significant work to lead to targets

- Two things are missing: not enough evidence to cover remote areas; and there needs to be a clear separation in addressing childhood as opposed to adult
- Schools need to be stronger player in delivering programs and being involved in policy environments and providing support mechanism for kids
- There is a need to get rid of the silo approach and an adoption of a multifaceted approach to prevention that includes finance, , budgeting, housing as well as a holistic approach for families.
- Instead of addressing individuals, there is a need to address families and to engage men in the process. Families need to look at issues and there is a need for role modelling within families
- There is a need to consider incentives and disincentives for people to look at goals
- Partnerships between cross community sector are needed
- Need to build evidence base with a national focus. With regard to data collection, there needs to be better sampling in remote areas in Northern Territory.

Table 5

- In general, the principles within the paper are okay and it is great to see leadership in this area.
- We need engagement of people in acute services area.
- NT is a different space to other states and territories due to its remoteness and urban locations.
- For a small investment in prevention in the Northern Territory, there would be a big return, particularly if we take these approaches on.
- Target of increasing price of tobacco to \$20 may not work in some areas as price is already >\$20.
- Health promotion interventions in territory are great but come and go – need engagement to skill-up the workforce, and interventions need to be planned, coordinated, multilayered. Some local initiatives could be reinvigorated that worked well previously.
- Need local focus that is culturally appropriate eg QUIT line callers in NT are connected to QLD.
- We should use some of the previously used fabulous ideas that have worked well.
- Councils should be involved in promotion.
- Currently we underutilising the approaches used by music and theatre. We could use these as role models. However health professionals and leaders also need to be role models – we have health professionals and community leaders that smoke.
- With regard to food we should focus on local supply and need guidelines to be fully implemented
- More uniform approach to legislation around Australian would be beneficial

CHALLENGE TWO

What Are The Next Steps – What Other Issues Should We Be Looking At?

Table 1

- We need to determine how to broaden the public policy and public health approach to get beyond the department and ensure a systematic approach that is broad and multifaceted, and that focuses on early life. Specific steps on alcohol, tobacco and obesity must start antenatally.
- We need to determine how to build resilience as strong part of any intervention.
- There is a strong connection between behaviours and mental health and this needs to be interwoven.
- In situations where Indigenous people are in cycles that need to be broken, there is limited community based support structures available for them.
- We need key strategies which are locally based and provide consistent support to break the cycle to allow people to more actively engage as a form of prevention and to provide a model for children as a means of intergenerational change.
- Legislation is required as an important part of control and access to tobacco and alcohol
- Social marketing – is using the shock value still working? Need to make messages more appropriate.
- Alcohol is everybody's issue not just the Indigenous community's issue – not just health or police, therefore we need to involve all areas.
- The previous public health strategies have provided a band-aid and have not addressed the cause.

Table Two

- There is a need to adopt more hypothecation of revenue. Hypothecation is a dedicated tax on tobacco for example, which goes into a fund for funding research and support structures. However, it does have its place when used for a specific purpose – when turned into a whole lot of little grants, it doesn't work for real prevention.
- We need a comprehensive approach to alcohol as supply just makes people move from one area to another. There is a need to focus on not leaving gaps and anticipate alternative behaviour that people will adopt.
- Access is an issue. Data is available in NT for all sales for alcohol - this can be drilled down to sales in each outlet. This is a strategy that could be applied across country to provide more detailed information however, it would require more resources.
- The siloing between health and justice could be addressed through the Ministerial Council on Drug Strategy as a starting point.
- Tobacco strategies that have been successful and similar negative media images could be applied to obesity and alcohol.
- There needs to be a shift in focus on overweight using BMI to unhealthy diet and exercise and not just a focus on whether you cross the line into obesity or not.
- A restructure of funding of health care structures to move to prevention focus is required.
- Lots of structure to help overweight people with but not being used (eg gyms) - need to come up with innovative ways to create structures that overweight people will use or make existing structures more accessible.

Table Three

- Need an integrated approach that supports local activities.
- Legislation needs to be common and not just state specific with uniform approaches and enforcement that don't require suspension of the *Racial Discrimination Act*.
- There is a need to better integrate between agencies – eg provide community gardens – local health prevention promotion workforce as community development.
- Workforce needs to be public health workforce rather than the siloed areas.
- Case studies and practical examples could be included in strategy.

Table Four

- There is a need to look at why some strategies work and others don't – the ABHI process evaluation could assist the Taskforce.
- There is a need for a sustainable and public health investment within Australia. While there has been lots of discussion in this area, there has not been anything that goes beyond the three year political cycle of elections. Changes in government can affect sustainability of programs. This should be part of the fundamental national preventative infrastructure.
- So far there has not been much evidence of Commonwealth implementation of strategies.
- There is limitation to the siloed approaches, and a need for a broader intersectoral focus.
- Health is in all portfolios: Premier and Cabinet; Treasury; Education and Employment. Treasury has an important role in prevention. The SA government policy document 'Health in all policies' could be an example. We should be focusing on driving prevention and not health.