

Preventative Health Taskforce Consultation

Café Grove, Wodonga

13 February 2009

Facilitators: Dr Lyn Roberts and Professor Paul Zimmet

Thirty two (32) participants attended the Wodonga general consultation.

Dr Roberts and Professor Zimmet provided participants with a general overview of the work of the Preventative Health Taskforce and the discussion paper.

Participants were then provided with three challenges and the outcomes of these are listed below:

Challenge One: Omissions/Innovative Ideas

General

Fantastic to have a national approach.

Develop mechanisms to translate innovation into mainstream and to fund them.

Focus on lifestyle as a whole – holistic approach.

Need holistic government policies and strategies aimed at whole models of community and that build capacity and becomes an enabler – e.g. need bike paths etc.

Need to break down the silos. Governments talk about partnering but continue to operate in silos.

Look at how to build the capacity of health promoting settings.

Clear and measurable indicators are required that allows for the sharing of data at the local level.

Drawing on example of bushfires destroyed communities – there is an opportunity to do some national pilots about re-building communities using a whole of government approach.

Remove state level of government.

Recognise the role of GPs as change agents in the primary care sector. Increase focus on practical strategies in primary care behaviour.

Harm reduction should not be just about prices – need to beware not too simplistic in this area.

Health is not the sole responsibility of the health industry.

Integrated planning (top down and bottom up) that is supported by funding and communication is required.

Occupational Health and Safety focus neglects the health aspects.

Improve data on the actual size of the problem – which should be available.

Strategy

Targets require smaller indicators to allow the progress to be tracked.

Need to look at programs that have worked as evidence and build on these.

Should the focus be on one priority at a time?

Strategies must start early.

Rural / Remote communities

More focus on participation and isolation for all levels and age groups – not just for physical activity.

Pit stop programs work well in rural communities.

Obesity

Recognise the accessibility issues apparent in rural areas, especially relating to access to physical activity opportunities.

Recognise the need for cultural change, especially relating to physical activity participation.

- Changes to the built environment to facilitate increased incidental physical activity.

Participation is not only about sport.

Missing elements are education, food labelling and domestic science in schools.

Recognise accessibility of physical activity for aged and for those in rural areas - need to know the size and extent of the problem at a national level – need for comprehensive data on this.

Increase the focus on climate change in relation to physical activity and food security.

Need for increased focus on climate change in relation to physical activity, food security and economic opportunity.

Specific Population Groups

Parenting in communities and communication skills can be an important vehicle for applying the preventative strategy.

Work with teenagers about what will work. Aim at primary and early teenage about what will work.

Need to consider gender – what works for men does not work for women.

Need to look beyond 2020 as the current younger population goes beyond 2020.

Challenge Two: Implementation

Need for national settings across state borders.

Learn from tobacco strategy that has worked well: QUIT which has shown a strong influence by incorporating strong bodies, pushing key issues. (Multi-level strategies are required – include national, state, and local).

Strengthen enforcement of legislation – especially around alcohol.

Need to consider the culture of alcohol and the way that it varies between rural and metropolitan settings. Also, that alcohol generates funding for clubs.

Consider price, availability and transport issues to rural areas.

4 year old Health Checks – example of good policy. An adolescent health check might also be useful but must have the support to facilitate this.

Develop a national register of programs – this could be a role for the National Prevention Agency.

Persevere with successful approaches.

Consider the need for different approach for target groups e.g. consider different approach for adolescent population – this does not only apply to the health arena.

Develop a point system for food.

Look at current successful models and recognise and support them – existing programs may be modified.

Public campaigns have worked however; there is a need for a more comprehensive approach – target vulnerable population groups.

Some evidence does exist on the success of campaigns that they have reached middle class, but some haven't reached high risk groups (eg. young men).

Learn from immunisation campaign – through a vehicle which has access to a large amount of the population including at risk groups and supported by funding through general practice.

Think outside the square with preventative strategies. Put more funding into health prevention. Currently less than 1% of GDP spent on health prevention. Look at practical, multi-approach solutions so that there is less demand for tertiary intervention.

Need to consider practical secondary and tertiary strategies which will impact on primary care.

Need to fund health promotion professionals in schools. Look at how to embed funded primary health into school curriculum.

Teach nutrition and health from early primary onwards – there is a generation of young parents today that don't know a lot about nutrition and exercise.

Break down the silos between the health and education sectors. Look at what has worked eg. school breakfast program, walking school bus program.

Community development models with long term investment and that are evaluated as a mechanism for engaging people at the local level. Use evaluation to build skills.

Consider the engagement with complimentary medicine eg. Massage, herbalists and other.

Integrated planning with all stakeholders supported by funding and qualified or access to qualified personnel.

Challenge Three: National Prevention Agency

Fantastic idea – spread across state boundaries – reporting the differences across all.

Looking at 10/20/30 year targets, but do funding mechanisms match this (3 year cycle – election cycle) – need to change funding mechanisms to invest in the community for longer.

National Prevention Agency should not be another level – need to break down the silos and incorporate peak bodies.

Utilise and resource existing structures and organisations.

Need to expand beyond GP focus to social workers and other health professionals – must also be part of the health prevention team.

Need to adopt a population health approach with integration of strategies and resources.

Need to move out of health silo – incorporate other areas and adopt a wholistic approach -

Example of UK fell in with Prime Minister & Cabinet and not specifically under health portfolio.

Key priorities for Taskforce

Key priorities identified for next steps for the Taskforce were:

Establish systems to deal with priorities as they arise – focus on systems and not just individuals.

Mental health must be considered.

Dental health and hygiene