



4. The case for prevention: alcohol

2020 target: reduce the prevalence of harmful drinking for all Australians by 30%

4.1 The current situation

Alcohol plays many roles in society – as a relaxant, as an accompaniment to socialising and celebration, as a source of employment and exports, and as a generator of tax revenue. It is intrinsically part of Australian culture.

The majority of Australians who regularly drink do so in moderation. Around three-quarters (72.6%) of Australians drink below levels that would incur long-term risk of harm. However, the short-term consumption of alcohol at harmful levels, while only occasional, is a prominent feature of Australia's drinking culture. One in five Australians (20.4%) drink at short-term risky/high-risk levels at least once a month. This equates to more than 42 million occasions of binge drinking in Australia each year. While these drinking patterns have not changed markedly over the past decade, they continue to produce substantial costs to the health of Australians, and trends among young people show cause for concern.

Australia's international reputation in action on alcohol is among the best in the world.

A recent review of alcohol policies in 30 OECD nations rated Australia as fifth overall, ranked behind Norway (1st), Poland, Iceland and Sweden.⁽⁵⁹⁾ Another recent comparison of alcohol policies in 18 countries reports that 'contrary to the generally pessimistic reports about alcohol policies, the case of Australia provides cause for optimism'.⁽⁶⁰⁾

Alcohol policy experts remind us that that while there are 'some significant disappointments', there are also 'some wonderful examples of successful Australian public policies around alcohol from the past two decades': drink driving legislation and enforcement, the compulsory fortification of bakers' flour with thiamine, and liquor licensing restrictions that are working well for some Aboriginal communities.⁽⁶¹⁾

None of this should be cause for complacency. If success is to be measured on the basis of any change in rates of overall per capita drinking, and of adult binge drinking and outcomes such as alcohol-related deaths, hospitalisations and crime, these strategies alone are not enough.

It is not only public health experts who are concerned about the harmful use of alcohol. The general community is also worried about alcohol's adverse health and social effects. A recent survey of Australians showed that 84% of people are concerned about the impact of alcohol on the community and that they consider intoxication to be unacceptable.⁽⁶²⁾

There is an urgent need to improve public safety by curbing rising levels of intoxication, reducing alcohol-fuelled violent and disruptive behaviour on the street and in the home, stepping up efforts to further reduce drink driving, and ensuring that the abuse and neglect of children through alcohol consumption is addressed. Equally important is the need for strong enforcement of current laws and practices that prevent the harmful use of alcohol.



CURRENT SNAPSHOT

- 83% of Australians are drinkers, and 1.4 million Australians consume alcohol on a daily basis. Overall per capita consumption of alcohol in Australia is high by world standards, with the country currently ranked within the top 30 highest alcohol-consuming nations, out of a total of 180 countries (WHO 2008)
- Consumption accounts for 3.2% of the total burden of disease and injury in Australia: 4.9% in males and 1.6% in females(25)
- The annual tangible net cost to the Australian community from harmful drinking is estimated to be almost \$11 billion(63)
- Much of this cost is borne outside the health system. One of the major tangible costs is lost productivity in the workplace (\$3.5 billion). An estimated 689,000 Australians attend work under the influence of alcohol each year(63)
- Other costs outside the health system include the costs of road accidents (\$2.2 billion), costs of crime (\$1.6 billion), and lost productivity in the home (\$1.5 billion)
- It is also estimated that alcohol is responsible for insurance costs totalling \$14 million a year
- The negative impacts of harmful consumption of alcohol by individuals on those around them is felt regularly by many Australians: 13.1% of Australians report being 'put in fear' by a person under the influence of alcohol, and 25.4% report being subjected to alcohol-related verbal abuse(64)
- The impact of drinking on children, by their parents and/or other adults, is a particular concern: 13% of Australian children aged two years or less are exposed to an adult who is a regular binge drinker.(65) It has been estimated that 31% of parents involved in substantiated cases of child abuse or neglect experience significant problems with alcohol use(66)

4.2 Patterns of drinking

Patterns of drinking show areas of high risk throughout life.

Overall, Australian males are more likely than females to drink at short-term risky/high-risk levels on regular (at least once a month) occasions (17% of females compared to 23% of males). However, among teenagers, females are more likely than males to regularly drink at levels of risky/high-risk of harm in the short term (28% of female teenagers compared to 24% of male teenagers). Victorian data show a worsening of the problem. The prevalence of risky drinking among 16-17 year old secondary school students in Victoria has risen from 15% in 1984 to 23% in 2005. (76)

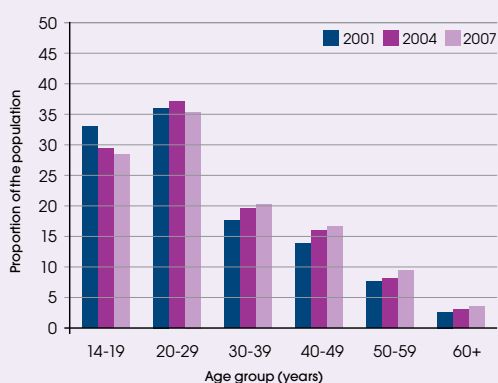


Between 2001 and 2007 there were only slight changes in the prevalence of drinking at risky/high risk of harm in the short term across the age groups.(4)

Among Australian teenagers in 2007, the prevalence of drinking at levels for long-term risk of harm was considerably higher among females (10%) than among males (7%).(4)

Figure 4.2

Monthly drinking at risky/high risk of harm in the short term* by age and year, proportion of the female population aged 14+ years, 2001 to 2007



Source: AIHW (2008a)

Older drinkers are also cause for concern. As the Australian population ages, heavy drinkers currently aged in their 40s and 50s are likely to present significant public health challenges by 2020 unless they reduce their alcohol consumption.

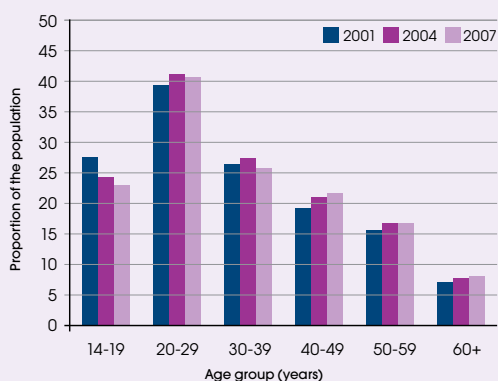
Harmful consumption of alcohol occurs in a range of different settings, and alcohol is sometimes consumed in combination with other drugs, including illicit and prescription drugs. It is also sometimes used as a substitute for other drugs.

The effects of alcohol consumption go beyond diseases, accidents and injuries to a range of adverse social consequences, both for the drinker and for others in the community. These consequences include harm to family members (including children) and to friends and workmates, as well as to bystanders and strangers. Alcohol-related disturbance and assault ranges from acts of vandalism, offensive behaviour and disruption to far more serious antisocial behaviour, which can result in violence or injury to others.(67) It is not surprising that much of the time and resources of policing in Australia are related to incidents involving alcohol.

Harmful alcohol consumption impacts significantly across a range of other areas, such as workforce productivity, healthcare services such as hospitals and ambulances, road accidents, law enforcement, property damage and insurance administration.

Figure 4.1

Monthly drinking at risky/high risk of harm in the short term* by age and year, proportion of the male population aged 14+ years, 2001 to 2007



Source: AIHW (2008a)

(*Risky/high-risk drinking in the short term = seven or more standard drinks on any one day for males; five or more standard drinks on any one day for females)



4.3 High-risk groups

There are variations in alcohol consumption across Australia and different impacts on specific high-risk population groups.

There is **geographic variation** in the levels and patterns of alcohol consumption across Australia, with per capita alcohol consumption varying significantly between urban and rural areas and between Australian states and territories. For instance, the prevalence of drinking at short-term risky/high-risk levels at least monthly is 18.7% in New South Wales, 19.4% in Victoria and 28.4% in the Northern Territory.

Indigenous Australians are about twice as likely to abstain from alcohol as non-Indigenous Australians, but those who do drink are up to six times more likely to drink at high-risk levels than non-Indigenous people.(68)

Childhood and adolescence are critical times for brain development, and the brain is more sensitive to alcohol-induced damage during these times.(67)

Initiation of alcohol use at a young age may increase the likelihood of negative physical and mental health conditions, social problems and alcohol dependence. Regular drinking in adolescence is an important risk factor for the development of dependent or risky patterns of use in young adulthood.

Drinking within families is an important consideration. Depending on the circumstances, it can be either a positive or negative influence on the drinking behaviour of young people. A recent Australian study estimates that 13.2% or 451,621 children aged 12 years or less are at risk of exposure to binge drinking in their home by at least one adult.(65)

Drinking contributes to the three leading causes of death among adolescents – unintentional injuries, homicide and suicide – along with risk-taking behaviour, unsafe sex choices, sexual coercion and alcohol overdose.(67)

Maternal drinking can result in a spectrum of harms to the unborn child, including fetal alcohol syndrome. Recent data show that 59% of Australian women drank alcohol at some time in their pregnancy and that 14% reported drinking five or more drinks in a sitting in the three months prior to pregnancy. However many women elect to abstain from alcohol some time during pregnancy – 58% during the first and second trimesters and 54% in the third trimester.(67) Although the risks from low-level drinking (such as one or two drinks per week) during pregnancy are likely to be low, a ‘no-effect’ level has not been established, and limitations in the available evidence make it impossible to set a ‘safe’ or ‘no-risk’ drinking level for women to follow in order to avoid causing harm to their unborn baby.

Other high-risk population groups

whose misuse of alcohol requires specific considerations include people who have a mental health condition, people who have multiple health issues (for example, drug dependence, general poor health) and certain occupational groups.

4.4 Benefits of reform

Strong preventative measures implemented now have the potential to reduce problems in the future. The results will most likely take a generation to be realised and they require a long-term effort. Cultural change is not instant – it involves steps along a continuum, as the tobacco experience has proven.

Reducing the prevalence of harmful consumption of alcohol is important at all life stages, as different risks emerge for different age groups. At a young age, regular drinking is a significant risk factor for the development of harmful drinking and alcohol problems in young adulthood and in later life.(67) Preventative measures that delay the uptake of drinking by young people as late as possible are critical in reducing the likelihood of drinking problems in the longer term.



IF WE ACT NOW, BY 2020:

- A 48% reduction in alcohol-attributable deaths could be achieved
- People of all ages and backgrounds will feel safer in public places at night, especially at weekends in our major cities
- Low-alcohol products will increase in availability and popularity
- Local communities will have a greater say in the availability and management of alcohol in their local area
- Commercial activity in city centres, particularly at night, will become more diverse and prosperous
- Policing of alcohol problems will be proactive and targeted to situations where enforcement is most needed
- Alcohol-caused road injuries and deaths will decline and rates of drink driving reach record lows
- People will be more in control of their drinking and take steps to change individual drinking habits and to improve their overall health
- Accident and emergency departments in hospitals will be less burdened by alcohol problems and better able to attend to people with other health problems
- Australia's productivity will increase, with reduced workplace absenteeism
- There will be less drunken behaviour on the street
and
- Enormous reductions in the social costs of alcohol-related harm could be realised from policy measures such as higher alcohol taxation (\$5940 million), brief interventions (\$5830 million), partial advertising and marketing controls (\$2450 million), and greater enforcement of drink drive laws (\$940 million)

Source: Collins and Lapsley 2008: The avoidable costs of alcohol abuse in Australia(63)

4.5 Challenges

Challenges facing prevention efforts for alcohol include:

COMPLEX SOCIAL FORCES INFLUENCE DRINKING BEHAVIOUR

Australia's drinking cultures are driven by a complex mix of powerful social forces. These include habits, customs, images and norms, and other interlocking and equally powerful forces relating to the social, economic and physical availability of alcohol, such as promotion and marketing, age restrictions, price, outlets, hours of access and service practices.(69)

DIVIDED COMMONWEALTH AND STATE RESPONSIBILITIES AND COMPLEXITY IN ACHIEVING COORDINATED ACTION

The policy levers that most influence the access to and price of alcohol in contemporary Australia are the alcohol taxation system (a Commonwealth responsibility) and liquor licensing systems (state and territory responsibility). Evidence from Australian and international research literature shows that economic availability (price) and physical availability (access) of alcohol within communities are two of the key determinants of harmful use of alcohol. In simple terms, when prices reduce or when access increases, consumption increases, but when prices increase or access decreases, consumption reduces.

DISPARITIES IN TAXATION

In Australia, different taxes are applied to different products (beer, wine and spirits) reflecting the history of alcohol consumption in Australia, the status of various alcohol products and changing powers of taxation between the Commonwealth and states and territories. These different taxation arrangements influence the prices of different categories of alcohol products unevenly, often in ways that do not promote low-risk consumption (see Figure 4.3).



Figure 4.3

Tax payable per standard drink* of alcohol, various products, Australia, as at 1 August 2008*



Note: *Includes a 1.15% Alcohol by Volume (ABV) excise-free concession for beer. Wine equalisation tax (WET) payable per standard drink of wine is based on a four-litre cask of wine selling for \$13 (incl. GST) ('Cask wine'), a 750 ml bottle of wine selling for \$15 (incl. GST) ('Bottled wine 1'), a 750 ml bottle of wine selling for \$30 (incl. GST) ('Bottled wine 2') and a 750 ml bottle of port selling for \$13 (incl. GST) ('Port, sherry'). A standard drink is equal to 0.001267 litres or 10 grams of pure alcohol.

GROWTH IN ALCOHOL AVAILABILITY

While not completely deregulated, liquor licensing laws and regulations in most jurisdictions have been significantly relaxed over the past decade, generally coinciding with the required reviews under the National Competition Policy. One of the effects of this has been a proliferation in the number of new licensed premises in some jurisdictions (see Figure 4.4).

Along with an increase in the total number of licensed premises, there has been an increase in the numbers of premises with extended trading hours, the numbers of licences to sell packaged liquor (i.e. take away) and over time an increased concentration of licences held by just a few business.

DIVERSITY AND COORDINATION

Future efforts to prevent harm from alcohol use will require integrated and coordinated arrangements. These arrangements will span all levels of government and fields of interest (health, law enforcement, road safety, finance and taxation), as well as non-government organisations, business and industry sectors.

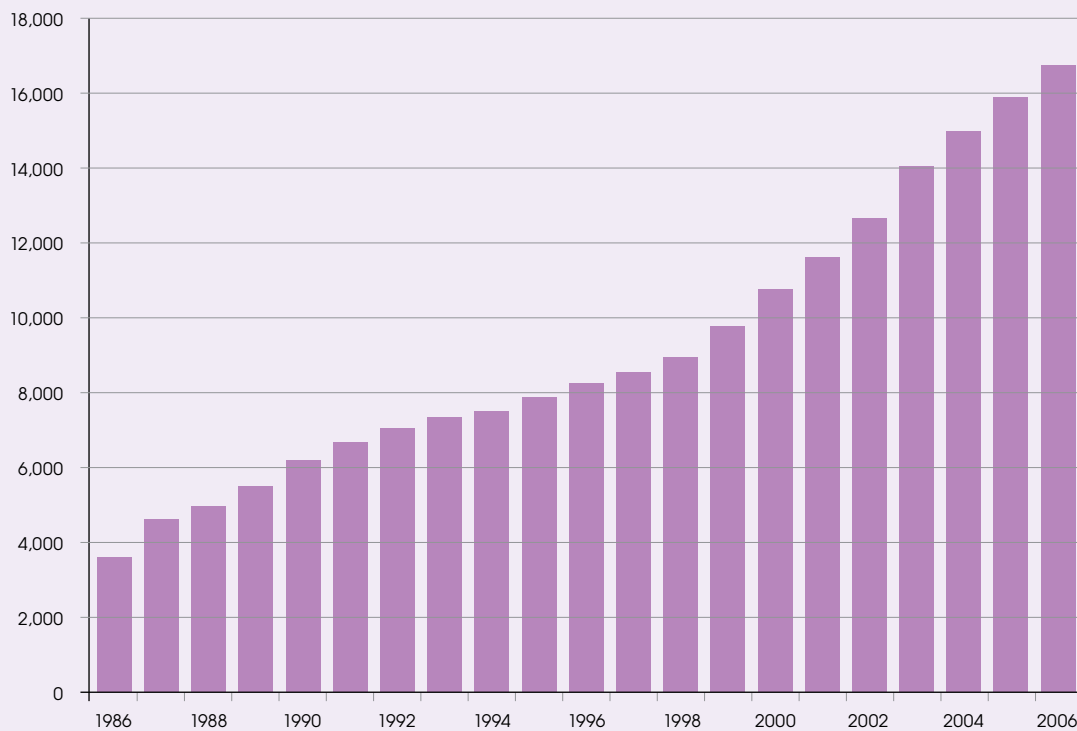
SELF-REGULATION OF ADVERTISING

Regulation of alcohol advertising in Australia is subject to industry self-regulation, known as the Alcohol Beverages Advertising Code (ABAC) Scheme. The scheme is funded and administered entirely by the alcohol industry, with limited Commonwealth and state and territory government representation on the ABAC Committee, and does not cover all forms of alcohol promotion.



Figure 4.4

Number of liquor licences by year, Victoria, 1986 to 2006



Source: Consumer Affairs Victoria, unpublished data

ADDRESSING THE CULTURAL PLACE OF ALCOHOL

A strong cultural acceptance of alcohol consumption exists in Australian society. Recent Australian research for the development of a national alcohol social marketing initiative reports, *'the challenge for communication is that intoxication is closely linked to alcohol per se. When we simply asked participants about their earliest memories in relation to alcohol there was an overwhelming tendency to leap to their first drunk experience. Further, these experiences were recalled with a sense of pride and nostalgia, even though the stories inevitably involved some embarrassment'*.⁽⁷⁰⁾

COLLECTION OF STANDARDISED DATA

The collection of data on alcohol sales by all state and territory governments at an outlet level is imperative. Collection will enable the analysis of changing patterns and trends in drinking and the effects of new and different types of alcohol outlets on alcohol consumption. It is also needed for the evaluation of the effects of alcohol policy measures on alcohol consumption and the rates of alcohol problems over time and in different communities.



4.6 Future outlook

The prevalence of harmful drinking and the incidence of alcohol-related harm in Australia are already at levels that cause significant social and economic costs to the community – costs that are preventable.

Current projections of the leading causes of disease burden to 2030 predict that there will be *no improvement*.

BASED ON CURRENT TRENDS:

- Young women will continue to overtake young men in the prevalence of binge drinking
- Night time economies, especially in our major cities, will demand significant resources to manage alcohol related anti-social behaviour, violence and crime
- Police services and hospital emergency departments will require significantly more resources to attend to alcohol-related issues, marginalising other social and health issues
- Young people will increasingly be targeted through planned and sophisticated multimedia-based alcohol advertising
- There will be a lack of low-alcohol beverage options available, with limited incentives to provide anything other than higher strength options
- Alcohol will be available in a wide range of locations, making it hard to restrict access to alcohol and impossible to enforce liquor licensing laws
- Health inequalities between Indigenous and non-Indigenous Australians, and between particular geographic areas of Australia, will be further widened

4.7 Priorities for action

Reducing the harmful consumption of alcohol requires a long-term commitment. There are many lessons to be learnt from the successes to date with tobacco control, including the phasing in of prevention strategies, and efforts to increase community understanding and shift social norms.

Internationally, experts agree that an effective strategy consists of a comprehensive approach including:

- regulation of alcohol availability
- enforcement of liquor laws
- marketing and accessibility
- raising awareness of the harmful effects of alcohol on individuals and society
- implementing brief interventions against the harmful use of alcohol
- improving health outcomes for Indigenous people

There is also agreement that an effective strategy needs to deal with under-age drinking, the harmful use of alcohol during pregnancy, and driving or operating machinery while under the influence of alcohol.⁽⁵⁾

In the first instance, the major imperatives for Australia are to:

RESHAPE CONSUMER DEMAND TOWARDS SAFER DRINKING THROUGH:

- Managing both physical availability (access) and economic availability (price). The high accessibility of alcohol – in terms of outlet opening hours, density of alcohol outlets and discounting of alcohol products – is an issue in many Australian communities.
- Addressing the cultural place of alcohol. Social marketing and public education are required, and will be more effective if the marketing of alcoholic beverages is restricted, including curbing advertising and sponsorship of cultural and sporting events.



RESHAPE SUPPLY TOWARDS LOWER-RISK PRODUCTS THROUGH:

- Changes to the current taxation regime that stimulate the production and consumption of low-alcohol products.
- Improved enforcement of current legislative and regulatory measures (such as Responsible Serving of Alcohol or bans on serving intoxicated persons and minors, or continuing to lower blood alcohol content in drink-driving laws).

STRENGTHEN, SKILL AND SUPPORT PRIMARY HEALTH CARE TO HELP PEOPLE IN MAKING HEALTHY CHOICES:

- Supporting brief interventions as part of routine practice by trusted health professionals and other health workers in primary healthcare settings can assist changes in drinking behaviour and attitudes to alcohol consumption.

CLOSE THE GAP FOR DISADVANTAGED COMMUNITIES

- There is a need for tailored approaches and services to reach Indigenous and other disadvantaged groups.

IMPROVE THE EVALUATION OF INTERVENTIONS THROUGH:

- Monitoring and evaluation of regulatory measures and other programs to underpin the further evolution of prevention strategies directed at inappropriate alcohol consumption.
- Developing effective models of safer patterns of alcohol consumption in different communities through changes to alcohol taxation arrangements, and an understanding of the impact of different types of alcohol outlets and their density on hospitalisation, violence and crime rates.

Recent reviews of available research evidence show that interventions targeting the whole population generally have higher effectiveness ratings and are cheaper to implement and maintain (on average) than those targeting high-risk groups.⁽⁷¹⁾ In general, on the basis of experience thus far (and recognising that some other interventions have not been fully implemented and evaluated), the types of interventions that are considered most effective according to the ratings are, in order:

- regulating physical availability
- taxation and pricing
- drink driving counter-measures
- treatment and early intervention

Other areas that have very promising potential for effectiveness include:

- altering the drinking context
- regulating promotion
- well-funded, sustained public education

There has not been enough experience to date for programs in these areas to be rated, although experience from tobacco in regulating promotion and public education is very encouraging.

High priority should be given to enforcing and extending existing legislation and regulation, coupled with public education and social marketing. The combination of these strategies has proven highly successful in tobacco control and the control of drink driving. In addition, innovative and intelligence-led approaches to law enforcement (for example, the use of information about the last place of alcohol consumption prior to an offence in order to pinpoint establishments not implementing responsible serving of alcohol) can be widely adopted.



New policy measures should also be considered. The current Treasury review of Australia's taxation system⁽⁷²⁾ provides an opportunity to review and reform flaws in the current alcohol taxation system, especially the ways in which the current taxation system does not treat all alcohol types equally, and does not adequately tax alcohol to compensate for the negative impacts it produces.

The review should consider alternative models of alcohol taxation for Australia by utilising key data sets on consumption and technical expertise to review the current alcohol taxation system, best practice models, means of regulating minimum price and the likely effects of different models on public health.

Table 3 below sets out some of the ways in which individuals and families, communities, health services, industry and governments can work together on these priorities to achieve change in alcohol-related harm.

PRIORITIES	ACTIONS	BENEFITS	Individuals and families	Communities & schools & workplaces	Health services	Industry	Cwith, States & Local Government
Reshape consumer demand towards low-risk drinking	Develop adequately funded and effective social marketing and public education campaigns to prevent misuse and reduce alcohol-related harm, including targeted approaches and local complementary initiatives for different population groups	State and territory governments support through additional media advertising and other targeted public education for priority population groups	■	■		■	
	Communities reinforce messages through funded innovative local activities						
Reshape supply towards lower-risk products	Review the taxation system to stimulate the production and consumption of low-alcohol products	Individuals are supported in low risk drinking	■			■	■
		Individuals are better able to limit alcohol consumption when driving	■				
Improve public safety		Price of low alcohol products is more attractive to young people	■			■	■
	Develop a staged approach to restrict alcohol advertising	The alcohol industry can promote and produce a wider range of low alcohol products				■	
	Remove tax deductibility for advertising, and develop a staged approach to restrict alcohol advertising	Community has less exposure to alcohol advertising		■		■	■
	Enforce legislation on responsible serving of alcohol, through intelligence-led policing programs that focus on the drinking establishment	Parents can provide greater support to young people on responsible drinking behaviour without alcohol advertising countering their efforts		■	■	■	■
		Public places are safer and licensees and employees are better equipped to uphold responsible service of alcohol and to adhere to liquor licensing laws, especially those prohibiting supply of alcohol to intoxicated or underage persons					





PRIORITIES	ACTIONS	BENEFITS	Individuals and families	Communities schools & workplaces	Health services	Industry	Cwith, States & Local Government
Close the gap for disadvantaged communities	Commission research on effective strategies to address social determinants of alcohol consumption in Indigenous and low-income communities	State and territory governments develop tailored approaches and services to reach Indigenous and low-income groups	■	■	■	■	■
Strengthen, skill and support primary health care to help people in making healthy choices	Develop and disseminate information and training packages (with a focus on screening, effective brief interventions and appropriate referral pathways for health and welfare workers	Communities reinforce messages through funded innovative local activities	■	■	■	■	■
Improve maternal and child health		All health professionals provide brief interventions to patients in primary health care settings about alcohol intake	■		■		■
		Pregnant women receive screening, advice and targeted programs from trained health professionals in ante natal clinics	■		■		
		Individuals at risk from harmful drinking are identified and supported in changing their drinking behaviour	■				
Build the evidence base	Model safer patterns of alcohol consumption in different communities from changes to alcohol taxation arrangements and understanding of the impact of different types of alcohol outlets and their density on hospitalisation, violence and crime rates	Governments, health services, communities and local business have a relevant evidence base on which to develop programs and effective practices		■	■	■	■
	Collect and analyse nationally consistent data about alcohol outlet density and alcohol-related health and safety outcomes with a view to regulate alcohol outlet density	Alcohol industry provides sales data to government to enable monitoring and evaluation of policies and programs				■	■

For more detail on preventative health reform and alcohol see [Technical Paper 3: Preventing alcohol-related harm: a window of opportunity: www.preventivehealth.org.au](#)



QUESTIONS

- Do you support a focus on the suggested priorities?
- If you do not support these actions, or have other suggestions, what would you propose we do as a nation to halt the toll of early deaths and disease caused through alcohol-related harm?
- What are the most important issues that can engage support from individuals, communities, industry and governments and drive cultural change?
- What prevention strategies work best for high-risk groups, particularly among young people and in Indigenous communities?



5. Supporting prevention

5.1 Common aspects across obesity, tobacco and alcohol

A comprehensive package of reform will require action on each of the following, both separately and in combination.

ACCESS AND AFFORDABILITY

The price of tobacco and alcohol products and their availability are two of the crucial factors in reducing smoking and alcohol consumption. Similarly, price and availability should not be barriers to healthy eating and physical activity. This requires healthy foods to be cheaper and more accessible, and physical activity options to be easy and cheap for individuals to undertake. Price and availability are generally changed through legislation, taxation and regulation.

PRODUCT MARKETING

Advertising, packaging, labelling and promotion of products are standard ways in which all manufacturers and retailers increase sales and drive up income. The more attractive the product, the greater the public interest. Reducing, curbing or (as with tobacco) eliminating these aspects of product marketing makes unhealthy products less attractive to the public in general and to children in particular.

Making unhealthy products less attractive will require different strategies in each of the three areas. For example, tobacco control requires the elimination of all forms of advertising and promotion. Action on alcohol and obesity will need effective controls, working *with* the food and beverage industries to ensure constraints on inappropriate marketing and to ensure the availability and promotion of healthy food and beverage options.

PUBLIC EDUCATION

Experience from tobacco control, road safety, HIV prevention and other areas demonstrates that well-planned, appropriately funded and sustained public education campaigns are a vital and effective component of prevention programs, and will be required over the coming years for obesity, tobacco and alcohol. Such campaigns also require investment at a level that enables targeting of different population subgroups, and locally based supporting strategies where appropriate.

COMMUNITY ENGAGEMENT

Without the goodwill and interest of Australian communities, reform will be difficult to achieve.

If individuals are to make healthy choices they require support and reinforcement from their families and communities that these are the *right* choices.

SETTINGS FOR ACTION

School communities, childcare and maternal health programs, workplaces, sports venues and local government settings provide useful designated environments in which to undertake a combination of interventions. To be successful, programs delivered in all settings should adopt an integrated approach incorporating the three priority areas of obesity, tobacco and alcohol.



MIX OF UNIVERSAL AND TARGETED ACTION

Shifting population norms requires small changes from everyone, but additional and different efforts are often needed for disadvantaged populations. Addressing health risks from obesity, tobacco and alcohol are important ways to help close the health gap. In order to target health inequalities, such as those in disadvantaged populations and settings, programs should be appropriate and meet the needs of the target group, and encourage and assist individuals to take action within their community.

A LIFELONG FRAMEWORK FOR ACTION

Policy reform and strategies for action require a lifelong approach. While emphasis is placed on pregnant women and early childhood, there are other critical times in life that are also important if momentum is to be maintained.⁽⁷³⁾ For example, there should be a focus on groups such as toddlers, school-aged children, first-time parents and older Australians.

SKILLED WORKFORCE

A skilled and motivated workforce, especially in the public health and primary healthcare sectors, will be essential to support delivery of health promotion and preventative health measures across the community. For example, bringing primary healthcare providers such as general practitioners, community pharmacists, nurses, psychologists and other allied health professionals together for community-based training and support provides a way of ensuring a comprehensive and well-coordinated approach to preventative health care. Development, dissemination and training to ensure the uptake of evidence-based guidelines is important, as is curriculum development to educate future generations of health professionals and community workers.

5.2 Support structures

The recent history of public health in Australia shows that preventative efforts have been most effective when effective supports have been put in place. Supports include:

- Leadership and coordination
- Research to build the evidence base
- Capability in surveillance, program evaluation, social marketing, legislation and regulation, and community mobilisation
- Targeted and sustained intervention strategies
- Sustainable financing and incentive-based funding
- An appropriately skilled workforce
- Integrated evidence, policy and practice
- Partnerships and collaboration
- Community engagement

Inadequately funded or single, short-term and ad hoc projects and programs are unlikely to succeed and may be counter-productive, as they give rise to an argument that 'prevention doesn't work', when in fact real and sustained prevention has not been tried.

Separate infrastructure investments for efforts targeting each risk factor will be costly. A robust prevention support system is required, including mechanisms for the coordination of strategies that cut across all the issues.

The strategies recommended above require interventions in schools, primary health care, workplaces and other settings, regardless of the specific health risk.

The planning and evaluation of these efforts will require a well-coordinated surveillance system that can track health conditions, risk factors, social and demographic factors, and exposures. All these activities will also require the concerted efforts of a well-trained workforce.



5.3 Major imperatives to strengthen support systems

LEADERSHIP AND COORDINATION

It is important to ensure leadership and coordination through the establishment of a National Prevention Agency.⁽⁷⁴⁾

A National Prevention Agency (NPA) is long overdue. Such an organisation would take the leadership role in ensuring the implementation and support of prevention programs nationally. The NPA could support the coordination of partnerships and interventions, ensuring the relevance and quality of workforce training activities, social marketing, public education and the monitoring and evaluation of interventions. The NPA would consist of a relatively small group of credible leaders in prevention, with a track record and capacity to 'make things happen' for preventative health reform.

By bringing together expertise across relevant areas, a national agency would provide leadership for the implementation of the National Preventative Health Strategy and build prevention systems with strong capabilities in the following areas:

- Ensure the delivery of a minimum set of evidence-based, prevention programs that are accessible to all Australians.
- Allocate funding to its partners for activities that deliver the National Preventative Health Strategy's goals and targets.
- Contribute to closing the gaps between Indigenous Australians and the rest of the population in association with other relevant organisations such as the National Indigenous Health Equity Council.
- Engage key leaders and build new partnerships across federal, state and territory governments, national agencies, professional associations, local government, peak community groups, NGOs, the private sector, the philanthropic sector and academe.
- Support the integration of research, policies and strategies for illness prevention/health promotion across sectors and settings within and beyond health care.
- Commission and promote the uptake of new monitoring, evaluation and surveillance models for illness prevention.
- Promote the benefits of illness prevention/health promotion as measured by these new evaluation models.
- Serve as an authoritative source of information on evidence, policy and practice.
- Develop the evidence base on prevention through the design, implementation and evaluation of large-scale programs to improve the health and wellbeing of the population, or population sub-groups, by testing innovative strategies, programs and policies for illness prevention/health promotion.
 - Ensure the development of the necessary national workforce for illness prevention/health promotion, working with and through relevant national, state and local agencies to build capability in:
 - surveillance, prevention research, evaluation, economic impact research and modelling
 - social marketing and public education
 - community development
 - legislation, regulation, economics and taxation
 - leadership and management.

The agency's approach would support the following groups in the workforce:

- People working in prevention including health promotion practitioners and public health researchers.
- Others working in the healthcare system, including general practitioners, allied health professionals, specialists, Aboriginal health workers and health service managers.
- Those working in other sectors that have a role in prevention; for example, in local government, police and justice, education, sport and recreation, urban planning, transport and agriculture.



SURVEILLANCE

Establish a comprehensive national surveillance system, working in partnership with AIHW and ABS. This would focus on the behavioural, environmental and biomedical risk factors for chronic disease (including factors such as food availability and food composition) to track and report on performance and outcomes, including the impact on health inequalities. (For example, expanding the national nutrition and physical activity survey program through the inclusion of biomedical data.)

PREVENTION RESEARCH AND EVALUATION

Partnerships with the National Medical and Research Council (NHMRC) and the Australian Research Council (ARC) and other state-based research funding organisations (such as health promotion foundations) will be important to ensure a coordinated investment approach for research and evaluation. Research would include an understanding of social determinants of health behaviour, the modelling of health impact of policy options and the evaluation of programs.

SOCIAL MARKETING AND PUBLIC EDUCATION

It will be important to commission research and development of targeted social marketing and public education campaigns. This mechanism would also be used to coordinate national media advertising with local program delivery, and to evaluate their effectiveness. Tobacco control has shown the effectiveness of these measures.

INCENTIVE-BASED FUNDING

A prevention benefit item included in the Medical Benefits Scheme would support delivery in primary care practices of brief interventions and follow-up (whether they were directed to tobacco, alcohol, obesity or other relevant chronic disease risk factors).

The structure of the item could be a small add-on to standard consultations in primary care practices when the intervention is delivered and as a stand-alone item at follow-up. Such a structure could help narrow the opportunities for inappropriate use and practice, as well as help improve the evidence base.

SUPPORTING PRIMARY HEALTH PRACTICES TO ENHANCE THEIR ROLE IN PREVENTION

Primary health care is a fundamental part of preventative health. This is seen in many areas, including immunisations, screening for cancers and, as we have seen earlier, brief interventions to discuss and advise on smoking and alcohol use. Three approaches are suggested:

- There is increasing consensus around the need to define the population that a practice is working with and for. This would have to start with enrolling or registering patients in a practice.
- Adequate incentives at the practice level (for example, Practice Incentive Payments) or at individual practitioner level (for example, Medicare Benefits Schedule item number) must be provided. Given that brief interventions and the use and promotion of life scripts can be very adequately done by practice nurses, this incentive would be better placed at the practice level.
- A system of accountability and reporting is needed to complement the incentive payment scheme.

QUESTIONS

- Do you support the development of a National Prevention Agency to lead and guide coordinated action for prevention?
- Is the suggested approach adequate? If not, or if you have other suggestions, what else should be considered?