



## Executive summary

### **Australia: the Healthiest Country by 2020**

A discussion paper by the National Preventative Health Taskforce

#### **The purpose of the paper:**

Australia is by international standards a very healthy country. But if we are to bequeath our children the legacy of the world's healthiest country, major reductions in disease caused by overweight and obesity, tobacco smoking and harmful consumption of alcohol are needed.

Combining these threats with the increasing disparities in health between Indigenous and non-Indigenous Australians, between city dwellers and rural and remote Australians and between rich and poor Australians, means we have a real challenge on our hands if we aspire to being the healthiest nation by 2020.

The discussion paper outlines the case for reform in our approach to the prevention of illness and the promotion of health. Major changes in the way we behave as individuals, as families, as communities, as industries, as states and as a nation will be required.

The solutions are not only about individual choice and personal responsibility but also about the role of governments, business and industry, and non-government organisations. The ideas proposed in this paper are for all Australians, not just governments.

The aim of this paper is to test our overall targets and the initial recommendations we have developed, in order to inform and provoke discussion and debate between Australians about how these targets can be achieved.

### **Targets for the healthiest country**

The Taskforce is convinced that we can achieve the following targets by 2020:

- Halt and reverse the rise in overweight and obesity
- Reduce the prevalence of daily smoking to 9% or less
- Reduce the prevalence of harmful drinking for all Australians by 30%
- Contribute to the 'Close the Gap' target for Indigenous people, reducing the 17-year life expectancy gap between Indigenous and non-Indigenous people(1)

### **The Taskforce**

The National Preventative Health Taskforce was created in April 2008 by the Hon Nicola Roxon MP, the Minister for Health and Ageing. Established initially for a three-year period, the Taskforce will produce the National Preventative Health Strategy in June 2009, focusing on the primary prevention of obesity, tobacco and harmful consumption of alcohol. Because of the need to prioritise these concerns, other important areas of preventative health such as mental health, injury, immunisation, sexual and reproductive health, and illicit substance use will be considered in the next phase of the Taskforce's work in 2009.

The Taskforce has based its recommendations on the best evidence to date. The evidence supporting the case for change and proposed actions is set out in the paper and in three comprehensive technical reports available online at [www.preventativehealth.org.au](http://www.preventativehealth.org.au).



## The call for urgent, comprehensive and sustained action

The answer does not lie in short-term projects. In order to reach the whole community, we need highly effective public education and the cooperation of mass media. We need every kindergarten, school and university, every workplace and business, and every community and neighbourhood in Australia involved and committed to improving and maintaining their health and productivity.

Chronic diseases not only result in death and disease, they are also a massive economic burden on the community and the health system. We can no longer afford to wait until we get sick. The answer lies in preventative action.

Consumer demand needs to be redirected towards healthier choices. This can be achieved by industry producing, promoting and marketing much healthier products. We also need effective legislation and regulation, using pricing, taxation and subsidies as a means to encourage healthier choices. It could be suggested that the community is not yet ready for some of these ideas, but just think how unlikely it would have been 25 years ago to have introduced the approaches to tobacco control that are now commonplace.

In order to succeed, we need greatly enhanced monitoring, evaluation and research. Prevention programs need to reach the whole of the population and they must be given time to take effect. Changing the attitudes and behaviours of populations does not happen overnight.

## Whose responsibility is preventative health?

Our health is not only determined by our physical and psychological make-up and health behaviours, but also by our education, income and employment; our access to services; the place in which we live in and its culture; the advertising we are exposed to; and the laws and other regulations in place in our society.

Australia cannot become the world's healthiest nation unless health becomes everyone's business. Industry as supplier, marketer and employer; unions; the media as promoter; community and non-government organisations; philanthropists; academe – they all have influential roles to play. Similarly, all governments – local, state and federal across many sectors, led by the health sector – have distinct roles. Prevention must become the business of state and federal Treasuries, and of leaders in the private sector.

We must be an inspiration to others: to early-learning centres, schools and universities; urban planners; the sports and recreation industries; public transport and infrastructure; agriculture; police and emergency services; and to the hospitality and entertainment industries.

Where the market is failing, governments need to act to protect our health – particularly the health of children and adolescents. Standards need to be established, regulations imposed where necessary and consumer education provided.

Governments, industry, advertising and the media need to work to reshape consumer demand in favour of healthy choices, and to make those choices available and accessible. Healthier choices could include lower-alcohol beverages and lower-energy nutrient-rich foods and drinks.

Given the huge preventable losses of workplace productivity due to obesity, tobacco and alcohol, the private and public sectors have key roles as employers and in the promotion of much healthier workplaces. The experience of the new WorkHealth program in Victoria provides an immediate example from which we can all learn.

While Australia's health care system plays a pivotal role in prevention, it requires better support and training in order to deal with these new challenges.



The National Health and Hospitals Reform Commission and the External Reference Group for the Primary Health Care Strategy are working on ways of ensuring that prevention is more effectively carried out across the health system as a whole, and in the primary health care system in particular.

Ultimately, it is communities, families and individuals who must change behaviours if we are to become a healthier nation.

### Inequities in health

Major health inequities exist not only between Indigenous Australians and non-Indigenous Australians, but between rich and poor, and between rural and city dwellers. Even within a city such as Melbourne, life expectancy can vary by up to five years within a matter of kilometres.<sup>(2)</sup>

The World Health Organization's Commission on the Social Determinants of Health makes three overarching recommendations to tackle the 'corrosive effects of inequality of life chances':

- Improve daily living conditions, including the circumstances in which people are born, grow, live, work and age.
- Tackle the inequitable distribution of power, money and resources – the structural drivers of those conditions – globally, nationally and locally.
- Measure and understand the problem and assess the impact of action.<sup>(3)</sup>

With respect to obesity, tobacco and alcohol, Australian governments at all levels have a role in funding and supporting programs in communities, schools and workplaces. These investments have to take into account the 'inverse care law' – that those with more get more, and those with less get less – and reverse it so that underserved communities receive the support and resources they need.

### The choices we have to make

We do have choices – we can do nothing new or do little – but this will mean a great deal of premature illness, suffering and death, all of which are preventable. As is already being seen, it will mean the overloading of hospitals, health and welfare services, a situation made more acute by the ageing of the Australian population. Similarly, it will mean rising costs within the health system and losses in workplace productivity.

We need urgent and sustained action.

Australia's record in prevention has been outstanding in many areas such as tobacco, road trauma, cardiovascular disease, skin cancer and immunisations. These preventative actions have been crucial in increasing our life expectancy, but they have required substantial long-term funding.

The certainty of what needs to be done varies between the three immediate priorities: tobacco, alcohol and obesity. We know what we need to do to get our smoking rates down. Much is known about measures to reduce the harm caused by alcohol and overweight and obesity, but there is more to be learned. However, our need for knowledge should not stop action – we must act now on the basis of what we know, following the best practice and advice available, and learning by doing.

The necessary actions to reduce tobacco smoking are clear. They include making cigarettes more expensive, eliminating all forms of promotion and marketing, and revitalising public education campaigns. Lessons from tobacco control are instructive, but approaches to obesity and alcohol will differ as governments, industry and communities work together to reshape consumer demand and support individuals in exercising healthy choices. The emphasis will be on reshaping attitudes and behaviours, rather than prohibiting them.



## Why the focus on obesity, tobacco and alcohol?

Put together, smoking, obesity, harmful use of alcohol, physical inactivity, poor diet and the associated risk factors of high blood pressure and high blood cholesterol cause approximately 32% of Australia's illness.(4)

***The World Health Organization estimates that, for many people, modifying these risk factors could help them gain an extra five years of healthy life.(5)***

The prevalence of overweight and obesity in Australia has been steadily increasing over the past 30 years. In only 15 years, from 1990 to 2005, the number of overweight and obese Australian adults increased by a staggering 2.8 million.

If the current trends continue unabated over the next 20 years, it is estimated that nearly three-quarters of the Australian population will be overweight or obese in 2025.

The National Children's Nutrition and Physical Activity Survey 2007 indicates that almost a quarter of Australian children are overweight or obese, an increase from an estimated 5% in the 1960s. Nearly a third of children don't meet the national physical activity guidelines. Only one-fifth of 4–8-year-olds and one-twentieth of 14–16-year-olds met the dietary guidelines for vegetable intake.

***Recent trends in Australian children predict that their life expectancy will fall two years by the time they are 20 years old, setting them back to levels seen for males in 2001 and for females in 1997(6). This is not a legacy we should be leaving our children.***

As the following examples illustrate, if these health threats are left unchecked, our health systems will find it increasingly difficult to cope:

- Type 2 diabetes is projected to become the leading cause of disease burden for males and the second leading cause for females by 2023, mainly due to the expected growth in the prevalence of obesity. If this occurs, annual health care costs will increase from \$1.4 billion to \$7 billion by 2032. (27)
- Almost 2.9 million Australian adults smoke on a daily basis. Around half of these smokers who continue to smoke for a prolonged period will die early; half will die in middle age.(7) Smoking-related illness costs up to \$5.7 billion per year in lost productivity. (9)
- The most recent national survey of drug use estimates that one in five Australians drink at a level that puts them at risk of short-term harm at least once a month. (64)

Almost three-quarters of Australians drink below levels for long-term risk of harm. However, among young adults aged 20–29 years, the prevalence of drinking at levels for long-term risk of harm is significantly higher (16%) than among other age groups.

The harmful consumption of alcohol not only causes problems for those who drink at risky levels but has repercussions across our society. Alcohol is involved in 62% of all police attendances, 73% of assaults, 77% of street offences, 40% of domestic violence incidents and 90% of late-night calls (10 pm to 2 am).(8)

The annual costs of harmful consumption of alcohol are huge. They consist of crime (\$1.6 billion), health (\$1.9 billion), productivity loss in the workplace (\$3.5 billion), loss of productivity in the home (\$1.5 billion) and road trauma (\$2.2 billion).(9)

***In total, the overall cost to the health care system associated with these three risk factors is in the order of almost \$6 billion dollars per year, while lost productivity is estimated to be almost \$13 billion.(9, 10)***



Our focus on obesity, tobacco and alcohol is also due to two other important factors:

- The burden of disease caused by obesity, tobacco and alcohol makes up a significant part of the 17-year difference in life expectancy between Indigenous and non-Indigenous Australians. Similarly, a large part of the differences in health status between rich and poor Australians and between city dwellers and rural and remote Australians can be attributed to obesity, tobacco and alcohol.
- A relationship exists between growth and development during foetal and infant life and health in later years. Poor nutrition, cigarette smoking and alcohol use during pregnancy can result in long-term adverse health effects. Early life events play a powerful role in influencing later susceptibility to chronic conditions such as obesity, cardiovascular disease and type 2 diabetes.

### What has prevention achieved?

In the 1950s three-quarters of Australian men smoked. Now less than one-fifth of men smoke. As a result, deaths in men from lung cancer and obstructive lung disease have plummeted from peak levels seen in the 1970s and 1980s. (4)

Similarly, deaths from cardiovascular disease decreased dramatically from all-time highs in the late 1960s and early 1970s to today.

Road trauma deaths on Australian roads have dropped 80% since 1970, with death rates in 2005 being similar to those in the early 1920s. (4)

Australia's commitment to improving immunisation levels has resulted in much higher immunisation coverage rates, eliminating measles and resulting in a decrease of nearly 90% in sero-group C meningococcal cases in only four years. These results have come about because of a 34-fold increase in funding over the last 15 years.

Deaths from Sudden Infant Death Syndrome (SIDS) have declined by almost three-quarters, dropping from an average of 195.6 per 100,000 live births from 1980 to 1990 to an average of 51.7 per 100,000 live births between 1997 and 2002.(11)

### Prevention – a great investment

A study commissioned by the Department of Health and Ageing in 2003 showed quite spectacular long-term returns on investment and cost savings through the preventative action of tobacco control programs, road safety programs and programs preventing cardiovascular diseases, measles and HIV/AIDS.(12)

*For example this report estimated that the 30% decline of smoking between 1975 and 1995 had prevented over 400,000 premature deaths(13) and saved costs of over \$8.4b, more than 50 times greater than the amount spent on anti-smoking campaigns over that period.*

The recent US study *Prevention for a Healthier America* shows that for every US\$1 invested in proven community-based disease prevention programs (increasing physical activity, improving nutrition and reducing smoking levels), the return on investment over and above the cost of the program would be US\$5.60 within five years.(14)

### What are some of the road blocks to progress?

There are a number of barriers to increasing the level of investment in effective prevention programs.

Despite the evidence, some influential people within the community still do not believe that prevention works, or that population-level behaviour change can occur.

Vested interests such as tobacco companies will do everything in their power to discredit or dilute prevention programs.



The effectiveness of preventative methods has also been affected by variable popular demand. Results are not immediate, and it takes time before the benefits are seen by the community. The Taskforce sees prevention as an essential and complementary part of our national health system, and of our overall national infrastructure. It is now clear from the Australian 2020 Summit and the work of the National Health and Hospital Reform Commission that overall community support for preventative approaches is increasing.

Prevention has sometimes been seen as ‘blaming the victim’, thus not endearing itself to the public.<sup>(15)</sup> It can also be seen as a means of controlling people’s behaviour if legislation or regulation are required, particularly where economic market forces fail. Unnecessary community antagonism to regulation can be successfully diminished over time, as has happened here and in many other countries with the introduction of legislation on tobacco advertising.

As noted earlier, our health behaviours are driven by a complex mix of social, economic and environmental forces – levels of income, education, employment, habits, customs, images and norms, advertising, prices of products, and so on. The Taskforce believes it is the role of governments to enable people to make the healthiest choices they can. However, those who believe that health behaviours result only from individual responsibility are much less inclined to see a role for regulation or effective, scaled-up public education.

Balanced, effective regulation and legislation, usually alongside effective and sustained public education, have been an essential element of most prevention programs to date.

Divided responsibilities can present real difficulties. For example, where the state and territory governments control liquor licensing and the Australian Government controls alcohol taxation, pricing and promotion. National leadership is needed, along with an increase in the capacity of monitoring, evaluation and research systems.

## What do we need to do?

### OBESITY

**The Taskforce believes that in order to halt and reverse the rise in overweight and obesity the major actions are:**

- **Reshape industry supply and consumer demand towards healthier products** by increasing availability and access to healthier food and activity choices and through the development of comprehensive national food policy (eg. modelled on the UK’s *Food Matters*).
- **Protect children and others from inappropriate marketing** of unhealthy foods and beverages, and improve public education and information.
- **Embed physical activity and healthy eating in everyday life** through school, community and workplace programs. At the same time these are reinforced by individuals and families choosing to become more active and to eat healthier foods.
- **Reshape urban environments towards healthy options** through consistent town planning and building design that encourage greater levels of physical activity and through appropriate infrastructure investments (for example, for walking, cycling, food supply, sport and recreation).
- **Strengthen, skill and support primary health care and the public health workforce** to support people in making healthy choices, especially through the delivery of community education and advice about nutrition, physical activity and the management of overweight and obesity.
- **Close the gap for disadvantaged communities** through the development of targeted approaches to overweight and obesity for disadvantaged groups, particularly Indigenous and low-income Australians, pregnant women and young children.
- **Build the evidence base**, monitor and evaluate the effectiveness of actions.



## TOBACCO

**The Taskforce believes that in order to reduce the prevalence of daily smoking to 9% or less, Australia needs to:**

- **Ensure that cigarettes become significantly more expensive**, and that efforts to achieve this through increases in excise and customs duty are not undermined by the increasing availability of products on which these duties have been evaded.
- **Further regulate the tobacco industry** with measures such as ending all forms of promotion including point-of-sale displays and mandating plain packaging of tobacco products.
- **Increase the frequency, reach and intensity of education campaigns** that personalise the health risks of tobacco and increase a sense of urgency about quitting among people in all social groups.
- Ensure that all smokers in contact with any single part of the Australian health care system are identified and given the strongest and most effective **encouragement and support to quit**.
- Ensure access to **information, treatment and services for people in highly disadvantaged groups** who suffer a disproportionate level of tobacco-related harm.
- **Increase understanding** about how being a non-smoker and smoking cessation can become more 'contagious' – so that these processes can be accelerated among less well-educated groups and among disadvantaged communities.

## ALCOHOL

**The Taskforce believes that in order to reduce the prevalence of harmful drinking for all Australians by 30% the major actions are:**

**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. If managed well this leads to reduction in alcohol-related violence, injury, hospitalisation and death.
- **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).
- **Removal of tax deductibility** for advertising and development of staged approach to restrict alcohol advertising.

**Strengthen, skill and support primary health care to help people make healthy choices:**

- **Support brief interventions** as part of routine practice by health professionals and other health workers in primary health care settings to 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.

### What action do we need for effective national prevention ?

Inadequately funded or single, short-term and ad hoc projects and programs are unlikely to succeed. In fact, they may even be counter-productive, as they can give rise to an argument that 'prevention doesn't work'.

Australia's experience in immunisation, HIV/AIDS control and road trauma has demonstrated admirable returns on investment in preventative action. The successful outcomes have eventuated, however, because of substantial and long-term funding, supporting well-coordinated and well-directed national and state programs.

Separate infrastructure investments for efforts targeting each of the three risk factors will be costly. A robust 'prevention support system' is called for, including mechanisms for effective coordination across all strategies.

**An essential component to enable effective action** is to ensure leadership and coordination through the establishment of a National Prevention Agency.

At the national level, such an agency is needed to support the coordination of partnerships and interventions, ensure the relevance and quality of workforce training activities, effective social marketing and public education, and the monitoring and evaluation of interventions.

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

Among its tasks, a national agency would:

- Ensure the delivery of a minimum set of evidence-based, illness prevention/health promotion programs that are accessible to all Australians.
- Engage key leaders and build new partnerships across federal, state and territory governments, national agencies, professional associations, local government, peak community groups, non government organisations, the private sector, the philanthropic sector and academia.
- Commission and promote the uptake of new monitoring, evaluation and surveillance models for illness prevention.
- 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
- legislation, regulation, economics and taxation
- leadership and management.

## Conclusion

We are constantly changing our behaviours. Just look at the changes in our nutrition, physical activity and smoking behaviours over the last 30 years. To be the healthiest country by 2020, and to have that good health shared by all Australians, will require substantial new shifts. There are no magic tablets in the laboratory. It will require all of us as individuals and families to make healthier choices.

It will also require industry, governments and community organisations to make healthier choices – whether it is the products they make and promote, or the policies, regulations and programs for which they are responsible.

Health is a fundamental human right. It is also, as the Prime Minister has pointed out, a major determinant of social inclusion, workforce participation, productivity growth and a potentially huge drain on the public and private purse. Get it right and literally everyone wins. Prevention is an essential element of getting it right.

## Our invitation to you

This paper proposes a range of actions to improve our health in the three action areas of concern. The aim of the paper, and the ensuing consultation, is to seek community and stakeholder views on the framework and ideas we have developed.

We invite you all – individuals, community groups, government and non government organisations and industry groups – to participate by making a submission on how we can make Australia the healthiest nation by 2020.

At the end of each chapter in the discussion paper, we propose a series of questions which will guide the Taskforce's consultations and which we hope will be useful to guide your contributions.

Please contribute to the Taskforce by using the form provided at the Taskforce website: [www.preventativehealth.org.au](http://www.preventativehealth.org.au)

**Submissions will be accepted until 2 January 2009.** The Taskforce will be holding meetings in each capital city and some major rural centres between October 2008 and February 2009.

We hope you will join the challenge to make Australia the healthiest nation by 2020.