



**Australian
General Practice
Network**

*Delivering local health solutions
through general practice*

Submission to the National Preventative Health Taskforce

Australian General Practice Network



December 2008



AGPN is one of the largest representative voices for general practice in Australia. It is the peak national body of the divisions of general practice, comprising 111 divisions across Australia, as well as eight state-based organisations. Approximately 90 percent of GPs are members of local divisions of general practice.

Australian Divisions of General Practice

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Executive summary

The Australian General Practice Network (AGPN) welcomes the Government's commitment to the development of a National Preventative Health Strategy and the opportunity to comment on discussion papers released by the National Preventative Health Taskforce.

A national prevention agenda for health cannot be developed in isolation of other reform agendas, most notably the National Health and Hospitals Reform Commission, the commitments to prevention by the Council of Australian Governments (COAG) and the National Primary Health Care Strategy - a whole-of-system approach is needed. A number of particular recommendations made by AGPN in this submission are therefore also relevant to the broader health reform context and will be reflected in our contributions to these processes.

It is well established in the public health literature that, to be effective, preventative action must be taken at both macro (measures that impact on the structural determinants of health and target whole populations) and micro levels of policy (measures that address individual level risk and protective factors).

Macro policy

A national prevention agenda for a healthier Australia by 2020 demands a number of macro policy changes outside of the health portfolio as well as an investment in public health/prevention infrastructure. Macro level policy reform can promote environmental changes that will encourage healthy lifestyle choices and help to enable more widespread engagement in health promotion activities across multiple settings. Importantly, a prevention agenda also requires a strong primary health care sector with enhanced capacity to deliver quality prevention and health promotion services and to link with and support prevention and health promotion initiatives in key settings such as schools, families, workplaces and communities.

AGPN supports a cross-sectoral strategy for prevention with actions at all levels of prevention and the establishment of a national prevention agency to provide national leadership and direction and build the evidence base for prevention including increased access to reliable population health data.

Recommendation 1: AGPN recommends that the proposed national preventative health agency has cross portfolio government, non-government and community sector representation.

Environmental changes to encourage healthy lifestyle choices

Policy reforms can promote a more systematic approach to reducing the barriers and increasing the enablers to healthy lifestyle choices. The taxation system and its impact on product and service pricing is a particularly relevant public policy lever that can help to enable healthier lifestyle choices. Australian and international evidence shows excise taxes on products such as tobacco and alcohol curb consumption behaviours.

Elements of town planning such as secure well lit exercise pathways and public transport options close to businesses can encourage more physical activity. In combination with tax reforms, restricting access to alcohol, cigarettes and energy dense foods through restricted hours and locations of sale can help to further reduce consumption of these products. Increased understanding and more effective use of social marketing tools can also help to promote healthy lifestyles choices and discourage harmful behaviours.

Recommendation 2: AGPN recommends that the proposed increased taxes on alcohol, cigarettes and energy dense food are accompanied by a volumetric tax for alcohol and the abolition of the duty exemption on imported cigarettes.

Encouraging health promotion in multiple settings

There are multiple settings in which prevention and health promotion can occur including educational settings, workplaces, and the community. AGPN recommends a stronger focus on the role of these settings in prevention and health promotion as part of policy reforms. Specifically, incentives (and disincentives) should be introduced which promote the take up of health promotion programs in these settings (for example, healthy workplaces which promote regular exercise through programs available in or through the workplace, and improved diet through healthy canteens). The incentives should be focused at this level because this is where real structural reform is needed. The primary health care sector is then well placed to respond to demand for primary health care services which is generated through these incentives (for example, with follow up health checks, immunisation, screening, lifestyle modification and early intervention).

Recommendation 3: AGPN recommends that healthy worker initiatives agreed by COAG in November 2008 are promoted through offering tax incentives for workplaces. Consideration should also be given to including a prevention and wellness focus in Australia's current corporate responsibility index. The performance and impact section of the index looks at companies' performance across a range of social and environmental impact areas, which includes health, safety and wellbeing. The index is supported by Government and could be extended more broadly to promote a systematic approach to prevention across the corporate sector.

Early intervention in health promotion and primary prevention is vital. The healthy children's initiatives agreed by COAG in November this year will help to raise awareness of healthy behaviours among children and families. Initiatives that connect education and primary care sectors¹ are vital as they help to ensure that at risk children are referred to appropriate interventions and receive appropriate follow up through primary care.

As well as raising awareness of healthy behaviours, barriers to behaviour change need to be identified and addressed to maximize positive outcomes resulting from health promotion and prevention interventions. Offering training in evidence based parenting skills is vital to equip parents with the skills needed to effect positive behaviour changes in their children. *For this reason, healthy children initiatives agreed by COAG in November 2008 need to be supported by investment in evidence-based parenting programs.*

Recommendation 4: AGPN recommends national roll out of the Every Family program, a cross-sectoral multilevel parenting intervention, to equip parents with the skills needed to modify children's behaviour.

Building the capacity of primary health care

Public policy reforms to encourage health promotion and environmental changes need to be accompanied by systematic changes to enhance the capacity of the primary care sector to engage in prevention and health promotion.

¹ An example is the Eat it Work it Move it program implemented by Macarthur Division of General Practice in collaboration with the National Rugby League.

The primary health care setting is central to a national prevention agenda – Australians regularly attend their local general practice. Many GPs already engage in prevention. For example the national immunisation program that has been operational since the mid 1990s owes its success to General Practice participation. There is also strong evidence demonstrating that GP delivered brief interventions are among the most effective health promotion interventions in terms of their capacity to contribute to behaviour change. Models of chronic disease management highlight the importance of productive interactions between patient and clinician in predicting a patient’s level of engagement in the management of their health. These productive interactions are also vital to effect behaviour change among patients as part of primary prevention and health promotion efforts.

The Reforms proposed by the taskforce to support primary care delivered prevention include patient registration with practices and practice or practitioner level incentives for prevention. In response to these suggestions, AGPN recommends that:

Recommendation 5: A system of practice level voluntary registration is introduced which offers the flexibility for patients to choose their own doctor and practice and to see an alternative doctor or practice as needed. This will allow practices to build a data set on their practice population and its risk profile. Such data can be linked with recall and reminder systems to allow more effective monitoring and follow up of patients. Practice population data can also be used to set and monitor prevention targets.

Recommendation 6: Both practice and practitioner level incentives for prevention continue to be delivered through a blended payment system and are linked to a framework of prevention-focused performance indicators.

Recommendation 7: The current practice incentive payment program is expanded to encourage prevention, and a practice-level capitation system to deliver a range of team-based, evidence-driven preventative services is trialled. Practice level payments give practices the flexibility to deliver what is appropriate to their population as well as the scope to mobilise the workforce best suited to deliver the required services.

Patient registration and practice incentives alone will not encourage the productive interactions between clinician and patient that are required to achieve effective primary prevention and health promotion. AGPN recommends that further investment is made at

the general practice and divisional level to improve access to quality prevention and health promotion. Specifically, we recommend more investment in educating and training clinicians to engage effectively in prevention and health promotion with their patients, and providing them with e-health tools to enable more effective screening and monitoring of patients. **Measures that will improve the quality of patient interactions need to be accompanied by funding models that offer cost effective service delivery to improve patient's access to prevention and health promotion.**

To improve patient access to prevention and health promotion, AGPN recommends:

Recommendation 8: The introduction of funding models to support enhanced access to multidisciplinary prevention including:

- **wider adoption of divisional level funding** to allow direct purchasing of allied health services to deliver specific, evidence based locally driven and coordinated prevention and health promotion initiatives such as lifestyle modification programs and early child development programs
- funding for **a regionally based network of health promotion and prevention coordinators** to coordinate a regional prevention agenda. These coordinators could be located in divisions of general practice, or similar mid-level organisations with a focus on health (or could be shared between schools and divisions or workplaces and divisions, for example).

Recommendation 9: More effective utilisation of private insurance in prevention by offering rebates to private health insurance members who are referred to evidence-based prevention interventions.

To improve the quality of primary prevention and health promotion delivered to patients, AGPN recommends:

Recommendation 10: National implementation of secure electronic messaging and further investment in recall and reminder systems and data extraction tools for general practices and divisions. This will provide practices with the tools and infrastructure required to systematically map the risk profiles of their practice populations, systematically target risk factors and monitor population health improvement.

Recommendation 11: Increased investment in education and training in preventative health for all primary care professionals including:

- a core unit on prevention in undergraduate training for all primary care professions;
- training in prevention as part of practice nursing orientation and refresher training programs; and
- funding to develop, trial and evaluate continuing professional development programs on prevention for practice nurses, nurse practitioners and GPs to be implemented by divisions of general practice.

Building regional infrastructure to tailor prevention to local needs

As well as playing a vital role in building the capacity of primary care to engage in prevention, divisions of general practice also play a key role in linking primary care with the rest of the health sector and with the broader community.

To build the capacity of the primary health care sector to effectively link with preventative action in the wider community, AGPN recommends that:

Recommendation 12: A 'Communities of Prevention Practice' (CPP) development fund modelled on headspace's youth service development fund be established to support regional intersectoral partnerships for prevention. Partnerships may include local government, divisions of general practice, business and community organisations and will aim to build community capacity to implement evidence-based prevention initiatives relevant to local population needs.

Preventing obesity, smoking and alcohol misuse

AGPN supports in principle the Taskforce's recommendations as to how to expand the role of the primary care sector in preventing obesity, smoking and alcohol misuse with the following caveats:

- Routine use of brief interventions is recommended for all three risk factors along with national performance indicators to assess the proportion of at-risk patients receiving these interventions.
- Use of existing evidence-based guidelines for preventative care is recommended along with evaluation of use of and compliance with these guidelines.
- Incentives for coordinated preventive service packages and mechanisms to enhance communication between multidisciplinary teams should be given greater priority than the development of multidisciplinary training packages.

- Increased investment is required at division and practice level to enable the timely extraction of data to measure the effectiveness of programs and campaigns.

AGPN supports in principle the Taskforce's recommendations regarding public health interventions to prevent obesity, smoking and alcohol misuse with the following caveats:

- AGPN recommends that more priority is given to culturally appropriate prevention programs including funding for the development, trial and evaluation of culturally appropriate lifestyle modification programs for obesity, smoking and alcohol for both Aboriginal and CALD communities.

Introduction

This submission is made to the National Preventative Health Taskforce by the Australian General Practice Network (AGPN). The Australian General Practice Network (AGPN) is the peak national body representing 111 divisions of general practice and their state-based organisations (SBOs) across Australia. AGPN promotes the health and wellbeing of Australians through the divisions network by strengthening the effectiveness and vitality of the general practice sector through support to members, contributing to national health policy, promoting collaboration and communication with national organisations and providing national leadership in health service development. The first local divisions were established in 1992. Over 90 per cent of general practitioners are members of a local division of general practice. Health promotion and illness prevention is core business for the divisions network.

The National Preventative Health Taskforce (the Taskforce) has been formed to develop a National Preventative Health Strategy for the Minister for Health and Ageing. The Strategy will provide a blueprint for tackling the burden of chronic disease currently caused by obesity, tobacco, and excessive consumption of alcohol. It will be directed at primary prevention and will address all relevant arms of policy and all available points of leverage, in both the health and non-health sectors, in formulating its recommendations.

The National Health Preventative Taskforce has released 4 discussion papers:

- Australia: the healthiest country by 2020
- Obesity in Australia: a need for urgent action
- Tobacco control in Australia: making smoking history
- Preventing alcohol-related harm in Australia: a window of opportunity

AGPN welcomes the opportunity to provide a submission in response to the recommendations made by the Taskforce in these discussion papers. We note the discussion papers provide specific recommendations regarding how obesity, alcohol and smoking can be tackled through interventions such as reshaping consumer demand and supply towards safer, lower-risk products and behaviours; strengthening the health sector to support healthy choices; creating environmental enablers to healthy eating through public education; infrastructure changes and reform in workplaces and educational institutions. The discussion papers also discuss the support structures that

are common to all three risks factors and highlight the primary care sector as a key support structure.

We also note the recent commitments by the Council of Australian Governments (COAG) to a National Health Prevention Partnership Payment – a new form of payment - which includes commitments to increased public awareness of the risks associated with lifestyle behaviour, provision of incentives for workplaces and local communities and enabling infrastructure such as a national preventative health agency.

This submission:

- provides advice on aspects of public policy that AGPN believes is fundamental to a prevention-oriented system;
- provides recommendations for building the capacity of the primary health care sector to deliver primary prevention and health promotion, with particular reference to general practice;
- considers the role of Australia's divisions of general practice in a prevention agenda and the particular role they can play to bridge primary health care with wider community-based prevention initiatives; and
- responds to the Taskforce's specific recommendations regarding the prevention of obesity, smoking and alcohol misuse in Australia.

A prevention-oriented system – the public policy levers

Apart from a desire to take the cost pressures off Australia's acute care system into the future, one of the other major drivers for a prevention agenda in health is the relationship between the health of the community, workforce participation and our national productivity. This has been most recently recognised by the most recent Council of Australian Government's meeting which pledged Health Prevention National Partnership payment of \$448.1 million over 4 years and \$872.1 million over six years starting from 2009-10 for a range of preventative health initiatives².

Given the multiple social determinants of health, it is clear that a prevention agenda requires cross-sectoral, multi-level interventions that extend beyond the health sector into action in sectors such as housing, welfare, justice, immigration, employment, agriculture, education, family and community services, Indigenous affairs and communications³. AGPN supports a comprehensive whole-of-government national preventative strategy that incorporates actions in all these sectors.

The prevention literature discusses three levels of prevention at which intervention is required:

- Level 1: Universal prevention targets an entire population (national, local community, neighbourhood, or school) or a whole population group that has not been identified to have individual risk. Examples include use of social marketing tools including media and public education campaigns, legislative reform, tax reform and regulation.

² Council of Australian Governments November 2008 Communique accessed from [http://www.coag.gov.au/coag_meeting_outcomes/2008-11-29/docs/communique_20081129.pdf] on [3 December 2008].

³ Wilkinson, R. & Marmot, M. 2003, Social determinants of health: the solid facts (2nd Edition), World Health Organisation, Geneva.

- Level 2: Selective prevention targets individuals or specific subgroups of the general population whose risk is significantly higher than average for developing a problem. The 45 to 49 year health check is an example.
- Level 3: Indicated prevention targets high risk individuals. An example is lifestyle modification programs for persons identified as at risk of type 2 diabetes.

The proportion of the population requiring intervention decreases as the prevention level increases.

At a systems level, the World Health Organisation's (WHO) Ottawa Charter for Health Promotion describes five broad levels of action for health promotion:

- Promoting healthy public policy
- Creating supportive physical and social environments
- Coordinating and supporting community action
- Developing personal skills; and
- Re-orienting health services.

Interventions made at each level need to be informed by the best available evidence, be cost-effective and rigorously evaluated. Importantly, each level of action overlaps with and has implications for activities undertaken at other levels. This underscores the need for a coordinated national strategy for prevention and health promotion in Australia.

Re-orienting health services and promoting healthy public policy are fundamental to a National Preventative Health Strategy. Two key actions that need to be taken to reorient health services to focus more on prevention are increasing health expenditure on prevention and workforce reforms to expand and restructure the public health workforce.

Increased health budget expenditure on prevention

Currently, only 2.7 percent of the Australian health budget is spent on prevention⁴, yet between 40 and 50 percent of the burden of disease is caused by preventable risk factors⁵. Australia's levels of expenditure on prevention are significantly lower than

⁴ Productivity Commission, 2006, *Potential Benefits of the National Reform Agenda*, Report to the Council of Australian Governments, Canberra.

⁵ Begg S, Vos T, Barker B, Stevenson C, Stanley L, Lopez AD, 2007. *The burden of disease and injury in Australia 2003*. PHE 82. Canberra: Australian Institute of Health and Welfare.

similar OECD countries such as Canada and New Zealand who spend 8.6 percent and 7.4 percent of their respective health budgets on prevention. A critical action to be taken at the public policy level to help re-orient health services to focus on prevention and health promotion is to increase health budget expenditure in health promotion and illness prevention. AGPN welcomes COAG's recent commitment under the prevention National Partnership to spend \$448.1 million over 4 years and \$872.1 million over six years starting from 2009-10 on a range of preventative health initiatives. This is an important first step and hopefully will stimulate further expenditure on prevention in Australia.

Workforce development

A skilled public health workforce is essential to a prevention agenda. Across all areas of Australia, there are shortages in workforce supply particularly in general practice, medical specialty areas, dentistry, nursing and some key allied health areas such as psychology⁶. Reform is needed to address these shortages. Expanding and restructuring the health workforce to allow more attention to prevention and health promotion is also warranted. Potential actions to achieve this could include offering more commonwealth supported places for university study in areas of shortage; abolition of, or reductions in, Higher Education Contribution Scheme repayments to attract health professionals to work in rural and remote areas; and an elevated role for practice nurses in prevention.

Promoting healthy public policy requires some changes outside of the health portfolio as well as an investment in the public health infrastructure. Critical public policy reforms are those that will promote environmental changes to encourage healthy lifestyle choices; help to enable more widespread engagement in health promotion across multiple settings; and building the evidence base on prevention. We discuss these areas in further detail in the next section.

Environmental changes to encourage healthy lifestyle choices

Policy reforms can promote a more systematic approach to reducing the barriers and increasing the enablers to healthy lifestyle choices.

The taxation system and its impact on product and service pricing is a particularly relevant public policy lever that can help to enable healthier lifestyle choices. It is well established in the public health literature that tobacco and alcohol consumption in particular is largely influenced by price. Tax reform, to the extent it can increase product price, is essential to prevent obesity, smoking and alcohol misuse. Given the strong

⁶ Productivity Commission, 2005, *Australia's Health Workforce: Productivity Commission research report*, Canberra: Commonwealth of Australia.

international evidence to support the efficacy of taxes on alcohol⁷ and cigarettes⁸ and to suggest their potential efficacy in reducing consumption of energy dense foods⁹, AGPN recommends increased taxes be applied to all three products. We also recommend that an increased tax on alcohol be delivered through a volumetric tax as research from the World Health Organisation (WHO)¹⁰ and the Australian Alcohol Education and Rehabilitation Foundation¹¹ has shown a volumetric tax system for alcohol to be the most sustainable and cost-effective intervention to reduce harmful alcohol consumption.

In combination with tax reforms, restricting access to alcohol, cigarettes and energy dense foods through restricted hours and locations of sale can help to further reduce consumption of these products. Increased understanding and more effective use of social marketing tools can also help to promote healthy lifestyles choices and discourage harmful behaviours. Elements of town planning such as secure well lit exercise pathways and public transport options close to businesses can encourage more physical activity.

Encouraging health promotion in multiple settings

There are multiple settings in which prevention and health promotion can occur including educational settings, workplaces, and the community. AGPN recommends a stronger focus on the role of these settings in prevention and health promotion as part of policy reforms. Specifically, incentives (and disincentives) should be introduced which promote the take up of health promotion programs in these settings (for example, healthy

⁷ Babor T. et al, 2003, *Alcohol: no ordinary commodity*. Oxford Medical Publications: Oxford.

⁸ Chaloupka, F. 1999, Macro-social influences: The effects of prices and tobacco control policies on the demand for tobacco products, *Nicotine and Tobacco Research*.

⁹ Goodman C. & Anise, A (2006). *What is known about the effectiveness of economic instruments to reduce Consumption of foods high in saturated fats and other energy-dense foods for preventing and treating obesity?* Copenhagen, WHO Regional Office for Europe (Health Evidence Network report;

<http://www.euro.who.int/document/e88909.pdf>, accessed [5 December 2008]).

¹⁰ Chisholm, D., Rehm, M. van Ommeren, M., Monteiro, M. & Frick. U. 2004, The comparative cost-effectiveness of interventions for reducing the burden of heavy alcohol use, *Journal of Studies on Alcohol*, 65, 782-793.

¹¹ Australian Alcohol Education and Rehabilitation Foundation, 2008, *Volumetric taxation highlighted as the most cost-effective intervention to reduce alcohol-related harm*, Media Release published 31 July 2008.

workplaces which promote regular exercise through programs available in or through the workplace, and improved diet through healthy canteens). The incentives should be focused at this level because this is where real structural reform is needed. The primary health care sector is then well placed to respond to demand for primary health care services which is generated through these incentives (for example, with follow up health checks, immunisation, screening, lifestyle modification and early intervention).

Workplaces can be more effectively harnessed to prevent disease and promote health. There is strong evidence to support the impact of workplace health promotion programs in reducing sick days, outpatient and hospitalisation costs¹². Workplace health promotion programs and occupational health and safety policies could be more effectively utilised to increase healthy eating and exercise, reduce smoking and alcohol consumption. Workplace level policies could include abolishing sale of junk food in cafeteria and vending machines, prohibiting smoking outside the workplace, and offering lunchtime exercise programs and gyms. Tax incentives could be provided for workplaces to offer exercise programs, for workplace cafeterias to sell healthy foods, and to abolish junk food in vending machines. These measures could be reinforced by including a healthy workplace clause in Australian occupational health and safety legislation. Consideration could also be given to including a prevention and wellness measure in the corporate responsibility index. The performance and impact section of the index looks at companies' performance across a range of social and environmental impact areas, including health, safety and wellbeing.

Another important environment that plays a crucial role in prevention and health promotion is the family environment. Early intervention in health promotion and primary prevention is vital. The healthy children's initiatives agreed by COAG in November this year will help to raise awareness of healthy behaviours among children and families. Initiatives that connect education and primary care sectors¹³ are vital as they help to ensure that at risk children are referred to appropriate interventions and receive appropriate follow up through primary care.

As well as raising awareness of healthy behaviours, barriers to behaviour change need to be identified and addressed to maximize positive outcomes resulting from health

¹² Bertera, R.L. 1990, The effects of workplace health promotion on absenteeism and employment costs in a large industrial population. *American Journal of Public Health*, 80, 9, 1101-1105.

¹³ An example is the Eat it Work it Move it program implemented by Macarthur Division of General Practice in collaboration with the National Rugby League.

promotion and prevention interventions. Brief interventions, delivered to patients by their GP, are an effective means of changing patient behaviour and are discussed in more detail in another section of the submission. Offering training in evidence based parenting skills is vital to equip parents with the skills needed to effect positive behaviour changes in their children. For this reason, healthy children initiatives agreed by COAG in November 2008 need to be supported by investment in evidence-based parenting programs.

Building the evidence base on what works in prevention

The Taskforce recommends building the evidence base on the prevalence of obesity in Australia and the most effective interventions for prevention. We would argue that building the evidence base is crucial for smoking and alcohol misuse as well as obesity. AGPN supports the development of a national prevention agency to take responsibility for building the evidence base in prevention and to provide national leadership and coordination of Australia's approach to prevention. We also support the proposal that one of the key objectives of the agency would be to "ensure the delivery of a minimum set of evidence-based prevention programs that are accessible to all Australians". The agency could also play a role in evaluating the uptake of and patient outcomes from existing national initiatives in prevention and health promotion such as the Australian Primary Care Collaboratives, Lifescripts, and the COAG Type 2 diabetes prevention program. To date, no rigorous evaluation of these programs has been undertaken and consequently their impact on patient health outcomes is unknown.

AGPN also advocates that this national agency be supported by a dedicated fund for prevention and health promotion, and a mechanism to guide the prioritisation of these funds. AGPN believes that the notion of a Preventative Priorities Advisory Committee and mechanisms for determining funding allocations between public health and clinical interventions and determining prevention 'best buys' as discussed by Harris and Mortimer in their options paper for the National Health and Hospitals Reform Commission, warrants

further exploration¹⁴. Given the multiple social determinants of health, to encourage a cross-sectoral approach to prevention, we recommend that this agency has cross-portfolio government representation as well as members from non-government and community sectors.

SUMMARY POINTS

AGPN supports a cross-sectoral strategy for prevention with actions at all levels of prevention and the establishment of a national prevention agency to provide national leadership and direction.

Recommendation 1: AGPN recommends that the proposed national preventative health agency has cross portfolio government, non-government and community sector representation.

Reorientation of the Australian health system to focus more on prevention and promotion is needed. This requires reform to public policy outside of the health portfolio as well as specific health programs.

Recommendation 2: AGPN recommends that the proposed increased taxes on alcohol, cigarettes and energy dense food are accompanied by a volumetric tax for alcohol and the abolition of the duty exemption on imported cigarettes.

Workplace interventions are underutilised in prevention.

Recommendation 3: AGPN recommends that healthy worker initiatives agreed by COAG in November 2008 are promoted through offering tax incentives for workplaces. AGPN also supports the inclusion of a health and wellbeing measure in the corporate responsibility index.

¹⁴ Harris, A. & Mortimer, D. 2008, *A preventative priorities advisory committee and prevention benefits schedule for Australia*, Options paper prepared for the National Health and Hospitals Reform Commission, accessed from [http://www.nhhrc.org.au/internet/nhhrc/publishing.nsf/Content/16F7A93D8F578DB4CA2574D7001830E9/\\$File/A%20Prevention%20Priorities%20Advisory%20Committee%20and%20Prevention%20Benefits%20Schedule%20for%20Australia%20\(A%20Harris%20D%20Mortimer\).pdf](http://www.nhhrc.org.au/internet/nhhrc/publishing.nsf/Content/16F7A93D8F578DB4CA2574D7001830E9/$File/A%20Prevention%20Priorities%20Advisory%20Committee%20and%20Prevention%20Benefits%20Schedule%20for%20Australia%20(A%20Harris%20D%20Mortimer).pdf)

Supporting the primary health care sector to deliver primary prevention and health promotion

Primary health care is about providing 'first level' health care which is universally accessible to individuals and families in the community and provided as close as possible to where people live and work. To ensure universal access to prevention and health promotion in Australia, primary health care involvement at all levels of prevention is crucial.

Primary health care professionals - including nurses, general practitioners and allied health professionals working in community settings - have a role to play at all levels of prevention, but play a more significant role at level 3 prevention which involves targeted interventions for high risk groups. At the universal level of prevention (level 1), primary care professionals can support universal interventions by advising on the evidence-base for recommended behaviour modifications or assessing the prevention needs of a community or sub-population. At the selective level of prevention (level 2), they may be involved in 'risk factor' screening of selected individuals or sub-populations. This may lead to a more intensive intervention at level 3 which may take the form of a brief intervention, referral to community resources or group programs, or one-on-one support delivered through a multidisciplinary team.

Within the primary health care sector, the general practice setting and divisions of general practice are key domains for prevention. An investment in increased prevention capacity in both general practice and the divisions network would make a substantial contribution to a national prevention agenda.

The role of general practice in prevention

One of the key roles of general practice is to prevent disease and promote health and well-being. As primary health care providers who see around 86% of the population every year, general practitioners and their staff play a central role in preventive care that:

- is opportunistically provided when patients present with other problems or concerns
- anticipates the preventive needs of their patients by providing reminders for preventive care, and

- proactively targets high risk individuals who may be least likely to seek out such care¹⁵.

In treating patients with or at risk of obesity, alcohol misuse or who smoke, GPs and other members of the general practice team such as practice nurses offer a range of services including brief interventions, engaging in early intervention through routine screening, immunisations, administering Lifescripts, offering patient education, and referring patients to lifestyle modification programs and allied health professionals where required. There is strong evidence demonstrating that GP delivered brief interventions are among the most effective health promotion interventions in terms of their capacity to contribute to behaviour change among patients. Models of chronic disease management highlight the importance of productive interactions between patient and clinician in predicting a patient's level of engagement in the management of their health. These productive interactions are also vital to effect behaviour change among patients as part of primary prevention and health promotion efforts.

The role of divisions of general practice in prevention

Divisions of general practice play a key role in prevention which includes:

- holding government funds to contract allied health services;
- supporting practices to engage in prevention through tools such as recall and reminder systems and data extraction;
- delivering education and professional development to GPs;
- collaborating with other organisations;
- creating referral pathways for lifestyle modification programs; and
- implementing national prevention programs such as Lifescripts, Australian Primary Care Collaboratives (APCC), engaging in the Australian Better Health Initiative and conducting practice level prevention activities.

¹⁵ Royal Australian College of General Practitioners, 2005, Guidelines for preventive activities in general practice (The Red Book) 6th Edition, Accessed from [<http://www.racgp.org.au/guidelines/redbook>] on [19 November 2008].

According to the 2006-07 Annual Survey of Divisions of General Practice¹⁶, all divisions conducted a program or activity focused on prevention and early intervention. These activities included immunisation, type 2 diabetes prevention, Lifescrpts, health promotion, physical activity programs, alcohol and other drug programs, nutritional programs, smoking, and bowel cancer screening.

Mid-level health organisations like divisions of general practice can play a significant role in enabling improved integration of prevention into primary health care because their unique position in the system allows them to link individual care delivered through general practice and primary care with broader public health goals. Agencies like Divisions can also link the relevant players in the care and prevention space – care providers, industry / local business, government, communities, the education sector, secondary care - so they can be the hub that draws the many spokes required to deliver comprehensive health and preventative care to Australians. While the following examples illustrate how this is already happening, there is scope to more systemically implement a prevention program through divisions of general practice:

- through the Australian Primary Care Collaboratives, a number of divisions are working with practices to help link individual care provided to patients with diabetes and coronary heart disease, with public health goals to reduce these conditions and their associated adverse health consequences .
- through the *GP exercise referral scheme*, one division is providing a pathway for GPs to refer patients with conditions such as cardiovascular disease or diabetes (or risk factors for these conditions) who are engaging in low levels of physical activity to an exercise physiologist;
- in partnership with local high schools and the National Rugby League, another division is working to prevent overweight and obesity in kids through a multi-factorial intervention within a health promoting schools framework (*the Eat it Work it Move it Program*); and
- another division has funded the development of an organic school garden accompanied by classroom based education on nutrition, healthy cooking and healthy school lunches;

¹⁶ Hordacre, A.L., Howard, S., Moretti, C., Kalucy, E. 2008, Moving ahead. Report of the 2006-2007 Annual Survey of the Divisions of General Practice, Adelaide: Primary Health Care Research and Information Service, Department of General Practice, Flinders University and Australian Government Department of Health and Ageing.

promotion of physical activity; and newsletters for parents on nutrition (the *Leaping Lizards* program).

Most importantly, all these programs have demonstrated reductions in risk factors for participants and/or demonstrated improved patient outcomes. Detailed case studies outlining the objectives and outcomes from the *GP exercise referral scheme*, the *Eat it Work it Move it* program and the *Leaping Lizards* program are provided at **Attachment A**.

Building the capacity of the primary care sector

The need for better integration of prevention and health promotion in the primary care sector is widely acknowledged in the literature but is constrained by two key factors. First, systems for preventative health care are significantly less effective and less well-developed than systems for acute health care¹⁷. This has implications not only for the prevention of obesity, smoking and alcohol misuse but for health promotion more broadly. Second, there is a limited evidence base to inform the selection of prevention interventions to be delivered through primary care, particularly for risk factors such as obesity¹⁸, and to a lesser extent for smoking and alcohol misuse. Both issues need to be addressed to ensure universal access to evidence-based primary prevention and health promotion through primary care.

The Taskforce acknowledges the need to build the capacity of the primary health care sector to engage in prevention and health promotion and recommends two key actions to address this:

- enrolment or registration of patients with a practice, and
- new incentive payment arrangements for engagement in preventative health care at both the individual practitioner and practice level linked to a reporting and evaluation system.

AGPN supports both actions proposed by the Taskforce and emphasises that these actions also need to be considered within the context of the broader reforms being undertaken through the National Primary Health Care Strategy and the National Health and Hospitals Reform Commission. Patient registration and practice incentives alone will not encourage the productive interactions between clinician and patient that are required

¹⁷ World Health Organisation 2002, Integrating prevention into primary care, Fact Sheet no. 172, accessed from www.who.int/mediacentre/factsheets/fs172/en/print.html on 19 November 2008

¹⁸ Lawlor, D.A. & Chaturvedi, N. Treatment and prevention of obesity—are there critical periods for intervention? *International Journal of Epidemiology* 2006 35(1):3-9.

to achieve effective primary prevention and health promotion. AGPN recommends that further investment is made at the general practice and divisional level to improve access to quality prevention and health promotion. In addition to i) patient registration and ii) practice incentives, we recommend iii) more investment in educating and training clinicians to engage effectively in prevention and health promotion with their patients, and iv) providing them with e-health tools to enable more effective screening and monitoring of patients. Measures that will improve the quality of patient interactions need to be accompanied by v) funding models that offer cost effective service delivery to improve patient's access to prevention and health promotion. We outline our position on each of these five action areas in the next section.

Voluntary patient registration

Voluntary registration is crucial to improve both population level and individual level prevention and health promotion in general practice. It enables practices to have a more thorough understanding of their practice population. **It is therefore a critical first step in identifying those populations and individuals within the practice who are most in need of preventative care.** When supported by appropriate practice systems including e-health and information management infrastructure, voluntary registration can also help inform better planning at practice, divisional, regional, state and territory and even national levels, through facilitating sharing of de-identified patient data. Patient registration also enhances a practice's capacity to engage in prevention and health promotion by identifying populations for individually tailored packages of preventative care facilitated by tools such as health checks, recall and reminder systems and coordinated care packages. **AGPN supports a system of practice level voluntary patient registration provided it allows patients to choose their own doctor and practice, and to see an alternative doctor if they wish.** Having this system in place will also expand the options available for providing practice level incentives for prevention and has the potential to enhance the efficacy of e-health systems such as recall/reminder systems and data extraction in prevention.

Incentive payments for prevention at the practice or practitioner level

AGPN supports a combination of incentive payments at both practice and practitioner level to encourage engagement in prevention. The current blended payment system which consists of a mix of quality incentive payments at the practice level as well as fee for service at the practitioner level, offers the flexibility to support the variety of reactive and proactive approaches required within primary care. Current fee-for-service

arrangements under the MBS, however, provide a disincentive to prevention and need to be reformed to address this. More innovative models of practice level incentives for prevention at the practice level also need to be explored. Evidence from the Australian Primary Health Care Research Institute (APHCRI) suggests that **flexibility in funding options** offered through **multiple funding mechanisms and models that support multidisciplinary care tailored to individual needs are crucial**¹⁹.

Reform to practitioner level incentives

Current fee for service arrangements via the MBS item numbers play an important role in one-off episodic care. However, we acknowledge that the current focus of the MBS on time-based consultations, reimbursement of inputs, and lack of incentives to avoid hospitalisations provides a disincentive for health professionals to engage in prevention and health promotion. A secondary issue is that the current MBS system is too complex and administratively burdensome. **AGPN supports the review of the current MBS to simplify current arrangements and ensure they promote quality of care, chronic disease prevention and management.**

Practice level incentives

AGPN supports blended payments at the practice level. Currently, under the Australian Government's practice incentive program, accredited practices receive retrospective incentive payments for delivering services such as after hours care, cycles of care for patients with asthma and diabetes, cervical cancer screening as well as for having the capacity for electronic data transfer and prescribing, employing practice nurses in practices in RRMA 3-7 regions and teaching undergraduate medical students.

The advantage of the current practice incentive program is that it already provides an outcome-based payment for meeting certain preventative targets in areas such as immunisation coverage and number of patients screened for cervical cancer. However, the scope of preventive services is restricted. There are no payments to directly encourage prevention of obesity, alcohol misuse, and smoking. In addition, eligibility criteria require practices to be accredited to participate in the program and billing for

¹⁹ Australian Primary Health Care Research Institute, 2005, Primary Health Care Position Statement: a scoping of the evidence, A paper commissioned by the Australian Divisions of General Practice.

services is reported to be complex which discourages practice participation in the program – this particularly applies to some Aboriginal Medical Services (AMS). **To maximise impact, any system of practice level incentives for prevention ideally needs to be universally accessible by practices. It also needs to be linked to a reporting and accountability framework of national performance indicators to encourage maximum uptake by practices, and reward practices for setting and achieving targets.**

There are a number of options that could be considered by the Taskforce in improving the current practice level incentive program. One option could be to expand the current program to include payments for delivering brief interventions for alcohol, smoking, obesity; weight management programs, exercise referral program and smoking cessation programs. **The structure of these payments would include an upfront component and an outcome payment component** linked to targets around screening for overweight, alcohol misuse, smoking etc and participation rates for at-risk patients in these programs. To encourage more multidisciplinary care, there would also be value in including an incentive payment for coordinated packages of preventative services under the program.

Another option could be to undertake a trial of a practice-level capitation payment systems which offer incentives for all practice members, not just GPs, to engage in prevention. A review undertaken by the European Observatory on Health systems suggests that capitation funding systems are most likely to encourage physicians to provide preventative services²⁰. Because capitation systems allocate GPs a fixed amount of money per patient per year to service the health needs of their registered patient population, they require some form of patient registration to be in place. US and Canadian experiences of capitation based payments when delivered as part of a blended payment system, have been shown to encourage physician participation in prevention and improve professional satisfaction²¹.

²⁰ Grep, S., Delnoij, M.J., Groenewegen, P.P. 2006, Managing primary care behaviour through payment systems and financial incentives, Primary care in the driver's seat, European Observatory on Health Systems.

²¹ Young, D., Gunn, J., Naccarella, L. 2008, Funding policy options for preventative health care within Australian Primary Health Care, Accessed from [http://www.nhhrc.org.au/internet/nhhrc/publishing.nsf/Content/16F7A93D8F578DB4CA2574D7001830E9/\$File

An options paper commissioned by the NHHRC has proposed a model for an up-front per capita payment (weighted by population group) to practices to deliver and coordinate a person-centred 'basket of team-based preventative services'. The paper proposes this basket could include but not be limited to services such as smoking cessation programs; cervical screening; immunisation; nutrition and physical activity advice; brief interventions for alcohol, tobacco and obesity; weight management problems. The authors propose the practice level payment would be linked to performance against targets such as having in place appropriate e-health infrastructure, human resources, offering adequate training opportunities to staff and demonstrating improvements in patient participation levels in these programs. The benefit of this model is it appears to be less administratively complex than the current practice incentive program, as practices receive an up-front payment to undertake a package of services, rather than having to bill for individual services. It also offers an incentive for team-based arrangements which is absent from the current program. **AGPN supports the development, trial and evaluation of a practice-level capitation funding model to encourage greater primary health care engagement in prevention.** Pending the outcomes of the evaluation of this trial, further consideration could be given to rolling out such a system at a national level.

Practices awarded the capitation payment should be required to report against the targets listed above. There would also be value in these targets being included in the prevention national performance indicators for divisions of general practice. Currently these prevention NPIs focus on the number of 45 to 49 year old health checks administered to at risk patients, immunisation coverage rates, and number and proportion of immunisation records transferred to the Australian Childhood Immunisation register (ACIR). Additional NPIs for prevention worthy of consideration include the proportion of high risk patients administered brief interventions or referred to lifestyle modification programs for smoking, obesity or alcohol; proportion of current smokers, alcohol abusers and obese recalled for follow-up consultations.

e/Funding%20Policy%20Options%20for%20Preventative%20Health%20Care%20within%20Australian%20Primary%20Health%20Care%20(D%20Young%20J%20Gunn).pdf] on [25 November 2008].

SUMMARY POINTS

AGPN supports a blended payment system which offers incentives for engagement in prevention at both practitioner and practice level.

Specifically, AGPN recommends that:

Recommendation 5: A system of practice level voluntary registration is introduced which offers the flexibility for patients to choose their own doctor and practice and to see an alternative doctor or practice as needed.

Recommendation 6: Both practice and practitioner level incentives for prevention continue to be delivered through a blended payment system and are linked to a framework of prevention-focused performance indicators.

Recommendation 7: The current practice incentive payment program is expanded to encourage prevention, and a practice-level capitation system to deliver

AGPN strongly supports the current review of the MBS and advocates that it be simplified and better promote chronic disease management, primary prevention and health promotion.

Funding models to support enhanced access to multidisciplinary prevention and health promotion

Multidisciplinary teams are an essential component of primary health care and disease prevention. They are cost-effective and ensure allied health professionals as well as primary health care workers collaborate effectively to ensure comprehensive coverage of all key risk factors for disease. AGPN has strongly advocated for the importance of multidisciplinary teams and coordinated care in its Primary Health Care Position Statement. In preventing obesity, smoking, and risky alcohol consumption, multidisciplinary teams are particularly important given evidence that GP engagement in brief interventions for and management of these risk factors is often low^{22, 23, 24}, and all

²² Creitkos, M.A., Valenti, L., Britt, H.C., and Baur, L.A. 2008, General Practice management of overweight and obesity in children and adolescents in Australia, *Medical Care*, 46, 11, 1163-1169.

three health issues are known to have significant psychological antecedents and consequences²⁵.

A key challenge for the Taskforce is to implement reforms that ensure equitable access to preventative health services. Currently, the distribution of the health workforce and health services overall is inequitable and largely urban-centric, with the exception of the nursing workforce²⁶. As a result, per capita Medicare funding decreases with increasing rurality. Therefore, alternative funding models that provide flexibility to attract and retain primary and allied health workforce are needed. Funding models that encourage high quality, well-coordinated multidisciplinary approaches are also crucial. Infrastructure support is also needed to encourage multidisciplinary approaches to prevention.

Division of general practice level funding, the model currently used for the More Allied Health Service Program (MAHS) and the Access To Allied Psychological Services Program (ATAPS), is worthy of wider adoption to increase access to preventative health services. This model allows divisions of general practice to directly purchase the services of allied health professionals using government funds (or another primary funding source). In the case of MAHS and ATAPS, this funding model has been shown to be particularly effective in increasing patient access to care in rural areas^{27, 28}. For patients, it offers increased access to multidisciplinary team care; and for GPs, it offers more referral options to a wider pool of allied health providers. It also gives divisions of

²³ Roche, A. & Freeman, T. 2004, Brief interventions: good in theory but weak in practice, *Drug and Alcohol Review*, 23, 11-18.

²⁴ Degenhardt, L., Knox, S., Barker, B., Britt, H. & Shakeshaft, A. 2005, The management of alcohol, tobacco and illicit drug use problems by general practitioners in Australia, *Drug and Alcohol Review*, 24, 499-506.

²⁵ Australian Bureau of Statistics, 2008, National Survey of Mental Health and Wellbeing 2007: Summary of Results.

²⁶ Australian Government Department of Health and Ageing, 2008, *Report on the Audit of Health Workforce in Rural and Regional Australia, April 2008*. Canberra: Commonwealth of Australia.

²⁷ Justine Fletcher, Bridget Bassilios, Jane Pirkis, Fay Kohn, Grant Blashki, Philip Burgess, April 2008, Evaluating the Access to Allied Psychological Services component of the Better Outcomes in Mental Health Care program. Twelfth Interim Evaluation Report Making an impact on the Australian mental health care landscape. Melbourne University: Centre for Health Policy, Programs and Economics

general practice more flexibility to tailor the purchasing of services to local needs and to offer health professionals attractive remuneration packages.

This model has significant potential to be adopted to improve access to and targeting of preventative health programs to address health issues such as obesity, alcohol misuse, smoking, and mental health promotion. Informed by information about its patient population acquired through data extraction tools (see next section), divisions could fund lifestyle modification programs, exercise referral schemes, parenting programs and mental health promotion programs for at-risk populations. Patient data collected through these programs could then be linked to recall and reminder systems to ensure adequate follow up of the patient's progress. The division could also facilitate referrals between prevention/health promotion programs and health providers as required.

Incentives for coordinated packages of preventive services can ensure effective coordination of these services in circumstances where patients require multiple services delivered by multiple health professionals. So for example, a patient who is overweight, smokes, drinks too much and has mental illness might benefit from a number of different lifestyle modification programs, and referral to a psychologist. A coordinated package of preventive services would ensure a staged approach to these interventions, and promote sharing of health outcomes between the different professionals as required.

To enable appropriate identification and follow-up of candidates for coordinated packages of services, practices will need to have appropriate recall and reminder systems in place. The incentive payment would be awarded on the basis of participation rates of high risk individuals/subpopulations in lifestyle modification programs and other preventative health activities. Depending on practice and divisional capacity to coordinate these packages of services, the payment may be made directly to the practice to deliver and coordinate the services, or a proportion of the payment could be made directly to the division to coordinate and purchase services to be delivered as required.

Health insurance can be more effectively utilised in prevention and health promotion. Inadequate insurance reimbursement for preventive health services has

²⁸ Department of Health and Ageing 2007. www.health.gov.au/internet/main/publishing.nsf/Content/health-pcd-programs-mahs

been identified as a major barrier to uptake of these services²⁹. AGPN advocates that the Taskforce give consideration to encouraging private health insurance companies to offer rebates on gym membership and subsidise weight management programs, smoking cessation programs and alcohol-focused lifestyle modification programs, particularly, for demographics at disproportionate risk of these three health issues. We do however recognise that this approach will not necessarily reach low socioeconomic status groups who may not have private health insurance and who may also be in most need of preventive health services.

A three-pronged approach to e-health

AGPN supports a three-pronged approach to e-health comprising nation-wide implementation of shared electronic health records; recall and reminder systems; and data extraction tools. This approach is needed to increase access to prevention services for at-risk groups, enable effective multidisciplinary approaches to prevention, ensure ongoing follow-up of patients, and maximise the quality of preventative services delivered.

Shared electronic health records

Secure electronic messaging systems can provide the capacity for electronic exchange of clinical information between health care providers, in a way that preserves confidentiality and integrity. For those who smoke, misuse alcohol, or who are at risk of obesity, shared e-health records can help enable more comprehensive, multidisciplinary approaches to prevention and health promotion.

In past submissions, AGPN has advocated for the national rollout of secure electronic messaging software through the divisions of general practice to facilitate wider use of shared electronic health records by primary care providers. Because many allied health professionals have limited access to computers, any investment in secure electronic messaging software would need to be accompanied by measures to increase allied health professionals' access to computers.

²⁹ Kimberly S. H. Yarnall, MD, Kathryn I. Pollak, PhD, Truls Østbye, MD, PhD, Katrina M. Krause, MA and J. Lloyd Michener, 2003, Primary Care: Is There Enough Time for Prevention? American Journal of Public Health, Vol 93, No. 4 635-641

Recall/reminder systems

Empirical evidence shows recall and reminder systems increase patient return visits to general practice, particularly when used for immunisation and cervical screening³⁰. In Australia, the use of reminder systems in preventive care is reportedly less widespread than in other similar OECD nations as around 62% of Australians reported that they **do not** receive reminders for preventive care (compared with 55% in NZ and 40% in the USA)³¹.

Recall and reminder systems are currently used effectively in risk factor management for patients with chronic diseases such as diabetes, asthma and cardiovascular diseases. There would be value in using these systems to monitor patients who are obese or at risk of obesity, alcohol dependence and who smoke not only for their progress with these health issues; but also for their risk of other secondary chronic diseases. This could be achieved by linking these recall and reminder systems with existing screening tools such as lifescrpts and the Australian Primary Care Collaboratives.

The current model of the collaboratives program focuses on secondary prevention for diabetes and coronary heart disease. Given its strong evidence base and significant impact on patient outcomes, there would be value in adapting the model for more use in primary prevention as a mechanism to screen and monitor lifestyle risk factors (including the SNAP factors and BMI) and record these factors for each patient in medical software. Similarly, data collected on patient smoking status, alcohol consumption, BMI, and physical activity level collected as part of a lifescrpts consultation, could be recorded in medical software. This data could then be linked with recall and reminder systems so that those who have a positive smoking status, high BMI, or high level of alcohol consumption are reminded to have more regular check-ups.

³⁰ Centres for Disease Control and Prevention. *Reminder and recall by vaccination providers to increase vaccination rates*. Recommendations of the Advisory Committee on Immunization Practices, the American Academy of Pediatrics, and the American Academy of Family Physicians: Use of. *MMWR* 1998; 47:715-717

³¹ Doggett, J. 2008, A new approach to primary care for Australia, Centre for policy development occasional paper 1, Accessed from [http://cpd.org.au/sites/cpd/files/u51504/a_new_approach_to_Primary_Care_-_CPD_June_07.pdf] on [25 November 2008].

Data extraction tools

Data from these recall and reminder systems could be used by divisions in data extraction to help identify patients for coordinated packages of care in areas such as weight management, smoking cessation and alcohol-focused lifestyle modification programs. Examples of data extraction tools currently used by divisions and practices include the PEN clinical audit tool, the practice health atlas and cardiab. These tools could also be used to identify patients who require education and guidance in nutrition; minimum levels of physical activity; or who are candidates for controlled drinking, smoking cessation and/or positive parenting programs or require referral to a psychologist.

Education in preventative health for primary care professionals

Currently, the structure of curricula of undergraduate programs for primary care professionals tends to adhere to a medical model and is disease focused. There appear to be no minimum standards of training in prevention and health promotion as part of undergraduate primary health care courses, so the level of education in prevention varies from state to state. AGPN notes the taskforce's recommendation that more education be provided to primary care professionals to help expand the supply of the workforce skilled to prevent obesity. AGPN advocates for a minimum of one compulsory core unit of training in prevention and health promotion as part of *all* undergraduate training for primary care professionals. The unit could include but not be limited to brief interventions, motivational interviewing, effective rapid screening assessment tools, evidence-based lifestyle education programs for patients, and multidisciplinary approaches to prevention and health promotion.

As the taskforce notes, many preventative health and health promotion services can be undertaken by nurses who are often less impeded by time constraints than doctors/GPs. Evidence suggests the quality of preventative care delivered by nurses is equal to that delivered by GPs, and that nurse-led prevention may be associated with higher levels of patient satisfaction³².

³² Sibbald, B. 2008, Should primary care be nurse led? Yes. *British Medical Journal*, 337, 1157.

To facilitate and promote an elevated role for nurses in prevention, AGPN advocates for more opportunities for nurses to access ongoing professional development in prevention and health promotion. In past submissions, AGPN has advocated for practice nurse orientation and refresher programs which aim to provide nurses with a pathway into working in general practice and prepare them for the work in this environment. There would be value in including a unit on prevention and health promotion in both these programs. Another option could be to develop an in-service continuing professional development (CPD) program on preventative health for practice nurses, GPs, and other members of the general practice team. This CPD course could be developed, trialled and evaluated with support from a sample of divisions. Pending outcomes of the evaluation of the trial, the program could be implemented nationally through the divisions network.

SUMMARY POINTS

To improve patient access to prevention and health promotion, AGPN recommends:

Recommendation 8: The introduction of funding models to support enhanced access to multidisciplinary prevention including:

- **wider adoption of divisional level funding** to allow direct purchasing of allied health services to deliver specific, evidence based locally driven and coordinated prevention and health promotion initiatives such as lifestyle modification programs and early child development programs
- funding for **a regionally based network of health promotion and prevention coordinators** to coordinate a regional prevention agenda. These coordinators could be located in divisions of general practice, or similar mid-level organisations with a focus on health (or could be shared between schools and divisions or workplaces and divisions, for example).

Recommendation 9: More effective utilisation of private insurance in prevention by offering rebates to private health insurance members who are referred to evidence-based prevention interventions.

To improve the quality of primary prevention and health promotion delivered to patients, AGPN recommends:

Recommendation 10: National implementation of secure electronic messaging and further investment in recall and reminder systems and data extraction tools for general practices and divisions. This will provide practices with the tools and infrastructure required to systematically map the risk profiles of their practice populations, systematically target risk factors and monitor population health improvement.

Recommendation 11: Increased investment in education and training in preventative health for all primary care professionals including:

- a core unit on prevention in undergraduate training for all primary care professions;
- training in prevention as part of practice nursing orientation and refresher training programs; and
- funding to develop, trial and evaluate continuing professional development programs on prevention for practice nurses, nurse practitioners and GPs to be implemented by divisions of general practice.

The bridge between primary health care and community prevention programs

One of the key challenges in providing effective primary prevention and health promotion is to enable effective linkages across a variety of sectors including primary care, education, workplaces, community and non-government sectors who engage in prevention and health promotion. Well-coordinated, efficient and effective action in prevention and health promotion can be further facilitated by having in place a common plan including shared objectives to inform the actions taken by all these sectors.

Building regional infrastructure to tailor prevention to local needs

A regionally based network of health promotion and prevention coordinators could assist to plan and deliver a regional prevention agenda. These coordinators could be located in divisions of general practice, or similar mid-level organisations with a focus on health or could be shared between schools and divisions or workplaces and divisions for example.

At the division of general practice level, **service coordinators** employed in divisions of general practice will enable consumers at higher risk of chronic disease to more easily transition between the health professionals within the team. The proposed service coordinators would be clinically qualified (for example a nurse) and could be employed by a division of general practice to serve a number of practices. The service coordinator would help patients to coordinate and manage their appointments with the different members of the multidisciplinary team. This in turn would contribute to better coordination and continuity of patient care; better patient self management; and the avoidance of unnecessary hospital admissions.

A '**Communities of Prevention Practice' (CPP) development fund** could be established to fund regional level communities of prevention practice. The fund would support innovative regional intersectoral partnerships for prevention involving local government, divisions of general practice, business and community organisations. This would assist to promote linkages between primary health care and communities and build community capacity to implement evidence-based prevention initiatives relevant to regional populations

in keeping with the groundswell towards a regionalisation agenda in the wider health debate. The CPP fund could be modelled on **headspace's** youth service development fund.

Coordinated regional or local level partnerships for prevention will afford the opportunity to tailor solutions to the needs of regional/local populations in much the same way that divisions of general practice do this for local level primary care needs. As with the headspace youth service development fund, the fund would aim to build the capacity of local communities to identify early, and provide effective responses to the preventative health needs of their population.

The proposed fund could be used to support regional-level partnerships/consortia of organisations responsible for the delivery of prevention and health promotion services which may include but not be limited to divisions of general practice, community health services, educational services, workplaces and businesses, and the non-government sector. Each partnership/consortium would be coordinated by a lead agency and each fund would be required to have a prevention plan including key shared objectives and outcomes for all partner organisations to guide the allocation of funds. The proposed objectives and outcomes for each partnership/consortium would also be aligned with those of the proposed national prevention agency.

SUMMARY POINTS

AGPN supports funding for division-based service coordinators and regionally based health promotion and prevention coordinators

To build the capacity of the primary health care sector to effectively link with preventative action in the wider community, AGPN recommends that:

Recommendation 12: A 'Communities of Prevention Practice' (CPP) development fund modelled on headspace's youth service development fund be established to support regional intersectoral partnerships for prevention.

AGPN's response to the Taskforce's recommendations on obesity, smoking and alcohol misuse

Overall, AGPN commends the cross-sectoral approach proposed by the Taskforce to address obesity, smoking and alcohol misuse and the recognition of the multiple social determinants of health recognised in the recommendations. Generally, the recommendations proposed have merit and are supported by international evidence. AGPN supports in principle most of the recommendations made by the Taskforce. We urge the taskforce to ensure consideration is given to the feasibility of implementing its proposed recommendations including potential impacts on industry. We start with suggested improvements to the recommended actions that apply across all three health issues. We then respond to the three sets of recommendations individually.

A focus on the early years

AGPN believes more acknowledgement of the importance of early intervention in the three health issues is required. The discussion paper does recognise the influence of the school environment and the need to enable healthy choices within this environment. However, minimal reference has been made to the impact of family environments, particularly parenting practices, or childcare centres on childhood and adolescent risk of obesity, smoking and alcohol misuse. Greater priority needs to be given to the influence of the family environment, parenting practices and childcare centres on all three health issues and for obesity in particular within the taskforce's recommendations.

Evidence from the longitudinal study of Australian children shows parenting styles can impact on children's risk of obesity³³. Evidence also suggests successful obesity prevention programs for children and youth need to include changes to parenting practices and educational information providing advice and strategies for parents to improve nutrition and increase physical activity levels³⁴. Parenting programs also

³³ Wake M, Nicholson JM, Hardy P and Smith K. (2007). Preschooler obesity and parenting styles of mothers and fathers: National population study. *Pediatrics* 120 (6): 1520-1527.

³⁴ Whitaker, R.C. (2003). Obesity Prevention in Pediatric Primary Care: Four behaviours to target.

appear to be useful in prevention of child and youth alcohol consumption and smoking, although the evidence is less clear than for obesity prevention^{35,36}.

Primary care workers who identify families with children and/or youth who have or are at risk of obesity, smoking or alcohol misuse need to provide parents with practical advice on nutrition, physical activity, and alcohol misuse and smoking prevention. General practice and divisions of general practice can also support the referral of high risk families to parenting programs to gain the skills required to enable healthy behaviours and choices for children and youth. *The Every Family Program*, an evidence-based parenting skills program based on the internationally recognised triple p program, can help to facilitate these referral pathways, and provide parenting skills for high risk families³⁷. Australian and international clinical trials have demonstrated Triple P has cross-cultural validity and effectiveness including with Indigenous parents (Turner et al. 2007), Chinese parents (E.g. Leung et al., 2003; Matzumolo et al., 2007) and African American parents and service providers (Prinz et al., under review). 43 randomized clinical trials have shown triple p to contribute to positive outcomes including reduced behavioural and emotional problems in children, increased parental self-efficacy, reduced dysfunctional discipline, reduced parental distress including depression, stress and anger, reduced couple conflict over parenting, and improved work performance in working parents.

The Every Family program provides a cross-sectoral approach to parenting support and delivers interventions in educational, workplace, primary care and community health settings. Interventions delivered range from a local mass media strategy targeting all parents, to intensive parenting skills training targeted to parents with families and

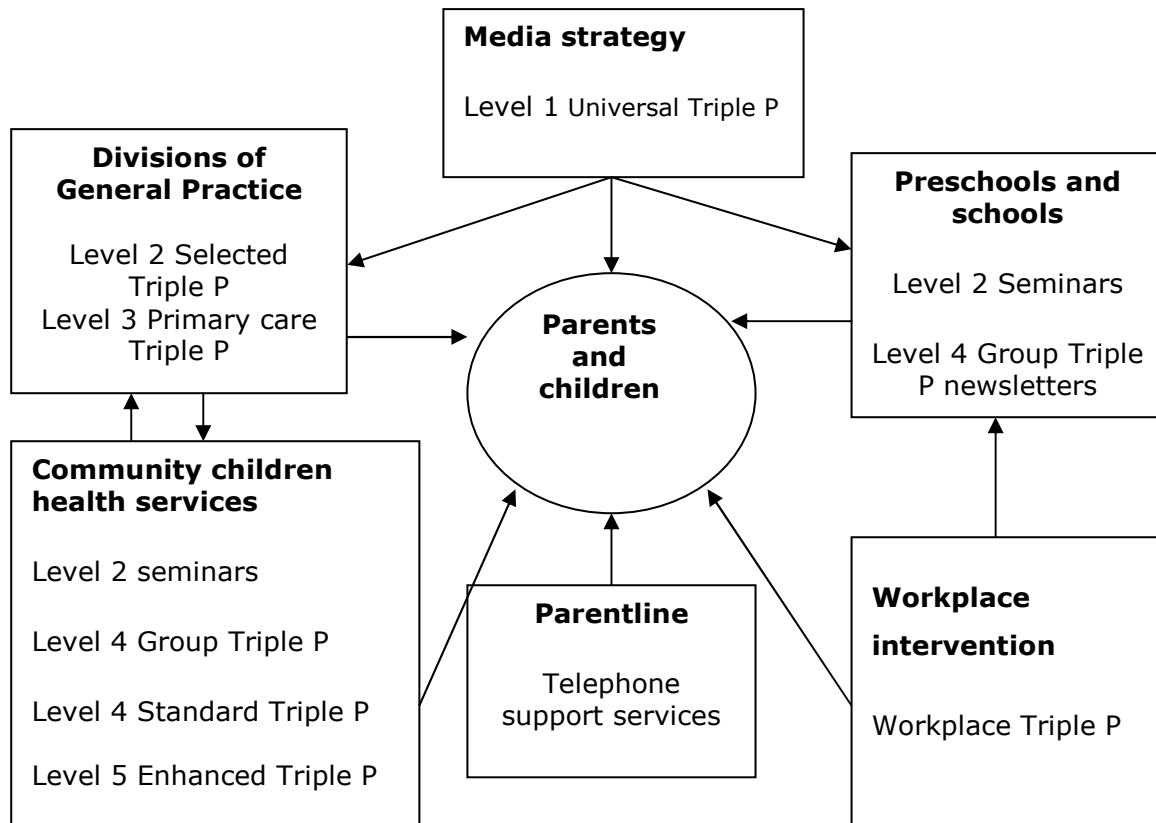
Archives of Pediatric and Adolescent Medicine, 157, 725-727.

³⁵ Hayes, L., Smart, D., Toumbourou, J.W. and Sanson, A. 2004, Parenting influences on adolescent alcohol use. Research report no. 10, Australian Institute of Family Studies. Accessed from [insert link] on [insert date].

³⁶ Thomas, RE. Baker, P.R.A., Lorenzetti, D. 2008, Family-based programmes for preventing smoking by children and adolescents, Cochrane Review, http://mrw.interscience.wiley.com/cochrane/clsysrev/articles/CD004493/pdf_fs.html

³⁷ The evaluation report for the trial of *Every Family* is available at http://www.triplep.net/cicms/assets/pdfs/pg1as100gr5so41_v.pdf

children at the highest risk of behavioural and emotional problems. The diagram on the next page illustrates the multilevel, cross-sectoral approach to parenting support delivered through Every Family.



Every Family has been successfully trialled with approximately 1500 families in southern Brisbane, Queensland, coordinated through the divisions of general practice and funded by *beyondblue*. Evaluation of the Queensland trial shows that the *Every Family* program contributed to the following key outcomes:

- A reduction (by 32%) in significant mental health problems in children (behavioural and emotional problems)
- Reduction in the risk of children developing later problems such as depression, by decreasing family risk factors that contribute to childhood depression and other mental health problems.
- Reduced emotional distress in parents (by 22%), including depression and stress; and
- Reduction in the use of coercive parenting methods (by 32%).

The *Every Family* program could incorporate lifestyle Triple P skills training for families with children and youth who are obese or at risk of obesity. AGPN recommends the

national rollout of the every family positive parenting program³⁸ to ensure all Australian parents have access to high quality, evidence-based parenting advice and support. This investment could help to more adequately equip parents with the skills to ensure their children develop healthy behaviours and make healthy lifestyle choices.

Culturally appropriate prevention and health promotion

The Taskforce provides a number of recommendations as to how to prevent obesity, smoking and alcohol misuse among Indigenous Australians. However little consideration is given to targeted interventions for Culturally and Linguistically Diverse (CALD) populations and Aboriginal and Torres Strait Islander populations who are also disproportionately at risk of or affected by obesity, smoking and alcohol misuse³⁹.

AGPN supports in principle the recommendations made by the Taskforce to prevent obesity, smoking and tobacco among Indigenous groups. The actions proposed could be further supported by the introduction of targeted lifestyle modification programs for Indigenous Australians to be delivered through the primary health care system. Such programs would also be valuable to target high risk CALD populations. AGPN therefore recommends the Taskforce gives consideration to the development, trial and evaluation of culturally appropriate lifestyle modification programs focused on nutrition, physical activity, smoking and alcohol use, targeting Indigenous Australians and CALD populations which are subsidised by the Government.

The high rates of obesity and diabetes among Indigenous Australians and CALD populations also need to be better accommodated in the COAG Type 2 Diabetes Prevention Program. This could be achieved in two ways. First, the age eligibility criteria for Indigenous Australians and high-risk CALD groups to be referred to lifestyle modification programs under the initiative needs to be lowered. Second, consideration should be given to the development, trial, and evaluation of culturally appropriate

³⁸ *Every Family* is an evidence-based parenting program based on the highly regarded Triple P program – Positive Parenting Program. *Every Family* could provide all Australian families with access to learning and developing positive parenting skills. The program would achieve this by equipping primary care providers, who are the first port of call for distressed families and children with behavioural difficulties, with skills and resources to respond more effectively.

³⁹ 2004-05 National Aboriginal and Torres Strait Islander Health Survey (NATSIHS), 2008, Australian Bureau of Statistics: Canberra.

versions of the lifestyle modification program for Indigenous Australians and CALD populations for use in the initiative.

SUMMARY POINTS

To facilitate early intervention, parenting programs and childcare environments need to be assigned higher priority in the Taskforce's recommendations.

Recommendation 13: AGPN recommends the national implementation of Every Family through the divisions of general practice.

Recommendation 14: AGPN recommends that more priority is given to culturally appropriate prevention programs including funding for the development, trial and evaluation of culturally appropriate lifestyle modification programs for obesity, smoking and alcohol for both Aboriginal and CALD communities.

Response to recommended primary care interventions for preventing obesity, smoking and alcohol misuse

The need to build the capacity of the primary care sector to engage in prevention is acknowledged for all three risk factors. For obesity, the recommendations made by the taskforce focus primarily on:

- more education and training for primary health care workers including allied health professionals;
- development and promotion of evidence-based clinical guidelines and multidisciplinary training packages; and
- more funding for patient education programs.

AGPN supports these recommendations and suggests they apply across all three health areas, not just for obesity. AGPN has outlined how more education and training can be provided in preventative care for allied health professionals earlier in this submission. Evidence-based clinical guidelines for preventative health already exist and are published by the RACGP ("the

red book" and "the green book") and are available in electronic forms⁴⁰. AGPN supports the continued use of these guidelines but notes that mechanisms are needed to increase and evaluate use of and compliance with the guidelines.

AGPN has provided a strong case for the utility of coordinated preventive service packages, direct purchasing of allied health professionals by divisions, and networks of service coordinators earlier in this submission. These reforms would help to enable greater access to high quality multidisciplinary preventative health care for obesity, smoking, and alcohol misuse.

For alcohol misuse, the key recommendation made by the Taskforce is to support the routine use of brief interventions in primary health care. Given evidence that brief interventions have efficacy in smoking cessation⁴¹ and weight loss⁴² as well as in reducing alcohol consumption, this recommendation should also be extended to tobacco and obesity. The challenge is to increase uptake of brief interventions by GPs and other primary care workers. AGPN supports more training for GPs and other primary care workers such as nurses in brief interventions. AGPN supports the suggestion made by the Taskforce to develop health system performance indicators around the proportion of current smokers, overweight or obese people and people at risk of short or long term harm of alcohol misuse who receive brief interventions in primary care settings.

The Taskforce makes little mention of the role of primary health care in managing tobacco use, other than to recommend that health care agreements between the Australian Government and States/Territories be amended to require all health and human services to routinely identify those who smoke, advise these patients to quit, provide them with Nicotine Replacement Therapy (NRT), and refer them to Quitline where appropriate. It also advocates for subsidisation of NRT for disadvantaged groups which AGPN strongly supports. Smoking can be effectively prevented through the primary care sector through the delivery of brief interventions, subsidised smoking cessation programs, and patient education programs.

⁴⁰ Electronic versions of the RACGP's red book and green book are available at <http://www.hl7.org.au/docs/eRed%20Book%20One%20Pager.doc>

⁴¹ Roche, A. & Freeman, T. 2004, Brief interventions: good in theory but weak in practice, *Drug and Alcohol Review*, 23, 11-18.

⁴² Campbell, K., Engel, H., Timperio, A., Cooper, C. and Crawford, D. 2000, Obesity Management: Australian General Practitioners' Attitudes and Practices, *Obesity Research*, 8, 6, 459-466.

SUMMARY POINTS

AGPN supports the taskforce's recommendation for more education and training for primary care and allied health professionals in prevention and advocates for this for all three risk factors.

AGPN supports the continued use of the RACGP's evidence-based guidelines for preventative care but advocates for the investigation of mechanisms to increase and evaluate use of and compliance with these guidelines.

AGPN supports the taskforce's recommendation for more funding for patient education programs for all three risk factors not just obesity.

AGPN believes incentives for coordinated preventive service packages and mechanisms to enhance access to and communication between multidisciplinary teams of health professionals should be given priority over the multidisciplinary training packages recommended by the taskforce.

AGPN supports the routine use of brief interventions for all three risk factors and the development of performance indicators around the proportion of at-risk patients receiving these interventions.

AGPN strongly supports the subsidisation of Nicotine Replacement Therapy for disadvantaged groups.

Attachment A

GP Exercise Referral Scheme *Sutherland Division of General Practice*

The *General Practice Exercise Referral Scheme* aims to improve physical activity levels of people who are assessed as not doing sufficient physical activity to gain health benefits.

The main objectives of this program are to:

- Increase GP prescription of physical activity for sedentary patients
- Increase numbers of previously inactive patients undertaking regular physical activity
- Maintain collaboration with Sutherland Shire Council and other stakeholders in the implementation of a specifically targeted physical activity intervention.

The initiative is designed for patients with risk factors who are not currently active as well as those with existing conditions such as cardiovascular disease and diabetes.

The Scheme provides a pathway for GPs to refer their patients to an accredited Exercise Physiologist (EP) for individual assessment, exercise prescription, monitoring and follow-up over a five-week period. The pathway provides a time-efficient way for GPs to refer patients for lifestyle modification.

Since the *GP Exercise Referral Scheme* was implemented in the Sutherland Shire in 2004, more than 1,600 patients have completed the Scheme. Of these patients 58% were female with the largest proportion aged between 50-74 years (70.3%).

In the short term, the *GP Exercise Referral Scheme* suggests a modest effect on absolute changes to physiological measures (BMI, VO₂ Max⁴³, Heart Rate, and Blood Pressure) but the proportion of patients making changes or showing improvements in levels of physical activity was considerable.

Prior to the intervention almost half of participants were undertaking less than 15 minutes of physical activity on most days of the week. Three months after completing the program a statistically significant 94% of participants were meeting the recommended levels of physical activity of 30 minutes or more physical activity on most days of the week. The improvements in lifestyle were sustained at the six month follow-up, particularly exercise levels and diet. This model shows sustained physical activity outcomes rather than just short-term increases achieved through brief GP advice.

To strengthen the evaluation, the Division has now started a formal study in partnership with the University of NSW. The study aims to measure both the short and long-term impact of the *GP Exercise Referral Scheme* on physiological outcomes and lifestyle change. Results from the study are expected in 2009.

⁴³ the volume of oxygen consumed while exercising at maximum capacity

Eat It Work It Move It: *A partnership between Macarthur Division of General Practice Ltd and Elizabeth Macarthur High School*

NSW data⁴⁴ indicates that 25% of boys and 23.3% of girls are overweight or obese. Prevention of overweight and obesity involves targeting behaviours which focus on physical activity and healthy eating. The *Eat it Work it Move it* (EWM) program utilises the *Health Promoting Schools* framework, incorporating the whole school in a multi-factorial intervention.

A pilot program was implemented with the support of Elizabeth Macarthur High School in August 2006. Baseline survey data was collected from 144 Year 7 students and 22 teachers. Ninety-seven Year 8 students and 22 teachers were re-surveyed 12 months after baseline. A comparison of survey results before and after the intervention showed the following key improvements in healthy eating:

- a 6.5% reduction in the proportion of students consuming packaged snack foods on most, if not all days of the week;
- a 7% reduction in the proportion of students drinking 2 or more cans of soft-drink on the day before the survey; and
- a 9% increase in the proportion of teachers drinking no soft-drink on the day before the survey.
- Survey results also showed increased levels of physical activity following the intervention including:
 - A 9% increase in the proportion of students using active transport to get to and from school;
 - A 15% increase in the proportion of students involved in organised sports after school on 3 or more days of the week.
 - An 8% reduction in the proportion of students watching 4 or more hours of television; and
 - A 21% reduction in the proportion of and teachers watching 2 or more hours.
- Self-reported concerns about body weight reduced, and body image improved among students.

Curriculum links, education, a healthier canteen, policy development, healthy fundraising and opportunities for additional physical activity all became a part of the school's cultural change. Targeting the whole school through EWM with support from dietitians, exercise physiologists, general practitioners, teachers and the community (particularly the program sponsors: Western Suburbs League Club Campbelltown, Wests Tigers Rugby League Club and the National Rugby League), is effective in changing the school environment and behaviours associated with healthy eating and physical activity. The result of this partnership between the school and the division has enabled this program to be rolled out to another 12 high schools delivering services to around 1000 kids in the area.

⁴⁴ Booth et al, NSW SPANS 2004, 2006

Leaping Lizards, Pilbara Division of Practice

Leaping Lizards is an early intervention program that aims to prevent overweight, obesity and associated health problems by promoting fun physical activity and encouraging healthy food choices in primary school children and the broader community.

Leaping Lizards consists of two parallel programs:

- One program in a school in Onslow targeting malnutrition and the promotion of healthy lifestyles - funded by Building Healthy Communities; and
- A second program which covers the Shire of Roebourne including schools in Dampier, Karratha, Roebourne, Wickham, Tom Price and Paraburdoo - funded by Rio Tinto and the Pilbara Development Commission (PDC)

For both program streams, activities implemented include:

- Visiting schools to promote healthy nutrition and physical activity
- Conducting interactive in-class nutrition lessons and healthy cooking sessions
- Developing a program to target healthy school lunches
- Disseminating information on nutrition to parents through newsletters and by holding community events

In Onslow, an organic school garden has been established which provides the schools and general community with a wide range of fresh produce. This produce is also used in lunches and cooking lessons delivered by the school canteen.

A key outcome related to the Onslow program is that community health professionals have reported fewer presentations of skin and general health-related conditions. Building on the success of the vegetable garden in Onslow, the shire of Roebourne program has also incorporated the garden concept into its program by offering three \$5000 grants using funding from Rio Tinto and Pilbara Development Commission.