Discussion Paper
Australia: The Healthiest Country by 2020
National Preventative Health Taskforce

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General Comments

This is a worthwhile discussion paper and highlights several areas of need in preventative health/care in Australia. There are several points I wish to make under the relevant chapter headings.

Comments by chapters

Executive summary

This paper is entitled 'Australia: the healthiest country by 2020' but at no time does this discussion paper define exactly what this means and against which international benchmarks success will be judged. (The performance indicators in Chapter 6 are noted).

viii. RE: 'Where the market is failing, governments need to protect our health…'. The phrase 'Where the market is failing' should be deleted. In this country, all levels of governments have a responsibility to protect health whether or not the market is failing. While the economic definition of 'market failure' is understood, some public health problems arise as a result of a successful market- marketing of alcohol, fast food, etc. Clearly, government has a role in regulating market successes particularly when such marketing is directed at vulnerable members of the community such as children.

Tobacco control- Given the significantly higher prevalence of smoking among Aboriginal Australians, a specific recommendation in relation to this group is needed, particularly if we are to make in-roads in 'closing the gap'. This should be accompanied by funding at a later date to support the process.

1. Introduction

P7.

Selected settings for action. Intuitively, schools are an excellent setting to promote health. However, in order to achieve anything beyond a short term benefit, there needs to be a sustained commitment to health programs within the curriculum from K-Y12. This will require the support of the education departments around the country and adequate training of staff to deliver such programs. 'Walking school buses' and 'healthy breakfast' programs are difficult to sustain in the absence of ongoing support.

A strong support system. Point 1: Adequately funded and relevant research. This should extend to the adequate funding of community-based research with grassroots links to public health units and non-government organisations. Funding bodies (and their assessors) need to recognise that randomised controlled trials are not always possible to assess public health interventions. As yet, the number of programs developed in academic settings successfully translated into programs delivered by public health units around the country seems to be limited. Calls for grants should require academics to collaborate with government agencies and/or community organisations engaged in public health. Clearly, investigators from non-academic settings will not have the peer-reviewed publication lists of their academic colleagues and in this case weighting needs to be given for other types of relevant public health activities and publications e.g. government reports, public health advocacy, committee membership, etc.

2. The case for prevention: Overweight and obesity

P14.

Priorities for Action. To manage obesity, our aim is to prevent its occurrence and where already present assist weight loss *and its maintenance*. Many studies have shown reductions in weight loss on the basis of various programs. However, these losses have not been maintained in the longer term. Ideally, one of the priority areas should address this critical issue given that the prevalence of overweight and obese adult Australians is already so high (in other words, the horse has bolted). Ongoing support for existing programs with demonstrated short term success is needed to monitor whether weight loss is sustained in the long term. If this support is to be provided under a research initiative then there needs to be a mechanism for longer term funding of the project to document long term success (e.g. a 5 year program).

P16.

'Enhance food labelling…' This needs to be accompanied by a community education program to teach the public about how to interpret food labelling. Much information is available for certain groups e.g. diabetics but simplifying the key messages and advertising them more broadly is needed.

P17.

RE: Consistent town planning. This is a critical area. Many new developments are being built with complicated networks of cul de sacs and no pedestrian pathways reducing the opportunity to use walking as a means of transport. Good community planning should provide opportunities for purposeful walks to shops, playgrounds and other basic amenities.

RE: Expand supply of relevant allied health workforce (e.g. nutritionists). Obesity and socioeconomic status are inversely correlated. While the supply of a relevant workforce is crucial, there is a potential equity issue if the cost of accessing these services means that the most disenfranchised remain so. Will these types of services come under Medicare and how will the effectiveness of

the services be monitored? What measures will be undertaken to ensure that Aboriginal people have access to these services?

P18.

RE: Supporting ongoing research especially among Aboriginal communities. NHMRC rarely funds community-based, public health research not involving a randomised controlled trial (RCT). When conducting research in Aboriginal communities there needs to be greater understanding from funding agencies of the time taken to develop the partnerships and gain the confidence of the community. Furthermore, ethical, logistic and cultural concerns may limit the use of RCTs in this setting. Investing in community-based research which can demonstrate real-world effectiveness is indicated.

3. The case for prevention: tobacco

A target of 9% prevalence by 2020 seems reasonable. However, this could be achieved while ignoring the 2% of the population that continues to smoke at a much higher rate, namely, Aboriginal Australians. There needs to be a stated commitment and recognition that additional resources will be needed that are quarantined for this group specifically.

P26.

Opportunities for in-patient smoking cessation counselling (above and beyond 'brief intervention') should be made available in the hospital setting. This should include free nicotine replacement therapy (NRT) while an in-patient and appropriate referral to services on discharge. Key target groups would include women accessing midwifery services during pregnancy, pre-operative patients and patients with smoking-related conditions.

RE: 'Increasing availability of Quitline service…' Is there any evidence that Australian Aboriginal women (or non-English speakers) like to use phone services for advice? The data in the preamble that states that 52% of Aboriginal women continue to smoke during pregnancy suggests that Quitlines have not been too successful in this endeavour to date. This action also presupposes that all homes have a phone line (or internet access) which may not be the case, particularly in remote areas.

P27.

Supporting the development of culturally appropriate materials that could form the basis of smoking cessation programs for delivery within the Aboriginal community is warranted. Funding should encourage collaboration between government services (e.g. public health units) and local indigenous health organisations. Funding should be given not just for the development of programs but also to support program delivery and evaluation.

RE: Correctional facilities. Initiatives should include subsidised NRT post release particularly in juvenile detention centres where the period of incarceration may be brief.

P28.

Re: QUESTIONS

Do you support our government taking the following actions, which in combination could halve smoking rates:

progressively increasing the tax on tobacco products to the levels in places such as Ireland, Scandinavia and the UK, and reaching $20 for a packet of 30? YES

investing $40–50m a year in public education – less than 1% of revenue from tobacco tax? YES, AT LEAST

If you do not support these actions and investment, or have other suggestions, what would you propose we do as a nation to halt the toll of early deaths and disease caused by smoking?

Should we prohibit all remaining forms of promotion of tobacco products and mandate plain packaging? YES

Should we move by 2020 to a system where cigarettes are sold only through a limited number of specially licensed outlets? YES

4. The case for prevention: alcohol
P40.

RE: 'Commission research on effective strategies… in Indigenous … communities'. An additional action is needed, namely, 'Support programs in Aboriginal communities to reduce the use of alcohol or its ill effects.' Successful models are already operating in certain communities and these can inform initiatives in other places. While some of the health effects may take longer to realise, reductions in police arrests/infringements, reductions in domestic violence and other intentional violence can be observed in a timely manner and provide clear benefit to the community. Such programs need to be comprehensive and focus not only on reducing the availability of alcohol but also providing adequate services to assist people with alcohol-related problems to cut down.

RE: 'Improve maternal and child health' There is no action listed under this priority. In relation to the benefits, there is no acknowledgement of the difficulties that are faced in accessing high-risk women who tend to present for antenatal care very late (30 weeks+). The actions should describe how this issue will be addressed.

5. Supporting prevention
P45.

While the establishment of a National Prevention Agency seems reasonable, the funding for this should be *IN ADDITION TO* the current level of

expenditure on public health. Such an agency should not be seen as an alternative to existing services.

P46.

Please define what is meant by the term ‘biomedical data’
Correct the name of the NHMRC

6. Choosing performance indicators

P48.

Proposed performance indicators:

Tier 1- Death and hospital separation data by Indigenous status. In order to do this a necessary precursor would be to require all jurisdictions to document Indigenous status in their health records and this is not the case currently.

Tier 2- Information by Indigenous status would presumably only be accurate to a state/territory level.

Tier 3- Other factors could be monitored using police and crash statistics in relation to alcohol misuse.

There is a focus on expenditure; however, program delivery (number of programs delivered) and reach (how many people attended) may be valuable additional measures that are relatively easy to compile.

P50.

Performance monitoring. Public health should receive core funding. There is also some role for additional incentive funding in certain areas e.g. in primary health care. Penalties are inappropriate as this could disadvantage jurisdictions that need the most resources due to economic, cultural or geographic reasons. Naturally, targets should be set but failure to meet targets should prompt a review of processes to examine the reasons for failure rather than exacerbating the problem by financially penalising a jurisdiction.

Funding is a critical issue if gains are to be achieved. The recent COAG announcement in relation to public health funding was an important first step but I would be keen to see the detail of how the funding is to be used.