

# National Preventative Health Taskforce

## Australia: the healthiest country by 2020 A discussion paper

### Input from the Population Health Priority Taskforce

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#### Regarding the formation of National Prevention Agency

The proposal to form a National Prevention Agency is worthy of serious consideration. A national agency could provide national leadership and drive national advocacy for prevention issues. Central resources to enable and support program delivery could be developed in a manner that would avoid unnecessary duplication across jurisdictions. If the agency was formed outside the government departmental structure, it would also have the freedom and capacity to address issues that departmental agencies cannot and respond to pressing issues faster by being less restrained by bureaucratic processes.

However there are a number of questions and concerns that must be addressed if the potential of the agency is to be fully realised.

- How will the agency be tied in to the existing organisations and agencies that oversee prevention?
- How will duplication of the activities of these existing organisations and agencies be avoided or rationalised?
- How will the agency ensure that much-needed funds are not spent on governance and process at the cost of prevention outcomes?
- How will the agency be structured and managed?
- Will there be adequate engagement of key stakeholders regarding the structure and governance of the new agency?
- Is this just “governments talking to governments”? How can we be sure that the non-government and community sector will be effectively engaged?
- What will this new agency provide that does not already exist within current structures?

Clearly much discussion and consultation is needed regarding this proposal. To that end, the following recommendations are provided to suggest a possible focus and structure for the proposed agency.

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**Recommendation 1:  
The appropriate roles and responsibilities of a National Prevention Agency**

A National Prevention Agency should:

- 1.1 "Lead and coordinate" rather than "do". A National Prevention Agency should show leadership but not attempt to directly deliver programs.
- 1.2 Influence policy across all relevant sectors (not just health).
- 1.3 Propose and drive innovation, particularly in areas where the need for prevention is greatest, such as Indigenous health.
- 1.4 Act as a central organisation to develop and disseminate evidence around prevention interventions (akin to the role of the AIHW in developing and disseminating health statistics).
- 1.5 Identify gaps in prevention research and direct funds to address these (either through direct funding provision and/or influencing the way in which existing research funding is distributed, particularly through the NHMRC).
- 1.6 Act as a "broker" to bring together key players and potential key players (eg bringing the police together with health to work more effectively to address alcohol).
- 1.7 Build capacity to support intervention delivery.

These recommendations should be clearly and carefully defined in formal Terms of Reference for the proposed agency.

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**Recommendation 2:  
The effective function of a National Prevention Agency**

To be effective, a National Prevention Agency will need to:

- 2.1 Have a strong understanding of how government works, and how best to influence government policy and practice.
  - 2.2 Have effective links to all relevant government bodies and committees (such as COAG, AHMAC and NHMRC), so that it can function strongly, efficiently and in a timely manner.
  - 2.3 Engage society in a manner beyond what is normally achieved by government departmental agencies. Substantial cultural changes to our society are required if issues such as obesity and alcohol are to be truly addressed, and to achieve this, the engagement and participation of the community will be required.
  - 2.4 Be well-funded, but most of the funding should be channelled into activities to be delivered by others ("Lead and coordinate" not "Do") with suitable accountability.
  - 2.5 Be funded for a significant period of years: an initial decade commitment would not be too long. Prevention is not achieved quickly, and short-term funding will only lead to an inappropriate focus on process indicators rather than long-term outcomes.
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### **Recommendation 3: The structure and governance of a National Prevention Agency**

A National Prevention Agency should:

- 3.1 Sit outside the government departmental system.
- 3.2 Not report to Health – this would colour the perceptions of potential partners and limit the scope of potential activities. Prevention activities must not be limited to the health system, or even seen to be primarily driven by it. Ideally, the agency would report to the Prime Minister.
- 3.3 Be structured in a way that allows effective central leadership and efficient dissemination. A “hub and spoke” model may be appropriate. It is worth looking at the structures of existing non-departmental agencies such as the AIHW.
- 3.4 Be structured according to a professional and business-like model, considering appropriate governance models which include an independent Board and a strong Executive.
- 3.5 Have relevant policy experience that “speaks to government”.
- 3.6 Have a balanced mix of people from government and non-government sectors.

Is it essential that there be substantial consultation regarding this structure and governance, particularly with health agencies in all jurisdictions, relevant non-health government agencies, relevant professional bodies, non-government organisations and universities. The success of the proposed agency will depend upon its capacity to work effectively with these groups in the future.

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### **Comments on the prevention strategies proposed**

The Population Health Priority Taskforce (PHPT) generally supports the priorities and strategies proposed in the discussion paper and accompanying technical papers. These strategies are commonly held to offer the most effective way forward in addressing the harm caused by tobacco, obesity and alcohol. The PHPT further supports the selection of these three issues themselves as the first set of priorities for action. Their collective burden of illness and broader social consequences make them an appropriate choice.

More broadly however, the proposal could benefit from a stronger focus on “upstream” issues. The discussion paper includes a useful conceptual framework for determinants of health as they relate to obesity, tobacco and alcohol (Figure 1.2, page 5). This framework identifies a number of broad features of society, environmental factors and socioeconomic factors that are important upstream determinants of health behaviours. It is an important inclusion, but it is not well reflected in the remainder of the discussion paper, being most notably absent in the specific strategies that are recommended. It is important that these upstream issues are an integral focus of programs and interventions, not just a framework that may or may not be appropriately considered by those who ultimately deliver them. This approach will have the additional benefit of flow-on positive effects in other areas such as the second proposed set of priorities: mental health, injury, immunisation, sexual and reproductive health, and illicit substance use.

The focus on equity and Indigenous health is welcome, but could also be strengthened. In all three areas – obesity, alcohol and tobacco – a dominating factor is poverty. This is a significant problem that of course extends beyond health considerations. We must effectively engage the welfare sector, economics and many different aspects of government planning, and consider a host of other factors if we are to achieve any real or lasting change.

As well as being the focus of specific programs and interventions, it is essential that these issues are considered across all aspects of prevention planning – for example, in research funding priorities and processes. Competitive funding criteria tend to favour programs in controlled, urban environments where it is quicker, cheaper and easier to demonstrate outcomes. Indigenous or rural areas are constantly avoided because the logistics of implementation are more challenging. This has a compounding negative effect. Our best evidence does not necessarily apply to Indigenous or rural populations. Dissemination of programs supported by trials often does not extend to these populations, or fails when it does because of differing context, needs and logistics. The capacity of the Indigenous and rural health workforces to do trials themselves and/or implement their results is very limited, because they have difficulty in attracting competitive funding. These circumstances sustain and even increase the health inequities experienced in these communities. It should be a goal of a National Prevention Agency to not just encourage more research in these areas but require it.

Likewise, a National Prevention Agency should also be well placed to increase the focus on intervention research. It is commonly lamented that the health and medical research “spend” is dominated by descriptive epidemiology or basic science. While this research is certainly important, there is a dearth of intervention research to inform the evidence-based practice that we demand of our prevention services. Does intervention research (whether at the population or clinical level) suffer in terms of funding because it is more demanding and difficult to do than other types of study? Can assessment criteria be modified to take this into account or are there other ways of increasing the capacity for or quality of intervention research? A National Prevention Agency could take the lead in addressing these issues.

Another potential advantage of a National Prevention Agency is its capacity to show strong leadership in terms of encouraging and supporting innovation. Despite general acknowledgement that new approaches are required, particularly in areas such as Indigenous health where successes have been limited, it is often beyond the capacity of organisations delivering front-line services and programs to venture beyond the norm. Small funding pots with short-term timeframes, process-dominated performance indicators and prohibitive infrastructure are simply not conducive to innovation. But with funding, infrastructure, political capital and effective links across the prevention industry, a National Prevention Agency could drive the innovation that is so clearly needed in this field.

The proposed focus on workforce capacity and development is also welcome. It will be important to ensure that a broad scope is considered when defining this workforce. For example, within the health sector, there is as-yet untapped potential in health professionals such as pharmacists or dentists, who have an opportunity to deliver brief interventions whenever they are in contact with clients. Dentists, in particular, have a three-minute window of opportunity every time they administer a local anaesthetic. Outside the health sector, welfare agencies may present a valuable opportunity to access and support those who are most disadvantaged in our communities. These are not new ideas, but they are rarely well realised.

In the discussion of appropriate settings for preventive action, some balance may be required in our expectations of settings such as schools. School-based programs require a special, sensitive and education-oriented approach. But schools have become the main target of many interventions, particularly around childhood obesity, and risk being overwhelmed. There needs to be a balanced assessment of the role that schools can play, and consideration of additional settings.

Additional specific comments on the strategies proposed for tobacco, obesity and alcohol are detailed in the recommendations below.

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**Recommendation 4:  
Broad strategies for prevention**

Priority strategies should include:

- 4.1 A much stronger focus on "upstream" issues: broad features of society, environmental factors and socioeconomic factors that strongly determine health behaviours.
- 4.2 A much stronger focus on equity, notably but not exclusively Indigenous health.
- 4.3 Clear and specific strategies to increase research in Indigenous and rural health.
- 4.4 Clear and specific strategies to increase the proportion of public health funding allocated to intervention research (both research and service delivery).
- 4.5 A focus on innovation.
- 4.6 A focus on building the capacity of the primary prevention workforce.
- 4.7 A broad definition of that workforce.

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**Recommendation 5:  
Specific strategies for prevention – Tobacco**

Priority strategies should include:

- 5.1 Specific, tailored targets and performance indicators (beyond the broad targets already described in recognition of the increasing gap between the higher and lower socio-economic groups).
- 5.2 Targets and strategies relating to occasional smoking, in addition to the focus on daily smoking that is already described.
- 5.3 Appropriate focus on people with co-existent problems such as mental health and other substance abuse who have relatively high rates of tobacco use.
- 5.4 Greater emphasis on regulation and tobacco tax increases.

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**Recommendation 6:  
Specific strategies for prevention – Obesity**

Priority strategies should include:

- 6.1 Specific, tailored targets and performance indicators (beyond the broad targets already described in recognition of the increasing gap between the higher and lower socio-economic groups).
  - 6.2 Clarity regarding the scope, purpose and function of a national food strategy.
  - 6.3 Strong connectivity between the many different agencies already invested in nutrition and food (eg Food Standards Australia New Zealand). The current situation is already complex. The introduction of a National Prevention Agency should aim to simplify this.
  - 6.4 An appropriate focus on physical activity (notably sedentary behaviour) as well as nutrition.
  - 6.5 A reasonable approach to interventions in school settings and balanced consideration of additional settings.
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**Recommendation 7:  
Specific strategies for prevention – Alcohol**

Priority strategies should include:

- 7.1 Specific, tailored targets and performance indicators (beyond the broad targets already described in recognition of the increasing gap between the higher and lower socio-economic groups).
  - 7.2 A major emphasis on the first imperative: reshaping consumer demand towards safer drinking. The cultural change required to achieve this will require a major investment and innovative approaches, and is likely to take many years; without it, the health and social burden of alcohol will probably remain high.
  - 7.3 Consideration of our experiences from tobacco control. There are many parallels, notably around cultural issues of demand and legislative approaches to control supply.
  - 7.4 A very cautious approach to partnerships with the alcohol industry. There may be merit in collaboration in some situations, but the inevitable conflict of interest must be managed.
  - 7.5 A better understanding of how alcohol advertising and social marketing work. The subtleties of alcohol advertising must be understood, and very careful consideration given to what types of social marketing approaches are likely to have an influence on behaviour, particularly given the strong cultural context of alcohol consumption in Australia.
  - 7.6 An effort to "get our own house in order". Mixed messages continue to be given out by health professionals – such as whether or not it is appropriate for pregnant women to consume small quantities of alcohol.
  - 7.7 A greater focus on social and criminal harms – impacts on justice systems, welfare systems and so on – as well as the medical impact.
  - 7.8 A greater focus beyond the health sector, such as ways in which police can operate in a preventive/interventionist mode to deal with local alcohol
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- problems.
  - 7.9 Involvement of key partners including local government, non-government organisations, primary health care and specialised drug and alcohol services.
  - 7.10 Consideration of the prevention of alcohol addiction.
  - 7.11 Consideration of mental health implications, including the complication of existing mental health conditions and the risk of alcohol-related suicide.
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### **The important role of primary health care**

The discussion paper notes that the National Health and Hospitals Reform Commission and the External Reference Group for the Primary Health Care Strategy are working on ways of ensuring that prevention is more effectively carried out across the health system as a whole, and in the primary health care system in particular. These parallel activities are welcomed, but it is important that the role of primary health care is also the focus of further consideration in the current consideration of a preventative health strategy for Australia.

There is nothing new in the suggestion that brief preventive interventions can and should be delivered by primary health care professionals. There are countless Medicare items, policies, guidelines and even support tools already in existence. What continues to falter is our approach to implementation planning and support. Primary health care professionals must be engaged. Prevention needs to move from an "add-on" to a core part of routine business. What lessons can be learned from overseas?

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#### **Recommendation 8: Prevention in primary health care settings**

Strategies to increase prevention interventions in primary health care settings should consider:

- 8.1 How to engage and build the capacity of primary health care professionals more effectively.
  - 8.2 Efforts for a cultural change, where there is genuine acceptance that prevention is part of core business rather than an "add-on".
  - 8.3 A move away from "care by Medicare number". Funding brief prevention interventions in this manner perpetuates the perception that prevention is an additional task to be fitted in and reimbursed only when the opportunity arises and suits.
  - 8.4 Development of novel ways of providing cost-effective support to the delivery of evidence-based prevention programs in primary care. This could include strategies such as expanding role of practice nurses to provide preventive advice and advocating for payment systems to support this activity
  - 8.5 A shift in research priorities from the potential efficacy of brief interventions, which is already well established, to strategies for effective implementation support.
  - 8.6 Lessons from overseas models such as "Pay for Performance" in the UK.
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## **PHPT Membership**

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