Issue 17 • November 2015

Consumers Health Forum of Australia

Health Voices

JOURNAL OF THE CONSUMERS HEALTH FORUM OF AUSTRALIA

Preventive health... a cure for the future

representing consumers on national health issues

In this issue

Preventive health: a cure for the future

Leanne Wells

If there is one message that clearly comes through from this edition, it is that we need to turn up the heat on the case for federal investment in prevention.

Our authors remind us of the healthcare costs and economic burden generated by preventable diseases as well as the costs of inaction in prevention.

They also remind us that preventive health is so much about action by the health community in collaboration with other community services. I recall the 2012 report on the social determinants of health showing how Australia could benefit from the World Health Organisation's 2008 report, *Closing the Gap Within a Generation* if it were implemented:

- 500,000 Australians could avoid suffering a chronic illness
- 170,000 extra Australians could enter the workforce, generating $8 billion in extra earnings
- Annual savings of $4 billion in welfare support payments could be made
- 60,000 fewer people would need to be admitted to hospital annually, resulting in a saving of $2.3 billion in hospital expenditure

This clearly says to us that investing in prevention is not at the 'soft' end of health policy.

Our authors reinforce the repeated call for a concerted and coordinated preventive health effort aimed particularly at diet and exercise. We all recognise the prime causes of the plague of chronic disease and obesity that afflict so many Australians yet we have failed as a nation to make the hard fixes.

The ubiquitous promotion and consumption of cheap unhealthy food, barriers to regular exercise, sedentary lifestyles dominated by TV and device screens and car-dominated transport in anti-pedestrian urban areas all contribute to Australia's disturbingly high rate of unhealthy body weight.

The current Federal Government initially treated with scepticism an active preventive health policy, particularly concerning food, defunding the Australian National Preventive Health Agency and other preventive initiatives. The food star labelling system had a rocky start but is now being vindicated as food companies reformulate products to secure more stars. All at minimal cost to the taxpayer and with significantly positive results for Australians' diet and health awareness.

We are encouraged by Health Minister, **Sussan Ley's** declaration that preventive health, particularly in relation to chronic disease, is an increasing challenge for the health system and is something "that I am determined to address".

She says that alarmingly, one-in-five have at least two of the most common eight chronic diseases including diabetes, cardio-vascular disease and mental health.

We all have a role to play in developing a sustainable health system that is efficient and delivers better quality outcomes for those with chronic conditions. Better health often starts at home with the individual, Ms Ley says.

Several other authors however suggest it is difficult for individuals to change behaviour when surrounded by unhealthy influences, behavioural and structural barriers.

Catherine King states there's no one simple preventive health program. The health policy a truly modern government would pursue would recognise that the only way to significantly tackle the increasing burden of chronic disease is through a co-ordinated program at all levels of government to invest in prevention and promote healthier lifestyles at work, at school, at home and in the community.

Richard Di Natale writes that we already know what works. A combined Deakin and Queensland universities report found the 20 best prevention interventions would cost $4.6 billion to fund but return $11 billion in health savings. "There's a lot of low hanging fruit when it comes to serious public health issues like obesity and alcohol-related harm."

Australia's single greatest preventive health challenge is to "close the gap" in the disparity of health outcomes between indigenous and non-indigenous Australians. This year's "Closing the Gap" score card shows a disturbing lack of progress on most measures. Accompanying that bleak score card is the executive summary of a report on Planning, Implementation and Effectiveness in Indigenous Health Reform. The report is by **Melbourne University and Lowitja Institute** researchers. It states that the idea that engaging Aboriginal and Torres Strait Islander people and organisations in the planning and governance of interventions to improve their health will lead to greater benefits is one of the most fundamental concepts in Aboriginal and Torres Strait Islander health and a core tenet of the Aboriginal community-controlled health sector.

It is instructive that health ministers of the past are remembered mainly for what they did in the field of preventive health. **Rob Moodie** has prepared a report card on Australia's recent performance on preventive health and says "I have come to the conclusion that Australia is 'a bright child but just won't apply itself to the new tasks at hand'. He says preventive health proponents can face virulent criticism in campaigning for changes that ultimately yield enormous health benefits. "It takes courage to stick your head above the parapets!"

One of those campaigners is **Jane Martin** who blames our high obesity rates, in part, on a lack of a concerted national strategy to address the drivers of the problem in a meaningful way. "Much of the current approach from the federal government relies on encouraging people to change their behaviour in an environment which promotes poor choices."

Britt Johnson and **Paul Zimmet** write "As we have learnt from public health challenges such as tobacco control, we need to "lift our gaze" from focusing solely on individual responsibility. To make any impact on chronic disease prevention we need to implement system-wide, population approaches that address the broader policy, structural and environmental drivers of unhealthy behaviours."

Louise Sylvan cites the importance of independence in the prevention task and says good governments should value and act on fearless advice. "And given the powerful commercial influences at play in areas of central importance to preventive health– like food and beverages for instance– independence is vital."

Michael Moore says that despite growing obesity rates, governments are reluctant to regulate even the marketing of junk food to children. The excuse is often cited as the "Nanny State". A healthier, more productive society facilitated by good government stewardship is better for everyone. This can only be achieved if governments take action to ensure choices made by the individual are not ones that have been blanketed by the sales pitch of conglomerates.

Alcohol's contribution to the ill-health burden is significant, says **Michael Thorn**. Globally, alcohol is the fifth leading cause of death and disability and third among the leading risk factors in developed countries after tobacco and blood pressure. Fixing Australia's incoherent system of alcohol taxation would make a major contribution to reducing chronic disease through reducing levels of harmful consumption of alcohol.

Mary Barry suggests economic arguments are coming into play, citing the recent national reform summit's conclusion that preventive care can achieve strong economic and social returns, and the Productivity Commission's research report on Efficiency in Health earlier this year which suggested that Australia is "missing good opportunities to invest in preventive health".

GP **Dr John Litt** provides an insight into how a doctor's agenda may not always be the same as the patient's agenda, and this can have important preventive health implications. The patient may just be seeking treatment for an acute condition while the doctor identifies the need for other preventive interventions.

And as **Debbie Rigby** suggests, as consumers become more engaged in their own healthcare and preventive health, with so much information available via the internet, social media and television, the need for a trusted advisor has never been greater. Pharmacists should be seen as an 'information broker', to help consumers sift through the myriad of conflicting and sometimes non-evidence based information.

Marilyn Wise and **Don Nutbeam** say that as impressive as the successes of the 20th and early 21st centuries have been in improving health care, lack of progress in reducing inequities in health reflects a collective failure in our society. Given it is now possible to predict social, economic and environmental conditions that enable people to stay healthy, it is vital that this evidence be used by policy makers and practitioners to guide their decisions – including decisions about land use and urban design.

Poor integration with primary care, lack of access to patient data, costs of delivery and funding arrangements are just some of the issues currently discouraging private health insurers from making a greater contribution to preventive solutions, says **Dr Andrew Cottrill**. Chronic disease management plans have a vital role as a preventative measure to help patients manage their conditions and avoid unnecessary hospitalisations.

Rachel Davey and **Deborah Lupton** look at the potential of modern technology to aid and complicate preventive health. "Big data" may greatly enhance opportunities to predict long-term health conditions and identify non-traditional intervention points, as well as to design better diagnostics tools and prevent chronic diseases such as heart disease, diabetes. But the tendency to use such technologies in ways that do not acknowledge the social determinants of health has emerged in some initiatives. Such campaigns tend not to highlight the social and cultural factors that shape whether or not people take up these behaviours, such as their income or educational level.

Demonstrating just how much preventive health campaigns can benefit from people power and the political effectiveness of good organisation, **Anita Tang** says public health organisations need to build an effective constituency around prevention. People power complements the advocacy of public health organisations and helps ensure that politicians consider community interest when deciding on policy.

And if there's one concluding message from this edition of *Health Voices* it comes from **Sally Crossing** in her consumer vignette: could the various disease charities and state and Commonwealth agencies please consider coming together to send out one great big meaningful and helpful message to all Australians? Eat and live healthily, and enjoy doing it.

Leanne Wells is the CEO of the Consumers Health Forum of Australia. She was previously CEO of the ACT Medicare Local and served as CEO of the Australian General Practice Network and as Transitional CEO of the Australian Medicare Local Alliance. Ms Wells has been a senior public servant in health, family and aged care portfolios. She is a member of the Australian Institute of Company Directors and the Australian Institute of Management.

Preventive health an increasing challenge I am determined to address

Sussan Ley

Earlier this year, I addressed a CHF forum in Canberra. Capped off with a lively Q and A, as is so often the case, it was a full and frank discussion. I certainly took a lot away from that chat, so my thanks to all who took the time to attend, especially those who asked questions or voiced an opinion.

Preventive health, particularly in relation to chronic disease, is an increasing challenge for the health system and Australians generally and is something that I am determined to address.

I am committed to engaging with health professionals and patients to reform the way we treat people with chronic and complex conditions.

A recent report from the Australian Institute of Health and Welfare paints a stark picture of the challenges we face. The figures show that half of all Australians have a chronic disease.

Alarmingly, one-in-five have at least two of the most common eight chronic diseases including diabetes, cardio-vascular disease and mental health conditions. These morbidities and comorbidities are associated with poorer health outcomes, more frequent use of health services, and higher healthcare costs.

I'm so proud of our health system in Australia and our mainstream health services do a good job for most of us, most of the time. But if you need multiple services from different professionals to maintain your health, the current system does not make it easy for you.

Variations in clinical practice across providers, services and geographic locations frequently lead to variable patient outcomes, inefficient use of health funding and at times, poor quality care.

Put simply, our current health system is not set up to effectively manage long-term conditions, which can lead to more expensive care requirements and potentially poorer health outcomes for the patient. In 2013–14, there were 285,000 hospital admissions for chronic conditions that may have been preventable if appropriate primary health care had been provided. Something needs to change.

Primary health care is the first point of contact with the health system for most of us, and as such, has a pivotal role to play in addressing our current health challenges.

In April this year, I announced a comprehensive review of primary care to ensure Australians continue to receive the high-quality and appropriate care in the right place at the right time.

The Primary Health Care Advisory Group has been tasked with investigating options to provide better care for people with complex and chronic conditions, innovative care and funding models, better recognition and treatment of mental health conditions, and greater connection between primary health care and hospital care.

I'm pleased Consumer Health Forum CEO Leanne Wells is part of this Advisory Group and her consumer-focused experience is proving to be invaluable in helping shape this new model.

Evidence tells us that health systems with strong integrated primary health care at their core are both effective in improving patient outcomes and experiences, and efficient at delivering appropriate services where they are needed most.

Frontline staff, working as I say at the coal face, who experience primary health care first-hand are often best placed to tell me what works and where we could improve.

The Advisory Group has included extensive public and stakeholder consultations across a number of metropolitan and regional centres and has received feedback and submissions from over 2,000 organisations and individuals.

The Advisory Group is currently in the process of reviewing this feedback and is expected to report to Government on short, medium and long-term options for reform by the end of the year.

But our commitment to preventive health goes far beyond this reform project.

The Australian Government already funds a number of programmes and organisations to assist and support people with mental illness including programmes which focus on prevention and early intervention. These activities promote awareness of mental illness, aim to reduce the stigma of mental illness and promote help-seeking by people with, or at risk of, mental ill-health.

The Turnbull Government is committed to a national mental health approach that moves from a service-centred approach to one where services are organised around the needs of the individual. A consumer-centred approach to service delivery and a strong focus on early intervention is vital.

The National Mental Health Commission's Review of Mental Health Programmes and Services identified complexity, fragmentation and duplication within our existing approach to mental health funding. The subsequent consultation with the sector has been very valuable in helping to shape the Government's response to the Review, as has the advice from the Expert Reference Group on how to transform the Review's findings from paper to policy.

I will outline the government's response to the review, and provide a strong statement on mental health reform before the end of the year.

Consumer feedback will also be at the core of other preventive health strategies on chronic conditions currently in development, such as the National Strategic Framework for Chronic Conditions, the National Diabetes Strategy and the National Asthma Strategy, which aim to develop appropriate approaches to address the impact of these conditions in the community.

While reforming our health system to provide better quality care for those with chronic conditions is a significant priority for the Australian Government, better health often starts at home with the individual.

A good diet and regular physical activity is one of the best things we can all do to reduce the risk of developing chronic disease and obesity.

Earlier this year I had the pleasure of launching Play.Sport.Australia – the Government's plan for getting more Australians active.

This launch coincided with the roll-out of the $100 million Sporting Schools programme which provides fun, active opportunities for Australia's primary school children to sample more than 30 of Australia's favourite sports.

Already more than 4,000 schools have registered for Sporting Schools, which offers sports programmes that are free to primary school children, before, during and after school. It's not too late, so if you know of a school that's not involved, please encourage them to sign up and be a part of it.

The next stages of Play.Sport.Australia. will focus more on getting the adult population playing more sport. We want to show Australians how easy it is to get involved in sport, either for the first time, or those who just need an extra nudge to get back into it after other distractions got in the way.

Sport keeps the doctor away and can reduce the risk of coronary heart disease, stroke, diabetes, hypertension, colon cancer and breast cancer.

We all have a role to play in developing a sustainable health system that is efficient and delivers better quality outcomes for those with chronic conditions and I look forward to continuing to work with you on this.

I'm sure we'll speak soon.

Sussan Ley is Minister for Health, Aged Care and Sport. Before entering Parliament in 2001 as MP for Farrer, Ms Ley held a variety of occupations, including as an air traffic controller, commercial pilot and as an Australian Taxation Office employee. She held a range of parliamentary secretary positions up to 2007. In Opposition she held several shadow portfolios including Housing, Status of Women and Assistant Treasurer. On returning to Government in 2013 Ms Ley was appointed Assistant Minister for Education with responsibility for child care until her appointment as Health Minister in December 2014.

Preventive health is the smart investment

Catherine King

Recent research finding 37,000 Australians can avoid cancer every year pose a very simple question for anyone serious about containing heath costs in Australia – is it cheaper to treat 37,000 cases of cancer or prevent them?

The answer is obvious, and one that could be repeated for any number of chronic health conditions that can be dramatically improved via simple changes in behaviour.

Labor gets this. Labor gets that prevention must be at the heart of what we do in every part of the health care system.

That's why our recently adopted ALP National Platform declared "Labor believes in national leadership to improve the health of all Australians. This is a vital social and economic priority. We cannot allow the challenges of an ageing society to be compounded by increasing numbers of working-age adults being denied participation in the labour force because of preventable chronic and complex conditions."

These are not just words. In government, Labor's National Preventative Health Taskforce laid down the challenge on obesity, alcohol, tobacco and physical activity.

It laid the framework for a new national partnership agreement in prevention that included increased funding to the states and territories to undertake prevention initiatives particularly to tackle obesity, as well as a national body to invest in prevention research and evaluation and to disseminate its findings.

Australia's health system is under pressure from an ageing population, and the increasing prevalence of preventable chronic diseases such as obesity, cardiovascular disease and diabetes.

The agreement recognised the only way to reduce this burden and create lasting improvements in health and wellbeing was through the development of a co-ordinated and sustainable approach to preventative health, developed in partnership with all levels of government, to complement our healthcare system.

It sought to tackle lifestyle related chronic disease by laying the foundations for healthy behaviours in the daily lives of Australians in their communities, schools and workplaces.

There were grants to local government targeted at adults not in the paid workforce to help them engage in physical activity and healthy eating.

States were funded to specifically target the underlying causes of chronic disease, including smoking, poor nutrition, alcohol misuse and physical inactivity.

A fantastic example of this was Victoria's Healthy Together which works with childcare centres, schools, business, local government, sporting clubs and even food outlets to "target change in the places where Victorians live, work, learn and play."

There's no one simple preventive health program. Helping people to stop smoking, eat better and cut down on alcohol will deliver real benefits. For others simply doing any exercise, such as taking up walking will deliver real and immediate benefits.

This is the health policy a truly modern government would pursue – recognising that the only way to significantly tackle the increasing burden of chronic disease is through a co-ordinated program at all levels of government to invest in prevention and promote healthier lifestyles at work, at school, at home and in the community.

But in its very first budget the Abbott/Turnbull Government vacated the field, scrapping the $367 million National Partnership Agreement on Preventive Health.

This may seem small compared with the $57 billion ripped from public hospitals, but few decisions in health in recent years have been more short-sighted.

This of course comes on top of the continuing attack on general practice which plays an important role in preventative health care, catching and managing illness and disease before far worse outcomes lead to greater costs for both patients and the health system.

If the new Liberal leader is serious about his claims to have put together "a 21st century government, a ministry focused on the challenges of the future", then he has to show he is serious about preventative health.

Because as it stands, his government's health policy is still firmly stuck in the past when it comes to prevention, abandoned under the Liberals, in yet another example of the Commonwealth abrogating any leadership role in health policy.

Instead of ripping billions of dollars from the health budget, a government serious about the long term health budget would be investing in programs designed to tackle the increasing burden of chronic disease and promote healthier lifestyles.

The ultimate goal of any healthcare system is a healthy population and that means investing in prevention.

That's what Labor did in government, and if the Liberals are serious about wanting to make Medicare sustainable, this is the area crying out for investment, not targeting it for short term budget savings for a long term cost.

Catherine King, the Shadow Health Minister, was elected Federal MP for Ballarat in 2001. She has been a Parliamentary Secretary in portfolios including Health and Ageing and later Minister for Regional Australia, Local Government and Territories. She holds degrees in social work and in public policy and is currently completing a law degree.

Prevention the key to a sustainable health system

Richard Di Natale

Sir Michael Marmot's work on health inequalities has been the holy grail of health policy for the last 30 years, helping us understand that it's the conditions of daily living that determine a person's chances of maintaining good health.

This is a view that I developed from a theoretical concept to the real world during my time working in general practice and public health. Working in an Aboriginal health service in the Northern Territory, I came to appreciate that writing a script to help treat an Aboriginal man with chronic diabetes, or travelling for hours just to dispense eye ointment, was not addressing the reasons that made people sick.

I came to understand that if we are to make real progress in health, we need to address those factors that lie outside the health system. Our efforts as health professionals are futile unless we also improve people's access to housing, education, clean air and water, secure employment, and participation in community life. The reality is that inequalities in health arise because of inequalities in society. Reducing health inequalities is a marker of our progress towards a fairer society. At its core, health is a social justice issue.

Studies show that by 2025 there will be around 37 cities with at least 10 million residents. A United Nations report says that by 2050, 75 per cent of the world's population will live in interconnected cities. Urban planning plays one of the most important roles in enabling us to have healthy, happy, active lives. We cannot talk about preventive health in isolation. Open space, active travel, public transport, local services and amenities all tie together to map the physical landscape in which preventive health programs can target lifestyle factors such as obesity, alcohol and tobacco consumption.

Some progress was being made under the previous government with the development of the National Urban Policy and a number of supporting programs, which focused on livable, sustainable cities. The Greens have shown, through Scott Ludlam's 'Transforming Perth' report, for example, our commitment to healthy places.

But it's not just about the physical environment. The society we are born into is just as important.

Rising inequality and the tendency for markets and government policies to exacerbate this plays a critical role. We need progressive taxation reform, and a welfare system that actually provides support, education can still be the silver bullet, and, of course, we need to address climate change. Fundamentally changing the life sustaining systems that support us will impact on all our health.

We spend about 9% of our GDP on health, that's below the OECD average, and almost half what the US spends. While this has risen from 8% a decade ago, the proportion of commonwealth spending has actually been stable for several decades.

It is true that over the next decade we will see more demand on health care, which may take the proportion we spend on health closer to the OECD average, somewhere around 10% of GDP.

Some of that increase is a consequence of an ageing population but most of the projected increase in spending is fueled by new health technologies, new diagnostic imaging techniques, new treatments and new medicines.

So in a decade we will be spending close to the OECD average on health, about half what's spent in the US and we will be doing that to give people access to health technologies that help people live longer, healthier and more productive lives. I don't consider that to be a crisis. I believe it's something to celebrate.

The question of sustainability is a values question, not an empirical one. It's sustainable if we choose to continue funding it.

I believe that the purpose of human progress, of continued economic growth, is to be able to spend money on the things we value. Given that people almost universally identify good health as the thing they value most in life then what could be more important than spending that dividend of sustained economic grown on providing people with access to health care.

But we are at a crossroads. We are faced with some important choices. We can choose to give people access to universal health care, so that they can live longer and healthier lives, or we can choose to ration health care through price barriers such as co-payments in an effort to rein in health spending.

So let's start with a much bigger investment in health promotion and illness prevention. Rather than dismantling the only health agency with a dedicated focus on prevention and taking money away from prevention programs delivered by state governments, which the current government has done, let's increase our investment.

We know what works. A combined Deakin and Queensland universities report found the 20 best prevention interventions would cost $4.6 billion to fund but return $11 billion in health savings. There's a lot of low hanging fruit when it comes to serious public health issues like obesity and alcohol related harm.

According to the ABS 2011–13 Australian Health Survey, nearly two-thirds of Australians aged 18 or over are now overweight or obese, compared with about 56% in 1995. Coronary heart disease was an associated cause of death for 51% of deaths due

to diabetes, 28% of deaths due to chronic and unspecified kidney failure and 19% of deaths due to chronic obstructive pulmonary disease (COPD). Hypertensive disease was an associated cause of death for 35% of deaths due to diabetes, 28% of deaths due to cerebrovascular diseases (which include stroke), and 21% of deaths due to coronary heart disease. And kidney failure was an associated cause of death for 26% of deaths due to diabetes.

The costs to Australia's healthcare system due to preventable disease continue to rise, and without coordinated action by government they will continue to do so.

Senator Di Natale is the Leader of the Australian Greens, a GP and a former public health specialist.

Not closing the gap

Progress against the targets

Key findings:

Target	Target year	Progress	Results
Close the gap in life expectancy within a generation	*2031*	*Not on track*	*Limited progress.*
Halve the gap in mortality rates for Indigenous children under five within a decade	*2018*	*On track*	*Long term progress.*
Ensure access for all Indigenous four-year-olds in remote communities to early childhood education	*2013*	*Not met*	*In 2013, 85 per cent of Indigenous four-year-olds were enrolled compared to the target of 95 per cent.*
Close the gap between Indigenous and non-Indigenous school attendance within five years	*2018*		*New target, baseline 2014.*
Halve the gap in reading, writing and numeracy achievements for Indigenous students	*2018*	*Not on track*	*There has been no overall improvement in Indigenous reading and numeracy since 2008.*
Halve the gap for Indigenous Australians aged 20-24 in Year 12 attainment or equivalent attainment rates	*2020*	*On track*	*The gap is narrowing in Year 12 or equivalent attainment.*
Halve the gap in employment outcomes between Indigenous and non-Indigenous Australians	*2018*	*Not on track*	*There was a decline in employment outcomes since the 2008 baseline.*

Department of Prime and Cabinet

Planning, Implementation and Effectiveness in Indigenous Health Reform

Margaret Kelaher, Hana Sabanovi, Camille La Brooy, Mark Lock, Shahadat Uddin and Lawrence Brown

The idea that engaging Aboriginal and Torres Strait Islander people and organisations in the planning and governance of interventions to improve their health will lead to greater benefits is one of the most fundamental concepts in Aboriginal and Torres Strait Islander health and a core tenet of the Aboriginal community-controlled health sector.

This is supported by growing evidence that providing increased voice to vulnerable or disenfranchised populations is important to improving health equity at a number of levels .

This embryonic literature suggests that how governing bodies involve the community in their processes can have a significant impact on their ability to improve health equity. The Planning, Implementation and Effectiveness in Indigenous Health Reform (PIE) project, funded by the Lowitja Institute and the Australian Research Council, carried out by the University of Melbourne, arose from concerns by Aboriginal and Torres Strait Islander people that despite the importance of participation and investment in collaborative governance, little research focused on capturing current practice and identifying best practice is being done.

The advent of the National Indigenous Reform Agreement (NIRA) and the Indigenous Health National Partnership Agreements (IHNPAs) has led to further development/application of collaborative approaches to governance through committees and forums at national, State and regional levels.

The activities associated with these committees and forums are referred to throughout this report as collaborative governance. This report focuses on building the evidence base around best practice based on case studies of collaborative governance in relation to the NIRA.

The report addresses:

1. the processes through which Aboriginal and Torres Strait Islander community members and organisations are involved in governance
2. the impact of their engagement on decisions and relationships with others
3. the aspects of engagement that are associated with: a. greater satisfaction with the process b. greater confidence in implementation c. improvements in access to health services.

Key findings and recommendations

Overall, the findings of the PIE project suggest that the incorporation of Aboriginal and Torres Strait Islander communities and organisations in regional planning plays an important role in improving health equity.

Achieving this requires strong links between Aboriginal and Torres Strait Islander organisations and mainstream organisations and among Aboriginal and Torres Strait Islander organisations.

The study makes an important contribution to understanding the processes through which the incorporation of disenfranchised groups into governance might contribute to health equity. It highlights the potential role of social networks in the processes.

The study also provides empirical evidence of the links between engagement in governance and the effectiveness of implementation, the achievement of health benefit, and satisfaction with the processes.

In doing so, it confirms one of the longest standing and central tenets in Aboriginal and Torres Strait Islander health—the importance of engaging Aboriginal and Torres Strait Islander people in the planning, governance and delivery of programs to improve their health.

The incorporation of Aboriginal and Torres Strait Islander communities and organisations in governance plays an important role in improving satisfaction with planning processes and the outcomes of health programs, including access to health assessments and prevention of avoidable hospitalisations.

This suggests three main recommendations.

Recommendation 1: The incorporation of Aboriginal and Torres Strait Islander communities and organisations in the governance of health programs should be further supported and developed.

Recommendation 2: Governance processes should include mechanisms to ensure that perspectives of Aboriginal and Torres Strait Islander participants are valued and inform decision making.

Recommendation 3: Future interventions should consider where relationships between organisations need further strengthening and should develop strategies/activities to achieve this. The implementation of the IHNPAs was associated with a significant shift in power from central government to regional forums, which comprised local health service providers and community groups. Regional forums, for the most part, provided an effective platform to involve Aboriginal and Torres Strait Islander people and organisations in governance. The results showed that the inter-organisational networks formed in the context of these forums influenced improvements in access to health services as a result of the IHNPAs. Two further recommendations are associated with this.

Recommendation 4: Support for the role of regional forums with the continuation of regional approaches to planning and funding for secretariats should be continued.

Recommendation 5: The equity of processes to select projects for funding in order to ensure an optimal regional service mix should be improved.

Measures to achieve this should include:

a. providing support in proposal development
b. ensuring that data on performance is considered in decision making
c. identifying ways in which potentially competing organisations can work together.

A number of complexities were involved in coordinating IHNPA activities across national, state and regional levels. Working with tripartite forums was seen as an effective mechanism to offer state-wide and national solutions to advance Aboriginal and Torres Strait Islander health. A strong feeling that regional forums were under-utilised as a mechanism for co-ordination and communication was also apparent and led to a further recommendation.

Recommendation 6: State-level (tripartite) and regional planning forums should be used as a means to improve communication and co-ordination between different programs.

This is the executive summary of a final report, published in May 2015 written by Margaret Kelaher (The University of Melbourne), Hana Sabanovi, Camille La Brooy, Mark Lock, Shahadat Uddin and Lawrence Brown and published by the Lowitja Institute. Reproduced with permission from the Lowitja Institute.

Health prevention in Australia: a Report Card

Rob Moodie

Life wasn't meant to be easy as a Health Minister in Australia, whether at the state or federal level. The demands are constant and ever more expensive, and it is easy for the heart-rending exception to create a new very costly budget line. However, because as governments and as individuals we have a finite amount to spend we are rationing our resources whether we like it or not. And I'm sure we could get a lot better health results if we allocated our resources more efficiently.

Because of these relentless shearing forces on health budgets we should be constantly looking for the best investments and for the best outcomes. That might be as Professor Philip Clarke points out getting a much better pricing for our huge national pharmaceutical buy, or by ending or at least reducing futile end-of-life care and by greatly reducing ineffective and highly expensive interventions such as arthroscopies, PSA testing for prostate cancer, knee MRIs, as was highlighted in the recent episode of *Four Corners* entitled Wasted.

There is a moral imperative to look for the most cost effective interventions to improve health, as Oxford philosopher Toby Ord points out. There is also a moral imperative to prevent suffering and early death where we can. As English epidemiologist Geoffrey Rose propounded "It is better to be healthy than be ill or dead. That is the beginning and the end of the only real argument for preventative medicine. It is sufficient."[1]

The most cost effective interventions are often found in the world of prevention. A 2003 study commissioned by the then Federal Department of Health and ageing demonstrated how much death and suffering have been prevented through vaccination, tobacco control, road trauma prevention. These are all 'blue-chip' investments yet public health spending in Australia (which includes prevention activities) peaked at 2.22 per cent of total recurrent health funding in 2007/08, and has declined significantly since then. In 2012/13, spending on public health was only 1.54 per cent of total recurrent health spending.[2] This places Australia out of step with other like countries. OECD data reports Australia's spending on prevention and public health as a share of total recurrent health spending was 2.0 per cent, much less than New Zealand (6.4 per cent), Finland (6.1 per cent) and Canada (5.9 per cent)".[3]

From 2008–2011, I chaired the development of the National Preventive Health Strategy (NPHS). We set out an ambitious agenda to 2020 to reduce the burden of death and suffering from obesity, tobacco and the harmful use of alcohol. In reviewing the Report card of Australia's health against these national targets set by the National Preventive Health Strategy and the Council of Australian Governments (COAG) in 2009, I have come to the conclusion that Australia is "a bright child but just won't apply itself to the new tasks at hand".

Tobacco control gets an **A+** given the impact of ongoing increases in the cost of cigarettes (though excise taxes), a global first with the plain packaging of cigarettes and major new investments in indigenous tobacco control programs. This is the good student.

However, for the reducing the harm from alcohol, as documented by a review of progress by the Foundation for Alcohol Research and Education, **Australia gets a D-**.

For the work in Obesity, **Australia gets an E – a clear fail**. Child and adult overweight and obesity have increased significantly in the last twenty years and this trend has not been halted or reversed. Both childhood and adult obesity are major health concerns, and are associated with many preventable chronic diseases. Australia is not on track to meet either COAG or NPHT targets for overweight and obesity

By its nature prevention is the least heroic form of medicine. As Geoffrey Rose further points out "a preventive measure that brings large benefits to the community may offer little to each participating person" in what is known as the prevention paradox.[4]

Prevention deals with populations and not just individuals. It has to deal with strongly entrenched behaviours, beliefs and attitudes. And to be effective (as we have seen with road trauma and tobacco control) it generally requires legislative and regulatory approaches to reduce the danger of unhealthy products or behaviours, the regulation of pricing (making unhealthy products more costly); widespread, repeated well-researched and highly effective social media campaigns; a mobilised health profession and community and lastly multi-party political support and funding.

The need to challenge and confront deeply held beliefs or commercial vested interests means that local heroes such as Police Surgeon John Birrell one of the architects in Australia's road trauma successes, Nigel Gray the head of the Victorian Anti Cancer Council and doyen of anti-tobacco strategists and latterly Jane Martin, the director of the Obesity Policy Coalition, have been the target of virulent criticism. They are by no means on their own but all have been savagely attacked in the mainstream media. It takes courage to stick your head above the parapets!

Which is why we need great leadership (for example Neil Blewett on HIV/AIDS, Michael Wooldridge on vaccinations and Nicola Roxon on plain packaging) which becomes supported by bi-partisan or multi partisan approaches. One of the most damaging features of

highly adversarial politics is every time governments change their policies and the programs they support change with it. Australia has performed best in programs that have bipartisan support – and again road trauma, immunization and tobacco control come to mind.

We are falling behind, we could be producing much better health outcomes. We could prevent a lot more early death and suffering. Wake up Australia!

Rob Moodie is Professor of Public Health at the College of Medicine, University of Malawi, and Professor of Public Health at the University of Melbourne's School of Population and Global Health. He was the inaugural Director of Country Programs for UNAIDS in Geneva from 1995–98, and was CEO of VicHealth from 1998–2007. He chaired the National Preventative Health Taskforce from 2008–2011. He chairs the GAVI Alliance's Evaluation Advisory Committee, and advises the WHO in the areas of NCDs and Health Promotion.

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Curbing obesity rates: what does the evidence show?

Jane Martin

Australia's obesity rates are climbing and the frightening statistic is that rates in women are rising at a faster rate than anywhere else in the world.[1] Diet and overweight and obesity are the leading risk factors for poor health in Australia, leading to a range of preventable diseases such as diabetes, heart disease and cancer.[2]

Our high obesity rates are due, in part, to a lack of a concerted national strategy to address the drivers of the problem in a meaningful way. Much of the current approach from the federal government relies on encouraging people to change their behaviour in an environment which promotes poor choices. In the meantime, Australian governments are failing to implement measures and policies to counter this concerning trend and have a significant impact.

Admittedly, we're not alone in this.

Countries with high obesity rates such as the US and the UK are also struggling to slow and reverse rates of obesity and reduce the associated health burden.

However, what we do know is that there is no magic bullet and no single strategy is going to work in isolation. We also know that education is important, but by itself is weak in supporting people lead active lives and to eat healthy diets.

Sugar in the Diet

The evidence is clear: added sugar, particularly in sugary drinks, is a major contributor to overweight and obesity, as well as poor dental health. A comprehensive review of the evidence relating to sugar added to food, and also including fruit juice, resulted in recommendations that ideally men should consume no more than 9 teaspoons of added sugar and women 6 per day for the best health benefits.[3]

A number of countries have introduced a tax on sugar sweetened beverages as well as junk food. A report by the World Health Organization (WHO) Europe reviewed the evidence on the impacts of food taxes and concluded that a tax on sugary drinks is the best option. Recent polls show Australians support a tax if it is then used to make healthy food cheaper.[4]

Currently the amount of sugar added to food is not required to be outlined on the label. This should be a requirement given the impact added sugar can have on health and interest by the public.

Junk Food Marketing

Junk food marketing has become so integrated into our daily lives that we often fail to notice it. For our children it is wallpaper, it wraps around them through the sports that they play and follow. It targets them through digital technology such as Facebook, interactive games and YouTube – and it is often disguised as entertainment. It embeds itself in schools through chocolate fundraisers, vending machines and funding. It follows them home on public transport, in trams, on bus shelters and it saturates transport hubs with conveniently placed products and too-good-to-ignore promotions. That's not to mention traditional promotional tools, such as television. Of an evening, unhealthy food is promoted during the ad breaks of the highest-rating kids TV shows, such as X-Factor, The Voice and The Block, and movies, while the talent on these shows act as human billboards for these junk food products and brands.

The evidence is clear that unhealthy food advertising influences children's food preferences, purchase requests and consumption, and as such contributes to overweight and obesity as well as poor health outcomes. The World Health Organization recommends countries

reduce the exposure of children to this marketing as the cornerstone of a strategy to deal with the problem.[5]

In Australia, this advertising is largely self-regulated. However, research from here and overseas has shown that this approach is ineffective to reduce the amount of marketing that children see.[6] As a result public health experts agree that the evidence justifies government intervention, and that urgent action is required to comprehensively restrict unhealthy food advertising to children.

Clear Food Labelling

Health Star Ratings

Easy-to-understand food labelling that helps people make healthier choices is another element to empower people to make more informed purchases. In Australia the Health Star Rating system was developed using stars to illustrate the healthiness of the food – the more stars the better. This has been implemented by a number of companies, with star ratings now appearing on around 1,000 products. However, to work well it needs to be placed on all packaged foods so shoppers can compare products easily.

Kilojoule labelling

In chain fast food outlets, providing information on the energy in kilojoules next to products is another way to provide information to shoppers. This scheme has been implemented in NSW, ACT and South Australia. The NSW initiative was accompanied by an education campaign which resulted in a significant reduction in the amount of kilojoules ordered by customers.[7] Given the number of meals purchased in these outlets, this approach can have a significant impact across a population.

Public Education Campaigns

Public education campaigns, when coupled with other policy measures, can lead to increased knowledge and intention to change behaviour. Public education campaigns are also useful for raising public awareness about a public health issue and gaining support for environmental changes. They can also help to simplify the messages around complex nutritional issues.

The public education campaign LiveLighter is now underway in four Australian jurisdictions – WA, ACT, Victoria and NT. In 2014, 62 per cent of 25–49 year olds in Victoria were able to recall having seen the campaign in its first six weeks. Early results in Victoria have shown Victorians found the campaign believable (91%) and a strong message (87%). Those who were overweight were more likely to find the campaign self-relevant compared to those who were not overweight (68% cf. 42%). 92% of Victorians support government investment in campaigns like LiveLighter.[8]

Meanwhile evaluation of a 2013 Western Australian obesity campaign also showed an initial reduction in sugary drink intake among overweight adults.[9]

Evidence from previous public education campaigns (tobacco, UV exposure and road safety) indicates a need for ongoing campaigns coupled with a supportive environment to demonstrate behaviour change. Investing in effective public education campaigns along with robust evaluation is imperative for shifting behaviour towards healthier choices.

Comprehensive action urgently needed

There is an urgent need for strong leadership and comprehensive action by Australian governments to halt increasing overweight and obesity rates and avoid unsustainable burdens on Australia's health system, economy and society.

A comprehensive package of policies is needed to create an environment that supports healthy eating and physical activity. Isolated or individual-focused initiatives will have little impact on what is a complex, multi-factorial, societal problem. Action is needed at all levels of government across all portfolios, and by a range of public and private stakeholders. This action should be led by the Australian Government to ensure an integrated and effective approach.

Obesity must become a priority issue for governments and the focus must be on prevention.

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Preventing chronic disease: Why targeted approaches are not enough

Britt Johnson and Paul Zimmet

Lifestyle related diseases, such as obesity, type 2 diabetes and cardiovascular disease are serious illnesses that undermine health, shorten life expectancy, and contribute to a large proportion of Australian deaths, disability, and economic costs.

The problem is significant and rapidly worsening. With Australia's ageing population and the high prevalence of lifestyle-related diseases and their co-morbidities, the future public health burden is expected to escalate, leading to catastrophic impacts on health, the economy and society. Strategic investment in prevention is needed to help curb this epidemic.

Chronic diseases are largely brought on by environmental and behavioural factors, including three common modifiable risk factors: unhealthy diet, physical inactivity, and tobacco use. These risk factors are expressed through intermediate risk factors of: raised blood pressure, raised blood glucose levels, abnormal blood lipids, overweight and obesity. The maternal environment also plays a role creating epigenetic changes in the foetus that can determine heightened disease risk in adult life, for example for type 2 diabetes (T2DM). This can have an intergenerational effect creating a vicious cycle whereby "diabetes begets diabetes".

In addition to shared risk factors, there are also complex causal relationships between chronic diseases, whereby each may be caused by, or be a complication of the other. As a result, these disorders are more likely to occur together— this is known as multi-morbidity. For instance, people with T2DM are more likely to have high blood pressure and elevated cholesterol and triglycerides. Accordingly, people with diabetes are 2 to 5 times more likely than the general population to have a heart attack or stroke. The consequences of combinations and clustering of these chronic diseases are disability and functional decline, poor quality of life, and high health care costs.

Changes in weight and waist circumference have been shown to be key modifiable risk factors in reducing the risk of T2DM and CVD. Small weight change can have significant impacts on their risk, for example it has been demonstrated that the relative risk of T2DM is reduced by 16% for each kilogram of weight lost. Consequently, T2DM and CVD prevention strategies are similar to general population based lifestyle behaviour change interventions for weight loss.

A time and place for targeted approaches

In the case of preventing T2DM, the predominant prevention strategy has been targeted, high-risk approaches. This strategy involves targeting interventions to particular individuals or groups within the population who are at higher risk and who need additional support to increase their capacity to live healthy lifestyles and reduce their risk of developing T2DM.

There is strong evidence that T2DM in high-risk individuals can be prevented by intensive lifestyle behaviour change to achieve sustained changes to diet, physical activity levels, and healthy weight. The high-risk approach has been demonstrated to reduce T2DM risk by up to 60%, however these interventions are highly structured and intensive, and potentially more expensive; with real world application resulting in less favourable outcomes.

Several large scale programs, such as those adopted by Finland, USA, Japan, India and others, have translated lifestyle modification interventions into community-based programs for high risk individuals.

In Australia, the high-risk approach focuses on risk stratification in populations known to be at increased risk of developing T2DM using the validated AUSDRISK tool in a range of settings, and offering preventive interventions. The Victorian *'Life! Helping you prevent diabetes, heart disease and stroke*' program provides an example of a high-risk program that uses the AUSDRISK tool.

While targeted, high-risk approaches have their place in prevention strategies, they are limited in that they only address a small percentage of the population. What they fail to do is address the whole risk prevention spectrum- it is simply not feasible or sustainable to roll out high-risk approaches to the whole population. Furthermore the impact of high-risk approaches can be severely impinged by broader influences such as the environment and policy context.

Seeing the bigger picture: the need for system-wide change

As we have learnt from public health challenges such as tobacco control, we need to "lift our gaze" from focusing solely on individual responsibility. To make any impact on chronic disease prevention we need to implement system-wide, population approaches that address the broader policy, structural and environmental drivers of unhealthy behaviours.

Important reports such as the Foresight *Tackling obesities: future choices* and the McKinsey *Overcoming obesity: An initial economic analysis* reports inform us that the only way to tackle obesity, a major driver for T2DM, is for population approaches that make healthy behaviours easier. To make healthy choices easier, a 'whole of community' prevention approach should include public policy aimed at driving environmental changes throughout the community that ensure

healthy food and healthy physical activity environments, and a reduction in sedentary behaviour for all. These include strategies such as reducing default portion sizes, changing marketing practices, and restructuring urban and education environments to facilitate physical activity.

Population based interventions have been proven to be highly cost-effective, such as tax increases on tobacco, alcohol, and unhealthy foods, and limits on salt in processed foods. Large-scale, demonstration projects, such as Finland's notable 1972 North Karelia Project, have demonstrated that community-based interventions can have a major impact in improving people's lifestyles and reducing chronic disease. By adopting multiple intervention strategies and working with multiple sectors to create system-wide changes, the North Karelia Project radically adjusted the behavioural and dietary habits of a whole community. Long-term follow-up evaluations identified remarkable declines in risk factors and mortality rates, including reductions of more than 60 per cent in CVD and cancer mortality. Healthy Together Victoria and OPAL in South Australia offer promising next-generation Australian examples of a system-wide approach for chronic disease prevention.

In reflecting on lessons learnt from the past, it is critical to recognise that targeted approaches are simply not enough. Tackling the problem of chronic disease prevention is not going to be easy. However if we are to make any progress, all sectors need to throw their weight behind a comprehensive, coordinated systems approach that addresses the underlying systemic drivers of unhealthy behaviours.

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Paul Zimmet AO MD PhD FRACP FRCP is Director Emeritus, Baker IDI Heart and Diabetes Institute, Adjunct Professor, Monash University and Honorary President, International Diabetes Federation. He has an international record in diabetes and obesity, particularly in epidemiology and public health. In 2015, he is listed as one of the 400 biomedical researchers in Clinical Medicine in Thomson Reuters' "World's Most Influential Scientific Minds". His studies in Mauritius and in Pacific Ocean nations have provided new insights into the genetic and environmental contributions to type 2 diabetes. His research has been a major trigger in demonstrating and predicting the global type 2 diabetes epidemic. He was a member of the 2009-10 Government Preventative Health Taskforce and is Co-Chair of the Federal Government's National Diabetes Strategy Advisory Committee to develop a new diabetes strategy for the nation.

Prevention should be the first priority

Michael Moore

Improvements in health have come some way since John Snow and the Reverend Henry Whitehead identified that preventing cholera by identifying the source in the London water supply was much more effective than constantly treating new cases. Over a hundred and fifty years ago – and prevention rather than cure has not yet been fully embraced.

Lip service on prevention is part and parcel of the tools of election campaigns. But it is mostly lip service. How often does the prevention message have to be reiterated? "It is time to stop sending the ambulance to the bottom of the cliff and time to build the fence at the top". Such clichés demonstrate just one part of public health. Even so, spending on public health and prevention still remains at below 2 per cent of health budgets across Australia.

Hospitals remain the political focus. As important as their role is, we ought to have learnt better by now. In 1978 the Declaration of Alma Ata (now the city of Almaty in Kazakhstan) at the *International Conference on Primary Health Care* pointed out that Primary Health Care "addresses the main health problems in the community, providing promotive, preventive, curative and rehabilitative services".

The cuts to the National Partnership Agreement on Preventive Health in the first budget of the Abbott government emasculated public health and prevention as a priority.

Public health incorporates a comprehensive primary health care approach and is fundamentally underlined by principles of equity.

Public health is integrally involved in equity. This is because, as revealed in the report of the *WHO Commission on the Social Determinants of Health* chaired by Sir Michael Marmot, there is a lineal relationship between wealth and health. In a nutshell, the wealthier — the healthier. *The Health Values Statement* that forms part of the Public Health Association of Australia (PHAA) Constitution states: "Health is a human right … the health status of all people is impacted by the social, political, environmental and economic determinants of health".

Last year's Ebola outbreak in Western Africa is illustrative of why equity is so fundamental to health care. The lack of hospitals for treatment was one factor in the spread of the disease. However, it was a minor factor compared to the poverty that meant even simple hand washing was difficult as running water and soap were not readily available in many homes. There were also issues such as governance, nutrition and education that made control of the outbreak difficult. The conditions in which people were living provided the foundations for the outbreak.

In Australia, whilst appropriate precautions were taken, it was highly unlikely that the disease would have spread to more than a few people. Indeed this was the case in the United States. However, our living conditions including education and nutrition are also not equitable – remote indigenous communities, for example, would have been much more susceptible to spread of the disease – as they are to other diseases.

The cost of health care has also been attributed to non-communicable disease. Tobacco remains a major factor. Two thirds of people who smoke tobacco will have their lives considerably shortened. Similarly, obesity and overweight are indicators of ill-health to come. Taxpayers of tomorrow will wear the burden of the profits made by junk food and other unhealthy commodity companies of today.

Despite growing obesity rates, governments are reluctant to regulate even the marketing of junk food to children. The excuse is often cited as the "Nanny State". A healthier, more productive society facilitated by good government stewardship is better for everyone. This can only be achieved if governments take action to ensure choices made by the individual are not ones that have been blanketed by the sales pitch of conglomerates. (See PHAA submission on the Nanny State).

From an international perspective the World Federation of Public Health Associations (WFPHA) has worked closely with the World Health Organization (WHO) to develop *A Charter for the Public's Health* which sets out core services for public health as information, protection, prevention and promotion. Additionally, the *Charter* adds a group of enabler functions including governance, advocacy and capacity building.

The motivation for a new *Charter* of this kind is summarised by a statement from Dr Margaret Chan, the WHO Director-General told her Executive Board in 2012, "The challenges facing public health, and the broader world context in which we struggle, have become too numerous and too complex for a business-as-usual approach".

The *Charter* deals with the fundamentals of public health. In more detail they explain the umbrella nature of public health goes well beyond simple concepts of self-care, medical assistance or tertiary care that is the dominant drag on health finances in Australia.

Considering the statement of Margaret Chan on the complexities of public health within today's world, how effective progress on public health may be made is summarised by the following:

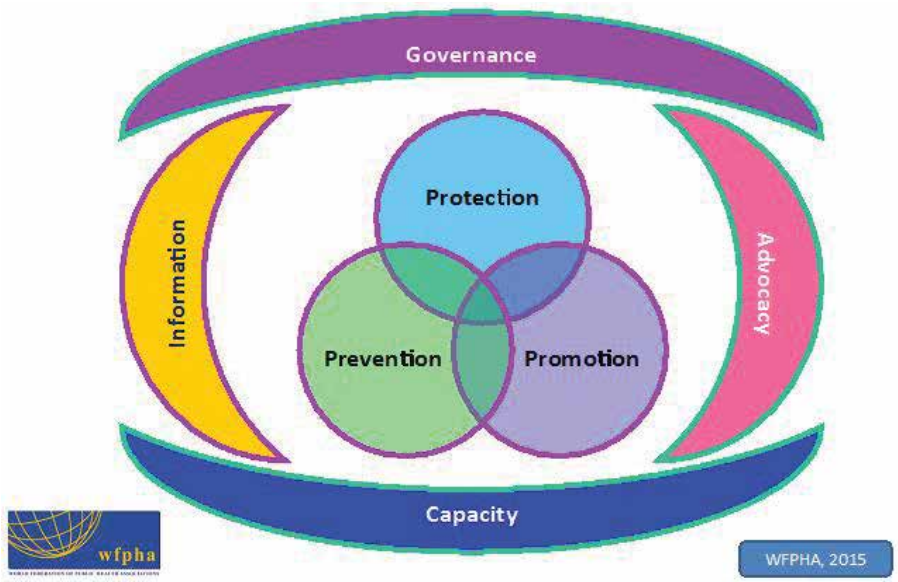

Diagram from A Global Charter for the Public's Health

1. **Governance:** public health legislation; health and cross-sector policy; strategy; financing; organisation; assurance: transparency, accountability and audit.
2. **Information:** surveillance, monitoring and evaluation; monitoring of health determinants; research and evidence; risk and innovation; dissemination and uptake.
3. **Protection:** international health regulation and co-ordination; health impact assessment; communicable disease control; emergency preparedness; occupational health; environmental health; climate change and sustainability.
4. **Prevention:** primary prevention: vaccination; secondary prevention: screening; tertiary prevention: evidence-based, community-based, integrated, person-centred quality health-care and rehabilitation; healthcare management and planning.
5. **Promotion:** inequalities; environmental determinants; social and economic determinants; resilience; behaviour and health literacy; life-course; healthy settings.
6. **Advocacy:** leadership and ethics; health equity; social-mobilization and solidarity; education of the public; people-centred approach; voluntary community sector engagement; communications; sustainable development.
7. **Capacity:** workforce development for public health, health workers and wider workforce; workforce planning: numbers, resources, infrastructure; standards, curriculum, accreditation; capabilities, teaching and training.

Health does not sit in isolation. The *Charter* begins by pointing out that health is "crucial to achieving growth, development, equity and stability throughout the world". It goes on to argue "Health is now understood as a product of complex and dynamic relations generated by numerous determinants at different levels of governance. Governments need to take into account the impact of social, environmental and behavioural health determinants, including economic constraints, living conditions, demographic changes and unhealthy lifestyles".

Michael Moore is the CEO of the Public Health Association of Australia and is the Vice President/President Elect of the World Federation of Public Health Associations. He is the chair of a number of health networks. He is an Adjunct Professor at the University of Canberra, was formerly a teacher and consultant and served four terms as an elected member of the ACT Legislative Assembly from 1989 to 2001. Michael was Australia's first independent Minister when he was appointed as Minister of Health and Community Care.

Prevention our greatest health solution

Mary Barry

Every two years, the Australian Institute of Health and Welfare publishes a hefty tome that chronicles, in great detail, the state of the nation's health.

The current edition – *Australia's Health 2014* – came with an emphatic warning: "*Chronic disease – Australia's biggest health challenge*".

Chronic disease, it cautioned, accounts for 90% of all deaths and 85% of the total disease burden.

"From any perspective, the size of the chronic disease problem in Australia is large." Australian Health Survey data reveals that:

- one third of the nation – seven million people – has at least one chronic condition
- more than one million Australians have heart or vascular disease, or had suffered a stroke
- 999,000 are living with diabetes, and
- 360,000 are living with cancer.

By any measure, chronic disease takes an immense toll on this nation. Premature death and suffering touches nearly every family.

But chronic disease also has a much greater impact on some population groups. Those bearing the brunt of the burden include those who are socio-economically disadvantaged, those living in rural and remote areas and Aboriginal and Torres Strait Islanders.

The economic cost is also great. Cardiovascular disease alone accounts for $7.7bn in direct health care costs each year, or 10.4% of total disease expenditure.

While cardiovascular disease is the most expensive disease group, the top four costly chronic conditions --- the others are oral health, mental health and musculoskeletal conditions --- together conservatively account for more than a third of all allocated health expenditure.

Though the human and economic impact of chronic disease is immense, there is good news, and the good news comes in two parts.

First, much of the disease burden can be prevented or postponed.

And second, investment in prevention can be highly cost-effective, and often cost-saving.

For example, a Department of Health study in 2003 found reduced smoking rates resulting from tobacco control campaigns have – on conservative estimates – yielded net benefits of $2 billion in the three decades between 1970 and 2000, averting more than 17,000 deaths in 1998 alone.

The study also showed that, between the 1970s and 1990s, tobacco control, physical education and other programs to reduce heart disease cost $810 million. But these yielded benefits estimated to be worth an astounding $9.3 billion.

There are, of course, numerous other examples, covering everything from road safety to immunisation. But the message is clear.

We can – and must – do more do prevent disease before it starts.

We can – and must – do more to detect those who are about to get sick and prevent disease progression.

And for those living with chronic conditions, we can – and must – do more to reduce morbidity for those living with disease.

This can be achieved through primary and secondary prevention.

But are we, as a nation, putting enough emphasis on prevention?

In general, investment in public health is seen in terms of the share of the government health budget dedicated to prevention and related activities.

The latest data, released by the AIHW in September (for the financial year 2013-14) reveals that Australians collectively spend just 1.5% of total health outlays on public health. That's down from 2.3% in 2007–08.

Disturbingly, this puts us in the lowest third of OECD nations, well behind the class leader, New Zealand, on 7% and Canada, on 5.9%.

For a nation that prides itself on innovation and leadership in preventive health, this is a very sorry result.

In the Heart Foundation's Budget submission, we have called for a staged increase in investment in prevention, to lift the current rate from the miserly 1.5% to 5% over time. This should be funded by a modest allocation from tobacco and alcohol taxation and potentially from a health levy on sugar sweetened beverages as well.

Greater investment in public health is a highly achievable objective that can be reached without difficulty, even in tough economic times.

There are some encouraging signs that the message is not being lost on those who have their hands on the biggest levers of change – our politicians.

The Health Minister, Sussan Ley, has embarked on an ambitious primary care reform agenda that will, she says, lead to more comprehensive care for those with chronic and complex conditions.

In August, she said that, as the population ages, "we know that the prevention and treatment of chronic disease is an increasing challenge for the health system and Australians generally. Not only do half of all Australians have a chronic disease, but one-in-five have at least two of the most common eight chronic disease including

diabetes, cardiovascular disease and mental health conditions."

Even the former Treasurer, Joe Hockey, acknowledged the need to put more emphasis on active ageing, declaring after releasing the Intergenerational Report in March that:

> *... longevity is one thing and age expectancy is one thing, that's terrific. But the other thing we need to think about is how active we are during the course of our lives.*

There are also encouraging signs that a broader community – including the business community – are waking up to the need for greater investment.

The recent national reform summit, convened under the auspices of News Limited and Fairfax newspapers, drew together business, unions and welfare groups, among others. They concluded that;

> *Rising public debt reduces opportunities for public investment in areas such as education, training, research and development, innovation, infrastructure, childcare and preventative health care, which can achieve strong economic and social returns.*

Even more compelling for those concerned with the state of the nation's coffers, was the Productivity Commission's research report on Efficiency in Health earlier this year.

Though the report receive scant attention, it deserves close reading. It suggests that Australia is "missing good opportunities to invest in preventive health".

A critical point, especially in these times of fiscal restraint, is that prevention measures do not necessarily come with big price tags or without any price tag at all. Many are not only cost-effective, but cost-saving.

Taxes on tobacco, alcohol and sugar-sweetened beverages – measures which have substantial public support – can raise much needed revenue, some of which should be used to support greater investment in prevention.

Regulation can also be used, for example, to improve information disclosure, protect children from advertising of energy-dense, nutrient poor foods and decrease the salt content of processed food.

Investment in early detection of people at high risk of diseases such as heart disease, stroke, kidney disease and diabetes, should also be supported so we can stop disease before it starts.

There are some good things happening. We are continuing to invest in tobacco education campaigns, plain packaging of tobacco products laws are being defended against international trade challenges and there is a continuing emphasis on the high rates of smoking amongst Aboriginal and Torres Strait islanders. The Health Star Rating system is being rolled out and – we hope – the national food reformulation program will soon be re-started.

But there is much more to be done.

This has been emphatically recognised in Australia's Health, which concluded that the challenges presented by an ageing population and the prevalence of overweight and obesity, along with the chronic diseases they initiate, "are fertile areas for the attention of prevention research, policy and action for the foreseeable future".

Australia should also pay heed to the global commitment to address chronic disease – or non-communicable disease as it is termed by the World Health Organisation.

Following a summit at the United Nations in 2011, the world has embraced a series of global chronic disease targets and indicators. These were signed off by all WHO members — including Australia — in 2013.

The WHO members agreed to focus on four major disease groups – including heart disease and cancer – and six major risk factors: tobacco use, physical inactivity, salt intake, harmful use of alcohol, obesity/diabetes and raised blood pressure.

The Heart Foundation in Australia sees some clear priorities, including:

- Australia needs a national physical activity action plan, with inactivity and sedentary lifestyles contributing to an estimated 14,000 deaths a year. We have commenced a Move more, Sit less! advocacy campaign to secure commitments from major parties ahead of the next election.
- We need a national obesity prevention action plan, including a stronger emphasis on a national food reformulation program.
- We must keep the pedal to the metal and ensure our commitment to tobacco control doesn't go off the boil.
- We need to provide an incentive to support implementation of the integrated health check – combining a cardiovascular risk assessment, kidney and diabetes check – in general practice. This is – in essence – a prevention measure that can ensure people at high risk of heart attacks and strokes and other vascular diseases can be identified and managed to keep them alive and well and out of hospital.

Australia is starting to talk the talk. We now need to walk the walk. If chronic disease is our biggest health challenge, prevention is the greatest health solution.

Mary Barry has been CEO of the National Heat Foundation of Australia since January 2014. Her role is to provide strategic leadership to the federated Heart Foundation of Australia working in collaboration with the CEOs of the foundation's eight State and Territory Divisions. Previously Mary was CEO of Victorian State Emergency Service and before that inaugural CEO of VAHEC, representing aged care providers and bush nursing centres and hospitals in Victoria. She has held senior management positions in other health care settings and was general manager at the Shire of Melton.

Corrective taxes and chronic disease – consider alcohol

Michael Thorn

Reducing the burden of chronic disease is an Australian health priority, but the nation's policy approach is lame and ineffective.

Arguably, under former Prime Minister Tony Abbott's administration, tackling chronic disease was handicapped by the wholesale dismantling of Australia's national preventive health program and an in-built bias against government-led intervention, including applying tax driven solutions.

The demise of Mr Abbott has been seen as an end to the politics of division, characterised by sloganeering, aggression and ideology. Only time will tell.

In the meantime, there is an opportunity to give serious consideration to meaningful public policy action that will address the challenge of chronic disease. Prime Minister Malcolm Turnbull has made it clear that he will not be positioned to rule policy options 'in' or 'out'. This is a good start for evidence-based policy.

The burden of chronic disease is both wide and deep. It is costly to lives and wellbeing as well as to the budget and to taxpayers.

Chronic diseases are responsible for 83 per cent of all premature deaths in Australia[1] and 85 per cent of the total burden of disease,[2] making it our nation's greatest health challenge.

Conditions such as heart disease, stroke, heart failure, chronic kidney disease, lung disease and type 2 diabetes, are all too common in Australia, placing great pressure on our healthcare systems as they struggle to deal with the increasing flow of patients.

Dealing with these diseases comes at a $27 billion cost to the Australian community and accounts for more than a third of our national health budget.[3] This equates to 36 per cent of all allocated health expenditure.

There are many factors contributing to this burden – too many to canvas in the space available here. Suffice to say, this is neither a challenge that is not understood, nor one without solutions.

The analysis of the burden of chronic disease and pre-mature death can be seen through different lenses. Either through the disease lens: cancers, cardiovascular disease, chronic respiratory disease and mental health conditions. Or through the lens of risk factors: drinking, smoking, sedentary lifestyle and obesity. Or a combination thereof.

Alcohol's contribution to this burden is significant. Globally, alcohol is the fifth leading cause of death and disability, and third among the leading risk factors in developed countries after tobacco and blood pressure.[4]

In Australia the consumption of alcohol has remained at about ten litres of pure alcohol per person a year for about 25 years – rising and falling over this period. We are currently on a slight downward trend, and below ten litres. Over the last 100 years Australia's per capita consumption reached its peak of about 13 litres in the mid-1970s and a low of less than three litres in the 1930s.

The heaviest drinkers, the top ten per cent, consume 53.2 per cent of all the alcohol, 20 per cent of adult Australians are non-drinkers, and 50 per cent of drinkers account for as little as 6.9 per cent of overall consumption.

The patterns of drinking have changed markedly over time. Peak drinking levels in the 1970s were due to drinking

by blue-collar men. But times have changed. Women's drinking has increased (about six litres per year), people are living longer and sustaining their drinking, and rates of episodic drinking (binging) have increased. All behaviours which are contributing to increased health harms.

Each year, more than 5,500 people die and over 150,000 people are hospitalised from the consumption of alcohol.[5] Ambulance callouts where alcohol is the main cause are increasing, as are presentations to hospital emergency departments. We know that alcohol contributes to more than 200 diseases,[6] including cancers of the mouth, throat and breast, as well as cardiovascular disease and cirrhosis of the liver.

Health Ministers have recently initiated work to develop a new chronic disease framework to replace the National Chronic Disease Strategy 2005, and early indications are this will be a protracted process. Critical in any new plan will be a need for a strong focus on prevention. Not to do so will be regarded as a major fail.

Chaos in Australian public policymaking over recent years has prevented recourse to the best policy buys, as recommended by the World Health Organization (WHO), for preventing and reducing health harms.

In alcohol's case, like for tobacco and junk food, the best policy buys to prevent and reduce harm are increasing price, limiting availability and restricting marketing and advertising.

Price effects are best achieved through corrective taxes. The Commonwealth Government's Reform of Federation[7] process has importantly identified corrective taxes as a major policy option to address the economic externalities of the use of alcohol (costs beyond the drinker). As it should.

Taxation is important for the operation of the modern state and corrective taxes are a critical component of the overall suite of tax options available to governments. Corrective taxes are a useful because they offset economic externalities, raise revenue for services, nudge people to change harmful behaviours, and research shows they target the heaviest drinkers.[8]

If price is the most determinative factor in the consumption of alcohol then the use of corrective taxes must be a 'go to' public policy option.[9] Taxation, which targets alcohol, also has the benefit of being a cost-effective policy intervention.[10] It is cheap to enact and can be effected quickly. Contrast this with policies that target individual drinkers through costly public awareness campaigns or direct interventions by health professionals.

Overcoming chronic disease and reducing its burden will not happen overnight, but rational efforts to develop strong responses must focus not only on health and medical interventions but also on a strong preventive health agenda.

To this end the Public Health Association of Australia (PHAA) and the Foundation for Alcohol Research and Education (FARE) have launched Prevention 1st to put preventive health back on the political agenda.

One of the first policy responses must to be fix Australia's incoherent system of alcohol taxation and thereby afford the opportunity to make a major contribution to reducing chronic disease through reducing levels of harmful consumption of alcohol. Adopting a sensible approach to the employment of corrective taxes as part of an overall suite of policy measures is absolutely essential.

Hopefully, Prevention 1st can play a role in achieving this aspiration.

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ANPHA lives! What can we learn?

Louise Sylvan

If Australia has another opportunity to re-create a national preventive health organisation within government, how should we do it?

As readers will recall, the former Abbott Government defunded the Australian National Preventive Health Agency (ANPHA) as of July 1 2014. The then Minister, Peter Dutton, also unsuccessfully attempted to abolish the Agency formally but failed in the Senate where the Labor Party and some independents voted the legislation down.

So ANPHA still exists on the books for anyone keen to revive it! All it needs in theory are funds to begin operating again and a strong commitment to enhanced prevention activi-ties.

One of the things that Australia got right in creating ANPHA was its establishment as an independent agency as opposed to a taskforce or an advisory group or an interdepart-mental committee or a section in a health department.

Independence in the prevention task is important - and good governments should want fearless independent advice. Line departments are driven by ministerial priorities, are of-ten highly risk-averse, and are by definition not independent; taskforces and advisory groups have little teeth. And given the powerful commercial influences at play in areas of central importance to preventive health --- like food and beverages for instance --- inde-pendence is vital. The best option for strong robust evidentiary advice is from an entity de-signed to provide such independent and sometimes unwelcome advice - often in the public domain to ensure transparency. In our form of government, that means a statutory body responsible through a Minister to the Parliament. ANPHA was a first step along that path, and it's well past time to take the next step and tackle the prevention task with even more vigour.

ANPHA was created by agreement of the Commonwealth Government and the States and Territories having been recommended by both the National Health and Hospitals Reform Commission (June 2009)[1] and the National Preventative Health Taskforce (June 2009).[2] While everyone expected a machinery of government recommendation from the Preventa-tive Taskforce, it was especially significant that the Health and Hospitals Reform Commis-sion was also of the view.

Professor Christine Bennett, the inaugural — and last — Chair of ANPHA, who also chaired the Commission, was fond of saying that the creation of the Prevention Agency was one of the most important recommendations for ensuring that Australia had a strong and viable health system into the future. Other countries, the UK, Canada and many European na-tions, were also significantly beefing up their expenditure and government machinery for prevention activity.

ANPHA had only a bit under two years of functional existence: it became fully operational toward the end of 2011 and spent its last months after the election in 'winding down' activi-ties awaiting the guillotine. So there wasn't a lot of time to really tackle in depth some of the harder prevention questions such as primary healthcare reform. But what did we learn in that short period?

First up, we need Commonwealth leadership from both parties. Prevention isn't a party-political job; as with many other areas of national leadership, some things just need to be done in a more sensible bipartisan mode. The problems that result from not addressing prevention - i.e. an enormous blowout of the health and social welfare budgets at both state and Commonwealth levels - are a huge challenge irrespective of what party happens to be in power. And the requirements of good prevention policy need leadership that is able to hold to the course over a significant period of time.

Second, the key risk factors that ANPHA was tackling still remain the right ones in general - tobacco, alcohol, diet and physical activity. These risks drive much of non-communicable diseases in both Australia and other parts of the world. But it is important for such an Agency not to be limited to the 'behavioural' and primary side of the prevention equation - there are a whole range of prevention tasks that would benefit from being combined into one entity. Secondary prevention for example is equally critical and involves the im-portant treatment side of the equation and includes good enabling self-management. Thus, and thirdly, one can build a stronger constituency when all the key players are in-volved in the task of transforming to a health system that gives equal emphasis to preven-tion and treatment.

And transforming to a prevention orientation is the key task. That it involves a lot of play-ers is one of the reasons that prevention is often difficult to do well. Leadership is needed from consumers, clinicians, researchers, governments at all levels, public health advo-cates, local GPs, private sector businesses and many others not least politicians. While not all stakeholders can be on a governance body, a wide reflection of those interested - who can help bring their networks with them - is needed. A Prevention Agency needs to reflect this diversity on its board and enable many players to show leadership in the pre-vention journey.

Having said that, one crucial question is whether an independent Prevention Agency be-longs in a health department? Much of the work of

prevention sits in non-health areas. A few examples of areas that need a prevention approach: urban design - cities that are planned to simplify walking and cycling and being outdoors as a natural part of the day, and which create good social spaces helping create better mental as well as physical wellbeing; transport policy; assisting in the thinking and tasks addressing poverty and dis-advantage (which are major predictors of chronic disease - the social determinants of health); re-thinking workplace spaces and tasks in terms of prevention of a sedentary day; addressing violence. There are many more non-health areas to add to the list. (For a taste of the range of issues, see the US National Prevention Strategy.)[3]

This "connectedness" of the prevention task is a real challenge for siloed government de-partments. In examining the costs to the whole of the government budget of a child who becomes obese for example and remains so through adulthood, only a small proportion of the typical costs will actually fall to a health budget[4] - more than 75% of the costs will be in social welfare and other systems. Is it likely that a welfare department will tackle head-on a task like reducing Australia's obesity and overweight levels? Not highly probable. But it's not just about the money. Placing prevention (and thus wellness) at the heart of an approach from governments and in the centre of a range of policy areas provides the best chance for success and the best contribution to both social and economic productivity.

A last learning from ANPHA's existence is about innovation and trying new things. Even within the 'old' task of stopping smoking, finding new and effective ways to reach smokers is needed. The Agency took risks like sponsoring the Summernats street machines event - the young male market was a high priority. It proved to be one of the more successful (including on a cost-benefit analysis) smoking cessation activities undertaken. That kind of success should speak for itself - that it was in fact attacked as part of party-political mane-ouvering shows how far out of touch the political class can get.

Prevention isn't an episodic one-off engagement with a provider - it's an ongoing relation-ship-based partnership with clear outcomes in mind; the current emphasis on primary care reform is crucial to a prevention orientation and it is a shame to see the old lines being drawn primarily focussed on costs savings. Prevention is also smarter thinking to help re-design our environments to promote healthy behaviours. While the need for better pre-vention is uncontroversial, how as a society we carry that out is less so. And that's a de-bate we all need to engage in.

With all of this widespread support for ramping up prevention across the world, was it sur-prising that abolishing this Agency was such a high priority for the Abbott Government? This is a tough question. Initially, savings were said to be the rationale; but later revela-tions at Senate Estimates showed savings to be only about $6 million over the four-year period to 2017-18. For the Commonwealth Government, or even just the Health Depart-ment, that is an almost unnoticeable pimple in the expenditure lines.

More relevantly, abolishing the Agency was in the top immediate actions for the new gov-ernment put to it by the influential conservative Institute of Public Affairs (google 'preventa-tive' on their website to get a sense of the agenda which they label 'nanny state'); and perhaps this ideology was the key influencer. Whatever the rationale, we lost the national emphasis and synthesising potential in our preventive activity. And it remains absent in Australia's often excellent but vey piecemeal and unconnected current prevention work.

Louise Sylvan was the first and only Chief Executive of ANPHA. She has served as a Commissioner of the Productivity Commission, and was Deputy Chair of the Australian Competition and Consumer Commission. Prior to that, she headed CHOICE - the Australian Consumers Association for 10 years. She currently chairs Bush Heritage Australia, Louise is a Director of the Social Enterprise Fund Australia and serves on the Economic Advisory Committee of the NSW Aboriginal Land Council. She is with the Prevention Research Collab-oration at the University of Sydney, louise.sylvan@usyd.edu.au

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Pharmacist's role in preventive health

Debbie Rigby

The ageing population and increasing burden of chronic diseases demands a greater role for pharmacists in preventive health. Preventive health is important across all ages - when planning pregnancy, in children, teenagers and young adults, through to older people. Community pharmacists are the most accessible health professionals in the community, and can provide consultation and advice without an appointment. This may be especially relevant among younger adults, who are less likely to access routine care with a general practitioner.

Pharmacists have recently taken more visible roles in preventive care, primarily as front line advocates of screening for major diseases and through the promotion and administration of vaccines. Their roles have expanded to include more direct patient care, such as preventive healthcare and disease management services, and this development continues to evolve.

As consumers are becoming more engaged in their own healthcare and preventive health, with so much information available via the internet, social media and television, the need for a trusted advisor has never been greater. Pharmacists should be seen as an 'information broker', to help consumers sift through the myriad of conflicting and sometimes non-evidence based information. Pharmacists are further able to tailor those messages for individual consumers who seek follow-up advice. Pharmacies also serve as a platform for public health initiatives such as 'Know your numbers' campaign targeting blood pressure assessment and the NPS Medicinewise 'Be Medicinewise week'.

Many conditions such as diabetes, high blood pressure, stroke, heart attacks and osteoporosis can be prevented by lifestyle changes such as diet, exercise, smoking cessation, stress management and relaxation techniques; and pharmacists are trained to give advice on this. Screening and risk assessment for conditions such as high blood pressure, heart attacks, stroke, diabetes and osteoporosis is now provided by many community pharmacies. Pharmacists can also help consumers identify their risk factors for these conditions, and provide advice and sometimes treatments for early intervention. For patients deemed not at risk, pharmacists can provide patient-friendly education and materials that outline ways to reduce the risk of developing these costly diseases.

Pharmacists can also provide advice and products for smoking cessation, together with valuable ongoing support and encouragement. Whilst nicotine replacement therapy patches, gum and lozenges are available from supermarkets, a pharmacist's advice and ongoing support may be critical to successful cessation of smoking.

Another part of preventive health is learning to recognize changes in your body which may signal the need for further investigation of signs and symptoms by a doctor. Community pharmacists can provide reassurance or help consumers understand the need and perhaps urgency to seek further medical advice.

Many pharmacies now provide vaccinations including the annual influenza vaccination. Pharmacies may be more convenient to some consumers, especially those who do not qualify for the National Immunisation Program. In some states such as Queensland, pharmacist-administered immunisation has recently expanded to include whooping cough and measles vaccination.

Adherence to and persistence with taking medications is critical to gaining the most benefit from prescribed medicines, so pharmacists can provide dose administration aids or dosette packs to help prevent missed doses and provide reassurance that all medicines are taken as prescribed.

Some medications prescribed by doctors are for management of existing conditions, preventing future flare-ups or exacerbations. 'Preventers' for control of asthma are often under-used, leading to poor control and unnecessary hospital admissions. Having a conversation with a pharmacist can help to understand the benefits of preventer inhalers and address any concerns about the long-term use of such medicines. Similarly some medicines are prescribed to reduce the risk of future events such as heart attacks and strokes. Pharmacists can also make an assessment of ongoing need for preventive medicines such as aspirin, cholesterol-lowering medicines (statins), blood pressure lowering medicines (antihypertensives) and medicines for the treatment and prevention of osteoporosis (bisphosphonates). This is especially relevant towards the end of life and in palliative care, and suggestions can be communicated to the GP.

Now more than ever, team-based healthcare is gaining support. Pharmacists have strong professional partnerships and active engagement with other health professionals. Collaborative care models that include a pharmacist can help alleviate some of the demand for GP-provided care, reducing the cost to the health system. A growing number of pharmacists are now working in general practice surgeries, and have access to patient history. They can provide timely advice of preventive care in collaboration with the GP and community pharmacy.

Home Medicine Reviews are a government-funded service that is provided by specially trained

pharmacists on referral from a GP. The service is at no cost to the consumer, and allows a pharmacist to do a home visit to discuss all aspects of medication use including advice on preventive care. Issues such as use of calcium and vitamin D supplements to improve bone strength and prevent osteoporosis can be discussed in the privacy of the home.

It is really important that any screening and preventive care provided by pharmacists is communicated to a consumer's usual GP. Any results of screening should either be sent to the GP by the pharmacist, or provided to the GP at the next visit. Consumer registration for the personally controlled electronic health record system will enable access to a summary of their personal health information whenever they need it. It also allows general practitioners, specialists, hospitals, pharmacists and allied health practices access to this information, to inform decision making and provide appropriate prevention and treatment.

As the landscape continues to evolve toward more coordinated, cost-effective, and team-based care, community pharmacists and general practice pharmacists have an important role to play in preventive healthcare. Because pharmacists are among the healthcare professionals that patients visit most frequently, they can play a key role in educating patients on the importance of preventive care services.

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Improving the health of communities by increasing critical health literacy

Marilyn Wise and Don Nutbeam

In the early 21st century, Australians, at birth, can expect to be among the longest-lived people in the world. For a century or more, our health and life expectancy has been improving.

We have learned that our health is protected and sustained by safe physical environments and supportive social networks. We also need opportunities to acquire the knowledge and skills that make healthy choices easier.

Education, employment, income, housing, transport, and access to health care are widely known to be essential to health. We are also healthier and more likely to thrive in communities in which we feel that we are the equal of others, secure and respected; in which we can both give and receive material and social support, and in which we participate in making collective decisions – through government, business, and community organisations.

However, we have not, yet, been able to put these conditions in place for everyone and some people's health is at risk (or already compromised) by both their environments and their lifestyles. To change this requires both social and personal actions - a combination of public policy, public education, collective action, modification of health services, and environmental changes.

We know that using theory to guide the design and implementation of each of these strategies, that engaging communities, and that reinforcing positive changes in behaviours, environments and social norms over time are all important in determining long-term and sustainable improvements in health. It follows that successes have often been incremental, and hard won over time.

Disappointingly, our success in improving health overall has not been matched by progress in reducing unfair and avoidable inequalities in health within and between communities. Generally speaking, social groups with the most limited material resources are routinely and systematically under-represented in the groups making decisions about the future distribution of resources. And in this way inequity becomes entrenched.

Sadly, in Australia in 2015, inequalities in the distribution of income and wealth are increasing. Improving the average life expectancy of populations at the same time as reducing inequalities in health requires policies and interventions that improve the health of the poorest, fastest. This simple challenge has eluded public policy makers and the health system over successive decades in Australia. One part of the challenge has been to enable social groups to be present in policy making both to argue directly for the resources necessary to resolve problems they have identified, and to confer social recognition and respect - replacing

negative stereotypes with positive cultural representation.

In short, although we can describe and predict the economic, social, and environmental conditions in which populations have the greatest opportunities to become and stay healthy, and although we can reduce risks to health and reduce inequities in health, we have not, yet, been apply that knowledge and skill as effectively as possible.

What next?

Health literacy is generally defined as a set of skills that enable people to obtain, understand and use information to improve their health. Improving health literacy is central to many of the educational and communication initiatives that make critical contributions to improved health – by increasing positive health behaviours, and by influencing underlying public opinion about changes in policy and practice necessary to address major health problems. Current initiatives to reduce domestic violence or to reduce stigma associated with mental illness are examples of this in Australia.

However, improving health literacy can mean more than this – encouraging more interactive forms of learning to support people and communities to participate actively in decisions being made by the health sector; to improve people's understanding and confidence to critically analyse information about health and its determinants; and through that to enable people to take individual and collective action to increase their control over the social determinants of health. This "critical" health literacy is not only a means to improve control over personal decisions, but is also a set of skills that enables people to participate more actively in political and social decisions affecting their health – exactly what is required to enable the most disadvantaged to participate actively in health-related decision-making.

As well, critical health literacy – the capacity to predict the health impact of decisions made by sectors other than health – is required by policy makers and practitioners in the key sectors of government relating to the economy, education, housing, employment; or by those responsible more locally for urban design and land use.

The role of critical health literacy in improving the health of communities is challenging even within the health sector, which has yet to find the best way to engage and empower the most disadvantaged communities in actions to promote health, and is only recently finding ways to work effectively with other sectors so that the impact of their decisions on health is positive. A recent study found that academics, practitioners and policy makers from within the health sector (Sykes et al, 2013) had varied understandings of the key attributes of health literacy – with most of them still describing it as functional cognitive skills held by individuals who were seeking to 'look after their health', navigate the health system, or to participate in health care. Few understood the concept as including the cognitive and social skills required to work through the political system or through social movements to change social, economic, or environmental conditions for health.

Implications for the future

Improving health and reducing the prevalence of chronic disease requires multiple actions across societies by individuals, groups, organisations, and governments – in the community sector, the private sector and government. As impressive as the successes of the 20th and early 21st centuries in improving health are, lack of progress in reducing inequities in health reflects a collective failure in our society. Moreover, given that it is now possible to predict the conditions (social, economic, environmental) that give people the greatest opportunities to become and stay healthy, it is vital that this evidence be used by policy makers and practitioners in all key economic sectors to guide their decisions – including decisions about land use and urban design.

Though convenient to focus attention on individual behaviour and individual choice, and to limit health interventions to those designed for specific functional outcomes, it will not be enough to sustain progress overall, and is completely inadequate as a response to the persistent inequalities in health in Australia. Progress will be dependent upon interventions that improve the "critical" health literacy of populations and of policy makers and practitioners – so that all members of society to participate in decisions that affect our health.

This will require systems of governance that include and are open to the full range of voices, that are transparent about the decisions being made, and that consider the impact of decisions on health and equity in the population.

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Don Nutbeam is Visiting Professor at the Sydney School of Public Health, University of Sydney.

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Prevention in general practice — getting the balance right

John Litt

As a GP I find that your agenda as a doctor may not always match your patient's agenda, and this can have important health implications. Similarly it can be a challenge to balance preventive activities with the need to deal with the patient's main problem/concern.

I recently saw Norm, a 61 year old local courier driver who had accidentally smashed up his finger between the tray of his ute and a pallet that he was loading. While I was writing out the Xray form and cleaning up his finger, he told me he doesn't like doctors much and hadn't seen a GP for nearly 10 years.

My agenda was that Norm's finger needed a careful assessment and treatment. But he hadn't seen a GP in a long while and I had an opportunity to identify his risk of cardiovascular disease which was likely to be high.

Norm's agenda was that he wanted his finger fixed and the pain managed.

After a careful examination and clean up of Norm's finger I checked Norm's BP and did a finger prick to check his blood sugar level. His blood pressure was high (170/105) and his sugar level was also high (11). After a more thorough examination and some blood tests, I calculated that Norm's absolute cardiovascular risk was 30%*. This meant that he has about a 1 in 3 chance of having a major cardiovascular event in the next 5 years. Norm had no symptoms at all.

I spent some time explaining to Norm what this absolute cardiovascular risk score meant and encouraged him to think about a number of treatment options including stopping smoking and starting a medication to lower his blood pressure and cholesterol level.

I think it was useful and appropriate to ask Norm about some relevant preventive activities. I accept that he now has several 'disease' labels. I also believe that the interventions will reduce his subsequent likelihood of morbidity and even death.

It is useful to look at the types of preventive care, the potential role of the GP and the factors that might influence getting the balance right.

What is prevention?

Prevention can be divided into three categories (see figure 1 page 25)

- **Primary:** the ecological promotion of health and the prevention of illness, for example, immunisation and making physical environments safe
- **Secondary:** early detection and prompt intervention to correct departures from good health or treating the early signs of disease, for example, cervical screening, mammography, blood pressure monitoring and blood cholesterol checking
- **Tertiary:** reducing impairments and disabilities, minimising suffering caused by existing departures from good health or illness, and promoting patients' adjustment to chronic or irremediable conditions, for example, prevention of complications

In the context of general practice, a 'preventive approach' incorporates the prevention of illness, injury and disease, rehabilitation of those with chronic illness and the reduction in the burden of illness in a community. A preventive approach recognises the social, cultural and political determinants of health and is achieved through organised and systematic responses. It includes both opportunistic and planned interventions in the general practice setting.

Why should GPs be involved in providing preventive care?

There are several reasons to support the GP role in preventive care.

GPs:

- have both access and opportunity;
- are seen as a credible and trusted source of health advice
- can tailor the advice and support to the patient's context and circumstances
- view prevention as an integral part of providing holistic and comprehensive patient care
- can be both effective and efficient in their delivery of preventive care
- can provide a 'one-stop' shop for comprehensive and holistic care that includes prevention.

Effective preventive care enhances quality of life, reduces unnecessary morbidity and mortality and improves health outcomes.

At the same time preventive care can have potential adverse impacts:

- it may cause harm through inappropriate medicalisation and labelling healthy, asymptomatic people with a disease with subsequent exposure to unnecessary and potentially harmful medications.
- it can contribute to over-diagnosis where the patient gets a disease label but the condition will never cause symptoms or morbidity
- it can consume scarce health resources through treatment(s) with variable effectiveness at the expense of treatment for existing health conditions

So is the adage that '*an ounce of prevention is worth a pound of cure*' true? Prevention is often more desirable and more cost effective (eg seat belts, plain tobacco packaging; increasing tobacco excise; immunisation) than

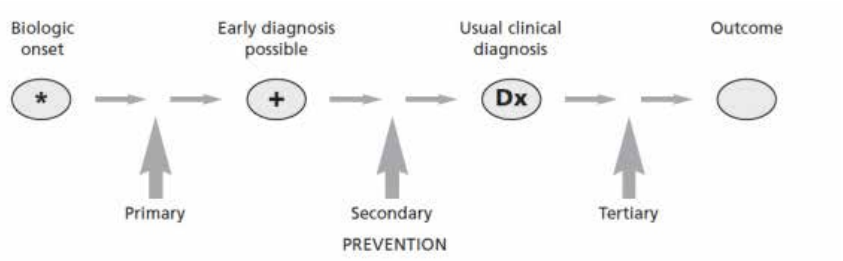

Figure 1. The natural history of disease. RACGP Green book, 2006 p1

focussing on treatment and cure once a disease arises. Nevertheless in primary prevention the putative prevention activity or intervention is often:

- unclear or unknown
- currently unaffordable or not available

Some examples include primary prevention of atherosclerotic heart disease; preventing age-related loss of skeletal muscle mass and function; primary prevention of rheumatoid arthritis and multiple sclerosis.

I believe we need to find an appropriate balance between prevention and treatment/care. As the case study below shows, the challenge is to get this balance right. One strategy that I have adopted as a clinician is to try and identify:

- one (or perhaps more) thing(s) *I think* (with my knowledge of the patient) would make a big difference to the patient's health.

  It might be their needing to stop smoking. It may also be to find a partner that they can confide in or to take a regular holiday.
- an issue/concern or activity that the *patient* feels would make a big difference to their health

What can help us get the balance right?

Was it reasonable to ask Norm about his cardiovascular risk factors when he clearly had some issues with doctors?

At an individual level, a strong doctor-patient relationship (and alliance) coupled with a good continuity of care and a greater recognition of patient priorities and preferences should help to determine the relative balance of prevention vs clinical care. An astute, holistic GP is in an ideal position to do this.

For over 26 years, the Royal Australian College of General Practitioners (RACGP) has published best practice guidelines on what preventive activities are worthwhile and effective. The guidelines (known as the Redbook) are peer reviewed and adhere to the WHO principles for screening. The ninth edition will be printed later next year and the current edition is available at no cost on the RACGP website (www.racgp.org.au).

These guidelines have been transformed into a consumer guide by Michael Kidd (an ex-president of the RACGP) and Leanne Rowe (a Melbourne GP). This guide is now in its second edition (Save Your Life and the Lives of Those You Love; Allen and Unwin, 2011)

So the next time you see your GP, ask them about what the RACGP Redbook says is timely and appropriate for you. It would also be useful to think about what things would be very important to help you to stay healthy.

*see http://www.cvdcheck.org.au/ The absolute cardiovascular risk calculator guidelines make recommendations for assessing and managing absolute cardiovascular risk in adults aged over 45 years (35 years for Aboriginal or Torres Strait Islander people) who are without known Cardiovascular disease. They use information like you age, gender, blood pressure, smoking status and cholesterol levels to estimate your level of risk. Ask you GP about it.

Acknowledgements: I would like to acknowledge and thank Richard Clark, Tony McBride and Christine Walker for their comments on earlier drafts.

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Using social media to promote wellbeing and preventive health


Rachel Davey


Deborah Lupton

Rachel Davey *looks at the possible benefits*

Public health as defined by the World Health Organisation includes "all organized measures (whether public or private) to prevent disease, promote health, and prolong life among the population as a whole"[1]. The core aim is to promote health and wellbeing of populations, rather than a focus on individuals.

Increasingly, public health organisations and practitioners are exploring internet technologies to help assess, protect and promote public health. There are now numerous online websites and applications that enable users to create and share content or to participate in social networking e.g. Facebook, Twitter, LinkedIn, Instagram.

Realizing the potential of social media in public health can provide timely and relevant information of public health importance. Numerous social media campaigns have successfully raise awareness, educated and prompted action regarding some of our most complex and challenging health issues, ranging from AIDS to obesity, substance abuse to cancer, pandemic flu and cardiovascular health.

A recent study by researchers at the University of Sydney examined a number of case studies that used social media for public health communication[2].

One of the case studies cited was from the Burnett Institute which established the "FaceSpace" project to examine whether social networking sites could be used successfully to deliver health promotion messages. This trialled the delivery of sexual health promotion via social networking sites to two key at-risk groups: young people aged 16–29 years, and men who have sex with men. They reached a total of 900 people across the five Facebook pages. They found significant increases in sexual health knowledge between baseline and follow up surveys[3].

As well as using social network sites for health promotion campaigns, they have also been used for public health surveillance. The Centers for Disease Control and Prevention (CDC) in the USA have been evaluating the use of social media for monitoring flu outbreaks for several years. Data from social media is usually available in real-time and may provide useful information in a timely manner. Researchers develop a process for collecting tweets containing flu-related terms (such as "flu", "influenza", and "Tamiflu"), the time at which each tweet is published and the geographical location from which the tweet is sent. They can also use this data to help predict how many people in adjacent areas might get flu.

Modern technology now allows for the potential to collect an immense volume of 'big data'. Combined with existing data, the behavioural data obtainable from mobile devices (mobile phones, fitness activity trackers etc.) may greatly enhance opportunities to predict long-term health conditions and identify non-traditional intervention points, as well as to design better diagnostics tools and prevent chronic diseases such as heart disease, diabetes.

Combined with data analytics the use of social media can provide unique insight into human behaviours and can give citizens information about their own health. It can provide government and business with data that can help with innovation of services and health needs and identify health disparities. Data-driven innovation and digital solutions also has enormous economic value (e.g. new goods and services; optimized and integrated health services; targeted social marketing and faster research and development).

1 The World Health Organisation: http://www.who.int/trade/glossary/story076/en/

2 Freeman B, Potente S, Rock V, McIver J. Social media campaigns that make a difference: what can public health learn from the corporate sector and other social change marketers? Public Health Res Pract. 2015;25(2):e2521517. doi: ttp://dx.doi.org/10.17061/phrp2521517

3 A systematic examination of the use of Online social networking sites for sexual health promotion. Gold J, Pedrana AE, Sacks-Davis R, Hellard ME, Chang S, Howard S, Keogh L, Hocking JS, Stoové MA. BMC Public Health. 2011 Jul; 11:583

Deborah Lupton *considers the potential problems of social media in health*

There is no doubt that many people have gained benefits from using social media to seek and exchange information about health and medical issues and offer and receive support from others. While there has been much interest among preventive health professionals in the use of digital media and devices to promote health, a note of caution also needs to be sounded.

The tendency to use such technologies in ways that do not acknowledge the social determinants of health has emerged in some initiatives. A politically conservative approach that focuses on using social media to effect individual behaviour change has tended to dominate, to the exclusion of taking up social media for activism. For example, social media campaigns often focus on using platforms such as Facebook as outlets for messages concerning healthy eating, the importance of physical exercise or safer sex. Such campaigns tend not to highlight the social and cultural factors that shape whether or not people take up these behaviours, such as their income or educational level.

Social media are well-known platforms for efforts to agitate for government action. They have the potential to improve the living conditions of socioeconomically disadvantaged groups, directing attention from 'blaming the victim'. Citizen science initiatives that involve people collecting

data about their environment and aggregating these data as part of activist efforts are one example. Such campaigns help people to draw authorities' attention to such substandard living conditions as poor housing and high and crime pollution levels. Yet many of those working in preventive health tend to continue to take an individual behaviour change approach when considering the uses of social media.

A further concern relates to digital data privacy and security. Personal health and medical data have become increasingly valuable; and not only to public health researchers. People's interactions with social media – their Facebook status update, their tweets and their interactions on fitness self-tracking or patient support platforms, for example – are a goldmine for the new industry of data harvesters. Once these data are transmitted to the computing cloud, they are open to a range of uses. These data are now used by a range of actors and agencies, not only in the health and medical professionals, but also beyond this domain. Data harvesters construct profiles of people using these and other data available online that can be employed to target people for advertising or marketing offers. More seriously, these data are also now commonly used for making decisions about whether people are offered employment, insurance or credit. Personal health and medical information is a prime target of cyber criminals, as it can be used to make fraudulent health insurance claims or obtain drugs and medical devices.

It is vital that people who work in preventive health are aware of these issues if they are seek to use social media. Not doing so means that further social inequities and disadvantage may be perpetuated rather than alleviated, to the detriment of health and wellbeing.

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The need for an integrated approach to chronic disease management in Australia

Andrew Cottrill

Chronic disease is a significant burden on health systems and underlines the importance of preventive health measures. As a private health insurer, HCF recognises its responsibility to help keep members healthy but the road to better prevention and chronic disease management is long and needs a fundamental shift in approach.

Poor integration with primary care, lack of access to patient data, costs of delivery and funding arrangements are just some of the issues currently discouraging private health insurers from making a greater contribution to solutions. What is clear is that inaction is not an option.

The Australian Institute of Health and Welfare revealed earlier this year that half of all Australians suffer with a chronic condition and one in five are affected by multiple conditions. Most common are cardiovascular disease (CVD) and diabetes. Data shows around one million Australians were living with diagnosed diabetes in 2012 and highlights CVD as the leading cause of death across the country.

The related costs of treating these conditions are rising at an alarming rate. Projections for healthcare expenditure for Australia in the 30 years from 2003 to 2033 estimate a rise of 436% in costs related to diabetes and 142% in costs related to cardiovascular disease[1].

In the private health sector, utilisation of hospital benefits is also ringing alarm bells. According to our own data, around 1.6% of HCF members consume half of all HCF hospital product benefits. That means approximately 20,000 members are consuming over $700 million in hospital benefits each year, and at least 60% of this expenditure is related to chronic disease.

The problem is daunting and amplified by an ageing population and increasingly inactive and unhealthy lifestyles. The burden will continue to grow at an accelerated rate if left unchecked.

There is an imperative for health funds to develop long term strategies and interventions to address this clear and growing issue. But there are also many challenges.

When the Federal government introduced a series of major reforms to private health insurance in 2007, it opened the door to Health Funds like HCF to begin offering programs for members to help manage, and reduce the effects of, chronic disease. This enabled HCF to play a greater role in keeping members healthy and led to the launch of its My Health Guardian Chronic Disease Management Program (CDMP) in 2009, which within 12 months of launch had enrolled 25,000 participants.

The program provides eligible HCF members with interactive web and phone–based support from qualified nurses, dieticians and exercise physiologists, to help manage their health and disease management requirements.

The Fund has conducted Australia's only large-scale study to evaluate the effectiveness of an Australian CDMP (My Health Guardian); a challenging

proposition given there can be a lag of many years before unhealthy behaviours actually result in hospitalisation.

The most recent HCF study[2] found that over a four year period, participation resulted in significant reductions in hospital admissions (<11.4%) readmissions (-36.7%) and bed days (-17.5%) for participants with heart disease or diabetes.

The study demonstrated the significant gains made through implementation of the program, but calculating the true return on investment in financial terms is a complex task.

The HCF study focused on data available to, and measurable by, a private health insurer, but a program such as My Health Guardian can deliver benefits across the health system. These could include savings on PBS drugs, GP visits, emergency room visits, outpatient investigations and special consults, but none of these savings would be delivered to private health insurers who fund the CDMPs. The economic viability of these programs is eroded because the cost is borne by one segment of the healthcare industry but the benefits are shared across multiple segments.

The return on investment for health funds investing in CDMPs is further eroded by current Risk Equalisation arrangements. When the government reformed private health insurance legislation in 2007, it also enabled the costs of CDMPs to be included in Risk Equalisation. However, when CDMPs are effective and reduce hospitalisations, there is an associated reduction in the amount returned to the insurer by the RE.

At current estimates, approximately 40% of the cost of My Health Guardian is covered by the Risk Equalisation pool but 47% of the savings are lost to competitors who don't invest in their own CDMPs. In a recent submission to the Parliamentary Inquiry into Chronic Disease Prevention and Management in Primary Care, HCF recommended reforms to the RE pool to ensure those Funds who do invest in CDMPs are not disadvantaged by doing so.

The effectiveness of CDMPs is also limited because health insurers may not even be aware a patient suffers from a chronic condition until they end up in hospital – meaning that the optimum time for intervention has passed. Collaboration with primary care is important to ensure that interventions are properly targeted and effectively delivered at the optimal time.

HCF currently has 12% of national market share but accounts for 50% of the private health insurance industry's investment in CDMPs. While HCF is making a significant contribution to the development of CDMPs there is an imbalance which suggests the system is failing to encourage private health insurers more broadly to invest.

We recognise the vital role of CDMPs as a preventative measure to help patients manage their conditions and avoid unnecessary hospitalisations. However, in our view, there needs to be greater collaboration within the healthcare industry to ensure early detection and intervention supported by changes to legislation and regulation to ensure that incentives are aligned.

Dr Andrew Cottrill, MBBCh, MAP, MBA is Medical Director for HCF, Australia's largest not-for-profit private health insurance company. During his time at HCF he has been responsible for HCF's Chronic Disease Management programs, Clinical Governance, Doctor Networks and Utilisation Review. He is a graduate of the University of the Witwatersrand Medical School and worked in general practice and primary care clinics in Johannesburg before working in health informatics. In 2000 he completed his MBA at Cambridge University in the UK, after which he moved to Australia joining HCF in 2004.

1. Goss J (2008) Projection of Australian health care expenditure by disease, 2003 to 2033 Australian Institute of Health and Welfare, Canberra
2. Hamar GB, Rula EY, Coberley C, Pope JE, Larkin S (2015) Long-term impact of a chronic disease management program on hospital utilization and cost in an Australian population with heart disease or diabetes. BMC Health Services Research, 15:174 www.biomedcentral.com/1472-6963/15/174

Evidence plus people-power: a winning combination for prevention

Anita Tang

Governments can be reluctant to adopt policies to prevent cancer, even when there is clear evidence for action. Reasons for this include lobbying by industries profiting from products such as tobacco, alcohol, junk food, and the absence of an active constituency for prevention.

Evidence alone is rarely enough to move politicians to action, particularly if there are strong profit-driven industry interests. But this can be countered using a resource that already exists in our communities – people power. We need to convert latent support into community action, to show politicians that there is public interest in prevention.

Cancer Council NSW has supported consumer advocacy and grassroots campaigning for over a decade. There are three situations where grassroots campaigning and community activism is particularly effective in shifting prevention policy.

The three activism opportunities are:

ONE: Where there is industry opposition to proposed prevention measures

In April 2008, the NSW Government proposed putting tobacco out of sight in retail outlets, consistent with evidence about the impact of displays on smoking behaviour. Predictably, the tobacco industry objected, and urged retailers to do the same. Our challenge was to show the Government that the community supported the measure.

Surveys found that around 90 per cent of the community agreed that cigarettes should be stored out of sight of children.[1] Our focus was on encouraging the community to actively express their support for the move. During the campaign:

- Over 6500 community members made submissions supporting the proposal to put tobacco out of sight in shops. This accounted for around 50 per cent of the submissions received by government.
- We know of at least 150 people who phoned their MP asking them to support the proposal.
- Three community members addressed the Parliamentary Forum on the matter. One young person spoke about having friends who smoked and were trying to give up. Two mothers of young children shared their hopes and fears for the future health of their children. One of these mothers presented letters from children in her son's class.
- Every Cabinet Minister was contacted by at least one constituent, asking them to prioritise children's health over the interests of big tobacco.

In July 2008, the Premier announced a ban on tobacco displays in NSW. Verity Firth, the Minister responsible at the time, argues that "if you want to defeat big money interests, you need to show public support." She noted that community activism was key to securing these reforms: "We knew that we had to build community momentum, and this is where Cancer Council NSW was absolutely brilliant and organised on the ground. They had events at schools, rallied their membership, created media opportunities."[2]

TWO: When policy processes lead nowhere

Prevention issues tend to not be a high priority for governments. For example, the NSW Department of Education had not updated its sun protection guidelines for 15 years. Cancer Council had raised the issue with the Department for over 5 years, with no progress.

In 2012, we launched a campaign with community delegations to 35 Parliamentarians in a single day. During the campaign, community advocates conducted a further 38 delegations to Parliamentarians. Over 2,200 people "chalked" a message to the Minister for Education, which we collated into a photo album and presented to the Minister in person.[3] The campaign also included media advocacy, and strategic research with parents of school-aged children.

The Minister finalised a new set of guidelines for sun protection in schools within one year of launching the community campaign, an outcome that we had been unable to achieve during years of organisational engagement through government channels.

THREE: To demonstrate community support for an issue that is not on the policy agenda

Sometimes evidence and community opinion is far ahead of political readiness to act. In these situations, grassroots action can be important in helping place new prevention opportunities on the policy agenda.

One example of this is the new frontier in tobacco control – addressing the ubiquitous availability of tobacco for sale throughout the community. The public health sector has recognised that there is a need to address the easy supply of tobacco. However, the tobacco industry will be vigorous in opposing anything that endangers the basis of its distribution strategy.

In 2012, Cancer Council NSW wanted to show policy makers that the community wanted action on this issue.

During the campaign, over 7,000 photos were taken of people with the 'harmful not helpful' sign, with some participants

sending the photos to their MPs via email or social media. Advocates met with their local MPs 34 times to express their concerns about retail availability, and asked their MPs to take the photo pledge of 'harmful not helpful'.

The community action was designed to raise awareness of MPs about the issue and secure their agreement that it needed to be addressed. The meetings also helped identify potential political champions for policy change in this area.

The Cancer Council NSW has been able to engage and mobilise people in campaigns for prevention policies because it has invested in developing training and supporting community advocates. Since 2002, CCNSW has trained consumers for advocacy, established local cancer advocacy networks, and developed advocacy leadership roles for volunteers.

The CanAct Community is now an organised network of over 18,000 individuals (often cancer survivors, carers or friends) forming an active constituency for cancer issues in NSW. It provides an important counterweight to the industries that profit from harmful products. Members are 'ordinary people' who would not have considered themselves activists until they realised that their voice could make a difference.

Community advocacy helped secure multiple prevention wins in NSW. It will be important in the battles ahead around junk food marketing, alcohol, and the retail availability of tobacco.

Public health organisations need to build an effective constituency around prevention. People power complements the advocacy of public health organisations and helps ensure that politicians consider community interest when deciding on policy.

Anita Tang is an Advocacy Advisor and Campaign Coach, supporting NGOs and individuals working for social change. For over 12 years she led the Cancer Council NSW's advocacy approach, embracing grassroots engagement and community organising, with resulting campaign wins in tobacco control, and reforms to improve access to treatment. In 2014, she was listed in Impact 25 — The Not for Profit Sector's Most Influential People.

1 Cotter T, PerezD, DessaixA, Crawford J, Denney J, Murphy M, Bishop JF. NSW Smokers' attitudes and beliefs: Changes over 3 years; Sydney: Cancer Institute NSW, February 2008

2 The Hon Verity Firth, former Minister for Cancer, at the University of Sydney School of Public Health Research Presentation Day 28 September 2015

3 This was a blackboard photo petition: people wrote a message about the issue on a small blackboard and had their photo taken with the message

Healthy lifestyle = healthier life: One size does fit all

Sally Crossing

No one can argue against doing more about promoting the prevention message out there, loud and clear: a healthy lifestyle leads to a healthier life.

May I be blunt? As a community we need to begin discussions about, even tackle, the sadly novel idea that Australians should hear one big healthy living message. Let's move away for each disease-specific organisation or government agency trumpeting the same message about eating, drinking, smoking and exercising, all under the different banners of each specific unpleasant /life-threatening disease no-one wants to get.

We in the cancer slot have heard so much of this. Its main impact is to make us feel guilty; did we eat the wrong things, too much of them, did we have too much / too little red wine, did we not achieve our three hours of heart pumping exercise a week?

I suggest that letting the same health messages be shot from so many different cannons is confusing. They lose credibility, are likely to be less than effective and are definitely wasteful of the money, often tax-payers' or charitable donors' money, spent on them.

I've been living with my "home base" disease, cancer (there's nothing else wrong with me yet at 69), for 20 years. I and so many others like me are constantly bombarded with strictures to not do this, or to do that to avoid getting a diagnosis or recurrence of Australia's number one killer, cancer. Most are based on those odd population statistics which show similarities, but not necessarily causal links except for some well-established ones like smoking and too much sun exposure. Not that I disagree with living healthier and moderately for a moment!

I think the only way out is to have another glass of red wine, (good this week, bad next), go for a walk and hope that someone powerful realises that the prevention messages are exactly the same for whatever major or minor illness or condition you are likely to have, especially as you age. Could the various disease charities and state and commonwealth agencies please consider coming together to send out one great big meaningful and helpful message to all Australians. Eat and live healthily, and enjoy doing it.

Sally Crossing AM chairs Cancer Voices NSW and is Convenor of Cancer Voices Australia. She is a longtime member of the Consumers Health Forum. Last year Sally was awarded an Honorary Doctorate by the Faculty of Health Sciences at Sydney University for her advocacy on behalf of consumers living with cancer. She was first diagnosed and treated for breast cancer in 1995. Within two years she founded the Breast Cancer Action Group NSW and chaired its Committee f or 11 years.

Health Voices

Health Voices is published twice each year. Each issue has a theme that promotes debate on issues of interest to health consumers, government and industry.

Readers are encouraged to write letters to CHF in response to journal articles or other issues in Australian healthcare.

Health Voices is freely available online at www.chf.org.au. Printed copies are sent to CHF members as a benefit of membership, subscription holders and key stakeholders.

The Consumers Health Forum of Australia

The Consumers Health Forum of Australia (CHF) is the national peak body representing the interests of Australian healthcare consumers.

CHF works to achieve safe, quality, timely healthcare for all Australians, supported by accessible health information and systems.

CHF does this by:

1. advocating for appropriate and equitable healthcare
2. undertaking consumer-based research and developing a strong consumer knowledge base
3. identifying key issues in safety and quality of health services for consumers
4. raising the health literacy of consumers, health professionals and stakeholders
5. providing a strong national voice for health consumers and supporting consumer participation in health policy and program decision making

CHF values:

- our members' knowledge, experience and involvement
- development of an integrated healthcare system that values the consumer experience
- early intervention, prevention and early diagnosis
- collaborative integrated healthcare
- working in partnership

CHF member organisations reach Australian health consumers across a wide range of health interests and health system experiences. CHF policy is developed through consultation with members, ensuring that CHF maintains a broad, representative, health consumer perspective.

CHF is committed to being an active advocate in the ongoing development of Australian health policy and practice.

Disclaimer: The views and opinions expressed in this journal are those of the authors and do not necessarily reflect the official policy or position of the Consumers Health Forum of Australia.

Health Voices

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Publisher: Consumers Health Forum of Australia Ltd

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ISSN 1835–5862 (Print)
ISSN 1835–8810 (Online)


www.chf.org.au