

Preventative Health Taskforce

Consultations

Dubbo 7 November 2008

Facilitator: Mr Shaun Larkin

Participants

22 Participants attended the Dubbo consultations

- Participants at this session had travelled long distances to attend – eg from Kempsey Tamworth and Walgett.
- Several people expressed disappointment that notice was short for the consultation so many people who would have liked to attend could not. Given the effort many had made to travel, they felt the session was disappointingly short and they had not had enough time to explore each topic thoroughly. For consultations in other rural settings, early notice and a longer timeframe for the session should be considered (and provision of lunch).
- Participants were encouraged to put in submissions to the Taskforce via the web.
- For future consultations it would be good to take extra copies of the discussion document as most people at the consultation had colleagues they felt should read it. In rural areas, access to the web can be limited so hard copy distribution remains an important means of dissemination.

Overview

Mr Shaun Larkin provided a general overview of the work of the Taskforce, referring to the powerpoint presentation.

- Noted that the Taskforce has a three year time frame while other similar groups (eg Primary Care and HHRC) have shorter timeframes.
- Indicated the Strategy therefore could focus on 1, 2 and 5 year segments + measurement, enabling clear outcomes n 2020.
- An opportunity for strong investment in prevention
- Financial markets – will influence capacity to invest – Taskforce will need to take into account Opportunity to set some ‘stretch’ targets
- Best buys for prevention will need to be identified as well as longer term measures.
- Rural and remote issues will be included.

Questions following the overview included:

- A need to focus on implementation rather than rhetoric
- Request for more detailed description of the Taskforce and how they were appointed
- Request for Strategy to be whole of government and cross sectoral
- A need to address all relevant arms of policy

- How much influence does Taskforce in State issues? (outlined connections with COAG and the broad consultation process)
- Advertising standards – a range of players need to be involved. How can the Taskforce influence these players?

Challenge 1

Omissions to the discussion paper and any other/innovative ideas?

OVERWEIGHT AND OBESITY

- Discussion paper provides a good snapshot and direction for the future.

Targets

- Target too broad – keep current one but add a specific second target for a particular age group. Suggested 17 – 25 and improve their knowledge and health – benefit of focus on this age group is that in 12 years they become those who will be responsible for next generation – i.e. transfer good eating/physical activity habits to next generation, improve sustainability of Strategy targets.

Equity

- Highlight equity and social inclusion
- Focus on disadvantaged communities – disadvantaged groups
- As 30% Australians are born overseas (nationally) – close the gap for CALD.
- Increase the capacity of the workforce to assist CALD as part of solution.
- Address isolation (rural and remote especially).
- Address high risk groups – Indigenous groups in particular

Scope

- Whole of country approach
- Need to set in the context of social determinants of health
- Generally know what can be done but need to identify how and who
- Endorse a learning by doing approach – as the evidence base is built
- Good time to introduce change – community and health sector is ready
- Strategy need to be driven from Federal Government down but must have state govt on board too and action (bottom up) from local level
- Introduce a life course approach
- Strengthen reference to infant nutrition – new parents education – early childhood
- Improve education (general education) from beginning of school years (ie consider as an important social determinant of health)
- Sport – needs higher profile in the Strategy

Strategies for action

- Educate people from wide range of areas including food suppliers eg Woolworths, Coles, IGA.
- Endorse and expand ‘confectionary free’ aisles.

- Congratulate food outlets when they do right thing – keep them in the loop.
- Local Government – stop them serving party pies and sausage rolls - educate to supply healthy foods
- Education around healthy food – people don't understand what healthy food is – eg local example – breakfast is scrambled eggsplus automatically a large serve of chips on the side.
- Reduce portion sizes – in food outlets and in retail packaged foods.
- Address children's menus across all types of food outlets – not just fast food outlets but restaurants as well as children's menus are invariably nuggets, sausages etc + chips
- Improve population's ability to budget for healthy foods and to cook especially in areas where fresh food is limited.
- Use new strategies – eg through technology – SMS, mobile phones etc and internet. Young males don't /wont to go to Dr and want to SMS info back and forwards – not a tool Drs commonly use. (NB there is a current trial for young people interacting with GPs and using SMS for regular progress reports for mental health - ?Victoria)
- Are we looking at existing programs that are doing well (nationally) and internationally (and locally)? (Participants invited to email in good examples)
- Walgett (Indigenous community) has some programs established – examples provided (Shaun has these).
- Set up stores like school canteens –use the green, orange and red – offer discount on good stuff. Provide advice on packaging and in store on 'how to cook'.
- Traffic light idea is simple
- Labels – yes for those who can read – traffic lights much simpler for all
- Labelling laws crack down: remove labelling ads.
- Subsidise healthy foods
- Farmers markets
- Regulating the dieting industry
- Introduce health impact statements as well as environmental statements for planning
- Veggie patch – reduced rates, free water.

Settings

- Schools: Pilot a school based program that links with local community and food suppliers. Get buy in from headmaster down – pilot – kids and parents buy in – evaluate.

- Workplace: Strong opportunity for healthy food, physical activity leading to happier workforce – improved productivity – healthier workforce.

- Corporate:– turn weight loss into a goal for business settings.

Infrastructure

- Economic drivers are important – research shows that energy dense food is cheapest – fruit and veg are at other end of spectrum (internationally) so must provide incentives and subsidies to counter this.
- Sometimes we put lots of money into targeted approaches for high risk groups even when we don't know if they work well– move to put this money into universal strategies for best effect.
- Lots of money gets put into small programs – maybe best to target the 'big things' eg environment, supply, price

- Switch money from late interventions (ie not when people are obese) to earlier
- Note the limited and isolated buckets of funds for prevention – eg 12 state plan outcomes in physical activity that cant be adequately covered with existing funds.
- Encourage grants for programs in own areas
- Evidence base – limited around what to do – can cause *inactivity*
- Work on reasonable ideas – don't be afraid
- Increase emphasis on structural change – too much emphasis at present on behavioural change.
- Measure thoroughly – just pre and post testing isn't enough
- Evaluation – for all programs
- Link evaluation /policy to practice
- Expand criteria and incentives (eg practice/service rebates) for allied health workforce
- Improve/introduce incentives for private practitioners in rural contexts for working outside immediate practice in other settings – eg with schools, supermarkets, workplaces etc
- Improve access to the (preventative health) workforce for women in part time capacity (eg those with children) and maximise use of their skills. Many women who would return into the workforce in this capacity.

Messages

- Important to get the messages consistent and measure impact of messages through uptake at local program level.
- Because of limited evidence base, can't agree on causes
- Community is getting different and mixed messages – needs to be addressed so there is consistency in messages nationally.
- Public education and messages – public education should let people know how and why various strategies work for them – eg legislation, price, tax, social marketing etc) not just focus on personal behaviour change.
- Indigenous – Explain through practical ways the laws and being healthy.

Barriers

- Big business wins every time
- Large supermarkets have monopoly on sale of fruit and vegetables.
- Many new apartments are built without kitchens except for microwaves.
- In overcrowded households there are limited facilities for cooking for multiple occupants
- People making decisions at last minute about what to eat (and want to eat immediately)
- In rural areas – easy solution is to take funds to drive through or local takeaway. Drive through +++ profits
- 'Best I can do today' – choice isn't there and money isn't there
- People – especially younger people – don't know how to cook. Skills are no longer being passed on from parents to children.
- 2:5 food message is OK but only works where its well promoted. (example: one client ate five serves of chips a day and said – well its veggies....)
- Decisions on food purchase made mostly at point of sale – so need consistency – across food outlets/across suppliers.
- Loss of family values /family meal times.

- Mental health issues – emotional eating is a growing issue - leads to uneducated or impulsive eating.
- Planning laws – makes refusal (of fast food outlets etc) difficult.
- False advertising – many products say ‘healthy’ for you but are in fact not.
- Economic development officers seek out business – many may seek out business to ‘fill the gap’ but make inappropriate choices in relation to health and wellbeing – educate and guidance is needed.

TOBACCO

Re Questions in Discussion document:

- Take out the ‘if not’ in the discussion document questions –it’s not an either or solution but a ‘do both’ solution

Equity

- If it gets results yes (group generally acknowledged the correlation between price and giving up)
- Focus on price must not detract from maintaining a comprehensive package of strategies
- Price rises may disadvantage the already disadvantaged.
- Could encourage touse the money saved for other things.
- Smoking is a result of addiction – for those who are addicted they will find money to buy cigarettes anyway – wont stop.
- Very difficult for the disadvantaged, especially those with mental health issues, in households where everyone is a smoker, or in correctional facilities.

Strategies for Action

- Agree with those in discussion document
- NRT on PBS for disadvantaged
- NRT available at point of purchase
- Try new drugs – if proven (12 weeks) – only one course free (would need to expand this option)
- Increase and support guidance from health and allied health professionals
- Focus on education and support
- Increase access to QUIT lines and counselling
- Sales to minors – blaming the victim not a good way to go. Improve surveillance and compliance with law, limit place of sale, increase penalties and increase license restrictions/take away licences for recalcitrant retailers.
- Education in primary school – comprehensive programs
- ETS – second hand smoke – in cars especially – enforce nationally

Barriers

- Decisions to smoke made as a child
- Sales between each other (kids) – secondary supply (from retail outlets) less than 10% - most young people buy own or obtain from home and sell on.

Indigenous

- Work with kids – best bet

- Difficult for kids to stay smoke free or to give up when one of 12 in household where everyone smokes
- Pressures mean young indigenous people grow up to smoke early, to drink early, are in the juvenile justice system early and in this setting both behaviours are reinforced because of the peer group.– same as jail – need to alter broader social structure.
- Community role modelling needed to break cycle
- Correctional facilities – difficult area to achieve outcome – need to provide structured programs for staff and inmates and follow through on release – as for substance use. Also need to address the structural issue that cigarettes are currency in jail.
- Sales to minors - businesses in Indigenous communities are working in tight knit local communities –are fearful of being ostracised by rest of family and others in community if they deny kids smokes.

ALCOHOL

Re Discussion Paper

- Support the approach described
- Support priorities

Strategies for Action

- Price on alcopops didn't work – needs to be across the board not just one type of beverage.
- Solutions lie outside health system – essential for industry and other sectors to work together.
- Need much stronger enforcement of current legislation.
- Cultural issue – targets hard to achieve in some population groups.
- Restrict opening hours and density of liquor outlets in known trouble spots.
- Violence – police to look at social consequences.
- Back up by better policing and management/dispersement of groups in public places – (eg management of groups once pubs/clubs close).
- Improve policing in and around clubs.
- Support community driven strategies – alcohol free zones etc
- Support Accords – even if no action - people get together and talk to each other...Discussion is part of community outcomes.

Young People

- Young people get access to Centrelink funding at an early age – leave home – bypass family – make a lot of mistakes.
- In rural towns (eg Dubbo) retaining students in town is a problem– especially in 'gap year'.
- Parental responsibilities – how realistic is this?
- Underage drinking a major issue.
- Children are militant – different and difficult to stop drinking culture.
- Parents buy slabs of beer for end of year parties.....
- Further restrict/improve safe environments for schoolies week.
- Young People – Indigenous example – grow up with the expectation (and role models) that you smoke early, drink early and go to jail (especially young boys).

Need to focus on access to education, sport, other opportunities and breaking the cycle of negative expectation.

Challenge 2

Are there common public health approaches?

What other areas can we learn from?

- This challenge was not given to the group as it had been partially covered under Challenge One and time was short.
- Development of Prevention Agency was generally supported provided it be set up to be broad ranging and not limited to the health sector (ie include attention to all social determinants of health)

Challenge 3

What else should the Taskforce consider (after Obesity, Tobacco and Alcohol) in future development of the Strategy?

General

- Make changes in welfare system to prevent negative impacts especially for young people.
Build health education and good modelling back into education system
- Improve opportunities for sport in school settings and (because of lack of phys ed teachers and time in school curriculum) link school physical activity programs to after school community based supporting and phys ed programs.
- Maintain high level of employment across Australia
Social inclusion – economic development – get it right or else negative impact on health will follow.
- Taskforce and Prevention Strategy should work as one ‘family’ in Australia – ie whole of Government approach not just for Health Minister.

Mental Wellbeing

- Support Mental Health as part of current Strategy and higher focus in ‘next steps’ for Strategy.

Example - Story line from participant - typical profile is:

Young person builds up smoking early, uses cannabis, dependency is welfare driven – know if they can have a ‘label’ they get money – lose family - move to medication – eg antipsychotic drugs – medication increases obesity and lethargy – negative cycle.

- This kind of profile is on the increase.
- High need to reduce stigma associated with mental illness/drug use.
- Vital that mental health is seen across the health system as PART of the whole not separate or outside mainstream health.

Settings

- Target Mental Health services and inpatient facilities
- Target correctional services

Infrastructure

- Improve the link up between risks, systems and outcomes from a population health perspective.