

Preventative Health Taskforce

Consultations

Sydney 26 November (General) 2008

Facilitators: Mr Shaun Larkin and Dr Christine Connors

Thirty three participants attended the Preventative Health Taskforce general stakeholder consultations in Sydney on November 26 2008.

Dr. Connors and Mr Larkin provided participants with an overview of the work of the Taskforce covering role and composition and the work undertaken to date.

Are there omissions in the discussion paper and any other/innovative ideas?

Feedback from groups

- How will we make things happen?
- Do we have money?
- Are we tasked to act?
- Can we look at other issues outside O T A
- Mental illness – multiple needs
- Prevention needs higher focus on those with multiple needs
- Children, early years, abuse
- How does this fit with other whole of Govt initiatives
- Submissions – timing – can it be extended?
- Framework and inclusion of social determinants of health - supported
- Relationships - how are we strengthening between social inclusion and health
- How will coordination take place
- Not a problem to look at whole of Government approach
- Not what you find but how you address it
- Eg comorbidity – disadvantaged areas of health bear brunt of mistakes of the past
- Reviews are often embedded in siloed departments
- Must be whole of government
- Must have community leadership
- Primary health care – empower practice nurses and use them as key access point for patients in primary health care
- Use the right workforce – eg nutritionists

Obesity

- Targets and priorities for action need to be split into children and adults
- Example for children, levels of childhood obesity (UK) have stabilised – so target is to maintain current levels – then start decreasing
- Need to prevent rise in adults
- Continue to collect data on prevalence rates - but don't let it get in the way of action
- Engage communities from outset
- Engage in land – planned use of land

- Some healthy foods can be cheaper but need to know how to prepare
- Need Local government funding to implement community action
- Missing – workplace health
- Be more specific – reshape industry supply – who are we talking about? More detail needed
- Improve maternal and child health – close the gap – detail actions
- High risk groups are important
- It is those who are most at risk that need support and access to make healthy choices
- Interventions need to be demographically targeted
- Funded local level intervention is important
- Ensure genuine community consultation – feasibility decided at community level
- We are starting too far downstream
- Prevention and treatment of obesity use different levels of prevention
- Many are already overweight and obese so different levels of prevention needed
- Interesting grouping – overweight and obesity is an outcome – its nutrition and physical activity that should be addressed.
- National preventive agency should engage all stakeholders in nutrition and physical activity – whole range
- Look to government for national campaigns – food industry would get on board if there was a framework that would show then the way
- Low socio economic groups + all groups across lifespan
- Medicare items – why not one for obesity?
- Prefer the more positive spin of activity and nutrition
- Focus on smaller chunks of work for obesity – (until we know more about what works)
- Requires attention to a broad set of factors (environmental and work related)
- Targets overly optimistic - healthiest country?
- Key players and how to engage them – *fund* partnerships
- Improve consistency and branding of messages
- Promote a message about public nutrition – right through all stakeholders industry, health, education etc
- Introduce a public campaign for healthy nutrition
- Develop a cross sector/cross government framework for consistent messages
- Industry and consumer groups could pick up message
- Build evidence base - NHMRC type of research

Tobacco

- Do all of it (i.e. as described in tobacco paper)
- Difference on topics – tobacco is a damaging product, alcohol and foods are harder to categorise
- Is it about the interventions or the fact that this product is unhealthy?
- Ban the product? (Unlikely that Australia would step outside the global effort and ban)
- How low do you go – before you say ‘we’ve done it’?
- Get to tipping point – invest to get to 9%
- Focus - continue prevention of uptake + stopping smoking
- Need to add in strategies for pregnant women – should add home visiting etc.
- Community nurses talking to pregnant women – motivational interviewing - has results
- Know what to do – how do we shift political will – we know the strategies
- Cigarettes on prescription only

- Provide subsidies to get growers to change product
- More than 1% (as suggested in discussion paper)
- Lets make \$20 pack **now**
- Protect individuals – rather than allow individual rights
- Place significant focus on ETS - Exposure is still high
- Supermarkets breaching legislation/reg – improve enforcement effort
- NRT - subsidise especially for those low socio economic groups, mental illness, drug users
- Increase price and acknowledge disproportional effect on low socio economic groups
- Must therefore add more support measures for these groups
- Uptake and quitting quite separate issues with separate strategies for action. Quitting is not primary prevention (however keep it in – don't exclude)
- Teenagers don't go to GP – not a good vehicle for intervention
- Preventing smoking in movies needs higher profile in Strategy
- Advertising and teenagers needs different approach
- Pregnancy in Indigenous women is not seen as a life changing event – not so easy to change behaviour in this group. (Important group to work with)
- Indigenous smoking - very few programs that are locally and culturally appropriate and that are known to work
- Lot of money goes on campaigns – message is there – may now get better effect through targeted local activity not huge amount of money on national ads
- Where is NSW tobacco tax money going?
- Environments – broaden sites (playgrounds etc)
- School based programs – focus on preventing uptake
- Research into other therapies (NRT) and true replacement
- Priorities need to be explicit

Alcohol

Divide into :

- Personally harmful drinking
- Socially harmful drinking
- Drinking v getting drunk
- There is cultural acceptance of alcohol
- Primary care – not the only stakeholder – local government may be a better sector to work with to get traction
- Action is mostly outside health
- Excessive and above level consumption – 2 aspects, chronic conditions – high level chronic drinking
- And episodic/binge drinking leading to social harms, injury and violence
- Focus on both – separate out.
- Direct health costs less than social costs
- Indigenous people drink less but when do so have more problems – important population group to work with
- Close the Gap – primary health care issue?
- Alcohol programmes target alcoholics not young people
- Parental influence/policing roles important
- Fetal alcohol syndrome –higher focus in Strategy
- Maternal health–important aspect
- Evidence base – where does alcohol sit? What else do we need to know?

- Different population groups – how much do we know?
- Want to know more about underlying causes of binge drinking and binge behaviours, violence and tattoo culture.
- Motivation – what makes us in the top 30 what works in other cultures to reduce levels?
- Do we need to regulate ‘behaviour’?
- Easy availability and access to alcohol is a problem
- Much consumed *away* from licensed premises
- Co located sales with supermarkets – can use bonus points etc – needs to be stopped
- Parents buying for kids – education that this is not OK (or at a minimum that it will not be the only alcohol the young person consumes.
- Price issue - Reduction for lower strength a positive step
- Focus on non-acceptance of inappropriate behaviour and drunkenness
- Role of advertising – association of sport needs targeting
- The current focus is on the tail end of getting hammered – is this where the disease burden lies?
- Or is it lower levels over chronic period of time?
- Volumetric taxing - yes
- Wowser factor - avoid
- Note the adverse role that sporting advertising and sponsorship is playing Inconsistencies around messages - ‘no drinks’ seems unrealistic in real world
- Drinking age – 18 - ? evidence from US for 21
- Hard to justify change from a civil society and rights perspective – ie at 18 are voting, going to war, but not drinking??
- Licensing in US policed much better than Aus – need better enforcement here.
- Reduction in licensing hours and density of outlets - supported
- Govt should bite the bullet on licensing
- Rewarding the good – eg incentives for low alcohol options
- Responsibility of advertising agencies – aimed very much at young: point of age advertising
- Penalties for under age drinking are not enforced
- Number of drinks and 2/4 message is very unclear – who understands it?

Supporting prevention

- Time excluded discussion on this issue. Participants were invited to consider the best leadership and guidance for preventative health in Australia
- To put in a submission outlining responses, and where to head to next.

Close 12md.