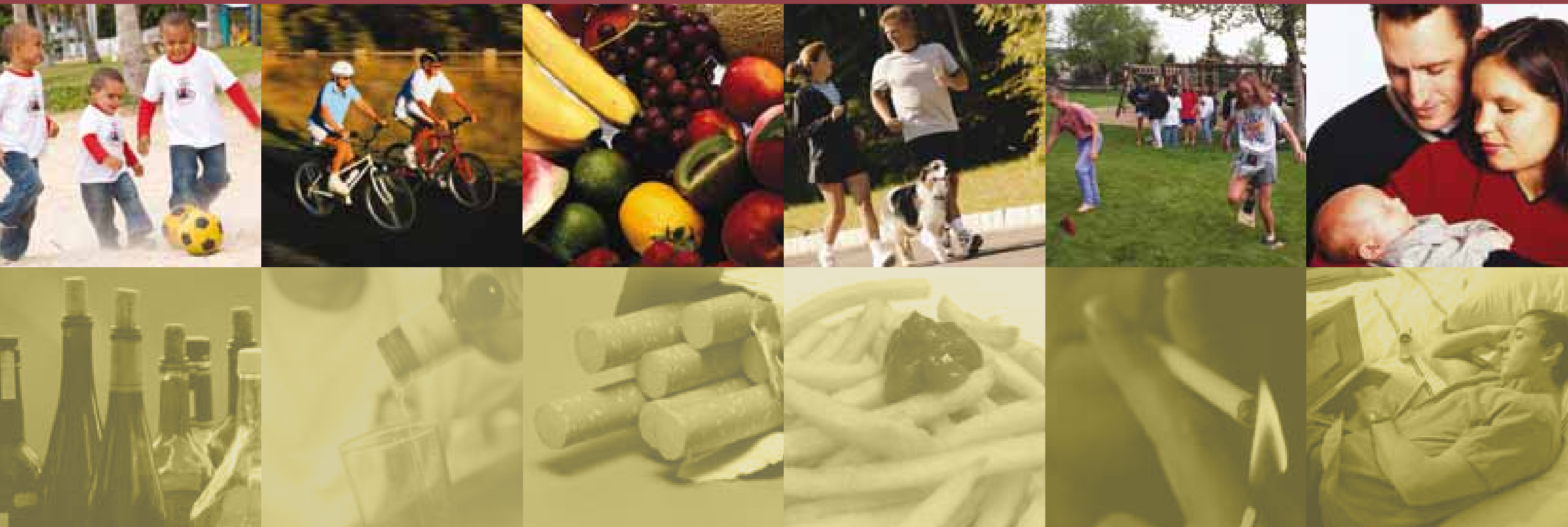
Australian Government

Preventative Health Taskforce

AUSTRALIA: THE HEALTHIEST COUNTRY BY 2020



National Preventative Health Strategy – Overview

30 June 2009

prepared by the National Preventative Health Taskforce

Australia: The Healthiest Country by 2020 – National Preventative Health Strategy – Overview

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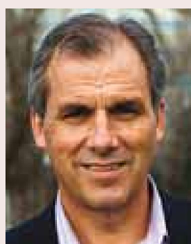
Table of Contents

The Preventative Health Taskforce	**1**
Chair's Foreword	**5**
The purpose of the Strategy	**6**
What is in the Strategy?	**6**
Targets	7
The need for urgent, comprehensive, prioritised and sustained action	**7**
The burdens associated with obesity, tobacco and the harmful use of alcohol	7
What will be different because of the Strategy?	**9**
Prevention works	**10**
Progressive, staged and comprehensive action	**10**
The Strategy – summarised, prioritised and phased	**12**
Obesity	13
Tobacco	17
Alcohol	22
Supporting infrastructure for all phases	25
The conceptual framework for the Preventative Health Strategy	**26**
Influencing markets	26
Inequities in health	26
Developing effective policies	27
Investing for maximum benefit	27
Strategic directions	**28**
1. Shared responsibility – developing strategic partnerships	28
2. Act early and throughout life	29
3. Engage communities	30
4. Influence markets and develop connected and coherent policies	33
5. Reduce inequity through targeting disadvantage	35
6. Indigenous Australians – contribute to 'Close the Gap'	37
7. Refocus primary healthcare towards prevention	39

Ensuring effective implementation – the national infrastructure for prevention	41
Conclusion – a call to action	43
ACTION ON OBESITY: A ROLE FOR ALL AUSTRALIANS	44
ACTION ON TOBACCO: A ROLE FOR ALL AUSTRALIANS	46
ACTION ON ALCOHOL: A ROLE FOR ALL AUSTRALIANS	48
A FOUNDATION FOR PREVENTATIVE HEALTH ACTION IN AUSTRALIA	50
References	52
Acknowledgements	56

Chair's Foreword



The National Preventative Health Taskforce was established in April 2008 and given the challenge to develop the National Preventative Health Strategy, focusing initially on obesity, tobacco and excessive consumption of alcohol. The Strategy is directed at primary prevention, and addresses all relevant arms of policy and all available points of leverage, in both the health and non-health sectors.

The Strategy is the outcome of a great deal of thinking, debate, evidence gathering and consultation across a wide range of Australians, from individuals and local communities to major organisations, corporations, NGOs and governments. This has been accompanied by international experience and evidence, as there are many countries from which we can learn a great deal.

The Taskforce acknowledges the work to date of governments at all levels, of individuals and groups leading community initiatives, of industries that want a healthier Australia, and of researchers and academics who seek to build our knowledge base.

The Taskforce has considered a rapidly growing volume of evidence, as can be witnessed in the Technical Reports and addenda available online at www.preventativehealth.org.au. Opposing and diverse views have been taken into account, and the Strategy is built on the best available evidence and experience. The Taskforce does not presume that it will not be challenged by different interest groups. Where the evidence is still developing or is hotly debated, we seek to learn by doing – to build evidence for future action.

The Taskforce invites your help in making Australia a healthier country. It is keen to hear, and to tell others, of your contribution. An online national forum for organisations, local governments, businesses and industry, community groups, families and individuals will be developed to share your commitments and plans to making Australia healthy.

The Strategy is presented with the direct intention of reaching the goal of Australia being the healthiest nation by 2020, with ambitious targets that respond to the need for urgent, comprehensive and sustained action. We have developed the strategy across three multi-year phases until 2020. Not surprisingly, many of the actions are required in the first four-year phase. The Taskforce appreciates the level of resources and the workload required to successfully implement the Strategy and reach the targets that have been set by the Council of Australian Governments. However, sitting on our hands is not an option.

Rob Moodie

ROB MOODIE
Chair
National Preventative Health Taskforce

Overview

The purpose of the Strategy

The Strategy is needed to prevent hundreds of thousands of Australians dying prematurely, or falling ill and suffering, between now and 2020. It is needed to minimise the impending overload of the health and hospital systems, and to increase the productivity, and therefore the competitiveness, of Australia's workforce. It will assist in avoiding the health and social costs that would otherwise be incurred if we do little or nothing.

We need this Strategy because Australia has a national commitment to fairness. Currently, good and bad health is unevenly distributed – there is a social gradient, which means that those Australians with less money, less education and insecure working conditions are much more likely to get sick and die earlier. This inequity is extremely acute for Indigenous Australians.

This Strategy is important. It seeks to do. It is evidence-based, or where the evidence is yet to be developed, it is evidence-building. It seeks to constructively influence markets, develop and implement effective policies, enhance national preventative health infrastructure, and overcome the limited implementation of past and existing national strategies.

What is in the Strategy?

The Strategy is for all Australians, not just governments. It is presented as a comprehensive approach with seven strategic directions:

1. **Shared responsibility - developing strategic partnerships** – at all levels of government, industry, business, unions, the non-government sector, research institutions and communities
2. **Act early and throughout life** – working with individuals, families and communities
3. **Engage communities** – act and engage with people where they live, work and play; at home, in schools, workplaces and the community. Inform, enable and support people to make healthy choices
4. **Influence markets and develop coherent policies** – for example, through taxation, responsive regulation, and through coherent and connected policies
5. **Reduce inequity** through targeting disadvantage – especially low socioeconomic status (SES) population groups
6. **Indigenous Australians** – contribute to 'Close the Gap'
7. **Refocus primary healthcare towards prevention**

Each of these strategic directions requires strong infrastructure to support action, coordinated and driven via the National Prevention Agency working with a range of national, state and local partners.

These directions are reflected in each of the strategies for obesity, tobacco and alcohol, complemented by the support of national preventative health infrastructure. (See ***The Strategy - summarised, prioritised and phased*** later in this Overview for a summary of the key actions, prioritised over time).

TARGETS

The Strategy sets a number of ambitious targets:

- Halt and reverse the rise in overweight and obesity
- Reduce the prevalence of daily smoking to 10% or less
- Reduce the proportion of Australians who drink at short-term risky/high-risk levels to 14%, and the proportion of Australians who drink at long-term risky/high-risk levels to 7%
- Contribute to the 'Close the Gap' target for Indigenous people, reducing the life expectancy gap between Indigenous and non-Indigenous people

These targets have been aligned with a further set of interim targets set by the Council of Australian Governments (COAG).

The need for urgent, comprehensive, prioritised and sustained action

In assessing the urgent reasons for action, the formidable current and predicted personal, financial and service burdens arising from obesity, tobacco and the harmful use of alcohol are presented.

THE BURDENS ASSOCIATED WITH OBESITY, TOBACCO AND THE HARMFUL USE OF ALCOHOL

Obesity, tobacco and alcohol feature in the top seven preventable risk factors that influence the burden of disease, with over 7% of the total burden being attributed to each of obesity and smoking, and more than 3% attributed to the harmful effects of alcohol. Along with a range of other risk factors, and accounting for their interactions, approximately 32% of Australia's total burden of disease can be attributed to modifiable risk factors.(1)

The prevalence of overweight and obesity in Australia has been steadily increasing over the past 30 years. In only 15 years, from 1990 to 2005, the number of overweight and obese Australian adults increased by 2.8 million.(2)

Recent national data on the prevalence of overweight and obesity among children, available from the National Children's Nutrition and Physical Activity Survey 2007, indicated 17% of 2–16-year-olds were overweight and 6% obese.(3)

Further examination by the National Heart Foundation(4) of this survey data compared with data from previous studies clearly shows a disturbing upward trend in overweight and obesity rates in children over the last 20 years. Figure 1 shows the prevalence of overweight and obesity in Australian children aged 7–15 years in 1985, 1995 and 2007. As illustrated, the prevalence in overweight and obesity in boys in this age group has risen from 11% in 1985 to 20% in 1995 and almost 24% in 2007. For girls in the same age group the prevalence of overweight and obesity has increased from 12% in 1985 to 21% in 1995 to almost 27% in 2007.

Figure 1:

Prevalence of overweight and obesity in Australian children aged 7–15 years, 1985–2007

* Data weighted for age, gender and region.

Source: Roberts L, Letcher T, Gason A et al. 2009(4)

Recent trends predict that the life expectancy for Australian children alive today will fall two years by the time they are 20 years old, representing life expectancy levels seen for males in 2001 and for females in 1997.(5)

It is unacceptable that we as a nation are leaving this legacy to our children and grandchildren.

If these health threats are left unchecked, our health systems will find it increasingly difficult to cope. For example:

- The expected growth in the prevalence of obesity is the major reason for projections that, by 2023, type 2 diabetes will become the leading cause of disease burden for males and the second leading cause for females. If this occurs, annual healthcare costs for type 2 diabetes will increase from $1.3 billion in 2002/03 to $8 billion by 2032.(6)
- Around half of the 2.9 million Australian adults who currently smoke on a daily basis and who continue to smoke for a prolonged period will die early; half will die in middle age.(7) Smoking-related illness costs up to $5.7 billion per year in lost productivity.(8)
- In 2004–05 the harmful consumption of alcohol resulted in huge costs to the community. They include costs attributable to crime ($1.6 billion), health effects ($1.9 billion), productivity loss in the workplace ($3.5 billion), loss of productivity in the home ($1.5 billion) and road trauma ($2.2 billion).(8)

In total, the overall cost to the healthcare system associated with these three risk factors is in the order of almost $6 billion per year, while lost productivity is estimated to be almost $13 billion.(9, 10)

Our focus on obesity, tobacco and alcohol is also due to other important factors:

- Indigenous Australians suffer a starkly lower life expectancy than non-Indigenous Australians. The burden of disease attributable to obesity, tobacco and the harmful consumption of alcohol makes up a significant part of this gap.
- A large part of the differences in health status between advantaged and disadvantaged Australians, and between city dwellers and rural and remote Australians, can be attributed to obesity, tobacco and alcohol.
- The need to intervene early is becoming more evident as we better understand the relationship between growth and development during foetal and infant life, and health in later years. Poor nutrition, cigarette smoking and alcohol use during pregnancy can result in long-term adverse health effects. Early life events play a powerful role in influencing later susceptibility to chronic conditions such as obesity, cardiovascular disease and type 2 diabetes, as well as a range of negative social and economic outcomes.

New knowledge is constantly coming to light in each of these areas, and many new studies have emerged since the Taskforce's Discussion Paper was released in October 2008:

- A 2009 Organisation for Economic Co-operation and Development (OECD) report predicts that there will be continued significant rises in overweight and obesity levels over the next decade in Australia across all age groups to around two-thirds of the population.(11)
- Recent studies show that tax on tobacco is highly supported and likely to disproportionately benefit lower SES smokers.(12)

- Three major reviews just published have shown that:
  - Alcohol advertising and promotion increases the likelihood that adolescents will start to use alcohol, and to drink more if they are already using alcohol.(13)
  - There is a causal link between exposure to alcohol commercials and role models on acute alcohol consumption.(14)
  - Among young people who had previously not drunk alcohol, ownership of alcohol branded merchandise is independently associated with susceptibility to, and initiation of, drinking and binge drinking.(15)
- An Australian study published in 2009 has questioned whether there is in fact any safe level of alcohol use for those aged under 18.(16)

What will be different because of the Strategy?

If we implement the tobacco strategy, approximately one million fewer Australians will smoke, and the premature deaths of almost 300,000 Australians now living will be prevented between now and 2020 from just the four main diseases caused by smoking.(50) We will also see significant decreases in Indigenous smoking.

If we reach the targets for alcohol, the proportion of Australians who drink at short-term risky/high-risk levels will drop from 20% to 14%, and the proportion of Australians who drink at long-term risky/high-risk levels will drop from 10% to 7%. This will prevent the premature deaths of over 7200 Australians and prevent some 94,000 fewer person-years of life being lost. The impact on morbidity would approximate to 330,000 fewer hospitalisations and 1.5 million fewer bed days at a cost saving of nearly $2 billion to the national health sector by 2020.(17)

If current upward trends in overweight and obesity continue, there will be approximately 1.75 million deaths at ages 20+ years and 10.3 million years of life lost at ages 20–74 years caused by overweight and obesity in Australia from 2011 to 2050.(18) Each Australian aged 20–74 years who dies from obesity between 2011 and 2050 will lose, on average, 12 years of life before the age of 75 years. If we just stabilise obesity at current levels, we can prevent the premature death of a half a million people between now and 2050.(18)

A new national capacity will be developed. This begins with the capacity to effectively monitor, evaluate and build evidence. The COAG National Prevention Partnership has already committed to a National Prevention Agency (NPA), which will facilitate a national prevention research infrastructure to answer the fundamental research questions about what works best.

The NPA will also provide resources and advice for national, state and local policies, generate new partnerships for workplace, community and school interventions, assist in the development of the prevention workforce, and coordinate and implement a national approach to social marketing.

Prevention works

Well-planned prevention programs have made enormous contributions to improving the quality and duration of our lives. The public health revolutions of the 19th century led the way, and in recent years we have seen major improvements in areas such as tobacco control, road trauma and drink driving, skin cancers, immunisation, cardiovascular disease, childhood infectious diseases, Sudden Infant Death Syndrome (SIDS) and HIV/AIDS control.

In the 1950s three-quarters of Australian men smoked. Now less than one-fifth of men smoke (see Figure 2). As a result, deaths in men from lung cancer and obstructive lung disease have plummeted from peak levels seen in the 1970s and 1980s.(1)

Deaths from cardiovascular disease have decreased dramatically from all-time highs in the late 1960s and early 1970s to today.

Road trauma deaths on Australian roads have dropped 80% since 1970 (see Figure 3), with death rates in 2005 being similar to those in the early 1920s.(1)

Australia's commitment to improving immunisation levels has resulted in much higher immunisation coverage rates, eliminating measles and seeing a drop of nearly 90% in sero-group C meningococcal cases in only four years. These have come about as a result of a 34-fold increase in funding over the last 15 years.

Deaths from SIDS have declined by almost three-quarters, dropping from an average of 195.6 per 100,000 live births between 1980 and 1990 to an average of 51.7 per 100,000 live births between 1997 and 2002.(1, 19)

A study commissioned by the Department of Health and Ageing in 2003 shows spectacular, long-term returns on investment and cost savings from prevention – in tobacco control programs, road safety programs and programs preventing cardiovascular diseases, measles and HIV/AIDS.(20) For example, this report estimated that the 30% decline in smoking between 1975 and 1995 had prevented over 400,000 premature deaths,(21) and saved costs of over $8.4 billion – more than 50 times greater than the amount spent on anti-smoking campaigns over that period.(20, 21)

Internationally, a 2008 study, Prevention for a Healthier America, shows that for every US$1 invested in proven community-based disease prevention programs (increasing physical activity, improving nutrition and reducing smoking levels), the return on investment over and above the cost of the program would be US$5.60 within five years.(22)

Progressive, staged and comprehensive action

The Strategy spells out key action areas in the individual obesity, tobacco and alcohol strategies. Some of these actions require new human and financial resources, some of them require enhanced regulation or legislation, while others require further evidence for progress. Many need to be scaled up at sufficient intensity, scope and duration to have a tangible effect.

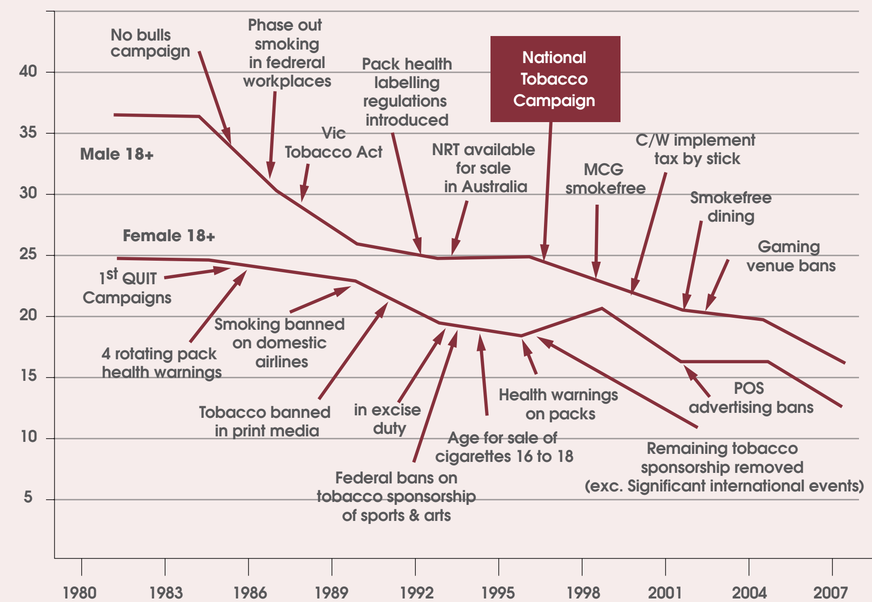
Many of the actions in the Strategy have been agreed upon previously in national strategies such as Acting on Australia's Weight, the National Alcohol Strategy 2006–2009, the National Tobacco Strategy 2004–2009 and the 1999 Wills Review of Health and Medical Research, but are yet to be fully implemented or, in some cases, implemented at all.

We have therefore designed the Strategy to focus on ***implementation***, ***measurement*** and ***accountability*** – a cyclical approach of '*do, measure, report – do, measure, report*'.

Not all approaches can or should be introduced simultaneously. In examining the Australian experience in tobacco control (Figure 2) and road trauma reduction (Figure 3), for example, it is clear that progressive, staged and comprehensive actions have been the hallmark of success.

Figure 2:

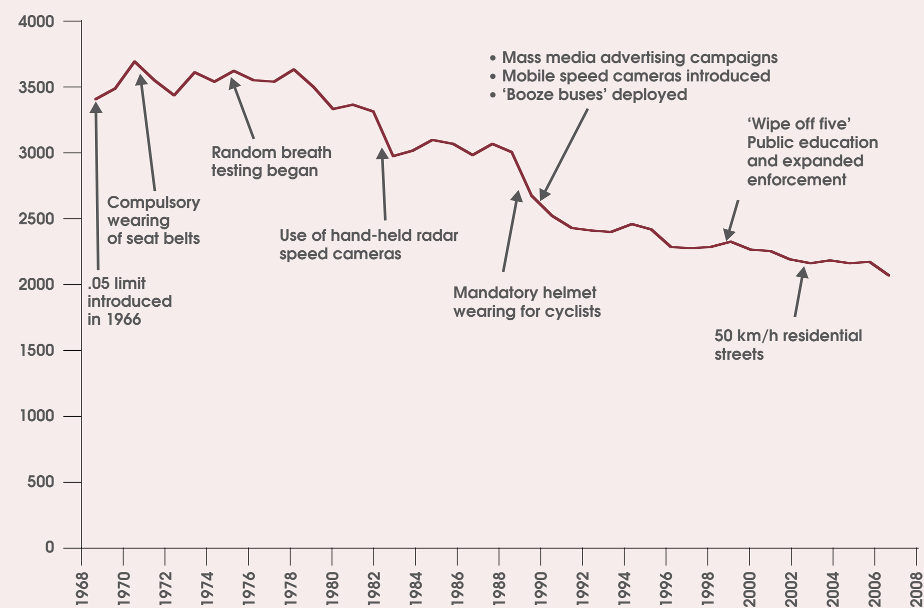
Milestones in reducing smoking in Australia 1980–2007



Source: The Cancer Council of Victoria 2009

Figure 3:

Road fatalities in Australia 1968–2008



Source: Transport Accident Commission 2009

The Strategy – summarised, prioritised and phased

What follows is a presentation of the most important actions in each of the areas of obesity, tobacco and alcohol. Detailed implementation plans for obesity, tobacco and alcohol describing a full set of actions, responsibilities, phasing and measures are set out in the Strategy document.

The actions are ***phased*** and sequenced over time, as it will not be possible or appropriate to initiate all actions in phase one. Phasing is also needed if evidence of effective interventions is lacking. For example, large community-based obesity prevention trials, underpinned by expert research and evaluation, are needed before they can be applied nationwide.

For areas such as regulation of food advertising to children or alcohol promotion and sponsorship, an approach using responsive regulation is required. This begins with the most persuasive self-regulatory approaches, and escalates to enforced legislation if the voluntary forms are unsuccessful.

The first phase sets in place the urgent priority actions. The second phase builds on these actions, learning from new research, the experiences of program implementation and the national trials carried out in the first phase. The third phase ensures long-term and sustained action, again based on learnings from the first two phases.

As a means to encouraging and supporting action across Australia the Taskforce proposes the establishment of an online national forum for organisations, local governments, businesses and industry, community groups, families and individuals to share their commitments and plans to making Australia the healthiest country.

This will be complemented by the development of a national recognition and award scheme for outstanding contributions, large and small, to making Australia the healthiest country by 2020.

OBESITY

First phase (2010–2013)

1. Drive environmental changes throughout the community to increase levels of physical activity and reduce sedentary behaviour

- Establish a Prime Minister's Council for Active Living and develop and implement a National Framework for Active Living encompassing local government, urban planning, building industry and developers, designers, health, transport, sport and active recreation
- Develop a business case for a new COAG National Partnership Agreement on Active Living
- Conduct research on economic barriers and enablers, policies and tax incentives to inform a national active living framework and actions

2. Drive change within the food supply to increase the availability and demand for healthier food products, and decrease the availability and demand for unhealthy food products

- Develop and implement a comprehensive National Food and Nutrition Framework
- Commission a review of economic policies and taxation systems, and develop methods for using taxation, grants, pricing, incentives and/or subsidies to promote production, access to and consumption of healthier foods
- Establish a Healthy Food Compact between governments, industry and non-government to drive change within food supply; develop voluntary targets
- Work with industry, health and consumer groups to introduce food labelling on front of pack and menus to support healthier food choices with easy to understand information on energy, sugar, fat, saturated fats, salt and trans fats, and a standard serve/portion size within three years.

3. Embed physical activity and healthy eating in everyday life

Fund, implement and promote comprehensive programs for workplaces that support healthy eating, promote physical activity and reduce sedentary behaviour.

Workplaces

- Develop a national accord to establish best practice workplace programs, including: protecting privacy of employees, workplace risk monitoring, risk assessment or risk modification programs
- Establish a voluntary industry scorecard, benchmarking and award scheme for workplace health
- Establish nationally agreed accreditation standards for providers of workplace health programs
- Establish a national action research project to strengthen evidence of effective workplace health promotion programs in the Australian context
- Establish a national workplace health leadership program and a series of resources, tools and best practice guidelines

- Commission a review of potential legislative changes to promote take-up of workplace health programs
- Investigate the feasibility of rewarding employers – through grants or tax incentives – for achieving and sustaining benchmark risk factor profiles in their workforce

Schools

Fund, implement and promote school programs that encourage physical activity and enable healthy eating.

- Incorporate Health and Physical Education (HPE) for all Australian children into the second stage of National Curriculum development
- Australian and state governments to establish a national program to support implementation of the new curriculum, including teacher curriculum guidance and professional development opportunities
- Expand the coverage of out-of-school care health programs such as *Active After School, Eat Smart, Play Smart*

Communities

- Establish, as part of the COAG Healthy Communities initiative, a national series of comprehensive five-year intervention trials in 10 to 12 communities (including low SES and Indigenous communities)
- Establish partnerships with the Australian Local Government Association (ALGA) to develop programs that support and encourage local councils to adopt *Healthy Spaces and Places* planning guidelines
- Develop, pilot and implement a new *Healthy and Active Families* initiative

4. Encourage people to improve their levels of physical activity and healthy eating through comprehensive and effective social marketing

- Develop and work with Australian, state and territory governments to implement a comprehensive, sustained social marketing strategy to increase healthy eating and physical activity, and reduce sedentary behaviour
- Choose messages most likely to reduce prevalence in socially disadvantaged groups and provide extra reach to these groups

5. Reduce exposure of children and others to marketing, advertising, promotion and sponsorship of energy-dense nutrient-poor foods and beverages

Phase out the marketing of energy-dense nutrient-poor (EDNP) food and beverage products before 9 p.m. on free-to-air and Pay TV, and phase out premium offers, toys, competitions and the use of promotional characters, including celebrities and cartoon characters, used to market EDNP food and beverages to children within four years by:

- Developing and adopting an appropriate set of definitions and criteria for determining EDNP food and beverages
- Monitoring and evaluating the impact of voluntary self-regulation in reducing children's exposure to unhealthy food advertising

- Identifying any shortfalls with the current voluntary approach, and addressing this through the introduction of a co-regulatory agreement; monitor, evaluate and report on effectiveness of co-regulation
- Introduce legislation within four years if these measures are not demonstrated to be effective

6. Strengthen, skill and support primary healthcare and public health workforce to support people in making healthy choices

- Expand relevant allied health workforce
- Improve access to services that provide physical activity, weight loss and healthy nutritional advice and support

7. Address maternal and child health, enhancing early life and growth patterns

- Establish and implement a national program to alert and support pregnant women and those planning pregnancy to prevent lifestyle risks of excessive weight, poor nutrition, smoking and alcohol consumption

8. Support low-income communities to improve their levels of physical activity and healthy eating

- Fund, implement and promote effective and relevant strategies and programs to address specific issues experienced by people in low-income communities
- Specific actions are also referred to in key action areas 3 and 4

9. Reduce obesity prevalence and burden among Indigenous Australians

- Fund, implement and promote multi-component community-based programs in Indigenous communities
- Strengthen antenatal, maternal and child health systems for Indigenous communities

10. Build the evidence base, monitor and evaluate the effectiveness of actions

- Carry out a National Risk Factor Survey in 2010
- Repeat the National Children's Nutrition and Physical Activity Survey in 2012
- NPA to work with national research agencies to establish a National Research Agenda for obesity
- Support ongoing research on effective strategies to address social determinants of obesity in Indigenous communities.

Second phase (2014–2017)

- Implement National Framework for Active Living, encompassing local government, urban planning, building industry, developers and designers, health, transport, sport and active recreation
- Use the Healthy Food Compact to continue to drive improvements within the food supply
- Implement measures agreed to under the Healthy Food Compact

Schools

- National implementation of HPE curriculum for all Australian children as part of second stage of National Curriculum development

Workplaces

- Learn from best practice and promote effective workplace health promotion programs throughout Australia
- Implement recommendations of the review of potential legislative changes to promote take-up of workplace health programs
- Implement *Healthy Spaces and Places* planning guidelines through partnership with ALGA
- Implement new phases of comprehensive, sustained social marketing strategy to increase healthy eating and physical activity
- Continue to phase out food and beverage marketing to which children are exposed, if self-regulation and co-regulation are demonstrated to be ineffective

Third phase (2018–2020)

- Monitor and report on progress with the implementation of the National Framework for Active Living
- Monitor and report on progress with the implementation of measures agreed to under the Healthy Food Compact
- Scale up school and workplace programs
- Scale up community interventions across Australia according to results of national trials
- Report on progress with the social marketing strategy to increase healthy eating and physical activity, and develop new phases as required

TOBACCO

First phase (2010–2013)

1. Make tobacco products significantly more expensive

- Ensure that the average price of a packet of 30 cigarettes is at least $20 (in 2008 $ terms) within three years
- Contribute to developing and implementing international agreements and a national strategy to combat the illicit trade of tobacco

2. Increase the frequency, reach and intensity of social marketing campaigns

- Develop and implement effective and sustained national social marketing campaigns through COAG tobacco initiative and coordinated by NPA
- Design messages and place media to ensure reach with young smokers and socially disadvantaged groups

3. End all remaining forms of advertising and promotion of tobacco products

- Legislate to eliminate all remaining forms of tobacco promotion, including, as feasible, through new and emerging forms of media
- Amend legislation nationally and in all states and territories to ensure that tobacco is out-of-sight in retail outlets
- Eliminate the promotion of tobacco products through design of packaging
  - Amend *Tobacco Advertising Prohibition Act 1992* to require that no tobacco product may be sold except in packaging of a shape, size, material and colour prescribed by government
  - Amend *Trade Practices CPIS (Tobacco) Regulations 2004* to specify exact requirements for plain packaging

4. Eliminate exposure to second-hand smoke in public places

- Amend current legislation to:
  - Ensure smoking is prohibited in any public places where children are likely to be exposed
  - Ensure children are not exposed to tobacco smoke when travelling in cars
  - Protect against exposure to second-hand smoke in workplaces, including outdoor areas

5. Regulate manufacturing and further regulate packaging and supply of tobacco products

- Improve consumer information related to tobacco products
  - Mandate standard plain packaging of all tobacco products to ensure that design features of the pack in no way reduce the prominence or impact of prescribed government warnings
  - Automatically review and upgrade warnings on tobacco packages at least every three years, with the Chief Medical Officer to have the capacity to require amendments and issue additional warnings of new and emerging risks in between
- Tighten and enforce legislation to eliminate sales to minors and any form of promotion at retail level
- Give government power to regulate design, contents and maximum emissions for tobacco and related products, and establish a regulatory body with responsibility for specifying required disclosure to government, labelling and any other communication to consumers
- Investigate the feasibility of legal action by governments and others against tobacco companies

6. Ensure all smokers in contact with health services are encouraged and supported to quit, especially pregnant women and their partners, and people living with chronic disease

- Ensure all state- or territory-funded healthcare services (general, maternity and psychiatric) are smoke-free, protecting staff, patients and visitors from exposure to second-hand smoke both indoors and on facility grounds
- Increase availability of Quitline services, and ensure that Quitlines are resourced to respond to projected demand from media campaigns
- Ensure that nicotine replacement therapy (NRT) is affordable for all those for whom it is clinically appropriate

7. Work in partnership with Indigenous groups to boost efforts to reduce smoking and exposure to tobacco among Indigenous Australians

- Establish multi-component community-based tobacco control projects that are locally developed and delivered
- Enhance social marketing campaigns for Indigenous smokers ensuring a 'twin track' approach of using existing effective mainstream campaigns complemented by Indigenous-specific campaign elements
- Provide training to Aboriginal and Torres Strait Islander health workers to improve skills in the provision of smoking cessation advice and in developing community-based tobacco control programs
- Place specialist Tobacco Control Workers in Indigenous community health organisations to build capacity at the local health service level to develop and deliver tobacco control activities

8. Boost efforts to discourage smoking among people in other highly disadvantaged groups

- Target surveillance and enforcement of sales-to-minors legislation in disadvantaged areas
- Target promotion aimed at encouraging GPs and other health professionals located in disadvantaged areas to refer to Quitlines
- Place the majority of any poster/outdoor or mobile advertising in highly disadvantaged neighbourhoods
- Increase efforts to discourage smoking among people living with, or at risk of, mental illness and mental health disorders
- Ensure all state-funded human services agencies and correctional facilities (adult and juvenile) are smoke-free and provide appropriate cessation supports

9. Assist parents and educators to discourage tobacco use and protect young people from second-hand smoke

- Convey the message that parents can help – by quitting smoking; by making their homes smoke-free; by choosing appropriate films, videos and games; and by making it clear that they do not want their children to smoke for the sake of their health.
- Make smoking a classifiable element in movies and videos

10. Ensure that the public, media, politicians and other opinion leaders remain aware of the need for sustained and vigorous action to discourage tobacco use

- Ensure that the public is constantly alerted to information about tobacco and its impact arising from new research findings

11. Ensure implementation and measure progress against and towards targets

- Establish a National Tobacco Strategy Steering Committee
- Address the current gaps in the developed surveillance system on tobacco to enable governments to assess whether adequate progress is being made to ensure that targets will be met

Second phase (2014–2018) and third phase (2018–2020)

Work in the second and third phase will include a continuing strong focus on population measures to discourage smoking, together with increasing emphasis on programs and services for disadvantaged groups and continuing smokers who have been unable to quit.

Taxation

- Further increase price of cigarettes to keep pace with international best practice
- Implement and enforce measures to prevent increases in illicit trade

Social marketing

- Continue social marketing campaigns, including in new forms of media and with increasing focus on disadvantaged groups

Legislation

- Enforce and introduce legislative changes to restrict promotion of tobacco products
- Enforce and if necessary tighten legislation that protects against exposure to second-hand smoke in public places
- Restrict the number and type of outlets from which tobacco products may be sold
- Refine systems to warn consumers of new and emerging health risks associated with smoking; refine requirements for disclosure to government and consumers about constituents of tobacco products
- Refine legislative requirements concerning product constituents, design and emissions in line with international research and practice

Health system and program implementation

- Continue to subsidise cost-effective treatments for smoking cessation
- Expand delivery modes for Quitline services
- Improve advice to smokers (provided by Quitlines and health professionals and in educational materials) based on research and smoking trends
- Expand and strengthen programs to ensure that health professionals are trained, prompted, supported and remunerated to consistently identify and encourage and support smokers to quit
- Assess the effectiveness of approaches to reduce young people's exposures to smoking in movies

Interventions for disadvantaged groups

- Assess effectiveness of approaches with Indigenous communities; review and refine strategies as required
- Expand programs for people living with mental illness, including those in institutional care, clients of out-patient and community-based services, and people with mental health problems who are not in contact with health systems
- Expand programs to prevent uptake and encourage cessation of smoking in low SES neighbourhoods

International development

- Continue to assist in developing guidelines to help countries to comply with the Framework Convention on Tobacco Control (FCTC) and advise and assist neighbouring countries in the Asia-Pacific region
- Promote tobacco control through overseas aid programs

ALCOHOL

First phase (2010–2013)

1. Improve the safety of people who drink and those around them

- States and territories to harmonise liquor control regulations, by developing and implementing best practice nationally consistent approaches to the policing and enforcement of liquor control laws
- Increase available resources to develop and implement best practice for policing and enforcement of liquor control laws and regulations
- Develop the business case for a new COAG national partnership agreement on policing and enforcement of liquor control laws and regulations

2. Increase public awareness and reshape attitudes to promote a safer drinking culture in Australia

- Develop and implement a comprehensive and sustained social marketing and public education strategy at levels likely to have significant impact, building on the *National Binge Drinking Campaign* and state campaigns

3. Regulate alcohol promotions

- In a staged approach, phase out alcohol promotions from times and placements which have high exposure to young people aged up to 25 years, including:
  - Advertising during live sport broadcasts
  - Advertising during high adolescent/child viewing
  - Sponsorship of sport and cultural events
- Monitor and evaluate the effectiveness of the voluntary approach to alcohol promotions agreed by the Ministerial Council on Drug Strategy (MCDS) in April 2009
- Introduce independent regulation through legislation if the co-regulatory approaches are not effective in phasing out alcohol promotions from times and placements which have high exposure to young people up to 25 years

4. Reform alcohol taxation and pricing arrangements to discourage harmful drinking

- Commission independent modelling under the auspices of Health, Treasury and an industry panel for a rationalised tax and excise regime for alcohol that discourages harmful consumption and promotes safer consumption
- Develop the public interest case for minimum (floor) price of alcohol to discourage harmful consumption and promote safe consumption
- Direct a proportion of revenue from alcohol taxation towards initiatives that prevent alcohol-related societal harm

5. Improve the health of Indigenous Australians

- Increase access to health services for Indigenous people who are drinking at harmful levels
- Support local initiatives in Indigenous communities
- Establish and fund a multi-site trial of alcohol diversion programs

6. Strengthen, skill and support primary healthcare to help people in making healthy choices

- Enhance the role of primary healthcare organisations in preventing and responding to alcohol-related health problems
- Develop a more comprehensive network of alcohol-related referral services and programs to support behaviour change in primary healthcare
- Increase access to primary healthcare services and improve health outcomes for hard-to-reach disadvantaged individuals who are at risk of alcohol-related health problems

7. Build healthy children and families

- Protect the health and safety of children and adolescent brain development by:
  - Developing nationally consistent principles and practices regarding the supply of alcohol to minors without parental/guardian consent
  - Promoting informed community discussion about the appropriate age for young people to begin drinking
- Support parents in managing alcohol issues at all stages of their children's development through community-level approaches

8. Strengthen the evidence base

- NPA to develop a system for nationally consistent collection and management of alcohol wholesale sales data to inform key alcohol policy developments and evaluations
- NPA to define a set of essential national indicators on alcohol consumption and health and social impacts

Second phase (2014–2017)

- Monitor implementation of approaches to the policing and enforcement of liquor control laws
- Implement and monitor performance-based national partnership agreement on policing and enforcement
- Monitor and evaluate first phase of social marketing strategy
- Develop and implement new phase of comprehensive, sustained social marketing strategy
- Continue phase out of alcohol promotions from times and placements which have high exposure to young people aged up to 25 years
- Introduce new pricing regime, including minimum price, based on work completed in the first phase
- Monitor and evaluate impact of new pricing regime
- Monitor and evaluate access to health services for Indigenous Australians and generation of new local initiatives
- Expand and scale up successful local initiatives for Indigenous Australians
- Monitor and evaluate role of primary healthcare organisations in dealing with alcohol-related health problems
- Report on progress in building alcohol referral services and programs, and increase in access to disadvantaged groups
- Monitor age and initiation of drinking alcohol
- Review progress in support to parents in managing teenage drinking behaviours
- Improve utilisation of key data sets on the harm to drinkers and harm to others
- Expand the collection of patterns of drinking data to include place of drinking, duration of drinking occasion, and reasons for drinking

Third phase (2018–2020)

- Evaluate outcomes of national partnership agreement on policing and enforcement
- Develop new approaches to policing and enforcement of liquor control laws, based on evaluated outcomes
- Monitor and evaluate second phase of social marketing strategy
- Monitor and evaluate effectiveness of legislative approaches if implemented
- Identify any additional measures required to address alcohol promotion across other media sources
- Refine new pricing regime, including minimum price, based on work completed in the first and second phases
- Evaluate progress in increasing access to health services and growth in quality and scale of local initiatives during first two phases
- Refine and redevelop primary healthcare systems for prevention and treatment of alcohol-related health problems
- Implement new approaches to protect children and adolescents from alcohol-related harm based on experience from phases one and two

SUPPORTING INFRASTRUCTURE FOR ALL PHASES

The establishment of the National Prevention Agency (NPA)

Establish the NPA as an independent agency able to translate broad policy intent into evidence-based strategies with built-in evaluation and the capacity to leverage a range of policy levers and partners

- Appoint an expert, cross-sectoral Board of Governance of the Agency
- The Taskforce recommends that the NPA:
  - Provides a national clearing house for the monitoring and evaluation of national policies and programs in preventative health
  - Publishes annual reports on the state of preventative health
  - Advises COAG, through the Australian Health Ministers Conference (AHMC), on national priorities and options for preventative health
  - Administers national programs, facilitates national partnerships and advises on national infrastructure for surveillance, monitoring, research and evaluation, as charged by AHMC
  - Develops for consideration by AHMC the next phase of preventative health reform to follow after this Strategy
  - Has a greater capacity and budget than that currently envisaged in the COAG agreement on preventive health
- NPA to develop a web-based clearing house/register for organisational policies, plans and achievements in order to share good practice across the country
- NPA to commission/conduct surveys of activities undertaken by different sectors, and the barriers to and enablers of action, and to report on these
- Develop a national recognition and award scheme for outstanding contributions, large and small, to making Australia the healthiest country by 2020

Social marketing

- NPA to develop and implement sustained social marketing strategies to:
  - Increase healthy eating and physical activity, and reduce sedentary behaviour
  - Reduce smoking, drawing on successful state campaigns as appropriate
  - Reduce harmful drinking

Data, surveillance and monitoring

- Implement and extend the National Health Risk Survey Program, funded under the COAG Agreement on Preventive Health
- Establish comprehensive national surveillance systems for obesity, tobacco and alcohol

National research infrastructure

- Establish a National Strategic Framework for preventative health research, a preventative health strategic research fund, and a national preventative health research register
- Develop a network of prevention research centres, which would partner with community interventions in the region they serve, and collaborate with NGOs and others in specialty areas (for example, obesity, tobacco or alcohol, school settings or disadvantaged populations)

NPA to foster leadership, mentoring and knowledge sharing across the prevention research centres, including hosting an annual symposium to share research findings, methods and ideas

Workforce development

- NPA to oversee as a matter of priority a national audit of the prevention workforce outlined in the 2008–09 COAG Agreement on Preventive Health; strategy arising from the audit to be brought to AHMC for implementation
- Ensure prevention becomes an important part of the work of the Health Workforce Australia Agency

Future funding models for prevention

- NPA to investigate and provide advice in regard to the potential development of a funding framework for prevention, both within and external to the health sector

The conceptual framework for the Preventative Health Strategy

The components of the Strategy are based on the following four rationales:

1. Influencing markets
2. Inequities in health
3. Developing effective policies
4. Investing for maximum benefit

INFLUENCING MARKETS

Food, physical activity, alcohol and tobacco are all consumables trading in our market system. When markets work efficiently, and consumers and producers act with full information, markets contribute significantly to community wellbeing. However, markets are imperfect and do not always produce optimal outcomes from a societal point of view.

Markets often under-provide the information consumers need in order to make healthy choices. When individuals have imperfect information about their own health, the range of choices available to them and the expected impact of particular lifestyle choices on their health, they may fail to act in the best interests of themselves or society.

Understanding how to adopt a healthy lifestyle is compromised by the complexity of the relationship between lifestyle behaviours and health, and an economic and social environment that promotes unhealthy choices. Efficient markets rely on a rational consumer able to critically evaluate information and weigh up, for instance, current pleasure and possible consequences.

Externalities, when the costs or benefits from actions impact on others, are another example of an imperfect market impacting on public health. The effects of smoking or excessive alcohol consumption extend beyond the individual, to impact on family members and the wider community.

Where imperfect information, the absence of rational decision making and negative externalities exist, there is a strong case for corrective action to be taken.

The Taskforce has considered the economic arguments with regard to these issues carefully and systematically, and has taken account of research evidence regarding the relative influence of market, government and individual actions on behaviours that have demonstrated adverse health outcomes. Further, it has considered the weight of views and arguments presented in the submissions and received from the community and in consultative forums.

Based on the above, it is the Taskforce's view that there are areas in which an imperfect market does in fact exist and which warrant corrective action – largely but not only through government action – if desired improvements in health are to be achieved. These areas are those identified as most clearly distorting consumption; for example, any form of marketing in the case of tobacco, and in the case of alcohol and obesity, marketing promotions aimed at children or adolescents that portray unhealthy choices as socially desirable.

However, in recommending measures that impose constraints on marketplace activity, it is the intention wherever possible to find ways in which both the private and social good can be served by shifting consumption in particular markets from less healthy to more healthy consumption patterns.

INEQUITIES IN HEALTH

Australians' concern with fairness in relation to preventative health, together with their concern for the suffering of others, demands actions to support equity of access to the means to lead a healthy life. This suggests, for instance, policies that promote access for all to nutritious food, physical activity, clean water and adequate housing. It also supports the provision of culturally relevant and accessible

preventative health services (including minimal co-payments) that discriminate in favour of high-risk groups and those in poorer health.

In formulating its recommendations, the Taskforce has been particularly concerned with the need to address the unequal distribution of health and risk in Australia. In this, the Taskforce's views are firmly in alignment with other contemporary developments in Australia and internationally, including:

- The National Health and Hospitals Reform Commission (NHHRC), which identified 'Facing inequities: recognise and tackle the causes and impacts of health inequities' as one of four major themes in its Interim Report
- The targets and priorities set out under the COAG 'Close the Gap' objective to address Indigenous disadvantage, which include both health, such as life expectancy and child mortality, and 'social determinants' targets, such as education and employment
- The Australian Government's Social Inclusion Agenda, and similar initiatives introduced at the state level (such as South Australia's *Social Inclusion* initiative)
- The Report of the World Health Organization (WHO) Commission on the Social Determinants of Health

DEVELOPING EFFECTIVE POLICIES

Ineffective policies can distort the health service mix and reduce the efficiency of the health system. Examples include the privileging of some modalities and settings over others, cost shifting between levels of government, inflexibility in supply, the failure of quality assurance and accountability mechanisms, and barriers to cross-sectoral initiatives.

Policy failure can also influence the type of preventative services likely to be funded, favouring medical and pharmaceutical services over lifestyle and community-based initiatives.

Another aspect of policy weakness is the unintended adverse consequences of non-health policies on health. These might relate to investments that favour the use of motor vehicles over active transport options, that result in urban design and land use that discourages activity and social connection, or the education curriculum that neglects health and physical activity.

The 'siloed' portfolio nature of government can result in policies that are consistent with the objectives of the agency and portfolio, but which are not necessarily in the interest of the wider society.

To avoid the negative health impacts of non-health policies, the types of initiatives suggested include the use of 'health impact assessments' and the *Health in All Policies* approach, in which health and wellbeing are taken into consideration in the policies of other government sectors.(23)

INVESTING FOR MAXIMUM BENEFIT

The fourth rationale involves minimising opportunity cost, or the benefits forgone in unfunded activities. This requires the identification of the relative cost-ineffectiveness of intervention options and the redirection of resources away from cost-ineffective to more cost-effective interventions.

While this offers a distinct rationale, it can also be pertinent in selecting strategy elements to address market and policy failure, which will maximise or at least enhance social wellbeing. Resources should be allocated where they yield the greatest benefit per unit cost.

Strategic directions

The Taskforce has identified seven critical strategic directions to be developed and implemented consistently and collectively for the National Preventative Health Strategy to be effective.

1. Shared responsibility – developing strategic partnerships

The Taskforce believes that health is a shared responsibility, with *individuals*, *families* and *local neighbourhoods* being at the centre of the Strategy. The diversity of players that can make significant contributions to this shared effort are outlined below (and further detailed in the Tables at the end of this Executive Summary).

- *Community-based organisations* such as Aboriginal Community Controlled Health organisations, local health, sporting, recreational, cultural and welfare groups.
- *Local governments* play a pivotal role in providing local amenities, and can partner with local organisations in areas such as exercise, active recreation and sport, food security, managing alcohol outlets and tobacco regulations. They can also assist with planning to increase physical activity and active use of the local government area. To do this, they need resources, both human and financial.
- *State and territory governments* are key leaders, funders, legislators, regulators, service providers and employers across a range of sectors that underpin the nation's capacity to promote health and prevent illness; for example, health, education, alcohol licensing, law enforcement, urban planning, transport and housing.
- *The Australian Government* has the overall responsibility for national leadership, policy, legislation and regulation, and for the funding and implementation, measurement and accountability for the Strategy. All three levels of government are major employers, for whom promoting health and preventing illness will also mean increasing productivity.
- *Non-government organisations* play a vital role at the national and state levels as providers of research and development, advocacy, social marketing and primary care.
- Whether as producer, marketer or employer, the *private sector* has a profound influence on the health of Australians. The most relevant are the food, beverage and alcohol industries, media, advertising, private health insurance, workplace insurance, self-medication, fitness and weight-loss industries.
- *National and state entities* such as the National Health and Medical Research Council (NHMRC), Australian Research Council (ARC), the Australian Bureau of Statistics (ABS), the Australian Institute of Health and Welfare (AIHW), the Social Inclusion Board and the state-based Health Promotion Foundations are essential providers of research and practice expertise, advice, funding capacity and policy direction.
- *Professional associations* across a range of health promotion, primary care and other non-health sector disciplines and *research* and *academic groups* are essential to maintaining and growing the prevention research and practice workforce.
- *New partnerships* can develop to improve the health of 10 million Australians in the workplace. These can be between private and public sector employers, insurers, health insurers, unions and workplace health promotion providers. Similarly, partnerships between police, local government and hospitality and entertainment venues can better enhance alcohol licensing and tobacco regulations.

MAKING GOOD HEALTH THE RESPONSIBILITY OF ALL SECTORS

The sport and recreation sector provides programs, resources and opportunities for all Australians to participate in sport and recreation – at a number of different levels.

The education sector plays an important role in early childhood development and with children and young people in schools and tertiary education.

The infrastructure, public transport, planning and urban design sectors help shape active, connected and safe neighbourhoods.

The police, welfare and justice systems are vital to the reduction of alcohol-related harm.

Climate change is an overriding issue that impacts on this Strategy. There are obvious synergies between reduction in fossil fuel usage and increased personal energy expenditure through walking, cycling, public transport and other approaches to promoting physical activity in the workplace and community.

Treasuries and finance departments are key partners in prevention, playing the central role in investment in well-evidenced policies, in consideration of prevention evaluation results and promotion of important prevention strategies such as pricing and taxation.

2. Act early and throughout life

> *'A life-course perspective is essential for the prevention and control of non-communicable diseases. This approach starts with maternal health and prenatal nutrition, pregnancy outcomes, exclusive breastfeeding for six months, and child and adolescent health; reaches children at schools, adults at worksites and other settings, and the elderly; and encourages a healthy diet and regular physical activity from youth into old age.'* (24)

Interventions that integrate the different dimensions of child development are particularly successful, resulting in sustained improvements in physical, social, emotional and cognitive development, while simultaneously reducing the immediate and future burden of disease, especially for those who are most vulnerable and disadvantaged. (25)

MATERNAL AND EARLY CHILDHOOD SERVICES

Access to basic medical care for pregnant women and children can help prevent threats to healthy development, as well as provide early diagnosis and appropriate management as problems emerge. (26)

Evidence supporting this approach includes the positive effects of adequate prenatal and early childhood nutrition on healthy brain development, and the developmental benefits for very young children when parental problems such as maternal depression are identified and treated effectively.

Similarly, there is extensive research to indicate that children's participation in quality early childhood programs can make a substantial difference to cognitive and social outcomes. (27)

Given the extensive research into early childhood, Australia now has an excellent platform from which to reform and develop its service systems for children and their families. Australia currently has a patchwork of existing early childhood and family support services that reflect the legacies of previous policies and earlier understandings about how children grow and develop.

The keys to effective prevention during pregnancy and the early years of life, whether associated with obesity, tobacco, alcohol or other health and social risks, are:

- Early identification of family risk and need, starting in the antenatal period
- Response to need in pregnancy, early years and through parent support
- Monitoring of child health, development and wellbeing
- Service redevelopment and workforce training to meet maternal and childhood needs

OLDER AUSTRALIANS

Healthy ageing is '*the process of optimising opportunities for physical, social and mental health to enable older people to take an active part in society without discrimination and to enjoy an independent and good quality of life'.* *(28)* While the potential scope for policy and action is diverse, efforts to tackle and improve healthy ageing have four key areas:(29)

- Improved integration in the economy and community
- Better lifestyles
- Adapting health systems to the needs of the elderly
- Attacking the underlying social and environmental factors affecting healthy ageing

While all of these areas are important in ensuring that healthy ageing is supported, the encouragement of better lifestyles amongst the older population has the largest potential for improving the health of the elderly.(29) There is a strong reliance on prevention, it being never too early or too late to promote health.(30) Action to address obesity, alcohol misuse and tobacco consumption in older Australians is vital in achieving good health outcomes.(31)

3. Engage communities

LOCAL COMMUNITIES

There are many organisations, associations, businesses and individuals who contribute greatly to healthy community life. During the consultations, we discovered a great deal of excellent work across the three areas of obesity, tobacco and alcohol.

Local governments set and drive policies and programs, taking national and state policies to the local level and designing programs that are relevant to community need. They have the capacity to engage with people in the community, are essential sources of information and contribute to building health literacy in the community.

Chambers of Commerce engage with local business, and can reinforce and support consistent healthy policy and business practices throughout communities. Employers can provide healthy workplace programs (see below).

Schools, childcare and after-school programs can implement healthy food policy (for example, in canteens) and physical activity programs (see below).

Sporting clubs, gyms, exercise classes, walking and cycling groups provide opportunities for adults and children in the community to participate in sport and recreation.

Urban planners design environments that create healthy towns and other localities, ensuring play spaces for children, cycle paths linking home with work and schools, and road infrastructure that encourages the use of public transport.

The food industry sells its products through the retail sector in the local community, and can make a major contribution in making sure healthy food choices are easy choices for people in the community.

The police, welfare agencies and justice system play a vital role in prevention and early intervention in alcohol-related issues – and support the hospitality industry and the local community in ensuring safe and responsible drinking in public places.

Health services, especially in the primary healthcare sector, provide services, information and support on prevention and management of overweight and obesity and low-risk drinking, and assist with prevention of smoking and support for tobacco cessation.

Large community-based trials, backed by rigorous evaluation and research efforts, are required to guide us on what prevention approaches work best in local communities in Australia. Given the fact that Indigenous and low SES populations suffer the worst health and have the highest levels of unemployment, a number of these trials must therefore initially be carried out in low SES and Indigenous communities.

THE IMPORTANCE OF THE WORKPLACE

There are an estimated 11 million Australians in *workplaces*, and approximately 70% in full-time employment.

With the growth of the knowledge and services sector, technological changes in the workplace environment, increased car dependence and the decline of manual work, it is common for most individuals to spend at least half of their waking day sitting and being inactive. Self-reported measures of sedentary time have been shown to be significantly associated with metabolic risk, independent of structured exercise taken.(32) This is an area where small but widespread changes could yield significant health improvements.

There is a growing evidence base demonstrating the efficacy and cost effectiveness of workplace-based programs.(33) In addition to the health benefits for individual workers, workplace health programs can produce a range of benefits, such as decreased illness and absence, reduction in the rate of early retirement due to ill health, improved productivity and a reduction in occupational injury and workers compensation claims.

A large number of studies now point to the economic return on investment that can accrue through investments in employee health programs, with the average rate of return estimated at between 2:1 and 5:1.

An increasing body of evidence indicates that programs which integrate intervention on 'lifestyle' health behaviours and working conditions are more effective in protecting and improving worker health and wellbeing than more isolated or single issue programs.(34) While often harder to implement, the studies suggest that these programs:

- Attract higher participation rates
- Are more effective at changing health behaviours
- Prevent chronic disease by improving working conditions as well as health behaviours(35)

Australian governments have taken a renewed interest in workplace health promotion to address the growing burden and associated healthcare costs of chronic disease. The Victorian Government launched its *WorkHealth* initiative in 2008, and the COAG National Partnership Agreement on Preventive Health has allocated $290 million to fund states and territories to facilitate delivery of healthy living programs in workplaces. Also under the Agreement, the Australian Government will develop a national healthy workplace charter with peak employer groups.

As indicated in the key action areas outlined previously, the Taskforce believes there is a major opportunity to build on and strengthen this momentum. Examples include:

- Establishment of a national accord to establish best practice in workplaces including protecting privacy of employees, workplace risk monitoring, risk assessment or risk modification programs
- Developing a voluntary industry scorecard, benchmarking and award scheme for workplace health
- Establishment of nationally agreed accreditation standards for providers of workplace health programs
- Generating a national action research project to strengthen evidence of effective workplace health promotion programs in the Australian context
- Developing a national workplace health leadership program and a series of resources, tools and best practice guidelines, through the NPA
- Commissioning a review of potential legislative changes to promote the take-up of workplace health programs.

SCHOOLS, CHILDCARE, OUT OF SCHOOL HOURS CARE AND TERTIARY INSTITUTIONS

The national syllabus provides students with formal education about a range of health issues, including alcohol, tobacco and other drugs, nutrition and physical activity, as well as physical education and sports programs in schools. However, opportunities to promote health in this setting must extend far beyond the curriculum.

All schools can promote good health and wellbeing through their policies, programs and environments. We need to create school environments that are supportive of good health, and in particular promote healthy eating and adequate physical activity, by providing programs and services that build skills and knowledge, and reach people in need.

There are a number of approaches that schools can adopt, including:

- Providing adequate time for sport and recreation within school time
- Training and supporting teachers to teach physical education and sports, and to motivate and inspire children to engage in physical activity
- Encouraging children to walk or cycle safely to school
- Encouraging tap water in preference to high-energy drinks, and implementing healthy school canteens
- Providing access to school sports and playing fields to the broader community outside of school hours
- Supporting and encouraging parental efforts to promote healthy eating and physical activity, and to limit time spent watching television and playing computer games

The current approaches already being implemented at state and territory level must become a strong national approach in order to embed health and wellbeing, physical activity and healthy eating in all schools.

Out of School Hours (OOSH) care is also an important setting for preventative health. Increasingly, children are being cared for before and after school by these services due to parental work commitments. OOSH care provides a great opportunity for children to be active in a safe and supervised environment.

Childcare services provide care for children under six years prior to entering school. There is a range of legislative and policy frameworks governing the quality and standards of care that incorporate policies and programs around health, safety and nutrition. Providing quality care for young children, supporting parents and linking to health services as required ensures that childcare centres can play a role in ensuring children have a healthy start to life.

There are many very large tertiary institutions across Australia that act as educators of the preventative health workforce of the future, as employers, as leaders and as providers of a range of retail (food, alcohol and tobacco) services and activity programs. They have the opportunity to provide workplace health promotion programs for their staff, maximising the sale of healthy foods on campus, providing on-line alcohol and drug prevention programs, providing incentives for students and staff to participate in sport and active recreation, to use active transport and, finally, to ensure that future primary and secondary teachers, as well as health workers, are equipped and confident to promote health in their day-to-day work.

4. Influence markets and develop connected and coherent policies

The past successes in prevention, cited earlier in this Overview, have been distinguished by the clear level of policy coherence and agreement at national, state and local levels.

RESPONSIVE REGULATION

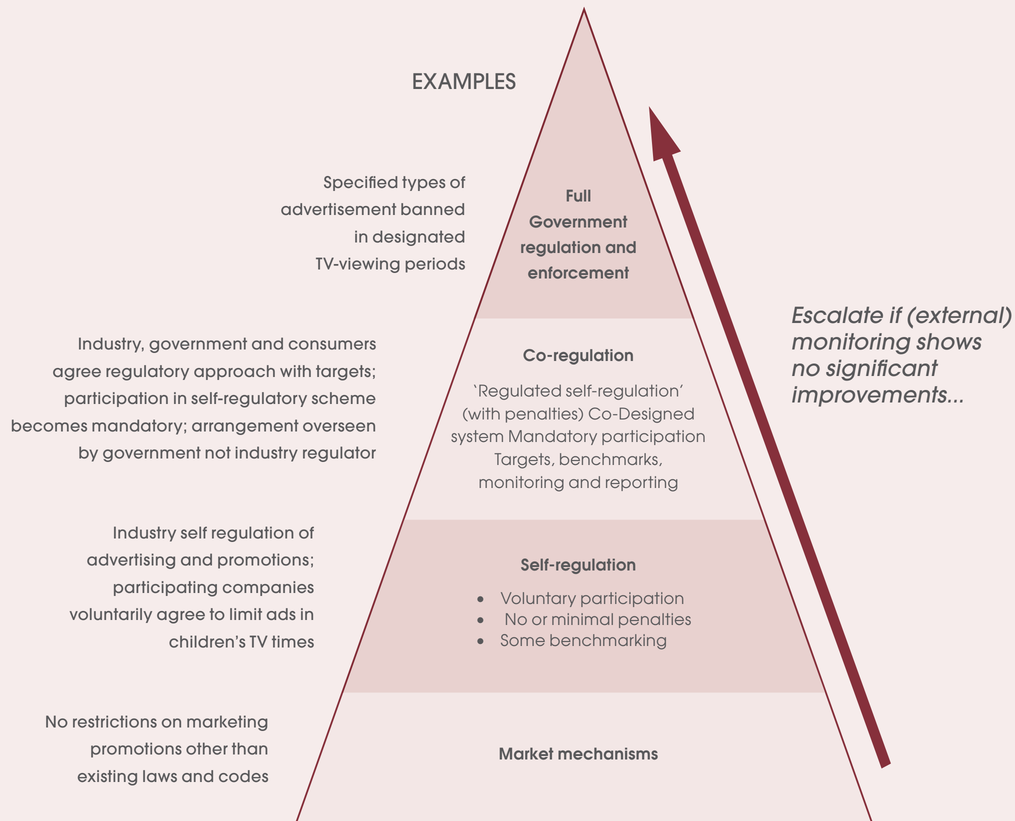
The Taskforce believes that in areas where government intervention is recommended, this should be informed by the approach known as ***responsive regulation***. The responsive regulation model has been extensively researched and is widely accepted in a range of non-health contexts; for example, in tax systems, in competition policy and in environmental regulation.

In essence, it proposes a staged but potentially escalating approach to change (see the diagram below). This allows for 'soft' mechanisms – such as voluntary change, self-regulation, co-design, public reporting or positive incentives – to be trialled, and the results measured and assessed, rather than opting immediately for 'harder' mechanisms of regulation, enforcement or fiscal sanctions. However, the responsive regulation model also requires an explicit commitment from government to escalate the degree and level of regulation if 'softer' approaches do not deliver the desired and agreed processes and outcomes.

This approach respects the fact that, when confronted with good evidence of the negative externalities arising from particular practices, many players in the marketplace want to do the right thing. Responsive regulation allows for voluntary adjustments and the development of creative solutions through government, industry and consumer partnerships, but these actions are clearly seen to occur within a framework of potential sanctions should the desired outcomes not be achieved.(36)

Figure 4:

Regulatory pyramid and regulatory mechanisms (advertising to children as an example)



Source: Adapted from Healy J, Braithwaite J. Designing safer health care through responsive regulation. MJA 184 (10): S56-S59

Currently in Australia we have voluntary, self-regulatory systems operating in the regulation of alcohol advertising and sponsorship, with much 'stronger' regulation and enforcement of drink driving and licensing for the sale of alcohol.

In 2009 a new voluntary, self-regulatory system has commenced in food and beverage advertising to children. This approach contrasts to that in tobacco, which over the last 30 years has moved from codes of conduct to regulation and legislation, using taxation as a very effective mechanism to increase pricing and reduce consumption.

The effectiveness of the voluntary codes that are in place can now be monitored and shifted to 'harder' mechanisms if they are found to be ineffective. This is all the more reason why Australia needs enhanced national infrastructure to monitor and measure the progress of different aspects of the Strategy.

INFORMING INDIVIDUALS AND FAMILIES

Promoting good health calls for interventions that assist all Australians to make well-informed decisions about their health. In this context, such interventions include knowledge of the impact of nutrition and physical activity tobacco and alcohol on health, and the knowledge and skills to avoid harmful behaviours and adopt health-promoting behaviours.

Given the complexity of these issues, and the complex social influences involved, this will inevitably require a multi-layered approach of social marketing, community-level initiatives, formal education in health literacy (for example, as proposed by the NHHRC(37)), specific information about products (such as product labelling), and regulations to prevent or limit the marketing of potentially harmful products.

This approach is seen as being integral to enhancing personal choice and responsibility, while also changing community norms to healthier behaviours and increasing demand for healthier products.

5. Reduce inequity through targeting disadvantage

Major health inequities exist not only between Indigenous Australians and non-Indigenous Australians, but between rich and poor, and between rural and city dwellers. Even within a city such as Melbourne, life expectancy can vary by up to six years within a matter of kilometres.

The WHO's Commission on the Social Determinants of Health (CSDH) makes three overarching recommendations to tackle the 'corrosive effects of inequality of life chances':

- Improve daily living conditions, including the circumstances in which people are born, grow, live, work and age
- Tackle the inequitable distribution of power, money and resources – the structural drivers of those conditions – globally, nationally and locally
- Measure and understand the problem and assess the impact of action(38)

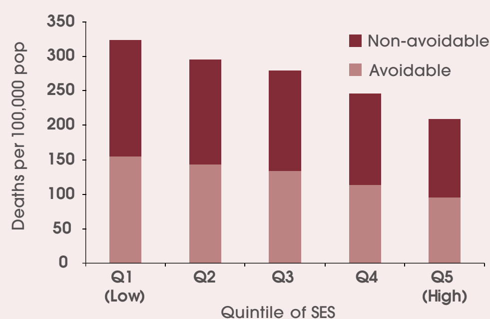
The poorest of the poor have the highest levels of illness and premature mortality. But poor health is not confined to those who are worst off. At all levels of income, health and illness follow a social gradient: the lower the socioeconomic position, the worse the health.

THE SOCIAL GRADIENT

Solely focusing on the difference in health experience at opposite ends of the social spectrum masks the graded relationship between social position and health. A recent analysis of mortality rates, and notably avoidable mortality rates, illustrates how death rates decrease progressively with increasing SES (Figure 5).

Figure 5:

Age and sex-adjusted mortality rates, Australia, aged less than 75 years, 2002

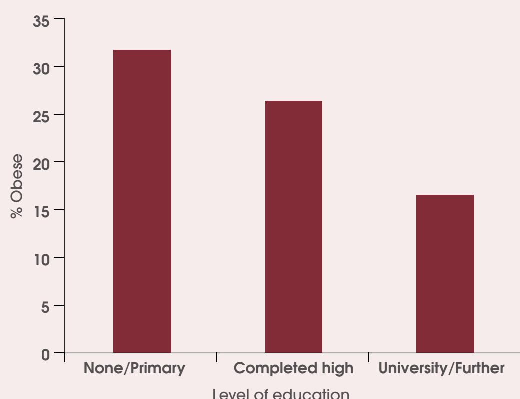


Source: Korda R, et al. Differential impacts of health care in Australia: trend analysis of socioeconomic inequalities in avoidable mortality. International Journal of Epidemiology, 2007.(39)

In Australia, excess body weight tends to be more prevalent among people further down the social and economic scale.(40) Analysis of the AusDiab 1999–2000 data shows a clear social gradient in the prevalence of obesity among adult women (Figure 6). A policy and programmatic focus on only the most disadvantaged, in this instance women with primary level education, would miss the equally significant health burden from obesity among women along the remainder of the education spectrum.

Figure 6:

Prevalence of obesity among women, by level of education



Source: AusDiab 1999–2000.

Understanding health inequity in terms of the social gradient in health allows us to embrace not only conditions of poverty and exclusion but social conditions that affect everyone. In doing so, policies and programs will have greater potential to reach a wider population, thereby improving the health of more people.

SOCIAL DETERMINANTS OF OBESITY, TOBACCO USE AND ALCOHOL CONSUMPTION

Of particular relevance to obesity, alcohol consumption and tobacco use is the nature of, and inequity in:

- The physical and social experiences in early life
- Access to and quality of education
- The nature of urbanisation – how cities are planned and designed – along with the liveability and sustainability of rural locations
- Transport options
- Distribution mechanisms and consumer price of food, alcohol and tobacco
- Exposure to marketing of energy dense nutrient poor (EDNP) foods, alcohol and tobacco
- The financial, psychosocial and physical conditions of working life
- The degree of social protection provided

Culture is a major social determinant of health. For Indigenous people, health status does not correlate with position in the social gradient, as for the general population. Irrespective of SES or geographical location, Aboriginality itself is associated with poor health.(41) Specific recognition of culture, as a major social determinant of Indigenous health, is important when designing preventative health programs to contribute to 'Close the Gap' (see below).

STRUCTURAL DETERMINANTS: POWER, MONEY AND RESOURCES

Promoting health equity through healthy weight, responsible alcohol use and no tobacco use also means tackling some of the fundamental political, economic and cultural issues that affect people's living conditions, their daily practices and behaviour-related risks.

That means dealing with matters of governance; national economic priorities; trade arrangements; market deregulation and foreign direct investment; fiscal policy; and the degree to which policies, systems and processes are inclusionary – each issue very much related to the CSDH recommendation of tackling the unequal distribution of power, money and resources. Addressing these structural determinants of health inequity not only helps empower individuals and communities but also empowers national government and other key public sector institutions. For example, good global governance and regulatory frameworks create support for national governments to introduce policies that tackle corporate pressures such as irresponsible marketing.(42)

In light of the strong relationship between health and social disadvantage and the clustering of risk in the most vulnerable populations, the Taskforce welcomes the Australian Government's Social Inclusion Agenda, and similar initiatives introduced at the state and territory level (such as South Australia's *Social Inclusion* initiative).

The Taskforce shares the Australian Government's vision of an inclusive society as one in which all Australians feel valued and have the opportunity to participate fully in social and economic life. Health is one of the key resources that enables participation; conversely, social exclusion can itself be a contributor and determinant of poor health.

6. Indigenous Australians – contribute to 'Close the Gap'

In the current context of high levels of chronic disease in the Indigenous population, obesity, alcohol and tobacco make significant contributions to the burden of sickness, injury and death in Indigenous communities.(43) Together, these factors contribute to almost a quarter of the 'health gap'.(44)

The proportion of the health gap attributable to obesity, tobacco and is also distributed unevenly. While Indigenous people in remote areas make up 26% of the total Indigenous population, they contribute 34% of the total health gap attributable to tobacco, 38% of the health gap due to high body mass, and a full 50% of the health gap due to alcohol.(43)

The announcement of the 'Close the Gap' commitment by all Australian governments in December 2007 recognised the extent and urgency of the problems facing Indigenous Australians.(43) To be successful in raising the life expectancy of Indigenous Australians to that enjoyed by non-Indigenous Australians within a generation, the disparity in levels of sickness and death attributable to obesity, tobacco and alcohol must be addressed.

Key principles for successful programs include:

- Genuine local Indigenous community engagement to maximise participation, up to and including formal structures of community control
- Integration of vertical, targeted programs on alcohol, tobacco and obesity with broad-based comprehensive primary healthcare
- Ensuring programs are adequately resourced for evaluation and monitoring so they can contribute to program and policy knowledge
- Evidence-based approaches that are reflective and that involve the local community in adapting what is known to work elsewhere to local conditions and priorities

- Adequate and secure resourcing to allow for actions to be refined and developed over time
- Performance indicators and measurement that are linked to accountability and action

HOW CAN PREVENTION HELP BRIDGE THE GAP?

Broad, multifaceted action is needed to address the contribution made by alcohol, tobacco and obesity to the health gap between Indigenous and non-Indigenous Australians, combining specific programs addressing these issues with broad action on the social determinants of health, and action to strengthen and extend health services, particularly comprehensive primary healthcare.

For Indigenous Australians, primary healthcare has come to be recognised by policy makers, health professionals and the Indigenous community as the key strategy for improving the health of Indigenous Australians. To the extent that there have been health improvements, these have been credited to improved primary healthcare.(45) Even where measurable improvements are limited (for example, in chronic disease mortality rates), the conclusion has been drawn that while the social determinants continue to drive high levels of ill health, improved primary healthcare services are at least providing a brake on what would otherwise be accelerating mortality rates.(46)

Actions will need to include:

- Support and resourcing for community agency and action through the establishment of local community leadership groups
- Adequate long-term investment in social marketing campaigns to shift social norms of smoking and alcohol consumption amongst Indigenous people
- Action to promote smoke-free workplaces, community spaces and events, especially through work with Indigenous organisations, possibly through the employment of tobacco control workers in National Aboriginal Community Controlled Health Organisation (NACCHO) affiliates
- Resourcing of multi-component community-based programs, including effective and professional evaluation
- Strengthening antenatal, maternal and child health systems for Indigenous communities
- Strengthening effective screening, intervention and referral pathways in primary healthcare and between primary healthcare and specialist services
- Reform and increased support for treatment and rehabilitation services for alcohol-related problems
- Actions on pricing of alcohol, including a broad review of Australia's alcohol taxation policy as part of a comprehensive approach to alcohol problems in Australia, as recently called for by the Royal Australasian College of Physicians
- Action to restrict alcohol supply, including the numbers and types of licences and hours of sale, especially for takeaway licences

7. Refocus primary healthcare towards prevention

There is a place for preventative health in all elements of the healthcare system, including within the acute care and hospital setting, community health and across primary healthcare. The NHHRC has been tasked with the review of Australia's healthcare system, and the Primary Health Care Expert Reference Group with reform for primary healthcare. The Preventative Health Taskforce has both contributed to their work and sought advice from the Commission and the Expert Reference Group in developing this Strategy.

The primary healthcare system has a great capacity to care for Australians across a vast range of disciplines, with multi-disciplinary team-based care increasingly recognised as the best approach to high-quality chronic disease management and prevention.

The Primary Health Care Strategy is supportive of focusing the whole system of primary healthcare on prevention as appropriate through the development of practice incentives and referral pathways. Other approaches include a strong focus on community development and community health outreach activities.

THE ROLE OF PRIMARY HEALTHCARE IN PREVENTING CHRONIC DISEASE

Early in 2006, COAG's *Plan for Better Health for All Australians*(47) identified the importance of promoting healthy lifestyles, including addressing alcohol use, nutrition, smoking and physical activity. Strategies to promote healthy lifestyles include:

- Supporting the early detection of lifestyle risks and chronic disease through a 'Well Person's Health Check' in general practice for middle-aged people with one or more identifiable risks that lead to chronic disease
- Supporting lifestyle and risk modification through referral to services that assist people who are wanting to make changes to their lifestyle

TARGETED PREVENTION FOR DISADVANTAGED POPULATIONS

In addition to population-wide prevention measures, targeted preventative activities are required to address the health needs of individuals and communities where:

- Existing basic services may not cope with the level of illness and need present in the community (such as in some Aboriginal and Torres Strait Islander communities)
- There are adverse health outcomes resulting from factors that may discriminate against disadvantaged groups (such as the cost of services or discrimination)
- There are specific cultural factors and conditions that make mainstream basic services inappropriate (such as Indigenous health and refugee health services)

Disadvantaged populations experience significantly greater mortality and morbidity relative to advantaged individuals and they may be less likely to receive appropriate preventative care.(48, 49)

The following are critical to an integrated primary healthcare system that puts preventative health at the forefront of quality practice:

CRITICAL SUCCESS FACTORS FOR INTEGRATED PRIMARY HEALTHCARE

A system that:

- Provides a viable option for people to enrol in a comprehensive primary healthcare system based on residential location – especially those who are disadvantaged or who have multiple needs
- Responds to the changing health needs of people throughout their lives and to those of their families
- Provides quality preventative healthcare in the most appropriate setting
- Promotes patient- and community-centred preventative healthcare with genuine options for community involvement in planning and service delivery
- Develops blended payment models that provide for payment of clinicians through a combination of fee for service, salaries, capitation and performance-based payments accompanied by a single fundholder for primary and community care and public healthcare, ideally funded through a 'needs adjusted' capitated formula
- Harnesses and coordinates the contribution to preventative health made by a wide range of health professionals
- Networks primary care organisations, avoiding silos and gaps in care
- Provides a comprehensive clinical governance and quality audit system
- Introduces an electronic patient record

In summary, the Taskforce notes the current limitations of the primary healthcare system in Australia in its ability to address lifestyle factors, and considers that a primary healthcare setting which works effectively for prevention should at a minimum be able to:

- Systematically identify people at risk and effectively assess the level of risk and readiness for change
- Deliver appropriate interventions on-site or refer to external services
- Have in place referral processes that allow ready access to appropriate, quality-assured lifestyle modification providers and programs
- Monitor and assess outcomes and sustain improvements over time

To achieve this, the primary healthcare sector requires:

- A multidisciplinary workforce with relevant skills and expertise
- Appropriate tools and resources
- Information systems that provide risk data on the practice population
- Effective linkages to wider community services.

Ensuring effective implementation – the national infrastructure for prevention

The National Prevention Agency will be viewed as a national leader for prevention in Australia. It must be capable of driving the prevention agenda across many sectors and within a diverse range of stakeholders through collaborative partnerships, coordination of activity at the national, state and local levels, and the provision of strategic advice to inform government policy.

The Taskforce proposes that the model for the agency include the following approaches:

- A national body, established by enabling legislation
- Have an expert, cross-sectoral Board of Governance comprising 10 to 12 members, selected on merit for their expertise
- While the proposed funding under the COAG agreement is welcomed, its capacity and budget will need to be further increased to ensure its national leadership in prevention
- Be a facilitator/coordinator and, as required, implementer and commissioner of interventions through and with partners
- Be independent from but working closely with government, reporting to the Commonwealth Parliament through the Minister for Health as responsible Minister, in consultation with the Prime Minister
- Facilitate the infrastructure for prevention including: social marketing; research, evaluation and the building and transfer of evidence; monitoring and surveillance systems; workforce development; and funding models.

Establishing the NPA in this way provides for an appropriate public and corporate governance model that will reflect the important role prevention plays in the health outcomes of all Australians, and provide reassurance that action is being taken. It will also facilitate a 'whole of government' approach to prevention by representing a central point for monitoring implementation and delivery, and provide a framework for accountable, efficient performance.

Roles and functions

These will include:

- Lead and facilitate the building of evidence for preventative health through research and evaluation, and the synthesis and translation of research findings into policy and practice
- Develop and implement comprehensive, sustained social marketing campaigns for obesity, tobacco and alcohol (see below)
- Provide a national clearing house for the monitoring and evaluation of national policies and programs in preventative health
- Publish annual reports on the state of preventative health, including reporting on progress towards the achievement of the 2020 goals specified in this Strategy
- Advise COAG, through AHMC, on national priorities and options for preventative health
- Administer national programs, facilitate national partnerships and advise on national infrastructure for surveillance, monitoring, research and evaluation (see below), as charged by AHMC
- Develop for consideration by AHMC the next phase of preventative health reform to follow after this Strategy

SOCIAL MARKETING

This approach recognises and integrates the substantial contribution to social marketing made by different state and national agencies (both government and non-government). In addition, it acknowledges the differing levels of sophistication and readiness for social marketing across the three priority areas. It would take a national approach on issues of national significance, adopt a pragmatic approach to use resources wisely, use social marketing to affect the social and economic determinants of health, and house a register of social marketing resources.

DATA, SURVEILLANCE AND MONITORING

Comprehensive and robust monitoring and surveillance systems are a critical requirement for the capture, analysis and interpretation of reliable, nationally consistent population health information.

There are a number of shortcomings at a national level which need to be rectified. Requirements include:

- Development of national data linkage systems, for health and non-health data
- Establishing a national health equity surveillance system

It is proposed that the NPA would take a key role in terms of the development, implementation and evaluation of prevention data, surveillance and monitoring infrastructure through:

- The development, management and benchmarking of evaluation tools to assess the effectiveness and impact of public health interventions
- The establishment of collaborative partnerships with key national agencies and groups

NATIONAL PREVENTION RESEARCH INFRASTRUCTURE

It is proposed that a National Strategic Framework to support and drive preventative health research be developed, covering obesity, tobacco and alcohol strategies and including the establishment of a preventative health research fund to:

- Invest in investigator-led, peer-reviewed research, using a common set of measures for comparing outcomes
- Increase priority and strategic research, as recommended in the Wills Review in 1998 and the Grant Review in 2004
- Assist the development of national registers of research

It is proposed that this increased investment would lead to:

- Large-scale, long-term (10–20 years), nationally relevant intervention, translational and dissemination research
- Increasing capacity and focus on research into the social determinants of health and the effects of interventions on reducing inequities
- Increasing capacity and a focus on Indigenous health research
- Long-term research and evaluation projects, such as major cohort studies
- Ensuring that postgraduate research occurs where interventions are taking place or policies are being developed, such as Departments of Health, Education, Planning, Transport, Treasuries, NGOs and local governments

WORKFORCE DEVELOPMENT

It is proposed that the NPA could facilitate the development and support of the preventative health workforce through:

- A national audit of the health prevention workforce and demographics to identify the workforce planning, strategic development and deployment necessary to build long-term competence and capacity
- The establishment of strategic partnerships with key health workforce bodies, and with key workforce agencies in other sectors
- The enhancement of the public health research workforce, and the skilling up of the preventative health workforce who understand inequity and the social and economic determinants of health
- Ensuring that prevention becomes an important part of the work of the Health Workforce Australia Agency.

FUTURE FUNDING MODELS FOR PREVENTION

The NPA may be well positioned to guide and inform the identification, examination and development of future funding models for prevention through:

- The investigation and provision of advice in regard to potential funding options for prevention, both within and external to the health sector
- The investigation and provision of advice in regard to the potential development of a funding framework for prevention, both within and external to the health sector, to guide the development and use of a number of funding models.

Conclusion – a call to action

The Preventative Health Taskforce invites your involvement in the implementation of the National Preventative Health Strategy.

Everyone has a role to play in prevention. Throughout the Strategy, the importance of working together and taking responsibility is emphasised for all Australians – whether they be individuals, communities, governments, industry, in health or other sectors. The Taskforce would like to hear your ideas about what you can do to help Australia become the healthiest country by 2020.

Please see the four accompanying tables that indicate what roles different groups can play.

The Taskforce is keen to hear and to tell others of your contribution to the health of all Australians. An online national forum for organisations, local governments, businesses and industry, community groups, families and individuals will be developed to share your commitments and plans to making Australia healthy. In the first instance, go to the Taskforce's website: www.preventativehealth.org.au.

Together with this, a national recognition and award scheme for outstanding contributions to making Australia the healthiest country by 2020 will be instituted. The Taskforce looks forward to receiving your contributions.

ACTION ON OBESITY: A ROLE FOR ALL AUSTRALIANS

TARGETS: halt and reverse the rise in overweight and obesity in Australia by 2020

- Increase the proportion of children and adults meeting national guidelines for healthy eating and physical activity by 15% within six years; and with healthy body weight by 3% within ten years
- Ensure Australian children have a healthy start to life

INCREASE LEVELS OF PHYSICAL ACTIVITY AND REDUCE SEDENTARY BEHAVIOUR

- Establish a Prime MInister's Council on Active Living and develop a National Framework for Active Living

INCREASE THE AVAILABILITY AND DEMAND FOR HEALTHIER FOOD PRODUCTS, AND DECREASE THE AVAILABILITY AND DEMAND FOR UNHEALTHY FOOD

- Develop a national food and nutrition framework

ENCOURAGE PEOPLE TO IMPROVE THEIR LEVELS OF PHYSICAL ACTIVITY AND HEALTHY EATING THROUGH SOCIAL MARKETING

- Implement sustained national social marketing campaigns to increase physical activity and healthy eating, and reduce sedentary behaviour

SCHOOLS

- Develop, implement and evaluate health, nutrition and physical activity policies
- Incorporate Health and Physical Education into the National Curriculum
- Establish a system to monitor the policy requirement of at least two hours of physical activity per week
- Support active transport to and from school
- Expand coverage of out of school healthcare programs
- Provide community access to school recreation facilities after-hours

WORKPLACES

- Work with government to develop a national accord for best practice in workplace health
- Implement workplace nutrition and physical activity policies in accordance with best practice
- Offer employees access to nationally accredited workplace health programs, including risk assessment and risk modification programs
- Participate in voluntary benchmarking and award scheme for workplace health
- Support active transport to and from work

AUSTRALIAN GOVERNMENT

- Conduct research into economic barriers and enablers, policies and tax incentives to:
  - Inform national active living framework and actions
  - Promote production, access to and consumption of healthier foods
- Reduce exposure of children and others to marketing, advertising, promotion and sponsorship of energy-dense nutrient-poor foods and beverages
  - Monitor and evaluate the impact of industry self-regulation
  - Identify shortfalls in the voluntary approach and address these through the introduction of a co-regulatory agreement
  - Introduce legislation if these measures are not effective
- Commission a review of potential legislative changes to promote the uptake of workplace health programs

LOCAL GOVERNMENTS, COMMUNITY & NON-GOVERNMENT ORGANISATIONS

- Adopt *Healthy Places and Spaces* planning guidelines in local government
- As part of the COAG *Healthy Communities Initiative*, establish a series of community intervention trials with a major focus on healthy eating and active living
- Develop, pilot and implement a new *Healthy and Active Families Initiative*

FOOD AND BEVERAGE INDUSTRY

- Establish a Healthy Food Compact with governments, non-government organisations and research institutions to drive change within the food supply
- Work with the Australian Government to design, implement and evaluate trials of a national food labelling system for front-of-pack and menus

ADVERTISING INDUSTRY

- Work with food and beverage industries to increase the marketing, advertising and promotion of healthy foods and beverages
- Work with governments to promote physical activity and healthy eating through social marketing

STATES AND TERRITORIES

- Introduce health impact assessments in all policy development
- Fund and promote policies and programs which encourage physical activity and healthy eating within schools, workplaces and the community

ACTION ON OBESITY: A ROLE FOR ALL AUSTRALIANS

INDIVIDUALS AND FAMILIES

- **Embed physical activity and healthy eating in everyday life**

Individuals

- Eat a variety of food, including vegetables, fruits, whole grains, lean meats, oily fish, beans, nuts, and low fat dairy products
- Limit intake of foods with high amounts of sugar, salt and fat
- Drink water and limit intake of soft drinks and alcohol
- Moderate portion sizes
- Be physically active every day, and if appropriate do some vigorous exercise
- Use active transport where possible – walk, ride a bike, take the stairs
- Reduce the amount of time sitting still at home and in the workplace
- Seek advice and guidance from your doctor, a dietician or physical activity health professional

Families

- Be a positive role model to children regarding physical activity and healthy eating
- Eat at least one healthy meal a day together as a family
- Turn off the TV or computer and get active
- Participate in fun physical activity as a family

PRIMARY HEALTH CARE

- **Strengthen, upskill and support primary health care workforce to support people in making healthy choices**
- Embed preventative health interventions in the primary health care setting
- Expand primary health services to deliver or develop referral pathways to advice and support about weight loss, physical activity and healthy nutrition
- Offer brief interventions to support specific issues experienced by people in low income communities
- Implement evidence-based clinical guidelines and training packages to support primary health workers to manage overweight and obesity

MATERNAL AND CHILD HEALTH SERVICES

- **Address maternal and child health, enhancing early life and growth patterns**
- Ensure women planning pregnancy and pregnant women receive information, education and support to prevent lifestyle risks of excessive weight, poor nutrition, alcohol and smoking.
- Encourage and support breastfeeding in accordance with the NHMRC *Dietary Guidelines for Children and Adolescents in Australia*

INDIGENOUS COMMUNITIES

- **Reduce obesity prevalence and burden and close the gap in Indigenous communities**
- Work with government and community organisations to implement multi-component programs which improve knowledge and promote healthier behaviours regarding physical activity and nutrition in the Indigenous community
- Work with Maternal and Child Health Services to strengthen antenatal, maternal and child health services for Indigenous communities
- Participate in *Healthy Communities Initiative* community intervention trials

LOW SES COMMUNITIES

- **Support low income communities to improve their levels of physical activity and healthy eating**
- Work in partnership with government and community organisations to improve knowledge and promote healthier behaviours regarding physical activity and nutrition in the community
- Participate in *Healthy Communities Initiative* community intervention trials

BUILD THE EVIDENCE BASE, MONITOR AND EVALUATE EFFECTIVENESS OF ACTIONS

- Develop a national research agenda for overweight and obesity
- Carry out National Risk Factor Survey

ACTION ON TOBACCO: A ROLE FOR ALL AUSTRALIANS

TARGETS: reduce daily smoking to under 10% by 2020

- Reduce the prevalence of daily smoking among adult Australians from 17.4% in 2007 to 10% or lower by 2020
- Eliminate exposure to other people's tobacco smoke, especially for children, and ensure smoking during pregnancy is minimal
- Substantially reduce smoking and exposure to tobacco smoke among Indigenous Australians

MAKE TOBACCO PRODUCTS SIGNIFICANTLY MORE EXPENSIVE

- Ensure that the average price of a packet of 30 cigarettes is at least $20 (in 2008 $ terms) within three years, with equivalent increases in the price of roll-your-own and other tobacco products
- Contribute to the development and implementation of international agreements and a national strategy to combat the illicit trade of tobacco
- End duty free tobacco sales in Australia and abolish concessions for all travellers entering Australia

INCREASE THE FREQUENCY, REACH AND INTENSITY OF SOCIAL MARKETING CAMPAIGNS

- Allocate long-term funding at federal and state levels for sustained media campaigns
- Run effective social marketing campaigns at levels of reach demonstrated to reduce smoking, choosing messages which ensure reach to young smokers and socially disadvantaged groups

INDIVIDUALS AND FAMILIES

Individuals

- Quit, as soon as possible
- Keep trying, even if previous attempts to quit have failed
  - Call the Quitline
  - Ask a GP or local pharmacy for advice about quitting
  - Consider using a medicine to help with withdrawal symptoms

Families

- Make home smoke-free
- Protect your baby's present and future health by quitting smoking
- Be a positive role model to children – the single most important thing parents can do to stop their children from smoking is to quit
- Make it clear that you do not want your children to smoke for the sake of their health

AUSTRALIAN GOVERNMENT

- End all remaining forms of advertising and promotion of tobacco products
  - Amend *Tobacco Advertising Prohibition Act 1992* to require that no tobacco product may be sold expect in packaging of a shape, size, material and colour prescribed by government
  - Amend legislation nationally and in all states to ensure tobacco is out-of-sight in retail outlets
- Improve consumer product information related to tobacco products; mandate plain packaging, review health warnings content regularly and establish a system for Chief Medical Officer to issue early warning of new and emerging health concerns.
- Ensure Nicotine Replacement Therapy is affordable for those that need it
- Give government power to regulate design, contents and maximum emissions for tobacco and related products, and establish a regulatory body with responsibility for specifying required disclosure to government, labelling and any other communication to consumers
- Make smoking a classifiable element in movies and video games

MENTAL HEALTH SERVICES

- Educate mental health professionals about the importance of quitting and not discouraging quit attempts by clients
- Educate GPs and other health professionals about quit smoking benefits and successes for people with mental health problems
- Ensure all child, adolescent and adult mental health facilities:
  - Are smoke free
  - Routinely identify smokers
  - Include smoking cessation advice and treatment of nicotine dependence in all patient treatment plans
  - Offer support to patients at transition points

ACTION ON TOBACCO: A ROLE FOR ALL AUSTRALIANS

SCHOOLS

- Assist parents and educators to discourage tobacco use and protect young people from second-hand smoke
- Cover the medical, social, environmental and economic aspects of tobacco in the school curriculum
- Enforce smoke-free policies for students, staff and visitors consistently, both indoors and on school grounds

WORKPLACES

- Extend smoke-free workplace policies to apply to building entrances and ban the retail sale of cigarettes in canteens and on-site shops
- Provide support and incentives for employees to quit and stay smoke-free

LOCAL GOVERNMENTS, COMMUNITY & NON-GOVERNMENT ORGANISATIONS

- Boost efforts to discourage smoking among people in other highly disadvantaged groups
- Implement community-based tobacco control projects, especially in highly disadvantaged communities

STATES AND TERRITORIES

- Eliminate exposure to second-hand smoke in public places
- Amend current legislation to:
  - Ensure smoking is prohibited in any public places where the public, particularly children, are likely to be exposed
  - Ensure children are not exposed to tobacco smoke when travelling in cars
  - Protect against exposure to second-hand smoke in workplaces, including outdoor areas
- Further regulate supply of tobacco products
- Amend current legislation to:
  - Preclude sales through vending machines, the internet, and at hospitality and other social venues
  - Require all tobacco retailers be licensed
- Ensure all smokers in contact with health services are encouraged and supported to quit
- Ensure all state and territory funded healthcare services are smoke-free indoors and on facility grounds
- Ensure all state and territory funded human services agencies and correctional facilities are smoke-free and provide appropriate cessation supports
- Increase availability of Quitline services

LOW SES COMMUNITIES

- Work with state and local governments and community organisations to discourage smoking in highly disadvantaged neighbourhoods
- Place the majority of any outdoor or mobile advertising campaign in highly disadvantaged areas

PRIMARY HEALTH CARE

- Ensure that all patients are routinely asked about their smoking status and supported to quit
- Train heath professionals in smoking cessation counselling

MATERNAL AND CHILD HEALTH SERVICES

- Ensure all pregnant women and those planning pregnancy are routinely asked about their smoking status and supported to quit

INDIGENOUS COMMUNITIES

- Boost efforts to reduce smoking among Indigenous Australians
- Establish multi-component community-based tobacco control projects that are locally developed and delivered
- Work with government to enhance social marketing campaigns for Indigenous smokers ensuring a 'twin track' approach of complementing mainstream campaigns with Indigenous-specific elements
- Train Indigenous health workers to provide smoking cessation advice and develop community-based tobacco control programs
- Trial incentive program for Indigenous young people to stay smoke free

MEASURE PROGRESS AGAINST AND TOWARDS TARGETS

- Address the current gaps in the developed surveillance system on tobacco to enable governments to assess progress and ensure targets will be met

ENSURE THE PUBLIC, MEDIA, POLITICIANS AND OTHER LEADERS REMAIN AWARE OF THE NEED FOR SUSTAINED AND VIGOROUS ACTION TO DISCOURAGE TOBACCO USE

ACTION ON ALCOHOL: A ROLE FOR ALL AUSTRALIANS

TARGETS: a safer drinking culture for Australia

By 2020:

- Reduce the proportion of Australians who drink at **short-term** risky/high-risk levels from 20.4% to 14.3%
- Reduce the proportion of Australians who drink at **long-term** risky/high-risk levels from 10.3% to 7.2%
- Reduce the proportion of Australian secondary school students aged 12–17 years who are current drinkers and consume alcohol at harmful levels from 31% to 21.7%

IMPROVE THE SAFETY OF PEOPLE WHO DRINK AND THOSE AROUND THEM

- Implement measures at the local, state and federal level to ensure a shift towards safety in local communities in the way licences are granted, managed and enforced across Australia

INCREASE PUBLIC AWARENESS AND RESHAPE ATTITUDES TO PROMOTE A SAFER DRINKING CULTURE IN AUSTRALIA

- Develop and implement a comprehensive and sustained social marketing and public education campaign, with a range of other complimentary actions, to de-normalise intoxication and long term risky/high risk drinking.

INDIVIDUALS AND FAMILIES

Individuals

- Drink no more than 2 standard drinks on any day to reduce the lifetime risk of harm from alcohol related disease or injury
- Drink no more than 4 standard drinks on a single occasion to reduce the risk of alcohol related injury
- For women who are pregnant or planning pregnancy, not drinking is the safest option
- For women who are breastfeeding, not drinking is the safest option

Families

- Protect the health and safety of children and adolescents' brain development:
  - Children under 15 years of age are at the greatest risk of harm from drinking; it is important not to drink alcohol at this age
  - For young people aged 15-17 years, the safest option is to delay the initiation of drinking for as long as possible
- Be a positive role model to children regarding responsible drinking of alcohol

AUSTRALIAN GOVERNMENT

- **Regulate alcohol promotions**
- In a staged approach, phase out alcohol promotions from times and placements which have high exposure to young people
  - Monitor and evaluate impact of industry self regulation
  - Identify shortfalls in the voluntary approach and address these through introduction of a co-regulatory agreement
  - Introduce legislation if these measures are not effective
- Require counter-advertising (health advisory information) within all alcohol advertising
- Require health advisory information labelling on containers and packaging of all alcohol products to promote safer drinking
- **Reform alcohol taxation and pricing arrangements to discourage harmful drinking**
- Commission independent modelling for rationalised tax and excise regime
- Develop the public interest case for minimum (floor) price of alcoholic beverages to discourage harmful and promote safe consumption
- Direct a proportion of revenue from alcohol taxation towards initiatives that prevent alcohol-related societal harm

POLICE

- Work with the States and Territories, private security and other law enforcement staff to develop and implement best practice for policing and enforcement of liquor control laws and regulations, and managing public safety
- Liaise with families, schools and communities at times when alcohol may pose risks to the health and safety of young people

ALCOHOLIC BEVERAGE & RELATED INDUSTRIES

- Drive change in the alcoholic beverage industry to develop less harmful alcohol products
- Support the harm-minimisation goals of liquor control legislation:
  - Inform and train staff to comply with and enforce Responsible Serving of Alcohol and other liquor licensing laws
  - Cease inappropriate alcohol promotions

ADVERTISING INDUSTRY

- Work with the Alcoholic Beverage Industries to increase the marketing, advertising and promotion of less harmful alcohol products

ACTION ON ALCOHOL: A ROLE FOR ALL AUSTRALIANS

INDIGENOUS COMMUNITIES

- Improve the health of Indigenous Australians
- Increase access to health services for indigenous people who are drinking at harmful levels by:
  - Supporting primary health care providers to work with Indigenous alcohol-dependent people
  - Train Indigenous health workers
  - Expanding community-based and residential alcohol treatment programs
  - Facilitating coordinated case management of alcohol-dependent persons
- Implement local initiatives in Indigenous communities, including:
  - Restricting physical availability of products
  - Reduce the number, density and opening hours of licensed premises in areas of high alcohol-related harm
  - Strengthen enforcement of Responsible Serving of Alcohol provisions
  - Establish local groups of senior Indigenous men and women to promote greater individual responsibility in relation to alcohol
- Establish a multi-site trial of alcohol diversion programs

STATES AND TERRITORIES

- Develop and implement nationally consistent best practice approaches to alcohol policy regarding:
  - Alcohol outlet opening times and density
  - Special licensing conditions for late night and high-risk outlets
  - Responsible Serving of Alcohol training and accreditation
  - Accreditation requirements prior to the issue of a liquor license
- Review the incentive structure for alcohol-related checks in primary health cares settings
- Develop nationally consistent principles and practices regarding the supply of alcohol to minors without parental/guardian consent

PRIMARY HEALTH CARE

- Strengthen, skill and support primary health care to help people in making healthy choices
- Enhance the role of primary health care organisations in preventing and responding to alcohol-related health problems by:
  - Developing collaborative initiatives to address alcohol-related risk factors with individuals and groups
  - Increasing the uptake of pharmacotherapy treatment for alcohol dependence
  - Promote the NHMRC guidelines on low risk drinking
- Develop a comprehensive network of alcohol-related referral services and programs to support behaviour change in primary health care
- Increase access to primary health care services for hard-to-reach disadvantaged individuals who are at risk of alcohol-related harm

LOCAL GOVERNMENTS

- Utilise land use planning controls to manage existing and proposed alcohol outlets;
  - Consider outlet density levels
  - Determine the most desirable mix of outlet types
  - Define appropriate operating hours, noise restrictions, etc… for new licenses
  - Require an annual liquor license renewal subject to satisfactory compliance

WORKPLACES

- Introduce workplace strategies to prevent and reduce alcohol-related harm, including:
  - Employee health checks
  - Employee assistance programs
  - Develop evidence informed workplace policies

SPORTING CODES

- Work with Government to develop national sporting codes of conduct to take greater responsibility for players' alcohol-related behaviour

MATERNAL, CHILD AND YOUNG PEOPLES HEALTH SERVICES

- Build healthy children and families
- Protect the health and safety of the child and adolescent brain development by promoting informed community discussion about the appropriate age for young people to start drinking
- Support parents in managing alcohol issues at all stages of their children's development
- Disseminate broadly the NHMRC guidelines on the risks of alcohol consumption for young people aged under 18 years and for women who are pregnant or breastfeeding
- Provide practical advice for handling alcohol issues among children and adolescents at key life stages and settings

SCHOOLS

- Promote key messages from social marketing campaigns within schools and develop complementary preventative health policies and programs
- Facilitate school-based parent networking for mutual support and information sharing about managing alcohol issues

STRENGTHEN THE EVIDENCE BASE

- Improve national reporting and monitoring of alcohol sales, by purchasing retail sales data from the private sector
- Define a set of essential national indicators on alcohol consumption and associated health and social impacts

A FOUNDATION FOR PREVENTATIVE HEALTH ACTION IN AUSTRALIA

Addressing inequities

Influencing markets

Developing effective policies

Shared responsibility – developing strategic partnerships

Responsibility for preventative health is shared by all Australians:

- Individuals, families and communities
- All levels of government
- Multiple sectors; including the health care system, business, industry, unions, professional associations, research community, non-government organisations and other sectors

Engage communities

Act and engage in preventative health activities with people in the settings where they live, work and play. Inform, enable and support people to make healthy choices.

- Trial community-based interventions to identify what works in prevention at the local level
- Build on existing workplace health promotion initiatives
- Promote good health and wellbeing through school policies, programs and environments

Reduce inequity

- Target disadvantage by addressing the social and structural determinants of health
- Recognise the distribution of risk across the social gradient, address the highest risk and the absolute risk in the population

Act early in life and sustain action across the life course

Give children the best start in life by addressing preventative health in pregnancy and the early years

- Starting in the antenatal period, identify family risk and need, and respond early
- Monitor child health, development and wellbeing
- Service redevelopment and workforce training to meet family and childhood needs

Encourage healthy ageing through:

- Better lifestyles and improved integration in the economy and community
- Attack the underlying social and environmental factors affecting healthy ageing
- Adapting health systems to the needs of the elderly

Influence markets and develop connected and coherent policies

- Ensure the public is well informed to make the best decisions about their health and wellbeing
- Keep people and families at the centre of preventative health action and empower them to manage their health and wellbeing
- Use responsive regulation to create environments that make it easy for individuals to make healthy choices

Close the Gap for Indigenous communities

Reduce the life expectancy gap between Indigenous and non-Indigenous Australians through:

- broad multi-faceted action on the social determinants of health,
- comprehensive primary health care, and
- targeted efforts towards the contribution of alcohol, tobacco and obesity to health inequities.

Refocus health systems towards prevention

- Include preventative health in all elements of the health care system, and especially in primary health care.
- Develop an integrated primary health care system which provides quality preventative health services, including risk factor assessment and behaviour change support, which are responsive to the local needs of the community

Influencing markets

Ensuring effective implementation – building and sustaining infrastructure

Establish the National Prevention Agency (NPA) as an independent agency which is able to:

- translate broad policy into evidence-based strategies
- monitor and evaluate national policies and programs in preventative health
- publish annual reports of the state of preventative health and progress towards the achievement of the Strategy goals for 2020
- advise COAG, through AHMC, on national priorities and options for preventative health
- administer national programs, facilitate national partnerships, and advise on national infrastructure for surveillance, monitoring, research and evaluation for preventative health

Social marketing

Develop and implement comprehensive, sustained social marketing strategies for preventative health

Data, surveillance and monitoring

Implement and extend the National Health Risk Survey Program

Develop comprehensive national surveillance systems for identified preventative health priority areas, which have the capacity to:

- collect and report against behavioural, environmental and biomedical risk factors
- incorporate newly identified/revised health indicators into datasets as appropriate
- become permanent systems of data collection
- provide representative data for the whole of population and populations of interest
- complement and build on existing data collection and monitoring mechanisms

National research infrastructure

Establish a National Strategic Framework for preventative health research

Foster leadership, mentoring and knowledge sharing across a network of preventative health research centres

Workforce development

National audit of the prevention workforce

Develop immediate, mid and long term strategies to build a competent national preventative health workforce with the capacity to meet the health care needs of all Australians

Future funding models for prevention

Develop sustainable and cost-effective funding models for a comprehensive and integrated approach to prevention both within and external to the health sector

Developing effective policies

Investing for maximum benefit

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