

## RESPONSE TO NATIONAL PREVENT(AT)IVE HEALTH TASKFORCE REPORTS

*Prevention Research Collaboration, University of Sydney, December 2008*

The Prevention Research Collaboration at Sydney University is a public health research group with specialized expertise in the prevention of obesity and chronic disease, and the promotion of physical activity and nutrition. The PRC is part of the School of Public Health, and linked with the Institute of Obesity, Nutrition and Exercise (IONE). The PRC is involved in research, university teaching and academic consultancy projects. This response is submitted on behalf of this group (key academics are named at the end of the submission).

### *Obesity in Australia*

1. The Taskforce report on obesity in Australia provides a soundly based multi-strategic approach. It seeks to build on best available evidence, engage different sectors and focus on making sustainable changes to the food and physical activity environments, including regulations to limit food marketing to children and to support population change. The proposed approach addresses the need for specific initiatives for disadvantaged groups, recognizes the value of health workforce development and the value of building the evidence base.
2. While there are specific comments and suggestions which can be addressed to each of the proposed approaches and the overall strategy, these remain unimportant unless there is a set of organizational and funding arrangements that genuinely ensure significant, long-term action. Implementation matters, and any substantial obesity prevention effort needs a strategy which has population reach and is carefully sequenced, synergistically multi-faceted and monitored. Some of these conditions for success are in fact the focus of the Overall Preventative Taskforce Discussion Paper, and are arguably fundamental to the specifics of each of the reports on the risk factors.

### *Australia: the healthiest country by 2020*

3. The overall Discussion Paper prepared by the Taskforce outlines the case for prevention and the rationale for focusing on three major risk factors: tobacco, alcohol and obesity, as major contributors to chronic disease and morbidity in Australia. These arguments and focus are important and strong, and many previous Australian policy frameworks over a long time have made similar points.
4. Importantly, however, there has never been national action to address chronic disease prevention that has been commensurate with the approaches outlined in national policy frameworks or the size of the problem. This failure to act effectively is a critical point, and the Taskforce recognition and discussion of road blocks is apt. The Discussion Paper notes the following 'road blocks':
  - Skepticism about the effectiveness of prevention
  - Lobbying against prevention by groups with vested interests
  - Limited community demand, because of delayed benefits but immediate costs
  - The blaming, controlling and moral stance that pervades some prevention initiatives
  - The pervasive influence of social, economic and environmental factors on behaviour choices and which are themselves not addressed in most prevention initiatives

- Division of responsibilities between states and national governments in relation to legislation and regulation.
- Lack of national leadership
- Lack of monitoring, evaluation and research systems.

Thus, in response to these road blocks, the Taskforce Discussion Paper proposes investment in infrastructure, and the establishment of a single national prevention agency. The tasks of such an agency are listed:

- ensure delivery of programs
  - engage leaders and build new partnerships
  - commission and promote monitoring, evaluation and surveillance
  - provide an authoritative source of information on evidence, policy and practice
  - develop the evidence base by designing, implementing and evaluating large-scale and innovative programs
  - ensure the development of national workforce, linked to national, state and local agencies.
5. In response, we would agree in general terms with the Taskforce’s analysis of ‘road blocks’ and support the fundamental point that investment in national prevention infrastructure is required. The key questions and discussion points thus concern whether the proposed response is adequate, appropriate and potentially effective in addressing the identified road blocks, and how the specifications for the National Prevention Agency are refined.

The following suggestions are designed to contribute to refining these specifications.

6. An additional ‘road block’ concerns the small size, low profile and position and diffuse nature of much prevention service delivery.

Firstly, the health sectors’ delivery system for prevention varies considerably between and within states, so it is difficult to quantify or characterize precisely. It variously includes defined health promotion teams, public health teams, primary health care professionals and general medical professionals to some extent. There are also some specific delivery systems which operate outside of the health sector, including non-government organizations and local government public health groups. While there are notable exceptions, these service delivery systems tend to be relatively small in scale, and do not have a high profile within their own organization, or publicly.

Beyond this, preventive actions are and can be integrated into a range of organizations and roles, including schools, early childhood, services and acute health services. In general, the work of delivery systems is enhanced by guidance from public health experts and groups.

While there has been a history within Australia of significant rhetoric about making ‘prevention everybody’s business’, this has not generally been developed as an operational delivery system, nor evaluated. While the sentiment may be appealing and appropriate, it is unlikely to have the capacity to mount initiatives on a sufficient scale to make a difference.

Overall, community-based health promotion delivery tends to be ‘invisible’, to policymakers, managers and the public. This is one reason why there is a tendency to revert to assumptions about the potential role of primary medical care in prevention. While this may form one of many delivery structures, it is unlikely to have adequate capacity (skills and structures, not just resources) to mount effective primary prevention efforts. Any scaled-up preventive efforts need to take this into account and reform and enhance systems for prevention service delivery.

7. A further, related road block concerns the disjunction between much health promotion theory and practice. While many people involved in prevention work understand the complex, multi-layered and social nature of health determinants, they are often not in a position to respond appropriately, given their role, organization and resources. The challenge of ‘thinking globally and acting locally’ is highly under-estimated and largely unexplored terrain<sup>1</sup>. The road block, then, is design of a comprehensive approach to prevention that is commensurate with the complexity and social nature of the problems, but also practicable.
8. Taking account of the road blocks, the proposed agency should be established according to the following criteria and specifications:
  - commitment for a minimum of 6 -10 years funding
  - established as an agency at arms length from government, not within government; able to operate across government portfolios; report to a central agency, and not the health portfolio.
  - operate supportively within a federal system and add value to the role of non-government, state and local government agencies, as well as established prevention research groups
  - avoid duplicating the role of existing infrastructure groups, particularly in relation to population health monitoring. The need for established, ongoing population health monitoring systems is widely recognized, and a National Prevention Agency may provide a suitable base for such infrastructure. However links with the AIHW should be carefully considered.
7. The operational role of the agency needs to be formulated in order to achieve the following:
  - (Policy) Provide detailed advice regarding national policy, regulatory and legislative actions (in tobacco, obesity, alcohol prevention)
  - (Policy investigation) Generate and investigate strategic policy options, through a variety of methods including costing and modeling studies, research on methods for

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<sup>1</sup> King L The role of health promotion: between global thinking and local action. HPJA 2006 17(3), 196-9.

the delivery of efficacious interventions and strategic planning methods.

- (Cross-sector partnerships) Broker and facilitate cross-sector relationships and actions, which encompass government agencies, non-government organizations and a mix of professional groups and disciplines.
- (Strategic and implementation planning) Map a comprehensive, multi-layered plan for the implementation of key programs, whereby a range of delivery groups can contribute and work synergistically to achieve common goals.
- (Infrastructure support) Develop and strengthen appropriate networks and systems for service delivery of alcohol, obesity and tobacco prevention actions
- (Implementation) Ensure large-scale, coordinated implementation of major initiatives (in tobacco, obesity, alcohol prevention), with reference to existing infrastructure and delivery systems
- (Social marketing) Develop and implement coherent, national social marketing programs
- (Build capacity and support applied intervention research) Sponsor and commission a strategic program of intervention research and implementation / service delivery research studies. This would include commissioning consultancies and studies for the design, development, implementation, costing and evaluation of innovative interventions that are potentially appropriate for scaled-up implementation. Any research program sponsored by the agency should seek to redress the 'inverse evidence rule', where the volume of evidence is inversely proportional to the value and appropriateness of the intervention under study<sup>2</sup>.

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<sup>2</sup> Nutbeam D. Getting evidence into policy and practice to address health inequalities Health Promotion International 2004 19(2), 137-140.