AUSTRALIAN
HEALTH POLICY
COLLABORATION

Chronic diseases in Australia: Accountability and action

Forum Report

Forum Report 2016-04
July 2016

Australian Health Policy Collaboration

About the Australian Health Policy Collaboration

The Australian Health Policy Collaboration was established at Victoria University in 2015 to build from the work of the health program at the Mitchell Institute over the previous two years. The Collaboration is an independent think tank that aims to attract much required attention to the critical need for substantial and urgent health policy reform focused on addressing chronic disease on a national scale.

This report was prepared by Rebecca Lindberg, Hazel Fetherston and Donna Cohen.

Chronic diseases in Australia: Accountability and action

Opening address

Professor Rosemary Calder AM, Director, Australian Health Policy Collaboration

Invited presenters and panel members

Professor Graham MacGregor, University of London

Ms Juliette Wittich, NCDFREE Global Coordinator for Australasia

Ms Alison Verhoeven, CEO Australian Healthcare and Hospitals Association

Ms Robin Whyte, CEO Eastern Melbourne Primary Health Network

Dr Bernie Towler, Principal Health Adviser, Australian Government Department of Health

Professor Bruce Neal, Senior Director at The George Institute for Global Health

Dr Zena Burgess, CEO Royal Australian College of General Practitioners

Mr Michael Moore, CEO Public Health Association of Australia

Mr Paul Grogan, Director of Public Policy and Knowledge Management, Cancer Council Australia

Attendees

Approximately 90 individuals, from across Australian academic, not-for profit and public health sectors

Facilitator

Dr Donna Cohen, Darcy Associates

Welcome and launch of *Australia's Health Tracker*

Professor Rosemary Calder AM welcomed the forum participants and thanked them for their ongoing involvement in – and commitment to – the process that commenced with the November 2014 forum to discuss the AHPC report *Chronic diseases in Australia: The case for changing course.*

Rosemary reminded the group that the priorities identified during that forum had served as the basis for the strategic framework presented in the follow-up policy paper *Chronic diseases in Australia: Blueprint for preventive action*. The forum also led to the establishment of a number of expert working groups, whose collective activities informed the technical paper *Targets and indicators for chronic disease prevention in Australia*. This work culminated in the second AHPC forum in November 2015, on *Targets, indicators and accountability* and led to the development of a prevention report card.

Rosemary then officially launched *Australia's Health Tracker*, a comprehensive report card on preventable chronic diseases, conditions and their risk factors, along with its two briefer, targeted report cards for adults and children/young people. She noted the *Health Trackers* are intended to be 'living' documents that are updated periodically on the AHPC website. They are a freely available, shared resource that can be used by health academics, advocates and policymakers to drive change. A technical appendix is available to provide further details on the *Health Trackers*.

Session I: Value and utilisation of *Australia's Health Tracker*

Four speakers from the not-for-profit sector; a hospitals and healthcare peak association; primary healthcare networks; and the Australian Government Department of Health, were asked to respond to the launch of Australia's Health Tracker, to provide their thoughts on how the report cards could be used to greatest effect to gain maximum policy and practice change.

All speakers agreed the Health Trackers are well-presented and accessible resources that provide clear information to all stakeholders, including health practitioners, politicians and policymakers, as well as members of the general public. The Health Trackers nominate tangible and explicit targets and provide an easy-to-interpret report on progress. Importantly, they represent an agreed set of outcomes that provides an important resource for collaborative action.The speakers raised a number of other points:

- There is a need for further data collection and analysis, particularly where data gaps have been highlighted on the report cards.
- In the recent Australian federal election campaign there was a notable lack of attention to health issues more broadly and chronic disease issues in particular. The Health Trackers provide an important tool to use in informing and resourcing public debate, political awareness and government engagement.
- While working with federal and state governments is clearly a priority, local governments also have an important role to play in many aspects of chronic disease policy and practice. Therefore, the Health Trackers represent an information and accountability tool for all three levels of government.
- General practitioners are essential agents of change for system reform, since they are at the frontline of both preventative and management aspects of chronic disease. Engagement with GPs is important to enable the Tracker reports to be tailored to their needs as useful resources and for initiatives aimed at resetting the dialogue around chronic disease more broadly.
- The data presented by the *Health Trackers* is very important, but helping the general public to

make sense of the facts and figures requires that information to be translated into stories that individuals can relate to. This is particularly important for children and young people.

- While the Health Trackers represent an agreed set of outcomes, the task of translating this into policy responses and actions is challenging and is only likely to be achieved in the context of an appropriate authorising environment.

Following the panellists' presentations, forum participants were invited to briefly discuss their ideas for utilising and/or maximising the value obtained from the Health Trackers. Suggestions included:

- Primary Health Networks (PHNs) and private health insurers should be encouraged to sign on to the indicators and targets.
- Encourage different groups of experts to focus on different indicators (or groups of indicators).
- Prioritise indicator monitoring, rather than trying to focus on everything at once.
- Use the report cards to ensure advocates, practitioners and policymakers are all 'singing from the same song sheet', rather than different groups using different points of reference and pulling in different directions.
- Publicise the report card widely at the community level, as it provides an easy-to-understand summary of chronic disease challenges.
- Make use of existing advocacy/practice alliances to take up particular themes and targets.
- Use the report cards to advocate for relevant data collection, particularly in general practice.
- Map the indicators of the report card against the National Preventative Health framework.
- Assist members of the general public to understand the indicators through stories that individuals can relate to.
- Use the *Health Trackers* as a tool to raise awareness, encourage debate and advocate for appropriate health budget investment in chronic disease prevention.

On the broader question of how to ensure the *Health Trackers* are a tool for accountability, there was general agreement that political leaders should be held accountable for achievement of outcomes, as they are decision makers when it comes to public expenditure on health. For this to work effectively, it was also agreed the indicators must be reported at the level where there is accountability. That is, political leaders need to be made aware of progress against the indicators, while the broader electorate – to whom political leaders are ultimately accountable – must also be aware of whether adequate progress is being made.

Session II: Achieving and sustaining success in prevention

The keynote presentation, delivered by Professor Graham MacGregor, showcased the UK experience in reducing salt and sugar intake across the general population.

Key messages from the presentation included:

- Australia has an excellent record with some chronic disease-related issues, such as tobacco, where it led the world with plain packaging and other preventative measures. However, while there is a need for Australia to do more in other aspects of chronic disease, it is also important to limit the focus to one or two areas to increase the likelihood of success.

- Unhealthy diet has been identified as the major underlying factor causing death, followed by high blood pressure, tobacco, air pollution and high BMI. In particular, processed foods and soft drinks contribute to increasing consumption of sugar, fat and salt, which contribute significantly to the development of dental caries, obesity, Type 2 diabetes, cancer, heart disease and stroke.
- In the UK, addressing the high salt intake of individuals began by asking the question: *what is the most effective way to reduce salt intake*? Of the five main strategies proposed, four (labelling of foods and public education; encouraging people to eat specific lower salt foods; promoting avoidance of high salt foods; a tax on salt content) were shown to not be effective, while incremental re-formulation of all processed foods was identified as highly effective.
- The benefit of food re-formulation is that salt consumption decreases slowly while consumers continue to enjoy the same foods. This approach does not rely on major behavioural modifications on the part of individuals and has the added benefit of enabling reduction targets to be reset every 2-3 years.
- While the food industry has primary responsibility for reducing salt content in processed foods, government also has a role to play in setting standards and enforcing regulations. On this point, it should be noted that the salt content of foods sold in Australia is much higher than their counterparts sold in the UK and produced by the same companies. Therefore, the fact that processed food producers have reduced salt content in one country does not automatically result in reductions to salt content in other jurisdictions, which is why government action is needed.
- In the UK, the reduction in salt consumption in the years 2003–2011 corresponded to population level reductions in blood pressure and 20,000 reductions in deaths associated with heart disease and stroke.
- The success of the salt reduction campaign resulted in a similar campaign – now underway in the UK – to reduce the sugar content of processed foods. As with salt intake, a number of options were identified (including: a sugar tax; subsidise healthy food; ban advertising of unhealthy food; restrict availability; reduce portion size; re-formulation), with food re-formulation identified as the option most likely to be effective.

Following Professor MacGregor's presentation, a panel of four speakers was asked to respond with their views on lessons for Australia from the UK experience. Key points are summarised:

There are three constituencies that need to be engaged to effect change:

- Community/civil society – engagement of this group is essential to drive change in the other two constituencies; however, junk food is so prevalent and commonplace that there are large barriers to getting a message through.
- Food industry – engagement with this group needs to address the industry need to remain viable and indeed maintain profits from healthier food.
- Government – this group pays for the consequences of poor health, works in both public health and the food industry.

Opportunities to engage include:

- Work through food retailers, rather than food producers, in the first instance
- Work through private health insurers
- Work through new crossbench MPs in the next federal parliament

Important to understand that change in food consumption behaviours happens at an individual level, not at a population level.

Bringing about behavioural change in individuals requires one-on-one engagement with a trusted health professional such as their GP. However, while GPs are interested in preventative health measures, consultations are not adequately funded through Medicare to allow time for this.

- Strategies that could be applied include:
    - Encourage all individuals to be voluntarily enrolled with a GP to have their health status regularly monitored.
    - Translate health statistics and Health Tracker indicator information into stories that people can relate to and apply to their own circumstances.
    - Make better use of mobile phones and social media to provide health information to people.
    - Collect more useful data through GPs.
- In Australia, attempts to reduce salt or sugar content of processed foods will have to overcome the 'nanny state' argument that is always raised in this type of public health campaign.
- It will be important to ensure Australian politicians understand the kinds of policies that will make a real difference and equally important to ensure the food industry is onside with the necessary changes. This will require significant coordination of effort.

It is actually very difficult to get traction on chronic health issues with current political dynamic. There are several factors that contribute to this:

- "We're falling behind other countries" is not a message that works particularly well in Australia.
- Australian life expectancy and health statistics tend to work against the call to action, since life expectancy and overall health indicators are generally very good by international standards.

In the ensuing discussion, the following points were made by forum participants in general:

- Senior politicians will generally respond to issues that impact on children (this was the case in the UK experience with reducing salt and sugar intake). Moreover, getting communities and professionals working together to promote these issues is likely to have more impact.
- Pressure applied through the media can also be very helpful for encouraging politicians to take up an issue. Indeed, a media blitz can create the impression that there is significant public desire for change.
- There is a problem in Australia with the food industry making political donations to both major political parties. In addition, big food and alcohol companies are significant employers, which makes politicians reluctant to adopt measures that might impact negatively on those businesses.
- Creating awareness amongst people about what is healthy is less likely to be effective than re-formulating the salt and sugar content of food.

Session III: Achieving collective action

Forum participants worked together in breakout groups to address the following two questions.

1. Which interventions/policy options have the potential for the broadest impact on chronic diseases?

   Consider the following (provided in in table action packs):

- ACE recommendations
- Assessment criteria
- Action areas
- Examples of popular public health actions

2. How can we make it happen?

   For each policy option nominated, what action is needed to ensure the option is viable? For example:

- Current activities that could be augmented or collaborated on.
- New activities to ignite community and political support.
- How can AHPC help with this?

Facilitator report back

The following table summarises the broad level of support amongst forum participants for action on unhealthy food products. A detailed summary of the group discussions is provided in the appendix.

Several tables nominated
Reduce intake of unhealthy products. • Food re-formulation (potentially mandatory) • Mandatory limits on salt in bread, margarine and cereals (*ACE recommendation #4*) • Protect children from junk food, alcohol and their advertising • Sugar tax • More effective food labelling

In the general discussion that followed the facilitator summary, the following key points were made:

Australia should consider following the UK's lead in ensuring it has groups of experts that are prepared to respond quickly to misinformation.

- The advantage of policies that impose taxation measures is that this collects funds that can be used to replace sports advertising of alcohol and junk food.
- On the other hand, the difficulty with policies on marketing around unhealthy food choices is that the definition of 'unhealthy' can be contentious. This led to the suggestion that all food advertising for children should be stopped.
- Although there are not really any questions over the science of the health impacts of salt,it will be

essential to work with the food industry. Food retailers may offer more opportunities than food producers.

- Although there is some evidence that the community is concerned about the salt, sugar and fat content of processed foods, this concern is not being effectively transmitted to decision makers. It was noted that the one food-related public health issue that did get political attention was the recent contaminated frozen berries issue. Issues that don't pose an immediate health risk, even though the health risks over time to the whole population are proportionately much larger, will be more challenging to get onto the political radar.
- There was general acceptance amongst most forum participants that food re-formulation measures (along the lines of what was achieved in the UK) offer many benefits. The cost of re-formulation to the food industry is not all that large (mainly the cost of replacing labels) and the cost to the government is minimal. However, there was a dissenting opinion that the focus on food reformulation is too narrow and that multiple initiatives should be pursued to maximise the opportunities for success. Another dissenting view was that *promoting physical activity* is a less contestable option than measures to reduce dietary intake of salt, sugar and fat.
- There was some discussion about the kinds of evidence that are needed to support the value of diet-related initiatives. It was noted that dietary studies are actually very difficult to do and the results can be inconclusive because of the variety of factors that have to be accounted for. Moreover, there have already been a number of cohort studies from various international settings (e.g. Japan and Finland) and other studies are unlikely to add any further value. It was also noted that politicians don't necessarily respond to more scientific evidence, especially if they are disinclined to support particular actions for political reasons, as has been the case with climate change.
- Other areas identified for action included
    - Mental health;
    - Socio-economic factors.

The forum concluded at 4:30pm

Next steps for the AHPC post forum

Action	Month
AHPC to produce and distribute forum summary	July 2016
AHPC to consult forum participants via survey	July 2016
AHPC and forum participants to disseminate Australia's Health Tracker incorporating ideas shared at forum for utilising and/or maximising the value	July-Aug 2016
AHPC to collaboratively pursue investment in future report card development and promotion	Ongoing
AHPC to work with forum participants to develop a collaborative policy action and implementation strategy to complement Australia's Health Tracker	FY16/17

Appendix

Thematic summary of afternoon table discussion

QUESTION 1 – Which interventions/policy options have the potential for the broadest impact on chronic disease?

NB - The most favoured interventions/options, as nominated by participants, are summarised first.

Healthier Food

- Salt reduction by food reformulation across products (CVD, hypertension & cancer) (Ace recommendation #4)
- Sugar and fat via food reformulation across products (obesity, diabetes type2, hypertension, CVD, cancer)
    - Focus on milestone achievements on the way to bigger targets e.g. sugar-sweetened beverage tax
    - Work to engage food industry positively.
    - Mandatory limits.
- Taxation on 10% of non-core foods (Ace recommendation #3).
    - Taxation on 'unhealthy food' redirected to subsidising healthy options.
- Restrictions to advertising/marketing of unhealthy food, marketing etc.
    - Advertising restrictions including on point of sale/placement in supermarkets (reduce impulse buying).
    - Improved Health star rating FOP system (Make food labelling work more effectively (with mandatory targets for ingredients of concern e.g. salt/sugar/palm oil) and FOP system - products health and environmental sustainability.
- Early education – what healthy food is, how to cook it.

Better Care & Early Intervention.

- Co-morbid coordinated care system.
    - Collaboration, bottom up, top down.
    - Smaller demonstrated place-based approach.
    - Population health screening for at risk of chronic disease individuals (ongoing, continuous, earlier and best use of workforce).
    - Support GPs with proper MBS funding – an alternative setting i.e. screening in pharmacies.

  - Maternal (pre and post natal) interventions.

- ACE #9 Screening for pre-diabetes.
  - Screening value is dependent on the interventions provided following identification of an issue.
  - Population-based has limited use > targeted screening.
- Poly-pill. Population and clinical interventions considered. (Ace recommendation #6).

Physical Activity

- Suite of activities to target physical inactivity was key (ACE recommendation #11).

Alcohol and Tobacco Control

- Tobacco tax continuing (Ace recommendation #1), no smoking policies and assist to quit for people with mental illness in hospitals, workplaces etc.
- Advertising restrictions.
  - Banning alcohol details on receipts.
- Ongoing relative price increases for (cigarettes, food and alcohol) harmful substances – progressive systematic.

Prevention Resourcing and Tools

- Increase prevention spend to 5% of GDP within 5 years.
- Commitment to sustainable population health surveillance system. Must be timely and comprehensive.
- Establish an independent preventative health agency.

Healthier Environments

- Modifying the environment.
  - Access to health facilities (i.e. subsidised/free gym membership for people enrolled at community health centres).
  - Density of take away outlets, take away alcohol etc.
  - Renovating playgroups to make them more enjoyable.
  - Lighting etc. to make places safer to use such as bike paths, playgrounds etc.

Other comments:

- ACE #1 and #10 done and implemented and should be maintained.
- ACE #7 no – not about prevention.

- Broadest impact: food, alcohol & tobacco interventions.
- When discussing reducing marketing of 'unhealthy' foods – the definition of 'unhealthy' can be perceived to be contentious, hence perhaps all food advertising to children should be banned.
- Targeting vulnerable populations > need a balance between these by Government funders.
- Focus on top 3 burdens of disease (Cancer, CVD & mental illness). Therefore focus needs to be on and continue to be tobacco and obesity and high risk population groups.
- ACE #8 Have to take into account the unexpected outcomes such as Vitamin D reduction with flows through to bone density etc.
- Consider multi-sectoral approaches.
- By reducing salt/sugar what are the possible consequences i.e. labelling costs for manufactures and salt industry? Will it actually change behaviours? Will people just consume more of other stuff?
- Tailoring responses to the community.
    - One size fits all approach does not work for some things.
- Public health lobby needs to be louder than the other groups (mass-medication scare tactics, nanny state, food industry etc.).

QUESTION 2 – How can we get it?

Healthier food

- <u>Reformulation and regulation</u>

- Responsible regulation: law more nuanced; soft law.
- Transparency & accountability: Find financial solution deliver profits ; Loyalty program/ supporting local schools; product placement – regulation; Monitor to name and shame.
- Supermarket partnerships: Suggested alternatives at point of purchase/on line purchasing; Country of origin labelling – how did they succeed and learn from them
- Need a targeted approach; partnership between Government, industry and dietitians to set realistic targets.
- Learn from UK approach – what worked best in reformulations - Create broad, cohesive, multi-pillar strategy to approach government for salt and sugar reformulation. Basically, take the UK strategy and apply it in Australia, however, don't say 'because the UK did it', as this does not seem to work.
- Health star rating is already helping reformulation to occur – acknowledge and build on this.
- Keep it on the agenda.
- Help Food and Health Dialogue/ Healthy Food Partnership to do its jobs.

- But keep up pressure for sugar-sweetened-beverage tax (even though it may be unlikely).
- Have a suite of options of what you want for a staged approach.
- Public appetite for change in diet/nutrition behaviours/disease/food environment is there.
- Daft 'science' needs to be challenged especially in food/nutrition space – need a group of experts than can speak out to clarify issues for public.
- Partnership with industry to find solutions to all the problems i.e. Government subsidies for new processing equipment & partner direct with growers to promote 'farm to table'.

- Protection of children from junk food and their marketing

- Advocate and build on existing activity to close the loop hole on sports advertising on TV.
- Regulate banned advertising of unhealthy food to kids (decrease sports clubs focus on harmful foods). Refer to blueprint on Cancer Council website.
- Advocate for supermarkets re-shelving unhealthy foods to top.
- Sign up all health professionals to advocate.
- Put in the suite of options when proposing this protection as multifaceted approach will be required and some options more palatable than others.
- Keep up citizen's outrage/advocacy for this.
- Leverage off Live Lighter.
- Work with employer organisations to adopt the tools for them – start with local government and engage sporting organisations (OH&S is big issue). E.g. fund raising with chocolates.

Chronic disease care & early intervention

- Integrated care; Get health professionals to implement e.g. screening; Nurse clinics in GP, CDM, Missing community link.

- Risk assessments for prevention through timely diagnosis

- Tailor risk measures with PHNs for their use and reporting – help PHNs design the resources to work for them.
- Health care homes (n=200) work to tailor these resources for them.
- For high risk, morbidly obese – lap banding surgery is very cost effective. Current policies in public health are inconsistent and discriminatory. An example of need for access and equity in prevention interventions and policy.
- Provide evidence for where local Government can achieve a balance between prevention/ intervention for high risk population groups and whole of population health risks.

Physical activity

- There needs to be a greater emphasis on using the existing evidence – e.g. suite of

interventions available for physical activity.

- Use Targets and Indicators for Chronic Disease Prevention in Australia report.

Commitment to sustainable population health surveillance system

- Population data, state and federal.
- Hook into big data innovation movement.
- Use Tracker to highlight importance of need for data and link to chronic conditions framework.
- Get average person to understand and buy into Tracker through public health leaders using this message.
- Harness technology for health tracking and communicate/integrate with patient files.

Prevention Resourcing and Tools

- The Australian National Preventative Health Agency take 2.
- Target independents now because there is an opportunity for them to have great influence.
- Link with National strategic framework for chronic conditions and Australian Health Tracker targets & indicators to underpin the framework.
- $$ needed and stakeholder support.
- Quarantine $$ in the budget for prevention so it is not subject/dependent on changing governments.
    - The need to expand data so that 'the broadest impact' is possible.
        - This includes state comparisons, as well as PHN and LGA.

General techniques:

Government relations

- Focus on State and territories rather than focus on federal: Use one state as a model: Help to align non-health/health objectives e.g. alcohol licensing and environmental planning.
- Resilience – never give up - sustained, long-term lobbying of the politicians and balance of power.
- Need same (clear) messaging/pitch to push politicians and community.
- Political block i.e. politicians need to re-elected and hence opportunities lie in identifying alignment of our desires and theirs for the community.
- Start with small changes and get government action on the first step before trying to advocate for the end-game.
- Engage cross benchers with information to use preventative health as a bargaining chip.

Multi-sector partnerships

- Multiple strategies/multi-faceted – funding to support.
- Multi-sector approach
    - Reducing obesity will save x admissions, $x in equipment costs, reduce workplace injuries and therefore insurance claims, reduce time off work which will reduce economic activity loss...
    - It is not just a department of health problem.
- Peer support networks for interventions such as maternal health.

Equity

- Poverty reduction - Canadian model (Ontario) started small and increased the scope

Community engagement:

- Need media attention.
- Amplify the consumer voice.
- Activate/use local champions.
- Have the local community be part of the local solution.
    - Has to be done from the beginning.
    - Have to understand who the community is in order to tailor the message (what are the drivers behind unhealthy behaviours).

Research and data

- Cost effectiveness; Do health economics to sell the argument.
- The good work of 'data' agencies needs to be continued, with a renewed focus on collaboration – AIHW, PHIDU, AHPC. AHPC has shown greater leadership in then translating the 'data' into a practical, workable tool – Australia's Health Tracker – other agencies could follow suit.
- Developmental interventions – not everything has to be perfect from day 1 – programs can evolve as results and evaluations provide opportunities for learning.
- Long term approach to trial programs.
    - Throwing piecemeal at constant trail is a waste > needs to be rationalised.
    - Need longitudinal data – needs funding.

Messaging

- If you market it as a health program you only bring health groups to the discussion.
- Every organisation to take back takeaway group message and advocating.

AHPC can assist via:

- Networks and events.
- Choose a few priorities and do them well.
- Promote individuals who have made great gains and promote their strategies and how did they do it.
- Good news stories shared for learning and inspiration.
- AHPC or others keep repeating annual/every 2 years the Australian Health Tracker.
- Youth suicide target for next report card.
- AHPC – tailor these resources for different sectors and collaborate with governments especially. I.e. National strategic framework for chronic conditions.
- The Aus Health Tracker is like the barometer – and it helps to measure progress on action so keep issuing the reports regularly.

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