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An Options Paper
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A national agency for promoting health and preventing illness

Professor Rob Moodie
Chair, Global Health, Nossal Institute for Global Health, University of Melbourne
Chair, Preventative Health Taskforce

Todd Harper
Chief Executive Officer, Victorian Health Promotion Foundation (VicHealth)

Professor Brian Oldenburg
Research Director, Australian Institute of Health Policy Studies
and Chair, International Public Health, School of Public Health and Preventive Medicine, Monash University

Produced with the assistance of
Kerry Grenfell, VicHealth
Kay Ansell and Brian Diamond, Fullpoint Media

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Part 1

Section 1: INTRODUCTION

Over recent months the National Health and Hospitals Reform Commission, the National Preventative Health Task Force, the Primary Health Care Strategy Reference Group and the Indigenous Health Equity Council have all been established, each with a mandate of health reform.

This provides a once–in–a generation opportunity to improve the health of millions of Australians by taking a national approach to illness prevention and health promotion.

The National Health and Hospitals Reform Commission has proposed design principles to shape the Australian health care system stating that "health care in Australia should be accessible to all based on health needs, not ability to pay". So, just as Medicare, the PBS and public health care embrace the principle of universality, access to illness prevention and health promotion services must become universal in Australia.

To date, despite major successes in the area of tobacco control, reduction of road trauma and HIV/AIDS, prevention is often perceived, developed, implemented and funded in many areas as a series of short term projects. Prevention is for life. It cannot be started and stopped. Illness prevention and health promotion services must become an essential part of our nation's shared infrastructure, just like hospitals, schools, roads and communications.

A national agency for promoting health and preventing illness ("the Agency") should be charged with ensuring the delivery of a minimum set of evidence-based, health promotion/illness prevention programs that are accessible to all Australians.

We propose that the Agency's most important responsibility would be to provide national leadership – particularly in the formation of prevention partnerships that unite people and organisations from a myriad of national, state and local entities. Leadership in implementing the National Preventative Health Strategy, to be finalised by June 2009, provides a natural starting point for such an Agency.

A measure of the Agency's leadership would be its capacity to engender ownership of health issues among Australians. In our various roles – as employers, employees, parents, and individuals – we all "pay" for the high social, economic and health impacts of chronic diseases that are largely preventable.

The leadership needs to include development of national capacity in surveillance of chronic diseases, prevention research, and in the development of new models of evaluation. National expertise and networks must be developed in social marketing and public education, just as they are needed

in the areas of legislation, addressing health inequalities, regulation and taxation.

An area of particular focus derives from the fact that although Australia is one of the world's wealthiest and healthiest countries, we have the worst health disparities between mainstream and Indigenous populations. The Agency's commitment to these issues is highlighted in Part 1 in 'Objectives' and 'Key Roles'.

This paper, commissioned by the National Health and Hospitals Reform Commission outlines the options for the establishment of a national agency for promoting health and preventing illness. Part 1 provides governance and funding options, and proposes objectives and key roles for the National Agency. In Part 2, we present the lessons learned from international experience, and we critically evaluate models from Australia and internationally.

A national agency for illness prevention and health promotion

Funding source options

- Pooled federal and state health promotion funding
- Income from a 'Future Fund' for Illness prevention/ health promotion
- Taxation reform on products such as alcohol, tobacco and, possibly, unhealthy foods
- Funding at an initial percentage of the overall health budget, rising as benefits are proven
- A prevention levy, as with Medicare, or a levy on private health insurance

The workplan

- Implement National Preventative Health Strategy and agreed priorities
- Set specific goals on health priorities, including targets for key health indicators such as smoking, nutrition, alcohol misuse, mental health, health inequalities and physical activity, as well as population determinants of good health such as food security, housing, and education

Involvement

- Government, across all levels and portfolios
- National NGOs (such as Diabetes Australia, the Cancer Council of Australia, National Heart Foundation)
- Peak professional associations and community organisations
- Local government associations at national and state levels
- Private sector organisations
- Philanthropic sector
- Academia
- Arts sector
- National sports/recreation bodies
- International organisations

Funding outcomes

Funding for programs that have proven benefits

Funding to develop innovative strategies for health promotion

All dedicated funding for health promotion to be tied to stringent evaluation strategies

Evaluation

- Development of a new evaluation model able to measure the diverse economic benefits of health promotion
- Staged assessment of programs as health promotion reaches agreed levels of the total health budget, with advancement to the next funding level based on effectiveness and equity outcomes

Delivery

National, state and regionally based health authorities and NGO partnerships to implement health promotion strategies to meet:

1. Specific goals on health priorities
2. Minimum set of health promotion programs accessible to all Australians
3. Specific health programs for priority population groups, to achieve equity objectives

Section 2: GOVERNANCE

For the goals of the National Preventative Health Strategy to be met, the national agency for promoting health and preventing illness ("the Agency") would need to have Cabinet level support and cross-portfolio engagement at the most senior levels. This would maximise the impact of prevention by ensuring that it is afforded a sufficiently high status and engages with the diverse portfolios and stakeholders who can influence prevention agendas in settings beyond health. We propose that the Agency report directly to the Prime Minister, or Federal Minister for Health, who would in turn report to COAG on the Agency's performance in achieving the goals of the National Prevention Strategy. A significant advantage of the Agency reporting to the Prime Minister would be to harness the capacity of diverse portfolios whose functions impact significantly on health outcomes such as transport, housing, education, justice, Indigenous affairs and employment.

Assuming the Agency is set up as a statutory authority [see Part 2 'Models'] it would operate under high degrees of both autonomy and accountability. It would provide to the Federal Health Minister and COAG (or the Prime Minister's Department) an annual report which includes its progress in meeting the goals and targets of the Strategy. An option could be to model its annual report on the federal State of the Environment Report, by setting baselines against which improvements in agreed indicators could be measured. This could be produced in collaboration with other national agencies, such as the Australian Institute of Health and Welfare (AIHW) and the Australian Bureau of Statistics (ABS).

The Agency's independent Board would be broadly based in composition, including members with health expertise, as well as leaders from peak bodies representing employers, employees, community groups, NGOs, education, law/regulation, social marketing, sport, the arts, Indigenous communities, disadvantaged Australians and local government. The Agency would also be advised by board committees and advisory panels that have the appropriate backgrounds for ensuring that the Agency is receiving a diversity of inputs from a range of relevant stakeholders.

These approaches are similar to governance arrangements for the Australian Institute of Health and Welfare (AIHW) and the National Health and Medical Research Council (NHMRC).

AIHW is Australia's national agency for health and welfare statistics and information. It is a statutory authority within the Health and Ageing portfolio, reporting to Parliament through the responsible Minister. The AIHW has delegated management of its affairs to the AIHW Director. The Director is appointed by the Minister on the recommendation of the Board. The AIHW's main governing agents are the Board, the Ethics Committee and the Audit and Finance Committee.

The National Health and Medical Research Council (NHMRC) is Australia's peak body for supporting health and medical research; for developing health advice for the Australian community, health professionals and governments; and for providing advice on ethical behaviour in health care and in the conduct of health and medical research.

NHMRC became an independent statutory agency within the Health and Ageing portfolio in 2006. This change brought with it an amended *NHMRC Act* that defines the NHMRC as the Chief Executive Officer (CEO), the Council and committees, and the staff of NHMRC. Under the amended *NHMRC Act*, the CEO is the accountable officer directly responsible to the Minister for Health and Ageing for setting the major objectives for NHMRC, identifying new and emerging health issues and developing strategies to address these issues as they arise.

The National Preventative Health Strategy

The National Preventative Health Strategy would guide how the Agency's funds are invested, according to the agreed priorities of the Commonwealth and State Governments, and would include targets for key health indicators. Targets would be adopted for the whole population as well as priority population groups, such as Indigenous Australians and others who have higher rates of many preventable diseases. The Agency would ensure the delivery of a minimum set of evidence-based health promoting programs that would be accessible to all Australians, to be comprehensively evaluated and updated accordingly.

A longer term option may see the development of a National Charter for Health as part of the Strategy, with the Agency responsible for its implementation [see 'References']. Such a Charter would identify targets for key risk factors and the determinants of improved health, to be endorsed by Federal, State and Territory governments and, where appropriate, also by local government and community agencies. These would include smoking, nutrition, alcohol, physical inactivity, and social inclusion. It should also address broader determinants such as education, employment and housing.

Sufficient time would need to be allowed before the Agency's progress can be properly evaluated, to factor in the lag time required to capture the diverse benefits of health promotion interventions. However, intermediate indicators would track progress in meeting the goals of the National Preventative Health Strategy.

The programs which achieve the Strategy's objectives would be devised and carried out by the appropriate agencies; the Agency's role would be to facilitate and ensure that the best models are identified, applied and evaluated.

Section 3: KEY OBJECTIVES FOR THE AGENCY

The Agency's key objectives would be aligned with the goals of the National Preventative Health Strategy. Our initial proposed objectives are that the new agency would:

1. Provide national leadership and coordination in health promotion and illness prevention
2. Build national prevention systems with capabilities in:
    a. surveillance, prevention research, evaluation
    b. social marketing and public education
    c. legislation, regulation and taxation
3. Develop the evidence base on prevention through the design, implementation and evaluation of 'scaled up' programs to improve the health and wellbeing of the population or population sub-groups
4. Contribute to closing the health gap between Indigenous Australians and the rest of the population in association with other relevant organisations such as the National Indigenous Health Equity Council
5. Ensuring the delivery of a minimum set of evidence-based, health promotion/illness prevention programs that are accessible to all Australians
6. Engage key actors and build new partnerships across federal, state and territory governments, national agencies, professional associations, local government, peak community groups, NGOs, the private sector, the philanthropic sector and academia.

Section 4: FINANCING

Health promotion in Australia has long been under-funded in proportion to its benefits. This has been detailed in many studies, including the AIHW's *National Public Health Expenditure Report 2005-06*. Just over $250 million is spent annually on health promotion in Australia, out of $1.4 billion spent on all of public health. The creation of the Agency is a long-awaited opportunity to redress this imbalance.

It is critically important that the funding for prevention – channelled through the Agency – be substantially increased to both accurately reflect and dramatically increase its returns on investment. Tobacco control programs, to cite one example, have since 1971 generated an estimated benefit/cost ratio of 50:1 (Applied Economics, 2003, *Returns on Investment in Public Health*).

The Agency's funding needs to be secure and long-term to ensure that it has the autonomy it needs to trial innovative strategies, programs and models. It needs to be able to invest its funding on the basis of the best available evidence, while remaining accountable through its governance structures.

The financing options we believe are most applicable to an Australian context are outlined below. Some of these options were assessed in greater detail in *Purchasing Prevention: Making Every Cent Count*, a background paper prepared by Dr Sharon Willcox for the National Health Policy Roundtable 2006 [See 'References']. Dr Willcox observed that "The adoption of a settings approach to prevention would suggest that boosting investment in prevention should occur through a multi-pronged approach. That is, it should not simply be about increasing spending by health departments on 'public health' responsibilities, but instead seek to embed a commitment to investing in prevention from many organisations".

Funding options

There are a number of funding options, of which, a number could work synergistically with one another:

1. Establish a 'Future Fund' for health promotion/illness prevention that provides the new agency with high levels of independence and autonomy, long-term security, and a predictable source of income that allows long-term planning. The amount of capital allocated towards the agency could be based in part on Treasury's own estimates of the predicted costs of the expected dramatic upsurge in chronic disease.
2. Pool together earmarked funding agreed under an appropriate intergovernmental mechanism. The funding would be managed and distributed by the Agency. This could provide a more transparent assessment of how much in total is being invested in prevention by federal, state and territory governments as measured against the goals of the National Preventative Health Strategy.
3. Utilise hypothecated funding from taxes on products such as alcohol and tobacco where price increases also contribute to reducing consumption. This approach was used in establishing foundations such as VicHealth, Healthway and ThaiHealth. Foundations offer a number of advantages, including flexibility in supporting engagement with a broad range of stakeholders and the capacity to take a longer term perspective. Foundations based on earmarked taxes were examined for the World Health Organisation in a 2004 study, in which an acknowledged benefit of this model was "the ability to make autonomous decisions about programs, policies and funding. The tobacco control experience suggests that the combination of effective tax measures and sustained social marketing campaigns represent perhaps the most powerful combination of prevention strategies (Wakefield et al, Impact of Tobacco Control Policies and Mass Media Campaigns on Monthly Adult Smoking Prevalence, American Journal of Public Health 2008).

4. Establish a prevention levy, as with Medicare, or a variation on the Swiss Health Promotion Foundation model which levies private health insurance. Dr Willcox has estimated that a 1% prevention investment target for private health insurers could generate an extra $95 million investment in disease prevention and health promotion.
5. Set funding at an initial percentage of the overall Federal health budget and increase it to agreed thresholds as its benefits are demonstrated. The development of new evaluation models that capture the full benefits of prevention investments would ensure that stepped increases in thresholds are based on returns on investment.

Section 5: THE AGENCY'S ROLES

The Agency would be a central player in Australian health promotion/ illness prevention adopting many of the roles demanded by the multi-faceted nature of health promotion/ illness prevention, while remaining a leader and facilitator across many sectors and stakeholders. The multi-disciplinary backgrounds of its staff would equip the new agency with the flexibility to engage in this wide range of activities.

1. Provide national leadership for the implementation of the National Preventative Health Strategy.

The Agency would cultivate high level access to the best advice and prominent pathfinders across all sectors, nationally and internationally. These connections, in addition to its own in-house capacities, would allow the Agency to draw on the technical expertise needed to address the complex issues associated with illness prevention. The Agency's facilitative approach would also ameliorate the structural fragmentation that inhibits current prevention efforts from achieving their full potential.

The Agency's initial priorities should be framed around the prevention of chronic diseases that have key risk behavioural factors or causes that epidemiological studies have demonstrated can be modified. As already identified by the National Preventative Health Task Force, these would include:

- Poor nutrition
- Physical inactivity
- Being overweight or obese
- Tobacco smoking
- Alcohol consumption.

Other priority areas should also include:

- Mental health promotion (social and economic participation, preventing discrimination and violence)
- Health inequalities
- Sexual and reproductive health.

2. Setting targets and standards

As the Agency's work plan, the National Preventative Health Strategy would be a tool for achieving change – a document that reflects Australia's current and future prevention needs. This means that the Strategy would need to be reviewed and updated in response to the information received through the various monitoring and evaluation processes that the Agency commissions, as well as feedback from other sources. Therefore the Strategy's targets and minimum set of prevention programs could be expected to evolve in order to keep ahead of trends in future needs.

3. Allocating funding to its partners for activities that deliver the National Preventative Health Strategy's goals and targets.

It is expected that the Agency would be directly involved in the tendering processes for initiating and commissioning the many activities involved in meeting the Strategy's overall goals and targets. Whether or not the Agency's model sees it delivering via centres of excellence and/or state-based statutory health promotion/illness prevention bodies, the Agency would take a stringent, transparent approach to the processes of preparing, assessing and granting of tenders, and evaluation of outcomes. We expect that the Agency may allocate funds in areas that could produce valuable contributions, including research, policy development, program development and delivery, monitoring, evaluation and promotion.

4. Closing the gaps in Indigenous health

For one of the world's most wealthy and healthy countries at an overall level, Australia has the worst health disparities between mainstream and Indigenous populations of any country in the world. Even areas of health promotion that have notched up substantial achievements over the past 30 years, such as tobacco have had little impact on Indigenous health. The Agency would increase research efforts into developing health promotion/illness prevention strategies by working with the new National Indigenous Health Equity Council in targeting such issues as alcohol misuse, diabetes and family violence.

5. Engage key actors and build new partnerships in health and relevant non-health sectors.

Much of the new national organisation's primary work would be about forging productive relationships, both with and between other key parties. As an illness prevention bridge-builder, its ability to bring disparate players together in meeting common agendas would be a paramount function of its leadership.

The Agency would be charged with identifying which organisations are most effective for specific health promotion/illness prevention functions, who needs to be included in consultations, and at what level or stage of the process these various parties should be engaged. Its networking activities would span governments at all levels, national agencies, professional associations, NGOs, the private sector, the philanthropic sector and academia. This would ensure that the transformative impact of its work is spread from boardrooms to factory floors, from hospitals to homeless shelters.

The Agency's role as a relationship broker at the highest levels would be critically important in driving through the National Preventative Health Strategy. An integrated approach to achieving the Strategy's goals would mean that the Agency would draw together senior decision makers, including those from across the business, academic and employment spectrums. The Agency would convene regular summits, initiate conferences and create the momentum needed to fulfil the Strategy's ambitious vision.

6. Supporting integration of research, policies and strategies for health promotion/illness prevention across sectors and settings within and beyond healthcare.

International models have shown that integration makes prevention greater than the sum of its parts – although the reinforcement of those various parts is essential to achieving that "greatness". The Agency's national focus would position it to promote both the integration of national policies and specific risk factor plans, designed to increase capacity, maximise efforts and minimise duplication (Fawkes et al, 2008 *A rapid review of chronic disease prevention strategies in selected OECD countries*).

In broad terms, an integrated approach to obesity, for example, could include the Agency commissioning research from centres of excellence (specialist institutes or research units within universities) that could be used as the basis of policies at federal, state and local levels.

These evidence-based policies and programs should be designed to ensure effective strategies that reach target groups in various settings, including disadvantaged groups, schools and workplaces, through partnerships with private sector employers, education departments, local councils and NGOs.

The Agency could ensure the evaluation of these activities and use the results to improve the delivery of the relevant components.

7. Commissioning and promoting uptake of new monitoring, evaluation and surveillance models for illness prevention.

Health promotion/illness prevention lacks surveillance systems that capture the full range of data spanning the behavioural, environmental and biomedical risk factors for chronic disease. This is essential if we are to effectively track, monitor and report on performance and outcomes, including health inequalities. Expanding the national nutrition and physical activity survey program through the inclusion of biomedical data would be an important input to such a system. The Agency would initiate the development of this surveillance system, working in partnership with centres of excellence such as the Australian Institute of Health and Welfare (AIHW) and the Australian Bureau of Statistics (ABS).

Another option would be for the Agency to establish and host a national population health observatory, linked to a network of state or regionally based observatories, along the lines of the UK model. Again, this initiative would be a partnership with other national agencies, such as the AIHW and ABS.

Investment in prevention faces in-built disincentives that include the way public health is evaluated. Its many benefits are typically shared so widely that they are rarely fully captured in any evidence-based evaluation. The limitations of current evaluation models include their failure to factor in issues related to equity, along with difficulties in fully measuring the diverse economic benefits of health promotion.

The Agency would commission the development of new, improved evaluation models. One option could be a hybrid model, combining the features of Australia's Pharmaceutical Benefits Advisory Committee, the new Medical Services Advisory Committee (MSAC), and the United Kingdom's new National Institute of Clinical Excellence (NICE). This would allow the development of evidence of efficiency, equity and effectiveness in prevention and ensure that this evidence is used to guide investment decisions in prevention essential services and research.

8. Promoting the benefits of health promotion/illness prevention as measured by these new evaluation models.

Evaluation models that accurately measure the real returns on investment in health promotion could be transformational in improving the ways that public health is perceived, and therefore funded, in Australia and internationally.

Improved evaluation models could ultimately be drivers of change by providing the evidence that could generate the high levels of support needed to effect cultural – leading to behavioural – evolution.

We need to broaden our perspective about our health promotion/illness prevention investment decisions by recognising that the benefits of prevention are wide ranging. Physical activity programs, for example, that encourage cycling to work and school could reduce the risk of heart disease, osteoporosis and cancer, and may lower or delay demand for medical services and cholesterol drugs, enhance mental health, improve economic productivity, and reduce traffic congestion and greenhouse gas emissions.

But these links in the benefits chain are not always captured by existing evaluation models that adopt a narrow perspective on health promotion. If this was achieved and the results were widely promoted, the positive impacts of these strategies and programs would undoubtedly be heightened.

9. Serve as an authoritative source of information on evidence, policy and practice.

Despite the upsurge of information now widely available thanks to the Internet, there is still insufficient credible information about health promotion/illness prevention that could be applied to the Australian context. As part of its leadership role, the Agency would foster access for all stakeholders to the best available knowledge on evidence, policy and practice.

An option could be for the Agency to create a virtual clearinghouse – a website – that stakeholders could access. It could also serve as a vital connecting hub for health promotion/illness prevention communities to learn from each other. This could also further the Agency's aim of encouraging community participation in health promotion/illness prevention [See 'References' for more on community participation].

The Agency would play a key role in connecting researchers with decision makers and program deliverers; this would be crucial to ensuring that this developing evidence base becomes the basis for policies and programs that meet Australia's needs.

An option could be for the Agency to expand on the NHMRC's new 'Partnerships' initiative, which aims to better integrate evidence into policy and improve the availability and quality of research evidence to help inform the policy process.

The Agency would consult partners in an ongoing process to:

- Create networks that encourage communication between researchers, decision makers and program deliverers
- Identify knowledge gaps
- Commission research from partners
- Ensure the results are actively provided and easily accessed by stakeholders.

10. Commission and evaluate large scale implementation trials to test innovative strategies, programs and policies for health promotion/illness prevention.

Illness prevention and health promotion need the capacity to experiment with new approaches – this would be another area in which the Agency would demonstrate leadership by pushing boundaries and finding new paths to greater knowledge.

Health promotion/illness prevention efforts are, by definition, intended to produce benefits for people as members of large groups, whether those groups be target at-risk segments or major wedges of the overall population. Therefore, small pilot studies provide only limited information in terms of their successful application to large population groups.

The Agency would have the autonomy and access to the information, the funding and the networks needed to oversee the commissioning, execution and evaluation of the large-scale trials that can comprehensively test innovative strategies. The Agency would operate with enough flexibility to sometimes intervene directly to create these valuable opportunities that may not otherwise be supported, not as the "actor" but as the "director" with the visionary overview to ensure that the bigger story is told.

11. Ensure the development of the necessary national workforce for health promotion/illness prevention, working with and through relevant national, state and local agencies to build capability in:

- Surveillance, prevention research, evaluation, economic impact research and modelling

- Social marketing and public education
- Community development
- Legislation, regulation, economics and taxation
- Leadership and management.

Much of health promotion/illness prevention involves decisions made in spheres outside health, such as economics, culture, business, education and the media, to cite a few.

Leadership and management have not been prioritised in health promotion/illness prevention training. The health promotion workforce, and particularly its leaders, need to be capable of operating in the real world, to understand and use all of the levers in these various spheres in order to overcome (or at least go around) the inherent hurdles blocking health promotion/illness prevention efforts.

The Agency would be committed to ensuring that there are many more health promotion/illness prevention professionals who have the required skill sets, by both the recruitment of the right new staff and the professional development of the current workforce.

The Agency's approach would address the three main groupings of the health promotion workforce:

- People working in prevention including health promotion practitioners and public health researchers
- Others working in the health care system, including GPs, allied health professionals, specialists, Aboriginal health workers and health service managers
- Those working in other sectors which have a role in prevention, for example, in local government, police and justice, education, sport and recreation, urban planning, transport and agriculture.

Section 6: PARTNERSHIPS

The new organisation's capacity to develop and support strong relationships with a range of partner organisations would empower it to strive for ambitious goals as Australia's leader in health promotion/illness prevention. By taking a national overview, this new Agency would improve the synchronicity of activities between the major players, thereby increasing levels of efficiency, effectiveness and equity across prevention efforts.

These partnerships should include disparate environments where prevention can achieve long term outcomes, ranging from board-level business networks to remote Indigenous communities.

Partnerships would also support the delivery of research, policies, strategies, programs, evaluation and surveillance.

The Agency's key relationships would mostly be conducted at national and state levels, with some strategic international partnerships.

It is through partnerships that the Agency would also foster community participation in prevention efforts.

The Agency's key partners would include:

- Federal, state and territory governments at departmental and Ministerial levels in portfolios such as Treasury, Finance, Health, Transport, Education, Environment and Employment
- Government department heads (portfolios as above)
- national NGOs (such as Diabetes Australia, the Cancer Council of Australia, National Heart Foundation,)
- peak professional associations
- peak community organisations

- local government associations at national and state levels
- private sector organisations
- philanthropic sector
- academia
- arts sector
- national sports/recreation bodies
- international organisations.

Part 2: LESSONS FOR AUSTRALIA

The report *A rapid review of chronic disease prevention strategies and programs in selected OECD countries* (S. Fawkes et al) was prepared recently for the Preventative Health Taskforce. It covered Thailand and five OECD countries: Canada, England, New Zealand, USA, and Finland. Some aspects of those models are included further below.

We have included an edited distillation of the report's 'Lessons for Australia' section in the context of the proposed agency model.

The lessons are presented in two sub-sections:

(1) Systems underpinning the strategies and programs and

(2) Strategies and programs for primary prevention and health promotion.

(1) Systems underpinning strategies and programs

Lesson 1: Establishment of a high-level government or equivalent committee with appropriate inter-sectoral partners is necessary to champion primary prevention of chronic disease and ensure high-level political commitment and accountability.
The highest status committee is a Cabinet Committee (and equivalents) that had cross-portfolio representation.

In England, a cross portfolio Sub-Committee on Health and Wellbeing has been established. Its terms of reference are: "To consider policy on health and wellbeing, including the prevention of ill-health, the promotion of healthy and active lifestyles and the reduction of health inequalities; and report as necessary to the Ministerial Committee on Domestic Affairs."

In New Zealand, a recent review of the Healthy Eating-Healthy Action program has recommended that a Ministerial Committee, chaired by the Minister of Health, be established to provide high-level, whole-of-government leadership that focuses on improving obesogenic environments. The Ministerial Committee would also work alongside a steering group to set agreed targets. The group would include non-government organisations, academics, Maori and Pacific representatives and the food and advertising industries.

Lesson 2: New approaches to long-term funding for primary prevention of chronic disease need to be developed that recognise the limited approaches of the past and the need for more innovative and sustainable financing models in the future.

A recent Australian Institute of Health and Welfare (AIHW) Report has estimated that Australia's total investment in 'public health' by all Australian health jurisdictions is currently 1.8% and unchanged in almost a decade (AIHW 2008), which is low compared to a (still inadequate) OECD average of about 3 per cent for 'prevention' (OECD 2000). The spending on prevention and health promotion is only a proportion of this 1.8%.

Relying on a very small proportion of funding from a national health budget to provide adequate, sustainable financing of a long-term and well organised chronic disease prevention and health promotion program has proven to be insufficient in most countries because of the inherent pressures on such funds from the health care delivery system. It also reflects a narrow understanding of what actions are needed and the roles of a wide range of stakeholders. Some innovative national financing models – such as Thailand's 2% surcharge on tobacco and alcohol taxes to fund ThaiHealth – have been developed in recent years.

Lesson 3: Strengthened system components are needed for developing and implementing an effective chronic disease primary prevention strategy and related programs.

Lack of integration among the jurisdictions and between programs has long been a criticism of the Australian situation.

Internationally, integration approaches include:

- Population health targets
- Workforce development
- Mechanisms to ensure continuous system learning.

Elements within Australia's systems need to be strengthened in different ways. Ideally, new infrastructure and resources developed through the Agency could enable Australia's health promotion/illness prevention systems to operate as an integrated whole, capable of adapting to emerging issues and resilient to stresses.

Lesson 4: Establishment of measurable targets for primary prevention and health promotion is critical for long-term monitoring and evaluation of implementation and outcomes.

Most countries considered in the 'Rapid Review' report have some form of national health targets that also include chronic disease. These need to include not only measurement of the disease conditions and the behavioural risk factors, but also the more upstream determinants and influences on these chronic diseases. Advocates of health targets propose that they would help to direct cross-sectoral efforts involving multiple settings, players and levels, without being prescriptive of how to achieve the targets.

Lesson 5: Establishment of sustainable infrastructure that facilitates the production, dissemination and use of evidence and learning is essential if strategies and programs are to be effective.

To continue improving the health and wellbeing of the population, reliable and relevant evidence on the most effective ways of protecting people from disease, preventing illness and promoting good health is required. This information can only come from research (including ongoing evaluation of strategies and programs).

Countries examined in this review have recognised the complexity of primary prevention interventions (especially for healthy eating and physical activity) and have, or are, implementing integrated research and surveillance agendas to align efforts nationally to effect change, and to ensure that:

- Policy and program decisions are based on timely, regular and meaningful data
- There is coordination and integration of investments in research, policy and practice
- Communities have easy, efficient, timely access to the knowledge they need, in usable form, to inform decisions
- Researchers are better able to conduct research to address policy and practice

- The existing research is synthesized and translated for use by population and public health organisations
- Key intersectoral stakeholders at all levels collaborate in the various phases of the knowledge development and exchange cycle, to create the ability to "learn as we go" – what works, and in what context
- Research, surveillance and evaluation are integrated with policy and program development.

The Agency would ensure that mechanisms which allow ongoing cross-strategy/program learning at national and international levels are developed so that the best available models and strategies are adopted.

(2) Strategies and Programs

Lesson 6: Strategies and programs should incorporate an integrated approach and a life-course perspective.

Chronic disease prevention initiatives have traditionally focused on specific diseases such as heart disease, diabetes, chronic obstructive pulmonary disease and some cancers. This leads to vertical programs that aim to bring about change in relation to some of the same risk issues. With growing evidence that these diseases share some of the same behavioural and social risk factors, the Agency would have a major opportunity, through the National Preventative Health Strategy, to set up a national framework for chronic disease prevention initiatives that applies a much more integrated approach. A number of OECD countries have developed such an approach. [See 'Models' below].

The Agency's national leadership could also promote the life-course approach to chronic disease prevention, reflecting the emergence of research that tracks associations between exposures and outcomes at the individual and population levels.

The evidence suggests that because of the multi-faceted, multi-level, multi-sector and population-wide nature of risk factors (proximal and distal) an integrated approach is more likely to:

- Ensure greater alignment, coordination and direction for all sectors
- Provide a national context and reference point for all sectors, governments and Aboriginal organisations to measure the success of their own strategies and interventions
- Provide a forum for multiple players to align efforts and to work collaboratively to address common risk factors
- Ensure stakeholders are better and more broadly informed, thereby facilitating greater synergy and improved identification of opportunities across sectors
- Overcome any inconsistencies or confusion of multiple "messages"
- Lead to an increase in large-scale efforts in knowledge development and exchange.

Lesson 7: Strategies and programs need to be adequately supported and funded to demonstrate their effectiveness.

There are usually no quick fixes when it comes to public health. It takes considerable time for coordinated funding and implementation of public health policies and programs to be implemented in integrated ways and for their benefits to be measurable. A long-term commitment to reliable implementation is essential. This requires significant levels of leadership and investment in all aspects of program development, delivery, research and knowledge exchange into policy and practice.

Lesson 8: Strategies and programs need to be well designed using the best available evidence and implemented using multi-level and multi-sectoral approaches.

The evidence informing integrated programs and strategies consistently points toward multi-faceted interventions that are:

- Addressing the fundamental behavioural and social causes of chronic disease
- Using multiple approaches simultaneously – laws, communication (social marketing and education), social and community support/capacity building, and economic incentives and disincentives
- Operating at multiple levels: individuals, families, schools, workplaces, communities, and nation
- Designed to account for the special needs of specific target risk groups, such as children, seniors, ethnic groups or at-risk communities
- Of sufficient duration, because change takes time and needs to be constantly supported for each subsequent generation
- Engaging with a variety of sectors that are not traditionally associated with "health", such as business, transport, engineering, law, media and others
- Implementing a nationally comprehensive communications and social marketing campaign that provides clear and consistent messages.

Lesson 9: Addressing inequalities and the health gap between different population subgroups needs to be a critical dimension of all strategies and programs.

Countries' efforts to address health inequalities and the health gap between different population subgroups demonstrate that this requires a whole-of-system response that addresses both the proximal and more distal influences of the inequalities. For example, England's approach to the issue of health inequalities includes setting targets, which helps to ensure accountability to the public for actions and supports the monitoring and evaluation of progress. This can be a useful way forward in what is often a complex and politically challenging area.

POTENTIAL MODELS FOR THE AGENCY

The following section considers some models of organisations involved in various aspects of health, as well as one or two operating in other sectors. For the sake of brevity and relevance to this paper, we have not listed their achievements but instead focused on their strengths in specific functions or factors that could be applicable to the Australian context and that the Agency could emulate.

For a more detailed overview, we refer you to their websites.

In creating a model for the Agency, Australia faces a range of inherent challenges, not least of which are the Constitutional and operational complexities of our Federation and the very strong history of state and territory jurisdictions that have operated with high levels of autonomy and rivalry.

To engender true national 'ownership' of the Agency and its goals would require the development of a hybrid model that, as far as possible, turns these unique characteristics to advantage, perhaps by harnessing interstate cooperation rather than competitiveness in the cause of health promotion/illness prevention.

The creation of this hybrid model in the Agency offers Australia the opportunity to once again be a world leader, just as it was when VicHealth was first established in 1987

In Australia

National Institute of Clinical Studies (NICS)

NICS is part of the National Health and Medical Research Council (NHMRC). "NICS works to improve health care by helping close important gaps between best available evidence (what we know) and current clinical practice (what we do)."

Aspects to investigate for the Agency's model include:

- Its role in developing and fostering networks, links, collaborations and partnerships, with clinicians, policy makers and health care professionals from across the health care spectrum (such as through its Partnerships initiative)
- The very wide-ranging reach of its work in benefiting a broad range of stakeholders, including general practitioners, cancer treatment centres, hospital emergency departments, State and Territory Governments, and thousands of other treatment centres
- NICS's role in developing and disseminating evidence-based resources to assist clinicians, managers, policy makers and consumers.

More information is at http://www.nhmrc.gov.au/nics/asp/index.asp

The Victorian Health Promotion Foundation (VicHealth) and Healthway

There are many facets of the Victorian Health Promotion Foundation model, and the Healthway model, that could be applicable to the agency, including:

- Their structure and governance as statutory authorities with an independent chair and board of governance with experience in health, sport, the arts, research and communication
- The original funding model – a hypothecated tax in the form of a levy on existing state tobacco fees (which stopped in 1997). The levy had the additional benefit of acting as an incentive to reduce smoking through increasing the price of tobacco
- Its partnerships with organisations, communities and individuals to promote good health and prevent ill-health
- The breadth of their activities in sectors as diverse as sport and active recreation, the arts, education, planning and built environment, community and local government.
- Their focus on building the public health evidence base and developing rigorous evaluation models.

More information is at http://www.vichealth.vic.gov.au and http://www.healthway.wa.gov.au/

Australian Housing and Urban Research Institute (AHURI)

AHURI is a national research organisation specialising in housing and urban research and policy. Its leadership role, overall aims and operating approaches share common characteristics with those of the proposed Agency, including:

- AHURI is a facilitator, which is "dedicated to drawing together researchers, policy-makers, industry and the community"
- AHURI's mission includes the creation and dissemination of knowledge and to ensure that knowledge is applied by linking quality research and the development of ideas with policy development, program evaluation and project development in the public and private sectors

- Its aims include to “be a leader in its field assisting policy makers at all levels in identifying trends, establishing possible solutions and drawing together the best information and understanding within Australia whilst drawing upon international experience”.

Its hub and node model may offer possibilities for the Agency, because AHURI outsources its research. “AHURI is organised as a network comprising a small management company, AHURI Ltd, in Melbourne, and seven participating Research Centres, throughout Australia. The role of AHURI Ltd is to lead the organisation, to manage and co-ordinate the research and dissemination process, and stimulate policy debate.”

More information is at http://www.ahuri.edu.au

Quit

Quit has been one of Australia’s pioneering successes in prevention/health promotion. Quit organisations now exist in every state and territory and are supplemented by strong NGO-based activity led by cancer and heart organisations. Quit adopts a comprehensive approach to tobacco control embracing program, policy, research, marketing and policy skills to achieve sustained outcomes in cessation, prevention and reducing harms from second-hand smoke. Aspects of interest to the Agency proposal include:

- Quit’s integrated approach and the variety of its activities
- The broad range of settings in which Quit is involved, from workplaces to schools, mental health agencies, Indigenous groups, sporting organisations and local government
- Its leadership in forging the effective partnerships with Government and non-government organisations, through which it pursues a united approach to policy and practice
- Its effectiveness in ‘punching above its weight’ in the David and Goliath battle against tobacco interests.

More information is at http://www.quit.org.au

International

Canada – Public Health Agency of Canada

This government agency’s focus includes improving efforts to prevent chronic diseases; its structure includes a Health Promotion and Chronic Disease Prevention Branch. Aspects of interest to the proposal include the branch’s:

- Leadership role in health promotion, chronic disease prevention and control
- Involvement with stakeholders at all levels
- Leadership in evaluation and surveillance
- Role in managing grants
- Education activities.

Its Pan Canadian Healthy Living Strategy may be a worthwhile case study of an integrated approach to chronic disease prevention.

More information is at http://www.phac-aspc.gc.ca/

United Kingdom – Department of Health, Public Health division

The department's integrated approach to its obesity strategy could serve an example for the Agency. The Healthy Weight, Healthy Lives strategy was announced in January 2008. Aspects worth noting include:

- The Cabinet-level backing of this cross-government strategy
- The multi-level strategy's policy framework
- The creation of a new public health obesity observatory to develop understanding of what changes behaviour
- The targets set – from large visionary goals to smaller specific ones (for example, to get a third of England walking at least 1000 more steps daily by 2012)
- Its partnerships with employers, individuals and communities
- Its commitment to addressing the issues where they arise – in homes, workplaces, schools etc
- Its focus on creating incentives for better health.

More information is at
http://www.dh.gov.uk/en/Publichealth/Healthimprovement/Obesity/DH_082383

Finland – Development Programme for the Prevention and Care of Diabetes in Finland (DEHKO)

Run in partnership by the Finnish Diabetes Association, with providers of primary health care, specialised medical care, and occupational health care, as well as Finland's National Public Health Institute (KTL), DEHKO was the first national program to include the prevention of type 2 diabetes.

The 10-year program began in 2000, with clear goals to be achieved by 2010 and 25 concrete recommendations for action, among them that measures aimed at the prevention of type 2 diabetes would be a permanent function of primary healthcare.

Aspects of the rollout of this program that are of interest include:

- the creation of a "cooperation network" by the Finnish Diabetes Association, with an estimated one hundred diabetes researchers, practical care professionals, people with diabetes and other partners involved in the initial set-up
- the continued growth of the "cooperation network" during the program's implementation
- a commitment from the outset to long-term funding from Finland's Slot Machine Association (the program's main sponsor), the Finnish Diabetes Association and diabetes-related companies
- the creation of the DEHKO Direction and Monitoring Group to regularly assess the program's progress.

More information is at http://www.diabetes.fi/sivu.php?artikkeli_id=831

Thailand – Thai Health Promotion Foundation (ThaiHealth)

The Thai Health Promotion Foundation (ThaiHealth) was established in 2001 as a statutory, independent public organisation. Its focus includes campaigns against tobacco use, drink-driving and alcohol consumption, and campaigns for promoting physical activity.

Aspects of interest to the proposal include:

- Its hypothecated funding model – it receives about US$50 million per year from a 2% excise tax on alcohol and cigarettes
- Its role as a catalyst and facilitator, fostering health promotion alliances and networks that enable its activities to reach as many people as possible
- Its "open grants" program that allows community-based and other organisations to secure funding for their heath promotion activities.

More information is at http://www.thaihealth.or.th/english/

India – Avahan

Avahan is funded by the Bill and Melinda Gates Foundation. It was started in 2003 with the aim of helping to slow the transmission of HIV in India. Like the proposed Agency, Avahan is a facilitator and delegator. It has three primary goals:

1. Build an HIV prevention model at scale in India
2. Catalyse others to take over and replicate the model
3. Foster and disseminate learnings within India and worldwide.

Aspects of interest to the proposal include:

- Avahan's 10-year timeframe
- Its national and international networks
- Its lean bureaucracy, with about 15 staff harnessing the efforts of thousands of peer educators and outreach workers, through Avahan's many partnerships
- Its ability to provide prevention services where they are most needed to clients who include sex workers, men who have sex with men, injecting drug users and truck drivers
- Its leadership in monitoring and evaluation of programs
- Its ability (through partners) to provide capacity building, advocacy, and mass communication support for its implementation partners
- Its in-house expertise, which includes staff with business MBAs, and marketing, public health and communications backgrounds
- The composition of its Board, which has high ranking and influential business, community, sporting and government leaders
- The composition of its technical Advisory Panel, which has international and Indian public health experts
- Its strong focus on implementation and "scaling up" of programs.

More information is at http://www.gatesfoundation.org/GlobalHealth/Pri_Diseases/HIVAIDS/HIVProgramsPartnerships/Avahan/

Definitions

Prevention (of disease): action to reduce or eliminate the onset, causes, complications or recurrence of disease (AIHW).

Health promotion: According to the World Health Organisation, health promotion is the process of enabling people to increase control over the determinants of health and thereby improve their health (WHO).

Determinants of health include the range of personal, social, economic and environmental factors which determine the health status of individuals or populations.

Health promotion represents a comprehensive social and political process. It not only embraces actions directed at strengthening the skills and capabilities of individuals, but also actions directed towards changing social, environmental and economic conditions so as to alleviate their impact on public and individual health.

References

AIHW, Chronic diseases and associated risk factors in Australia 2006

Core values for the practice of public participation, http://www.iap2.org/displaycommon.cfm?an=4 (International Association of Public Participation, IAP2).

Determinants of health, Victorian Government health information, http://www.health.vic.gov.au/healthpromotion/foundations/determinants.htm

Fawkes S et al, 2008 *A rapid review of chronic disease prevention strategies in selected OECD countries* (in press).

Harper TA, Oldenburg BF 2008 *Issues Paper: Call for a National Charter for Health* Victorian Health Promotion Foundation (in press).

Moodie R, 2006 *An ounce of prevention is worth a pound of cure: The case for a "newer" public health* Victorian Health Promotion Foundation, 2006

Oldenburg BF, Harper TA, 2008 *Investing in the future: prevention a priority at last* Medical Journal of Australia (in press).

Wakefield et al, 2008 Impact of Tobacco Control Policies and Mass Media Campaigns on Monthly Adult Smoking Prevalence, American Journal of Public Health 2008

Willcox S, 2006, *Purchasing Prevention: Making Every Cent Count*, background paper prepared for National Health Policy Roundtable 2006, http://healthpolicystudies.org.au/content/view/97/152/

World Health Organisation (WHO), 2004 *The Establishment and Use of Dedicated Taxes for Health*, World Health Organization, Regional Office for the Western Pacific, Available online at http://www.wpro.who.int/publications/PUB_9290611715.htm

WHO, 1986, Ottawa Charter for Health Promotion, Geneva.