



AUSTRALIAN
HEALTH POLICY
COLLABORATION



Chronic diseases: Commitment to changing course

Policy Forum Report

Issues paper No. 2015-02

July 2015

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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.

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Introduction

At a national forum in Melbourne on June 1, 2015, hosted by the Australian Health Policy Collaboration, Professor Allan Fels, AO, launched the report *Chronic diseases in Australia: Blueprint for preventive action* and a Statement of Commitment for national action co-signed by more than forty organisations across Australia.

The Blueprint, by Dr Sharon Willcox, builds on a previous report, *Chronic diseases in Australia: the Case for Change*, that summarised the evidence on the considerable harm to individuals and their families caused by chronic diseases, with concomitant effects on the health system and the economy. Both documents draw on shared principles to underpin action, including a systemic approach; evidence-based action; tackling health inequity and disparity; and taking a life course approach.

Although there is robust evidence on cost-effective interventions to prevent chronic diseases, Australia has a mixed record in implementing a comprehensive approach to prevention. The Blueprint calls for work on three strategic priorities: driving healthy behaviours and healthy environments; creating accountability for action and monitoring progress; and generating community support and action on prevention. Each strategy includes specific actions.

The joint Statement of Commitment supports the Blueprint for Action and has a particular focus on developing chronic disease targets and indicators as important elements of accountability for prevention. The Statement signals the commitment of the signatory organisations to work together to inform and influence policies and services critical to the implementation of prevention strategies nationally, locally and for individuals.

About the forum

The aim of the forum was to explore how targets and indicators have worked and can work in chronic disease prevention, and to strengthen a collaborative approach for preventive action. Discussion on the day was facilitated by Rosemary Calder, with Professor Maximilian de Courten.

Keynote addresses were delivered by two speakers:

- **Professor Roger Magnusson**, Professor of Health Law & Governance at Sydney Law School, University of Sydney— Accountability and Responsibility
- **Commissioner Mick Gooda**, Aboriginal and Torres Strait Islander Social Justice Commissioner, Australian Human Rights Commission—Closing the Gap: using measurement to improve health

They were followed by an expert panel comprising:

- **Daina Neverauskas**, Director Chronic Disease Policy, Commonwealth Department of Health
- **Associate Professor Paul Dugdale**, Director, Centre for Health Stewardship, Australian National University
- **Kaye Pulsford**, Senior Director, Preventive Health Unit, Queensland Health
- **Dr Erin Lalor**, CEO, National Stroke Foundation
- **Professor Maximilian de Courten**- Director of the Centre for Chronic Disease at Victoria University, led a workshop session on chronic disease targets.

Key themes from the forum

What is needed now is action- and not just by government

A great deal is known about chronic diseases, shared risk factors, and evidence-based, cost-effective interventions to address them. The Blueprint provides a way forward that is action focused, and that doesn't rely solely on action from governments.

The risk factor profile of Australians is worsening in most areas—obesity, physical inactivity, diet, and hypertension for example. There is more than sufficient evidence to act, using measurable, cost-effective interventions and strategies.

There are a range of players to engage or deal with

Government, industry, civil society and non-government organisations all have an interest and role to play in prevention. At present, government is not very engaged, and civil society involvement in Australia is small- scale and not very organised. Industry is active nationally and internationally, and has an obligation to support increased consumption of its products, which is often incompatible with reducing population exposure to risk factors. Non-government organisations are increasingly working together on shared issues.

At the moment we are asking individuals to do the work of public policy

A social policy approach is not accepted as a legitimate approach for public health generally. There has been a shift to promoting personal responsibility for chronic disease. Yet we don't make road safety a personal responsibility—many rules and regulations are in place to govern behaviour and improve outcomes for all.

Lack of controls over advertising is an example, with the advertisement of unhealthy products permeating areas such as sport and children's television. It is possible to create an environment that supports personal responsibility and healthier choices by individuals, but significant change and effort is required.

There is a need to measure and evaluate progress

Targets for Close the Gap provided a critical accountability mechanism for policy makers, service providers, and the public, promoting a focus on outcomes. Building in some small wins along the way is helpful where possible.

Australia is a member of the World Health Assembly, and has agreed to the World Health Organisation's (WHO) [Global Action Plan for the Prevention and Control of NCDs 2013-2020](#). Indicators for progress can be considered in a range of areas, not limited to the 25 x 25 targets. Possible indicators include measures of resourcing; supportive laws and policies; programs and investments; intermediate outcomes and national targets.

Health surveillance and health data can promote service improvement and responsiveness

Providing data back to health and hospital services, and to clinicians, focuses attention on performance. Queensland is providing comparable data on health risks such as obesity and diabetes, and on potentially preventable hospitalisations and mortality, to its sixteen health and hospital services. The investment in surveillance and information has been significant. Benefits include the capacity to identify and respond to issues such as smoking during pregnancy.

Information on processes of care will get the attention of clinicians. If reliable data is made available, practitioners will make use of it to improve care. The Australian Stroke Clinical Registry and the National Stroke Foundation's National Stroke Audit provides data

back to services, allowing hospitals to compare their services with others. Benchmarks have been created to drive change, with feedback on service adherence to specific processes of care, measured against top performers and mean performance. Quality improvement prompted by the data is supported through other quality improvement activities and action planning. The data has been received very positively, and has informed collaborative discussions regarding improvement. Regular reporting is important and must be more than annually.

Nationally, further investment is needed in health surveillance, for example in areas such as diabetes, hypertension and obesity. Regular biomedical measures of population health are essential.

A sophisticated approach to holding governments and the private sector to account is required, deploying a stronger mix of accountability levers

National governments should be the stewards of health. Neither the government nor the private sector appears to be feeling much pressure to respond to risk factors. The community needs to be viewed as an account holder, with a key role in demanding action to reduce chronic diseases.

Civil society can seek to hold governments and the private sector to account. This can occur through legal requirements, co-regulatory approaches, political levers and market-based levers. A multi-sectoral alliance, bringing together like-minded organisations and a people's movement could be helpful. Governments will respond to large numbers of people- the Close the Gap campaign membership is now some quarter of a million people, with 1300 events around the country on Close the Gap day.

Civil society, including public health, needs to scale up its activity on prevention, avoiding conflicts of interest as it does so. Non-government organisations can take effective action –for example, the Alcohol Advertising Review Board using billboards that often carry alcohol advertisements and replacing them with health and other messages, for example, 'Your children see these advertisements.'

Bi-partisan and bureaucratic support have been significant contributors to some key public health successes, such as tobacco control and Close the Gap. Agreement with states and territories is also important, as they are major players in public health.

Plan for the long term

Close the Gap commenced in 2008, and the life expectancy goal is to be met in 2031. Events have been important in maintaining momentum, such as the launch of the Prime Minister's report. Opinion leaders have been influential too in gaining investment.

Workshop session: Australian chronic disease targets

Targets should be compelling and relevant to capture attention and guide aspiration. A headline list may be helpful, and it is also useful to monitor the trajectory of progress. Policy making by disease should be avoided. Indicators of action, interest and investment should be considered, reducing data burden where possible. For some items, such as investment, Australia's results should be benchmarked against like countries. Specific comments on 25 x 25 targets included deleting the word 'harmful' in relation to alcohol use; including chronic kidney disease in the 25% reduction in mortality target; and including the number of fruit and vegetable serves daily as an indicator.

It was suggested that, in selecting targets, criteria will be important. The drivers towards target should be well understood, and the indicator series should be well accepted with

established data collections. Narrative is important, and it should be possible to tell a compelling story about the targets and indicators, working with partner organisations.

There was support for intermediary measures or targets, such as preventable hospitalisations. Measures that are meaningful to clinicians—relevant to practice and that can be influenced or changed—had support. Process measures have been used to good effect in Indigenous health, such as recording of BMI and HbA1c, and smoking status was another suggestion. Providing comparable data back to services, including impact and outcome data, can contribute to improvement and meeting national prevention targets.

The inclusion of mental health was strongly supported in Australian chronic disease targets was strongly supported. There was also support for effective use of existing data, such as health targets from Close the Gap. Monitoring of preventive measures such as health check take up; vaccination; and attendance at early childhood checks were suggested. Development of an obesity index with capacity to consider genetics was also suggested.

Equity

Equity is a key consideration as disadvantaged groups are more affected by chronic diseases than other Australians. Where possible, measures should be able to be disaggregated by Aboriginal & Torres Strait Islander status; socioeconomic status, rurality and cultural and linguistic diversity.

Next steps

Participants agreed that establishing principles to underpin targets and obtaining baseline data would be the starting points. Principles should be amenable to civil society action, and it may be necessary to establish initial targets for those items where data is available. Access to data (preferably comparable data) will be important, but may raise issues of expertise, workload, and privacy. Targets should be based on the Australian population.

Participants supported a number of actions, including:

- Further work on national chronic disease targets and underlying principles
- Development of a report card, noting that different products might be appropriate for different audiences
- Building a strong, positive shared narrative around prevention.

The forum concluded with a commitment by Rosemary Calder, Director of the Health Policy program, to follow up with forum participants on the identified actions.



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