AUSTRALIA: THE HEALTHIEST COUNTRY BY 2020

National Preventative Health Strategy – the roadmap for action
30 June 2009

prepared by the National Preventative Health Taskforce
NATIONAL PREVENTATIVE HEALTH TASKFORCE

The Strategy was prepared on behalf of the National Preventative Health Taskforce for the Minister for Health and Ageing, the Hon Nicola Roxon.

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Supported by the Australian Government Department of Health and Ageing
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Chair’s Foreword

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

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

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

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

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

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

ROB MOODIE
Chair
National Preventative Health Taskforce
CHAPTER 1: Building preventative health in Australian communities

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1 Vision, purpose and call to action

This Strategy sets out a vision for Australia to be the healthiest country by 2020. To realise this vision, the Strategy provides the roadmap for a series of strategic and practical actions, to be implemented across all sectors and by all Australians between now and 2020. This is a major challenge for the nation, but the rewards will be immense in terms of lives saved, and improved health and wellbeing.

In April 2008 the Minister for Health and Ageing, the Hon Nicola Roxon MP, appointed the National Preventative Health Taskforce to develop a National Preventative Health Strategy, focusing in the first instance on obesity, tobacco and alcohol. (The terms of reference and details of membership of the Taskforce are set out in Appendices 1 and 2.)

Significant shifts towards prevention in Australia continued in 2005 driven by the Productivity Commission’s Research Report on the Economic Implications of an Ageing Australia. The Report projected future cost pressures on the healthcare system, expected as a consequence of changes to demographic ageing in Australia. In light of this projection, in 2006, the Council of Australian Governments (COAG) established the Australian Better Health Initiative (ABHI), with the aim of refocusing the health system towards promoting good health and reducing the burden of chronic disease.

The Rudd Government made a pre-election commitment in 2007, endorsing the connection between better health and economic productivity, noting the need to:

‘treat preventative healthcare as a first order economic challenge because failure to do so results in a long-term negative impact on workforce participation, productivity growth and the impact on the overall health budget.’(1)

With the introduction of the COAG National Reform Agenda, governments identified the crucial importance of better health to economic productivity and opened the way for a new ‘whole of government’ approach to health. In particular, the recent 2009 COAG National Partnership Agreement on Preventive Health provides the largest single investment in preventive health in Australia’s history.

1.1 MAKING HEALTHY CHOICES EASIER CHOICES

‘Action currently under way does not adequately reflect the magnitude of the problem. There is indeed a need for a greater sense of urgency’ (Quote from submission)

Tackling the growing personal, social and economic burden of chronic illness is imperative, especially in a country with an ageing population. Prevention is increasingly being seen as a crucial means of reducing this burden. The three priority areas for action identified by the Australian Government are:

- Reducing the growing epidemic of overweight and obese Australians
- Accelerating the decline in smoking
- Addressing the health and social harms resulting from risky drinking
Australia must significantly scale up its prevention effort in these and other areas. Making healthy choices is often difficult – and there are many barriers to action at all levels. The Strategy provides a number of priorities and actions that will help reduce these barriers and enable healthy choices to become easier. In the first instance, these actions will help people maintain or achieve a healthy weight, prevent smoking and exposure to tobacco smoke, and limit intake of alcohol to safe levels.

The Taskforce has set out a phased program which seeks to match the magnitude of the problems and the required urgency of action, while also recognising that everything cannot be done instantly. The phased approach to the Preventative Health Strategy will be challenging, but it is feasible. The extent of the problem and the benefits to be gained for the health of the community require nothing less.

1.2 PREVENTION IS EVERYONE’S BUSINESS

‘Given the multiple social determinants of health, it is clear that a prevention agenda requires cross sectoral, multilevel interventions that extend beyond the health sector into sectors such as housing, welfare, justice, immigration, employment, agriculture, education, family and community services, Indigenous affairs and communications’ (Quote from submission)

The Strategy is for all Australians, not just governments. Throughout the Strategy, the Taskforce has identified comprehensive and staged directions that rely on mutual support between those who will benefit (individuals, families and communities) and those who can provide the infrastructure and support to enable effective action (governments, industry, the non-government and business sectors).

2 Australia’s response to the call to action

‘There are many positive changes that individuals and families can make, but if the environment in which they exist – where they work, live and play, interact and experience life – is not conducive to health, the impact of individual behaviours may be severely limited’ (Quote from submission)


2.1 FEEDBACK FROM CONSULTATIONS

Formal consultations were held in 16 metropolitan and regional sites across Australia, along with many meetings and 10 roundtable discussions that aimed to understand the views of particular groups and to encourage debate on issues such as the food supply, physical activity, sport, fitness and weight loss, alcohol supply, demand and harm reduction and tobacco control. There were consultations with Indigenous Australians (including a special consultation with the National Indigenous Health Equity Council), primary healthcare providers, food and alcohol industries, the recreation, sport, fitness and weight-loss industries, and the private health insurance industry, as well as researchers, urban planners and those driving health promotion in the workplace. Consultations were also held with all state and territory governments, with representation from a wide range of portfolios (see Appendix 3).
More than 400 submissions were received from a range of individuals, organisations, associations and governments (see Appendix 4). The Taskforce also took into account submissions about prevention that had already been provided to the Australia 2020 Summit, the National Health and Hospitals Reform Commission (NHHRC) and the House of Representatives Inquiry into Obesity.

Several comprehensive papers were commissioned on topics of particular interest to the Taskforce. Information from these papers has been incorporated into the Strategy. A list of the commissioned papers and authors is at Appendix 5.

2.2 BUILDING ON CURRENT PREVENTION ACTIVITY

Prevention in health is not new. Many important preventative interventions have made a crucial contribution to improving and protecting Australia’s health over the years, and a range of valuable measures are already included in many aspects of health and other government policy. During the development of this Strategy, the Taskforce has worked in alignment with other reform processes and with other groups, including COAG through the Prevention Partnership, the NHHRC (whose expressed priorities include looking at ways of ensuring a greater emphasis on prevention across the health system), Treasury (through contribution to the Henry Review), the External Reference Group advising the National Primary Health Care Strategy, the National Indigenous Health Equity Council and the National Health Workforce Taskforce (NHWT).

The Taskforce received very positive and encouraging feedback from its consultation processes, confirming broad support for the approaches proposed in the Discussion Paper. The important themes are outlined below, and they include a range of calls for action on prevention. Such calls are in part a response to the increasingly high burden posed by chronic illnesses (such as heart disease, diabetes and some cancers), which are in large measure caused or exacerbated by lifestyle choices; for example, smoking, sedentary lifestyle and poor diet.

While the vast majority of submissions and contributions supported the approaches taken in the Discussion Paper, often seeking further and more urgent action, there were also some that disagreed or offered alternative perspectives. The Taskforce has taken account of these in developing the Strategy. There was, however, an overwhelming sense that the Strategy provides an opportunity for prevention to be at the forefront of healthcare, and that there is great anticipation of the action following its release. In developing the Strategy, the Taskforce was aware that across all the issues considered there are a wide range of views, and that there will be some differing interpretations and perspectives. The Taskforce has reached its conclusions on the basis of careful consideration of the evidence and of all the views expressed to it.
IMPORTANT THEMES ARISING FROM CONSULTATION

- Action and leadership on preventative health is urgent and long overdue in Australia.
- A coordinated and comprehensive approach to prevention is needed, rather than the piecemeal approach adopted to date.
- Strong leadership will be needed to drive and coordinate action and achieve targets.
- Action will need strong contribution from outside as well as within the health sector, and may involve new partnerships.
- There will need to be stronger partnerships between all three tiers of government, non-government organisations, industries, the business sector and communities, as well as action by individuals and families to improve their own health.
- Action to improve health is required across a person’s lifetime, starting early in life and with an emphasis on identifying the key opportunities to influence change.
- Emphasis should be placed on the social determinants of health within the Strategy. These determinants should be linked with priorities and action.
- Achieving results will require sustained and significant investment for many years but will ultimately be cost effective and deliver benefits for individuals, families and communities as well as governments.
3 The need for action

3.1 THE BURDEN OF DISEASE – A FOCUS ON OBESITY, TOBACCO AND ALCOHOL

Obesity, tobacco and alcohol feature in the top seven preventable risk factors that influence the burden of disease (see Figure 1.1 below), with over 7% of the total burden being attributed to each of obesity and smoking, and more than 3% attributed to the harmful effects of alcohol. Along with a range of other risk factors, and accounting for their interactions, approximately 32% of Australia’s total burden of disease can be attributed to modifiable risk factors.[2]

While the prevalence of smoking is declining (though not enough), overweight and obesity and the harmful use of alcohol are escalating. The scale and pace of efforts in all these areas must be increased.

The prevalence of overweight and obesity in Australia has been steadily increasing over the past 30 years.

If the current trends continue unabated over the next 20 years, it is estimated that nearly three-quarters of the Australian population will be overweight or obese in 2025.[4]

In only 15 years, from 1990 to 2005, the number of overweight and obese Australian adults increased by 2.8 million. Almost a quarter of Australian children are overweight or obese, an increase from an estimated 5% in the 1960s. Nearly a third of children do not meet the national physical activity guidelines. Only one-fifth of 4–8-year-olds and 5% of 14–16-year-olds meet the dietary guidelines for vegetable intake.[3]
Recent trends indicate that the life expectancy for Australian children alive today will fall two years by the time they are 20 years old, representing life expectancy levels seen for males in 2001 and for females in 1997.\(^4\) This is not a legacy we should be leaving our children.

If these health threats are left unchecked, the impact on individuals and families, our healthcare systems, the economy and society more generally will be profound.

- Type 2 diabetes is projected to become the leading cause of disease burden for males and the second leading cause for females by 2023, mainly due to the expected growth in the prevalence of obesity. If this occurs, annual healthcare costs for type 2 diabetes will increase from $1.3 billion to $8 billion by 2032.\(^5\)

- Almost 2.9 million Australian adults smoke on a daily basis. Around half of these smokers who continue to smoke for a prolonged period will die early; half will die in middle age.\(^6\)

- The total quantifiable costs of smoking to the economy (including the costs associated with loss of life) were estimated at over $31 billion in 2004–05.\(^8\)

- There can be no cause for complacency while one-sixth of Australian adults smoke, thousands of children start smoking each year, and adult and young non-smokers alike are exposed to the dangers of passive smoking.

- The most recent national survey of drug use estimates that one in four Australians drink at a level that puts them at risk of short-term harm at least once a month. Around 10\% of Australians drink at risky levels of harm in the long term. However, among young adults aged 20–29 years, the prevalence of drinking at levels for long-term risk of harm is significantly higher (16\%) than among other age groups.

- The harmful consumption of alcohol causes problems for those who drink at risky levels and has repercussions across our society. Alcohol is involved in 62\% of all police attendances, 73\% of assaults, 77\% of street offences, 40\% of domestic violence incidents and 90\% of late-night calls (10 pm to 2 am).\(^7\)

- The annual costs of harmful consumption of alcohol are huge. They consist of crime ($1.6 billion per annum), health ($1.9 billion), productivity loss in the workplace ($3.5 billion), loss of productivity in the home ($1.5 billion) and road trauma ($2.2 billion) in 2004–05.\(^8\)

The cost to the healthcare system alone associated with these three risk factors is in the order of almost $6 billion per year, while lost productivity is estimated to cost almost $13 billion.\(^8, 9\)

There are further and especially important reasons for urgent action in these areas:

- ‘Close the Gap’: the burden of disease caused by obesity, tobacco and alcohol makes up a significant part of the life expectancy gap between Indigenous and non-Indigenous Australians. Similarly, a large part of the differences in health status between rich and poor Australians and between city dwellers and rural and remote Australians can be attributed to these risk factors.

- Intervening early in life is important. A relationship exists between growth and development during foetal and infant life, and health in later years. Poor nutrition, cigarette smoking and alcohol use during pregnancy can result in long-term adverse health consequences. Early life events also play a powerful role in influencing later susceptibility to chronic conditions such as obesity, cardiovascular disease and type 2 diabetes.
Since the release of the Taskforce’s Discussion Paper, many new studies have emerged, and have been reflected in updated versions of the three Technical Reports on obesity, tobacco and alcohol. Important examples are described below:

For obesity:
The National Children’s Nutrition and Physical Activity Survey 2007 provides the most recent measurement of Australian data on the prevalence of overweight and obesity among children. Overall, this survey indicated 17% of 2–16-year-olds were overweight and 6% obese.[10]

Further examination by the National Heart Foundation[11] of this survey data, and data from previous studies, clearly shows a disturbing upward trend in overweight and obesity rates in children over the last 20 years.

For children aged 7–15 years, levels of overweight and obesity have increased for both girls and boys. For girls, rates have risen from 12% in 1985 to 22% in 1995, reaching 26% in 2007. Similarly for boys, levels have increased from 11% in 1985 to 20% in 1995, rising to 24% in 2007. Figure 1.2 below shows the prevalence of overweight and obesity in Australian children aged 7–15 years, 1985–2007.

A 2009 Organisation for Economic Co-operation and Development (OECD) report further predicts that there will be continued significant rises in overweight and obesity levels in Australia over the next decade across all age groups to around two-thirds of the population.[12]

For tobacco:
A vast range of reports have been published since the Taskforce released the Discussion Paper. Reports cover issues such as:

- The consequences of active and passive smoking
- The effectiveness of various tobacco control strategies and progress in the implementation of new tobacco control measures, both internationally and nationally
- Guidelines developed and recently adopted to assist parties to the Framework Convention on Tobacco Control (FCTC) with the implementation of various articles of the treaty
- The importance of packaging in communicating positive imagery about smoking and reinforcing false ideas about the relative harmfulness of various products
- Recent studies show that tax on tobacco is highly supported and likely to disproportionally benefit lower SES smokers.(12)
- Strong public support for a wide range of tobacco control measures

For alcohol:
Four major reviews published in 2009 have shown:

- Alcohol advertising and promotion increases the likelihood that adolescents will start to use alcohol, and to drink more if they are already using alcohol[14]
- There is a causal link between exposure to alcohol commercials and role models on acute alcohol consumption[15]
Among young people who had previously not drunk alcohol, ownership of alcohol branded merchandise is independently associated with susceptibility to and initiation of drinking and binge drinking.[16]

An Australian study has questioned whether there is in fact any safe level of alcohol consumption for those aged under 18,[17] and the National Health and Medical Research Council (NHMRC) released its low-risk drinking guidelines in 2009.

Broad trends

Other broad trends with a continuing impact on the health and wellbeing of Australians and on our health system include:

- **The ageing of the population** has important implications for health services usage and labour force participation.
- **Increasing levels of disability, chronic illness and injury** will continue to increase and challenge health services, workplaces, communities and families.
- **Increasing discrepancies in health status and outcomes for some population groups** must be a high priority, particularly the needs of Indigenous communities, whose life expectancy at birth is around 17 years less than that of non-Indigenous Australians.
- **Other disadvantaged groups** including rural and remote Australians, recent immigrants – especially refugees and those escaping conflict – those on limited incomes, people with disabilities and people with low levels of education.
- **Climate change and sustainability**: this Strategy does not address climate change, but recognises it as an area of the utmost importance for health as well as the national and global community, requiring urgent action. There are also many areas where improving health is entirely compatible with increasing sustainability; for example, promoting walking and cycling as a means of transport.

3.2 OUTCOMES FOR AUSTRALIA

If we implement the action recommended in the Strategy, there will be:

- One million fewer people smoking in Australia by 2020. If we implement the recommendations on price and public education alone we will prevent the premature deaths of almost 300,000 Australians now living, simply from four of the most common diseases caused by smoking.[130]
- A reduction in the proportion of Australians drinking at short-term risky/high-risk levels from 20% to 14% and the proportion of Australians who drink at long-term risky/high-risk levels from 10% to 7%. This will prevent the premature deaths of over 7200 Australians and prevent some 94,000 fewer person-years of life being lost. The impact on morbidity would approximate to 330,000 fewer hospitalisations and 1.5 million fewer bed days at a cost saving of nearly $2 billion to the national health sector by 2020.[18]
- The prevention of half a million premature deaths if we stabilise obesity at current levels between now and 2050.[19]
- A new national capacity to plan, implement and evaluate preventative health policies and actions.
Australia’s knowledge base about effective action for tobacco control has been consistently built over the past 50 years. We know that if we implement the actions recommended for tobacco strategy we will see approximately one million fewer Australians smoking. Simply implementing two key components of the Strategy – tax increases and public education – will prevent the premature deaths of almost 300,000 Australians now living from four of the most common diseases caused by smoking. We will also see significant decreases in Indigenous smoking, which is currently the cause of 20% of deaths in Indigenous people. (19)

If we reach the targets for alcohol, the proportion of Australians who drink at short-term risky/high-risk levels will drop from 20% to 14%, and the proportion of Australians who drink at long-term risky/high-risk levels will drop from 10% to 7%. This will result in the prevention of over 7200 premature deaths and some 94,000 fewer person-years of life lost. The impact on morbidity would approximate 330,000 fewer hospitalisations and 1.5 million fewer bed days, at a cost saving of nearly $2 billion to the national health sector by 2020. (18)

If current upward trends in overweight/obesity continue, recent projections indicate there will be approximately 1.76 million deaths at ages 20+ years and more than 10 million years of life lost at ages 20–74 years caused by overweight or obesity in Australia from 2011 to 2050. (19) Each Australian aged 20–74 years who dies from obesity in 2011 to 2050 will lose, on average, 12 years of life before the age of 75 years. (19) Building capacity for preventative health policy and actions is a vital component of the Strategy. The COAG National Prevention Partnership has already committed to the establishment of a National Prevention Agency (NPA). In addition to coordinating and developing action, the agency will facilitate a national prevention research infrastructure to answer the fundamental research questions about what works best, as well as providing resources and advice for national, state and local policies, generating new partnerships for workplace, community and school interventions, assisting in the development of the prevention workforce, and coordinating the implementation of a national approach to social marketing.
4 What we know: prevention works

“The new preventative program, drawing on a broad constituency, can catalyse population-level thinking and wellbeing so that the health of the 21st-century population is improved and sustained” (Quote from submission)

4.1 ABOUT PREVENTION

The World Health Organization (WHO) defines prevention as:

Approaches and activities aimed at reducing the likelihood that a disease or disorder will affect an individual, interrupting or slowing the progress of the disorder or reducing disability.

Primary prevention reduces the likelihood of the development of a disease or disorder. Secondary prevention interrupts, prevents or minimises the progress of a disease or disorder at an early stage. Tertiary prevention focuses on halting the progression of damage already done.

While acknowledging the vital importance of secondary and tertiary prevention, it should be noted that the Taskforce has been specifically asked to focus on primary prevention.

Effective prevention brings significant benefits to society as a whole, including improved economic performance and productivity.

Prevention includes a focus on health promotion, defined by WHO as:

"the process of enabling people to increase control over the determinants of health and thereby improve their health." (21)

4.2 PREVENTION GETS RESULTS

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

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

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

Road trauma deaths on Australian roads have dropped 80% since 1970, with death rates in 2005 being similar to those in the early 1920s.(2)

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

PREVENTION CAN:

- Reduce the personal, family and community burden of disease, injury and disability.
- Allow better use of health system resources.
- Generate substantial economic benefits, which although not immediate are tangible and significant over time.
- Produce a healthier workforce, which in turn boosts economic performance and productivity.(20)
Deaths from SIDS have declined by almost three-quarters – dropping from an average of 195.6 per 100,000 live births between 1980 and 1990 to an average of 51.7 per 100,000 live births between 1997 and 2002.\(^2\), \(^{22}\)

A study commissioned by the Department of Health and Ageing in 2003 showed spectacular, long-term returns on investment and cost savings from prevention – in tobacco control programs, road safety programs and programs preventing cardiovascular diseases, measles and HIV/AIDS.\(^{23}\) For example, this report estimated that the 30% decline in smoking between 1975 and 1995 had prevented over 400,000 premature deaths,\(^{24}\) and saved over $8.4 billion – more than 50 times greater than the amount spent on anti-smoking campaigns over that period.\(^{23, 24}\)

A recent US study, Prevention for a Healthier America, shows that for every US$1 invested in proven community-based disease prevention programs (increasing physical activity, improving nutrition and reducing smoking levels), the return on investment over and above the cost of the program would be US$5.60 within five years.\(^{25}\)

5 Taking action

There is no denying the enormity of the tasks that lie ahead in implementing the Preventative Health Strategy. However, this represents the required response that is in proportion to the severity of the problems Australia faces with obesity, tobacco and the harmful use of alcohol.

5.1 A PHASED APPROACH

What follows are the most important actions in each of the areas of obesity, tobacco and alcohol. Detailed implementation plans for obesity, tobacco and alcohol, describing a full set of actions, responsibilities, phasing and measures, are included in the accompanying chapters of this document.

The actions are phased and sequenced over time, as it will not be possible or appropriate to initiate all actions in phase one.

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

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

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

First phase (2010–2013)

1. Drive environmental changes throughout the community to increase levels of physical activity and reduce sedentary behaviour
   - Establish a Prime Minister’s Council for Active Living and develop and implement a National Framework for Active Living, encompassing local government, urban planning, building industry, developers and designers, health, transport, sport and active recreation
   - Develop a business case for a new COAG National Partnership Agreement on Active Living
   - Conduct research into economic barriers and enablers, policies and tax incentives to inform a national active living framework and actions
   - Australian and state governments to consider the introduction of health impact assessments in all policy development (for example, urban planning, school education, transport), using partnership models such as the Health in All Policies (HiAP) approach in South Australia

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

3. Embed physical activity and healthy eating in everyday life

Workplaces

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

Commission a review of potential legislative changes to promote the take-up of workplace health programs, including options such as:
- Changes to Fringe Benefits Tax Assessment Act and Income Assessment Act to provide incentives
- Employer commitment to a percentage of annual payroll allocated to workplace health programs (similar to the former Training Guarantee Levy)

Investigate the feasibility of rewarding employers – through grants or tax incentives – for achieving and sustaining benchmark risk factor profiles in their workforce

Schools
Fund, implement and promote school programs to increase physical activity and healthy eating:
- Establish a partnership with the education sector
- Incorporate Health and Physical Education (HPE) for all Australian children into the second stage of National Curriculum development
- Australian and state governments to establish a national program to support implementation of the new curriculum, including teacher curriculum guidance and professional development opportunities
- Education sector to encourage all schools to develop, implement and evaluate health, nutrition and physical activity policies
- Establish system to monitor the policy requirement of at least two hours of physical activity per week for all students K–10
- Expand the coverage of out-of-school-care health programs such as Active After School and Eat Smart, Play Smart
- Education sector to examine how to build the capacity of schools and teachers to promote health and resilience more effectively
Communities

- Establish, as part of the COAG Healthy Communities initiative, a national series of comprehensive five-year intervention trials in 10 to 12 communities (including low SES and Indigenous communities)
- Establish partnerships with the Australian Local Government Association (ALGA) to develop programs that support and encourage local councils to adopt Healthy Spaces and Places planning guidelines
- Develop, pilot and implement a new Healthy and Active Families initiative as an additional intervention to the activities proposed for Healthy Communities sites; begin with the intensive intervention sites and roll out successful program elements as results become available
- Develop strategies to mobilise and engage local communities including, through the NPA, the development and delivery of a national healthy community leadership and education program

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

- Develop and work with Australian, state and territory governments to implement a comprehensive, sustained social marketing strategy to increase healthy eating, physical activity and reduce sedentary behaviour, building on Measure Up and state campaigns such as Go for 2&5, Find Thirty and Go for Your Life.
- Choose messages most likely to reduce prevalence in socially disadvantaged groups and provide extra reach to these groups

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

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

- Development and adoption of an appropriate set of definitions and criteria for determining EDNP food and beverages
- Monitoring and evaluating the impact of voluntary self-regulation in reducing children’s exposure to unhealthy food advertising
- Identifying any shortfalls with the current voluntary approach, and addressing this through the introduction of a co-regulatory agreement; monitor, evaluate and report on the effectiveness of co-regulation
- Introducing legislation within four years if these measures are not demonstrated to be effective
6. **Strengthen, skill and support primary healthcare and public health workforce to support people in making healthy choices**
   - Expand the relevant allied health workforce
   - Improve access to services that provide physical activity, weight loss and healthy nutritional advice and support
   - Fund and implement evidence-based clinical guidelines for health and community workers

7. **Address maternal and child health, enhancing early life and growth patterns**
   - Establish and implement a national program to alert and support pregnant women and those planning pregnancy to prevent lifestyle risks of excessive weight, poor nutrition, smoking and alcohol consumption

8. **Support low-income communities to improve their levels of physical activity and healthy eating**
   - Fund, implement and promote multi-component community-based programs in low SES communities
   - Fund, implement and promote effective and relevant strategies and programs to address specific issues experienced by people in low-income communities
   - Specific actions are also referred to in key action areas 3 and 4

9. **Reduce obesity prevalence and burden among Indigenous Australians**
   - Fund, implement and promote multi-component community-based programs in Indigenous communities
   - Strengthen antenatal, maternal and child health systems for Indigenous communities

10. **Build the evidence base, monitor and evaluate the effectiveness of actions**
    - Implement the expanded National Risk Factor Survey funded under the COAG National Partnership Agreement and ensure that this:
      - Becomes a permanent national periodic collection
      - Ensures coverage of adults and the Indigenous population
      - Forms part of a comprehensive national surveillance system focused on the behavioural, environmental and biomedical risk factors for chronic disease, including capacity to track changes in health inequalities
    - Ensure the National Children’s Nutrition and Physical Activity Survey is repeated on a regular basis to allow for the ongoing collection of national data on children
    - NPA to work with national research agencies to establish a National Research Agenda for obesity
    - Support ongoing research on effective strategies to address social determinants of obesity in Indigenous communities

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

Schools

- National implementation of the HPE curriculum for all Australian children as part of the second stage of National Curriculum development
- Monitor the policy requirement of at least two hours of physical activity per week for all students K–10

Workplaces

- Learn from best practice and promote effective workplace health promotion programs throughout Australia
- Implement recommendations of the review of potential legislative changes to promote the take-up of workplace health programs
- If feasible, implement a system to reward employers for achieving and sustaining benchmark risk factor profiles in their workforce
- Implement Healthy Spaces and Places planning guidelines through partnership with ALGA
- Implement new phases of comprehensive, sustained social marketing strategy to increase healthy eating and physical activity
- Continue to phase out food and beverage marketing to which children are exposed if self-regulation and co-regulation are demonstrated to be ineffective

Third phase (2018–2020)

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

First phase (2010–2013)

1. **Make tobacco products significantly more expensive**
   - Ensure that the average price of a packet of 30 cigarettes is at least $20 (in 2008 $ terms) within three years, with equivalent increases in the price of roll-your-own and other tobacco products
   - Contribute to developing and implementing international agreements and a national strategy to combat the illicit trade of tobacco

2. **Increase the frequency, reach and intensity of social marketing campaigns**
   - Develop and implement effective and sustained national social marketing campaigns (through the COAG tobacco initiative and coordinated by the NPA) at levels of reach demonstrated to reduce smoking, drawing on successful state campaigns as appropriate
   - Design messages and place media to ensure reach with young smokers and socially disadvantaged groups

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

4. **Eliminate exposure to second-hand smoke in public places**
   - Amend current legislation to:
     - Ensure smoking is prohibited in any public places where children are likely to be exposed
     - Ensure children are not exposed to tobacco smoke when travelling in cars
     - Protect against exposure to second-hand smoke in workplaces, including outdoor areas
     - Address exposure to tobacco smoke in outdoor places where people gather or move in close proximity, and from smoke-drift in multi-unit developments
5. **Regulate manufacturing and further regulate the packaging and supply of tobacco products**

- Improve consumer information related to tobacco products:
  - Mandate standard plain packaging of all tobacco products to ensure that design features of the pack in no way reduce the prominence or impact of prescribed government warnings
  - Substantially increase the size of required pack warnings
  - Prohibit misleading labelling, brand names and product characteristics
  - Automatically review and upgrade warnings on tobacco packages at least every three years, with the Chief Medical Officer to have the capacity to require amendments and issue additional warnings of new and emerging risks in between
  - Tighten and enforce legislation to eliminate sales to minors and any form of promotion at retail level
  - Require all tobacco retailers be licensed
  - Preclude sales through vending machines, the internet, and at hospitality and other social venues

- Give government power to regulate the design, contents and maximum emissions for tobacco and related products, and establish a regulatory body with responsibility for specifying required disclosure to government, labelling and any other communication to consumers

- Investigate the feasibility of legal action by governments and others against tobacco companies

6. **Ensure all smokers in contact with health services are encouraged and supported to quit**

- Ensure all state- or territory-funded healthcare services (general, maternity and psychiatric) are smoke-free, protecting staff, patients and visitors from exposure to second-hand smoke both indoors and on facility grounds

- Ensure all patients are routinely asked about their smoking status and supported to quit, both while being treated and post-discharge

- Increase the availability of Quitline services, and ensure that Quitlines are resourced to respond to projected demand from media campaigns

- Ensure that nicotine replacement therapy (NRT) is affordable for all those for whom it is clinically appropriate
7. Work in partnership with Indigenous groups to boost efforts to reduce smoking and exposure to passive smoking among Indigenous Australians

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

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

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

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

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

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

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

11. Ensure implementation and measure progress against and towards targets

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

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

Taxation

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

Social marketing

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

Legislation

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

Health system and program implementation

- Continue to subsidise cost-effective treatments for smoking cessation
- Expand delivery modes for Quitline services
- Improve advice to smokers (provided by Quitlines and health professionals, and in educational materials) based on research and smoking trends
- Expand and strengthen programs to ensure that health professionals are trained, prompted, supported and remunerated to consistently identify and encourage and support smokers to quit
- Assess the effectiveness of approaches to reduce young people’s exposures to smoking in movies
- Continue to increase awareness that selling tobacco products is incompatible with principles of social responsibility
- Investigate potential for legal action against tobacco companies that proves feasible, and act if feasible
Interventions for disadvantaged groups

- Assess the effectiveness of approaches with Indigenous communities; review and refine strategies as required
- Explore whether financial incentives might be effective in helping people to quit or stay non-smokers
- Expand programs for people living with mental illness, including those in institutional care, clients of out-patient and community-based services, and people with mental health problems who are not in contact with health systems
- Expand programs to prevent uptake and encourage cessation of smoking in low SES neighbourhoods
- Expand programs to support quitting among clients of correctional services (adult and juvenile)

International development

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

First phase (2010–2013)

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

- States and territories to harmonise liquor control regulations by developing and implementing best practice nationally consistent approaches to the policing and enforcement of liquor control laws, including
  - Outlet opening times and outlet density
  - Accreditation requirements prior to the issuing of a liquor licence
  - Late-night and other high-risk outlets
  - Responsible serving of alcohol and training model

- Increase available resources to develop and implement best practice for policing and enforcement of liquor control laws and regulations, relating to:
  - Optimal levels of enforcement of drink-driving laws
  - Intelligence-led, outlet-focused systems of policing and enforcement
  - Annual review of liquor licences as part of annual licence renewal process
  - Demerit points penalty systems for licensees who breach liquor control laws, with meaningful and graduated penalties depending on the severity and frequency of the offence
  - Monitor and report on enforcement of legislation

- Develop the business case for a new COAG national partnership agreement on policing and enforcement of liquor control laws and regulations

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

- Develop and implement a comprehensive and sustained social marketing and public education strategy at levels likely to have significant impact, building on the National Binge Drinking Campaign and state campaigns to:
  - Help build a national consensus on healthy alcohol consumption
  - Raise awareness and understanding of NHMRC guidelines
  - De-normalise intoxication
  - Raise awareness of the longer term risks and harmful consequences of excessive alcohol consumption
3. **Regulate alcohol promotions**

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

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

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

5. **Improve the health of Indigenous Australians**

- Increase access to health services for Indigenous people who are drinking at harmful levels through:
  - Providing resources to primary healthcare providers
  - Training of staff, including Indigenous health workers
  - Expanding both community-based and residential alcohol treatment programs
  - Increasing health service capacity to facilitate coordinated case management of alcohol-dependent persons
- Support local initiatives in Indigenous communities, including:
  - Restricting the physical availability of products
  - Reducing the number, density and/or opening hours of licensed premises in areas of high alcohol-related harm
  - Strengthening enforcement of the Responsible Serving of Alcohol provisions
  - Establishing local groups of senior Indigenous men and women to promote greater individual and family responsibility in relation to alcohol
- Establish a reliable, regular and sustained system for the collection and analysis of population statistics on alcohol and drug use among Indigenous people
- Establish and fund a multi-site trial of alcohol diversion programs
6. **Strengthen, skill and support primary healthcare to help people in making healthy choices**

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

7. **Build healthy children and families**

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

8. **Strengthen the evidence base**

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

- Monitor the implementation of approaches to the policing and enforcement of liquor control laws
- Implement and monitor the implementation of the national partnership agreement on policing and enforcement of liquor control laws and regulations
- Monitor and evaluate the first phase of the social marketing strategy
- Develop and implement the new phase of the comprehensive, sustained social marketing strategy
- Continue the phasing out of alcohol promotions from times and placements which have high exposure to young people aged up to 25 years
- Introduce a new pricing regime, including minimum price, based on work completed in the first phase
- Monitor and evaluate the impact of the new pricing regime
- Monitor and evaluate access to health services for Indigenous people and the generation of new local initiatives
- Expand and scale up successful local initiatives for Indigenous Australians
- Monitor and evaluate the role of primary healthcare organisations in dealing with alcohol-related health problems
- Report on progress in building alcohol referral services and programs; and increase in access to disadvantaged groups
- Monitor age and initiation of drinking alcohol
- Review progress in support to parents in managing teenage drinking behaviours
- Improve the utilisation of key datasets on the harm to drinkers and harm to others
- Expand the collection of patterns of drinking data to include place of drinking, duration of drinking occasion, and reasons for drinking
Third phase (2018–2020)

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

The establishment of the National Prevention Agency (NPA)

- Establish the NPA as an independent agency able to translate broad policy intent into evidence-based strategies with built-in evaluation and the capacity to leverage a range of policy levers and partners, both within and outside government
- Appoint an expert, cross-sectoral Board of Governance of the Agency
- The Taskforce recommends that the NPA:
  - Provides a national clearing house for the monitoring and evaluation of national policies and programs in preventative health
  - Publishes annual reports on the state of preventative health, including reporting on progress towards the achievement of the 2020 goals specified in this Strategy
  - Advises COAG, through the Australian Health Ministers Conference (AHMC), on national priorities and options for preventative health
  - Administers national programs, facilitates national partnerships, and advises on national infrastructure for surveillance, monitoring, research and evaluation (see below), as charged by AHMC
  - Develops for consideration by AHMC the next phase of preventative health reform to follow after this Strategy
  - Has an increased capacity and budget to that currently envisaged in the COAG agreement on preventive health

- NPA to develop a web-based clearing house/register for organisational policies, plans and achievements in order to share good practice across the country
- NPA to commission/conduct from time to time surveys of activities undertaken by different sectors, and barriers to and enablers of action, and to report on these
- Develop national recognition and award scheme for outstanding contributions, large and small, to making Australia the healthiest country by 2020

Social marketing

- NPA to develop and implement a comprehensive, sustained social marketing strategy to increase healthy eating and physical activity, and reduce sedentary behaviour
- NPA to develop and implement effective and sustained national social marketing campaigns at levels of reach demonstrated to reduce smoking, drawing on successful state campaigns as appropriate
- NPA to develop and implement a comprehensive and sustained social marketing and public education strategy, building on the National Binge Drinking Campaign and state campaigns
Data, surveillance and monitoring

- Implement and extend the National Health Risk Survey Program, funded under the COAG Agreement on Preventive Health.

- Comprehensive national surveillance systems for obesity, tobacco and alcohol are essential tools for the purposes of collecting and managing relevant datasets, monitoring progress against specified targets and reporting trend information over time. To be effective, these systems should have the capacity to:
  - Collect and report against behavioural, environmental and biomedical risk factors relevant to obesity, tobacco and alcohol.
  - Expand and incorporate newly identified and/or revised indicators into datasets as required and appropriate.
  - Become permanent systems of data collection undertaken at predetermined regular intervals.
  - Provide representative data for the whole of population and also populations of interest (for example, Indigenous, children and adolescents, disadvantaged).
  - Complement and build upon other existing data collection and monitoring mechanisms as required and appropriate.

National research infrastructure

- Establish:
  - A National Strategic Framework for preventative health research.
  - A preventative health strategic research fund.
  - A national preventative health research register.

- Develop a network of prevention research centres which would:
  - Partner with community interventions in the region they serve, with NGOs and other collaborators.
  - Have a national specialty role (for example, in obesity, tobacco or alcohol, school settings or disadvantaged populations).
  - Have a workforce development role in education, research and intervention practice.

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

Workforce development

- NPA to oversee as a matter of priority a national audit of the prevention workforce outlined in the 2008–09 COAG Agreement on Preventive Health; strategy arising from the audit to be brought to AHMC for implementation.

- Ensure prevention becomes an important part of the work of Health Workforce Australia Agency.

Future funding models for prevention

- NPA to investigate and provide advice in regard to the potential development of a funding framework for prevention, both within and external to the health sector.
The following sections of this chapter relate to the rationale, structure and approach, as well as some of the important themes considered in the development of the Strategy.

6 A conceptual framework for the Strategy

The purpose of the Strategy is to improve the health, wellbeing and life expectancy of Australians, and to remedy disadvantage in health status. Within this context, the components of the Strategy are based on the following four rationales:

- Influencing markets
- Inequities in health
- Developing effective policies
- Investing for maximum benefit

Later in this chapter, these concepts are applied to the strategic directions put forward by the Taskforce.

‘In a political economy that measures progress in terms of growth and consumption there are many underlying environmental, social and political determinants. In this context the introduction of policy and regulatory interventions is essential to make real impact’ (Quote from submission)

6.1 INFLUENCING MARKETS

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

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

Understanding how to adopt a healthy lifestyle is compromised by the complexity of the relationship between lifestyle behaviours and health, and an economic and social environment that promotes unhealthy choices. Efficient markets rely on a rational consumer able to critically evaluate information and weigh up, for instance, current pleasure and possible consequences. Alcohol, food and smoking are particularly vulnerable to compulsive choices and alcohol and tobacco can be addictive; in addition, alcohol directly affects capacity for rational decision making. Children and teenagers require special consideration, given their under-developed abilities to weigh the consequences of their behaviour.

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

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

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

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

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

6.2 INEQUITIES IN HEALTH

Australians’ concern with fairness in relation to preventative health, together with their concern for the suffering of others, demands actions to support equity of access to the means to lead a healthy life. This suggests, for instance, policies that promote access for all to nutritious food, physical activity, clean water and adequate housing. It also supports the provision of culturally relevant and accessible preventative health services (including minimal co-payments) that discriminate in favour of high-risk groups and those in poorer health.

At the system level, providing equity of access is the major argument for funding primary and community care according to a needs-adjusted capitation formula. A predominant fee-for-service payment system results in highest Medicare Benefits Schedule spend in regions with the highest SES and higher levels of health. It is also an argument for strengthening universal health cover and reconsidering policies not consistent with equity.

We know that health is a major indicator of inequity. If you want to judge how affluent a suburb is, you could check its tax returns – or you could look at its medical records. Rates of diabetes, of heart disease, early deaths, infant mortality, how many teeth a person has left – all are clear markers of socio-economic status. …In three areas – prevention, workforce, and the provision of health services by both public and private providers – a confused combination of government regulation and badly designed markets can hamper our ability to deliver the healthcare that people deserve. Which means health inequalities are becoming entrenched in our community.[26]

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

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

To support a health promoting society, broad structural reform is required not only within the health system but to address the structures, environments and institutions that influence and impact on the health of the population and the individual.” (Quote from submission)

As submissions and consultations noted, to date much of Australia’s prevention policy has been ad hoc, and has been developed to suit single rather than multiple issues managed by single departments rather than coordinated between government portfolios. The combined effect – while sometimes reflecting policies that are consistent with the objectives of the agency and portfolio but not necessarily in the interest of the wider society – has been to distort the health service mix, reduce the efficiency of the health system and to have favoured some medical and pharmaceutical services over lifestyle and community-based initiatives.

Policy failure within health and the wider economy provides an important rationale for the Strategy’s components. To be effective, prevention policy needs to maintain a balance across a comprehensive and complex set of approaches and settings, avoid cost shifting between levels of government, and encourage cross-sectoral initiatives that allow flexibility in supply. The introduction of new policies must be accompanied by quality assurance and accountability mechanisms. Appropriate responses will often include regulatory or system level initiatives.

FOR EXAMPLE:

- A person who is obese can receive subsidised pharmaceuticals and medical care, but will struggle to find public dietetic services, physical activity programs or multi-disciplinary weight loss services, even given evidence of cost-effectiveness.

Non-health policies can also have unintended negative consequences on people’s health.

FOR EXAMPLE:

- Approaches that favour the use of motor vehicles over active transport options.
- Urban design and land use that discourages activity and social connection.
- An education curriculum that does not adequately recognise the importance of health, nutrition and physical activity.

Health distortions of particular concern for prevention include:

- The differential funding arrangements across governmental and departmental budget silos. This is far from the ideal of a level playing field in which all services can compete equally for resources, regardless of modality, setting, stage of disease or delivery mode.
- The lack of accountability and quality assurance mechanisms for preventative health.

Reform options are set out by the NHHRC,[27] in various commissioned papers for the NHHRC and for this Taskforce, as well as in the wider health services literature. Some components of health reform have emerged, such as enrolled populations and electronic patient records. Health reform issues, especially for primary healthcare, are covered later in this chapter, although it is recognised that some of these issues are being addressed by other initiatives such as the Primary Health Care Strategy.

Examples of ways to address health impacts from non-health policy can include the introduction of health impact assessments in all policy development (for example, in urban planning, school education or transport), and the development of partnership models such as the Health in All Policies approach described below.
EXAMPLE: THE HEALTH IN ALL POLICIES APPROACH (HIAP)

The South Australian Strategic Plan provides the framework for the HIAP approach. In 2007, through the Adelaide Thinkers in Residence program, Professor Ilona Kickbusch developed a proposal for integrated policies and strategies around the broad theme of ‘Healthy Societies’. High-level commitment from both the central government agency (the Department of Premier and Cabinet) and the Health Department was obtained. (28)

Obesity was one of the areas included in the HIAP plan, building on the existing partnerships between the Department of Health with:

- Primary Industries and Resources of South Australia (PIRSA) through encouraging fruit and vegetable consumption
- Department of Transport, Energy and infrastructure (DTEI) through support of active transport
- Department of Education and Children’s Services (DECS) through the Right Bite school canteen program
- Department of Environment and Heritage (DEH) through the Healthy Parks Healthy People program
- Recreation and Sport through Be Active workplaces (29)

6.4 INVESTING FOR MAXIMUM BENEFIT

The fourth rationale for selecting components of the Strategy is that of minimising opportunity cost – that is, the opportunities and benefits missed because of activities that have not been funded. This requires the redirection of resources away from cost-ineffective to more cost-effective interventions. Put simply, resources should be allocated where they yield the greatest benefit per unit cost. The approach taken by the Taskforce has been to work wherever possible from a well-researched evidence base – and where the evidence is not yet clear, to build evidence to inform future cost-effective investment in prevention activity.
7 The roadmap for prevention

The roadmap for action outlines the themes, targets and strategic directions that will bring about the results we seek.

7.1 THE ROADMAP

Figure 1.3:

Roadmap

Strategy Vision

AUSTRALIA: the healthiest country by 2020

Maximising community wellbeing

Shared responsibility – working together

Addressing health equity

Ensuring quality implementation

Whole of government and all levels of government working with individuals, families and communities

Whole of country encompassing industry, business, unions, non-government sector, professional associations, research community

Develop strategic partnerships

Act early and across life

Engage communities

Influence markets/develop coherent policies

Reduce inequity

Refocus health systems towards prevention

Strategic Directions

Approach

Target Populations

Settings for action, home, schools, workplaces, communities, primary healthcare, and other healthcare settings

OBESITY

TOBACCO

ALCOHOL

INDIGENOUS

OBESITY

• Halve and reverse the rise in overweight and obesity by 2020

TOBACCO

• A reduction in the prevalence of daily smoking among adults (aged 18+) from 17.4% in 2007 to 10% or lower by 2020

• By 2020 Australians, especially children, are not being exposed to second-hand smoke in their day-to-day lives and smoking during pregnancy is minimal

ALCOHOL

• Reduce the proportion of Australians who drink at short-term risky/high-risk levels to 14%

• Reduce the proportion of Australians who drink at long-term risky/high-risk levels to 7%

INDIGENOUS

• Contribute to the Close the Gap target for Indigenous people, reducing the life expectancy gap between Indigenous and non-Indigenous Australians
7.2 PRINCIPLES

The principles underpinning the Strategy have been identified from evidence from the research literature, and confirmed through consultations and submissions to the Taskforce. In this first National Preventative Health Strategy, these principles guide action in relation to obesity, tobacco and alcohol, but they can also be used for other prevention issues such as mental health promotion or the prevention of injury or blood-borne viruses.

- **Maximising community wellbeing** – by building a roadmap with staged approaches for strategic prevention across the whole of life, in a variety of settings and for a wide range of population groups.

- **Working together** – with individuals, families, communities, health professionals, industry, employers and governments to build prevention in Australian communities.

- **Addressing health equity** – through recognition and response to the causes and effects of health inequity, especially for Indigenous people.

- **Ensuring effective implementation** – through a strong infrastructure that supports individuals and communities in making and sustaining healthy choices.

7.3 TARGETS AND INDICATORS

**Targets**

The Taskforce has set four key targets. By 2020 Australia will:

- Halt and reverse the rise in overweight and obesity.
- Reduce the prevalence of daily smoking among adult Australians aged 18+ from 17.4% in 2007 to 10% or lower.
- Reduce the proportion of Australians who drink at short-term risky/high-risk levels to 14%, and the proportion of Australians who drink at long-term risky/high-risk levels to 7%.

Achieving these targets will require a staged approach over time, including substantial new injections of funding and sustained effort.

These targets are consistent with those of the COAG National Partnership Agreement on Preventive Health and the National Healthcare Agreement performance targets, which include:

- Increase the proportion of children and adults meeting national guidelines for healthy body weight by 3 percentage points within 10 years
- Increase the proportion of children and adults meeting national guidelines for healthy eating and physical activity by 15% within six years
- Help assure Australian children of a healthy start to life, including through promoting positive parenting and supportive communities, and with an emphasis on the new

In addition to these targets and aligned with the COAG outcome measures, the Taskforce has developed a number of interim targets and performance measures for each of the topic areas, which are set out in the relevant chapters.
Measuring progress

It is necessary to strengthen Australia’s capacity to effectively monitor, evaluate and build evidence around preventative health. A number of ambitious targets relating to overweight and obesity, alcohol and tobacco have been set by this Strategy, and Australians will need to know how effective our preventative health programs are and whether we are on track to meet these targets.

The Strategy has been designed to focus on **implementation, measurement and accountability** – a cyclical approach of ‘do, measure, report – do, measure, report’. The development of a robust performance framework to underpin the Strategy and inform its implementation is therefore a priority.

Progress will be monitored at three levels:

- **Health status and outcomes**
- **Determinants of health**
- **Program and systems performance**

Changes in health outcomes and determinants of health are the long-term measures of the success of this strategy. However, these indicators are most reliably measured over several years at the population level, and changes cannot easily be attributed to specific program elements. Complementing these longer term measures are the shorter term program and system-level performance indicators more closely related to the specific priority actions and programs. These program and system performance measures are summarised in the tables within this strategy. In addition, indicators relevant to enabling infrastructure for prevention will also be developed and monitored.
PERFORMANCE INDICATORS FOR OBESITY, TOBACCO AND ALCOHOL PREVENTION

Health outcome measures (all to be reported by Indigenous status)
- Deaths attributable to tobacco, alcohol, overweight and obesity
- Hospital separations for tobacco, alcohol, overweight and obesity

Determinants of health measures (all to be reported by Indigenous status and by index of relative social disadvantage of place of residence)
- Proportion of adults who are daily smokers
- Proportion of adult smokers who have attempted to quit in last year or who intend to quit in next three months
- Proportion of children who smoke at least weekly or monthly and proportion who have smoked at least 100 cigarettes
- Proportion of adults and children who live in a home where anyone smokes indoors
- Proportion of adults and children at risk of long-term harm from alcohol
- Proportion of adults and children at risk of short-term harm from alcohol at least once a month
- Proportion of adults and children overweight or obese
- Proportion of adults and children eating sufficient daily serves of fruit and vegetables
- Proportion of adults insufficiently physically active to obtain a health benefit
- Proportion of people walking, cycling or using public transport to travel to work or school
- Proportion of babies breastfed for six months or more

Program and system performance measures (reporting by Indigenous status and by index or relative social disadvantage as appropriate)
These measures are summarised in the tables within the obesity, tobacco and alcohol chapters. They include but are not limited to the following measures:
- Knowledge, attitudes and awareness of risks associated with tobacco use, risk drinking and overweight and obesity
- Recall of social marketing campaigns for obesity, tobacco and alcohol
- Proportion of Australian population not covered by legislative restrictions on promotion and use of tobacco and alcohol that operate at state and territory level
- Proportions of overweight or obese people, smokers or people at risk of short- or long-term harm from alcohol receiving brief interventions in primary healthcare settings
- Children’s exposure to advertisements for EDNP food and beverages
- Food price disparity in rural and remote areas
- Number and proportion of state and municipal plans that include steps to tackle obesity
- Number and proportion of schools with comprehensive programs in place that support healthy eating and physical activity
- Number and proportion of workplaces that have comprehensive programs in place to support healthy living
- Proportion of retailers breaching tobacco-related legislation
- Number of instances where tobacco products are being promoted
- Price of cigarettes (recommended retail price, average price paid by consumers and price in comparison to average weekly earnings)
- Proportion of smokers surveyed who report purchase of illicit tobacco products and proportion of children who report that they have been able to purchase tobacco products from retail outlets
- Alcohol outlet density by city/town and region
- Taxation incentives for the production and consumption of low alcohol products
- Systems and practices to proactively police licensed venues, events and harms
- Expenditure on research and evaluation relating to the control of alcohol, tobacco and overweight and obesity in Indigenous and other disadvantaged communities

Enabling infrastructure measures
These may include indicators relevant to workforce, investment in social marketing campaigns and investment in prevention research including understanding of social determinants of health behaviour, modelling of health impact policy options and evaluation of programs. They would also include measures relevant to the development of partnerships and engagement/participation of stakeholders with the Strategy.
7.4 STAGING CHANGE

Reaching the targets we have set for Australia to become the healthiest nation in 2020 is ambitious but achievable. Each incremental step over the years to 2020 will need to be carefully monitored and built on to achieve the end goal, recognising that not all approaches can be introduced at once.

After nearly 60 years experience, we know what works in tobacco control. Comprehensive action across a number of strategies (for example, public education, taxation, legislation, regulation, rigorous monitoring, research and evaluation) has resulted in significant falls in smoking prevalence and changes in public attitudes to smoking.

We also have many years of experience in addressing alcohol problems, particularly drink driving, although there is still a long way to go to having a safer culture of drinking in Australia, including public perceptions of high-risk drinking and the secondary effects experienced by families and communities.

Tackling obesity is a comparatively new task. As part of the comprehensive approach proposed, it will be important to place a special emphasis on further building the evidence base so that the most cost-effective and efficient interventions are pursued systematically. In this area in particular, interventions will need to be staged over time. For example, some community-based obesity prevention programs will need to start as trials, underpinned by research and thorough evaluation, before being scaled across the country. Similarly, in areas such as the regulation of food advertising, an approach using responsive regulation is required, beginning with an evaluation of self-regulation, moving to co-regulation and independent regulation and legislation where stronger measures are required. This follows the cyclical ‘do, measure, report – do, measure, report’ approach to staged change and partnership approaches.

The figures below illustrate the progressive, determined and iterative processes, using multiple strategies over time, which has proved so successful for tobacco and road trauma.

Figure 1.4: Milestones in reducing smoking in Australia 1980–2007

Source: The Cancer Council of Victoria 2009

No bulls campaign
Phase out smoking in federal workplaces
Pack health labelling regulations introduced
Vic Tobacco Act
NRT available for sale in Australia
MCG smokefree
C/W implement tax by stick
C/W implement smoking free dining
Gaming venue bans

Male 18+
Female 18+

1st Quit Campaigns
4 rotating pack health warnings
Health warnings on packs
Health warnings on excise duty
Age for sale of cigarettes 16 to 18
Remaining tobacco sponsorship removed
(exc. Significant international events)

Stadium bans
Federal bans on tobacco sponsorship of sports & arts
POS advertising bans

Source: The Cancer Council of Victoria 2009
7.5 STRATEGIC DIRECTIONS

The Taskforce has identified seven critical strategic directions to be developed and implemented consistently and collectively for the National Preventative Health Strategy to be effective. Learnings from tobacco control and other prevention strategies show that addressing some strategies selectively but not others, or downgrading a strategy just as progress becomes apparent, will significantly reduce overall effectiveness.

To ensure the development of a comprehensive approach to prevention, the strategic directions are:

i. **Shared responsibility** – developing strategic partnerships – at all levels of government, industry, business, unions, the non-government sector, research institutions and communities.

ii. **Act early and throughout life** – working with individuals, families and communities.

iii. **Engage communities** – act and engage with people where they live, work and play (for example, in the most relevant settings: home, school, workplaces and community). Inform, enable and support people to make healthy choices.

iv. **Influence markets and develop connected and coherent policies** – for example, through taxation, responsive regulation, and through coherent and connected policies.

v. **Reduce inequity** through targeting disadvantage – especially low SES population groups.

vi. **Indigenous Australians** – contribute to ‘Close the Gap’
vii. **Refocus primary healthcare towards prevention** - one of the most important sectors of the health system for preventative health.

Each of these strategic directions will require strong infrastructure to support action, coordinated and driven via the National Prevention Agency (NPA). The key elements of this infrastructure – prevention research, effective social marketing, national data, surveillance and monitoring of progress, workforce development and the development of the most effective funding models for prevention – are described later in this chapter.

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i. **Shared responsibility – developing strategic partnerships**

Health is a shared responsibility between those who will benefit from making healthy choices (for example, individuals, families and communities) and those who provide the infrastructure, services and support (governments at all levels, professional associations, the non-government sector, the research community, industry and business, and unions). Individuals, families and local communities are central to this shared approach. Effective prevention programs will depend on the participation of all Australian communities, at all levels – in the cities, in the bush and in the remote areas of the country. The figure below illustrates the range of players who contribute to preventative health.

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**Figure 1.6:** Working together
Australians as individuals will make prevention work. It is individuals who will take up regular physical exercise and make the right food choices for themselves and their families, who can voice a concern for public safety and an intolerance of drunken behaviour, and who can help make Australia a virtually smoke-free nation.

Individuals cannot achieve change on their own. They will need the support of employers and workplaces, unions, community leaders, industry, business and private sectors, the health services and all three levels of government.

Governments play a vital role in driving change and putting in place the support structures needed to achieve change.

Genuine and sustained partnerships between the three levels of government are essential if Australia is to achieve the targets described in this paper.

In broad terms:

- The Australian Government has responsibilities for policy and program implementation and coordination, across-government policy, fiscal incentives and regulation, the development of a strong evidence base and practice guidelines, monitoring and surveillance systems, and partnerships with national organisations, including employer and employee organisations and community agencies.

- Local governments have responsibility for local planning and support structures. They play a vital part in engaging local communities, and in providing some of the services, amenities and programs that prevent illness and promote good health.

For the three tiers of government to work well together, excellent coordination of the respective roles and responsibilities will be required, along with clear accountability for all their activities and outcomes.
Good health is the business of other sectors too – not just health:

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

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

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

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

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

- The non-government sector also plays a vital role. NGOs, at all levels, are partners and often leaders in prevention, providing research and development, advocacy, social marketing, public information and primary care, as are professional associations and academic groups.

- Other national and state-based agencies such as the NHMRC, Australian Research Council (ARC), Australian Bureau of Statistics (ABS), Australian Institute of Health and Welfare (AIHW), Social Inclusion Board and state-based health promotion foundations are integral to the Strategy’s ‘do, measure, report’ cycle.

- The private sector (for example, the food and alcohol industries, media, advertising, private health insurers, employers and the fitness and weight-loss industries) is particularly important to this Strategy, especially in relation to food, beverages and physical activity, and in assisting in making healthy choices the easy choices.

- Private health funds play a prominent role in Australia’s healthcare system. Today, over 11 million Australians hold some form of hospital and/or general treatment cover. Since 2007, through the Broader Health Cover initiative, legislative change has allowed private health funds to more actively engage in primary prevention, and many funds are actively seeking to have such preventative programs delivered to their members. Clearly, it is in the interest of each private health fund to ensure the funding of such programs on an ongoing basis is based on evidence that demonstrates the promotion of improved health and prevention of illness. Such interest aligns with the Taskforce’s focus of supporting infrastructure, as private health funds in Australia represent a source for preventative health in terms of research. In particular, private health funds in a number of areas have datasets that are unique within the health sector. The appropriate access and utilisation of this data could be of significant value.
ii. Act early and throughout life

‘A life-course perspective is essential for the prevention and control of non-communicable diseases. This approach starts with maternal health and prenatal nutrition, pregnancy outcomes, exclusive breastfeeding for six months, and child and adolescent health; reaches children at schools, adults at worksites and other settings, and the elderly; and encourages a healthy diet and regular physical activity from youth into old age.’ (31)

The life course of individuals is shaped by their experiences in the earliest years of their life. The early childhood period has a profound impact on all aspects of development, and establishes the foundations of an individual’s future development. Early childhood experiences may place children on health and developmental pathways that are costly and difficult to change. Therefore, children necessarily form the cornerstone of any prevention agenda.

Research indicates that:

‘virtually every aspect of early human development, from the brain’s evolving circuitry to the child’s capacity for empathy, is affected by the environments and experiences that are encountered, in a cumulative fashion, beginning in the prenatal period and extending throughout the early childhood years.’ (32)

In short, what happens to children at the earliest age has direct, identifiable outcomes in areas such as their health, life expectancy, the extent to which they rely on the economic and social support of the community and their capacity to contribute productively to their society. Children with poorer health do significantly less well in school, complete fewer years of education, and have significantly poorer health as well as lower earnings as adults. (33)

Investments in children’s health make significant differences not only to their health outcomes but also to a broad range of social, demographic and economic factors. There is strong evidence to show that investments that improve children’s health lead to higher cognitive development and school attainment, increased propensity for parents to invest in children, reduced cost of medical care and increased participation of parents in the labour market; all of which are associated with improved economic performance and stronger economic growth as well as reduced inequality in societies studied. (33)

‘...from conception, the early years of a child’s life influence health outcomes and life opportunities; an equitable start for all Australian children offers the best life chances for health and wellbeing in later years’ (Quote from submission)

The literature shows that ‘making greater investment in children’s health results in better educated and more productive adults, sets in motion favourable demographic changes, and shows that safeguarding health during childhood is more important than at any other age because poor health during children’s early years is likely to permanently impair them over the course of their life’. (33)

The significance of these findings is reinforced by epidemiological evidence that adult disease can be linked to factors as early as foetal nutrition. Babies born with low birth weight, especially small for gestation age, are at increased risk of hypertension, dyslipidaemia, insulin resistance, type 2 diabetes, ischemic heart disease and breast or prostate cancer in adult life. (34-37)

The impact of poor nutrition during pregnancy (as indicated by low birth weight) can be compounded by ongoing poor nutrition and poor early childhood circumstances. (38) Studies have found that poor early childhood circumstances, including low income and family discord, interfere with healthy development and lead to increased risks of onset of asthma, hypertension, diabetes, coronary heart disease and stroke or heart attack in adults, as well as significantly increased risk of poor mental health. (39)
same combination of conditions interferes with cognitive development and health capital in childhood, reduces educational attainment, and leads to worse labour market and health outcomes in adulthood.\(^{40}\)

**FOR EXAMPLE:**

The Adverse Childhood Experiences (ACE) Study\(^ {41}\) is a major US research study that compares current adult health status to childhood experiences decades earlier. The findings are important medically, socially, and economically.

‘The ACE Study reveals a powerful relation between emotional experiences as children and adult emotional health, physical health, and major causes of mortality in the United States. Moreover, the time factors in the study make it clear that time does not heal some of the adverse experiences common in the childhoods of a large population of middle-aged, middle-class Americans. One doesn’t “just get over” some things.’\(^ {41}\)

While it is true that Australia, like the United Kingdom and the United States, is a wealthy country with generally good social services, recent UNICEF figures indicate that we have little reason for complacency and much yet to do. UNICEF recently established benchmarks for OECD countries in infant mortality, birth weight and immunisation. Australia was below the benchmark in each of these three areas (see Figure 1.7 below).

While research has demonstrated that children’s life courses can be significantly disrupted by poor early childhood experiences, it is also demonstrated that high-quality preventative programs can substantially change this life course. Although no single program has been identified as a ‘magic bullet’, there is substantial evidence that by acting early governments are in a position to ameliorate the effects of poor quality environments and intervene in the intergenerational transmission of disadvantage.

In summarising this research,\(^ {42}\) the National Scientific Council on the Developing Child has identified a number of core principles, which they have labelled ‘effectiveness factors’. The first of these identifies that access to basic medical care for pregnant women and children can help prevent threats to healthy development as well as provide early diagnosis and appropriate management as problems emerge. Evidence supporting this factor includes the positive effects of adequate prenatal and early childhood nutrition on healthy brain development, and the developmental benefits for very young children when parental problems such as maternal depression are identified and treated effectively.

Similarly, there is extensive research to indicate that children’s participation in quality early childhood programs can make a substantial difference to cognitive and social outcomes. Longitudinal studies in the United States, following significantly disadvantaged families, have demonstrated substantial differences in wellbeing, income, social participation and adjustment between adults who experienced high-quality early childhood programs compared to those who did not.\(^ {43}\)

Taken as a whole, the extensive research on early childhood gives Australia an excellent platform from which to reform and further develop its service systems for children and their families.
The Taskforce considers that the keys to effective prevention during pregnancy and the early years of life, whether associated with obesity, tobacco, alcohol or other health and social require risks, are:

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

Australia has a clear opportunity to build on these initiatives and to create a service system which focuses on the health, learning and development of young children and which supports their families to provide the best possible environment to ensure their health and wellbeing. The Platforms program provides one example of a multi-strategy approach to such a service system.

EXEMPLARY: THE PLATFORMS PROGRAM: CCCH MELBOURNE

- Community engagement and planning
- Raising awareness of early child development through dissemination of research
- Multi-disciplinary training for professionals who work with children and their families
- Early identification of need through the development of a national tool and systematic application of checks at 18 months and three years of age
- Provision of evidence-based information for parents
- Evidence-based information accessible to communities, providing choices for interventions in a variety of settings
- Collection of population data at community, state and national levels to inform sound policy decisions
- A national monitoring and evaluation strategy to measure progress

Australia has a patchwork of existing early childhood and family support services which reflect the legacies of previous policies and earlier understandings about how children grow and develop. Governments have recognised the importance of supporting families to ‘get the early years right’. Work is under way through COAG to enhance service quality and delivery in early childhood settings. All governments recently endorsed the National Child Protection Framework, and COAG is currently addressing early childhood more broadly through development of a National Early Childhood Development Strategy, due for release in July 2009. In its December 2008 Interim Report, the NHHRC placed strong emphasis on approaching health systems reform from a life-course perspective (with a focus on early years) and the Maternity Services Review(44) provides a number of key recommendations to improve care and support for women during the antenatal period.

‘the importance of prevention for children, young people, their families and the broader community is now recognised and reflected in various policy initiatives around Australia’
(Quote from submission)
Keeping older Australians healthy

‘Approach preventative health policy through a framework of a commitment to active ageing and the promotion of healthy lifestyles and interventions that enable older Australians to age well and in place’ (Quote from submission)

Population ageing is a common characteristic of many developed countries, including Australia, and is due mainly to a combination of decreasing fertility rates and increased life expectancy, much of which is due to past successes in prevention. Australian men and women currently aged 65 can expect to live to 83 and 86 years, respectively.

Life expectancy trends are anticipated to continue, with current population projections indicating that by 2036 the proportion of the Australian population aged over 65 years will have increased from 13% (2.7 million people) in 2006 to 24% or 6.3 million people. This is also likely to result in changes to the profile of older Australians over the next 30 years and increase the degree of heterogeneity within this group. These include:

- Rapid increases in the number of Australians aged over 85 years (333,000 in 2006 rising to 1.1 million in 2036) and 100 years and over (just under 5000 rising to more than 25,000).
- A shift in gender distribution, due to the life expectancy of Australian men improving at a faster rate than that of Australian women.
- By 2011 one in five older Australians aged over 70 will be from culturally and linguistically diverse backgrounds.
- An increase in the number of older Australians still actively engaged in the workforce.
- Almost half of women and a third of men aged 65 years will enter permanent residential care at some time in their remaining lives.

The anticipated changes to the number and profile of older Australians have the potential to significantly impact on the quality of life outcomes for this population group, presenting challenges to both government and the community. Whilst some sections of the older population will maintain their health and activity levels well into their later years, others will face considerable problems related to their health and quality of life.

The increased prevalence of chronic disease as individuals age is one such consideration, with older members of the population likely to have more than one chronic health condition as compared to younger individuals. Many conditions common in older age are associated with behavioural and biomedical risk factors such as obesity, alcohol misuse and tobacco consumption that can be modified to prevent the onset of chronic disease and consequently improve the quality of health outcomes through ‘healthy ageing’.

Healthy ageing is ‘the process of optimising opportunities for physical, social and mental health to enable older people to take an active part in society without discrimination and to enjoy an independent and good quality of life’.

While the potential scope for policy and action is diverse, efforts to tackle and improve healthy ageing have four key areas:

- Improved integration in the economy and community
- Better lifestyles
- Adapting health systems to the needs of the elderly
- Attacking the underlying social and environmental factors affecting healthy ageing
Whilst all of these areas are important in ensuring healthy ageing is supported, the encouragement of better lifestyles amongst the older population has the largest potential for improving the health of the elderly.\(^\text{[56]}\) There is a strong reliance on prevention, as it is never too early or too late to promote health.\(^\text{[57]}\) Action to address obesity, alcohol misuse and tobacco consumption is vital in achieving good health outcomes.\(^\text{[53]}\)

**Healthy weight**

Current trends in overweight and obesity have had a substantial impact on Australia’s ageing population. The prevalence of obesity among Australians approaching retirement is between 25% and 30%. Those aged in their 50s and 60s have experienced weight increases as they age, and the current cohort of older Australians are estimated to be six to seven kilograms heavier than 20 years ago.\(^\text{[58]}\) Factors contributing to this increase in obesity in older Australians are physical activity levels, nutrition and diet.

Exercise is considered the ‘best preventive medicine for old age’.\(^\text{[56]}\) Evidence suggests that the impacts from a wide range of physical health and mental health conditions and dependency in old age can be reduced or minimised through regular physical activity of moderate intensity.\(^\text{[59]}\) The inherent challenge is how to encourage the uptake and maintenance of physical activity amongst the older population, especially for those who have not been active over their lifetime or who have experienced a change in their level of mobility or living arrangements.\(^\text{[56]}\)

A balanced diet and adequate nutrition is also vital in ensuring good health outcomes in the elderly. The diets of older Australians must be sufficient to provide their minimum nutrient requirements, which should include sufficient levels of fruit and vegetables and lower rates of fat and salt.\(^\text{[47]}\) However, changes in food consumption patterns can affect the intake of food and health outcomes of the older population.\(^\text{[56]}\) For example, a growing reliance on pre-packaged and processed foods could result in the risk of older Australians becoming overweight or obese, along with other health-related problems. However, a decline in food consumption associated with increasing age due to disability, the secondary effects of medication or bad eating habits as a result of social isolation could lead to malnutrition and risk of under-weight.

**Tobacco**

As in the general population, giving up smoking improves the health outcomes of older Australians. The decrease in smoking among adults over the last 20 years was initially apparent amongst older Australians. This was mainly due to a greater prevalence of smoking cessation and the greater mortality of smokers as compared to non-smokers within this population group.\(^\text{[47]}\)

The relationship between continued smoking as people age and the increased risks of illness and premature death are well documented.\(^\text{[56]}\) However, in keeping with the notion of it being ‘never too early and never too late to promote health’, even older smokers who quit between the ages of 65 and 70 can substantially reduce their excess risk of premature death.\(^\text{[55]}\)

**Risky alcohol consumption**

In 2004–05, 8.1% of the Australian population aged 65 years and over consumed alcohol at risky levels for long-term harm.\(^\text{[47]}\) Whilst the overall prevalence is lower in older populations, alcohol misuse disorders are common and can be associated with health issues such as some cancers, cirrhosis of the liver, cognitive problems, negative interactions with medications and falls.\(^\text{[55]}\)

With alcohol playing an important role in Australian social life, there is expanded opportunity for consumption of alcohol in retirement and older age.\(^\text{[47]}\) Combined with a general decrease in alcohol tolerance with age, this may result in further potential for risky consumption.
Achieving healthy ageing

‘Health promotion activities and equal access of older persons to preventative healthcare and services throughout life is the cornerstone of healthy ageing’ (Quote from submission)

Whilst the point has been made that encouraging older people to adopt healthier lifestyles has the largest potential for improving the health of the elderly, behaviour modification alone will not be enough to ensure the best health outcomes for older Australians. To be successful, healthy ageing must incorporate strategies and policies that target the individual, communities, the healthcare system and other services, and government needs to provide the necessary responsibility and infrastructure to encourage the active participation and engagement of older members of the population.(48)(53)

iii. Engage communities

A number of key settings provide logical places for prevention activity. Interventions are intentionally designed for local settings where people live, work and play – in homes and throughout communities, in childcare, through maternal and childcare services, schools, universities and TAFEs, and importantly in the workplace.

‘The challenge is to increase the number and reach of sustainable community programs that build on existing efforts and prioritise those most in need’ (Quote from submission)

The community is the central setting where prevention actually happens. It is the setting where food is bought and consumed, where people gather to drink alcohol in pubs, restaurants and clubs, where tobacco products are sold and smoked, and where individuals and families meet, work, study and play.

Each community includes important players who drive prevention policies and messages home at the local level. These people know their local community; they know what works and what doesn’t in their locality, and they work with people in their communities to shape the environment to meet local need. They are essential in the reinforcement of national policies at the local level, the introduction of policies within the community and engagement with the people that make up their communities.

This Strategy includes the introduction of community-based trials to identify what works in prevention (particularly in relation to obesity) at the local level and which combination of interventions will improve health outcomes, especially in disadvantaged communities. Trials will require the whole community to work together. Some of the many examples of the associations and services that contribute to a whole of community approach, together with the important roles they play in preventative health, are listed below.
WHAT COMMUNITIES CAN DO

- Local governments can set and drive policies and programs, taking national policies to the local level and designing programs that are relevant to community need.
- Local governments engage with people in the community and are vital in dissemination of information and in building health literacy in the community.
- Chambers of Commerce engage with local business and can reinforce and support consistent healthy policy and business practices throughout communities.
- Employers can provide healthy workplace programs (workplaces are described in more detail below).
- Schools, childcare and after-school programs can implement a healthy food policy (for example, in canteens) and physical activity programs (schools, childcare and after-school programs are discussed in more detail below).
- Sporting clubs and the recreation sector can provide opportunities for adults and children in the community to participate in sport and recreation.
- Gyms, exercise classes, walking and cycling groups can provide opportunities for physical activity and for weight loss.
- The public transport sector plays an important role in local infrastructure development that can help shape active neighbourhoods.
- Planners can design environments that create healthy towns and other localities, ensuring play spaces for children, cycle paths linking home with work and schools, and road infrastructure that encourages public transport.
- The food industry sells its products through the retail sector in the local community and can make a major contribution in making sure healthy food choices are easy choices for the people in the community.
- The hospitality industry can set in place responsible service practices to ensure the safety of their customers.
- The police, welfare agencies and justice system can play a vital role in preventing and intervening early on alcohol-related issues – and support the hospitality industry and the local community in ensuring safe and responsible drinking in public places.
- Non-government organisations are vital partners in prevention, providing research and development, advocacy, social marketing, public information and primary care and support for local organisations to embed prevention at the local level.
- Health services, especially in the primary healthcare sector, provide services, information and support on prevention and management of overweight and obesity, low-risk drinking and assist with prevention of smoking and support for tobacco cessation.
- The media at all levels, including local media reinforce healthy behaviour through reporting and disseminating information on weight, physical activity, tobacco and alcohol.
The importance of the workplace as a setting for action

‘The workplace is an ideal opportunity to engage individuals in taking more control of their health’ (Quote from submission)

‘Not only does the workplace provide a captive audience to which messages can be targeted but there is a secondary effect through the influence on families and friends’ (Quote from submission)

There is increasing recognition of the scope for preventative health measures to be delivered in or through the workplace. These measures can complement and reinforce initiatives in the wider community, and those delivered through the healthcare system.

The workplace is a setting where most adults spend around half of their waking hours. It offers the potential to reach a substantial proportion of the population who may not otherwise respond to health messages, may not access the primary healthcare system, or may not have time to make sustained changes to their behaviour, such as taking more regular exercise.

Nearly 11 million Australian adults are in paid employment, with around 70% in full-time employment. Approximately five million (2004–05) Australian employees are overweight (of whom 1.3 million are obese). In 2001 obesity was associated with an excess 4.25 million days lost from the workplace. Obesity rates are highest among mature age workers aged 45–64, who comprise almost a third of the labour force. As obese people age, sick leave increases at twice the rate of those who are not obese. (60)

Of all those employed, around 70% are sedentary or have low levels of exercise. With the growth of the knowledge and services sector, technological changes in the workplace environment, increased car dependence and the decline of manual work, it is common for most individuals to spend at least half of their waking day sitting and being inactive. Self-reported measures of sedentary time have been shown to be significantly associated with metabolic risk, independent of any structured exercise taken. (61) This is an area where small but widespread changes could yield significant health improvements.

There is a growing evidence base demonstrating the efficacy and cost effectiveness of workplace-based programs. (62) Research commissioned for the UK Black Review found ‘considerable evidence that health and wellbeing programs produced economic benefits across all sectors and all sizes of business: in other words, that good health is good business’. (63, 64)

In addition to the health benefits for individual workers, workplace health programs can produce a range of other benefits such as:

- Decreased illness/absence
- Reduction in rate of early retirement due to ill health
- Improved productivity
- Reduction in occupational injury and workers compensation claims
- Improved attraction and retention of staff and reduced turnover

A large number of studies now point to the economic return on investment that can accrue through investments in employee health programs, with the average rate of return estimated at between 2:1 and 5:1.
An increasing body of evidence indicates that programs that integrate intervention on lifestyle health behaviours and working conditions are more effective in protecting and improving worker health and wellbeing than more isolated or single issue programs. Such programs are based on “a new approach to workplace health, which reflects the growing appreciation of the complexity of influences on worker health and the interactions between work-based and non-work factors”. While often harder to implement, the studies suggest that these programs:

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

A substantial number of Australian employers are introducing health and wellness programs in the workplace, supported in many cases by a growing body of private providers. It is estimated that currently over 1500 corporate and government employers provide health assessment and intervention programs for over 400,000 employees. The Business Council of Australia has stated that “More people at work in better health, more productive companies and less pressure on the public health system are goals worth working towards”.

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

The Taskforce believes there is a major opportunity to build on and strengthen this momentum. Examples include:

- The development of a national trial of integrated workplace health improvement programs based on the US National Institute for Occupational Safety and Health (NIOSH) WorkLife Initiative, involving partnerships between state and territory occupational health services, volunteer enterprises and nominated research centres.

**WORKLIFE INITIATIVE – NIOSH: CENTRE FOR DISEASE CONTROL**

WorkLife aims to:

- Sustain and improve worker health through better work-based programs, policies and practices.
- Build a vision for workplaces that are free of recognised hazards, with health-promoting programs and services that protect health, safety and wellbeing.
- Share responsibility between workers, their families and employers.
- Improve collaboration between the employment community, the research community, occupational health and the public health sector.
The establishment of a national workplace health leadership program, through the NPA, to help build a network of senior employer and employee champions of work health initiatives, and accelerate the process of cultural change.

Public sector organisations (Australian, state/territory and local governments) should set an example by introducing workplace health promotion programs. For example, they can develop intervention trials targeting a reduction in sitting time among office workers (based on the Baker/IDI Stand Up Australia initiative). There is an opportunity to identify and replicate successful public sector programs that serve as models of good practice to the employment sector as a whole.

Introduction of legislative changes that promote and accelerate the take-up of workplace health programs, particularly in small to medium enterprises. Options could include:

- Legislation that addresses changes to the Fringe Benefits Tax Assessment Act and Income Tax Assessment Act to provide incentives for employers to offer employee health programs. Introduction of legislation could ensure workplace health programs are exempt from fringe benefits tax, are tax deductible and GST free. Tax deductibility could – for a specified period of time – allow for a higher rate of deductibility (with defined eligibility criteria), as was the case with the Research and Development tax concession.

- An alternative to a tax incentive could be a version of the former Training Guarantee Levy. Under this arrangement, employers would commit a small percentage of annual payroll to workplace health programs.

Measures of this kind could help to accelerate the mainstreaming of workplace health and complement the funding initiatives under the Preventive Health Partnership Agreement.

Schools, childcare and out-of-school-hours care

‘Pre-schools and schools are agencies for social change and offer opportunities to build understanding and awareness, as well as creating healthy environments’ (Quote from submission)

Childhood is an important time in which children develop the knowledge, skills and behaviours that influence health throughout their life. Schools are an important setting for preventative activities, influencing not only children but also their families and the broader community.

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

A new National Curriculum is currently being developed in two stages. The Stage One subjects/content areas are Maths, English, Science and History. Until recently the only subjects for Stage Two were Languages and Geography. At the April 2009 meeting of the Ministerial Council on Education, Employment, Training and Youth Affairs (MCEETYA), Ministers agreed to include Arts in the second phase of development (Ministerial Council on Education, Employment, Training and Youth Affairs Communiqué, 17 April 2009).
The Taskforce’s view is that Health and Physical Education (HPE) are essential components of any child’s education and should at the very least have equal standing with the Arts. Shaping these components will require that:

- HPE be incorporated into the second stage of National Curriculum development to ensure a curriculum entitlement to HPE for all Australian children.
- A shaping paper be developed on the same timeline as those for other Stage Two subjects.
- Resourcing appropriate to the implementation of a national program be assigned by both Australian and state governments to support implementation of the new curriculum. This should include teacher curriculum guidance, support materials and a sustained national professional development program.

It is also recommended that:

- The Australian Government’s policy requirement of at least two hours of physical activity per week for all students K–10 be at the least maintained in all state and territory government education/curriculum policy requirements of all schools, regardless of the system or sector.
- The two hours of physical activity form part of the quality assurance and reporting framework for all schools.
- The Australian Government gather data from states to monitor the progress and all schools to report on school-provided opportunities for all Australian students to be active as part of a balanced curriculum.

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

**SOME KEY STRATEGIES INCLUDE:**

- Promoting a strong focus on fundamental movement skills and ensuring adequate time is made available for sport and recreation within school time.
- Building the capacity of schools and teachers to promote healthy eating and physical activity more effectively.
- Ensuring that teachers, particularly in primary schools, have the skills and confidence to teach physical education and sports, and to motivate and inspire children to engage in physical activity.
- Encouraging children to walk or cycle safely to school, and working with community organisations to promote a focus on physical activity and healthy eating within the community.
- Encouraging the consumption of tap water in preference to other drinks such as soft drinks.
- Implementing healthy school canteens in all primary and secondary schools across all school sectors – public, faith-based and independent schools.
- Encouraging schools to consider providing access to school sports and playing fields to the broader community outside of school hours.
- Supporting and encouraging parental efforts to promote healthy eating and physical activity, and to limit time spent watching television and playing computer games.
Schools can and do support the efforts of parents, governments, industry and communities through promoting physical activity and healthy eating, and reinforcing messages about tobacco and alcohol use. However, more can be done in this area. We need to enhance the current approaches already being implemented at state and territory level, and build a strong national approach to embed health and wellbeing, physical activity and healthy eating into all schools.

**Out of school hours care**

Out of School Hours (OOSH) care is also an important setting for preventative health. Increasingly, children are being cared for before and after school by these services due to parental work commitments. Providing healthy meals/snacks rather than foods high in fat, salt or sugar at a time when children are particularly hungry improves children’s health. Many children also attend vacation care as well as before and after-school care, which means that they can spend a significant time at these services. OOSH care provides a great opportunity for kids to be active in a safe and supervised environment, and a number of programs have focused on supporting this approach.

Childcare services provide care for children aged under six years prior to school. Many children begin childcare at a very early age and spend a considerable amount of time at these services. There are a range of different types of services and providers, including family day care, private and community-based long day-care services, kindergartens and pre-schools. There are a range of legislative and policy frameworks governing the quality and standards of care, which incorporate policies and programs around health, safety and nutrition. Providing quality care for young children, supporting parents and linking to health services as required ensures that childcare centres can play a role in ensuring children have a healthy start to life.

**Tertiary institutions**

Tertiary institutions operate as educators of the preventative health workforce of the future, as employers, as researchers and as providers of a whole range of retail services and activity programs. They have the opportunity to provide workplace promotion programs for their staff, maximising the sale of healthy foods on campus, providing smoke-free environments, providing incentives for students and staff to participate in sport and active recreation, and to use active transport. These institutions can ensure that future primary and secondary teachers, as well as health workers are equipped and confident to promote health in their day to day work.

**EXAMPLES:**

- The Heart Foundation’s Eat Smart Play Smart program (www.heartfoundation.org.au/Healthy_Living/Healthy_Kids/Eat_Smart_Play_Smart/Pages/default.aspx)
iv. Influence markets and develop connected and coherent policies

The conceptual framework for the Strategy (described earlier in this chapter) shows that where imperfect markets are found, which the Taskforce has agreed is the case in Australia, consumption patterns can lead to poor health outcomes.

In this Strategy, action is specifically applied to improving markets, policies and cost-effective investments directed towards obesity, tobacco control and reduction of harmful consumption of alcohol. Similar actions are also relevant for other areas of preventative health – for example, for mental health, immunisation and injury prevention – and they are central to future preventative health strategies.

While the policies required to action change will be government-led, improvements in market efficiency will require substantial cooperation from industry and business, the non-government sector, the research community, health insurers, unions – and, most importantly, from individuals, families and the communities in which they live.

The conceptual framework links directly to four elements of policy development. These are described below:

- Ensuring a well-informed public
- Keeping people and families at the centre of action
- Responsive regulation
- Supporting vulnerable groups

A well-informed public

For prevention programs to work, individuals, families and communities need to have access to information, and be able to make informed choices about their health. Government action is critical to ensuring that people are well informed and can make the best decisions for their health and wellbeing, including choices about optimal health-promoting behaviours. A comprehensive approach offers the best way forward. The key components of such an approach include:

- Social marketing that is sustained, appropriately funded and well implemented, including approaches that reflect the specific needs of individual groups and communities
- Curbs on marketing of harmful or potentially harmful products and activities
- Accessible and simple product information
- Locally generated community initiatives
- Assistance for people to assess the appropriateness and quality of services available
- Health literacy education (as proposed by the NHHRC)

Keeping people and families at the centre of action

As well as good information, a sound prevention system will need to empower individuals and families to manage their health and wellbeing. To achieve this, people need:

- Access to professionals who are trained to empower their patients
- Health practices that are accountable for, and reward, patient-centred approaches
- Involvement in decision making at the community level
Responsive regulation

This Strategy places substantial emphasis on the use of responsive regulation.

Consumers and providers face a number of confusing signals about the products on offer in the community. Adjustments may be needed to pricing so that people in the community receive clear signals about the full cost of harmful behaviours and purchases.

Adjustments can be achieved through revisions to taxation, so that the price of a product that can harm consumers and others (for example, alcohol and tobacco) reflects the full cost of that product, and through regulatory approaches that reduce the promotion of, or access to products with high potential for harm.

‘Responsive regulation’ has been extensively researched and is widely accepted in a range of non-health contexts; for example, in tax systems, in competition policy and in environmental regulation. It proposes a staged and potentially escalating approach to change, allowing for ‘soft’ mechanisms to be trialled, such as voluntary change, self-regulation, co-design, public reporting or positive incentives. Where appropriate, rather than opting immediately for harder mechanisms of regulation, enforcement or fiscal sanctions, the results are measured and assessed, with action to follow if necessary.

Source: Adapted from Healy J, Braithwaite J. Designing safer health care through responsive regulation. MJA 184 (10): 556-559.
This approach respects the fact that, when confronted with good evidence of the negative externalities arising from particular practices, many players in the marketplace want to do the right thing. Responsive regulation allows for voluntary adjustments and the development of creative solutions through government, industry and consumer partnerships, but actions are clearly seen to occur within a framework of regular review and the introduction of sanctions should inappropriate behaviours persist.

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

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

The Commission has called on all nations, including Australia, to develop and implement public policies, private sector responsibility and social action that puts health equity as a central societal goal.

Social determinants of health

‘Australian governments have an obligation to build community support and capacity to enjoy good health, particularly among those who are most vulnerable and have least capacity to make choices and changes in their lifestyle or living conditions that might improve and protect their health: the very young, the old, the poor and disenfranchised’ (Quote from submission)

Choosing to eat healthy food, being physically active, limiting alcohol consumption and not smoking requires people to be empowered to make these choices. It means that the healthy choice must be physically, financially and socially the easier and more desirable choice than the less healthy option. This is not always the case, particularly with decreasing social position.

Currently in Australia a voluntary, self-regulatory system operates in the regulation of some forms of alcohol advertising (but not sponsorship), with much stronger regulation and enforcement of drink-driving measures and licensing for the sale of alcohol.

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

The effectiveness of the voluntary codes that are in place can now be monitored and shifted to “harder” mechanisms if they are found to be ineffective.

v. Reduce inequity through targeting disadvantage

Major health inequities exist not only between Indigenous Australians and the general population, but between rich and poor and between rural and city dwellers. Even within a city such as Melbourne, life expectancy can vary by up to six years within a matter of kilometres.
What, and how much, people eat, drink and smoke and how they expend energy are responses to a number of factors – political, economic, environmental and cultural. A significant proportion of the global population now eats large volumes of energy-dense nutrient-poor foods, does not expend enough energy, smokes and consumes harmful quantities of alcohol. The harmful health consequences of these behaviours, and the inequity in their social distribution, are the result of both market failure and failure by government to protect the health of all its citizens. Greater accountability (by both parties) is needed.

The health gap

In some countries around the world there are differences in life expectancy among population groups of nearly 30 years. Australia, one of the wealthier countries in the OECD, has a highly concerning gap in life expectancy between Indigenous males, compared to the non Indigenous males. While there have been some improvements in Indigenous death rates, in particular a narrowing of the gap between Indigenous infants and other Australian infants, the overall gap between Indigenous and non-Indigenous death rates is widening.

Tobacco use, alcohol consumption, poor nutrition and inadequate physical activity are associated with a plethora of non-communicable diseases, including cardiovascular diseases, obesity, diabetes, cancers and acute respiratory conditions. Health inequities exist between the top and bottom SES quintile of the Australian adult population for a number of these health issues and their associated behavioural risk factors (Figure 1.9). Overweight and obesity and regular tobacco use are significantly greater among the lowest socioeconomic quintile compared to adults in the highest quintile.

**Figure 1.9:**
Proportion of people aged 18 years and over reporting selected health risk factors and long-term conditions, by socioeconomic status, 2004–05
The social gradient

Solely focusing on the difference in health experience at opposite ends of the social spectrum masks the graded relationship between social position and health. In Australia, as in most other countries, as one moves down the socioeconomic ladder the risk of shorter lives and higher levels of disease risk factors increases. A recent analysis of mortality rates, and notably avoidable mortality rates, illustrates how death rates decrease progressively with increasing SES (Figure 1.10).

Figure 1.10:
Age and sex-adjusted mortality rates, Australia, aged less than 75 years, 2002


Overweight and obesity have become increasingly more prevalent among socially disadvantaged groups, particularly in urban areas, with the exception of very poor countries. In Australia, like most other risk factors for ill health, excess body weight tends to be more prevalent among people further down the social and economic scale. Analysis of the AusDiab 1999–2000 data shows a clear social gradient in the prevalence of obesity among adult women (Figure 1.11). A policy and programmatic focus on only the most disadvantaged, in this instance women with primary level education, would miss the equally significant health burden from obesity among women along the remainder of the education spectrum.

Figure 1.11:
Prevalence of obesity among women, by level of education

Source: AusDiab 1999–2000

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

Social determinants of obesity, tobacco use and alcohol consumption

Social inequities in daily living conditions, lead to inequities in health outcomes. Of particular relevance to obesity, tobacco and alcohol consumption is the nature of, and inequity in:

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

The degree of social protection provided

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

**Structural determinants: power, money and resources**

Promoting health equity through healthy weight and reducing smoking and excessive alcohol use also means tackling some of the fundamental political, economic and cultural issues (the structural determinants) that affect people’s living conditions, their daily practices and behaviour-related risks.

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

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

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

**vi. Indigenous Australians – contribute to ‘Close the Gap’**

“We believe that initiatives targeting Indigenous Australians must be embedded within communities, using local knowledge, skills and expertise” (Quote from submission)

In the current context of high levels of chronic disease in Indigenous communities, obesity, tobacco and alcohol make significant contributions to the burden of illness, injury and disease in Indigenous communities.

The burden of ill health is not evenly shared by Indigenous Australians, with geographical distribution having a major influence. The majority of Indigenous Australians live in urban towns and cities (75%), as compared to those living in remote communities (25%). Reflecting this distribution, those living in urban areas constitute 60% of the health gap and therefore a greater burden of ill health, whereas the remaining 40% of the gap in health is attributed to those living in remote communities, usually with the greatest needs.

The announcement of the ‘Close the Gap’ commitment by all Australian governments in December 2007 recognised the extent and urgency of the problem facing Indigenous Australians. To be successful in reducing the life expectancy gap between Indigenous and
non-Indigenous Australians within a generation, the disparity in levels of sickness and death attributable to obesity, alcohol and tobacco must be addressed. Health inequity is intimately bound up with these processes. (78)

It is now known that a person’s social and economic position in society, their early life experiences, their exposure to stress, their educational attainment and their employment status all exert a powerful influence on their health throughout life. (79) Social exclusion and the amount of control people have over their lives have been shown to be critical social determinants of health. (80-83)

The poor nutrition and lack of physical activity which contribute to obesity and the use of tobacco and alcohol are embedded in a complex social, historical and political context, marked by processes of intergenerational powerlessness, poverty and social exclusion. There is a strong association between obesity, tobacco and alcohol use and these social determinants of health. (79) Therefore, addressing the broader social determinants of health – including poverty, lack of education and social exclusion – is a critical element in a broader strategy to tackle obesity, tobacco and alcohol in the Indigenous community.

In the current context of high levels of chronic disease in Indigenous communities, obesity, tobacco and alcohol make significant contributions to the burden of sickness, injury and death in these communities. Together, these factors contribute to almost a quarter of the ‘health gap’. (84)

The proportion of the health gap attributable to alcohol, tobacco and obesity is also distributed unevenly. While Indigenous people in remote areas make up 26% of the total Indigenous population, they contribute 34% of the total health gap attributable to tobacco, 38% of the health gap due to high body mass, and a full 50% of the health gap due to alcohol. (77)

Impacts associated with obesity, tobacco and alcohol

Overweight and obesity

Overweight and obesity have been estimated as contributing to 11% of the total burden of injury and disease of Indigenous Australians, and is particularly associated with type 2 diabetes and ischaemic heart disease. (84) In 2004–05, 57% of Indigenous adults were overweight or obese, a significant increase from 1995 (48%). (86) Obesity and overweight is also an issue for Indigenous children. (85, 96)

Tobacco

‘…need to take a large scale, more systematic approach to tackling tobacco in Indigenous communities rather than continuing to undertake small scale or pilot projects’ (Quote from submission)

Tobacco smoking is the cause of 20% of deaths and 12% of the total burden of disease and injury in the Indigenous community, and is the major single contributor to illness, predominantly through ischaemic heart disease, chronic obstructive pulmonary disease (COPD) and lung cancer. (84) A high proportion of Indigenous people smoke (around 50%), (89) compared to the Australian population as a whole (16.6%), (90) with smoking rates of up to 83% for men and 73% for women being recorded in some communities. (91)

There appears to have been minimal or no change in these rates, while the trends in smoking rates for Australia as a whole have been consistently downwards since the early 1970s. (92-94)
Alcohol

‘...although Indigenous Australians are more likely to abstain from alcohol than non Indigenous Australians – those who do consume alcohol are more likely to drink at risky levels’ (Quote from submission)

Alcohol is associated with 5% of the burden of disease and injury borne by Indigenous Australians, in particular through homicide, violence and suicide. For Indigenous men in particular, it is strongly associated with four of the top 10 causes of premature mortality: suicide (9.1% of potential years of life lost), road traffic accidents (6.2%), alcohol dependence and harmful use (3.9%), and homicide and violence (2.8%).[84]

Drinking while pregnant is also associated with Foetal Alcohol Spectrum Disorders (FASD), which are estimated as being between three and seven times more common in the Indigenous population.[85]

One in six Indigenous adults reports drinking in such a way as to pose a long-term high risk to their health, up from 13% in 2001; one in five (19%) reports short-term high-risk (or binge) drinking at least once a week.[86]

There is emerging evidence that alcohol is also making a major contribution to premature deaths from heart disease in Indigenous communities, consistent with the possible impact that binge drinking has had on cardiac deaths in Russia.[87, 88]

Key principles for successful interventions[77]

- Genuine local Indigenous community engagement to maximise participation, up to and including formal structures of community control.
- Integration of targeted programs on alcohol, tobacco and obesity with broad-based comprehensive primary healthcare.
- Ensuring programs are adequately resourced for evaluation and monitoring so they can contribute to intervention policy knowledge.
- Evidence-based approaches that are reflective and that involve the local community in adapting what is known to work elsewhere to local conditions and priorities.
- Adequate and secure resourcing to allow for actions to be refined and developed over time.
- Performance indicators and measurement that are linked to accountability and action.

How can prevention help ‘Close the Gap’?

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

Primary healthcare has come to be recognised by policy makers, health professionals and the Indigenous community as the key strategy for improving the health of Indigenous Australians. To the extent that there have been health improvements, these have been credited to improved primary healthcare.[97] Even where measurable improvements are limited (for example, in chronic disease mortality rates), the conclusion has been drawn that while the social determinants continue to drive high levels of ill health, improved primary healthcare services are at least providing a brake on what would otherwise be accelerating mortality rates.[98]

A well-resourced and robust, comprehensive primary healthcare system is a critically important platform in order to deliver the full range of core services required under a comprehensive model of primary healthcare to ‘Close the Gap’, including that part of the health gap attributable to alcohol, tobacco and obesity.
vii. Refocus primary health care towards prevention

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

The primary healthcare setting is one of the most important sectors of the health system for prevention. It provides essential services for all Australians, connecting care across the life course, and offers many opportunities for primary prevention. Primary healthcare also has a great capacity to care for Australians across a very wide range of disciplines, including medicine, nursing, physiotherapy, occupational therapy, dietetics, pharmacy, psychology, chiropody and naturopathy.

The Taskforce agrees with the WHO Commission, the NHHRC, the Primary Health Care Taskforce, submissions provided to the Taskforce and those with whom the Taskforce consulted in stressing that:

*Primary healthcare reform is the single most important strategy for improving our health and making the health system sustainable. Community-level prevention and primary healthcare is essential to restoring universalism and efficiency in Australian healthcare.*

**ACTIONS WILL NEED TO PROVIDE:**

- Support and resourcing for community agency and action through the establishment of local community leadership groups.
- Adequate long-term investment in social marketing campaigns to shift social norms of smoking and alcohol consumption amongst Indigenous people.
- Smoke-free workplaces, community spaces and events, especially through work with Indigenous organisations and possibly through the employment of tobacco control workers in National Aboriginal Community Controlled Health Organisation (NACCHO) affiliates.
- Resourcing of multi-component community-based programs, including effective and professional evaluation.
- Robust antenatal, maternal and child health systems for Indigenous communities.
- Effective screening, intervention and referral pathways in primary healthcare, and between primary healthcare and specialist services.
- Reform and increased support for treatment and rehabilitation services for alcohol-related problems.
- Actions on pricing of alcohol, including a broad review of Australia’s alcohol taxation policy as part of a comprehensive approach to alcohol problems in Australia.
- Restriction of alcohol supply, including the numbers and types of licenses and hours of sale, especially for takeaway licences.
Preventative healthcare starts in the community, where people are born, grow up, raise their families, work and grow older. Primary healthcare is the gateway to a healthy life for Australian communities at each of these life stages, and is an important setting for the delivery of preventative healthcare.

Primary healthcare includes services to the community that are accessed directly by the general public. It is often, but not always, the first point of contact with the health system when a person has questions about their own or their family’s health. There is an expectation from the public that, when they visit a primary healthcare provider, they will receive information and assistance regarding preventative health issues. The evidence shows that there are significant gaps in prevention activities for chronic disease in general practice, including the infrequency of assessing alcohol consumption and smoking, and counselling about hazardous drinking, smoking, physical inactivity and diet.

In 2005–06, 34.6% of general practice encounters were with overweight patients (over 22% being obese), nearly 26% with those who drank alcohol at risky levels and 17% with daily smokers. Less than one in five patients were routinely asked about their drinking, two-thirds were asked about their smoking, only a third were asked about exercise and physical activity, and about 15–30% of patients received some form of dietary advice. Importantly, less than one in five GP consultations involved an intervention to support behaviour change.

The role of primary healthcare in preventing chronic disease

The primary healthcare system has an important role within a whole-of-society, integrated approach to tackling chronic disease. Early in 2006, COAG’s Plan for Better Health for All Australians identified the importance of promoting healthy lifestyles, including addressing alcohol use, nutrition, smoking and physical activity. Strategies to promote healthy lifestyles include:

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

**EXAMPLE: LIFESCRPTS**

Lifescrpts is a ‘lifestyle prescription’ program which provides a suite of resources (including waiting room materials, assessment guidelines, assessment tools and prescription pads) implemented through Divisions of General Practice. Resources are accompanied by training and practice visits to support their use.

In 2006/07 the Annual Survey of Divisions showed that 85% of Divisions had a Lifescrpts project. In relation to the behavioural risk factors, 40% had smoking projects, 46% nutrition, 54% alcohol and 55% physical activity. Most of these projects involved education and support for practices, with 42–49% of Divisions providing direct diet or physical activity services for patients, mostly through the employment of allied health staff.
**Targeted prevention for disadvantaged populations**

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

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

Although disadvantaged populations experience significantly greater mortality and morbidity relative to advantaged individuals, they may be less likely to receive appropriate preventative care. (110, 111)

Both structural and patient factors may explain poorer preventative care status, rather than differentials in a practitioner’s care for disadvantaged patients relative to more advantaged patients within the same practice. (117) General practices may charge co-payments for preventative care that are likely to restrict access to preventative care, particularly for people on a low income living in areas with a restricted choice of general practices, such as rural and remote areas. Also, there is some evidence that general practices situated in disadvantaged areas may respond to financial incentives for better quality of care, including preventative care. (118)

Strategies that have been shown to be effective in improving access to preventative care in primary healthcare include:

- Doctor and specialist nurse clinics focused on preventative care (119)
- Outreaching services (such as nurse-run clinics for the homeless) (120, 121)
- Reducing cost and other barriers to access
- Developing culturally appropriate services, and increasing the skills and resources that will enable people to adopt more health-promoting lifestyles (122, 123)

**EXAMPLE – IMMUNISATION**

- Single parent and migrant families and those where the parents are unemployed, on a low income or have low education levels are at risk of lower levels of age-appropriate immunisation. (112, 113)
- General practices in socioeconomically disadvantaged areas tend to provide immunisations less frequently and have fewer long consultations with their patients. (114-116)
EXAMPLE: WISEWOMAN

In the United States, the WISEWOMAN project coordinated by the Centers for Disease Control and Prevention (CDC) has demonstrated cost-effective interventions for improving preventative care in disadvantaged groups.\(^{(124, 125)}\) The project uses a socio-ecological model to identify partners at individual, organisational, community and state levels, and tailors interventions to the target populations and settings.\(^{(126)}\) Elements include:

1. Screening of risk factors for cardiovascular disease and other chronic diseases
2. Lifestyle interventions linking up a wide range of primary healthcare providers and services
3. Assurance of access to treatment and medication required
4. Follow-up visits for monitoring and evaluation

CRITICAL SUCCESS FACTORS FOR INTEGRATED PRIMARY HEALTHCARE

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

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

Integrating primary healthcare practices

While general practice provides an important setting for primary healthcare, other models of integrated primary healthcare should also be considered. For example, Primary Care Partnership organisations have been established in Victoria. These provide a structure for integrated health promotion and prevention activities engaging a wide range of community organisations as well as Divisions and State Health.\(^{(127)}\)
Funding primary health care

A regional fundholding model for primary health care is more likely to prioritise prevention as future health benefits are reaped by the fundholder. The activities of large single fundholders such as Veterans Affairs, transport accident and WorkCover agencies illustrate this principle. Also, the Northern Territory Government is currently rolling out a primary care reform model, similar to that described here, to promote high-quality, efficient care for the prevention and management of chronic disease,(128) following successful implementation in Katherine West.(129)

Options for the further development of the role of primary healthcare in behavioural risk factor management need to be considered within the context of broader primary healthcare reform and changing population health priorities for prevention. The measurable benefits are likely to include improvements to access and to the quality of preventative interventions. Mechanisms need to be established to enable these to be monitored more effectively than at present.

In summary

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

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

To achieve this, the primary healthcare sector requires:

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

8.1 BUILDING AND SUSTAINING INFRASTRUCTURE

Adequate and appropriate national infrastructure is vital in order to implement a strategic and comprehensive approach to address preventative health issues relating to obesity, tobacco and alcohol. To be successful, infrastructure must be made available not only to support individuals, families, communities, industry and government but also to have the capacity to sustain this support to achieve long-term, optimal health outcomes – across a range of prevention priority areas.

The National Partnership Agreement on Preventive Health announced by COAG provided funds for the establishment of enabling infrastructure to support and sustain activity promoted in the Agreement, and the current and future work of the National Preventative Health Taskforce. National infrastructure includes but is not limited to:

- The establishment of the NPA
- Social marketing
- Data, surveillance and monitoring
- National research infrastructure
- Workforce development
- Future funding models for prevention

8.2 NATIONAL PREVENTION AGENCY

‘The development of a National Preventative Health Strategy and of a National Preventative Health Agency provides a unique opportunity to provide strong leadership and coordination of the preventative reform agenda’ (Quote from submission)

Preferred model and rationale

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

In its interim report, the NHHRC proposed the establishment of an independent national health promotion and prevention agency. The Taskforce agrees with this recommendation and proposes that the model for the agency include the following approaches:

- A national body, established by enabling legislation
- Have an expert, cross-sectoral Board of Governance comprising 10 to 12 members, selected on merit for their expertise
- While the proposed funding under the COAG agreement is welcomed, its capacity and budget will need to be significantly increased to ensure its national leadership in prevention
- Be a facilitator/coordinator and, as required, implementer and commissioner of interventions through and with partners
Be independent from but working closely with government, reporting to the Commonwealth Parliament through the Minister for Health as responsible Minister, in consultation with the Prime Minister.

Facilitate the infrastructure for prevention including: social marketing; research, evaluation and the building and transfer of evidence; monitoring and surveillance systems; workforce development and funding models.

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

Roles and functions

These will include:

- Lead and facilitate the building of evidence for preventative health through research and evaluation, and the synthesis and translation of research findings into policy and practice.
- Develop and implement comprehensive, sustained social marketing campaigns for obesity, tobacco and alcohol (see below).
- Provide a national clearing house for the monitoring and evaluation of national policies and programs in preventative health.
- Publish annual reports on the state of preventative health, including reporting on progress towards the achievement of the 2020 goals specified in this Strategy.
- Advise COAG, through AHMC, on national priorities and options for preventative health.
- Administer national programs, facilitates national partnerships, and advises on national infrastructure for surveillance, monitoring, research and evaluation, (see below) as charged by AHMC.
- Develop for consideration by AHMC the next phase of preventative health reform to follow after this Strategy.
- Develop a web-based clearing house/ register for organisational policies, plans and achievements in order to share good practice across the country.
- Commission/conduct from time to time surveys of activities undertaken by different sectors, and the barriers to and enablers of action, and to report on these.
- Develop a national recognition and award scheme for outstanding contributions, large and small to making Australia the healthiest country by 2020.

In order to effectively perform in this role, the NPA will require expertise across a diverse array of disciplines and interests.

Due to the collaborative and cross-sectoral linkages and partnerships proposed for the NPA, an externally oriented culture will be critical to its success. The development of strategic partnerships and intersection with other relevant national strategies or initiatives will be vital. A visual representation of the functional relationships proposed for the NPA is presented in Figure 1.12 below.
Figure 1.12:

Functional relationships of the NPA

Governance
- Parliament
- Prime Minister / Minister of Health
- Minister of Finance
- Auditor-General

Advocacy
- COAG
- AHMC/AHMAC
- Committees
- Consumer groups
- Whole population

Policy Advice
- Policy Partners
  - COAG
  - AHMC/AHMAC
  - DoHA
  - Other Ministries / Ministerial Committees
  - Other national strategies

Evidence Building
- Collaborating Partners
  - NHMRC
  - ARC
  - AIHW
  - Universities

Workforce Development
- Technical Partners
  - AHWAC
  - AIHW
- Health Workforce Australia

Health Promotion Interventions
- Coordinating Partners
  - COAG
  - State and Territory jurisdictions
  - Peak bodies
  - Professional bodies

Implementing Partners
- Local government
- Communities
- NGO's
- Community Health Services
- Schools
- Workplaces
- Consumer groups

NPA

Coordinating Partners
- COAG
- State and Territory jurisdictions
- Peak bodies
- Professional bodies

Implementing Partners
- Local government
- Communities
- NGO’s
- Community Health Services
- Schools
- Workplaces
- Consumer groups
Governance

It is recommended that the NPA be established, by enabling legislation, as an incorporated Commonwealth statutory authority (as is the AIHW) and allow for the engagement of personnel through the agency as well as the Public Service Act 1999. The proposed governance model has these characteristics:

- General direction and control of the NPA to be vested in a Board of Governance/Council comprising 10 to 12 members, appointed by the Governor-General on the recommendation of the responsible Minister.
- CEO to be directly responsible to the board for the development and implementation of a three-year strategic plan, stakeholder relationships, strategic partnerships and organisational development.

8.3 SOCIAL MARKETING

A successful social marketing program will require sustained, adequate funding and strong collaborative relationships between the NPA and the states and territories, which should both maintain and enhance their own commitments to social marketing and be engaged as partners in national programs. It will also be important to work collaboratively with NGOs (at both national and state levels), and draw on their expertise, as they have significant experience in the area. There will be much potential for extending state-based programs nationally.

Social marketing programs should take account of the principles set out in this Strategy (for example, a commitment to reducing health inequalities), make use of the considerable body of expertise already in place in Australia and ensure good consultation with key stakeholders.

The NPA will be able to provide advice to a range of stakeholders on aspects of social marketing campaigns, including design, scope, implementation, funding, sustainability, tracking impacts and evaluation of outcomes.

A national approach on issues of national significance

Currently, many social marketing campaigns are state developed and run. A national approach to social marketing would necessitate the NPA adapting or developing social marketing material that had national application and significance. However, the model would continue to give states the opportunity to either top up or extend the reach of campaigns or develop state-based campaigns using their current funding commitments on state issues. The best application of this approach would be where legislation differs considerably between states. For example, the regulations regarding smoking in cars in which children are travelling differs between states; individual states might therefore develop and/or fund a social marketing campaign that aims to highlight the effects of environmental tobacco smoke on children and influence social norms around this issue.

It would also be vital that states and territories saw the establishment of the NPA as a reason to increase, not reduce their commitments to social marketing and related activity.

A pragmatic approach to use resources wisely

Consistent with the approach of utilising the issue-based and social marketing expertise, wherever it is in the country, is a pragmatic approach to the use of existing resources. Harnessing current knowledge on social marketing practices, as well as the potential to not only develop new campaign material but use existing, proven resources, will enhance our ability to achieve campaign objectives. Hand in hand with effective creative material, and fundamental to comprehensive campaigns, is optimal investment and the efficient buying of media.
Social marketing and the social and economic determinants of health

Built in to a national approach to social marketing must be a strong and consistent focus on the reduction of health inequalities. This can be achieved if health inequalities are taken into account during the entirety of the social marketing process – in its development, implementation and evaluation.

Register of social marketing resources

An initial task is to review and compile a national compendium of existing social marketing resources and expertise (people) across tobacco, obesity and alcohol. It would also be important to consider the use of existing material for the first national phases of social marketing in these areas. This approach would have two benefits: 1) it would allow time for exploratory research and commissioning specific material; and 2) the time and costs savings would be significant.

Importantly, current state-based funders of social marketing campaigns are key stakeholders, so early consultation and consensus building will be a key to success. In addition, early harnessing of the enthusiasm and commitment of the developers (program managers, advertising agencies, media strategists and evaluators) will be essential to defining the goals and scope of future national approaches to social marketing.

The NPA should be able to provide advice to a range of stakeholders on aspects of social marketing campaigns, including design, scope, implementation, funding, sustainability, tracking impacts and evaluating outcomes.

8.4 DATA, SURVEILLANCE AND MONITORING

‘Rather than rejecting innovation, we need to provide support to adequately measure and evaluate the impact of untested strategies and approaches’ (Quote from submission)

‘Research, reliable data gathering and evaluation…to sustain the most productive forms of support, interventions and clinical practice…’ (Quote from submission)

Comprehensive and robust monitoring and surveillance systems are a critical requirement for the capture, analysis and interpretation of reliable, nationally consistent population health information. However, as health outcomes are also dependent upon a number of other social and structural determinants, standardised data from outside the health sector must also be collected.

Through the 2008–09 COAG Partnership Agreement on Preventive Health, the Australian Government has recognised the important role national surveillance systems play in the areas of obesity, tobacco and alcohol. However, there is currently great variation in the data available to assist in the development of baselines for comparison and tracking of trends via surveillance and monitoring in these areas.

The Taskforce emphasises the essential nature of systems with the capacity to provide this information at national, state and local levels, as well as other key groups such as Indigenous Australians, other disadvantaged populations, and children and adolescents.

To achieve this, strategic investment and partnerships are required to develop and implement standardised and harmonised data collection and analysis mechanisms across multiple jurisdictions. The involvement of data and surveillance agencies, such as the ABS, AIHW, NHMRC, the new NPA, Australian Population Health Development Principal Committee (APHDPTC) and Population Health...
Information Development Group (PHIDG), along with relevant levels and sectors of government and key agencies from other sectors (for example, NGOs, universities and, if appropriate, industry), will be essential to achieve these outcomes.

**Comprehensive national surveillance systems for obesity, tobacco and alcohol**

Comprehensive national surveillance systems for obesity, tobacco and alcohol are essential tools for the purposes of collecting and managing relevant datasets, monitoring progress against specified targets and reporting trend information over time. To be effective, these systems should have the capacity to:

- Collect and report against behavioural, environmental and biomedical risk factors relevant to obesity, tobacco and alcohol
- Expand and incorporate newly identified and/or revised indicators into datasets as required and appropriate
- Become permanent systems of data collection undertaken at predetermined regular intervals
- Provide representative data for the whole of population and also populations of interest (for example, Indigenous, children and adolescents, the disadvantaged)
- Complement and build upon other existing data collection and monitoring mechanisms as required and appropriate

The National Health Risk Survey Program, recently announced as part of the 2008–09 COAG Agreement on Preventive Health, incorporates many of these elements and has the endorsement of the Taskforce. Due for implementation every five years post 2010, it proposes to collect and report comprehensive, up-to-date and representative data about the prevalence of chronic disease and their risk factors (including indicators for obesity, tobacco and alcohol) through self-report and biomedical data. With an initial focus on Australians aged over 17 years, it is proposed that future surveys will target other populations of interest including children and Aboriginal and Torres Strait Islanders.

Where issues exist in regard to the potential for overlap and duplication with existing data collection and monitoring mechanisms (for example, the National Nutrition and Physical Activity Survey Program and ABS dataset on alcohol consumption in Australia), these will need to be resolved.

**Wholesale and retail sales datasets**

Wholesale and sales data should be an integral component of a comprehensive national surveillance system, particularly in the areas of tobacco and alcohol. While this information is already collected by industry for the purposes of marketing development and monitoring sales, these datasets are not readily accessible by government or researchers and policy makers in the public health sector. Access to these datasets would facilitate monitoring and surveillance functions, as well as better inform effective policy directions in these areas.

**Other relevant datasets**

Other datasets from other sectors can provide further information about the impacts of obesity, tobacco and alcohol, and should form part of a comprehensive surveillance system. For example, a comprehensive national surveillance system for alcohol should include data on consumption as well as health and social impacts, and could potentially include:

- Expanded collection of drinking patterns data
- Police datasets – random breath testing, ignition interlock devices and crimes against property and the person
- Child and family welfare agencies datasets
- Health services datasets – hospitals, primary care services, ambulance services and specialist treatment services
- Local government datasets – management of public space, clean-up costs, noise issues and enforcement of local laws
- Other relevant datasets – fire services, property insurance and medical insurance
Other national requirements for monitoring and surveillance

There are a number of other shortcomings at the national level which need to be rectified in order to achieve comprehensive surveillance systems for obesity, tobacco and alcohol. These include:

- Development of national data linkage systems, for health and non-health data, in order to develop nationally representative and consistent baseline information
- Establishing a national health equity surveillance system, with routine collection and analysis of inequities in health outcomes, the behavioural risk factors and their social determinants
- The development, management and benchmarking of evaluation tools to assess effectiveness and impact of public health interventions

8.5 NATIONAL PREVENTION RESEARCH INFRASTRUCTURE

‘National surveillance and research will be key to developing and directing cohesive prevention strategy’ (Quote from submission)

Policies and interventions in preventative health must be underpinned by strong, interdisciplinary research and evaluation capacity and strategy that supports innovation and incorporates both universal and targeted approaches. This includes:

- The capacity to conduct research into ‘what works’ to improve health and wellbeing
- To promote, synthesise and translate evidence-based findings into practical and effective interventions
- To evaluate the outcomes of interventions

Once again, investment in core infrastructure and collaborative partnerships will be important in attaining this vision for preventative health.

Within the areas of obesity, tobacco and alcohol, there is significant variation in the available infrastructure, capacity and status of research currently being conducted in Australia. Significant gaps in knowledge and evidence also exist which need to be addressed in order to inform policy and other initiatives in these areas, particularly in regard to children and adolescents, disadvantaged communities and the Indigenous population.

The Taskforce is supportive of a range of initiatives outlined below that would address this imbalance and drive national research agendas in obesity, tobacco and alcohol through investment in capacity building and strategic partnerships. Central to the success of these initiatives is the involvement of key research agencies and institutions (NHMRC, ARC, CSIRO, AIHW), various levels of government, other sectors (for example, universities, private NGOs and industry) and communities.

The NHMRC has established a Public Health Research Advisory Committee (PHRAC), chaired by Professor Don Nutbeam, whose report has recently been published. It will be important to follow through the recommendations of this review, especially in areas such as funding levels, improved funding mechanisms, a focus on intervention research, adequate support for researchers, appropriate structure, coordination and workforce development.
A National Strategic Framework for preventative health research

A National Strategic Framework for preventative health research is a fundamental element of infrastructure. The development and implementation of national research strategies for obesity, tobacco and alcohol as part of this framework will identify and drive the research agenda in each of these areas, and build upon and consolidate the available evidence base.

The Taskforce has identified a number of key research and evaluation priorities within each of the national strategies:

- Obesity – evidence-based interventions in maternal and child health, Indigenous and other disadvantaged populations
- Tobacco – evidence-based interventions in Indigenous and other disadvantaged populations
- Alcohol – alcohol taxation modelling to encourage safe consumption in Indigenous and other disadvantaged populations, maternal and child health

A preventative health research fund

Both the Wills Review (1998) and the Grant Review (2004) recommended increases in priority and strategic research. This could be facilitated through the establishment of a preventative health research fund which would make a significant contribution to building the levels of available research evidence in obesity, tobacco and alcohol.

Investment that enables the further development of investigator-led, peer-reviewed research which utilises a common set of measures to compare outcomes is essential in further developing the evidence base.

National prevention research centres

If Australia is to build research collaboration and partnerships, critical mass is required and this is only likely to be achieved through multi-institutional cooperation. The Taskforce recommends:

- The development of a network of prevention research centres, coordinated and part funded by the NPA, similar to the US CDC Prevention Research Centers and appropriate to the Australian context. These would build on the work of the Public Health Education and Research Partnership (PERHP).
- The centres would partner with community interventions in the region they serve, with NGOs, and have a national specialty role (for example, in obesity, tobacco or alcohol).
- The centres would also have a workforce development role in educational terms (MPH or similar), in research terms (Masters by research, PhDs and post docs) and in intervention practice. The NPA would foster leadership, mentoring, and knowledge sharing.
- The NPA can host an annual symposium to share research and ideas.

National preventative health research registers

National research registers will be of great benefit to researchers, policy makers and other interested parties. They will enhance the transparency of the conduct and the reporting of research results, enhance access to evidence to facilitate the transfer of knowledge through synthesis and translation of evidence into practice, and be used for meta analyses, where possible and appropriate.

National research registers can also assist policy makers and researchers in identifying gaps in knowledge and minimise the potential for duplication of work.
What this will do

It is proposed that this increased investment in research infrastructure would result in positive outcomes for preventative health research, especially in the areas of obesity, tobacco and alcohol. These include:

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

8.6 WORKFORCE DEVELOPMENT

Workforce shortage has been a long-standing issue across the health sector, particularly in regard to areas relevant to prevention such as chronic disease attributed to obesity, tobacco and alcohol.

A National Health Workforce Strategic Framework was adopted by AHMC in 2004 to guide national health workforce policy and planning and Australia’s investment in its health workforce. However, the principles and strategies outlined in the framework did not make specific reference to the important role that prevention plays in the health outcomes of Australians or the workforce required to deliver these services.

As the burden of chronic disease attributable to factors such as obesity, tobacco and alcohol has increased, recognition has grown of the important role prevention plays as part of a comprehensive approach to healthcare. In order for prevention to achieve this potential, a national preventative health workforce that has the competence and capacity to meet the chronic disease and other healthcare needs of all Australians is vital. The development of a national preventative health workforce for Australia will require time, investment and infrastructure.

A national agency for the Australian health workforce

The announcement of a new national agency by COAG, Health Workforce Australia, to manage and oversee major reforms to the Australian health workforce is a key element of infrastructure and is supported by the Taskforce. Health Workforce Australia will be fundamental to the future development and support of a national preventative health workforce.

Putting prevention on the workforce agenda

Workforce shortages across the health sector mean competing demand for resources. It is essential that the important contribution prevention and the preventative health workforce can make both within and outside the health sector is recognised and identified as a priority area. The NPA must take national leadership on this issue and work in partnership with Health Workforce Australia to ensure this is achieved.
Building competence and capacity

A national preventative health workforce must have both the competence and the capacity to provide the services required. To date, there has not been a national audit or review of the preventative health workforce in terms of a range of factors including but not limited to:

- Identification – who constitutes the preventative health workforce (clinical and non-clinical) and where they are currently located
- Supply needs – on the basis of community health status
- Core competencies – what knowledge and skills are required to effectively meet these needs
- Education, training and accreditation processes – from initial qualification and registration through to postgraduate training and ongoing professional development and vocational training
- Models and scope of practice – what currently exists and are there opportunities for innovation and expansion
- Support mechanisms – what is required to enable the preventative health workforce to effectively and efficiently perform their role

The national audit of the prevention workforce outlined in the 2008–09 COAG Agreement on Preventive Health will provide an initial foundation on which to develop immediate, mid and long-term strategies and policy actions. The Taskforce strongly supports the audit and encourages the government to further build upon this initial investment to ensure that the mid to long-term strategies can be implemented to achieve a competent national preventative health workforce with the capacity to meet the healthcare needs of all Australians.

Some specific areas of need are in prevention research and education (see the section on national prevention research infrastructure above), and in the skilling up of the preventative health workforce who understand inequity and the social and economic determinants of health.

Partnerships in preventative health

The workforce outside the health sector also has a significant influence on preventative health, particularly in regard to obesity, tobacco and alcohol. These include but are not limited to: education; local government; social and community services; sport and recreation; justice and policing; urban planning, transport and infrastructure; and agriculture.

Engaging with these sectors via collaborative partnerships and programs will also contribute to improved health outcomes through prevention.
**8.7 FUTURE FUNDING MODELS FOR PREVENTION**

Sustainable and cost-effective funding models are vital to support a comprehensive and integrated approach to prevention. This approach includes adequate funding for research infrastructure, program design and delivery, workforce planning and resourcing, social marketing, surveillance and monitoring and evaluation. Whilst the primary healthcare setting has been the most recent model, and an important focus in terms of the development of suitable funding models for preventative health, this must not be at the expense of other settings or sectors that also contribute to and enhance health outcomes.

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

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

**9 Conclusion – a call to action**

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

The Taskforce is keen to hear and to tell others of your contribution to the health of all Australians. An online national forum for organisations, local governments, businesses and industry, community groups, families and individuals will be developed to share your commitments and plans to making Australia healthy.

Together with this a national recognition and award scheme for outstanding contributions to making Australia the healthiest country by 2020 will be instituted. The Taskforce looks forward to receiving your contributions.
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# CHAPTER 2: Obesity In Australia: A need for urgent action

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CHAPTER 2: Obesity in Australia: A need for urgent action

The case for prevention

Australia is one of the most overweight nations in the developed world, with over 60% of adults and one in four children overweight or obese. This is one of the greatest public health challenges confronting Australia and many other industrialised countries.

The prevalence of overweight and obesity has been steadily increasing over the past three decades, sharply escalating in the last 10–15 years. In the decade between 1995 and 2004/05, the number of Australians who were overweight and obese increased by two million, rising to 7.4 million. If current trends continue, it is predicted that almost two-thirds of the population will be overweight or obese in the next decade. By 2025, 6.9 million Australians will be obese.

Australian health survey results paint a disturbing picture. The 2007–08 National Health Survey has for the first time since 1995 measured the exact height and weight of adults and children rather than using only self-report data. Preliminary results suggest that overweight and obesity prevalence in adults has continued to increase.

The 2004–05 data indicated overweight and obesity increased from 2001 levels. In 2001 58% of men and 42% of women were overweight or obese based on self-report data for height and weight. (5) The 2004–05 survey found 62% of men and 45% of women were overweight or obese. Men in the 45–54-year age group had the highest rates of obesity (23.2%), and men in the 55–64-year age group had the highest rates of overweight (45.9%). Women in the 55–64-year age group had the highest rates of obesity (21.7%), and women in the 65–74-year age group had the highest rates of overweight (30.8%). (6) The problem of overweight and obesity is not evenly distributed across Australian society. It is most prevalent among the more disadvantaged groups in society, Indigenous Australians and some ethnic population groups, exacerbating existing health inequalities.

Approximately 60% of Indigenous Australians aged over 18 are overweight, of whom 31% are obese. (7) Indigenous Australians are 1.2 times as likely as non-Indigenous Australians to be overweight, 1.9 times as likely to be obese and over three times as likely to be morbidly obese. (7) Men in the most disadvantaged economic group are also significantly more likely to be obese than those in the most advantaged group (19.5% compared with 12.7%), while for disadvantaged women the rate is nearly double (22.6% compared to 12.1%).

Obesity is linked to many chronic diseases that can have a devastating impact on individuals, families and communities. (8) Recent estimates show that obesity causes almost one-quarter of cases of type 2 diabetes (23.8%) and osteoarthritis (24.5%), and around one-fifth of cardiovascular disease (21.3%) and colorectal, breast, uterine and kidney cancer (20.5%). (3) In 2003 high body mass was responsible for 7.5% of the total burden of disease and injury in Australia, ranked behind only tobacco (7.8%) and high blood pressure (7.6%). (11)

There is also evidence that overweight and obese Australians have a lower life expectancy compared to those in the healthy weight range. Research shows that moderately obese people died two to four years earlier than those with a healthy body mass index (BMI). Being morbidly obese (a BMI of 40–45) reduced life expectancy by 8–10 years. (12) Similarly, other research estimating the impact of obesity on life expectancy (from age 40) found a mean loss of seven years associated with obesity – similar to the life expectancy loss from smoking. (9)

1 The standard definition of obesity is BMI>30. The health effects of ‘high body mass’ in the Burden of Disease study were estimated using new methods – see references (9) and (10).
The social and economic costs associated with overweight and obesity are significant. It has been estimated that the overall cost of obesity to Australian society and governments was $58.2 billion in 2008 alone.\(^2\) In terms of productivity, in 2001 more than four million days were lost from Australian workplaces due to obesity. Obese employees tend to be absent from work due to illness significantly more often and for a longer time than non-obese workers, and are more likely to be ‘not in the labour force’.\(^{13}\)

Of particular concern, however, is the increasing prevalence of overweight and obesity in children. As shown by the 2007 National Children’s Nutrition and Physical Activity Survey\(^{14}\) nearly a quarter of all children are now overweight or obese. Data from the survey found that for children aged 2–16 years, 17% were overweight, 6% obese and 5% were found to be underweight. Other studies suggest that the prevalence may be much higher among low socioeconomic groups, Indigenous people and some ethnic population groups.\(^{15-17}\)

Overweight and obese children face many of the same health conditions as adults, and can be particularly sensitive to the effects on their self-esteem and peer-group relationships.\(^{18}\) Symptoms in children and adolescents include poor psychosocial functioning, increased cardiovascular disease risk factors and abnormal glucose metabolism.\(^{8}\) Overweight in adolescence has been shown to be significantly associated with long-term mortality and morbidity.\(^{8}\)

However, the most significant outcome of childhood obesity is the likelihood that these children will progress to being obese adults and suffer chronic diseases at a much younger age.\(^{8, 18}\)

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\(^2\) This includes an estimate of $49.9 billion for the impact of obesity on quality of life. Readers of companion technical papers in this series should note that directly comparable estimates for the burden of diseases caused by alcohol and tobacco are not available.
The Taskforce welcomes these initiatives and sets out a number of recommendations and actions that can contribute to, inform and enhance the work of COAG in these areas, ensuring a sustainable and effective national response to overweight and obesity.

Other major developments in Australia have included the release of the House of Representative’s Inquiry into Obesity. Their report, *Weighing It Up*, released in May 2009, complements the National Preventative Health Taskforce process. The report has made general recommendations on the role of governments, industry, individuals and the community and has provided a platform for sharing of ideas, views and stories from a wide range of stakeholders. Their recommendations in the prevention area are largely consistent with the strategic actions outlined in the Taskforce’s National Preventative Health Strategy.[20]

The Senate Standing Committee on Community Affairs released its report on the *Protecting Children from Junk Food Advertising (Broadcast amendment) Bill 2008* in December 2008. The Committee stated that they considered it was premature to bring forward legislative changes to food and beverage advertising whilst the National Preventative Health Taskforce was developing a national strategy and before the industry’s voluntary initiatives had been assessed. They also referred their report and the information received by the Committee to the Taskforce for consideration.[21]

**THERE IS A NEED FOR URGENT ACTION AND A COMPREHENSIVE RESPONSE**

“In a political economy that measures progress in terms of growth and consumption, there are many underlying environmental, social and political determinants of obesity. In this context the introduction of policy and regulatory interventions is essential to make real impacts on the prevention of obesity”

(Quote from submission)

There is an urgent need to act immediately to address the causes of obesity. A failure to address rising obesity rates among adults and children will lead to significant increases in chronic disease, eroding many of the health gains of past decades.

**IF CURRENT TRENDS CONTINUE:**

- Australians will continue to become more overweight and obese.
- There will be six million obese Australians by 2020 and 6.9 million by 2025.[3]
- The percentage of the Australian population who will be overweight or obese will have grown to a record 73% in 2025. This includes one-third of our children and three-quarters of our adult population.[22]
- Recent trends in Australian children predict that their life expectancy will fall two years by the time they are 20 years old, setting them back to levels seen for males in 2001 and for females in 1997.[23]
- A projected rise in the rates of type 2 diabetes, mainly due to expected growth in the prevalence of obesity, will increase healthcare costs by $6.7 billion (from $1.3 to $8.0 billion) by 2032.[24]
- The burden of disease attributable to high body mass is likely to overtake tobacco as the leading preventable cause of burden as smoking rates decline.[25]
The complexity and multitude of health, social, economic, cultural and environmental determinants demand a long-term, comprehensive and well-funded response to overweight and obesity. No single measure in isolation will solve the problem. Action is required from all levels of government, industry, non-government organisations, individuals and communities.

Changes are needed in our environments, transport systems, food supply, workplaces, schools, local communities and healthcare systems to make the healthy choices the easy choices, and to empower and motivate individuals and families to lead healthier lives. (26)

**Sedentary lifestyles**

Highly prevalent and pervasive elements of the obesity-promoting environment are clearly identified in the research literature – including passive forms of entertainment, transport such as cars, and labour-saving devices which are widely available and heavily promoted and which encourage sedentary behaviour. (27) In addition, many people lead busy lives with little time for recreation and sport. While individuals ultimately ‘choose’ what activities to undertake, there is good evidence that environmental factors are a major influence on these ‘choices’. (27) Prolonged sitting and insufficient physical activity have become a part of daily life for many people, and changes in transport, occupations, domestic tasks and leisure activities have had negative effects on daily energy expenditure.

Figure 2.2 below illustrates the complexity and diversity of a broad range of factors that influence body weight.

![Figure 2.2: The influence of individual, social, lifestyle/behavioural and environmental factors on energy balance and BMI](source: Papas M, Allburg A, Ewing R, 2007)
Globally, obesity prevention and control is relatively new. Therefore, evidence of effective approaches in some areas is still being developed. For other areas, strong evidence exists from other aspects of public health, such as tobacco control. These factors speak to a ‘learning by doing’ approach – that is, the staged trialling of a package of interventions accompanied by comprehensive monitoring, evaluation and research. Achieving long-term sustainable change is likely to be difficult and resource-intensive, and will take time. It is not something that individuals or governments can do alone.

To be effective, the approach needs to focus on engaging individuals, families and communities to make changes to their lives that will enable them to improve their nutrition and increase physical activity levels. Programs and strategies will need to be coordinated across all levels of government and across diverse portfolios, such as Transport, Treasury, Education, Health, Sport and Recreation. Partnerships with a range of industry groups and sectors will need to be strengthened and new alliances developed. In particular, partnerships with the food industry, private health insurance, media and advertising industry will be necessary for success. There is a need to build on the programs already undertaken by state, territory and local governments, and by the non-government sector.

The priorities discussed in this strategy are critical to achieving change. These priorities focus on embedding healthy eating and physical activity in the everyday lives of every Australian. Delivering programs and policies in key settings where people live, work and play is essential. Social marketing campaigns supporting these programs are required to encourage and motivate individuals and families to make changes to their lifestyle and to the built environment. Partnerships with industry to influence the availability and consumption of healthy food are vital, as are measures to reduce children’s exposure to advertising of unhealthy food and drink. Additional support will be provided to those most at risk, and the program of work will be underpinned by ongoing population data collection, evaluation and research.

If current trends in overweight and obesity continue in Australia, there will be approximately 1.75 million deaths at ages 20+ years caused by overweight and obesity in the years 2011 to 2050, and 10.3 million premature years of life lost (PYLL)\(^3\) at ages 20–74 years. Each Australian aged 20–74 years who dies from overweight and obesity in 2011 to 2050 will lose, on average, 12 years of life before the age of 75 years.\(^29\)

If we can halt or stabilise obesity rates in Australia over this time period, we could save half a million lives.\(^29\)

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\(^3\) The person-years of life lost as a result of exposure of the population to a particular condition, in this case overweight/obesity.
Targets

The aim of this strategy is to halt and reverse the rise in overweight and obesity in Australia by 2020.

A range of targets relevant to obesity have been agreed upon as part of the COAG National Partnership Agreement on Preventive Health. The outcomes and detailed performance benchmarks are detailed in the Monitoring and Evaluation chapter. The Taskforce accepts these measures as appropriate long-term and interim targets for this strategy.

The Agreement sets the following medium to long-term outcomes for obesity:

- Increase the proportion of children and adults with healthy body weight by 3% within 10 years.
- Increase the proportion of children and adults meeting national guidelines for healthy eating and physical activity by 15% within six years.
- Help assure Australian children a healthy start to life, including through promoting positive parenting and supportive communities, and with an emphasis on the newborn.
### Key action areas

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Key action areas

The key action areas are described below, followed by details of the specific actions required. The Taskforce considers all key action areas to be important. They should be considered as a package – a phased set of actions that, when combined, will provide the most effective roadmap to address the overall targets.

At the end of the chapter, a summary table provides an overall implementation plan to guide action by the relevant parties.

**Key action area 1: Drive environmental changes throughout the community that increase levels of physical activity and reduce sedentary behaviour**

‘The environmental quality of cities, towns and suburbs will be of critical importance to the health and wellbeing of their communities over the next twelve years to 2020 and beyond’ (Quote from submission)

It is well established that the physical environment, which incorporates the built and natural environments, impacts on our health and wellbeing – both at the individual level and at the community level. The design of our local environments and neighbourhoods influences walking, cycling and public transport use, as well as recreational physical activity. (27)

Prolonged sitting and insufficient physical activity have become a part of daily life for many people – changes in transport, the nature of work, labour saving devices and less active leisure activities have all had negative effects on daily energy expenditure. In general, more physically active societies are healthier and have less obesity.

In 2007–08, more than 70% of Australians (aged 15 years and over) reported being sedentary or having low levels of physical exercise – a proportion virtually unchanged since 1995. The Active Australia Surveys, conducted between 1997 and 2000, also found no change or a slight increase in physical inactivity levels for some age groups.

An example of the gradual environmental and behavioural changes that have affected participation in physical activity is seen in a recent analysis of household travel surveys in New South Wales. This study found that the percentage of children aged 5–9 that walked to school was 57.7%, 44.5%, 35.3% and 25.5% in 1971, 1981, 1991 and 1999–2003, respectively, whereas the percentage of children aged 5–9 that were driven to school by car in the four surveys was 22.8%, 37.3%, 53.9% and 66.6%, respectively. This suggests that a complete reversal of the proportion walking versus driving occurred over a period of 30 years.

In 2005–06, almost one in three of the population aged 15 years and over participated in sports and physical activity twice per week (32% of females and 27% males). However, approximately 5.5 million people (34%), reported that they did not participate in any such activity in the 12 months before being interviewed.

The 2003 Victorian Neighbourhood Lifestyle Environment (VicLANES) study conducted across Melbourne found that people living in more disadvantaged areas, who were more likely to be overweight or obese, were less able to exercise due to health conditions and childcare responsibilities. The more disadvantaged areas had better street connectivity, a predictor of walking and cycling for transport, but traffic conditions were worse and there were fewer bicycle lanes. (31)

There is already a range of measures to encourage sporting and recreation activities. Additionally, through the Australian Government’s Health portfolio, grants are provided for 98 community projects that provide a range of sporting and recreational opportunities to Australian families ($46.8 million over three years), including support for the 2009 World Masters Games in Sydney and in 2007–08 providing funding for the Football Federation of Australia to promote participation in and
support for football in Australia. The Taskforce welcomes these initiatives and recommends further development of a coordinated national effort to enhance sport and recreation opportunities across Australia.

Sport plays a major role in Australia. It helps define our national identity, and provides avenues for participation, physical activity, learning of individual and team skills, and social connection, as well as being a significant employer and major leisure and entertainment industry. The Taskforce sees great synergies between the Preventative Health Strategy and the work of the Independent Sport Panel’s review to build our national capacity in junior sport, community participative sport, informal active recreation and elite sport. The Taskforce also believes there is a need to strengthen and encourage partnerships between preventative health agencies and sporting groups, and suggests that greater collaboration between the NPA, the Australian Sports Commission and national sporting bodies would deliver benefits in terms of encouraging healthy lifestyles.

A greater focus on active transport to and from work can increase opportunities for physical activity among working populations.[30] as illustrated by the UK Healthy Weight Healthy Lives Walking into Health initiative.[32, 33] Results from the pilot of a UK program, Sustainable Travel Towns, indicate that walking has increased by around 20% and cycling by almost 50% in two years, accompanied by reductions in car and public transport use.[32]

There is evidence that well-designed and sustained initiatives which influence attitudinal, behavioural and environmental factors can lead to significant improvements in population rates of physical activity, through increases in both incidental (for example, walking to catch public transport) and organised (for example, participating in active recreation or sporting activities) activities. They include:

- Good urban design and land use at a street level (improved lighting, ease and safety of street crossings, pathway continuity, presence of traffic calming structures, aesthetic enhancements) increase physical activity levels by 35%.
- Each kilometre walked reduces the odds of being obese by 4.8%, whereas every additional 60 minutes per day spent in a car increases the odds of being obese by 6%.
- Having access to places for physical activity (trails, facilities, parks, safety, affordability) increases physical activity by 48.4%.[34]
- Each quartile increase in land use mix (combining residential with other uses such as retail, workplaces etc) is associated with 12.2% reduced odds of being obese.[35]

Increasingly, however, many of our built environments are reinforcing sedentary behaviour and contributing to inactive lifestyles, particularly by encouraging car dependence.[36] State and local governments play a critical role in influencing the shape and design of the built environment and, ultimately, the health of their communities. There is strong support from consumers for communities that support healthy, sustainable living and which understand the connections between the environment, climate change and our economy. Creating built environments that help individuals to be more active and to eat healthier food will benefit the whole population.
There are a number of opportunities to build on current initiatives at the state, territory, local government and non-government level, some of which are described below.

Australian initiatives illustrating the importance of long-term planning, policy and infrastructure measures to address the urban obesity-promoting environment:

**THE HEALTHY SPACES AND PLACES PROJECT**
This project is funded ($700,000 in 2008–09) through the Australian Government to develop a national guide for local planners. A partnership has been established between the Australian Local Government Association, the National Heart Foundation of Australia and the Planning Institute of Australia.

An evidence-based national planning guide has now been developed to assist practitioners and decision makers at all levels of government, industry, private sector and community groups to understand the connections between planning and health. Due for release in mid-2009, the guide showcases existing initiatives and draws on current practices that apply to and are consistent with the proposed framework and principles. In particular, it demonstrates effective policy development and implementation that encourages and requires integrated outcomes for wellbeing.

**DESIGNING PLACES FOR ACTIVE LIVING**
The NSW Premier’s Council for Active Living (PCAL) has developed a comprehensive web-based resource with six design areas of focus: cities, towns and neighbourhoods; walking and cycling routes; public transport; streets; open space; and retail areas. The resource includes a design objective, important design considerations and links to key references. Additional resources for detailed design guidelines and specifications are provided for each focus area.

**THE LIVEABLE NEIGHBOURHOODS PROJECT**
The project comprises principles and guidelines for health-promoting urban planning. Liveable Neighbourhoods applies to structure planning and subdivision for “green field” sites and for the redevelopment of large “brown field” and urban infill sites. This development demonstrates an increasing acceptance of good design principles over time, and of regulation as an acceptable means of achieving more active, liveable communities. Mandatory requirements establish consistency, a level playing field for developers, and more equitable access to good urban design for residents. (27)

The guidelines have been adopted by the Western Australian Planning Commission as operational policy, and are required in all design and approval of urban development. (37)

**HEALTHY BY DESIGN**
The National Heart Foundation’s Healthy by Design (38) is a guide for professionals such as planners, developers and urban designers. The guide presents considerations, evidence, tools and case studies to facilitate the design of environments for active living.
The Taskforce recognises the importance of building on initiatives such as those described above. For example, the development of a resource for transport planners similar to Healthy Spaces and Places (that is, a national guide to assist transport planners to design transportation systems that foster health and wellbeing) would be a useful initiative that could be commenced immediately. Similarly, to enhance infrastructure development, linking funding allocation for built environment programs to specific criteria and to the introduction of health impact statements would strengthen the focus on identifying the health impacts (in particular, the likely impact on physical activity and sedentary behaviour) at an early stage in the process.

Transport systems are a key component of the built environment, as they shape the ways in which people carry out the diverse activities of daily life. Car-reliant cities encourage sedentary transport choices and contribute to obesity as well as additional health, environmental, transport and social harms.\(^{36}\)

Transport systems in Australia are often designed to move cars rather than people, and have resulted in urban environments that limit opportunities for walking, cycling and using public transport resulting in low rates of active travel.\(^{39}\)

When countries adopt more balanced transport systems, citizens have a greater choice of travel mode, car use declines (though not necessarily car ownership), and walking and cycling increases.\(^{40}\) Obesity levels are also lower.\(^{40, 41}\)

There are also social benefits associated with increased active living. For example, reducing car dependency would reduce traffic congestion, improve air quality and community liveability, lower car space requirements and costs, reduce energy and fossil fuel use, and reduce greenhouse gas emissions.\(^{27, 36}\)

Traffic safety concerns are a major barrier to active transport in Australia.\(^{42-44}\) Improved cycling and walking infrastructure is often the focus of attention to address these concerns, but supportive ‘invisible infrastructure’ is also a key feature of transport policies in countries with high rates of active travel.\(^{40}\)

It is acknowledged that solutions to address the obesity-promoting environment, such as changes in public policy, transport infrastructure and urban design, can be difficult and expensive; however, these environmental strategies are likely to impact on a large proportion of the population and are fundamental to improving the health of Australians.\(^{45}\)

It is well documented that public policies across a range of government portfolios impact on obesity levels and health more broadly. Health is an outcome of a wide range of factors – such as changes to the natural and built environments, and to social and work environments – many of which lie outside the activities of the health sector and require a shared responsibility and an integrated and sustained policy response across government. Accordingly, government policies can have positive or negative impacts on the determinants of health. Such impacts are reflected in the health status of the population today, and in the health prospects of future generations.\(^{46}\)
CASE STUDY: HEALTH IN ALL POLICIES – SOUTH AUSTRALIAN GOVERNMENT

Health in All Policies is an innovative strategy adopted by the South Australian Government, which recognises that public policies across all government portfolios have an impact on health. It aims to address health challenges through an integrated policy response across portfolio boundaries, introducing population health outcomes and ‘Closing the Gap’ as shared goals across government. By incorporating a concern with health impacts into the policy development process of all sectors and agencies, it allows government to address the key determinants of health in a more systematic manner. It also takes into account the benefit of improved population health for the goals of other sectors. Fundamental to the successful implementation of this approach has been high-level commitment from both the central government agency (Department of Premier and Cabinet) and the Health Department.

In November 2007 the South Australian Government convened the Health in All Policies conference. A significant outcome was the development of a set of core principles articulating the values that underpin the Health in All Policies approach.

The South Australian Government is now considering how best to support the continued application of a Health in All Policies approach as part of the implementation of their Strategic Plan. This includes developing effective ongoing governance mechanisms, building the capacity of all sectors to consider the health impacts of their policies, and expanding the technical skills of the health sector to support agencies to use Health in All Policies tools and processes. Other potential actions include experimenting in the application of this methodology to other portfolios such as Education, considering issues such as gender and the health gap, and further expanding this process to include other actors, in particular local government.

Adapted from an editorial, Health Promotion International Vol 23 No 1 by Kickbusch, McCann and Sherbon. (46)

The Taskforce believes that consideration should be given to the introduction of health impact assessments across priority government policy areas (including urban planning, school education and transport) to ensure that health impacts associated with new policies are explicitly identified and considered in a systematic way early in the policy development process. Governments and policy makers can then determine the need for any policy changes or additional supporting strategies that may need to be implemented at the same time as the policy.

The Taskforce is convinced by the evidence that there are social and environmental benefits associated with active living. As people walk and cycle more, and make greater use of public transport, the accompanying reductions in car use can help reduce traffic congestion, improve air quality, enhance community liveability, lower car space requirements and costs, reduce energy and fossil fuel use, and reduce greenhouse gas emissions.

There is now an opportunity to draw together many of these current, but diverse activities – such as Travel Smart, Healthy Spaces and Places, recent infrastructure programs and investment, the Review of Sport in Australia – into a comprehensive, sustained, national approach to support ‘getting Australians moving’. This idea was strongly supported in submissions to the Taskforce.

The Taskforce therefore proposes the establishment of a Prime Minister’s Council for Active Living to provide high-level leadership on this issue, and drive the development of a comprehensive National Framework for Active Living that addresses the built environment, transport and social engagement.

The National Framework for Active Living will also inform the development of a business case for consideration by COAG to deliver a new funding partnership agreement between governments. The partnership agreement would leverage future infrastructure funding for the built environment, transport and social engagement against agreed active living outcomes.
A National Framework for Active Living would identify key impediments and enablers of physical activity in relation to the built environment, transport and social engagement. This will include reviewing:

- Built environment – relevant Australian and state government legislation, including building codes; and planning guidelines, including examples of good practice that incorporate healthy living (for example, Healthy Spaces and Places, Healthy by Design).

- Transport – relevant transport policy and guidelines, including examples of good practice in active transport (for example, TravelSmart, national cycling strategy).

- Social engagement – strategies and initiatives to promote social engagement in active living and sport, which may include consideration of the recommendations of the forthcoming Independent Sport Panel Review, social marketing and community engagement programs.

The development of an Active Living Business Case for COAG consideration would provide governments with options to increase active living through the built environment, active transport and social engagement, with objective measures and outcomes to monitor the impact of various options, and ultimately lead to a new funding partnership agreement between governments.

**Action 1.1**

*Establish a Prime Minister’s Council for Active Living and develop and implement a National Framework for Active Living encompassing local government, urban planning, building industry and developers, designers, health, transport, sport and active recreation.*

**Action 1.2**

*Develop a business case for a new COAG National Partnership Agreement on Active Living.*

**Action 1.3**

*Australian and state governments to consider the introduction of health impact assessments in all policy development (including urban planning, school education and transport), using partnership models such as the Health in All Policies (HiAP) approach in South Australia.*

**DRIVING CHANGE THROUGH ECONOMIC AND TAXATION POLICY**

Currently there are few Australian Government tax breaks, subsidies or incentives for active transport, particularly walking and cycling. Within the policy/regulatory environment, a range of government transport policies encourage inactivity by effectively promoting private motor vehicle use and discouraging walking, cycling and public transport.

**FOR EXAMPLE:**

- Funding for road infrastructure but not public transport or bicycle facilities(43)
- Reduction in fuel excise to offset the price of carbon emissions(47)
- Financial support for car manufacturers(27)
- Taxation incentives through fringe benefits tax (FBT) for private motor vehicle use but not for forms of transport such as public transport or walking and cycling to work(48)
Under the current FBT system in Australia, private transport is encouraged, as cars of higher-income workers are subsidised. As the taxable value of the car and therefore the FBT payable is reduced with the number of kilometres travelled each year, there is incentive for people using the scheme to maximise car use during the FBT year in order to qualify for the greatest FBT benefit. Numerous groups and several parliamentary inquiries have called for this tax concession to be repealed.\(^{48}\)

An important first step will be to undertake a review and conduct research on economic barriers and enablers, policies and tax incentives to inform a national active living framework and actions. This review would also inform the development of the National Strategy on Active Living and the development of the business case for COAG on Active Living.

There are no comparable financial incentives for people to use active transport modes such as public transport, walking and cycling. The introduction of similar tax advantages would encourage and support increased physical activity among Australian workers, and is likely to have a subsequent beneficial environmental impact through a reduction in greenhouse gas emissions and urban traffic congestion.

Many workplaces currently provide subsidies that promote private and company motor vehicle use, such as subsidised car parking and novated leases. Inducements that encourage employees to walk, cycle or take public transport to work could be promoted in place of such subsidies. These might include fare rebates, shower and safe bicycle parking facilities, bicycle maintenance vouchers and bonuses for use of alternative forms of transport.

Taxation relief and financial subsidies could also make it easier to participate in physical activity, helping to make active choices a cheaper and easier alternative for individuals, families and business.

**FOR EXAMPLE:**

- Employer contributions towards activities such as cycling to work or subsidised corporate gym membership\(^{49}\)
- Tax deductibility for physical activity participation (such as club memberships, sporting equipment, bicycles and clothing) in a range of settings
- Subsidised sporting club fees for children, especially in families that experience financial hardship
- Taxation deductions for families for children’s registration and tuition in organised sport (as occurs in Canada and has been suggested for Australia)\(^{50, 51}\)

Some of the suggestions from the fitness industry in submissions to the Taskforce called for the provision of tax incentives or rebates for gym memberships in order to remove an initial barrier to participation. However, the rebate or subsidy would not be given until evidence of actual use of the membership was provided, such as gym attendance records. Under such a scheme, setting minimum participation levels for eligibility for an additional activity rebate would encourage at least minimum levels of activity.

The Canadian Government has implemented programs providing healthy living tax credits.\(^{51}\) The United Kingdom is also currently piloting several initiatives that link economic incentives with physical activity.\(^{52}\) These initiatives may provide a useful model for further consideration by Australian governments.
CASE STUDY 1: THE UK’S FREE SWIMMING PROGRAM

The Free Swimming Program is a partnership between the national government, local councils, Sport England and the Amateur Swimming Association. The program has been developed to support Change4Life, a national movement that aims to prevent people from becoming overweight through the promotion of healthier eating and physical activity.

Local councils apply for funds to help meet the cost of providing free access to pools during standard swimming sessions, including improving existing facilities or building new ones.

At launch, the scheme involved more than 1000 pools run by almost 300 local councils. The program also includes a national network of swimming experts recruited to work with participating councils and 100,000 free lessons offered to non-swimmers.

Incentives in the form of extra funding are offered to participating councils with the best record in developing the scheme and making an impact in their communities.

It is hoped the scheme will be extended to the whole population by 2012. [53]

CASE STUDY 2: HEALTHY LIVING TAX CREDIT

Since 2005, the government in Nova Scotia, Canada, has provided a Healthy Living Tax Credit to help with the cost of registering children and youth in eligible sport or recreation activities that offer health benefits. [51] Initially based on a maximum annual spending of $150 per child, it is estimated that the tax credit costs the Nova Scotia Government $2.2 million annually.

In 2006 the Children’s Fitness Tax Credit was announced, which allowed parents to claim a non-refundable tax credit of up to $500 in fees for the enrolment of a child under the age of 16 in an eligible program of physical activity. An evaluation is currently being completed. [51]

Action 1.4

Commission a review of economic policies and taxation systems, and develop methods for using taxation, grants, pricing, incentives and/or subsidies to promote active living and greater levels of physical activity and decrease sedentary behaviour.
Key action area 2: Drive change within the food supply to increase the availability and demand for healthier food products, and decrease the availability and demand for unhealthy food products

In the course of the consultations undertaken and in reviewing the submissions to the Taskforce, the need for the Australian Government to establish a comprehensive National Food and Nutrition Framework was repeatedly raised. Among those submissions that supported this measure, a significant number specifically nominated the integrated and comprehensive approach detailed in the United Kingdom’s strategy *Food Matters* as a useful model worthy of consideration.\(^{54}\)

In the first instance, a comprehensive framework to drive change within the food supply is needed. All stakeholders in the food system will need to engage in the development of the framework, and in the future implementation of a national food strategy. Stakeholders include primary producers, processors, food manufacturers, retailers, individuals in the transport, storage and retail sectors, and consumers.

The framework would consider the context of preventative health in general, and more specifically the role of prevention in reducing the rates of overweight and obesity in Australia. Such a strategy needs to consider food policy in the context of providing practical measures for addressing access to food and food security, achieving healthier diets, food safety, and issues related to food production and agricultural policy that ensure a safe and environmentally sustainable food supply chain.

A National Food and Nutrition Framework will articulate a policy framework and key actions for government, industry and other partner organisations to achieve a safer, healthier and more sustainable food supply. It will:

- Ensure that issues relating to healthy eating and nutrition are considered appropriately within the same policy context as food safety, food supply and environmental issues
- Provide an opportunity to strengthen partnerships
- Develop a voluntary Healthy Food Code of Practice where signatory companies in the food sector commit to the promotion of healthy eating in line with the elements of the code
- Identify and implement strategies by which affordable, healthy, fresh, good-quality foods are available to all Australians
- Target population groups at particular risk; for example, males and people of lower socioeconomic status (SES) who have lower levels of fruit and vegetable consumption

**Action 2.1**

*Develop and implement a comprehensive National Food and Nutrition Framework, covering:*

- **Price, choice and access to food and food security through open and competitive markets**
- **Achieving healthier eating patterns**
- **Food safety**
- **Issues related to food production and agricultural policy that ensure a safe and environmentally sustainable food chain and food supply**
DRIVING CHANGE THROUGH ECONOMIC POLICY AND TAXATION

Taxing unhealthy foods

To promote improvements in the food supply, the use of economic instruments such as a tax on unhealthy foods may encourage food manufacturers to produce healthier foods by reformulating existing products or developing new ones to maintain market share.(51) As consumers are responsive to price, taxes on unhealthy foods that increase the price to consumers may be effective in discouraging and lowering consumption.(55)

- UK modelling data has estimated that taxing a wide range of food products to reduce fat, salt and sugar intake to maximise health outcomes would prevent up to 3200 deaths from heart disease and stroke annually, and increase food expenditure by 4.6%. (56)
- In Denmark, it has been estimated that the population’s diet would be consistent with national guidelines if tax exemptions for ‘healthy’ products such as fruit, vegetables, rice, pasta and fish products were combined with a 30% tax increase on ‘unhealthy’ products. (57)

However, further evidence on the outcomes of economic policies such as targeted food taxes is required, as it is unclear whether such policies would actually change consumers’ buying habits; the magnitude of resulting health gains is also unknown. (55, 56, 58)

Modelling of scenarios in the United Kingdom indicates the need for a cautious approach to targeted taxes. Modelling showed a reduction in saturated fat consumption but a concomitant rise in salt intake and reductions in polyunsaturated and monounsaturated fat intake. (56)

An important first step for Australia will be to undertake a review and conduct research into economic barriers and enablers, policies and tax incentives influencing the promotion production, access to and consumption of healthy and unhealthy foods. Targeted taxation on unhealthy foods is considered by some people to be regressive, as it would impact disproportionately on individuals and families on lower incomes who spend a larger proportion of their income on food than higher income earners. (55, 59)

An alternative is to subsidise healthy foods, specifically targeting subsidies to support the most disadvantaged consumers. This highlights interventions encouraging a greater intake of healthy (lower energy density) foods rather than policies encouraging a decreased intake of unhealthy foods. There is research suggesting that there may be more weight loss benefit in increasing the intake of healthy foods rather than decreasing the consumption of unhealthy foods. (55, 60)

A recent comprehensive review of evidence on the effects of food prices on weight outcomes found the evidence supported a multi-pronged approach to changing prices – taxing unhealthy foods and subsidising healthier products. (61) The study concluded that fiscal policies could be used to improve weight outcomes, noting that substantial price changes are required to ensure significant improvements. Most importantly, these effects were particularly likely to be observed among children and adolescents and low SES groups, who are most at risk of being overweight. (61)

Several countries have targeted taxation policies on widely available popular foods and beverages such as soft drinks, which are inherently high in energy and empty of any important nutrients. Results of a meta-analysis found that the intake of sugared beverages displaces the consumption of healthier beverages, and is associated with higher body weight and poor nutrition. (62) In addition, the risk of obesity and diabetes increases with rising intake. Drinks such as soft drinks that are rich in sugars (both added and natural) have also been shown to reduce appetite control, leading to increases in weight gain and increased risk of obesity. (63) Increased liquid carbohydrate consumption is not accompanied by a
OBESITY

reduction in solid food consumption;(63) in fact, soft drink intake has been identified in a range of research as a key contributor to increasing levels of overweight and obesity,(62) as well as increased rates of dental decay.(64)

EXAMPLES OF SOFT DRINK TAX:

- In the United States, 40 states have small taxes on sugared beverages and snack foods.(65) Large taxes on sugared beverages have been proposed in Maine and New York (NY) State: in New York, an 18% tax on non-diet soft drinks has been proposed for implementation in June 2009. (65, 66) Small soft drink taxes have been introduced by individual states to reduce consumption, raise revenue and improve public health; as the taxes were extremely low, impacts on health were not expected to be large. During the 1990s, around half of all states taxed soft drinks and 20 states changed their soft drink tax rate. An evaluation of the impact of changes in state soft drink taxes on BMI indicated that soft drink taxes modestly reduced BMI. The impact varied across demographic groups. The results were extrapolated to conclude that if the soft drink tax was as high as cigarette tax, the proportion of obese adults would decrease by nearly 1 percentage point.(62)

- In Denmark in February 2009, the government announced the extensive restructuring of its income tax system. Under the government’s proposals, pollution, cigarettes and unhealthy food (foods and drinks with a high sugar and fat content) will be subject to higher taxation. Ice cream, sweets and chocolate will see a duty increase of 25%, while saturated fats in dairy products and oils will be levied at 20 kroner per kilogram.4


Action 2.2

Commission a review of economic policies and taxation systems, and develop methods for using taxation, grants, pricing, incentives and/or subsidies to:

- Promote the production of healthier food products, including reformulation of existing products
- Increase the consumption of healthier food and beverage products
- Decrease production, promotion and consumption of unhealthy food and beverage products
- Promote healthy weight

INCREASING THE AVAILABILITY OF HIGH-QUALITY FRESH FOOD – THROUGH PRICING POLICIES

There is a need to reduce and to minimise the barriers to people selecting and consuming fresh fruit and vegetables, particularly concerning cost and access to fresh, high-quality, healthy food. Pricing is a crucial issue to consider in shifting consumer demand. Food prices have risen significantly in Australia recently, including large increases in the price of many fresh products. These price rises have been associated with factors such as the drought, adverse weather conditions, increasing costs of raw materials and other products crucial to farm production, such as petrol and fertiliser, as well as rising international food commodity prices.(67)

Food is more costly in rural areas compared to metropolitan areas across Australia,(68-70) and the availability, accessibility and costs of nutritious food can influence consumers who are socially or geographically disadvantaged, affecting their ability to consume healthy food.(71) Australians at particular risk of food insecurity include older people, those living in rural and remote areas, and those with a disability.(72)
While both food and non-food items have seen a fairly similar rise in price in recent years, there has also been an increase in the general affordability of food over the last 20 years. This is associated with substantial increases in consumer incomes.

Trend data on the price of 57 items designed to meet the nutritional needs of a family of five (a healthy food basket), collected in the Illawarra region of New South Wales at five time points between 2000 and 2007, indicated an increase over time in food prices of 20.4%.

The affordability of the basket items relative to income (based on average weekly earnings and on welfare payments) showed little change over seven years. The largest increases were seen in the prices of vegetables (55.7%) and fruit (46.7%), a trend also found in Queensland data. There is a discrepancy between such price rises and consumer campaigns promoting increased consumption of these foods, such as the national Go for 2&5 campaign.

Low-income Australians report lower levels of consumption of fruits and vegetables, often related to difficulties in accessing, purchasing and storing these foods. People on lower incomes spend a higher proportion of their income on food and are less likely to meet dietary guideline recommendations for levels of fruit and vegetable consumption than higher income consumers. They are more likely to consume energy-dense foods (high in fat and sugar) and lower amounts of plant-based foods (fruits and vegetables and wholegrain bread). While it is not known whether this is due mainly to food prices or access issues (for example, accessibility of food outlets and appropriate transport), energy-dense foods are often perceived as being more affordable, more filling, more acceptable to family members and more readily available in disadvantaged areas.

Action 2.3

Examine and develop systems and subsidies that increase the availability of high-quality fresh food for regional and remote areas, focusing on:

- Regional and remote transport
- Increasing the production of high-quality, locally grown fresh foods that are available to the local community

DRIVING CHANGES TO THE FOOD SUPPLY – IMPROVING POPULATION NUTRITION

The development and reformulation of existing food products is one way to increase the availability and accessibility of healthy food options, and to help create a supportive environment for behaviour change. Such changes to the food supply can increase the availability of healthier products and drive consumer demand, with consequent improvements in population health.

Addressing diet as a key risk factor for largely preventable chronic diseases, through improvements in population nutrition, has been successful in the prevention of chronic disease. Policy examples of population reductions in nutrient intake and overall health improvements associated with national policies targeting nutritional behaviours are illustrated below:
INTERNATIONAL EXAMPLES:

- In the United Kingdom, the government partnered with the food and drink manufacturing industry to reduce salt content in almost a quarter of manufactured foods over several years.

- In Mauritius, a government-led effort lowered the population’s cholesterol largely by promoting soybean oil rather than palm oil for cooking.

- In Japan, government-led health education campaigns have reduced blood pressure population-wide, and stroke rates have fallen by more than 70%.

- In Finland, health education and nutrition labelling led to population-wide reductions in cholesterol and many other risks, followed by a precipitous decline in heart disease.

- In the United States, a decrease in saturated fat intake in the late 1960s began the large decline in coronary heart disease deaths seen in the last few decades.

- In New Zealand, introduction of recognisable food labelling logos for healthier foods led many companies to reformulate their products. The benefits included large decreases in the salt content of processed foods.

- In Norway, combined food subsidies, price manipulation, retail regulations, clear nutrition labelling and public education focused on individuals were effective in turning around a population shift towards high-fat, energy-dense diets.

One of the most successful national programs to improve population health through sustained changes in behaviour is the North Karelia Heart Health Program in Finland, which incorporated an integrated food policy approach. Significant changes in the diet included the increased consumption of fish, vegetables, fruit and berries over 20 years; an increase in the proportion of people using mainly vegetable oil for cooking between 1972 and 1997; and the decreased consumption of salt and energy from saturated fats between 1972 and 1997, with an associated major decline in cholesterol levels (18% over 25 years). Stroke and cancer mortality also decreased, with impacts on life expectancy and diminished mortality. Heart disease rates dropped by 65% between 1971 and 1995. The major factor in the reduction in cardiovascular disease has been identified as improved diet associated with decreased blood pressure and cholesterol.

The Finnish experience indicates that obesity levels did not stabilise or decline over this period but rather increased. While specific risk factors such as high blood pressure and cholesterol were targeted and successfully reduced, weight was not a focus of the intervention. Factors relating to the prevalence of obesity in the Finnish population over this time that were not taken into account in the study include frequency and quantity (serve size) of food consumption. Soft drink and alcoholic beverage intake also increased over this time.

(89) The roles of many other factors such as foods and beverages consumed outside the home, consumption of energy-dense snacks and physical activity and sedentary behaviour levels are also unknown. Clearly, it is crucial to consider overall energy balance (intake and expenditure) and implement strategies to address all factors in order to make a difference in weight.

It is important that a comprehensive approach is taken to address population nutritional factors such as energy, saturated fats, salt and trans fats. Each of these factors has a significant role to play in health, but it is necessary to address whole foods rather than...
individual nutrients in order to produce a healthier food supply. When specific nutrients are targeted alone, there is a risk that the profile of food products is improved for one nutrient (for example, reduced fat) at the expense of another (for example, increased sugar), resulting in high energy-dense foods that consumers identify as healthier options, unaware of the impact of the food over time on their weight and overall health. Encouraging the reformulation of existing products and the development of new products to produce healthier options in which all nutrients are considered is therefore crucial.

THE ROLE OF INDUSTRY AND THE NON-GOVERNMENT SECTOR

Both the food industry and the non-government sector play an influential role in shaping the population’s health. Governments recognise the importance of collaborative approaches with industry and with the non-government sector.

FOR EXAMPLE:

- The Australian Government, together with the Australian Food and Grocery Council developed a national physical activity and nutrition survey of over 4400 children. The survey results were released in October 2008.
- As part of the COAG National Partnership in Preventive Health agreement (2009–15), $1 million over four years is allocated for the establishment of partnerships with relevant industry and non-government sectors. The aim is to progress cooperative approaches that reshape consumer demand and industry supply towards healthy living choices.
In March 2006, the UK Food Standards Agency (FSA) set voluntary targets for the level of salt in 85 categories of food. An estimated 75% of salt intake comes from foods people purchase, highlighting the key role product reformulation by industry must play. The UK program involved around 70 firms and trade associations, and a broad range of products. The most recent survey evidence (July 2008) indicates daily average salt consumption in the United Kingdom has fallen from 9.5g to 8.6g since 2000. The FSA is currently reviewing the targets and considering further reductions to maintain progress towards the daily average intake target of 6g of salt.

In April 2009 multinational food company Unilever announced that, rather than targeting salt reductions based on individual products, it would be reducing salt across its 22,000 products globally. The aim is to achieve a daily intake of 6g of salt per person by 2010, and the World Health Organization (WHO) recommended 5g maximum by 2015.

In Australia, partnerships with the food industry include reformulating food products with lower salt options through the Heart Foundation Tick program and the Australian Division of World Action on Salt and Health (AWASH) Drop the Salt! campaign.

In May 2009 the FSA released new salt reduction targets which represent the next step towards achieving the daily average intake target of 6g of salt. See www.salt.gov.uk/industryactivity.

See www.nutraingredients.com/content/view/print/244336.
In the United Kingdom, the FSA introduced a voluntary scheme for food service outlets to display calorie counts in January 2009. By June 2009, more than 450 food outlets, including workplace caterers, sit-down and quick-service restaurants, theme parks and leisure attractions, pub restaurants, cafes and sandwich chains, are expected to have introduced calorie information, some on a pilot basis. Outlets include 18 major catering companies and businesses such as Burger King, KFC, Marks and Spencer, Sainsbury’s Cafes, Pizza Hut, Subway, and Tesco and Unilever staff restaurants. Each company will:

- Display calorie information for most food and drink they serve
- Print calorie information on menu boards, paper menus or on the edge of shelves
- Ensure the information is clear and easily visible at the point where people choose their food

Research is planned to assess customer understanding and use of the system, as well as practicalities and costs. This will be used to inform the next steps for a wider rollout of calorie labelling on menus.

Evidence suggests that displaying information about restaurant menu items at point of sale or on menus is more effective than making this information available to the public via other means, such as on the internet, and may be associated with lower calorie purchases by consumers who see the information.

National policy on front-of-pack food labelling is currently being considered in Australia. The four options presented for consideration in a February 2009 consultation paper developed by the Food Regulation Standing Committee (FRSC) ranged from maintaining the status quo to a scheme which may require some prior knowledge from consumers (for example, percentage daily intake) or a colour-coded interpretable scheme (for example, traffic light labelling).

The Taskforce believes that the best approach involves a front-of-pack food labelling system based on extensive consumer testing, readily understood by most demographic groups, especially people of lower SES. The scheme must support consumers to select healthier products through clear, simple and easy to interpret information that is consistent across all products and uniformly applied throughout Australia, based on Nutrient Reference Values and Dietary Guidelines. The scheme must be actively enforced with appropriate penalties, and closely monitored and evaluated against its specified goals and objectives.

The Taskforce recommends a phased approach over three years for the introduction of a front-of-pack food labelling system. Implementation would commence with a national trial of appropriate approaches across a sample of products. Following the evaluation of the effectiveness of the approaches, a national system would be implemented.

**Action 2.5**

*Introduce food labelling on front of pack and menus to support healthier food choices, with easy to understand information on energy, sugar, fats, saturated fats, salt and trans fats, and a standard serve/portion size within three years.*

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7 In October 2008 the Australia New Zealand Food Regulation Ministerial Council agreed that the FRSC should develop a draft policy guideline on front-of-pack labelling for Council consideration in May 2009. Consolidated feedback from consultation and a draft policy guideline was to be provided to the Ministerial Council in May 2009, with the Council providing a progress report to COAG on the food labelling law and policy review in July 2009. The Ministerial Council has sought input into the review from the Australian Health Ministers Conference (AHMC).
Key action area 3: Embed physical activity and healthy eating in everyday life

ACTING WHERE ADULTS, CHILDREN AND FAMILIES LIVE, WORK, LEARN AND PLAY

Interventions to counter obesity are premised on the need for simultaneous action in the structural environment – through legislation and regulation – and at the local community and individual level. The notion of a ‘settings’ approach becomes particularly important.

A ‘setting’ is a context – and a complex set of relationships and structures – within which people live, work, trade and socialise. A settings approach has long been seen as a way of reaching a captive audience, providing entry points and access to specific populations as well as channels for delivering health promotion programs. Settings are also understood as ‘creating supportive environments’ to ‘make healthy choices easy choices’.

‘There are many positive changes that families and individuals can make, but if the environment in which they exist – where they work, play, interact and experience life – is not conducive to health, the impact of individual behaviours may be severely limited’ (Quote from submission)

For these reasons, it is important to undertake a combination of interventions in schools and workplaces, as well as in local government areas to make local environments healthy and active. Local governments are in a unique position to shape the local natural and built environment, and to integrate efforts in different sectors. The linking of the work within these settings at the local level may particularly benefit disadvantaged communities.

The potential benefits in terms of health and from an economic perspective are significant. It is estimated that:

- Increasing fruit and vegetable consumption in Australia by just one serve a day would save between $8.6 million and $24.4 million in healthcare costs relating to various types of cancer. In addition, over $150 million would be saved in costs related to cardiovascular disease. (97)
- If more people were physically active for 30 minutes a day, the Australian healthcare system could save $1.5 billion annually. (98)
- $8 million per year could be saved for every 1% increase in the proportion of the adult population that is sufficiently active. (97)

For children, the home environment can influence active recreation and play through factors such as whether children have television sets in their bedrooms and a yard large enough to play in. (99) These characteristics are within the ‘micro-environments’ of families, and therefore potentially amenable to parental control. For example, parents can instigate simple but effective rules such as limiting the amount of television that their child watches and switching off the television during meal times. Support for families to modify home environments can assist parents to create more active environments for children. Workshops and other resources can be used to empower parents to overcome the ‘nag factor’ and restrict screen-based activities and television viewing.

Limiting the delivery of extended teaching blocks where children are sitting for up to 90 minutes at a time in class, and encouraging schools to provide children with physical activity ‘breaks’ during class time may substantially benefit children’s health. (100)
Active play and sports participation at school can be increased by providing open spaces (not necessarily grass), fixed equipment (such as basketball hoops), playground markers, loose equipment (such as balls) and teacher supervision. Physical education and sport can be promoted by having a classroom teacher who encourages physical activity, core curriculum requirements for physical education/sport, and access to sporting equipment and playing fields. In particular, health and physical education should be included in the national core curriculum for schools.\(^{(27)}\)

**Addressing ‘too much sitting’**

A body of new evidence identifies the time that adults spend sitting as being an important ingredient of the physical activity and health equation.\(^{(101)}\) Research has shown a dose-response relationship between sitting time and mortality, independent of leisure time activity.\(^{(102)}\) In the context of chronic disease prevention, the impacts on health of too much sitting need to be considered, in addition to the well-established preventative-health concerns about too little exercise. Findings from the national AusDiab study\(^{(101, 103)}\) have shown television viewing time – which may reflect some people’s broader dispositions to spending a lot of time sitting\(^{(104)}\) – to be significantly related to metabolic health. Prolonged television viewing time (particularly more than four hours a day) has been shown to be associated with:

- Higher waist circumference
- Higher blood sugar levels
- Higher blood fat levels
- Higher risk of the metabolic syndrome

The detrimental associations of television viewing time with metabolic health were observed even in adults who met the criteria for the National Physical Activity Guidelines for Adults.\(^{(105)}\)

AusDiab findings also show that the average person spends more than half of their waking hours (~9 hours) in sedentary behaviours – primarily prolonged sitting. The remainder of the day is spent in light-intensity activities, with only 4–5% of the day spent in moderate-to-vigorous intensity physical activity.\(^{(106, 107)}\) Importantly, participation in light-intensity activities (which can include housework, standing and moving about in office environments or shopping) has been shown to be beneficially associated with blood sugars and waist circumference.\(^{(101, 106)}\) Additionally, those who interrupted their sedentary time more frequently (for example, got up to get a drink, stood up to answer the phone) had a better health profile, compared to those whose sitting time was mostly uninterrupted.\(^{(106)}\)

Key components of the approach will include:

- Broadening Australia’s Physical Activity and Health Guidelines to address explicitly increasing ‘incidental’ activity and reducing prolonged sitting time in all aspects of daily life
- Funding, implementation and promotion of the:
  - National Physical Activity Recommendations for Children 0–5 years (due to be released in late 2009)
  - National Physical Activity Recommendations for Children and Youth (these cover 5–18-year-olds)
  - National Physical Activity Guidelines for Adults
  - National Physical Activity Recommendations for Older Australians (released in March 2009)
- Ensuring that physical activity is embedded in the national school curriculum
SCHOOLS

‘Preschools and schools are agencies for social change and offer opportunities to build understanding and awareness, as well as creating healthy environments’ (Quote from submission)

Schools are able to influence the nutrition and physical activity environment, and to educate children, families and the broader community about healthy lifestyles.

Promotion of healthy eating in schools may be weakened by a high level of unhealthy foods and beverages available in school canteens, and the presence of soft drink and confectionery vending machines. Recent Australian data indicate that children purchasing foods from school canteens had a higher energy intake from energy-dense foods than those who did not use the canteen.

Evidence-based guidelines recommend ensuring that all school policies and the school environment help children and young people to maintain a healthy weight, eat a healthy diet and be physically active. This includes policies relating to building layout and recreational spaces, catering (including vending machines) and the food and drink children bring into school, the curriculum (including physical education) and school travel plans (including provision for cycling).

The United Kingdom has recently announced that it will implement a ban on fizzy drink and junk food in school vending machines. France banned vending machines in schools in 2005. In 2006, former President Bill Clinton and the American Heart Association brokered a deal with the beverage industry in the United States, removing most soft drinks from almost every US primary and secondary school by the 2009–10 school year. Following the introduction of the agreement, the level of calories due to beverages delivered to schools in the 2007–08 school year decreased by 58%.

The Taskforce recognises that significant work has already been undertaken at the state and territory level to improve nutrition and physical activity in schools, particularly in relation to healthy school canteens. The Taskforce believes that there are significant opportunities to build on this action and develop policies and programs that support children and their families to adopt healthier lifestyles. The Taskforce proposes that schools should maintain a priority focus on health, nutrition and physical activity in the curriculum.

CASE STUDY: PRIMARY SCHOOL CHILDREN AND HEALTHY EATING

The Stephanie Alexander Kitchen Garden Program (SAKGP) is a school-based program providing primary school children with the opportunity to grow, harvest, prepare and eat fresh nutritious food. The program aims to positively influence children’s food choices and attitudes towards environmental sustainability. In April 2009 there were 49 Victorian schools and 43 schools participating nationally, with a further 147 schools to undertake the program over the next three years. Longitudinal evaluation of the program by researchers from Melbourne and Deakin universities is being conducted over 2.5 years to assess the program’s impact on school communities and students, including an economic appraisal. Preliminary findings indicate that school community members state they are willing to donate time to fundraising and general program maintenance, while parents have indicated willingness to pay increased voluntary school levies for the introduction or maintenance of the program at their school. Interestingly, each of the six matched comparison schools in Victoria (not participating in the program) indicated that they had an existing or planned garden program at the school.

8 See www.parentsjury.org.au/?p=191&ContainerID=soft_drink_ban_in_us_schools and (113).
and believes that the provision of mandated opportunities for all children to undertake appropriate levels of physical activity as part of their education is a fundamental strategy in addressing rising obesity levels in children. The Taskforce recommends that the existing policy requirement of at least two hours of physical activity per week for all K–10 students should be maintained in the state and territory government education/curriculum policy requirements of all schools, regardless of the system or sector. Further, the Taskforce recommends that the two hours of physical activity should form part of the quality assurance and reporting framework for all schools.

Other key approaches will include:

- Building on partnerships with the education sector to promote physical activity and healthy eating in schools
- Ensuring a curriculum entitlement to Health and Physical Education (HPE) for all Australian children by incorporating HPE into the second stage of National Curriculum development
- Australian and state governments to establish a national program to support implementation of the new curriculum, including teacher curriculum guidance and professional development opportunities
- Education sector to encourage all schools to develop, implement and evaluate health, nutrition and physical activity policies
- Ensuring implementation of the policy requirement of at least two hours of physical activity per week for all students K–10
- Expanding coverage of out of school care health programs such as Active After School, and Eat Smart, Play Smart
- Education sector to examine how to build the capacity of schools and teachers to promote health and resilience more effectively
- Development of comprehensive health policies in schools including:
  - Implementation of policies relating to building layout and recreational spaces
  - Strengthened school nutrition policies (for example, provide a healthy breakfast program for disadvantaged children; modify school canteen service; increase healthy options; provide healthy eating education; increase the availability, appeal and encouragement of fruit and vegetables at school; and increase the availability of healthy food options in all school environments: canteens, vending machines, fundraising, classroom rewards, excursions, and the food and drink children bring into school) and use of alternatives to foods in fundraising and other programs
- Introduction of school travel plans and support for active transport options to and from school, including cycling and walking
- Improved access to school-based recreational facilities by the community, especially after hours and in neighbourhoods that lack park and recreational facilities
- Promotion and support through state and territory governments for the National Healthy School Canteens Project, ensuring a nationally consistent approach to making healthy food available in school canteens, and the provision of foods and beverages in line with Australian dietary guidelines
- A comprehensive national approach to phasing out soft drinks in school canteens and vending machines

There is also a need to ensure key policy elements are appropriately reflected within the National Prevention Agreements.
Action 3.1

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

**WORKPLACES**

*The workplace provides an ideal opportunity to engage individuals in taking more control of their own health* (Quote from submission)

Workplaces represent an arena for social leadership and peer support in tackling behaviour change, while work and employment policies and practices can enable or work against positive changes within the workforce. Furthermore, workplaces provide an ideal opportunity to reduce sedentary behaviour in the population.

Prolonged inactivity, such as sitting, is now common during working, domestic and recreational time, and typically comprises over half of waking time activity. Over one-quarter of Australians (26%) report sitting for eight or more hours during a typical day. Recent Australian research has demonstrated the benefits of avoiding prolonged uninterrupted periods of sedentary (mainly sitting) time, interspersing periods of inactivity with breaks, and substituting (at minimum) light-intensity activity for sedentary time. These benefits include improved weight and metabolic outcomes.

While it is important to continue to promote the significant health benefits of regular moderate to vigorous physical activity, this research indicates that extended periods of sedentary time (as are common among office workers) may undo the benefits of such activity. The results suggest that simple interventions that can be implemented in the workplace and domestically to decrease passive sitting time and increase the number of breaks can also lead to substantial health improvements. The evidence highlights behaviours that may be more appealing and feasible for some people to undertake, which can still result in improved weight and metabolic effects; for example, the importance of lower-intensity activity throughout the day (including incidental activity such as standing) rather than a focus on more purposeful moderate to vigorous activity, such as going to the gym or jogging.

Simple strategies, such as standing up while talking on the telephone or watching television, using a telephone headset at the office to keep moving during phone calls and arranging regular short breaks during sit-down meetings, can be introduced and sustained in daily routines.

*Workplaces are best placed to provide the supportive cultures often needed to sustain lifestyle change* (Quote from submission)

Common factors of worksite health promotion programs with successful outcomes include regular participation, intervention intensity, the inclusion of dietary advice, supervised physical activity, support for physical activity outside the workplace, counselling and plant reorganisation. A meta-evaluation of research into economic returns associated with worksite health promotion programs found strong evidence that worksite health promotion was associated with average reductions in sick leave, health plan costs and workers’ compensation and disability costs of just over 25%. A review of workplace-based interventions targeting dietary behaviours through various education and environmental initiatives that were focused around the work canteen found positive modest changes in diet and food purchases or no impact. Some workplace initiatives promoting physical activity (interventions included health checks, motivational prompts and physical activity programs) have found inconsistent or inconclusive evidence, with some strong evidence for increased physical activity behaviour but inconsistent or no evidence for improvements in cardiovascular outcomes, body weight or general health. More comprehensive interventions, incorporating...
individual approaches and changes in workplace culture and organisational structure, were more successful.\(^{119}\)

WorkHealth is a recent initiative of the Victorian Government\(^9\). It is a five-year, $218 million program aimed at improving the health and wellbeing of Victorian workers through workplace-based health checks, and providing access to advice and education programs to help workers reduce their risk of chronic disease. The aims are to reduce absenteeism, improve productivity, reduce injuries and reduce the burden of chronic disease on the Victorian health system. This initiative uses the workplace as an opportunity for health promotion and disease prevention, and establishes partnerships between government, employers and workers, develops joint effective health solutions, and creates links to existing health initiatives and services.

These kinds of programs and opportunities could be provided to Australian employees more broadly as a standard condition of employment. Workplaces could offer risk assessment and risk modification programs, nutritional education for workers and families, and physical activity embedded in, or in association with, regular daily work practice. Incentives could be provided to employers to reduce the chronic disease risk profile of their employees.

‘Not only does the workplace provide a captive audience to which messages can be targeted, but there is also a secondary effect through the influence on family and friends’ (Quote from submission)

The Taskforce believes that the development of comprehensive healthy workplace programs will provide new opportunities to promote healthy living. Therefore the Taskforce proposes the funding, implementation and promotion of comprehensive workplace programs through the COAG Healthy Workers initiative, including:

- Development of a national accord to establish best practice principles for workplace programs including protecting the privacy of employees, workplace risk monitoring, risk assessment or risk modification programs
- Development of a voluntary industry scorecard, benchmarking and award scheme for workplace health
- Development of nationally agreed accreditation standards for providers of workplace health programs
- Development of a national action research project to strengthen the evidence of effective workplace health promotion programs in the Australian context
- Establishment of a national workplace health leadership program and a series of resources, tools and best practice guidelines
- A review of potential legislative changes to promote the take-up of workplace health programs, including options such as:
  - Changes to Fringe Benefits Tax Assessment Act and Income Assessment Act to provide incentives
  - Employer commitment to a percentage of annual payroll allocated to workplace health programs (similar to the former Training Guarantee Levy)
  - Reforms to the Private Health Insurance Act 2007, to enable private health insurance firms to provide health screening to workplaces
  - Investigation of the feasibility of rewarding employers – through grants or tax incentives – for achieving and sustaining benchmark risk factor profiles in their workforce

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Action 3.2

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

COMMUNITY INITIATIVES

The community is where prevention actually happens. Every sector of society will need to change in order to reduce obesity rates and achieve healthier lifestyles. Shifts of this magnitude are not simple but the rewards will be great – both for ourselves and our children.

There are number of community-wide interventions already under way that aim to control childhood obesity. For example, Eat Well Be Active recently published results following several years of community implementation in Colac, in regional Victoria. The program was designed to build the community’s capacity to address childhood obesity through the promotion of healthy eating, physical activity and healthy weight in 4–12-year-olds and their families. The action plan was designed and implemented by local organisations, including schools and parents, and local health, housing and government services. The program used nutrition strategies such as support from school-appointed dietitians, canteen menu changes, training for canteen staff and healthy breakfast days, while physical activity strategies included walking to school programs, sporting club equipment and coach training.

While overweight and obesity levels in children from both the campaign and the nearby comparison areas did not differ significantly and increased over time, children in the project area gained less weight and had smaller waist circumference measures (about 3 cm) after several years of the project. Project results were also promising in reducing obesity-related health inequalities: in Colac, changes in weight and other measures were not related to children’s SES, while in the comparison group the more disadvantaged children experienced greater unhealthy weight gain.

There are also a number of international community based obesity prevention programs.

Ensemble prévenons l’obésité des enfants (EPODE) – ‘together, let’s prevent obesity in children’ – is a community-based, family-oriented nutrition and lifestyle education methodology from France. The initiative involves local physical activity and healthy eating strategies aimed at parents and children, with engagement of influential community groups and individuals, including education and health professionals, retailers and the media.

At the local level, the program is led by a number of key partners supported by the Ministry for Health and Family, with private sector partners (including food and insurance companies) that have committed human and technical resources as well as US$1 million. While results from the 10 pilot towns will be published in 2009, initial results appear promising; for example, in one town, the prevalence of overweight children decreased markedly between 2004 and 2005 (from 19% to 13.5%).

The EPODE program now covers almost 1.8 million inhabitants in 225 French cities, 32 cities in Spain and 13 cities in Belgium (in all communities) and five cities in Greece, with implementation also planned for South Australia. In South Australia, it is called the Obesity Prevention and Lifestyle (OPAL) program and is to be implemented over five years with $22.3 million investment, with approximately 20 councils involved.
‘The challenge is to increase the number and reach of sustainable community programs that build on existing efforts and to prioritise those most in need’ (Quote from submission)

The Taskforce believes that it is important to generate new evidence about community-based obesity prevention initiatives within the Australian context. However, it is important that these community-based interventions are of a sufficient intensity and are adequately funded for a period of time that allows evidence of effectiveness to be assessed. Experience tells us that small-scale, ad hoc projects will not deliver results in obesity prevention. An integrated, well-funded, sustained effort is required.

The Taskforce suggests the following approaches:

- Establishing, as part of the COAG Healthy Communities initiative, a national series of comprehensive five-year intervention trials in 10 to 12 communities (including low SES and Indigenous communities), with a major focus on healthy eating and active living, building on effective approaches within Australia and internationally

- Development of strategies to mobilise and engage local communities including:
  - Development and delivery of a national healthy community leadership and education program
  - Establishment of an online national forum for organisations, local governments, businesses and industry, community groups, families and individuals to share their commitments and plans to making Australia the healthiest country
  - The development of a national recognition and award scheme for outstanding contributions, large and small, to making Australia the healthiest country by 2020

- Development, piloting and implementation of a new Healthy and Active Families initiative as an additional intervention to the activities proposed for Healthy Communities sites, beginning with the intensive intervention sites and rolling out successful program elements as results become available. This may include:
  - Provision of education that encourages parents to be positive role models for their children through healthy eating and regular physical activity
  - Locally targeted information on family-oriented physical activity opportunities
  - Development of programs that involve all family members within sporting and community clubs
  - Offering free/subsidised physical activity and nutrition programs in public spaces such as parks, beaches and recreation centres (for example, introduce free outdoor gym equipment in recreational areas)

The Taskforce recognises the important role that local governments can play in promoting healthy lifestyles. The role of local government in relation to urban design and infrastructure and the link to physical activity and sedentary living has already been discussed. The Taskforce suggests that as part of the Healthy and Active Families initiative outlined above, funding should be allocated to local governments and community organisations to support development of programs that aim to get families healthy and active and include a focus on existing infrastructure (for example, fun at the pool days, active parks programs).

Action 3.3

Fund, implement and promote comprehensive community-based interventions that encourage people to improve their levels of physical activity and healthy eating, particularly in areas of disadvantage and among groups at high risk of overweight and obesity.
Key action area 4: Encourage people to improve their levels of physical activity and healthy eating through comprehensive and effective social marketing

Effective and coordinated social marketing campaigns are needed to increase physical activity levels and improve eating habits. These campaigns should inform, encourage and motivate individuals and families to make changes to their lifestyles.

The best evidence on the effectiveness of social marketing campaigns indicates that long-term, well-funded, sustained campaigns underpinned by qualitative research are necessary to achieve behaviour change. Compelling evidence from areas such as tobacco control, drink driving/road safety, immunisation, sun protection and HIV/AIDS, as well as the commercial sector, shows that appropriately targeted investment in social marketing can provide health and economic gains across populations.[125-128] Lessons from these campaigns are transferable to obesity management and prevention.

The Go for 2&5 campaign in Western Australia, conducted between 2002 and 2005, comprised a comprehensive range of strategies including mass media advertising, public relations events, a website, point-of-sale promotions, and school and community activities. Over the campaign period, awareness of dietary fruit and vegetable recommendations increased among the target audience of adults. In addition, there was an increase in population consumption of 0.2 servings for fruit and 0.6 servings for vegetables per day. (129)

Queensland Health has invested $4.4 million over 4.5 years (2005–10) in a statewide Go for 2&5 social marketing campaign strategy. Prior to the implementation of the campaign in 2005, adult consumption of fruit and vegetables was 3.5 serves per day, around half the recommended intake. Phase one increased fruit and vegetable consumption by an average 0.4 serves per person per day in the target age group in January–March 2006. Ongoing campaign tracking has shown a peak increase of 1.1 serves per person per day. Data suggests that recent price increases in fruit and vegetables and long off-air periods have eroded some of the gains in fruit and vegetable consumption. Final evaluation data will be available in mid-2010. (130)

The eventual evaluation of the Australian Government’s Measure Up campaign will provide valuable evidence in refining and targeting future communication strategies. Building on these campaigns at the state and territory and national level is essential to an effective approach.

Results demonstrate the importance of extended periods of campaign implementation to sustain accompanying knowledge, intentions and behaviour changes. The importance of televised media campaigns broadcast at sufficient exposure levels over relatively frequent intervals in achieving population behaviour change has been clearly demonstrated for tobacco in decreasing population smoking levels. This research highlights the need for such campaigns to be ongoing to sustain population-level change. (131)

A significant challenge to the promotion of healthy eating and physical activity behaviours is the fact that advertising for energy-dense nutrient-poor (EDNP) products generally promotes behaviours that compete with public health recommendations and strengthen potentially negative or challenging behaviours. (132, 133) Even during a major national nutrition campaign, exposure to healthy fresh food advertising is likely to be much lower than that for unhealthy food, unless investment in social marketing is significantly increased. Data collection on food advertising undertaken in 2005, at the same time as the Go for 2&5 fruit and vegetable promotion was screened, showed fruit and vegetable advertisements to comprise 4.6% of total food advertisements during children’s viewing periods (as defined by the Children’s Television Standards). During the same period, high-fat, high-sugar food
advertising comprised 81.5% of total food advertisements; the observed differences have significant implications for the impact of nutrition promotion campaigns.[134]

SMALL CHANGES CAN MAKE A DIFFERENCE

Some studies have found that using an approach aiming at small changes (such as increasing daily walking) in a community setting has been effective in halting weight gain and in achieving weight loss. A ‘small changes’ approach has also been successful in increasing total physical activity, decreasing total energy intake, and halting or lowering excessive weight gain. It has been suggested that such approaches could thus be used to stop the rise in obesity while broader environmental and societal changes are made.[135]

Even small estimates of behavioural change associated with health programs can translate into significant impacts at the population level.[132] Research suggests that an additional 2000 steps daily is adequate to prevent weight gain in adults, increasing energy expenditure by around 100 kilocalories. This level of activity is achievable by most people through brisk walking for around 20 minutes.[135] Reducing energy intake by the same amount is equivalent to the consumption of one chocolate biscuit.

The Taskforce proposes that the NPA would work with Australian, state and territory governments to develop and implement a comprehensive, sustained social marketing strategy to increase healthy eating, physical activity and reduce sedentary behaviour. This strategy would build on existing campaigns, including Measure Up and state campaigns such as Go for 2&5, Find Thirty and Go for Your Life. The key elements of these social marketing campaigns would include:

- Fund media campaigns long term, at national and state level, on a par or potentially above what should be expended on tobacco to achieve this sustainability and level of impact – to ensure commercially realistic funding
- Ensure mass media is accompanied by funded local programs and skills development at the local level
- Implementation is repeated and broad, with scaled-up campaigns nationally, using above and below the line media nationally, using above and below the line media that are sustainable and have impact beyond immediate timeframe
- Place media for maximum reach among low SES groups and others at particular risk of overweight and obesity, including providing extra reach for the most socially disadvantaged groups and areas through, for example, further television, radio, outdoor, transit and other local advertising
- Establish governance around social marketing activities and co-ordination of approaches – determine the overseeing role of the NPA in partnership with government and non-government sectors
- Choose messages most likely to reduce prevalence in socially disadvantaged groups and provide extra reach to these groups

**Action 4.1**

**Fund effective national social marketing campaigns to increase physical activity and healthy eating and reduce sedentary behaviour; and support people to make informed choices about their health.**
Key action area 5: Reduce exposure of children and others to marketing, advertising, promotion and sponsorship of energy-dense nutrient-poor foods and beverages

It is now accepted by international health agencies such as WHO that restrictions on food and beverage marketing directed to children should form part of a comprehensive and multifaceted strategy to address the growing problem of childhood obesity. WHO has recognised that food marketing to children, particularly television advertising, is an important area for action to prevent obesity,(63) and has called upon governments to implement policies and strategies that reduce the impact of foods high in fat, sugar and salt, and promote the responsible marketing of foods and beverages to children.(26)

There is also growing international consensus that food advertising influences children’s food preferences, diet and health, and that this influence is harmful to children’s health, as most advertising to children is for products high in salt, sugar and fat.(136) International reviews have concluded that heavy marketing of fast food outlets and energy-dense micronutrient-poor foods and beverages is likely to be causative in weight gain or obesity.(63) Statistical evidence indicates that exposure to television advertising is associated with adiposity or body fatness in children aged 2–11 years and young people aged 12–18 years.(137) US research examining the effects on childhood obesity of television fast food restaurant advertisements targeted at children has found a strong association between exposure to fast food restaurant advertising and the probability of children being overweight.(138) Similarly, modelling to estimate the potential effects of reducing the exposure of 6–12-year-old US children to television food advertising on overweight and obesity prevalence predicts that reducing the exposure to zero would lower the prevalence of obesity from 17.8% to 15.2% for boys and from 15.9% to 13.5% for girls.(139)

Australian children’s exposure to television food advertising is amongst the highest in the world,(140) and a large proportion of these advertisements are for non-core or extra (EDNP) foods.(141-143) Australian children watching 20 hours of television or more per week (two hours and 51 minutes per day) are twice as likely to be overweight or obese as children who watch less television.(144) Evidence indicates higher rates of high-fat/high-sugar food advertisements on Australian television during children’s viewing hours, compared with adults’, and during popular children’s programs.(141)

The Taskforce has noted that the Australian Communications and Media Authority (ACMA) has released its draft Children’s Television Standards 2008 for public and industry comment. At this stage, ACMA is not proposing to introduce general restrictions on food and beverage advertising to children.

The draft standards do not impose general restrictions in relation to food and beverage advertising, arguing it would be a blunt form of regulatory intervention. However, they do propose to strengthen certain provisions regulating advertising to children. These proposals would further restrict the use of licensed characters, popular personalities and celebrities to promote and endorse products immediately before, during and after ‘C’ and ‘P’ periods. They would also clarify rules for premium offers, such as toys offered with food and beverage purchases.

The Taskforce believes there is a need to address persuasive marketing techniques (including premium offers, such as competitions, and the use of promotional characters, including celebrities and cartoon characters) to children. Persuasive marketing techniques are frequently used to advertise non-core foods to children, to promote children’s brand recognition and preference for advertised products. Recent Australian research examined children’s exposure to the
use of persuasive marketing (within television food advertisements). The study found that significantly more food advertisements were broadcast during children’s peak viewing times, compared to non-peak times, contained promotional characters and premium offers. During programs most popular with children, there were 3.3 non-core food advertisements per hour containing premium offers, compared to 0.2 per hour during programs most popular with adults. The majority of advertisements containing persuasive marketing during all viewing periods were for non-core foods.\(^\text{[145]}\)

The Taskforce believes that restrictions on the advertising and promotion of unhealthy food and drink are required to reduce children’s overall exposure to the marketing of EDNP foods. In addition, the Taskforce also believes there is a need to curtail the use of specific persuasive marketing techniques in the marketing of these foods. A staged approach will be required, commencing with the phasing out of marketing of these products on free-to-air and Pay TV before 9 pm. Television advertising has significant reach, and has been shown to independently influence children’s food preferences and purchasing requests.\(^\text{[137, 146]}\)

Phasing out the marketing of unhealthy foods during peak viewing periods and during periods when children and young people are likely to be watching television would help to reinforce and normalise healthy eating for Australian children, and enable them to make healthier food choices. Children are a distinct group of media consumers whose cognitive abilities require special consideration in relation to the content and presentation of advertising.

**DISPLACEMENT OF ADVERTISING**

Experience from tobacco control indicates that when restrictions do not cover all media, marketing is likely to become concentrated in those media that are not covered, or not as heavily restricted.\(^\text{[147]}\) This will need to be monitored carefully over time.

Research indicates that food marketers are responding to pressures to reduce television advertising by increasingly using print and new technologies, such as the internet, mobile phone text messaging and email to target children.\(^\text{[148]}\) These other non-broadcast media are often used by children without parental supervision, making them more difficult for parents to monitor and control.\(^\text{[149]}\)

**CURRENT INDUSTRY SELF-REGULATION IN AUSTRALIA**

The Responsible Children’s Marketing Initiative,\(^\text{[150]}\) developed by the Australian food and beverage industry, came into effect in January 2009, with the stated aims:

‘to ensure that a high level of social responsibility in marketing communication and marketing food and beverage products in Australia is maintained’\(^\text{[11]}\)

‘to provide a framework for food and beverage companies to promote healthy dietary choices and lifestyles to Australian children’.\(^\text{[150]}\)

RESPONSIBLE CHILDREN’S MARKETING INITIATIVE

Member organisations of the Australian Food and Grocery Council (AFGC) have voluntarily committed to the initiative, with 15 companies signed up at 24 April 2009.

Participating companies are required to publish individual company action plans outlining how they will meet the core principles of the initiative, including publicly committing to marketing food and beverages to children under 12 only when the products are healthy dietary choices consistent with government standards, AND when they are presented in the context of a healthy lifestyle encouraging good dietary habits or physical activity. The standards by which their products are assessed include Dietary Guidelines for Australians and School Canteen Guidelines.

This initiative applies to marketing communications directed to children under 12 in media where the audience is predominantly children and/or the programs are directed primarily to children. The key to determining whether programs are designed for children is whether the themes, visuals, language and concepts are those that are appropriate to children under 12. This includes all ‘P’ and ‘C’ programs, but also includes a number of G-rated programs which, based on the criteria outlined above, are considered to be designed for children.

The program is supported by an independent complaints resolution mechanism run by the Advertising Standards Bureau, with The George Institute for International Health acting as an independent arbiter.

Independent evaluation of this initiative will be important to assess the effect on children’s exposure to food marketing and promotion. The AFGC has announced it will commission a study over a period of 12 months from the commencement of the initiative, to monitor advertising to children and assess industry response. Industry is currently working on an independent monitoring project. Participating companies have also agreed to report their marketing activity and communication against their plans on an annual basis.

Source: Information provided by the AFGC

The limitations of this approach include:

- Specific times when the code applies are not specified, and the onus is on individual companies to ensure that they do not advertise in programs where the audience is predominantly children and/or having regard to the theme, visuals, and language used are directed primarily to children.
- Some companies define ‘targeting children under 12 years’ on television to be when the majority of the audience is under 12 years, which is extremely rare.
- Only some companies in the food industry are represented, due to the voluntary nature of the scheme.
- There are no specified nutrient criteria used to define healthy and unhealthy foods; making monitoring difficult.
- While complaints and compliance systems have been developed, including a public complaints program, there are no specified deterrents to ensure food companies will comply with the industry’s code. However, the AFGC advises that sanctions are to be developed.
- The code does not cover food marketing on food companies’ own websites, only paid advertising on third-party websites.
- The code does not cover forms of promotion such as sports sponsorship.

The AFGC has announced it will commission a study over a period of 12 months from the commencement of the initiative, to monitor advertising to children and assess industry response. However, independent evaluation of this initiative will be important to assess the

13 For example, OzTAM ratings data for January–June 2006 indicate no time slots across weekdays or across weekends when children 0–14 years comprise the majority of the overall viewing audience across commercial channels.
14 This covers the majority of food and beverage companies that produce HSFF products and that advertise to children.
effect on children’s exposure to food marketing and promotion, and determine whether there is a need for further action.

INTERNATIONAL REGULATION

There are extensive legislative prohibitions on advertising to children in Sweden and Norway, and in the Canadian province of Quebec. In Sweden and Norway, commercial advertising directed to children on television is prohibited, while in Quebec the commercial advertising (of all products and services, not just food) targeted at children via any medium is prohibited. In all of these countries, the ban is enforced by a government agency.[153]

The UK’s broadcasting regulator Ofcom began phasing in restrictions on the advertising of food products high in fat, salt and sugar (HFSS products) to children in 2007, in response to concerns about child obesity. HFSS advertisements were banned from children’s programming (aimed at children aged under 16 years) on most channels, and progressively reduced on children’s channels. The first review of these restrictions compared children’s exposure to HFSS advertising in 2005 with that in July 2007–June 2008. The review estimated that over this period the amount of HFSS advertising seen by children on television fell by 34%. Children were also reportedly exposed to less food and drink advertising using licensed characters such as cartoon and film characters, and fewer advertisements with brand equity characters, free gifts and health claims, while advertising featuring celebrities had increased.[154]

Ofcom expects further reductions in children’s exposure to advertising to have occurred following the implementation of the final phase of restrictions which occurred in January 2009, when all remaining HFSS advertising on children’s channels (on Pay TV) was required to be removed.[154]

In the United States, legislation was passed in March 2009 establishing an Interagency Working Group on Food Marketed to Children.[155] The group will examine how food is marketed to children, develop recommendations on food marketing standards to children under the age of 17 and establish which products are suitable to be advertised to this age group, as well as the scope of the media to which the standards should apply. Members will come from the Federal Trade Commission, Food and Drug Administration and the Centers for Disease Control and Prevention, as well as the Secretary of Agriculture. The group is to report by July 2010.

COMMUNITY VIEWS

There is strong community support for the introduction of restrictions on advertising to children. Significant concern about the frequency and nature of unhealthy food advertising targeted at children and support for restrictions has been demonstrated in numerous state and national community surveys in Australia,[156, 157] including strong support for government regulation.[156, 158]

In 2007, the Coalition on Food Advertising to Children (CFAC) led a campaign supporting the need for better regulations to protect children from food advertising. Member organisations collected over 20,000 postcards signed by community members supporting the campaign.[159] Several state jurisdictions are considering regulating the marketing of unhealthy food and beverages to children. For instance, the South Australian and Queensland governments announced consultations into television food and drink advertising for children in late 2008. In South Australia, the government has indicated a preference for national action, but will consider the introduction of state-based restrictions if national agreement is not reached. Health ministers in New South Wales and Western Australia have also called for restrictions on unhealthy food advertising to children.[160]
IN SUMMARY

In the area of food advertising to children, a topic that has been the subject of much controversy and community debate, several important new studies and reviews have been published (referred to above). These add to the substantial body of evidence that has been accumulating since the 2007 publication of the review of children’s television advertising prepared for ACMA. The Taskforce also commissioned work in this area.

The Taskforce finds that, on balance, the weight of evidence of the negative effects of inappropriate food advertising on children’s knowledge, attitudes, food preferences and consumption is now sufficiently compelling to recommend ameliorative action.

The Taskforce notes that reducing children’s exposure to the promotion of unhealthy foods alone will not solve the obesity problem, but in concert with the other actions recommended we believe – based on the available evidence – that it will make a significant contribution.

The Taskforce therefore recommends that a phased approach to reduce the exposure of children and others to marketing, advertising, promotion and sponsorship of EDNP foods and beverages is required as one of the key areas of action needed to tackle the obesity epidemic.

The Taskforce proposes that the marketing of EDNP foods and beverages on free-to-air and Pay TV before 9pm should be phased out within four years.

The Taskforce proposes that this measure should be accompanied by a focus on phasing out the use of premium offers, toys, competitions and promotional characters, including celebrities and cartoon characters, to market EDNP food and drink to reduce the exposure of children to this advertising across all media sources.

The Taskforce also proposes that the advertising of EDNP food and drink across other media sources is monitored as restrictions come into place across television to determine if there is a need to develop additional measures across other media sources.

To inform the implementation of this process, an appropriate set of definitions and criteria for determining EDNP food and drink will be developed and adopted.

The phased approach would include:

- Monitoring and evaluating the impact of self-regulation in reducing children’s exposure to unhealthy food advertising
- Identifying shortfalls and any other issues in the current voluntary approach, and addressing these through the introduction of a co-regulatory agreement; monitor and evaluate the effectiveness of co-regulation
- Introduce legislation if these measures are not effective in phasing out
- Marketing of EDNP food and beverages on free-to-air and Pay TV before 9 pm
- Premium offers such as toys, competitions and the use of promotional characters, including celebrities and cartoon characters, to market EDNP food and drink to children
- Consider whether there is a need for additional measures to address EDNP advertising across other media sources

Action 5.1

*Phase out the marketing of energy-dense nutrient-poor food and beverages on free-to-air television and Pay TV before 9 pm within four years. Phase out premium offers, toys, competitions and the use of promotional characters, including celebrities and cartoon characters, to market EDNP food and drink to children across all media sources. Develop and adopt an appropriate set of definitions and criteria for determining EDNP food and drink.*
Key action area 6: Strengthen, skill and support primary healthcare and public health workforce to support people in making healthy choices

“The Primary Health Care system has an important role within the whole of society, integrated approach to chronic disease”
(Quote from submission)

The role and contribution of the primary healthcare setting in terms of preventative health are outlined in Chapter 1 of this Strategy. Around 85% of Australians visit their GP each year. Primary healthcare is therefore an important setting because it is often the first point of contact with the health system for a person seeking information about their own health or that of their family. GPs and the broader primary care workforce can provide assessment, information and support to encourage Australians to be healthier throughout their life.

In tackling obesity, it is crucial to target patients in primary care settings, at all levels of prevention. The first priority is to reduce the risk of becoming overweight – to interrupt, prevent or minimise the progress of unhealthy weight gain at an early stage, and to attempt to halt and reduce existing disability and damage associated with unhealthy weight gain.

For those who are already overweight or obese, there is a need to offer services and support to ensure that they do not continue to gain weight, and ideally to support them to lose weight. This often requires access to suitable specialist care and high-quality, expert, multidisciplinary team care.

There is evidence that programs delivered by multidisciplinary teams may be more effective at maintaining weight loss(161) when typically there is a high degree of relapse in weight loss for overweight and obese people.(162, 163) There are also clear benefits of team care in improving chronic disease management.(164, 165)

Multidisciplinary patient care teams may include health professionals from a range of areas, such as a physician, dietitian, exercise expert, nurse and behavioural therapist/psychologist.(165)

There are a range of measures that could be implemented to improve the effectiveness of the primary healthcare setting in promoting health. The approach recommended by the Taskforce is outlined in Chapter 1.

Specifically in relation to the prevention of obesity, the Taskforce recommends a focus on workforce strategies for allied health to expand the supply of the allied health workforce available, particularly within the public system and in rural areas. The Taskforce also recognises that there are a number of existing barriers to individuals accessing health services that are appropriately resourced and skilled to deliver integrated assessment, support, advice and follow up regarding nutrition, physical activity and weight loss consistent with best practice.

Funding, implementing and promoting evidence-based clinical guidelines and other multidisciplinary training packages for health and community workers, and ensuring a quality-driven approach to prevention in primary care, are specifically recommended. Also, there are a number of existing clinical guidelines relating to overweight and obesity that have not been fully implemented due to a number of barriers. Strategies should be developed to ensure the increased awareness and implementation of best practice clinical approaches as set out in the guidelines.

It is recognised that addressing the lifestyle factors relevant to the prevention of obesity is most appropriately integrated with other risk factors for chronic disease; for example, drinking at risky levels and smoking. There is also a need to ensure Australia has an appropriate workforce with expertise in health promotion. This workforce will be essential to supporting and facilitating the cultural and organisational changes that will be required in key settings such as workplaces, local government and...
schools. The Taskforce believes that the approach outlined in Chapter 1 will deliver benefits in terms of achieving an integrated best practice approach to preventative health.

**Action 6.1**

*Contribute to relevant national policies (for example, the National Primary Health Care Strategy) to ensure key actions to improve preventative health are considered and implemented in the primary care setting. These may include:*

- Expanding the supply of relevant allied health workforce and number of funded positions
- Ensuring all individuals have easy access to health services that provide physical activity, weight loss and healthy nutrition advice and support
- Funding, implementing and promoting evidence-based clinical guidelines and other multidisciplinary training packages for health and community workers

**Key action area 7: Address maternal and child health, enhancing early life and growth patterns**

**THE CASE FOR PREVENTION**

The importance of maternal and child health in ensuring a healthy start to life is outlined in Chapter 1. There is a growing realisation and a substantial body of evidence highlighting the important links between maternal health and subsequent child health.

The epidemiological and experimental evidence supports a relationship between growth and development during foetal and infant life, and health in later years, noting two major implications:

‘First, it reinforces the growing awareness that investment in health and education of young people in relation to their responsibilities during pregnancy and parenthood is of fundamental importance. Secondly, any rational approach to healthcare should embrace a life course perspective.’[166]

These considerations have been recognised by WHO in consultations on diet, nutrition and chronic disease:

‘The outcome of a pregnancy must be considered in terms of maternal and neonatal health, the growth and cognitive development of the infant, its health as an adult, and even the health of subsequent generations.’[63]

The evidence for this paradigm has come through numerous epidemiological studies of men and women in middle life, who have accurate birth weight records. Typical of these studies is the UK study of individuals from Hertfordshire, used by the Barker group. [167] Such studies provide evidence for the association of low birth weight and increased risk for hypertension, type 2 diabetes, metabolic syndrome, depression, cardiovascular diseases and mortality. As obesity prevalence is highest in low-income populations, intensive efforts will be required in disadvantaged communities.

A baby’s growth rate in utero and beyond is, in part, determined by parental factors, especially with regard to the mother’s diet, and what and how she feeds her baby, as well as other environmental factors (for example, smoking and alcohol intake), and potentially dietary toxins. Conditions in early life may continue to have an impact on health risks in adult life, illustrating one aspect of the intergenerational component of obesity.

There is also evidence that the period soon after birth is a time of metabolic plasticity. Factors in the environment, such as nutrition, can have long-lasting consequences in that they appear to set the baby on a particular developmental trajectory. While there is less evidence of a direct link between birth weight and obesity, weight gain in early life appears to be critical.
There are serious adverse effects of overweight during pregnancy, with the risk of complications increased for both mother and baby. (168) Obstetric risk increases with BMI among overweight and obese women. (169) Therefore, programs targeting pregnant women that cover healthy eating, physical activity and maintaining a healthy weight could enhance obstetric outcomes and reduce healthcare costs of obesity-related increases in maternal and neo-natal morbidity.

PREGNANCY

The intrauterine environment influences the risk of developing type 2 diabetes. Hyperglycaemia in pregnancy is associated with an increased risk of childhood obesity. (170) More research is needed to determine whether Gestational Diabetes Mellitus (GDM) may be a modifiable risk factor for childhood obesity. (171)

There is increasing evidence that the presence of obesity and/or type 2 diabetes in the mother can be associated with the development of obesity and/or type 2 diabetes in the child in later life. The offspring of diabetic pregnancies are often large and heavy at birth, developing obesity in childhood and at high risk of developing type 2 diabetes at an early age. (172) Such individuals have lower insulin secretion than similarly aged offspring of non-diabetic pregnancies. (173) A substantial part of the excess risk of diabetes in the offspring of diabetic pregnancies appears to be the result of exposure to the diabetic intrauterine environment. Among offspring born to mothers before and after the development of type 2 diabetes, those born after the mother developed diabetes have a three-fold higher risk of developing diabetes than those born before. (174) The enhanced risk among the offspring from diabetic pregnancies among such women is therefore the result of intrauterine programming that has long-term effects on the child in later life.

BREASTFEEDING AND NUTRITION IN CHILDHOOD

Breastfeeding and early growth patterns provide the only period in which there is clear evidence to support the concept of a critical period of development associated with long-term consequences. Other stages of childhood, however, may offer good opportunities to modify behaviour. For example, there is limited evidence that behaviours such as liking fruit and vegetables can be established in early childhood. (175)

Breast-fed babies show slower growth rates than formula-fed babies, and this may contribute to the reduced risk of obesity later in life shown by breast-fed babies. (176) Observational studies suggest a longer duration of breastfeeding to be associated with a decrease in the risk of overweight in later life. As a result, in Europe and the United States high priority has been placed on research strategies investigating the effects of breastfeeding to prevent the development of obesity. (177-180)

In addition to the protective role breastfeeding may have in several chronic diseases, breastfeeding (including delaying the introduction of solids until babies are six months old) plays an important role in helping to prevent obesity in children. (181) This has been attributed to physiological factors in human milk as well as feeding and parenting patterns associated with breastfeeding. Weaning practices are also thought to be important, given the association between the characteristic weight gain seen in early childhood at approximately five years of age (early adiposity rebound) and later obesity. (182, 183)

The proportion of children receiving breast milk declines steadily with age. (184) While the proportion of Australian infants ever breast-fed was around 86–88% between 1995 and 2005, in 2001 less than half (48%) of all infants were receiving any breast milk at the age of six months, and none were being exclusively breast-fed. (181)
In 2001, the proportion of Australian children receiving breast milk was higher among more highly educated and older mothers (aged over 30 years). Indigenous mothers in non-remote areas appear to be less likely to initiate and continue breastfeeding than other Australian mothers.

There is a need to ensure the development of targeted interventions to improve maternal and child health among low SES and Indigenous women, as well as for younger and less educated mothers, particularly in regard to increasing levels and duration of breastfeeding.

The national toll-free breastfeeding helpline was recently upgraded (March 2009) to provide 24-hour support and breastfeeding information through Australian Government funding. Funding has also been allocated to providing training for health professionals and research to support breastfeeding, including barriers and enablers to breastfeeding, indicators of breastfeeding rates and the development of dietary guidelines for pregnant and breastfeeding women.

It is recognised that the Taskforce should work with other relevant groups to ensure the implementation of programs in maternal and child health that are likely to deliver benefits in relation to obesity prevention.

**Key action area 8: Support low-income communities to improve their levels of physical activity and healthy eating**

**SOCIAL DETERMINANTS OF INEQUALITIES IN OBESITY**

“The proposed approach (as described in the October 2009 Taskforce discussion paper) addresses the need for specific initiatives for disadvantaged groups, recognises the value of health workforce development and the value of building the evidence base.” (Quote from submission)

Any serious effort to promote wellbeing, prevent ill health and reduce health inequities must address the social determinants that shape the way people grow, live, work and age, which ultimately affect their health. Social determinants are the combination of structural factors and daily living conditions that ultimately determine health and health equity. An unequal distribution of factors supporting the opportunity to be a healthy weight underlies the unequal distribution of obesity observed in developed countries.

The effect of social structure on inequalities in the distribution of weight is suggested by epidemiological trends and patterns of obesity, illustrated in Figure 2.3 below.
Interventions directly aimed at encouraging people to improve their eating behaviours and increase their physical activity levels will not address underlying social determinants.\(^ {81}\) There is a need to acknowledge the role of the complex global social system that is driving the obesity epidemic and determines the social gradient of obesity rates. Obesity prevention can only be achieved through addressing inequities in the social system, providing:

- A sufficient, nutritious food supply
- Local urban planning and design that provide access to healthier choices for all, especially low-income earners
- Sufficient, equal material and psychosocial resources to support healthy living options for individuals and communities across all social groups

*The global obesity epidemic is unequally distributed within and between countries. It is being fuelled by economic and psychosocial factors as well as the increased availability of energy-dense food and reduced physical activity. Tackling it requires concerted action at national and international levels to promote a more equal distribution of affordable nutritious food, and improved, more equitable living and working conditions.*\(^ {81}\)
The increased prevalence of obesity is associated with significantly decreased energy expenditure, as well as dietary changes that have been occurring around the world since the mid-20th century, involving a greater intake of more refined foods, meat and dairy products containing high levels of saturated fats. Significant changes in food systems and behaviours have meant that dietary energy is increasingly available and readily accessible, with factors including: trade liberalisation exposing more countries to international markets; food subsidies contributing to a food supply that favours unhealthier food products; a global market in which EDNP foods cost little to produce; buying in bulk, convenience foods and supersized serves being promoted through the displacement of small stores and stalls by supermarkets and chains. (81)

**BARRIERS TO HEALTHY LIVING AMONG LOW-INCOME AUSTRALIANS**

Prices influence behaviour and choices, particularly among those on lower incomes, pensioners and the unemployed. Low income should not be a barrier to participation in physical activity or access to healthy food options. (49)

Poorer families, the elderly and Indigenous people are more likely to live in the outer suburbs, and more likely to live in depressed rural communities with poor or ageing physical activity infrastructure. Poorer members of the community are further disadvantaged by: (49)

- Transport policy and urban planning that is dominated by the car (rather than public transport, walking and cycling)
- Urban planning that fails to provide for accessible physical activity, sport, recreation, walking and cycling
- The high cost of physical activity, recreation and sport

**Action 8.1**

*Fund, implement and promote effective and relevant strategies and programs to address specific issues experienced by people in low-income communities, such as lack of access to affordable, high-quality fresh food.*

**Action 8.2**

*Fund, implement and promote multi-component community-based programs in low SES communities.*

**Action 8.3**

*Provide resources for brief interventions from the primary healthcare setting.*
Key action area 9: Reduce obesity prevalence and burden among Indigenous Australians

Among Aboriginal and Torres Strait Islander people, high body mass is the second highest contributor to disease burden (11.4%), after tobacco use (12.1%). In comparison, among the general Australian population, high body mass is the third highest contributor to disease burden (7.5%), after tobacco use (7.8%) and high blood pressure (7.6%).

In 2004–05, approximately 60% of Indigenous Australians aged 18 years and over were overweight, of whom 31% were obese. Indigenous Australians were 1.9 times as likely to be obese and over three times as likely to be morbidly obese (BMI >40).

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

NUTRITION-RELATED HEALTH AND INDIGENOUS AUSTRALIANS

“The enormous inequity in food availability and affordability for Indigenous Australians alone is a very fundamental issue to be addressed if there is any hope of ‘Closing the Gap’ (Quote from submission)

The majority (75%) of Indigenous Australians live in urban areas, while 25% live in remote communities. Reflecting this distribution, those living in urban areas constitute 60% of the health gap. Therefore strategies to improve Indigenous health must include a focus on rural, remote and urban communities.

Diet has been indicated as a risk factor in 57% of all deaths in Australia, based on Australian Bureau of Statistics (ABS) deaths data in 1983. Many of the main causes of ill health among Aboriginal and Torres Strait Islander peoples are nutrition-related conditions, such as heart disease, type 2 diabetes and renal disease.

Recent Aboriginal and Torres Strait Islander-specific health data indicate that the majority of Aboriginal and Torres Strait Islander peoples aged 12+ years reported some daily intake of vegetables (95%) and/or fruit (86%). Access to such fresh food may be more difficult for Aboriginal and Torres Strait Islander peoples in remote areas, as one in five (20%) of those living in remote areas reported no usual daily fruit intake compared with one in eight (12%) in non-remote areas. This difference was even greater for vegetables: 15% of people in remote areas reported no usual daily intake compared with 2% in non-remote areas.

Among those living in non-remote areas, 42% were eating the recommended daily intake of fruit and 10% the recommended daily intake of vegetables. While the intake of vegetables was broadly similar between Aboriginal and Torres Strait Islander and non-Aboriginal and Torres Strait Islander peoples, Aboriginal and Torres Strait Islander people generally reported eating less fruit than non-Aboriginal and Torres Strait Islander people. These questions were not recorded for remote and urban locations.

PHYSICAL ACTIVITY AND HEALTH OF INDIGENOUS AUSTRALIANS

The rationale for increasing the focus on physical activity among Aboriginal and Torres Strait Islander people is compelling. In 2004–05, information was collected relating to the frequency, intensity and duration of exercise undertaken by Aboriginal and Torres Strait Islander people living in non-remote areas. The proportion of Aboriginal and Torres Strait Islander people in non-remote areas who were sedentary or engaged in low-level exercise in the two weeks prior to interview was higher in

15 Based on results of the 2004–05 National Aboriginal and Torres Strait Islander Health Survey (NATSIHS) and adjusting for differences in the age structure of the Indigenous and non-Indigenous populations and survey non-response for height and weight measurements.
2004–05 (75%) than in 2001 (68%). In 2001 around 43% of Aboriginal and Torres Strait Islander adults living in remote areas reported no leisure-time physical activity, compared to about 30% of other Australians in the same areas.

Recreation, fitness, sports, active living, access to parks, arts and culture all contribute to social and emotional wellbeing, enhanced quality of life, fine motor skill development, overall health and weight control.

**KEY ACTIONS TO REDUCE THE BURDEN OF OBESITY AMONG INDIGENOUS AUSTRALIANS**

Key specific actions to reduce the high burden of disease due to obesity among Indigenous Australians include resourcing of interventions from the primary healthcare setting; strengthening antenatal, maternal and child health systems for Indigenous communities; and implementing multi-component community-based programs.

**INTERVENTIONS FROM THE PRIMARY HEALTHCARE SETTING**

Brief interventions on diet and exercise have been shown to be effective in the mainstream community to decrease fat consumption, increase fibre consumption and increase physical activity. There is no evaluated evidence specific to the Australian Indigenous context. Brief intervention programs for physical activity and nutrition for Aboriginal and Torres Strait Islander peoples are being piloted in Queensland, with future impact and outcome evaluation to be included in service expansion.

Successful interventions are likely to be dependent on the same factors as for alcohol and tobacco: adequate resourcing to allow a focus on non-acute issues, training, public health expertise on staff, and quality improvement systems. Follow-up sessions to the initial consultation are critical to improvements over the long term.

Notwithstanding the powerful effects of social determinants of health such as relative and absolute poverty, lack of education and powerlessness, a well-resourced and robust primary healthcare has significant potential to contribute to closing the Indigenous health gap.

**ANTENATAL, MATERNAL AND CHILD HEALTH SERVICES**

Poor nutrition in the first years of life and low birth weight are associated with lifetime higher rates of overweight and obesity, and increased risk of chronic disease later in life. Well-resourced and best-practice antenatal, maternal and child health services are a core component of comprehensive primary healthcare, and should include antenatal care, encouragement and support of breastfeeding, programs to monitor infant growth and development, support and advice to parents about child nutrition, and child growth monitoring and action. All primary healthcare services serving Indigenous communities should be resourced to deliver such services as a critical investment in future health.

There are numerous examples of health services that have acted on maternal and child health effectively, including Central Australian Aboriginal Congress, the Townsville Aboriginal and Islander Health Service, Nganampa Health Council, Maari Ma Health Aboriginal Corporation and the Northern Territory Government’s *Strong Women, Strong Babies, Strong Culture.*
MULTI-COMPONENT COMMUNITY-BASED HEALTHY LIFESTYLE PROGRAMS

‘Healthy lifestyle’ programs have been shown to be effective in the Australian Indigenous context in improving biochemical markers of chronic disease risk and health indicators,(197-200) and effective in overseas Indigenous populations in increasing physical activity.(201)

There are lessons to be learned from some interesting examples of interventions targeting Indigenous communities that are currently being implemented in Queensland. For example, Living Strong is a healthy lifestyle program for Aboriginal and Torres Strait Islander communities.17 Process evaluation has guided the development of the program, while impact and outcome evaluation is still to be conducted.

Depending on local community priority and capacity, possible areas for action in community-based health programs include nutrition, the availability and affordability of healthy food (for example, at community stores), and physical activity. Increasing opportunities for activity could include subsidised, affordable access to gyms, swimming pools and sporting facilities.(189) Ensuring that the physical and social environment in Indigenous communities is conducive to safe participation in physical activity would need to be addressed, along with providing participation opportunities for Aboriginal and Torres Strait Islander children at school and at home, including physical education at school.(49)

Possible models for implementation to maximise the affordability and availability of fresh food in remote areas include the Outback Stores program set up by the Australian Government in 2006, now running in stores across the Northern Territory and in Western Australia, and the subsidisation of fresh food costs in remote areas.(202)

It is also important to note the strong evidence that outstation living and access to traditional lands is associated with reduced risk of obesity, improved physical health and overall lower chronic disease risk and mortality.(203-207)

THE COST OF FOOD

Australians living in rural and remote areas are among those at particular risk of food insecurity.(72) In 2006 a healthy food basket cost on average 29% more (ranging from 24% to 56%) in remote areas of the Northern Territory compared with Darwin.(208)

A study in a remote Northern Territory Indigenous community found that food in general cost 50% more than in Darwin, and that families spent an average of 38% of their income on food and non-alcoholic beverages, compared with 14% for the average Australian household and 30% for low-income non-remote Australian households.(208)

At least 44% of household income and significant changes in purchasing patterns would be required to achieve dietary recommendations. While community members reported a preference for fresh produce, more than half the average energy intake in the community came from white bread and flour, sugar and milk powder, products that provide most calories for least cost, store well and divert hunger. However, when factors including store management and leadership, workforce development and improved infrastructure were addressed through a ‘whole of store’ approach, sales of fruit and fresh vegetables increased. Thus, while still facing significant economic barriers, people in the community purchased more fruit and vegetables when given the opportunity.(208)

The actions recommended in this strategy to address the availability of fresh food will have a positive impact on Indigenous communities in regional and remote locations. Strategies to improve access to healthy foods among rural and remote Indigenous Australians include:

- The provision of vouchers to buy a weekly basket of nutritious foods
- The examination of patterns of transport and marketing to reduce barriers to the trade of fresh local foods
- The support of economic development opportunities such as agriculture and horticulture, and the development of traditional food resources
- The provision of adequate remote food storage infrastructure
- The development of the Indigenous workforce in remote and rural stores.

It is critical to ensure the implementation and maintenance of relevant recommendations from the National Indigenous Health Equality Summit, including targeting healthy living practices such as the ability to store, prepare and cook food being available in three-quarters of all houses by 2013. Poor-quality diet in the Indigenous population is a significant risk factor for three of the major causes of death (cardiovascular disease, cancer and type 2 diabetes). Poor nutrition among many Indigenous people is associated with disadvantaged socioeconomic circumstances.

**INTERVENTIONS AMONG INDIGENOUS COMMUNITIES**

There is a lack of well-evaluated nutrition, physical activity and health programs for Aboriginal and Torres Strait Islander peoples. The results of research in remote Aboriginal and Torres Strait Islander communities of Australia indicate that community-directed nutrition programs, addressing both food supply and demand issues, can clearly improve a range of risk factors for chronic disease and that improvements can be maintained. A decrease in the prevalence of low birth weight children has been seen in Aboriginal and Torres Strait Islander communities associated with the implementation of culturally appropriate maternal and child health and nutrition programs.

Community involvement, management and ownership have been identified as essential components of any program promoting health in Aboriginal and Torres Strait Islander peoples, including those addressing overweight and healthy lifestyles.

**Action 9.1**

Fund, implement and promote effective and relevant strategies and programs to address specific issues experienced by people in Indigenous communities, such as lack of access to affordable, high-quality fresh food.

**Action 9.2**

Strengthen antenatal, maternal and child health systems for Indigenous communities.

**Action 9.3**

Fund, implement and promote multi-component community-based programs in Indigenous communities.

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18 On 18–20 March 2008, the National Indigenous Health Equality Summit was held in Canberra. The outcome was a statement of intent and a report detailing a series of targets aimed at achieving health status and life expectancy equality between Indigenous and non-Indigenous Australians by 2030. In December 2007 the Council of Australian Governments (COAG) agreed to a partnership between all levels of government to ‘Close the Gap’ on Indigenous disadvantage; notably, to close the 17-year gap in life expectancy within a generation and to halve the mortality rate of indigenous children within 10 years. The report is available at www.hreoc.gov.au/social_justice/health/targets/index.html.
Key action area 10: Build the evidence base, monitor and evaluate effectiveness of actions

DEVELOP A COMPREHENSIVE NATIONAL RESEARCH AGENDA FOR OVERWEIGHT AND OBESITY

“Creating new evidence from innovative and untested strategies and projects should be considered alongside those strategies and interventions that we know work”

(Quote from submission)

There is a clear need to increase the evidence base regarding obesity prevention and management through research, evaluation, monitoring and surveillance. This requires a much higher investment in research and evaluation related to weight reduction interventions and the causes of obesity.19

The development of a comprehensive national research agenda for obesity is essential. It is also vital to develop an agreed national assessment tool and reporting levels for overweight and obesity, particularly as they relate to children, young people and minority groups. A specific research agenda must be developed with appropriate levels of public and private funding, which must be supported by improved monitoring and harmonisation of surveillance systems across Australia. If the relative lack of evidence on obesity prevention and management is to be addressed, existing and future interventions require well-designed, rigorous evaluation (including economic analysis such as the assessment of cost-effectiveness).

19 The Australasian Child and Adolescent Obesity Research Network (ACACORN) has called for increased funds targeted specifically at childhood obesity research, and for a national childhood obesity research agenda. In an examination of funds allocated by major medical research funding bodies to obesity, ACACORN found, for example, that 5% of funding in the NHMRC December 2008 statement was for obesity-related projects (with a small proportion for childhood obesity). Bour LA, Wake M, Espinel PT. Audit of Australian childhood obesity research funding 2005–09. On behalf of the Australasian Child and Adolescent Obesity Research Network (ACACORN). April 2009.

Partnerships between the NPA and the National Health and Medical Research Council (NHMRC), the Australian Research Council (ARC) and other state-based research funding organisations such as health promotion foundations and non-government organisations will be important to ensure a coordinated investment in research and evaluation. Clearly the establishment of the NPA would greatly assist a coordinated approach and would be a mechanism for achieving this. Such an agency would be able to commission research and develop targeted social marketing and public education campaigns. This mechanism would also be used to coordinate national media advertising with local program delivery, and to evaluate campaign effectiveness. The success of the National Tobacco Campaign and the recent Measure Up campaign clearly indicates that such models for campaign development, implementation and evaluation are feasible and well accepted by all those involved. There is a unique opportunity to build upon the recent experience with the Measure Up campaign, and to ensure this momentum is maintained.

NATIONAL DATA COLLECTION – ADULTS

The Taskforce has identified the need to establish a comprehensive national surveillance system focused on the behavioural, environmental and biomedical risk factors for chronic disease (including factors such as food availability and food composition) to track and report on performance and outcomes, including the impact of health inequalities. The current plans to enhance nutrition and physical activity data through the collection of national biomedical data are strongly supported by the Taskforce. This data should be collected on an ongoing basis every five years through the National Health Risk Survey and other national data bases, and must include the capacity to collect data from the Australian Indigenous population.
Such a database will assist with the monitoring and reporting of the COAG National Partnership Agreement on Preventive Health performance indicators and allow reports on progress in achieving the COAG partnership interim targets.

NATIONAL DATA COLLECTION – CHILDREN AND ADOLESCENTS

There is also a need to ensure there is an appropriate mechanism for the ongoing collection of national data on children. This should cover two components. Firstly, the capacity to repeat at regular intervals the Australian National Children’s Nutrition and Physical Activity Survey undertaken in 2007. Secondly, the Taskforce is very supportive of the national data collection to be undertaken among adolescents by the state Cancer Councils, Cancer Council Australia and the National Heart Foundation of Australia, which will commence in 2009.

This survey aims to build on the well-established Australian Secondary Students’ Alcohol and Drug (ASSAD) surveys, and will monitor overweight and obesity prevalence, eating and physical activity behaviours among a nationally representative sample of around 20,000 secondary school students from year levels 8 to 11. Measured height, weight and waist circumference, food intake, dietary habits, physical activity, sedentary behaviour, barriers and enablers of physical activity and data on the school food and activity environment will be collected. This will be a rich data source and will enable ongoing monitoring of the attitudes and behaviour of adolescents, a group that is very important to influence if we are going to successfully halt and reverse the current trend in overweight and obesity in Australia.

EVALUATION OF INTERVENTIONS IN INDIGENOUS COMMUNITIES

There are several key principles for successful interventions in the Indigenous context,(189) including ensuring programs are adequately resourced for evaluation and monitoring so they can contribute to intervention policy knowledge. The evidence of ‘what works’ to address alcohol, tobacco or obesity is in some cases highly developed, but this evidence base is predominantly from mainstream and/or overseas populations. Taking account of this evidence is important. However, given the need to work with Indigenous communities’ own histories, priorities and capacities, flexibility and innovation on the basis of the evidence is likely to be more effective than attempts to rigidly apply interventions that worked elsewhere. It is important to ensure that programs contribute to evidence-based intervention policy knowledge through adequate resourcing for evaluation.

Indigenous communities require evidence-based approaches that are reflective and that involve the local community in adapting what is known to be effective elsewhere to local conditions and priorities. Obesity, tobacco and alcohol are not necessarily the top priorities for all communities. Any sustainable program needs to make provision for flexibility and negotiation between local priorities and program priorities. Community-controlled health services and their peak bodies provide an important arena in which the dialogue between community priorities and an evidenced-based approach to population health challenges can take place.

Action 10.1

NPA to develop a national research agenda for overweight and obesity with a strong focus on public health, population and interventional research.
Action 10.2

Ensure that the National Health Risk Survey Program will cover:
- Adults
- The Indigenous population

Action 10.3

Ensure that the National Children’s Nutrition and Physical Activity Survey is repeated on a regular basis to allow for the ongoing collection of national data on children.

Action 10.4

Support ongoing research on effective strategies to address social determinants of obesity in Indigenous communities.

ISSUES OUTSIDE THE SCOPE OF A NATIONAL PREVENTATIVE HEALTH STRATEGY

A few issues highlighted during the consultation and submission process were outside the scope of a National Preventative Health Strategy. The Taskforce provides the following comments in relation to two of these issues in the obesity area.

IS THERE A ROLE FOR THE COMMERCIAL WEIGHT-LOSS INDUSTRY IN PREVENTION?

There are currently inadequate regulations and voluntary codes of practice which apply to weight loss products and programs. A plethora of over-the-counter products and programs are available and promoted for weight loss in Australia, including through pharmacies, many with unsubstantiated claims of efficacy. Insufficient consultant training, lack of qualified supervision and no capacity to individually tailor advice and plans have been identified as common problems in a range of pharmacy-based weight loss programs in Australia. While these kinds of products and services cannot be recommended as part of a national obesity prevention strategy, it is an area that needs to be addressed through adequate action to ensure Australians have access to effective weight loss products and services. For complementary medicines, this would be addressed through the Therapeutic Goods Association (TGA); for the weight-loss industry, this is likely to be achieved through the Trade Practices Act.

There is a need to develop mechanisms that ensure safe industry practices within the commercial weight-loss industry and ensure access to effective weight loss products and services, including:

- Development of a national accreditation system (for example, based on the Weight Management Code of Practice, administered by the Weight Management Council of Australia) for weight management programs (including minimum training standards for consultants, nutritional standards, and eligibility criteria such as age of clients)
- Identification of a responsible administering body, and consideration of monitoring, compliance, enforcement and sanctions
- Implementation of industry and consumer education regarding the accreditation standards and criteria

20 Consultation was undertaken by the TGA for a draft guideline on evidence for listed medicines with indications and claims for weight loss (February–April 2009). See www.tga.gov.au/cm/consult/drweightloss.htm. The effectiveness of TGA requirements for listings of herbal and complementary medicines (for example, lack of burden of proof and product analysis) compared with requirements for registration of pharmaceutical drugs has been questioned; see www.thecardinalnews.com.au/story/0,25197,25306329-23289,00.html.

21 This would require review as the Weight Management Code of Practice applies to businesses in the Weight Management Industry who are members of the Weight Management Council of Australia; this has very limited membership (five companies) given the size of the commercial weight-loss industry. See www.weightcouncil.org/Activity.asp?page=350.
BARIATRIC SURGERY

Bariatric surgery is the most effective weight-loss treatment in severely obese patients. (162) It is being increasingly used in the treatment of obesity, particularly in the private health sector. However, there is no role for this procedure in the obesity prevention arena. Bariatric surgery is considered appropriate in well-defined clinical situations such as morbid obesity where non-operative methods (such as behavioural interventions) have failed. Appropriate protocols for this procedure, covering guidelines on patient selection, assessment (medical and psychological) and post-operative monitoring, should be followed. (162)

The Taskforce also notes that the lack of access to high quality publicly funded behavioural approaches to obesity management is potentially distorting choices in favour of surgery.
Summary Tables

**OBESITY: IMPLEMENTATION PLAN**

Summary of action required and how progress will be measured

<table>
<thead>
<tr>
<th>Key Action Areas</th>
<th>Responsibility</th>
<th>Staged Implementation</th>
<th>Measurement</th>
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<tbody>
<tr>
<td>Key action area 1: Drive environmental changes throughout the community which increase levels of physical activity and reduce sedentary behaviour</td>
<td>Lead agency: All governments (Australian/ state/ territory/local). Partners: Industry peak bodies; professional groups (e.g. planners and developers); building industry, developers transport groups; active living consumer and advocacy (e.g. cycling organisations); Australian Sports Commission, sporting bodies, health groups.</td>
<td>Years 1–4 Establish a Prime Minister’s Council for Active Living to provide high level leadership and oversee the development of the National Framework for Active Living. A National Framework for Active Living will identify key impediments and enablers of physical activity in relation to the built environment, transport and social engagement. This will include reviewing: - Built environment – relevant Australian and state government legislation (including building codes), planning guidelines including examples of good practice that incorporate healthy living (e.g. Healthy Spaces and Places, Healthy by Design). - Transport – relevant transport policy and guidelines including examples of good practice in active transport (e.g. TravelSmart, national cycling strategy). - Social engagement – strategies and initiatives to promote social engagement in active living and sport.</td>
<td>Prime Minister’s Council for Active Living established. National Framework developed and implementation commenced in agreed timelines. Population measures of physical activity for adults and children. Population measures of participation in sports and active recreation including cycling and walking. Infrastructure funding programs that include a focus on active transport and recreation.</td>
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<td>Years 5–8 Implement the National Framework.</td>
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<td>Years 8–10 Monitor and report on progress with the implementation.</td>
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<tr>
<td>KEY ACTION AREAS</td>
<td>RESPONSIBILITY</td>
<td>STAGED IMPLEMENTATION</td>
<td>MEASUREMENT</td>
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<td>1.2 Develop business case for a new COAG National Partnership Agreement on Active Living.</td>
<td>Lead agency: All governments (Australian/state/territory/local). Partners: Expert groups; NPA; community groups; sporting associations; non-government organisations.</td>
<td>The Framework for Active Living will inform the development of the business case for consideration by COAG. Years 1–4 The business case will be developed in tandem with the development of the Framework for Active Living described above. Implement the national partnership agreement if approved by COAG.</td>
<td>The business case for a new COAG National Partnership Agreement on Active Living is developed within three years.</td>
</tr>
<tr>
<td>1.3 Australian and state governments to consider the introduction of health impact assessments in all policy development (including urban planning, school education, transport), using partnership models such as the Health in All Policies (HiAP) approach in South Australia.</td>
<td>Lead agency: Australian, state and territory governments.</td>
<td>Years 1–4 Examine existing approaches in Australia including the Health in All Policies (HiAP) approach in South Australia and overseas. Implement a trial of appropriate approaches across a range of priority policies and portfolios. Monitor and evaluate effectiveness of approaches. Implement the system.</td>
<td>Health Impact assessment process trialed. Health Impact assessment process adopted. Health Impacts associated with policies are explicitly identified and considered at an early stage.</td>
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<tr>
<td>1.4 Commission a review of economic policies and taxation systems, and develop methods for using taxation, grants, pricing incentives and/or subsidies to:</td>
<td>Lead agency: Expert group in consultation with Treasury. Partners: Australian/state/territory/local governments; NPA; planners, developers, building industry; workplace/employer groups; private health insurance industry; sporting, public health and non-government organisations.</td>
<td>Years 1–4 Independent review commissioned and completed. Baseline measures collected. Implement review recommendations and develop strategies to overcome existing barriers and maximise opportunities. Implement monitoring system to measure impact of changes. Years 5–8 Review progress and consider need for additional measures.</td>
<td>Review commenced and work completed within 12 months. Introduction of new and/or modified relevant economic and taxation policies. Effect of economic and taxation policies on behaviour (particularly for disadvantaged populations). Population measures and trends in physical activity, active living and sedentary behaviour for adults and children. Changes in community knowledge, attitude, awareness, intention and behaviour. Population measures of car use, public transport, walking and cycling to work and school.</td>
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Key action area 2: Drive change within the food supply to increase the availability and demand for healthier food products, and decrease the availability and demand for unhealthy food products

| Lead agency: Australian Government. Partners: Whole-of-government; industry (including food, agriculture, horticulture, transport, planning and development, retailers, manufacturers, primary producers, restaurants); consumer groups; professional and public health organisations. | Years 1–4 Development of the National Food and Nutrition Framework that articulates a policy framework and key actions for government, industry and other partner organisations to achieve a safer, healthier and more sustainable food supply. It will: Ensure that issues relating to healthy eating and nutrition are considered appropriately within the same policy context as food safety, food supply and environmental issues Provide an opportunity to strengthen partnerships | National food supply framework developed. Relevant stakeholders engaged and participating. Public sector agencies adopting standards for healthier food in their workplace. Other workplaces adopting standards for healthier food in their workplace. Code of Good Practice for Food established and implemented. Compliance with the code. Price, quality, availability and source of fresh food. Healthy food basket surveys: prices of fresh foods in regional, remote and disadvantaged areas. |

- Price, choice and access to food and food security through open and competitive markets
- Achieving healthier diets
- Food safety
- Issues related to food production and agricultural policy that ensure a safe and environmentally sustainable food chain and food supply
<table>
<thead>
<tr>
<th>KEY ACTION AREAS</th>
<th>RESPONSIBILITY</th>
<th>STAGED IMPLEMENTATION</th>
<th>MEASUREMENT</th>
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<tr>
<td><strong>2.2 Commission a review of economic policies and taxation systems, and develop methods for using taxation, grants, pricing, incentives and/or subsidies to:</strong></td>
<td>Lead agency: Expert group in consultation with Treasury. Partners: Australian/state/territory/local governments; NPA; food industry (retail sector; food service; manufacturers; marketing and promotions; primary producers; horticulture); transport sector; workplace/employer groups; public health organisations.</td>
<td>Years 1–4</td>
<td>Review completed within 12 months.</td>
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<tr>
<td></td>
<td>Promote the production of healthier food and beverage products, including reformulation of existing products</td>
<td>Independent review commissioned and completed. Baseline measures collected. Implement review recommendations including any new measures. Develop strategies to overcome existing barriers and maximise opportunities. Implement monitoring and evaluation system.</td>
<td>Introduction of new measures.</td>
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<td></td>
<td>Increase the consumption of healthier food and beverage products</td>
<td></td>
<td>Impact of measures on behaviour (particularly for disadvantaged populations).</td>
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<tr>
<td></td>
<td>Decrease the production, promotion and consumption of unhealthy food and beverage products</td>
<td></td>
<td>Trends in pricing of food and beverage products and related services (transport, storage, infrastructure).</td>
</tr>
<tr>
<td></td>
<td>Promote healthy weight</td>
<td></td>
<td>Production, availability, price and promotion of healthier food products (requires assessment of ‘healthiness’ of food products).</td>
</tr>
<tr>
<td><strong>2.3 Examine and develop systems and subsidies that increase the availability of high-quality, fresh food for regional and remote areas, focusing on:</strong></td>
<td>Lead agency: Australian Government. Partners: State/territory and local governments; industry (transport, food, agriculture and horticulture industry); NPA; community groups; health groups.</td>
<td>Years 1–2</td>
<td>Price, quality, availability and source of fresh food.</td>
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<tr>
<td></td>
<td>Regional and remote transport</td>
<td>Consultation and development of best practice approach. Review existing transport and marketing systems and subsidies related to fresh food in regional/remote areas. Develop or revise systems to increase fresh food availability. Collection of baseline measures on price, quality and source of fresh foods. Implement approach in selected regional and remote communities and refine as necessary.</td>
<td>Healthy food basket surveys: prices of fresh foods in regional and remote areas.</td>
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<td></td>
<td>Increasing the production of high-quality, locally grown fresh foods that are available to the local community</td>
<td></td>
<td>Consumer expectations, attitude awareness, intention and behaviour for fresh food.</td>
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<td>Years 3–4</td>
<td>Availability, quality and proportion of food grown locally.</td>
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<td>Implement best practice approaches across regional and remote Australia. Monitor impact of changes and introduce amendments as necessary.</td>
<td>Retail outlet purchase/ordering/sales data and transport/manufacturer data: measure of proportion of fresh foods from local source versus transported.</td>
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<td>Promotion of fresh food in local area.</td>
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<td>KEY ACTION AREAS</td>
<td>RESPONSIBILITY</td>
<td>STAGED IMPLEMENTATION</td>
<td>MEASUREMENT</td>
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| 2.4 Drive change within the Australian food supply by establishing a Healthy Food Compact between governments, industry and nongovernment organisations to reduce the production and promotion of foods and beverages that are energy dense and nutrient poor, are high in sugar, fats, saturated fats and salt, and which contain trans fats, by setting targets for these nutrients. | Lead agency: Australian Government. Partners: Food industry; professional organisations; relevant public health and consumer organisations. | Years 1–4
- Establish the Healthy Food Compact.
- Examine the feasibility of providing incentives to the food industry to reformulate existing products or develop new ones to produce healthier alternatives. Examine successful approaches to date within Australia and internationally.
- Develop voluntary targets with the food industry (e.g. targets to reduce levels of energy, sugar, saturated fat, salt and trans fat; and standard portion sizes).
- Collect baseline measures.
- Implement reporting, monitoring and surveillance system.
- Implement strategies in partnership with the food industry to reformulate existing products or develop new ones.
- Review uptake and effectiveness of voluntary targets. If voluntary reformulation is ineffective, introduce government regulation to decrease levels of saturated fats, sugar and salt in foods and remove trans fats. | Uptake of voluntary targets by industry.
Products reformulated and/or new products developed.
Compliance with targets.
Consumer knowledge, attitude and awareness.
Consumption of foods and beverages that are energy dense and nutrient poor, are high in sugar, fats, saturated fats and salt, and which contain trans fats.
Uptake of incentives by industry. |
| Years 5–8
- Use the Healthy Food Compact to continue to drive improvements within the food supply.
- Implement measures agreed to under the Healthy Food Compact. | | |
| Years 9–11
- Monitor and report on progress with the implementation of measures agreed to under the Healthy Food Compact. | | |
### Key Action Areas

#### Key Action Area 2.5: Introduce food labelling on front of pack and menus to support healthier food choices with easy-to-understand information on energy, sugar, fat, saturated fats, salt, and trans fats, and a standard serve/portion size within three years in partnership with industry, health and consumer groups.

**Responsibility**
Lead agency: Australian Government/state/territory governments (AHMC). Partners: Food industry; public health organisations; consumer organisations; NPA.

**Staged Implementation**
- New food labelling system commences within three years.
  - **Years 1–2**: Implement a national trial of appropriate approaches across a sample of products. Review international experience with food labelling; monitor and evaluate effectiveness of approaches.
  - **Year 3**: Implement a national system with appropriate information, monitoring and enforcement systems.

**Measurement**
- Consumer knowledge, awareness, and understanding of food labelling and amount of energy, sugar, fat, saturated fats, salt, and trans fat in food.
- Consumer understanding of portion sizes.
- Consumer ability to use food labelling system to assist them in making healthier food choices.
- Consumer purchase behaviour and sales data.
- Consumer choices in quick service restaurants.
- Changes in the nutrient composition or availability of individual products or portion size.

#### Key Action Area 3.1: Fund, implement and promote school programs that encourage physical activity and enable healthy eating.

**Responsibility**
Lead agency: Australian Government. Partners: State/territory and local governments; education sector; NPA; school community including families, parents and teaching staff.

**Staged Implementation**
- **Years 1–4**
  - Build on existing approaches at state and territory level and enhance partnerships with the education sector.
  - Ensure a curriculum entitlement to HPE for all Australian children by incorporating HPE into the second stage of National Curriculum development.
  - Australian and state governments to establish a national program to support implementation of the new curriculum, including teacher curriculum guidance and professional development opportunities.
  - Education sector to encourage all schools to develop, implement and evaluate health, nutrition and physical activity policies.
  - Ensure implementation of the policy requirement of at least two hours of physical activity per week for all students K–10.
  - Expand coverage of out-of-school care health programs such as Active After School, Eat Smart, Play Smart.
  - Improved access to school-based recreational facilities by the community, especially after hours and in neighbourhoods that lack park and recreational facilities.

**Measurement**
- Number of schools with food and nutrition policies.
- Number of schools with physical activity policies, including school travel and active transport.
- Number of schools implementing the National Healthy School Canteens Project.
- Proportion of children meeting physical activity guideline recommendations.
- Proportion of children undertaking at least two hours of physical activity in schools per week.
- Proportion of children using active transport to and from school.
- Number of hours per week school children are participating in sport and recreation.
3.1 Fund, implement and promote school programs that encourage physical activity and enable healthy eating.

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<thead>
<tr>
<th>KEY ACTION AREAS</th>
<th>RESPONSIBILITY</th>
<th>STAGED IMPLEMENTATION</th>
<th>MEASUREMENT</th>
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</thead>
<tbody>
<tr>
<td>Promotion and support through state and territory governments for the National Healthy School Canteens Project, ensuring a nationally consistent approach.</td>
<td>National implementation of the Health and Physical Education (HPE) curriculum for all Australian children as part of the second stage of the National Curriculum development.</td>
<td>Monitor policy requirement of at least two hours of physical activity per week for all students K–10. Monitor and evaluate impact.</td>
<td>Scale up most effective approaches.</td>
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<tr>
<td>A comprehensive national approach to phasing out soft drinks in school canteens and vending machines.</td>
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<td>Ensure key policy elements are appropriately reflected within the National Prevention Agreements.</td>
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Years 5–8

Years 9–11
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<th>KEY ACTION AREAS</th>
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<tr>
<td>3.2  <strong>Fund, implement and promote comprehensive programs for workplaces that</strong></td>
<td><strong>Lead agency:</strong> Australian Government.</td>
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<tr>
<td><strong>support healthy eating, promote physical activity and reduce sedentary</strong></td>
<td><strong>Partners:</strong> State/territory governments; local government; workplace health program providers; employer groups and unions; workplace insurers.</td>
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<td><strong>behaviour.</strong></td>
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<td><strong>Years 1–4</strong></td>
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<td></td>
<td><strong>Fund, implement and promote comprehensive workplace programs through the COAG Healthy Workers initiative including:</strong></td>
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<td>- Development of a national accord to establish best practice principles for workplace programs including protecting the privacy of employees, workplace risk monitoring, risk assessment or risk modification programs.</td>
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<td>- Development of a voluntary industry scorecard, benchmarking and award scheme for workplace health.</td>
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<td>- Development of nationally agreed accreditation standards for providers of workplace health programs.</td>
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<td>- Development of a national action research project to strengthen evidence of effective workplace health promotion programs in the Australian context.</td>
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<td>- Establish a national workplace health leadership program and a series of resources, tools and best practice guidelines.</td>
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<td>- A review of potential legislative changes to promote take up of workplace health programs, for example changes to Fringe Benefits Tax Assessment Act, reforms to the Private Health Insurance Act and/or employer commitment to a percentage of annual payroll allocated to workplace health programs (similar to the former Training Guarantee Levy).</td>
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<td></td>
<td>- Investigation of the feasibility of rewarding employers – through grants or tax incentives – for achieving and sustaining benchmark risk factor profiles in their workforce.</td>
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<tr>
<th>STAGED IMPLEMENTATION</th>
<th>MEASUREMENT</th>
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<tbody>
<tr>
<td>National accord developed.</td>
<td>Uptake of voluntary scorecard and benchmark by industry.</td>
</tr>
<tr>
<td>Voluntary industry scorecard and benchmark developed and adopted by industry.</td>
<td>National action research program commenced.</td>
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<td>Increased number of workplaces implementing health policies with a focus on food and nutrition and physical activity.</td>
<td>Increased number of workplaces with health programs.</td>
</tr>
<tr>
<td>Uptake of voluntary scorecard and benchmark by industry.</td>
<td>Uptake of workplace policies and programs by public sector agencies at the Australian/state/territory/local government level.</td>
</tr>
<tr>
<td>Accreditation standards developed.</td>
<td>Active transport to and from work, level of physical activity and healthy eating by employees.</td>
</tr>
<tr>
<td>National action research program commenced.</td>
<td>Uptake of incentives by the private sector.</td>
</tr>
<tr>
<td>KEY ACTION AREAS</td>
<td>RESPONSIBILITY</td>
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</table>
| 3.2  Fund, implement and promote comprehensive programs for workplaces that support healthy eating, promote physical activity and reduce sedentary behaviour. | Years 5–8  
- Learn from best practice and promote effective workplace health promotion programs throughout Australia.  
- Implement recommendations of the review of potential legislative changes to promote take up of workplace health programs.  
- If feasible, implement system to rewarding employers for achieving and sustaining benchmark risk factor profiles in their workforce. | Years 9–11  
Scale up workplace programs that are most effective. |
| 3.3  Fund, implement and promote comprehensive community-based interventions that encourage people to improve their levels of physical activity and healthy eating, particularly in areas of disadvantage and among groups at high risk of overweight and obesity. | Lead agency: Australian/state/territory/local governments (COAG). Partners: NPA; ALGA; NGO/community agencies; research groups. | Years 1–4  
Establish, as part of the COAG Healthy Communities initiative, a national series of comprehensive five-year intervention trials in 10 to 12 communities, including low SES and Indigenous communities.  
Develop strategies to mobilise and engage local communities including:  
- Development and delivery of a national healthy community leadership and education program.  
- Establishment of an online national forum for organisations, local governments, businesses and industry, community groups, families and individuals to share their commitments and plans to making Australia the healthiest country.  
- The development of a national recognition and award scheme for outstanding contributions, large and small, to making Australia the healthiest country by 2020. | Knowledge, attitude, awareness and intentions of the community in regard to sedentary behaviour, physical activity and healthy eating.  
Population measures of nutrition and physical activity behaviours (by SES and LGA).  
Evaluation of the large-scale community trials as part of the Healthy Communities Initiative.  
Evaluation of the Healthy Active Families Initiative. |
<table>
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<th>KEY ACTION AREAS</th>
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<th>STAGED IMPLEMENTATION</th>
<th>MEASUREMENT</th>
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</table>
| 3.3 Fund, implement and promote comprehensive community-based interventions that encourage people to improve their levels of physical activity and healthy eating, particularly in areas of disadvantage and among groups at high risk of overweight and obesity. | Develop, pilot and implement a new Healthy and Active Families initiative as an additional intervention to the activities proposed for Healthy Communities sites. This may include:  
- Provision of education that encourages parents to be positive role models for their children.  
- Locally targeted information on family-oriented physical activity opportunities.  
- Development of programs in sporting and community clubs.  
- Offering free/subsidised physical activity and nutrition programs in public spaces such as parks, beaches and recreation centres.  
- Allocation of funding to local governments and community organisations to support development of programs that aim to get families healthy and active and include a focus on existing infrastructure.  
Years 5–8  
Implement programs. Monitor and evaluate impact and effectiveness to determine most effective approaches.  
Years 9–11  
- Scale up community interventions across Australia according to results of national trials. | | |
### Key Action Area 4: Encourage people to improve their levels of physical activity and healthy eating through comprehensive and effective social marketing

<table>
<thead>
<tr>
<th>Staged Implementation</th>
<th>Key Action Area 4: Fund effective national social marketing campaigns to increase physical activity and healthy eating and reduce sedentary behaviour, and support people to make informed choices about their health:</th>
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</thead>
<tbody>
<tr>
<td><strong>Years 1–4</strong></td>
<td>- Identify effective campaign messages through qualitative research and review of other campaigns. Build on effective campaigns to date (e.g. Go for 2 &amp; 5).</td>
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<td>- Ensure sufficient reach and frequency of campaigns.</td>
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<td>- Place media for maximum reach among low SES groups and others at high risk.</td>
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<td>- Strengthen partnerships with NGOs and industry to appropriately support the campaigns.</td>
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<td>- Implement the new campaigns.</td>
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<td>- Ongoing – evaluation and campaign tracking.</td>
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</table>

**Lead agency:** NPA.  
**Partners:** All governments (Australian/state/territory/local); non-government organisations; local communities; health professional organisations.

<table>
<thead>
<tr>
<th><strong>Years 5–8</strong></th>
<th>- Implement new phases of a comprehensive, sustained social marketing strategy to increase healthy eating and physical activity.</th>
</tr>
</thead>
</table>

**Years 9–11**          | - Report on progress with the social marketing strategy to increase healthy eating and physical activity and develop new phases as required. |

**Population measures of nutrition and physical activity behaviours (by SES and LGA).**  
Change in measures such as knowledge, attitudes, awareness, intention and behaviour relating to physical activity, healthy eating and sedentary behaviour. Understanding and recall of key campaign messages.
| Key action area 5: Reduce exposure of children and others to marketing, advertising, promotion and sponsorship of energy-dense nutrient-poor foods and beverages |
|---|---|---|---|
| **5.1** | **Lead agency: Australian Government.** **Partners: Industry (food, marketing); ACMA; health and consumer groups; broadcasting and media groups; retailers.** | **Years 1–3** | **Level of industry compliance with the restrictions.** **Level and type of public complaints.** **Children’s and adults’ exposure to food marketing – healthy food and beverages and EDNP food and beverages as determined by nutrient profiling.** **Sales data for specific products and product types.** **Use of persuasive techniques such as licensed characters and celebrities.** **Overall levels of advertising across all media.** **Advertising spending.** **Population surveys to monitor community attitudes towards restrictions over time.** |
| Phase out the marketing of EDNP food and beverage products on free-to-air and Pay TV before 9 pm within four years. Phase out premium offers, toys, competitions and the use of promotional characters, including celebrities and cartoon characters, to market EDNP food and drink to children across all media sources. Develop and adopt an appropriate set of definitions and criteria for determining EDNP food and drink. | Monitor and evaluate the effectiveness of the industry voluntary approach. Develop and adopt an appropriate set of definitions and criteria for determining EDNP food and drink. Introduce a co-regulatory approach to address any identified shortfalls in the voluntary approach and other issues. Monitor and evaluate the effectiveness of the co-regulatory approach. Year 4 Introduce legislation if these voluntary and co-regulatory approaches are not effective in: | | |
| | - Phasing out marketing of EDNP food and beverages on free-to-air and Pay TV before 9 pm. - Phasing out premium offers, toys, competitions and the use of promotional characters, including celebrities and cartoon characters, to market EDNP food and drink to children across all media sources. - Consider whether there is a need for additional measures to address EDNP advertising across other media sources. Year 5–8 Continue to phase out food and beverage marketing to which children are exposed if self-regulation and co-regulation are demonstrated to be ineffective. | | |
### Key Action Areas

**Key action area 6: Strengthen, upskill and support the primary healthcare and public health workforce to support people in making healthy choices**

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<tr>
<th>Key Action</th>
<th>Responsibility</th>
<th>Staged Implementation</th>
<th>Measurement</th>
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<tbody>
<tr>
<td>6.1 Contribute to relevant national policies (for example, the National Primary Health Care Strategy) to ensure key actions to improve preventative health are considered and implemented in the primary care setting. These may include:</td>
<td>Lead agency: Australian Government. Partners: State/territory government; National Primary Health Care Strategy External Reference Group; healthcare professionals and associations; health insurers; educational institutions.</td>
<td>Contribute to relevant national policies (e.g. The National Primary Health Care Strategy) to ensure that key actions that would improve preventative health are considered and implemented in the primary healthcare setting.</td>
<td>Increase in allied health workforce. Improved access to relevant allied health professionals and multidisciplinary teams. Appropriate referrals from GPs to allied health professionals. Curricula for all allied health professionals includes prevention of overweight and obesity. Guidelines for the clinical management of overweight and obesity are utilised. Increased number of health services providing healthy lifestyle advice and support. Appropriate referrals from GPs and other medical practitioners to health services providing healthy lifestyle advice and support.</td>
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<tr>
<td>- Expanding the supply of relevant allied health workforce and number of funded positions</td>
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<td>- Ensuring all individuals have easy access to health services that provide physical activity, weight loss and healthy nutrition advice and support</td>
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<td>- Funding, implementing and promoting evidence-based clinical guidelines and other multidisciplinary training packages for health and community workers</td>
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### Key action area 7: Address maternal and child health, enhancing early life and growth patterns

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<th>Key Action</th>
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<th>Staged Implementation</th>
<th>Measurement</th>
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<tr>
<td>7.1 Establish and implement a national program to alert pregnant women and those planning pregnancy to the ‘lifestyle’ risks of excessive weight, insufficient physical activity, poor nutrition, smoking and excessive alcohol consumption, and assist them to address these risks.</td>
<td>Lead agency: Australian Government. Partners: Maternity services (states and territories).</td>
<td>Years 1–4 Develop strategies to ensure women who are pregnant or planning a pregnancy receive appropriate information, advice and support from a range of sources (community based, GP primary care, antenatal and health services) to reduce their risk associated with unhealthy weight poor nutrition, lack of physical activity, alcohol use and smoking. Implement strategies and evaluate and monitor the impact.</td>
<td>National health promotion program and system of service delivery developed targeting women who are pregnant or planning pregnancy.</td>
</tr>
<tr>
<td>7.2 Support the development and implementation of a National Breastfeeding Strategy in collaboration with the state and territory governments.</td>
<td>Lead agency: Australian Government. Partners: NHMRC; maternity services (states and territories).</td>
<td>Contribute to the development of a National Breastfeeding Strategy to ensure appropriate consideration of obesity prevention issues and broader health benefits. Ensure key leadership roles and responsibilities at state/territory and Australian Government level are clearly articulated.</td>
<td>National Strategy developed. Proportion of mothers breastfeeding at three, six and 12 months. Knowledge, attitudes, awareness and intentions among women of child-bearing age.</td>
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<td>Key action area 8: Support low-income communities to improve their levels of physical activity and healthy eating</td>
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<tr>
<td><strong>8.1 Fund, implement and promote effective and relevant strategies and programs to address specific issues experienced by people in low-income communities, such as lack of access to affordable, high-quality fresh food.</strong></td>
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| **Lead agency:** Australian/state and territory governments.  
**Partners:** NPA. |
| **Ensure that all programs implemented under the strategy specifically target low SES (e.g., social marketing campaigns, community-based and school programs including the community trials). Primary care services located in disadvantaged areas will be supported to appropriately address behavioural risk factors. Other strategies will include provision of food vouchers with accompanying incentives to purchase healthy fresh foods; improvements to infrastructure and facilities to encourage and increase opportunities for incidental activity and organised sport.** |
| **Population measures and trends in physical activity, active living and sedentary behaviour for adults and children (low SES).**  
**Changes in community knowledge, attitude, awareness, intention and behaviour. Population measures of car use, public transport, walking and cycling to work and schools among low SES.**  
**Consumption of foods and beverages that are energy dense and nutrient poor, are high in sugar, saturated fats and salt, and which contain trans fats by low SES populations.** |
| **8.2 Fund, implement and promote multi-component community-based programs in low SES communities.** |
| **Refer to action 3.3.** |
| **Refer to action 3.3.** |
| **Refer to action 3.3.** |
| **8.3 Provide resources for brief interventions from the primary healthcare setting.** |
| **Refer to key area 6 and relevant actions.** |

| Key action area 9: Reduce obesity prevalence and burden in Indigenous communities and contribute to 'Close the Gap' |
|---|---|---|---|
| **9.1 Fund, implement and promote multi-component community-based programs in Indigenous communities.** |
| **Lead agency:** Aboriginal Community Controlled Health Services (ACCHS).  
**Partners:** National Aboriginal Community Controlled Health Organisation (NACCHO); NACCHO affiliates; Australian, state and territory governments; Menzies School of Health Research; Cooperative Research Centre for Aboriginal Health; other relevant academic institutions and public health groups. |
| **Years 1–4**  
Project sites identified. Baseline measures collected and evaluation strategy developed. Projects to be developed and led by local Indigenous communities. Organisation(s) with main responsibility for the projects depends on the location and nature of the projects, but may include local Indigenous health services, state/territory NACCHO affiliates, or regionally based associations of Indigenous health services. Projects may involve partnerships with Indigenous organisations from other sectors. These programs are linked with those listed under action 3.3.  
Projects funded and implementation commenced.  
Years 5–8  
Continue to implement programs. Monitor and evaluate to determine most effective approaches.  
Years 9–11  
Scale up community interventions across Australia according to results of evaluation and national trials. |
| **Percentage of Indigenous people aware of project activities.**  
**Changes in knowledge, attitudes, awareness, intention and behaviour in targeted compared to non-targeted communities in regard to nutrition and physical activity and sedentary behaviour.** |
### Key Action Areas

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<th>Key Action Area</th>
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<tr>
<td><strong>9.2</strong> Strengthen antenatal, maternal and child health systems for Indigenous communities.</td>
<td>Lead agency: ACCHSs. Partners: NACCHO and NACCHO affiliates; Royal Australian College of General Practitioners; Australian College of Rural and Remote Medicine; Australian General Practice Network; Australian Breastfeeding Association; Maternity Coalition; Australian College of Midwives; Council of Remote Area Nurses of Australia.</td>
<td>Years 1–4 Development of evidence strategies to strengthen antenatal, maternal and child health services for Indigenous communities. Implementation of strategies. Ongoing – evaluation.</td>
<td>Proportion of low birth weight infants &lt;2500 g. Proportion of children breast-fed to six months, 12 months and two years. Proportion of pregnant women presenting in first trimester for antenatal care.</td>
</tr>
<tr>
<td><strong>9.3</strong> Fund, implement and promote effective and relevant strategies and programs to address specific issues experienced by people in Indigenous communities such as lack of access to affordable high-quality fresh food.</td>
<td>Lead agency: Australian Government. Partners: State/territory and local government; social, welfare and community support organisations (e.g. ACOSS; public health and health promotion organisations); physical activity providers (e.g. gyms; swimming, tennis facilities) and cycling organisations.</td>
<td>Ensure that all programs implemented under the strategy specifically consider Indigenous communities. In particular, social marketing campaigns, community-based and school programs. Strategies to improve access to fresh food will also be particularly relevant. Additional specific strategies will be developed and implemented in consultation with Indigenous communities, building the evidence from the community-based programs.</td>
<td>Population surveys (physical activity levels, nutrition behaviours, overweight and obesity prevalence) and other specifically targeted surveys/data collection (e.g. qualitative data collection; specifically targeted respondent groups) for Indigenous people. Rigorous evaluation of trial programs.</td>
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### Key Action Area 10: Build the evidence base, monitor and evaluate effectiveness of actions

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<th>Key Action</th>
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<th>Staged Implementation</th>
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<tr>
<td><strong>10.1</strong> NPA to develop a national research agenda for overweight and obesity, with a strong focus on public health, population and interventional research.</td>
<td>Lead agency: NPA. Partners: Australian Government/state and territory Health Governments; ABS and AIHW; organisations/groups involved in public health research; NHMRC, CSIRO; NGOs and consumer groups.</td>
<td>Year 1 Development of a national research agenda. Development of links between researchers and policy makers and the field to enhance exchange of relevant information. Years 2–3 Funding and implementation. Year 4 Dissemination of key findings.</td>
<td>National research agenda completed within 12 months. Increase in funding provided for public health, population and interventional research into overweight and obesity. Knowledge of research findings among policy makers and the field.</td>
</tr>
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<td><strong>10.2</strong> Expand the National Health Risk Survey Program to cover adults and the Indigenous population.</td>
<td>Lead agency: Department of Health and Ageing. Partners: ABS and AIHW; organisations/groups involved in public health research; NHMRC, CSIRO.</td>
<td>Year 1 Survey to commence in 2010. The surveys are to include regular national data collection of comprehensive, up-to-date and representative health status and risk data for Australian adults and Indigenous people, including nutrition and physical activity behaviours, anthropometric measurements and biomedical data, with survey methods allowing comparison with other national surveys as well as the potential to develop a longitudinal dataset.</td>
<td>A national biomedical risk factor prevalence survey for adults and Indigenous Australians established and conducted in 2010 and then on a five-yearly basis.</td>
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<td>KEY ACTION AREAS</td>
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<tr>
<td>10.3  Ensure that the National Children’s Nutrition and physical activity survey is repeated on a regular basis to allow for the ongoing collection of national data on children.</td>
<td>Lead agency: Department of Health and Ageing. Partners: ABS and AIHW; organisations/groups involved in public health research; NHMRC, CSIRO.</td>
<td>Years 1–4</td>
<td>Australian National Children’s Nutrition and Physical Activity Survey (2007) repeated in 2012 and to include biomedical risk factor data.</td>
</tr>
<tr>
<td>10.4  Support ongoing research on effective strategies to address social determinants of obesity in Indigenous communities.</td>
<td>Lead agency: Australian Government. Partners: State/territory and local government; National Indigenous Health Equality Council; Aboriginal Community Controlled Health Organisations; Indigenous health staff and medical services; research/academic groups; health promotion organisations.</td>
<td>Commence within 12 months and ensure coverage within the national research agenda.</td>
<td>Research commenced and reported.</td>
</tr>
</tbody>
</table>
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CHAPTER 3: Tobacco: Towards world’s best practice in tobacco control

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CHAPTER 3: Tobacco: Towards world’s best practice in tobacco control

The case for prevention

‘Tobacco has a catastrophic but preventable impact on the health of Australians’ (Quote from submission)

The case for action on tobacco is clear. Since 1950, when the dangers of smoking were recognised, almost one million Australians have died because they smoked. (1)

Trends in recent years have been encouraging, (2) but there is no room for complacency while the death toll from tobacco continues. (3, 4) Thousands of young people each year start smoking. (5) Non-smokers are exposed to second-hand smoke. (2) Disadvantaged groups are disproportionately affected. (6-12) The overall cost of smoking to the economy is more than $30 billion each year. (13) And tobacco companies maintain efforts to promote sales of their lethal product. (14-16)

Australia has been among the global leaders in tobacco control – nationally, in the states and territories, and through the work of non-government organisations and researchers. At a time when the international commitment to tackling the tobacco problem has never been stronger, we have the opportunity to show the way to the rest of the world in terms of what can be achieved through a comprehensive, coordinated, evidence-based, long-term strategy that is conscious of the needs of the entire community.

We know what needs to be done. The strategies set out in this report are based on the best international evidence and research, together with advice from some of the world’s leading experts in tobacco control. We know what works in tobacco control; by contrast, we also know what does not work and should not be further pursued. We have also been assisted by some valuable insights from our consultations and submissions to the Taskforce. When implemented, this strategy will ensure that we have world’s best practice in tobacco control.

The target set by the Taskforce is that we should reduce daily smoking to under 10% by 2020. This will require a dramatic reduction in the numbers of children taking up smoking and in the percentage of smokers who try to quit. (17) But on the basis of evidence from Australia and internationally, we are confident that it is achievable. When we reach this target, we believe that smoking will continue to decline until rates are so low that it is no longer one of our most important health problems.

‘The target of further reducing the prevalence of smoking is achievable and can be advanced through collaboration with other key stakeholders’ (Quote from submission)

Achieving the target will require a strong commitment from all who can play a role in getting us there, and a special focus on working with and supporting disadvantaged groups and communities. Australia can also both be a role model for other countries and play a part in helping to implement similar policies, especially in low- and middle-income countries where tobacco promotion is rampant and tobacco control is in its infancy.

1 The International Framework Convention on Tobacco Control (FCTC) is the first treaty negotiated under the auspices of the World Health Organization (WHO). It was adopted by the World Health Assembly on 21 May 2003, and entered into force on 27 February 2005. See www.who.int/fctc/about/en/index.html for further details.
INDIVIDUALS CAN:

- Take action to stop smoking. The sooner a person quits, the more benefit they gain, not only from reduction of illness and early death but also in practical ways such as saving money and avoiding frequent breaks away from work. Individuals may need many attempts to quit for good but it is important to keep trying. (1) Those finding it difficult can:
  - Call the Quitline for information and counselling advice
  - Visit their GPs or ask their local pharmacist for help
  - Consider using medications that help lessen the effects of withdrawal from nicotine (18)

FAMILIES CAN:

- Give up smoking to increase the chances of having a healthy baby and to stop their children from taking up smoking. (19, 20)
- Establish good communication and relationships within the family. This makes it easier to discuss issues such as smoking – and quitting, (21) ensuring that young people know that smoking is addictive and that they should not experiment because of the health risks.

SCHOOLS CAN:

- Properly enforce smoke-free policies for staff, students and visitors alike.
- Use materials in the curriculum that incidentally increase understanding of the short and longer term effects of smoking.
- Include activities that raise awareness about smoking in drug education.
- Look for any evidence that retailers close to the school are selling cigarettes to students (and, if they are, ask the local council to take appropriate action).
- Be aware that students who are successful with their study and feel connected to their school are much less likely to take up smoking. (22)

WORKPLACES CAN:

- Discourage people from smoking near the entrances to buildings where they will be seen by (and cause difficulties for) quitters and ex-smokers when they enter and leave.
- Require anyone leaving the premises to smoke to do so in personal rather than company time.
- Not sell cigarettes from canteens or company shops.
- Offer bonuses to long-term employees who have quit and stayed smoke-free. Cash bonuses at one, three, six and 12 months after quitting could help individuals to maintain their resolve. A further bonus at five and 10 years after quitting could help employers retain valued staff.
Work carried out for the Taskforce shows that by simply implementing the two most important strategies recommended in this report (tax increases and extra media spend), we will see approximately one million fewer Australians smoking and will prevent the premature deaths of almost 300,000 Australians now alive just from the four most common diseases caused by smoking.(23)

The history of tobacco control shows the importance of adopting a comprehensive approach, as proposed in this strategy. Within that framework, measures such as removing all avenues for tobacco promotion, supporting disadvantaged groups and protecting non-smokers of all ages are emphasised as especial opportunities for early intervention.

The only significant opposition to this strategy will come from the tobacco industry, which in submissions disagreed with many of the major proposals in our Discussion Paper. We recognise that action designed to reduce smoking dramatically will always be opposed by tobacco companies, but also that the measures they most strongly oppose are those most likely to have the impacts we seek.

Implementing the strategy will require a comprehensive approach, strong leadership and support throughout the community. Surveys at all levels show very strong public support for both overall tobacco control and the specific approaches contained in this strategy.

Tobacco has been one of the great killers of the 20th century. Preventing the premature deaths of at least 300,000 Australians now alive is more than a noble target. This strategy shows how it can be done, ensuring that the Australian program is world’s best practice, and offering the opportunity for tobacco control to be one of the great public health success stories of the 21st century.

**Targets**

If the comprehensive approach outlined in this strategy is implemented, modelling(23) suggests that we can achieve a reduction in the prevalence of daily smoking among adult Australians (aged 18+) from 17.4% in 2007(24) to 10% or lower by 2020.2

The Council of Australian Governments (COAG) has agreed to a National Partnership Agreement on Preventive Health.(25) This agreement sets an overall target for daily smoking of no more than 10% over the 10 years from 2009, as well as interim targets. Interim targets specify that prevalence of daily smoking among Australian adults aged 18 years plus should decline to 15.4% or lower by 2011, and 14.1% or lower by 2013. In real terms, this equates to a decline of at least 11.5% in adult daily smoking in each state and territory in the four years from 2007 to 2011, and at least a 20% decline in smoking in the six years to 2013.3

Meeting these targets at both national and state levels will require a continuation of recent declines(5) in the percentage of young Australians who take up smoking each year, as well as a substantial and sustained increase in the proportion of adult smokers who are seriously trying to quit smoking.

It will also require significant declines in smoking among less educated smokers and those living in disadvantaged areas, which are at least as large as declines among more educated smokers living in more affluent areas.

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2 And no more than 9% for Australians aged 14 and over, as indicated in reports of the National Drug Strategy Household Survey in 2019.

3 The National Partnership Agreement on Preventive Health sets out the agreement of the states, territories and the Australian Government to meet numerous benchmarks including (i) reduction in state baseline for proportion of adults smoking daily commensurate with a two percentage point reduction in smoking from 2007 national baseline by 2011; 3.5 percentage point reduction from 2007 national baseline by 2013; Part 4 Clause 15.
‘Closing the Gap’ in health status between Indigenous and non-Indigenous Australians[26] will not be possible while Indigenous people smoke at a higher rate than other Australians. If prevalence were to halve over the next 10 years, around one in four Indigenous people would still be smoking in 2020. Realistic phased targets can be set for Indigenous smoking after the preliminary impact of the recommended strategies.

A further target for tobacco control in Australia is to eliminate exposure to other people’s tobacco smoke, so that by 2020 Australians, especially children, are not being exposed to second-hand smoke in their day-to-day lives and smoking during pregnancy is minimal.

**Key action areas**

Experience in Australia and overseas shows that a continuing decline in smoking will require a comprehensive approach, implemented with concerted and sustained effort.[27-30] This includes measures to reduce the affordability of tobacco products and to eliminate all forms of marketing of tobacco products, together with clear information for consumers, vigorous education campaigns and easily accessible support and effective and affordable assistance to smokers to quit.[31, 32] The more comprehensive the approach, the more likely it is that prevalence will decline among all social groups.[33, 34] Significantly reducing the social inequalities associated with tobacco use warrants additional attention for disadvantaged groups.[35] It is also likely that efforts to reduce social disadvantage – such as improving access to pre-school education[36] and improving the quality of teaching and school connectedness in disadvantaged areas[37] – can play a valuable role in reducing high-risk behaviours such as smoking.

To accelerate declines in smoking in Australia it is essential that we step up efforts in:

- Taxation policy
- Public education
- Legislation
- Health system interventions, particularly those aimed at high-need and high-risk groups.
Tobacco control achievements in Australia have been substantial, and efforts will continue as described in state and national tobacco control strategies. To achieve the targets set, however, action is required in the following 11 areas:

**Key action area 1:** Make tobacco products significantly more expensive

**Key action area 2:** Increase the frequency, reach and intensity of social marketing campaigns

**Key action area 3:** End all remaining forms of advertising and promotion of tobacco products

**Key action area 4:** Eliminate exposure to second-hand smoke in public places

**Key action area 5:** Regulate manufacturing and further regulate packaging and supply of tobacco products

**Key action area 6:** Ensure all smokers in contact with health services are encouraged and supported to quit, with particular efforts to reach pregnant women and those with chronic health problems

**Key action area 7:** Work in partnership with Indigenous groups to boost efforts to reduce smoking and exposure to passive smoking among Indigenous Australians

**Key action area 8:** Boost efforts to discourage smoking among people in other highly disadvantaged groups

**Key action area 9:** Assist parents and educators to discourage tobacco use and protect young people from second-hand smoke

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

**Key action area 11:** Ensure implementation and measure progress against and towards targets

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4 It is hoped that this Strategy will also provide the basis for strategies adopted by the Ministerial Council on Drug Strategy.
The case for action in each of the 11 key action areas is set out below, followed by actions measuring progress towards meeting the overall target.

**Key action area 1: Make tobacco products more expensive**

‘A high cigarette price, more than any other cigarette attribute, has the most dramatic impact on the share of the quitting population.’ Memo from Claude Schwab to John Heinenimas (Philip Morris), 5 March 1993

PM doc 2045447810

Increasing prices is one of the most effective measures that government can take to reduce tobacco consumption and prevalence. (27, 39)

Analysis of changes in smoking prevalence in the largest Australian states in response to changes in various interventions (40) found that the costliness of cigarettes has the most powerful impact of all the policies studied, and that the effect of price was greatest among those on lowest incomes. (41)

While concerns about future health are the main motivator for quit attempts among high socioeconomic status (SES) smokers, cost is a major trigger among smokers of lower SES. (42) International reviews (27, 43) as well as recent Australian (41, 44) and overseas studies (45) indicate greater reductions in smoking following tax increases in low compared to high SES groups. A 2008 review of population interventions to reduce tobacco use found that price increase was the only intervention for which there was strong evidence of a greater effect among those on low incomes and in lower-status occupations. (46)

Cigarettes in Australia are less costly than they are in many other comparable countries. In September 2008 a packet of 30 cigarettes cost $13.50 in Australia, but the equivalent price of 30 cigarettes in other English-speaking countries was around $20 in Dublin, $18 in London and $16 in Toronto; see Figure 3.1.

Figure 3.1:

<table>
<thead>
<tr>
<th>Price of 30 cigarettes in Australia and other English-speaking countries, A$, September 2008</th>
</tr>
</thead>
<tbody>
<tr>
<td>Source: Economist Intelligence Unit, September 2008, (47) popular brands from medium-priced stores.</td>
</tr>
<tr>
<td>Note: Prices were collected prior to the largest-ever increase in excise duty in the United States in April 2009.</td>
</tr>
</tbody>
</table>

In Australia, taxes presently comprise 68% of the total cost of cigarettes. This percentage is considerably higher in other Organisation for Economic Co-operation and Development (OECD) countries; for example, 80% in France, 78% in the United Kingdom and 76% in Canada. (24)
Modelling of the predicted impact of policy measures on future prevalence of smoking in Australia indicates that increasing the price of tobacco products by at least 50% in real terms within the next three years is vital if we are to achieve the target of 10% adult daily smoking by 2020. Most smokers make several attempts before quitting. Staged increases in price provide opportunities for smokers to think about the costs of smoking and for smokers who have relapsed to try again.

**Action 1.1**

*Ensure that the average price of a packet of 30 cigarettes is at least $20 (in 2008 $ terms) within three years, with equivalent increases in the price of roll-your-own and other tobacco products.*

While increasing the costliness of tobacco products is vital to reducing disparities in tobacco use, it is acknowledged that a large and abrupt increase in prices could trigger financial stress for some smokers who are unable to quit. Financial stress increases the likelihood of a smoker wanting to quit, but is associated with increased likelihood of relapse. There is little direct evidence of food insecurity attributable to tobacco use in Australia, although it is likely that some heavy smokers already spend less than is optimal on food, clothing and other goods and services. Raising taxes in several stages rather than in a single increase should maximise cessation, triggering many price-sensitive smokers to try to quit each time an increase is introduced or announced. Staged increases will also give remaining smokers time to reduce the number of cigarettes or amount of tobacco they smoke each day and adjust their tobacco and non-tobacco related expenditure.
RELATED ACTION

This strategy includes numerous measures to provide additional encouragement and assistance for smokers from socially disadvantaged groups. It also includes several measures to ensure that all smokers attempting to quit are able to afford clinically suitable quit-smoking medications including nicotine replacement therapy (NRT). Governments could ensure that smokers in immediate financial stress such as those using emergency housing and relief services and those highly disadvantaged groups who are clients of other state human services are directed to smoking cessation services and able to access available subsidies.

ILlicit TRADE

Any availability of illicit tobacco products (that is, products on which taxes have been avoided) undermines the effectiveness of taxation, particularly among low-income groups. Increases in excise and customs duty should therefore be complemented by measures to prevent any significant increase in illicit trade.

Since 2004 the Australian Tax Office has vigorously pursued operators who attempt to evade excise duty through the sale of illicit unprocessed tobacco known as chop chop. Locally grown chop chop has become less of an issue in Australia since the phasing out of tobacco growing in 2006; however, some unprocessed tobacco may still be available from overseas. The Australian Customs and Border Protection Service (ACBPS) has measures in place to detect the illegal importation of counterfeit cigarettes and other tobacco products on which customs duty has not been paid, and several offenders have been prosecuted over the last few years. However, so far there appears to have been little progress on measures specified under clauses 15.2, 15.4 and 15.6 of the World Health Organization (WHO) Framework Convention on Tobacco Control (FCTC) to cooperate with other parties on the elimination of illicit trade. No action has yet been taken to require manufacturers and importers to track and report on sales and distribution (as proposed in a November 2008 Chairperson’s text for a Protocol on Illicit Trade in Tobacco Products).

Action 1.2

Develop and implement a coordinated national strategy to prevent the emergence of illicit trade in Australia.

Action 1.3

Contribute to the development and implementation of international agreements aiming to combat illicit trade globally.

Action 1.4

Ban the retail sale of tobacco products via the internet.

Duty-Free Sales

Article 6 of the FCTC states:

2. Without prejudice to the sovereign right of the Parties to determine and establish their taxation policies, each Party should take account of its national health objectives concerning tobacco control and adopt or maintain, as appropriate, measures which may include: ‘...’

(b) prohibiting or restricting, as appropriate, sales to and/or importations by international travellers of tax- and duty-free tobacco products:’ WHO FCTC.

There are no legal barriers preventing the Australian Government from banning the sale of tax- and duty-free tobacco products in Australia. Additionally, obligations under current international agreements would not prevent Australia from introducing laws banning international travellers (both residents and non-residents) from bringing tax- and duty-free tobacco products into the country, provided
that the laws were introduced on public health grounds. Several European countries have recently taken action along these lines.

Action 1.5

End tax- and duty-free sales in Australia. Abolish tax and duty concessions for all travellers entering Australia (specified limits for personal use); and participate in negotiations on international agreements concerning the application of limits to international travellers.

Key action area 2: Increase the frequency, reach and intensity of social marketing campaigns

Well-funded, sustained media campaigns rank second only to price as a key to reducing smoking.

Media campaigns help to personalise the health risks of smoking and increase people’s sense of urgency about quitting. To successfully challenge strongly held personal opinions and entrenched self-exempting beliefs, campaigns need to be bold and to take some risks. In order to encourage people to make numerous attempts to quit, to persist through any withdrawal symptoms and to stay a non-smoker, media campaigns need to be on air most of the year. Effective campaigns need to draw on solid behavioural and communications research, and be funded at commercially realistic levels.

COMMERCIALY REALISTIC FUNDING

‘Evidence on the value of social marketing (mass media) quitting campaigns is clear: effectively developed and implemented, mass media campaigns can reduce adult smoking prevalence, increase quitting activity and drive calls to cessation services such as Quitlines. As such they form an integral component of any comprehensive tobacco control strategy’ (Quote from submission)

Studies of smoking trends in jurisdictions with and without media campaigns in the early 1980s in Australia(57, 58) and elsewhere(59, 60) indicate that they can be extremely effective in reducing smoking prevalence. As part of a comprehensive scientific review of all available international evidence concerning the impact of the media on smoking attitudes and behaviour,(61) the US National Cancer Institute concluded in its 2008 landmark report that well-funded campaigns can reduce smoking prevalence, with the extent of reductions highly related to levels of media expenditure.(62)

Experience in the United States shows that increases in per capita spending on tobacco control programs are clearly associated with accelerated declines in smoking in both adults(63) and youth.(64) A cohort study in Massachusetts found that, compared to smokers who had the lowest level of tobacco control media campaign exposure, about 280 Target Audience Rating Points (TARPs) per month, those who had the highest (about 838 TARPs per month) were over four times more likely to have quit two years later.

Based on the levels of response to social marketing campaigns observed over the past 15 years in Australia,(40) and taking into account the findings from studies internationally, members of the expert panel overseeing the production of the US National Cancer Institute report on the use of media in tobacco control(62) advise that media spending on Quit campaigns should be high enough to achieve at least 700 TARPs per month. In Australia, achieving an average of 700 TARPs per month would currently cost around $40 million per year, a figure likely to increase over time with increased media costs and an increasingly fragmented media market.(65)

Media advertising outside New South Wales, Western Australia and Victoria appears to be sporadic. Other than the NSW Cancer Institute (which spent more than $12 million in 2007),(66) spending on Quit campaigns is considerably

5 Australia’s Professor Melanie Wakefield was one of the two senior scientific editors of this report.
lower than the advertising budgets of major commercial retailers in Australia. To maximise the reach and impact of advertising messages, it will be important to capitalise on the remaining years in which free-to-air advertising is still predominant, and also to start moving towards a greater mix of media channels, including free-to-air and subscription television, cinema, print, radio and magazines. To ensure continuing impact over time, funds will also be needed each year for production of new material.

**Action 2.1**

*Run effective social marketing campaigns at levels of reach demonstrated to reduce smoking.*

**IMPACT OF MEDIA ON DISADVANTAGED GROUPS**

Analysis of smoking prevalence over the first two periods of the Australian National Tobacco Campaign shows that changes in smoking rates among blue-collar groups were of a similar magnitude to changes among white-collar groups. (67) This is consistent with the results of earlier research that showed no increase in the disparity between smoking rates among groups with different levels of education after the early Quit campaigns in Sydney and Melbourne. (68, 69)

A study of smoking among children in suburbs with varying degrees of socioeconomic disadvantage across Australia between 1987 and 2005 (70) found that the level of tobacco-control activity affected the consistency of change in teenage smoking prevalence across different SES groups. Prevalence increased very sharply in low SES teenagers during the period of low tobacco control activity, whereas there was little change among the higher SES teenagers.

A review of the literature published in 2008 has concluded that media campaigns can be equally effective with low and higher SES groups, but that attention must be paid to the placement and style of advertising.

(71) A new cohort study has reported that emotional and narrative advertising messages produced a greater quitting response after two years among lower SES smokers than among higher SES smokers. (72) Emotional narrative communication may be a better method for low SES groups because it enables people to fully and vividly imagine how it would feel to suffer a smoking-related disease. (73-75) Advertising can be placed in television programs more likely to be watched by low SES groups, and additional more localised advertising can be focused on low SES neighbourhoods.

**Action 2.2**

*Choose messages most likely to reduce prevalence in socially disadvantaged groups and provide extra reach to these groups through skewing of placement to television programs most likely to be watched by low SES groups, and by targeting radio, outdoor, transit and other local advertising to low SES neighbourhoods.*

**Key action area 3: End all forms of advertising and promotion of tobacco products**

Tobacco kills one in every two long-term users. (76) Many young people show signs of dependency on tobacco products (77-79) (including failure in quitting (80)) before they reach majority age. Anyone trying to introduce cigarettes on the market today would fail. Most Australians believe it would be a good thing if tobacco products were one day no longer sold in retail outlets. (81) There can be no justification for allowing any form of promotion for this lethal product.

The US National Cancer Institute has concluded that there is a causal relationship between the promotion of tobacco and increased tobacco use. (82) Both industry documents and scientific studies show that promotion continues to involve highly sophisticated targeting and segmentation of both existing and potential...
users; that the tobacco industry does not effectively self-regulate its marketing practices; and that companies typically respond to partial bans by increasing expenditure in ‘permitted’ media, such as payments to retailers and proprietors of entertainment venues to display or supply tobacco products, and through new media forms developing as a result of emerging technology. The National Cancer Institute report also points to activities designed to enhance public image and affect attitudes to smoking, such as entertaining influential individuals, sponsorship and donations to ‘good causes’. (83)

MODERNISING TOBACCO ADVERTISING PROHIBITION ACT

Australia’s Tobacco Advertising Prohibition Act 1992 and tobacco control legislation in the states and territories effectively prevent most promotion of tobacco through traditional forms of media. However, many newly emerged forms of marketing aimed primarily at young adults (such as viral marketing through internet sites, entertainment venues and events) also influence teenagers. (15) Staggering numbers of people are using social networking sites in which there is considerable discussion of smoking. (84) Submissions from expert health agencies (85) to a review of the Act in 2003 (86) identified numerous loose ends and important loopholes that need to be addressed to ensure that the Act remains effective into the 21st century. The May 2007 meeting of the Ministerial Council on Drug Strategy agreed that all governments would collaborate to ban the sale and advertising of tobacco products over the internet; however, legislative amendments have not yet been drafted, and none of the other recommendations from the 2003 review has been acted on.

Guidelines adopted in November 2008 by the WHO’s Conference of the Parties to the FCTC in relation to Article 13 (87) specify that in addition to plain packaging and bans on point-of-sale displays and corporate communication, legislation to restrict promotion by the tobacco industry should also cover modern communication technologies, including the internet, satellite television and mobile telecommunications.

**Action 3.1**

*Legislate to eliminate all remaining forms of promotion including advertising of price specials, public relations activities, payments to retailers and proprietors of hospitality venues, promotion through packaging (see Action 3.4 below) and, as far as feasible, through new and emerging forms of media.*

REPORTING ON EXPENDITURE ON ANY RESIDUAL PROMOTION

In the United States all tobacco companies must supply the Federal Trade Commission annually with detailed information on exactly what they spend on all forms of advertising and promotion of tobacco products. The Australian Government needs to be provided with similar information, not least so it can assess the need for action on any promotional activity that any company believes is not covered by existing Australian legislation.

**Action 3.2**

*Regulate to require mandatory reporting of amounts spent on any form of promotion – on payments to public relations companies or any other third parties, as well as details of any other promotional expenditure.*

POINT-OF-SALE DISPLAYS

Displays at point of sale normalise tobacco products in the eyes of children (88) and prompt impulse purchases in smokers and recent ex-smokers. (89) Children and smokers need protection from inducements to buy tobacco products. National consistency has been sought by industry in submissions to the Taskforce. Legislation is being progressively implemented in most jurisdictions, but is absent or not sufficiently robust in others.
Action 3.3

Amend legislation to ensure that tobacco is out-of-sight in retail outlets in all jurisdictions.

PROMOTION THROUGH PACKAGING

In Australia and other countries that have already banned traditional forms of tobacco marketing, packaging has become a cornerstone of marketing strategy. Brand names and package design enable the communication of personal characteristics, social identity and aspirations, and are a crucial aspect of marketing tobacco products. Market-testing studies show that package design – through the use of varying colour and other design elements – induces smokers to expect, and then actually experience, their cigarettes to be lower strength, lower in tar and lower in health risk than exactly the same cigarettes presented without this packaging. These misperceptions are part of the constellation of modifiable tobacco marketing factors that make smoking easier to take up and harder to quit.

As noted above, there can be no justification for allowing any form of promotion for this uniquely dangerous and addictive product which it is illegal to sell to children. ‘Plain packaging’ entails prohibiting brand imagery, colours, corporate logos and trademarks, and permitting manufacturers only to print the brand name in a mandated size, font and place, in addition to required health warnings and other legally mandated product information such as toxic constituents, tax-paid seals or package contents. A standard cardboard texture would be mandatory, and the size and shape of the package and cellophane wrapper would also be prescribed. A detailed analysis of current marketing practices suggests that regulations prescribing plain packaging would also need to encompass pack interiors and the cigarette itself, given the potential for manufacturers to use colours, bandings and markings, and different length and gauges to make cigarettes more ‘interesting’ and appealing. Any use of perfuming, incorporation of audio chips or affixing of ‘onserts’ would also need to be banned.

Consumer research indicates that decreasing the number of design elements on the package reduces its appeal and perceptions about the likely enjoyment and desirability of smoking. Requiring cigarettes to be sold in plain packaging would reinforce the idea that cigarettes are not an ordinary consumer item. It would also reduce the potential for cigarettes to be used to signify status. Plain packaging would increase the salience of health warnings: research subjects show an improved ability to recall health warnings on plain packs.

Guidelines for implementation of Article 11 adopted by the WHO’s Conference of the Parties to the FCTC state:

Parties should consider adopting measures to restrict or prohibit the use of logos, colours, brand images or promotional information on packaging other than brand names and product names displayed in a standard colour and font style (plain packaging).

Shareholder nervousness and industry opposition to restrictions on pack design are a strong indication of the importance of packaging to tobacco sales.

‘In our opinion, (after taxation) the other two regulatory environment changes that concern the industry the most are homogenous packaging and below-the-counter sales. Both would significantly restrict the industry’s ability to promote their products.’ Morgan Stanley Research (2007)

Threatened legal challenges from tobacco companies also testify to the importance they attach to packaging as a promotional mechanism. Given that trademark law is aimed at protecting broader public interests and does not provide for absolute private property rights, plain packaging is justifiable, proportionate and not inconsistent with international trade...
agreements. International agreements provide flexibilities and exceptions to protect public health.

The industry has argued that plain packaging would make it easier to counterfeit cigarette packets. However, this need not be the case. Strategies proposed in the FCTC’s draft protocol to combat illicit trade include the mandating of tax markings that would make cigarette packages extremely difficult to counterfeit.

**Action 3.4**

*Eliminate promotion of tobacco products through design of packaging.*

To speed the adoption of plain packaging, the Australian Government could consider a differential rate of excise and customs duty for plain packets introduced to market prior to the required date.

**Key action area 4: Eliminate exposure to second-hand smoke in public places**

Significant health risks are posed by exposure to smoke from tobacco products smoked by other people. It is well established that second-hand smoke causes coronary heart disease and lung cancer in non-smoking adults, induces and exacerbates a range of respiratory effects in infants, children and adults, and increases the risk of Sudden Infant Death Syndrome (SIDS) and other serious health outcomes in young children. There is no level of exposure to second-hand smoke that is free of risk. At particular risk are the young, who lack control over their environment, and the socially disadvantaged, who are more likely to be exposed to second-hand smoke at home and elsewhere.

The International Agency for Research Against Cancer (IARC) has recently reported results from its expert scientific review, which determined that evidence is sufficient to conclude that laws restricting smoking in workplaces and other public places reduce population exposure to second-hand smoke, consumption of cigarettes and respiratory symptoms in workers. The IARC found that such policies provide net benefits to business, with no adverse effects on overall sales in the hospitality industry. An international study of adolescents from 32 countries in Europe, Israel and North America published in 2008 confirms a strong relationship between the adoption of national smoke-free laws and declines in adolescent smoking. A review in 2008 and several additional studies confirm early suspicions that the introduction of smoke-free policies is followed by a rapid reduction in heart attacks among both smokers and non-smokers.

**Action 4.1**

*Amend legislation and departmental policies to ensure that smoking is prohibited in any public places where the public, particularly children, are likely to be exposed.*

**SMOKING IN CARS**

Alarming levels of exposure to toxic substances have been documented in children travelling with adults who smoke inside cars with windows open, with greater concentrations resulting from airflow when windows are open and exposure more common in lower SES families. Bans on smoking in cars are being adopted by an increasing number of North American jurisdictions and are or shortly will be in force in all but three Australian jurisdictions (Western Australia, the Australian Capital Territory and the Northern Territory), with Western Australia and the Australian Capital Territory also currently considering legislative proposals. Greater national consistency would be desirable to protect Australian children in all jurisdictions.
**Action 4.2**

Legislate to ensure that children are not exposed to tobacco smoke when travelling as passengers in cars.

**SMOKING IN WORKPLACES AND PUBLIC PLACES**

Over the past four years, all Australian states and territories have extended legislation to reduce public exposure to second-hand smoke. Legislation applies to hotels and nightclubs as well as to restaurants, with exceptions relating to gaming areas in some jurisdictions (New South Wales, Queensland and Victoria) and smoking areas still allowed in hotels in the Northern Territory. Because legislation has been introduced at different times in different places, several loopholes and inadequacies have emerged in some aspects of operation and enforcement. In 2008 a NSW Health Department study of outdoor areas where smoking was still allowed in hotels detected ‘poor’ air quality well above the WHO-recommended 24-hour exposure limit of 25 micrograms per cubic metre. A third of hotels recorded twice the limit, with some areas exceeding it by 500%. (119)

**Action 4.3**

Tighten and enforce legislation to protect against exposure to second-hand smoke in all workplaces (including both indoor and outdoor areas in restaurants and hotels, near the entrances to buildings and air-conditioning intake points, and in workplace vehicles).

**Action 4.4**

Introduce and enforce legislation, and encourage adoption of policies that restrict smoking outdoors where people gather or move in close proximity.

**SMOKING IN MULTI-UNIT DEVELOPMENTS**

In several states in the United States there has been much discussion about the problem of smoke-drift between apartments, some attempts at legal action (120) and growing pressure for legislation. In 2006 the NSW Consumer, Trader and Tenancy Tribunal upheld a case brought by occupants of an apartment against their smoking neighbours, requiring them to stop smoking in their adjacent apartment because of smoke drift. (121) This precedent could precipitate other such actions and give license to rental managers to advise tenants that smoking is banned in rental apartments. A Canadian survey found that 64% of apartment dwellers would prefer to live in an entirely smoke-free complex and that 46% had experienced smoke from a neighbour seeping into their apartment. (122) At least 36 public housing authorities in the United States have banned smoking within private apartments. (123)

People would be better able to choose accommodation free of smoke-drift if legislation required that the smoking policy in shared and indoor areas be specified in residential lease agreements in multi-unit apartments, and that all shared areas (lifts, stairwells, walkways, car parks) in multi-storey public housing developments be smoke-free. Currently in Australia, restrictions over smoking in apartment blocks apply in New South Wales and Queensland but not specifically in other jurisdictions.

**Action 4.5**

Protect residents from exposure to smoke-drift in multi-unit developments.
Key action area 5: Regulate manufacturing and further regulate packaging and supply of tobacco products

Unlike poisons, firearms and pharmaceutical products, there are relatively few controls in Australia on the ways in which tobacco products are manufactured, packaged and supplied to consumers. Several major deficiencies and loopholes should be addressed.

SUPPLY OF TOBACCO PRODUCTS

Legislation pertaining to the sale of tobacco products in retail outlets has been introduced at different times in different states and territories. All retailers should be licensed to aid communication of government regulations and as a means of ensuring enforcement of those regulations. The cost of the licence should be sufficient to cover the costs of education, compliance testing and investigation of prosecutions at levels necessary to ensure universal compliance. Any retailer who knowingly sells tobacco products to minors is unfit to hold a licence. Sales to minors could be minimised across the country if states and territories all moved to best practice concerning allowable retail outlets, provisions for checking proof of age, enforcement and penalties.

Action 5.1

Tighten and enforce legislation to eliminate sales to minors and any form of promotion of tobacco at the retail level.

CONSUMER PRODUCT INFORMATION

The previous four sets of health warnings required on cigarettes in Australia have been introduced only after protracted reviews and with extremely lengthy phase-in periods. During the 14 years it took to upgrade the 1973 warnings, the eight years it took to upgrade the 1987 warnings, and the 10 years it took to upgrade the 1994 warnings, extensive new evidence about the health effects of smoking became available, including much information about which consumers to this day still have not been warned. Consumers need to be warned about all the risks posed by smoking in a clear, systematic and much more timely manner.

The Department of Health and Ageing’s evaluation of graphic health warnings introduced in 2006 showed that while smokers strongly approved of the graphic form, and the tone and style of warnings, unaided recall of health information declined from 98% in 2000 to 91% in 2008. (124) Smokers interviewed confirmed the importance of the front of the pack for conveying health information, with many smokers commenting that the current warnings were too small and made less prominent by placement on the lid. The evaluation also indicated some wear-out of current warnings, and provided evidence that colours and other design features of cigarette packaging were competing with and reducing the impact of warnings.

Plain packaging increases the prominence of warnings; see 3.4 above. In addition, research by Health Canada indicates that graphic health warnings are most effective if they cover almost the entire surface of cigarette packages. Based on analysis of 38 different indicators, researchers concluded that warnings needed to increase to 90% if they are to ‘connect with emotions of various styles of young smokers’ and ‘make cigarette packs less attractive’.

Australia is now well behind when it comes to the potency of warnings.
Figure 3.3:
Examples of health warnings required on cigarettes in Singapore (neck cancer) and in Thailand (throat cancer)

Action 5.2

Improve consumer information related to tobacco products, including through the mandating of substantially larger front-of-pack health warnings, more regular reviews of health warnings and a more timely system of warning consumers of new and emerging risks.

MANUFACTURING OF TOBACCO PRODUCTS—REDUCED FIRE-RISK CIGARETTES

Nearly one-quarter of all fire deaths in Australia in 2004–05 occurred in fires started by cigarettes or matches. The total economic impact of these fires is conservatively estimated at $81 million each year.(13) New regulations requiring cigarettes to be produced to a standard that ensures they are quickly extinguished are due to come into force in March 2010, but the deadline for implementation has recently been brought forward by six months (from March 2011 to September 2010) so that all cigarettes on the market should be reduced fire-risk cigarettes prior to the commencement of the 2010–11 summer fire season.

Action 5.3

Ensure compliance with new regulations regarding reduced fire-risk.

DESIGN, CONTENT AND EMISSIONS

Cigarettes can be designed in ways that affect the emission of particular toxins. While it is not clear whether cigarettes can be manufactured to create any less harm to consumers, governments should consider the potential benefits of enforcing requirements for product modifications or reduced emissions with at least some prospect of reducing risk. A crucial element of such regulation would be to prevent any sort of communication with consumers by manufacturers that might provide false reassurance. It would also be essential to ensure that information was collected (in the form of monitoring of biomarkers and disease surveillance) to assess whether in fact any reduction in harm actually did eventuate.

No legislation currently exists enabling the government to mandate requirements regarding the contents or performance of Australian tobacco products; thus the government would currently not be able to mandate any modifications to cigarettes such as those recommended by the WHO’s expert advisory group, TobReg.(125) Further, no
legislation currently mandates the provision of information that would be required to assess the impact on consumers. Detailed requirements for such reporting are likely to be incorporated in guidelines currently being developed by an expert group reporting to the WHO’s Conference of the Parties to the FCTC.

**Action 5.4**

*Establish or nominate a body with the power to regulate the design, contents and maximum emissions for all tobacco products (and any alternative nicotine delivery devices that may be allowed onto the market), and with responsibility for specifying required disclosure to government, labelling and any other communication to consumers.*

**LEGAL ACTION**

Tobacco products cause the premature death of one in every two regular users, resulting in enormous social costs to the entire community, and unquantifiable misery to individuals and families. The continuing sale of such products through tens of thousands of retail outlets across the country raises important legal questions.

**Action 5.5**

*Investigate the feasibility of legal action by governments and others against tobacco companies with a view to recovering health and other costs.*

The sheer number of people who once smoked but now do not – around 4.3 million Australians in 2007 – shows that quitting is possible, but it can be a very difficult process nevertheless. Succeeding requires a great deal of determination and the adoption (conscious or not) of strategies to overcome withdrawal and triggers to smoke.

Smoke-free policies not only protect patients and staff from second-hand smoke, they also allow governments and healthcare institutions to reinforce how seriously they regard the health risks of tobacco use. Asking patients about their smoking enables health professionals to personalise those risks, often at highly ‘teachable moments’ when patients are suffering a serious illness or health incident. Clear advice from a concerned professional can motivate a patient to quit, whether the advice comes from a doctor, dentist, nurse or other health professional, and whether it occurs in practice rooms, in a community health centre or in a hospital.

**Action 6.1**

*Ensure all state- or territory-funded healthcare facilities (general, maternity and psychiatric) are smoke-free, protecting staff, patients and visitors from exposure to second-hand smoke, both indoors and on health service grounds.*
CLEAR ADVICE FROM HEALTH PROFESSIONALS

As demonstrated as long as 30 years ago, because doctors see a large proportion of smokers each year, even small effects can contribute significantly to reducing population prevalence. Small effects of treatments are clinically significant because of the very large health gains that accrue from stopping smoking.

Action 6.2

Ensure all patients, each time they consult a health professional in private or public, community, general practice or institutional settings, are routinely asked about smoking status and if smokers are advised to quit in line with guidelines developed for relevant professional groups.

EFFICACY OF TREATMENT

A very large body of research now confirms that an individual’s chances of quitting can be increased by taking medications that lessen withdrawal symptoms or reduce the reinforcing effects of tobacco-delivered nicotine. There is also overwhelming evidence that a structured program of cognitive behavioural advice and coaching can also be helpful, regardless of whether the assistance is provided one to one, over the phone or in a group (in the community or through work). Well-designed brochures help some people, but this is not enough for most. Success rates are better where advice can be personalised.

This can be achieved through telephoning helplines or through computer technologies (such as the QuitCoach available through the Australian Government’s website), which can be delivered at a much lower cost than printed materials. Programs delivered through peoples’ computers or web-enhanced mobile devices using e-mail, text messaging, live calendars and message boards are also likely to be cost-effective. Structured programs generally achieve greater success with increasing contact: four to eight sessions optimises chances at reasonable cost. People are also more likely to quit successfully if they use a combination of approaches. Adding medication to counselling (or vice versa) increases success rates.

Action 6.3

Improve quality of use of pharmacotherapies and services demonstrated to assist with smoking cessation.

AN INTEGRATED, COST-EFFECTIVE SYSTEM OF SERVICES AND AVAILABILITY AND SUBSIDY OF TREATMENTS

We need a combination of services, training, referral arrangements, remuneration and subsidies that will work together in the Australian context to provide evidence-based services and treatments for anyone who wants this assistance or is likely to benefit.

REFERRALS BY PROFESSIONALS TO QUITLINES

Many health practitioners routinely ask patients about their smoking status and offer prescriptions for anti-smoking medications; however, there is scope to greatly increase follow-up and referrals to Quitlines and other supports where these would be helpful.

Hospitals in New South Wales and Queensland have developed systems to identify all patients who smoke and advise them to quit, as well as offering NRT to help them comply with smoke-free policies. Much could be improved in these systems, and much more could be done in other jurisdictions.

6 For further details on the effectiveness of pharmaceutical and behavioural interventions, see the frequently updated meta-analyses published by the Tobacco Addiction section.


7 For further detail see the US Department of Health’s clinical guidelines: www.surgeongeneral.gov/tobacco/treating_tobacco_use08.pdf.
Quitlines are now advertised on every cigarette pack as part of required consumer information. Mass media advertising also drives calls to the Quitline. However, the Quitline is still an under-utilised service in Australia, partly because of a lack of understanding about what the service offers, and more could be done to promote its use.

For several years, governments in the United Kingdom, the United States, New Zealand and Australia have periodically updated and promoted detailed clinical guidelines for doctors on how best to treat tobacco dependence. An important innovation in the Australian clinical guidelines is the offer of two evidence-based strategies for providing cessation assistance: within the consultation, and/or referral to specialist cessation services. GPs can use fax-referral forms to trigger a phone call to their patients from a trained Quitline adviser. For referrals, the Quitline calls the smoker and discusses options for assistance, which allows callers to be directed to or offered the most appropriate form of support.

GP referral to the Quitline has improved patients’ chances of quitting. In a Victorian pilot program, referral to the Quitline has resulted in cessation rates two to three times that which resulted from efforts to encourage GPs to provide in-practice management. The effect was due to the smokers getting extra help to quit from outside the practice, while receiving the same amount of help from within it; the combination of the extra help increased both the number and success of quit attempts. The beneficial effect on quitting in the referral condition was sustained over time. The findings add to the growing body of evidence that health professional referral of patients who smoke to evidence-based Quit services is effective and acceptable to smokers.

**Action 6.4**

*Increase the availability of Quitline services, expanding the modes of delivery of advice and support, and tailoring services for high-need and highly disadvantaged groups, including pregnant women and their partners, people with chronic health conditions, those who do not speak English and people with mental illness. Ensure that funding is provided in line with increased demand generated by advertising, improved health warnings and greater activity by health professionals.*

**Subsidy of Treatments**

Data from the International Tobacco Control Study suggests that smokers in Australia as well as the United States, United Kingdom and Canada who use quit-smoking medicines are more successful in sustaining cessation than those who do not.

Use of quit-smoking medicines is highly related to price. Providing access to subsidised pharmacotherapy is a powerful method of increasing usage of quit treatments; it also increases the proportion of quit attempts that are successful.

In 2008 a large-scale demonstration project across six states in the United States reported that smokers doubled their success rates when given subsidised NRT and access to a Quitline, with savings in healthcare costs justifying full Medicare coverage of low-cost NRT and referral to Quitline services.

Although available on the PBS, varenicline and bupropion may have some serious side effects, and both are contraindicated for some patients. Good clinical practice for many patients would be to encourage use of NRT; however, NRT products are not affordable for many patients. Patches are already subsidised for Indigenous smokers and veterans, but...
several other highly disadvantaged groups – in particular people living with mental illness – would benefit from PBS listing or some other form of subsidy for NRT products.

**Action 6.5**

*Ensure that nicotine replacement therapy is affordable for all those for whom it is clinically appropriate.*

**FINANCIAL INCENTIVES**

Financial incentives within healthcare settings have been primarily directed towards providers. With significant potential co-benefits for individuals and governments, and some encouraging results and experiences from such initiatives overseas, (169-171) it may also be appropriate to consider incentives directed towards smokers and potential smokers.

**Action 6.6**

*Explore whether financial incentives might be effective in helping people to quit or stay non-smokers.*

**Key action area 7: Work in partnership with Indigenous groups to boost efforts to reduce smoking and exposure to passive smoking among Indigenous Australians**

"Reducing smoking prevalence among Indigenous Australians must be a high priority if the life expectancy gap is to be successfully closed" (Quote from submission)

Tobacco use among Aboriginal and Torres Strait Islander peoples causes disturbing levels of ill health and premature death in infants, parents and elders, and is a major contributor to the life expectancy gap. (8) In New Zealand, smoking has declined by more than 20% in Maori men and women over the last four years. (172) In Australia, smoking among Indigenous people appears to have not declined at all over the past 15 years, although rates in remote communities may have improved slightly.

**Figure 3.4:**


Shortly after its election, the Australian Government pledged $14.5 million over four years to help tackle smoking in Indigenous communities. (26) This has helped to get the issue on the Indigenous health agenda, and has resulted in a number of projects and initiatives. However, small pilot projects, no matter how well designed and run, will not make the inroads necessary to reduce smoking rates across the Indigenous population as a whole. While there is a place for trials of innovative new approaches, it is now time to scale up efforts, working closely with and through Indigenous organisations. Time and resources should be allowed for training and sharing of insights, and it should be acknowledged that quality of service will improve as staff become more experienced.
LEARNING THROUGH DOING

‘...there is a need to include both Indigenous-specific activities, as well as measures to ensure access of Indigenous people and communities to mainstream programs and services’ (Quote from submission)

Evidence suggests that multi-component community-based projects developed and implemented by local communities, and involving strong local drivers, are likely to impact on Indigenous smoking. Community control of these projects and the involvement of influential local community members will have greater impact on de-normalising tobacco use and reducing the social acceptability of smoking. A mix of multiple strategies as determined by the local community will reinforce anti-smoking messages and provide a variety of options for families and individuals to address their tobacco use. Projects should be established in a variety of locations, and could be extensions of existing projects. Funding must sustain the projects over a period adequate to evaluate processes and possibly impacts (at least two to three years). Capacity to undertake and evaluate these projects must be built and supported through the other activities suggested below.

**Action 7.1**

*Establish multi-component community-based tobacco control projects that are locally developed and delivered.*

SOCIAL MARKETING FOR INDIGENOUS PEOPLE

Mainstream social marketing campaigns are effective in increasing awareness and understanding of the health effects of smoking among Indigenous people.

Research conducted by the NSW Cancer Institute in 2008 indicates that many mainstream advertisements are considered personally relevant by Indigenous smokers. However, there should be more representation of Indigenous people and relevant themes in campaigns where possible. This may include talent, language, situations and calls to action relevant to Indigenous people. Messages also need to challenge the acceptability of smoking and the inevitability of smoking-related diseases for Indigenous people.

Campaigns that more accurately reflect the life of an Indigenous smoker, in terms of the high prevalence of smoking, experience of smoking-related health effects and cross-generational smoking behaviour, are likely to be powerful in moving Indigenous smokers further along the continuum towards quitting.

Research in New South Wales and experience in Western Australia suggest that the optimum way forward involves a ‘twin track’ approach of using existing effective mainstream campaigns and adding complementary Indigenous-specific campaign elements. Experience has shown that radio offers a number of opportunities as an inexpensive and complementary medium that can be tailored to local and regional areas.

As with all social marketing, campaigns must be of high quality, based on research, sustained – that is, ongoing for several years rather than one-off efforts – and sufficiently well funded to allow appropriate TARP levels to demonstrate an impact.

**Action 7.2**

*Enhance social marketing campaigns for Indigenous smokers, ensuring a ‘twin track’ approach of using existing effective mainstream campaigns complemented by Indigenous-specific campaign elements.*
TRAIN INDIGENOUS HEALTH WORKERS

Indigenous health workers should be supported to lead tobacco control activities (and also to be non-smokers). Training is needed to improve knowledge about tobacco use and to build skills in service and program delivery, including:

- Providing brief interventions
- Developing, implementing and evaluating community-based tobacco control programs
- Collection and use of data and evaluating programs

**Action 7.3**

*Provide training to Aboriginal and Torres Strait Islander health workers to improve skills in the provision of smoking cessation advice.*

TRAIN ALL STAFF WORKING IN INDIGENOUS HEALTH SERVICES

Training should include realistic and empowering strategies on how to discuss smoking cessation with patients, and how to develop programs that encourage change in social norms within communities around smoking. Training should be integrated in the multi-component community-based projects (Action 7.1 above).

**Action 7.4**

*Improve training in the provision of smoking cessation advice of other health professionals working in Aboriginal and Torres Strait Islander health services.*

BUILDING CAPACITY OF LOCAL HEALTH SERVICES

Indigenous health workers are already burdened with their daily work, and may have insufficient time and support to undertake tobacco control activities. Specialist workers have been successfully used in other areas, such as drug and alcohol therapy, sexual health and mental health.

Specialist Tobacco Control Workers are needed to assist local Indigenous health services to build their capacities to address tobacco use. The responsibilities of such workers will depend on local requirements but may include:

- Facilitate training and provide support to health service staff in tobacco control
- Support and advise health workers to lead in the development and delivery of community tobacco control programs
- Assist Indigenous organisations to develop and implement policies for smoke-free workplaces
- Advocate for the needs of Indigenous health services in the area of tobacco control (for example, around improved access to NRT)
- Provide support to multi-component community-based tobacco control projects (see Action 7.1)
- Assist Indigenous organisations to develop programs and policies that can support Indigenous health workers to quit smoking
- Collect smoking-related data at the local level
- Support communities and organisations to evaluate tobacco control programs

A clear structure is needed to support these Tobacco Control Workers. The BREATHE Project at the Aboriginal Health and Medical Research Council of NSW has a trial in place of Specialist Tobacco Control Workers in four Aboriginal Medical Services. This project could provide a model. A training package developed as part of the project could be enhanced (with further funding) to be used nationally with Specialist Tobacco Control Workers.

**Action 7.5**

*Place specialist Tobacco Control Workers in Indigenous community health organisations to build capacity at the local health service level to develop and deliver tobacco control activities.*
INCREASE EMPLOYMENT OF INDIGENOUS STAFF IN NGOS

The work of NGOs in the area of Indigenous tobacco control could be enhanced by the employment of Indigenous workers. Where possible, at least two workers should be employed to maximise the provision of a supportive work environment for Indigenous people.

**Key action area 8:** Boost efforts to discourage smoking among people in other highly disadvantaged groups, such as people living with mental illness, living in highly disadvantaged neighbourhoods, from cultural backgrounds with high rates of smoking or living in correctional facilities.

‘The decline in smoking prevalence in Australia has not been uniform across states and there are some populations in which the prevalence remains high, including Aboriginal Australians and many of the most disadvantaged groups in society’ (Quote from submissions)

**Action 7.6**

*Provide incentives to encourage NGOs to employ Indigenous workers.*

**Action 8.1**

*Boost efforts to discourage smoking in highly disadvantaged neighbourhoods.*
PEOPLE LIVING WITH MENTAL ILLNESS

‘Health and economic harm from smoking and from second-hand smoke impacts disproportionately on the most disadvantaged including people with mental health problems, the homeless, low income smokers and pregnant, disadvantaged women’ (Quote from submission)

People living with mental illness are more likely to develop, suffer and die from preventable health conditions[174] and are an under-addressed group in tobacco control.[175] They are at least as entitled to benefit from the health consequences of quitting and protection from second-hand smoke as any other members of the community.[176]

Rates of smoking are known to be significantly higher among people with conditions such as anxiety, depression,2, 10 bi-polar disorder[177] and schizophrenia.[178] Young people at risk of developing mental health problems appear to be more likely to try cigarettes and become regular smokers,[179, 180] and nicotine dependence appears to be closely associated with some aspects of clinical depression.[181] Time spent in psychiatric facilities with cultures that promote smoking can increase people’s tobacco consumption and reduce the likelihood of quitting.[182] It appears that tobacco smoking can increase the risk or worsen certain mental health problems,[183] and that nicotine withdrawal[184] can also temporarily increase symptoms of depression. While failure in quitting can worsen common mental health problems such as depression,[185] such symptoms can generally be managed, and cessation is possible without a deterioration in mental health.[186]

It is important that health professionals encourage people with mental health problems to quit smoking. Treatment for nicotine dependence should be part of the treatment plan for all patients who smoke. People living with mental illness who are not in contact with psychiatric services also need to be encouraged and supported to quit or, if appropriate, to reduce smoking in preparation for quitting.

**Actions 8.2**

*Ensure access to information, treatment and services for those with mental health problems.*

**Actions 8.3**

*Support cessation of smoking among those using mental health services.*

**Actions 8.4**

*Encourage cessation of smoking in those with mental health problems outside institutional settings.*

PEOPLE IN CORRECTIONAL FACILITIES

Completely smoke-free correctional facilities have been introduced successfully overseas (for example, the US Federal penitentiary system, at least 10 US states and some Canadian provinces). Such policies protect both prisoners and staff.

Quitting smoking would significantly improve the health prospects of people leaving correctional facilities, and may also improve their prospects for housing and even employment.

Careful planning and implementation, with cessation supports, are crucial; however, strong, well-enforced policies are entirely feasible.

**Action 8.5**

*Ensure all state-funded human services agencies and correctional facilities (adult and juvenile) are smoke-free and provide appropriate cessation supports.*
Parents can do much to discourage their children from taking up smoking. Governments can do much to assist parents’ endeavours.

FAMILIES

Young teenagers with one or more parents who smoke are more than three times more likely to experiment with smoking. Older teenagers are almost three times more likely to smoke regularly than the teenagers of parents who do not smoke.(187)

Analysis of New Zealand data in 2007 compared with 2001 has shown that the decline in smoking prevalence in teenagers has been greatest for students with no parents smoking, and least for students with both parents smoking (Table 7b of the NZ report).(188) An Australian longitudinal study shows that children of non-smokers are also more likely to remain non-smokers in the long term.(20)

Quitting by parents has a very strong effect on subsequent smoking by children, and is probably the single most important thing that a smoker-parent can do to prevent their children from also becoming smokers.(189)

Smoking by children is also highly related to sibling smoking, and older teenagers often state that they hope their younger siblings do not experiment with smoking; siblings may be an untapped resource for tobacco control.(190, 191)

Smoke-free homes increase adults’ chances of quitting,(192) and reduce the likelihood of children taking up smoking.(193-195) US studies(196, 197) have found that even after controlling for demographic factors and parents’ smoking status, children who lived in homes where smoking was banned were more than 20% less likely to take up smoking than children who lived in homes where smoking was allowed.

Children who spend more time with their families and deal effectively with conflict are less likely to take up smoking: eating dinner together most nights really does seem to be a very good idea!(21) Lack of parental supervision is also strongly associated with smoking experimentation.(187)

Action 9.1

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

SCHOOLS, UNIVERSITIES AND OTHER EDUCATIONAL INSTITUTIONS

Drug education appears to have limited efficacy in reducing uptake of smoking; however, issues surrounding tobacco – tobacco marketing, the medical aspects of tobacco use, and the public health, legal, social and environmental aspects of tobacco marketing and tobacco control – are very topical and important, and it is useful for young citizens to be informed. Thinking about the health and social justice aspects of tobacco is likely to discourage some young people from using the product.

Smoke-free policies in educational institutions provide a clear message that Australia is working towards a smoke-free future. Properly enforced, smoke-free policies in schools have been associated with lower uptake of smoking in children. They send a clear message that smoking is dangerous for everybody, and can also help to reduce peer pressure to experiment with smoking.

Action 9.2

Cover the medical, social, environmental and economic aspects of tobacco in the school curriculum and where appropriate in curriculum in tertiary institutions.
Action 9.3

Encourage schools to promote and consistently enforce smoke-free policies (buildings and school grounds) for all members of the school community.

Action 9.4

Encourage universities and other institutes of higher education to adopt smoke-free campuses, including outdoors.

MEDIA

Smoking is portrayed in movies to a much greater extent than it occurs in real life. (198-207) Reviews of the evidence by several scientific bodies (208-210) and several well-designed studies and meta-analyses (211-215) conclude that smoking by popular characters can exert a powerful influence on teenagers, particularly those with temperaments that make them prone to seeking novelty and excitement. (216, 217)

Tobacco-control experts in different countries differ as to the best approach to this problem. (218-220) Bans or automatic ratings for products depicting smoking are strongly opposed by the film and television industries, and would also not be supported by most public health advocates in Australia. One study has shown that the screening of anti-smoking advertisements before films depicting smoking would reduce the impact of such depictions. (221) but advocates fear that such advertisements would quickly become counterproductive unless they had high production values and were frequently replaced. Providing them would be expensive and labour intensive.

Australia should follow the lead of the United States and the United Kingdom, and require the Classification Board to take smoking into account when rating films and video games. Such a move would be consistent with broader government policy on censorship and classification. It may result in fewer damaging depictions of smoking in films seen by younger teenagers. For this measure to be effective, parents would need to ensure that their children only watch age-appropriate films.

Action 9.5

Make smoking a ‘classifiable element’ in movies and video games.

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

Advocacy is widely recognised as having played a crucial role in tobacco control achievements and in reducing smoking. This in turn has played a significant role in Australia’s international leadership to reduce the global burden of tobacco. It is vital that such advocacy is maintained in order to keep smoking and its effects in the news and on the political agenda. In addition to the effect of this in maintaining support for tobacco control among politicians and other decision makers, news coverage about smoking has been demonstrated to have a direct effect on quitting in adults and on smoking by children.

Action 10.1

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

Action 10.2

Ensure that politicians and other opinion leaders are aware of international developments in tobacco control, including guidelines developed to assist countries to meet international obligations under the Framework Convention on Tobacco Control, and research on the efficacy of tobacco control interventions.
Corporate social responsibility is defined as ‘the continuing commitment by business to behave ethically and contribute to economic development while improving the quality of life of the workforce, their families and the local community and society at large’.

Guidelines on the implementation of Article 13 accepted by the Parties to the FCTC(99) state that tobacco companies should be barred from contributing to any other entity for ‘social responsibility causes’ or from giving publicity to ‘socially responsible’ business practices, as both constitute advertising and promotion.

Australia should take this a step further and seek to have all companies report the percentage of their revenues generated from tobacco products.

**Action 10.3**

*Ensure greater awareness that profiting from the sale of tobacco products is incompatible with principles of corporate social responsibility.*

**Key action area 11: Ensure implementation and measure progress against and towards targets**

It will be important to ensure that the Tobacco Strategy is effectively implemented and monitored. Australia has a well-developed surveillance system on tobacco. For most targets, progress can be assessed using existing long-running regular surveys. A few gaps need to be addressed to enable governments to assess whether adequate progress is being made to ensure that targets will be met.

**ENSURING IMPLEMENTATION**

A National Tobacco Strategy Steering Committee should be established, overseeing and reporting to the Minister for Health and Ageing on implementation of the Strategy at all levels. This is especially appropriate for tobacco, where there is so much evidence on the action that is required and such strong support for its implementation.

**MEASURING PROGRESS TOWARDS OVERALL TARGET**

To assess whether we are on track in reducing the prevalence of daily smoking among adult Australians (aged 18+) – dropping from 17.4% in 2007(24) to no higher than 10% by 2020 – we need to monitor the proportion of adult Australians who report current or daily smoking in the Australian Bureau of Statistics (ABS) Health Survey scheduled for 2011 and subsequent surveys to be undertaken prior to 2020. Prevalence of daily and current smoking among Australians aged 14 and over will be reported in the National Drug Strategy Household Surveys scheduled for 2010, 2013, 2016 and 2019. Rates for Australians aged 18 and over could also be reported in these surveys.

A question about smoking has recently been included in the New Zealand census.(222) Because the response rate for the census is virtually universal, this allows calibration with data collected from other surveys (for which response rates are lower).

**Action 11.1**

*Establish a National Tobacco Strategy Steering Committee*

**Action 11.2**

*Include a question on smoking among Australians aged 18 years and over in the Australian Census scheduled for 2011, 2016 and 2021.*
If it proves impossible to obtain sufficiently reliable regular data on prevalence of smoking among adults, then the Australian Government will need to consider requiring tobacco companies to provide data on sales of tobacco products at a regional level. This could be built in to legislation requiring reports on promotional expenditure, which could also be supplied at a regional level.

MEASURING PROGRESS TOWARDS TARGETS FOR EACH STATE AND TERRITORY

The National Partnership Agreement on Preventive Health sets out the agreement of the states, territories and the Australian Government to meet a benchmark of ‘(j) reduction in state baseline for proportion of adults smoking daily commensurate with a 2 percentage point reduction in smoking from 2007 national baseline by 2011; 3.5 percentage point reduction from 2007 national baseline by 2013’, Part 4 Clause 15.

The survey instruments for measurement of these targets has not been specified. Annual population health surveys are held in New South Wales, Victoria, Western Australia and South Australia, but not in the other jurisdictions.

**Action 11.3**

*Establish a mechanism to collect reliable data on prevalence in 2011 in Queensland, Tasmania, the Australian Capital Territory and the Northern Territory.*

**MEASURING TARGETS FOR UPTAKE AND CESSATION**

To achieve substantial reductions in smoking prevalence requires both a reduction in the number of children taking up smoking and an increase in the numbers of smokers quitting.

Reports of the Australian Secondary School Survey of Smoking and the Australian School Students’ Alcohol and Drug (ASSAD) Survey regularly include the percentages of secondary school students (aged 12–15 and 16–17 years) reporting smoking at least monthly, weekly and daily. These will continue to be monitored in reports of ASSAD surveys conducted in 2011, 2014, 2017 and 2020.

**Action 11.4**

*Include in future reports of ASSAD surveys the proportion (and number) of teenagers who have ever smoked more than 100 cigarettes. Trends over time in this indicator would provide a useful estimate of the incidence and number of children taking up smoking each year.*

In addition to the proportion of adults who currently smoke, trends in attempts to quit (and also the numbers of cigarettes smoked) provide an early warning sign of any likely stalling in quit rates. This information is currently collected each year in the International Tobacco Control (ITC) Policy Evaluation Study (partly funded by the Department of Health and Ageing), which is tracking a cohort of people who were smokers at the commencement of the study in 2002.

**Action 11.5**

*Report on trends in the proportion of smokers and recent smokers who have attempted to quit in the previous three and 12 months, and the proportion who intend to quit in the next three months.*
MEASURING TARGETS FOR SMOKING AND SOCIAL DISADVANTAGE

To achieve substantial reductions in smoking prevalence also requires declines in smoking (preceded by declines in uptake and higher rates of cessation) among less educated smokers and those living in disadvantaged areas to be at least as large as declines among more educated smokers living in more affluent areas. Information on smoking in various SES groups is collected in the National Drug Strategy Household Survey.

**Action 11.6**

Report on trends over time in prevalence of smoking and numbers of cigarettes smoked for persons in all various SES groups, both in Australian Institute of Health and Welfare (AIHW) reports on detailed findings of the National Drug Strategy Household Survey, and in reports of the Australian School Students’ Smoking, Alcohol and Drug Survey.

MONITORING PROGRESS IN INDIGENOUS SMOKING

The National Aboriginal and Torres Strait Islander (NATSHI) Health and Social Surveys provide a reliable indication over time of the percentage of Indigenous Australians smoking. However, sample sizes are not sufficient in either survey to reliably detect small changes over time in Indigenous smoking at the state level and in the Northern Territory.

**Action 11.7**

Increase sample sizes of the NATSHI Health and Social Surveys to provide reliable indications of changes over time in each state and in the Northern Territory. This should be done in preference to trying to include sufficient Indigenous people in annual state population surveys.

**Action 11.8**

Use state population surveys to over-sample each year within two or three state health department regions with a high proportion of Indigenous residents, so that reliable estimates of prevalence at a regional level become available on a three-yearly basis.

**Action 11.9**

Analyse percentage changes in the prevalence of Indigenous smoking compared with percentage changes in previous periods, and compared with absolute and percentage changes in the non-Indigenous population.

As with the general population, smoking uptake and cessation also needs to be monitored in Indigenous people.

**Action 11.10**

Extend the ASSAD Survey to more remote areas of Australia and to Indigenous schools to ensure the inclusion of greater numbers of Indigenous children. This would enable a reliable indication of changes over time in Indigenous smoking in each state and territory.

**Action 11.11**

Establish a panel of Indigenous people who are currently smokers to enable the monitoring of intentions and attempts to quit, amounts smoked and the prevalence of smoking indoors and around others. The panel could also be used to monitor the impact of tobacco control policies among Indigenous people.

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*Over-sample schools in both urban and rural areas that are listed with Education Departments as having high numbers of Indigenous students.*
MEASURING TARGETS FOR EXPOSURE TO SECOND-HAND SMOKE

Data on levels of exposure to second-hand smoke in the community is currently being collected, but is not being reported on (or consequently monitored) in a systematic way.

**Action 11.12**

*Report on trends over time, by SES, in the proportion of Australians aged 14 years and over exposed to second-hand smoke at work and indoors at home.*

**Action 11.13**

*Report on long-term trends in the percentage of students (smokers and non-smokers) who have one or more parents who smoke, and who live in homes that are smoke-free.*

**Action 11.14**

*Report for each state and territory, for women living in areas of varying levels of social disadvantage, and for Indigenous and non-Indigenous women, the proportion of pregnant women who report smoking at early and late stages of pregnancy.*
# TOBACCO: IMPLEMENTATION PLAN

Summary of action required and how progress will be measured

<table>
<thead>
<tr>
<th>KEY ACTION AREAS</th>
<th>RESPONSIBILITY</th>
<th>STAGED IMPLEMENTATION</th>
<th>MEASUREMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.1 Ensure that the average price of a packet of 30 cigarettes is at least $20 (in 2008 $ terms) within three years, with equivalent increases in the price of roll-your-own and other tobacco products.</td>
<td>Australian Government – Treasury; Australian Tax Office (ATO).</td>
<td>Year 1 onwards</td>
<td>Recommended retail price of leading brands. Prices actually paid by consumers. Immediate month-on-month change (pre- and post-increases) in smoking status among various income groups and in sales of tobacco products. Changes in quit attempts and reported number of cigarettes smoked daily.</td>
</tr>
<tr>
<td>1.2 Develop and implement a coordinated national strategy to prevent the emergence of illicit trade in tobacco.</td>
<td>A lead government agency (to be nominated by the Australian Government) with input from the ATO, ACBPS, AQIS, Australian Federal Police, state police, Australian and state Departments of Health.</td>
<td>Year 1: Nominate lead agency. Year 2: Report. Year 4: Legislative reforms if required. Year 5: Review and refinements to Strategy.</td>
<td>Percentage of smokers reporting purchase of tobacco or cigarettes outside licensed outlets.</td>
</tr>
<tr>
<td>1.3 Contribute to the development and implementation of international agreements aiming to combat illicit trade in tobacco globally.</td>
<td>Lead agency (as above) and the intergovernmental group established by the Department of Health and Ageing to negotiate the FCTC protocol on illicit trade (the group currently comprising the Department of Health and Ageing, the ATO, Treasury, Attorney-Generals, Prime Minister and Cabinet, Department of Foreign Affairs).</td>
<td>Years 2–4 (and thereafter)</td>
<td>Australia plays a role in developing and implementing international agreements aiming to combat illicit trade in tobacco.</td>
</tr>
<tr>
<td>KEY ACTION AREAS</td>
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<td>MEASUREMENT</td>
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<tr>
<td>1.4 Ban the retail sale of tobacco products via the internet.</td>
<td>Australian Government.</td>
<td>Year 2 or 3</td>
<td>Legislation drafted and in force.</td>
</tr>
<tr>
<td>1.5 End tax and duty free sales in Australia; abolish tax and duty concessions for all travelers entering Australia (specified limits for personal use); and participate in negotiations on international agreements concerning the application of limits to international travelers.</td>
<td>ATO and ACBPS.</td>
<td>Year 3</td>
<td>Amendment Customs Regulations 1926 (Cth).</td>
</tr>
</tbody>
</table>

**Key action area 2: Increase the frequency, reach and intensity of social marketing campaigns**

2.1 Run effective social marketing campaigns at levels of reach demonstrated to reduce smoking.

2.1.1 Fund nationwide screening of most effective television advertisements, including those demonstrated to be most effective in state campaigns.

<table>
<thead>
<tr>
<th></th>
<th>Department of Health and Ageing and state/territory agencies</th>
<th>Year 1</th>
<th></th>
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</thead>
</table>

2.1.2 Provide long-term budget allocations at both federal and state levels to ensure commercially realistic funding for media campaigns (at least 700 TARPs per months until smoking prevalence reaches 9%).

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<thead>
<tr>
<th></th>
<th>Australian Government/ states and territories.</th>
<th>Years 2-5 (and thereafter)</th>
<th></th>
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</thead>
</table>

2.1.3 Fund development of a suite of effective materials covering a range of health issues including dramatic treatments.

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<thead>
<tr>
<th></th>
<th>Australian Government/ states and territories.</th>
<th>Years 2-5 (and thereafter)</th>
<th></th>
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</thead>
</table>

2.1.4 Place media to ensure maximum reach with smokers including young smokers and smokers from disadvantaged groups.

<table>
<thead>
<tr>
<th></th>
<th>National Prevention Agency (NPA)* and states and territories working with NGOs.</th>
<th>Years 2-5 (and thereafter)</th>
<th></th>
</tr>
</thead>
</table>

* or appropriate national agency

**Percentage of target audiences (including young and low SES smokers) who:**

- Have seen advertising used in recent campaigns
- Can name themes covered in advertising (unprompted and prompted)
- Correctly identify health risks and other disadvantages of smoking
- See such disadvantages as salient and relevant to themselves
- Agree that advertising contributed to their decision to quit or assisted with staying stopped
- Took action in the weeks during or following campaigns
- Number of Quitline calls in response to different creative material, program placement and advertising weight.
- Hits to cessation support websites over periods in which advertising is on air.
### KEY ACTION AREAS

| 2.2  | Choose messages most likely to reduce prevalence in socially disadvantaged groups and provide extra reach to these groups through the skewing of placement to television programs most likely to be watched by low SES groups, and by targeting radio, outdoor and other local advertising to low SES neighbourhoods. | Australian Government/states and territories/NGOs. | Years 1–5 (and thereafter) | Percentage of targets who have seen recent advertising. Number of Quitline calls and web-hits from people with disadvantaged postcodes, with and without extra advertising. |

### Key action area 3: End all forms of advertising and promotion of tobacco products

<p>| 3.1  | Legislate to eliminate all remaining forms of promotion, including advertising of price specials, public relations activities, payments to retailers and proprietors of hospitality venues, promotion through packaging and as far as feasible through new and emerging forms of media. | Australian Government. | Year 1 | Review legislation and policies. Year 2 | Amend legislation. Year 3 | Introduce restrictions. Year 4 onwards | Proactively enforce legislation and prosecute as deterrent to breaches. | Percentage of young people aware of tobacco promotion in media, sport or popular entertainment. |
| 3.2  | Regulate to require mandatory reporting of amounts spent on any form of promotion – on payments to public relations companies or any other third parties, as well as details of any other promotional expenditure. | Australian Government. | Year 2 | System established or not. |
| 3.3  | Amend legislation to ensure that tobacco is out-of-sight in retail outlets in all jurisdictions. | All state and territory governments. All states and territories to implement. | Year 1 | Year 2 (by end of 2011) | Percentage of teenagers and adults aware of tobacco advertising at point of sale. Percentage of stores where stock is visible. |</p>
<table>
<thead>
<tr>
<th>KEY ACTION AREAS</th>
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<tbody>
<tr>
<td><strong>3.4 Eliminate promotion of tobacco products through design of packaging.</strong></td>
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</tr>
<tr>
<td><strong>3.4.1 Amend Tobacco Advertising Prohibition Act 1992 to require that no tobacco product may be sold except in packaging of a shape, size, material and colour prescribed by the government, with no additional design features.</strong></td>
<td>Australian Government.</td>
<td>Year 1 or 2</td>
<td>Market weighted percentage of brands that comply with plain packaging regulations.</td>
</tr>
<tr>
<td><strong>3.4.2 Undertake research to establish optimal colours, pack sizes and fonts that would be prescribed.</strong></td>
<td>Department of Health and Ageing.</td>
<td>Years 2 and 3 Commission work.</td>
<td>Percentage of teenagers and adults with false beliefs about particular brands (smoother, less tar etc) and extent of positive appraisal of cigarette packaging and brand identities.</td>
</tr>
<tr>
<td><strong>3.4.3 Amend Trade Practices CPS (Tobacco) Regulations 2004 to specify exact requirements for plain packaging.</strong></td>
<td>Australian Government.</td>
<td>Year 3</td>
<td></td>
</tr>
<tr>
<td><strong>3.4.4 Commence new arrangements.</strong></td>
<td>Department of Health and Ageing and Australian Competition &amp; Consumer Commission.</td>
<td>Years 4–5</td>
<td></td>
</tr>
</tbody>
</table>

**Key action area 4: Eliminate exposure to second-hand smoke in public places**

| 4.1 Amend legislation and departmental policies to ensure that smoking is prohibited in any public places where the public, particularly children, are likely to be exposed. | All state and territory governments. | Year 1  
Legislate and introduce policies.  
Year 3  
Restrictions in force inline with best practice in all jurisdictions. | Percentage of Australian population living in jurisdictions not covered by legislation in each area. |
|---|---|---|---|
| **4.2** | All state and territory governments.  
Enforcement – state and territory governments. | Year 1  
Legislate  
Year 2 onwards: Enforce | Percentage of smokers with children who report sometimes or often smoking in cars.  
Percentage of people detected smoking in cars in observational studies. |
| **4.3** | All state and territory governments and local councils where applicable. | Year 1  
Review legislation and policies.  
Year 2  
Amend legislation.  
Year 4  
Restrictions in force inline with best practice in all jurisdictions. | Percentage of adults reporting exposure to second-hand smoke in their place of work.  
Measures on air-monitoring studies. |
<table>
<thead>
<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>4.4 Introduce and enforce legislation, and encourage adoption of policies that restrict smoking outdoors where people gather or move in close proximity.</td>
<td>All state and territory governments.</td>
<td>Year 1: Review legislation. Year 2: Amend legislation. Year 4: Additional restrictions appropriate to local practice in force in all jurisdictions.</td>
<td>Percentage of adults reporting exposure to second-hand smoke in their day-to-day life.</td>
</tr>
<tr>
<td>4.5 Protect residents from exposure to smoke-drift in multi-unit developments.</td>
<td>All state and territory governments.</td>
<td>Year 2: Review policies and explore options. Years 3 and 4: Legislate. By Year 5: Legislation in force in all jurisdictions.</td>
<td>Percentage of adults reporting exposure to second-hand smoke in their place of residence.</td>
</tr>
</tbody>
</table>

**Key action area 5: Regulate manufacturing and further regulate packaging and supply of tobacco products**

| 5.1 Tighten and enforce legislation to eliminate sales to minors and any form of promotion of tobacco at retail level. | All state and territory governments. | Year 1: Amend legislation. Year 2: All retailers in Australia to be licensed. | Percentage of tobacco retailers in Australia who are subject to licensing regulations. |

<p>| 5.1.1 Require all tobacco retailers be licensed. | All state and territory governments. | | |</p>
<table>
<thead>
<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>5.1.2 Legislate to preclude sales through vending machines, internet, at hospitality and other social venues.</td>
<td>All state and territory governments.</td>
<td>Year 1 Review legislation. Year 2 Amend legislation. Year 3 Best practice provisions operating in all jurisdictions.</td>
<td>Percentage of young people aware of tobacco products sold through entertainment venues, the internet etc.</td>
</tr>
<tr>
<td>5.1.3 Review and if necessary legislate to put the onus of proving age on retailers and to increase the penalties for breaches.</td>
<td>All state and territory governments.</td>
<td>Year 1 Review budgets for compliance monitoring and enforcement. Year 2 Amend legislation to increase licence fees accordingly. Year 3 Optimal budget for compliance monitoring and enforcement in all jurisdictions.</td>
<td>Percentage of revenues for enforcement programs in jurisdictions from licence fees.</td>
</tr>
<tr>
<td>5.1.4 Ensure licence fees are high enough to provide funds for education on the legislation, compliance monitoring and prosecution.</td>
<td>All state and territory governments.</td>
<td>Year 1 Review budgets for compliance monitoring and enforcement. Year 2 Amend legislation to increase licence fees accordingly. Year 3 Optimal budget for compliance monitoring and enforcement in all jurisdictions.</td>
<td>Percentage of revenues for enforcement programs in jurisdictions from licence fees.</td>
</tr>
<tr>
<td>5.2 Improve consumer product information related to tobacco products.</td>
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<tr>
<td>5.2.1 Mandate standard plain packaging of all tobacco products to ensure that design features of the pack in no way reduce the prominence or impact of prescribed government warnings – refer to 3.4.</td>
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<tr>
<td>5.2.2 Substantially increase the size of required front-of-pack warnings, prohibit misleading labelling, brand names and product characteristics, and ban products such as specially designed covers that would reduce efficacy of warnings.</td>
<td>Department of Health and Ageing.</td>
<td>Year 1</td>
<td>Percentage of smokers able to recall each of the mandated warnings and able to demonstrate understanding of: Magnitude of risk Severity of illnesses and consequences for quality of life Tractability of conditions (curability, survival rates and times) Percentage of smokers endorsing false health information or inaccurate beliefs.</td>
</tr>
<tr>
<td>Research to identify the optimal size for health warnings in the context of plain packaging</td>
<td>Department of Health and Ageing.</td>
<td>Year 1</td>
<td></td>
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<tr>
<td>Identify health issues that need to be covered in new warnings</td>
<td>Australian Competition and Consumer Commission. Australian Government.</td>
<td>Year 2</td>
<td></td>
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<tr>
<td>Specify all changes required to CPI (tobacco) regulations</td>
<td></td>
<td>Year 3, Year 6 and every three years</td>
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<tr>
<td>Amend regulations</td>
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<tr>
<td>5.2.3 Automatically review and upgrade warnings on tobacco packages at least every three years, with the Chief Medical Officer to have the capacity to require amendments in between.</td>
<td>Australian Health Protection Committee (AHPC) or other appropriate group.</td>
<td>Year 3</td>
<td>Amend Trade Practices Act to require such reviews and give the CMO this power.</td>
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<tr>
<td>5.2.4 Link the process of regularly reviewing mandated consumer product information to a process that would provide more timely warning to Australian consumers of new and emerging health risks through mechanisms such as alerts in the media and notices at point of sale.</td>
<td></td>
<td>Year 1</td>
<td>Average time from release of meta-analyses, major studies or major reports to issuing of public statement.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Year 2</td>
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<td></td>
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<td>Year 3</td>
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<tr>
<td></td>
<td></td>
<td>System operating.</td>
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<tr>
<td>5.3 Ensure compliance with new regulations regarding reduced fire-risk cigarettes.</td>
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<tr>
<td>5.3.1 Introduce reduced fire-risk cigarettes in the market.</td>
<td>Minister for Consumer Affairs.</td>
<td>From March to September 2010</td>
<td>Market-weighted percentage of cigarette brands sold that are compliant with the standard for reduced fire-risk. Number of fires known to be started by discarded cigarettes.</td>
</tr>
<tr>
<td>KEY ACTION AREAS</td>
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<tr>
<td>5.4  Regulate tobacco design, contents, emissions and labelling.</td>
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<tr>
<td>5.4.1 Establish or nominate a body with the power to regulate the contents and performance of tobacco products and any alternative nicotine delivery devices that may come onto the market in Australia, and with responsibility for specifying the exact wording of any public disclosures about contents and performance.</td>
<td>Department of Health and Ageing, Australian Government. Nominated body.</td>
<td>Year 2: Develop proposal. Year 3: Amend necessary legislation to establish body (or give powers to an existing body). Year 4: Commence.</td>
<td>Body established/nominated or not.</td>
</tr>
<tr>
<td>5.4.2 Specify the form and content of reporting required for all tobacco products, and the exact wording required for disclosures to consumers.</td>
<td>Nominated body.</td>
<td>Year 3</td>
<td>Reporting procedures in place or not.</td>
</tr>
<tr>
<td>5.4.4 Consider banning all additives that enhance palatability or addictiveness.</td>
<td>Nominated body.</td>
<td>Year 3</td>
<td></td>
</tr>
<tr>
<td>5.4.5 Specify any further modifications required, restrictions on additives or upper limits for emissions.</td>
<td>Nominated body.</td>
<td>Year 4 onwards</td>
<td></td>
</tr>
<tr>
<td>5.5 Investigate the feasibility of legal action by governments and others against tobacco companies to recover health and other costs.</td>
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</tr>
<tr>
<td>5.5.1 Investigate the legal implications of continuing sales of tobacco products and principles that should guide future regulation.</td>
<td>Australian, state and territory governments.</td>
<td>Year 2</td>
<td>Investigations under way or not. If the industry is found to be liable for costs, whether action is in place to recover. Whether or not fines, fees or surcharges are in place to ensure that the costs of addressing harm caused by tobacco have been established.</td>
</tr>
<tr>
<td>5.5.2 Investigate possible mechanisms for recovery of costs.</td>
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<tr>
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</tr>
<tr>
<td>Key action area 6: Ensure all smokers in contact with health services are encouraged and supported to quit, with particular efforts to reach pregnant women and those with chronic health problems</td>
<td></td>
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<td></td>
</tr>
<tr>
<td><strong>6.1</strong> Ensure all state- or territory-funded healthcare services (general, maternity and psychiatric) are smoke-free, protecting staff, patients and visitors from exposure to second-hand smoke both indoors and on facility grounds.</td>
<td>State and territory ministers and governments.</td>
<td>Depending on current status in jurisdictions. Years 1–2</td>
<td>Absence or presence of state-wide policies.</td>
</tr>
<tr>
<td><strong>6.2</strong> Ensure all patients are routinely asked about their smoking status and supported to quit, both while being treated and post-discharge.</td>
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</tr>
<tr>
<td><strong>6.2.1</strong> Include requirement in hospital accreditation procedures.</td>
<td>Hospital associations and accrediting organisations.</td>
<td>Year 1 Develop guidelines. Year 2 Implement.</td>
<td>Included or not.</td>
</tr>
<tr>
<td><strong>6.2.2</strong> Include a requirement in service funding agreements and performance contracts with senior staff.</td>
<td>State and territory Health Departments.</td>
<td>Year 1 onwards</td>
<td>Percentage of institutions in each jurisdiction that are subject to funding agreements. Percentage of staff for whom action on tobacco is included in performance contracts.</td>
</tr>
<tr>
<td><strong>6.2.3</strong> Provide training in institutional or health-service procedures for assessment and referral.</td>
<td>State and territory governments.</td>
<td>Year 2 onwards</td>
<td>Percentage of institutions in each jurisdiction that have established systems and percentage of staff that have undergone training.</td>
</tr>
<tr>
<td><strong>6.2.4</strong> Provide training in smoking cessation counseling in pre-service training and continuing professional education for all health workers.</td>
<td>Australian Government. Lead training provider institutions and professional associations in medical, nursing and allied health fields.</td>
<td>Year 2 onwards</td>
<td>Number of health professionals that have undergone training.</td>
</tr>
<tr>
<td><strong>6.3</strong> Improve the quality and use of pharmacotherapies and services demonstrated to assist with smoking cessation.</td>
<td>National Prescribers Service, pharmaceutical companies, health professionals, pharmacists and Quitline counsellors.</td>
<td>Year 1 onwards</td>
<td>Percentage of people using pharmacotherapies who receive behavioural information, support or counselling.</td>
</tr>
<tr>
<td>KEY ACTION AREAS</td>
<td>RESPONSIBILITY</td>
<td>STAGED IMPLEMENTATION</td>
<td>MEASUREMENT</td>
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<tr>
<td>6.4  Increase availability of Quitline service.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6.4.1 Ensure that Quitlines are resourced to respond to projected demand from media campaigns.</td>
<td>Department of Health and Ageing.</td>
<td>Year 1&lt;br&gt;Assess the likely increase in demand, additional resources required and optimal arrangements for service provision.&lt;br&gt;Year 2 onwards&lt;br&gt;Upgraded service operating nationwide.</td>
<td>Mised call rates in each state and territories.</td>
</tr>
<tr>
<td>6.4.2 Fund the development and delivery of interactive smoking cessation services using approaches such as internet, mobile phone and web-enabled mobile devices.</td>
<td>NPA. Nominated agencies.</td>
<td>Year 2&lt;br&gt;Preparatory work.&lt;br&gt;Year 3&lt;br&gt;Web 2.0 Quitline services operating nationwide.</td>
<td>Whether programs are in place.</td>
</tr>
<tr>
<td>6.4.3 Establish special Quitline counselling services for pregnant women, including call-back services and feedback to treating obstetricians/GPs/midwives.</td>
<td>NPA. Nominated agencies.</td>
<td>Years 2 and 3&lt;br&gt;From end of Year 3&lt;br&gt;Expectant and New Parent Quitline operating nationwide and promoted to all major obstetric care providers.</td>
<td>Number of callers using Expectant and New Parent Quitline, caller satisfaction levels, quit attempts and quit rates in evaluation samples.</td>
</tr>
<tr>
<td>6.4.4 Establish a group of counsellors within one or more Quitlines who would deal specifically with people needing to use interpreter services.</td>
<td>NPA. Nominated agencies.</td>
<td>Year 2&lt;br&gt;Preparatory work.&lt;br&gt;Year 3&lt;br&gt;Quitline via interpreter operating nationwide and promoted through national non-English language media.</td>
<td>Number of callers using Non-English Quitline, caller satisfaction levels, quit attempts and quit rates in evaluation samples.</td>
</tr>
<tr>
<td>6.4.5 Establish a group of counsellors within one or more Quitlines who would deal specifically with people receiving specialist treatment for chronic health conditions (asthma, diabetes, arthritis, CVD etc), mental illness, providing call-back services and feedback to treating health professionals.</td>
<td>NPA. Nominated agencies.</td>
<td>Year 2&lt;br&gt;Preparatory work.&lt;br&gt;Year 3&lt;br&gt;Chronic Care Quitline operating nationally and promoted with all major relevant providers.</td>
<td>Number of callers using Chronic Care Quitline, caller satisfaction levels, quit attempts and quit rates in evaluation samples.</td>
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<td>KEY ACTION AREAS</td>
<td>RESPONSIBILITY</td>
<td>STAGED IMPLEMENTATION</td>
<td>MEASUREMENT</td>
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<tr>
<td>6.5 Ensure that NRT is affordable for all those for whom it is clinically appropriate.</td>
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<tr>
<td>6.5.1 Investigate options for provision including through the Quitline and through the PBS.</td>
<td>Department of Health and Ageing.</td>
<td>Year 1 Develop proposal.</td>
<td>Number of prescriptions and proportion of prescriptions that are concessional.</td>
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<td>To be determined.</td>
<td>Year 2 Submit proposal to the Pharmaceutical Benefits Advisory Committee or direct to the Australian Government.</td>
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<td></td>
<td>Australian Government.</td>
<td>Year 3 Consider proposals and implement preferred arrangements.</td>
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<tr>
<td>6.5.2 Ensure availability of NRT and Quitline services for patients and clients of all state and territory health services.</td>
<td>State and territory governments.</td>
<td>Year 1 onwards NRT available through pharmacies of all public hospitals.</td>
<td>Percentage of public hospitals in each state and territory that routinely provide NRT.</td>
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<td></td>
<td>Year 2 Voucher scheme operating for clients of all other state-funded human services.</td>
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<td>6.6 Explore whether financial incentives might be effective in helping people to quit or stay non-smokers.</td>
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<tr>
<td>6.6.1 Consider exempting from Fringe Benefits Tax employers who cover the costs of cessation therapies or who provide financial incentives to quit.</td>
<td>Preventative Health Taskforce. Australian Government. Australian and state governments.</td>
<td>From Year 1 Exploratory research.</td>
<td>Whether or not pilot projects have been funded and evaluated.</td>
</tr>
<tr>
<td>6.6.2 Trial incentive program for young Indigenous children to stay smoke-free, remain at school etc.</td>
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<td>Year 2 or 3 Implementation to follow if appropriate.</td>
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<tr>
<td>6.6.3 Trial projects that use incentive payments to help people to retain their resolve to stay stopped after quitting.</td>
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</table>
### Key Action Area 7: Work in partnership with Indigenous groups to boost efforts to reduce smoking and exposure to passive smoking among Indigenous Australians

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<thead>
<tr>
<th>Key Action Areas</th>
<th>Responsibility</th>
<th>Staged Implementation</th>
<th>Measurement</th>
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</thead>
</table>
| **7.1** Establish multi-component community-based tobacco control projects that are locally developed and delivered. | - Project sites to be determined through a transparent process.  
- Projects to be developed and led by local Indigenous communities. Organisation(s) with main responsibility for the projects depends on the location and nature of the projects, but may include local Indigenous health services, state/territory National Aboriginal Community Controlled Health Organisation (NACCHO) affiliates, or regionally based associations of Indigenous health services.  
- Projects may involve partnerships with Indigenous organisations from other sectors. | Year 1  
Project sites chosen.  
Years 1–4  
Project is funded.  
Year 4  
Evaluation. | Percentage of Indigenous people aware of project activities.  
Changes in knowledge and attitudes in targeted compared to non-targeted communities.  
Percentage of community events and meetings that are smoke-free.  
Changes in wholesale orders of tobacco products in targeted communities. |
<p>| <strong>7.2</strong> Enhance social marketing campaigns for Indigenous smokers ensuring a ‘twin track’ approach of using existing effective mainstream campaigns complemented by Indigenous-specific campaign elements. | | | |</p>
<table>
<thead>
<tr>
<th>KEY ACTION AREAS</th>
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<th>MEASUREMENT</th>
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<tbody>
<tr>
<td>7.2.1 Identify and run existing mainstream tobacco control campaigns that have demonstrated an effect in terms of awareness, impact and relevance to Indigenous people.</td>
<td>Australian, state and territory governments, NPA, NGOs and Quit campaigns, NACCHO and other Indigenous organisations.</td>
<td>Year 1</td>
<td>Percentage of Indigenous smokers surveyed who: Have seen advertising used in recent campaigns Can name themes covered in advertising (unprompted and prompted) Correctly identify health risks and other disadvantages of smoking See such disadvantages as salient and relevant to themself Agree that advertising contributed to their decision to quit or assisted with staying stopped Took action in the weeks during or following campaigns</td>
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<tr>
<td>7.2.2 Identify existing campaign material that could be adapted to include greater representation of Indigenous people and include relevant themes and calls to action.</td>
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<td>Year 2 onwards</td>
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<tr>
<td>7.2.3 Develop new Indigenous-specific campaign material using radio and complemented by local print and/or outdoor campaigns.</td>
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<td>7.2.4 Link social marketing campaigns to community projects and activities of health workers.</td>
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<td>7.2.5 Enhance qualitative research efforts to examine the impact of campaigns and future campaign directions.</td>
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<tr>
<td>7.3 Provide training to Aboriginal and Torres Strait Islander health workers to improve skills in the provision of smoking cessation advice and in developing community-based tobacco control programs.</td>
<td>Strengthen delivery of tobacco control information within Aboriginal Health Workers (AHW) training and on-the-job – NACCHO state and territory affiliates, and RTOs providing AHW training, Delivery of brief intervention packages (e.g. Smokecheck, Quit) – state/territory government departments, NGOs (e.g. Quit Victoria).</td>
<td>Year 1</td>
<td>Revision of training packages. Year 1 and ongoing Delivery. Years 1 and 2 Roll out delivery of existing packages (with adaptation where necessary), and evaluation. Years 3 and 4 Revision of packages where necessary. Ongoing delivery and support to AHWs. Project evaluation.</td>
</tr>
<tr>
<td>7.4 Improve training in the provision of smoking cessation advice of other health professionals working in Aboriginal and Torres Strait Islander health services.</td>
<td>Developing and delivering TC programs – (e.g. CEITC ‘Talking Up Good Air’ kit), Up-to-date information through existing training available to GPs and RNs (e.g. through Divisions of GPs).</td>
<td>Years 1 and 2</td>
<td>Intensively during and ongoing. Years 3 and 4 Less intensive delivery and support activities. Year 1 and ongoing</td>
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<td>Years 3 and 4</td>
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<tr>
<td>7.5 Place specialist Tobacco Control Workers in Indigenous community health organisations to build capacity at the local health service level to develop and deliver tobacco control activities.</td>
<td>Specialist Tobacco Control Workers should ideally be placed within each Indigenous health service, or within a group of regionally associated Indigenous health services (to be determined with input from the Indigenous community-controlled health sector). State/territory-wide Tobacco Control Workers should also be based at NACCHO state/territory affiliates to support the service-level Tobacco Control Workers.</td>
<td>Year 1 - Process to determine placement of these workers. Years 1-4 - Workers to be placed. Year 4 - Evaluation of impact.</td>
<td>Number of workers in position.</td>
</tr>
<tr>
<td>7.6 Provide incentives to encourage NGOs to employ Indigenous workers.</td>
<td>Australian and state and Territory governments to provide incentives to NGOs (e.g. Cancer Councils, Heart Foundation, Quit).</td>
<td>Year 1 and ongoing</td>
<td>Number of Indigenous workers employed in NGOs.</td>
</tr>
</tbody>
</table>

**Key action area 8: Boost efforts to discourage smoking among people in other highly disadvantaged groups**

8.1 Boost efforts to discourage smoking in highly disadvantaged neighbourhoods.

8.1.1 Target surveillance and enforcement of sales to minors legislation in disadvantaged areas. | State and territory governments and local councils. | Year 1 onwards | Percentage of staff time and funding for education and compliance monitoring spent in low SES areas. Response and referral rates of health professionals. Number of calls to Quitlines (hits on website) from people giving their address indicating low SES postcodes. |

8.1.2 Target promotion aimed at encouraging GPs and other health professionals to refer to Quitlines to practices located in disadvantaged areas. | NPA or appropriate body, divisions of general practice and other local health agencies. | Year 2 onwards | |

8.1.3 Place the majority of any poster/ outdoor or mobile advertising in highly disadvantaged neighbourhoods. | Quit campaigns. | Year 1 onwards | |

8.2 Ensure access to information, treatment and services for those with common mental health problems.

8.2.1 Intervene more vigorously to prevent smoking uptake in young people at risk of developing mental health problems. | NPA in consultation with mental health agencies, advocacy groups. Other relevant government and non-government organisations. | Year 2 - Develop proposals. Year 3 - Assess and implement. | Whether discussions have been held and whether initiatives have been commenced. |
<table>
<thead>
<tr>
<th>KEY ACTION AREAS</th>
<th>RESPONSIBILITIES</th>
<th>STAGED IMPLEMENTATION</th>
<th>MEASUREMENT</th>
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<tbody>
<tr>
<td>8.2.2 Educate GPs and other health professionals that people with common mental health problems can succeed in quitting and benefit from greater control of withdrawal symptoms.</td>
<td>NPA, National Prescribing Service, agencies involved in GP training.</td>
<td>Year 1: Develop proposals in consultation with mental health agencies and advocacy groups. Year 2 onwards: Assess and implement.</td>
<td>Responses in studies of health professionals.</td>
</tr>
<tr>
<td>8.2.3 Ensure that the most clinically suitable pharmacotherapy to aid smoking cessation is affordable for all those with mental health problems.</td>
<td>Department of Health and Ageing.</td>
<td>Year 1: Investigate options for provision including through the Quitline and PBS.</td>
<td>Whether or not any person suffering mental health problems is able to receive or purchase at an affordable price the therapy their psychiatrist believes to be most appropriate.</td>
</tr>
<tr>
<td>8.2.4 Train all staff working on Quitlines about common mental health problems and how to support people living with such problems to quit successfully.</td>
<td>Quitlines.</td>
<td>Year 1: Develop plans and programs. Year 2 onwards Run ongoing professional development.</td>
<td>Whether or not training has occurred (and percentage of staff trained) in each state and territory.</td>
</tr>
<tr>
<td>8.2.5 Include information on quitting and common mental health problems in Quitbooks, internet and other educational materials.</td>
<td>Quit campaigns.</td>
<td>Ongoing</td>
<td>Whether information is included or not.</td>
</tr>
</tbody>
</table>

8.3 Support cessation among those using mental health services.

<p>| 8.3.1 Educate mental health professionals about the importance of quitting and the importance of not discouraging quit attempts in clients. | NPA. | Ongoing | Responses in studies of health professionals. |
| 8.3.2 Include in healthcare agreements requirements that child, adolescent and adult mental health services and drug treatment agencies: | State/territory governments. | Year 2 | Requirement included or not. |
| - Be smoke-free | | | Percentage of facilities in each jurisdiction subject to and in compliance with agreements. |
| - Routinely identify smokers | | | |
| - Include smoking cessation advice and treatment of nicotine dependence in all patient treatment plans | | | |
| - Offer support to patients at transition points | | | |</p>
<table>
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<tr>
<th>KEY ACTION AREAS</th>
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<th>MEASUREMENT</th>
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<tbody>
<tr>
<td>8.3.3 Support these processes by commissioning the production of national information packages for clinicians and facility managers.</td>
<td>Department of Health and Ageing.</td>
<td>Ongoing</td>
<td></td>
</tr>
<tr>
<td>8.3.4 Run a rolling program to train all staff in such services over a three-year period.</td>
<td>State and territory governments.</td>
<td>Ongoing</td>
<td>Number and percentage of professional staff in each jurisdiction who have undertaken training.</td>
</tr>
<tr>
<td>8.4 Encourage cessation in those with mental health problems outside institutional settings.</td>
<td>Australian Government / state and territory governments</td>
<td>Year 1: Improve staff training. Year 2: Commence promotion.</td>
<td>Number of referrals from each service.</td>
</tr>
<tr>
<td>8.4.1 Encourage GPs, maternal and child health nurses, other health professionals and services such as Kidsline, Mensline and the BeyondBlue information line to ask people about smoking status and extent of tobacco use and to refer smokers to Quitline.</td>
<td>State and territory governments.</td>
<td>Year 1: Evaluate South Australian project. Year 2 onwards: Adapt as appropriate in other states and territories.</td>
<td>Number of people attending such courses and quit rates in samples evaluated.</td>
</tr>
<tr>
<td>8.4.2 Fund Quit courses for people with mental illness in non-threatening community settings.</td>
<td>State and territory governments.</td>
<td>Year 1: Improve staff training. Year 2: Commence promotion.</td>
<td></td>
</tr>
<tr>
<td>8.5 Ensure all state-funded human services agencies and correctional facilities (adult and juvenile) are smoke-free and provide appropriate cessation supports.</td>
<td>State and territory governments.</td>
<td>Years 1 and 2: Planning. Year 3: All facilities completely smoke-free in all states and territories.</td>
<td>Percentage of facilities in each jurisdiction covered by and compliant with policies.</td>
</tr>
<tr>
<td>Key action area 9: Assist parents and educators to discourage use of tobacco and protect young people from second-hand smoke</td>
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<tr>
<td><strong>9.1</strong> Convey the message that parents can help – by quitting smoking; making homes smoke-free; choosing appropriate films, videos and games; and by making it clear that they do not want their children to smoke for the sake of their health.</td>
<td>Quit campaigns and prevention programs (Smarter than Smoking etc).</td>
<td>Ongoing</td>
<td>Track the percentage of parents of young people under 18 who: Ever smoke indoors Have tried to or succeeded in quitting Track the percentage of young people aged 12–15 and 16–17 years reporting: Being aware of the seductive depictions of smoking in films, television, video games etc That parents set clear rules about not smoking at home Know their parents would strongly disapprove of them smoking</td>
</tr>
<tr>
<td><strong>9.2</strong> Cover the medical, social, environmental and economic aspects of tobacco in the school curriculum.</td>
<td>Education systems.</td>
<td>Ongoing</td>
<td>Percentage of young people aged 12–15 and 16–17 years reporting: Remembering a lesson at school concerning smoking</td>
</tr>
<tr>
<td><strong>9.3</strong> Encourage schools to enforce smoke-free policies (grounds as well as buildings) for all members of the school community consistently both indoors and in grounds.</td>
<td>Schools.</td>
<td>Ongoing</td>
<td>Percentage of young people aged 12–15 and 16–17 years reporting schools enforcing smoke-free policies.</td>
</tr>
<tr>
<td><strong>9.4</strong> Encourage universities and other institutions of higher education to adopt smoke-free policies, including outdoors on campus.</td>
<td>Universities and other institutions of higher education.</td>
<td>Ongoing</td>
<td>Percentage of administrators reporting enforcement of smoke-free policies in schools and institutions of higher education.</td>
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<tr>
<td>KEY ACTION AREAS</td>
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<tr>
<td>9.5 Make smoking a ‘classifiable element’ in movies and video games.</td>
<td>Australian Government.</td>
<td>Year 2</td>
<td>Exposure of Australian teenagers (concentrating on those aged 14–15 years) to portrayals of smoking in movies (both at the cinema and on DVD). Desk-top study of the percentage of films (PG, M and MA) screening in Hoyts and Village cinemas in Australia with positive portrayals of smoking. Survey of which films the average 14–15-year-old sees each year.</td>
</tr>
<tr>
<td>9.5.1 Designate tobacco use as a ‘classifiable element’, to be taken into account by the Classification Board when rating films.</td>
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<tr>
<td>9.5.2 Produce guidance notes to the Board and to television licensees based on the literature on the impact of portrayals of smoking on young people.</td>
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<tr>
<td>9.5.3 Fund a project to raise awareness among people working in the Australian film, television and entertainment industries of the damaging effects of seductive portrayals of smoking in popular entertainment viewed by children.</td>
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<td>9.5.4 Include training to decode depictions of smoking in movies in drug education in schools.</td>
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<tr>
<td>Key Action Area 10: Ensure that the public, media, politicians and other opinion leaders remain aware of the need for sustained and vigorous action to discourage tobacco use</td>
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<tr>
<td><strong>10.1</strong> Ensure the public is constantly alerted to information about tobacco and its impact arising from new research findings.</td>
<td>NPA, Cancer Councils, Heart Foundation, Diabetes Australia, medical, nursing, pharmacy and other health professional associations and other health-oriented NGOs.</td>
<td>Track volume of media stories about: Health effects of smoking Need for tobacco control measures and percentage that is supportive.</td>
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<tr>
<td><strong>10.2</strong> Ensure that politicians and other opinion leaders are aware of international developments in tobacco control; including guidelines developed to assist countries comply with international obligations under the FCTC, and research on the efficacy of TC interventions.</td>
<td>Year 1 onwards</td>
<td>Track levels of public support for tobacco control measures.</td>
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<tr>
<td><strong>10.3</strong> Ensure greater awareness that selling tobacco products is incompatible with principles of corporate social responsibility.</td>
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<tr>
<td><strong>10.3.1</strong> Seek to make the percentage of revenue generated from tobacco products an agreed component of CSR award programs (e.g. Australian Business Awards; Telstra Business Awards and Australasian Reporting Awards).</td>
<td>Preventative Health Taskforce.</td>
<td>Number and percentage of business award programs where guidelines incorporate a requirement to report revenue generated from tobacco and where high levels of revenue preclude high CSR scores.</td>
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<td>Prime Minister’s Community Business Partnership.</td>
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<tr>
<td><strong>10.3.2</strong> Seek amendment of ASXCGC Best Practice Recommendations.</td>
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<p>| Key Action Area 11: Measure progress against and towards targets |
|---|---|---|---|
| <strong>11.1</strong> Establish a National Tobacco Strategy Steering Committee. | Australian Government | Year 1 | Committee established |
| <strong>11.2</strong> Include a question on smoking among Australians aged 16 years and over in the Australian Census. | Department of Health and Ageing. ABS. | Year 1 | Question in 2011, 2016 and 2021 census. |
| <strong>11.3</strong> Establish a mechanism to collect reliable data on prevalence in 2011 in Queensland, Tasmania, the Australian Capital Territory and Northern Territory. | Governments of Queensland, Tasmania, Australian Capital Territory and Northern Territory. | Year 1 onwards | Surveys established or questions included in existing surveys. |</p>
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<tr>
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<tr>
<td>11.4 Include in future reports of ASSAD surveys the proportion (and number) of teenagers who have ever smoked more than 100 cigarettes.</td>
<td>Centre for Behavioural Research in Cancer.</td>
<td>Year 1&lt;br&gt;Include in report of 2008 survey.</td>
<td>Section included in report.</td>
</tr>
<tr>
<td>11.5 Report on trends in the proportion of smokers and recent smokers who have attempted to quit in the previous three and 12 months, and the proportion who intend to quit in the next three months.</td>
<td>Department of Health and Ageing to request co-ordinators of Australian arm of International Tobacco Control study to provide triennial reports.</td>
<td>Year 1 onwards&lt;br&gt;Year 2 onwards</td>
<td>Reports produced and available.</td>
</tr>
<tr>
<td>11.7 Increase sample sizes of the NATSHI Health and Social Surveys to provide reliable indications of changes over time in each state and in the Northern Territory. This should be done in preference to trying to include sufficient Indigenous people in annual state population surveys.</td>
<td>Department of Health and Ageing to request. ABS.</td>
<td>Year 1 onwards</td>
<td>Inclusions in future NATSHI Health and Social surveys.</td>
</tr>
<tr>
<td>11.8 Use state population surveys to oversample each year within two or three state health department regions with a high proportion of Indigenous residents, so that reliable estimates of prevalence of Indigenous smoking at a regional level become available on a three-yearly basis.</td>
<td>State Departments of Health.</td>
<td>Year 1 onwards</td>
<td></td>
</tr>
<tr>
<td>11.9 Analyse percentage changes in the prevalence of Indigenous smoking compared with percentage changes in previous periods, and compared with absolute and percentage changes in the non-Indigenous population.</td>
<td>Department of Health and Ageing to commission a suitable research group.</td>
<td>Year 1</td>
<td>Report commissioned, produced and available.</td>
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<tr>
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<td>RESPONSIBILITY</td>
<td>STAGED IMPLEMENTATION</td>
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<tr>
<td>11.10 Extend the ASSAD survey to more remote areas of Australia and to Indigenous schools to ensure the inclusion of greater numbers of Indigenous children.</td>
<td>Department of Health and Ageing and Centre for Behavioural Research in Cancer.</td>
<td>Year 1 onwards</td>
<td>Incorporated in 2011 and future surveys.</td>
</tr>
<tr>
<td>11.11 Establish a panel of Indigenous people who are current smokers to enable the monitoring of intentions and attempts to quit, amounts smoked and the prevalence of smoking indoors and around others. The panel could also be used to monitor the impact of tobacco control policies among Indigenous people.</td>
<td>Department of Health and Ageing to commission a suitable research group.</td>
<td>Year 1 onwards</td>
<td>Panels established and regular surveys undertaken to provide data on the reach and efficacy of programs by monitoring, for instance, the use of NRT and other medications, perceptions of advice from healthcare providers, adoption of smoke-free homes and smoking around children.</td>
</tr>
<tr>
<td>11.12 Report on trends over time, by SES, in the proportion of Australians aged 14 years and over exposed to second-hand smoke at work and indoors at home.</td>
<td>Department of Health and Ageing to request research agency and AIHW.</td>
<td>Year 1 onwards</td>
<td>Inclusion of this data in reports on the 2010, 2013, 2016 and 2019 surveys.</td>
</tr>
<tr>
<td>11.13 Report on long-term trends in the percentage of students (smokers and non-smokers) who have one or more parents who smoke, and who live in homes that are smoke-free.</td>
<td>Department of Health and Ageing to request research agency and AIHW.</td>
<td>Year 1 onwards</td>
<td>Inclusion of this data in reports on the 2010, 2013, 2016 and 2019 surveys.</td>
</tr>
<tr>
<td>11.14 Report for each state and territory, for women living in areas of varying levels of social disadvantage, and for Indigenous and non-Indigenous women, the proportion of pregnant women who report smoking at early and late stages of pregnancy.</td>
<td>Perinatal Statistics Units.</td>
<td>Year 1 onwards</td>
<td>Inclusion of this data in regular reports.</td>
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References


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TOBACCO


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CHAPTER 4: Alcohol: Reshaping the drinking culture in Australia

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Introduction

In the past, Australia has held an impressive track record in taking bold action to prevent and reduce the harm caused by alcohol. Our drink driving campaigns, low taxes on light beer and thiamine fortification of bakers’ flour are examples of prevention measures that have been exported around the world. Measures such as these are now decades old, however, and while they provide a foundation to build upon, more determined and progressive action is required to tackle the nature and extent of the harmful drinking culture that prevails in Australia today and as we head towards 2020.

‘Alcohol use is embedded in a complex network of social, structural and cultural determinants as well as individual factors’ (Quote from submission)

All Australians, whether drinkers or non-drinkers, are touched in some way by the negative consequences of harmful alcohol consumption. These consequences include public intoxication, alcohol-fuelled violence, property damage, workplace absenteeism, road injury and alcohol-attributable diseases. Importantly, all Australians have a role to play in reshaping our drinking culture, including our governments, law enforcement agencies, the health and welfare sector, the alcohol beverage and related industries, local communities, families and individuals.

The rationale for action

Alcohol plays many roles in contemporary Australian society – as a relaxant, as an accompaniment to socialising and celebration, as a source of employment and exports, and as a generator of tax revenue. It is intrinsically part of Australian culture. The majority of Australians who regularly drink do so in moderation: around three quarters (72.6%) of Australians drink below levels for long-term risk of harm.(1)

However, short-term consumption of alcohol at harmful levels, while only occasional, is also a prominent feature of Australia’s drinking culture. One in five (over 20%) Australians aged 14+ years drink at short-term risky/high-risk levels at least once a month.(1) Put another way, this equates to more than 42 million occasions of binge drinking in Australia each year. According to the current National Alcohol Strategy, ‘too many Australians now partake in “drunken” cultures rather than drinking cultures’ and ‘to continue in this direction is in nobody’s interests; not individual Australians, their families and wider communities nor the alcohol beverage and related industries’. (2)

Australia’s overall per capita consumption of alcohol is high by world standards, with the country currently ranked within the top 30 highest alcohol-consuming nations, out of a total of 180 countries.(3) Consumption accounts for just over 3% of the total burden of disease and injury in Australia: nearly 5% in males and 1.6% in females.(4) There is little difference between men and women in the risk of alcohol-related harm at low levels of drinking.

At higher levels of drinking, the lifetime risk of alcohol-related disease increases more dramatically for women, and the lifetime risk of alcohol-related injury increases more dramatically for men.(5) Age is also an important variable in the health burden caused by alcohol, as harm from alcohol-related accident or injury is disproportionate among younger people. Over half of all serious alcohol-related road injuries occur among 15–24-year-olds. In addition, it is known that alcohol...
consumption at a young age can adversely affect brain development and is linked to alcohol-related problems later in life.\(^{(5)}\)

In Australia, concern among the general public about the adverse health and social effects of alcohol is prominent. A recent survey of Australians revealed that 84% of people are concerned about the impact of alcohol on the community.\(^{(14)}\) These consequences include harm to family members (including children), friends and workmates, as well as to bystanders and strangers. The impact of drinking on children, by their parents and/or other adults, is a particular concern: 13% of Australian children aged 12 years or less are exposed to an adult who is a regular binge drinker.\(^{(6)}\) It has been estimated that 31% of parents involved in substantiated cases of child abuse or neglect experience significant problems with alcohol use.\(^{(7)}\)

‘Apart from a desire to take the cost pressures off Australia’s acute care system into the future, one of the other major drivers for a prevention agenda in health is the relationship between the health of the community, workforce participation and our national productivity’ (Quote from submission).

Beyond the impact of alcohol on the health and wellbeing of individuals and communities, harmful consumption of alcohol also impacts significantly across a diverse range of other areas, including workforce productivity, healthcare services such as hospitals and ambulances, road accidents, law enforcement, neighbourhood amenity, property damage and insurance administration. The cost to the Australian community from alcohol-related harm in 2004/05 was estimated to be more than $15 billion.\(^{(8)}\) Much of this cost is borne outside the health system. One of the major tangible costs is lost productivity in the workplace ($3.5 billion). An estimated 689,000 Australians attend work under the influence of alcohol each year.\(^{(9)}\) Other costs outside the health system include road accidents (over $2 billion), crime ($1.6 billion) and lost productivity in the home ($1.5 billion). It is also estimated that alcohol is responsible for insurance costs totalling $14 million.\(^{(8)}\)

There are variations in alcohol consumption across Australia, and different impacts on specific high-risk population groups. Per capita alcohol consumption varies significantly between urban and rural areas, between Indigenous and non-Indigenous Australians, and between Australian states and territories.

**EXAMPLES:**

- While the prevalence of drinking at short-term risky/high-risk levels at least monthly is close to 19% in New South Wales and just over that figure in Victoria, it is more than 28% in the Northern Territory.\(^{(1)}\)
- Alcohol consumption levels (and alcohol-attributable mortality and morbidity) are consistently found to be lower for people living within major cities when compared to other regions.
- There are specific high-risk population groups whose consumption of alcohol requires special considerations. These include young people, pregnant women, older people, people who have a mental health condition, people who have multiple and complex health and social issues (for example, drug dependence, homelessness, general poor health), and certain occupational groups.
In order to reduce the health and other burdens caused by alcohol, the Taskforce recommends the long-term goal of reshaping Australia’s drinking culture to produce healthier and safer outcomes. A key component of reshaping the drinking culture in Australia will involve de-normalising intoxication. While alcoholism or alcohol dependence is often cited as the most serious alcohol problem, in Australia it is excessive single occasion drinking that produces far greater and wider-reaching impacts on the health, safety and wellbeing of individuals and communities.

Recent Australian research for the development of a national alcohol social marketing initiative reports the challenge for communication is that intoxication is closely linked to alcohol per se:

“When we simply asked participants about their earliest memories in relation to alcohol there was an overwhelming tendency to leap to their first drunk experience. Further, these experiences were recalled with a sense of pride and nostalgia, even though the stories inevitably involved some embarrassment.”[10]

By reducing the social acceptability of intoxication, Australia can shift towards a healthier and more sustainable drinking culture, one that does not forgo the enjoyment of safe, sensible and social drinking. A multi-pronged prevention strategy that includes a complementary set of actions is required to support this cultural shift, using economic levers such as taxation, legislative and regulatory measures, policing and law enforcement approaches, boosting support for local communities and individuals, as well as increasing awareness and shifting attitudes in the general community.

The place of alcohol in the lives of Australians, particularly in terms of aspects of the physical availability and the promotion and marketing of alcohol, is generally deregulated by governments or self-regulated by the alcohol industry. This situation has contributed to an exacerbation of alcohol-related problems across the community. It is now critical that we plan the future regulation of alcohol in Australia along a continuum that begins with self-regulation, potentially moving to co-regulation and independent regulation. As outlined in Chapter 1, this approach has been referred to as ‘responsive regulation’. It begins with the regulator attempting persuasion, escalating with more punitive regulation if persuasion proves ineffective.[11]

Australia has a unique window of opportunity to significantly expand this type of action in the prevention of alcohol-related harm. In part, this opportunity grows from increased community and political concern about the harmful consumption of alcohol (especially focused on youth drinking), and a heightened willingness from all levels of government to take action in the area. There is also an emerging leadership role in the prevention of alcohol-related harm being taken by police chiefs, emergency services and hospital emergency department physicians across all states and territories. The evidence base upon which important policy decisions can be made is now more robust – it is now clear which of the various policies and programs hold the most promise of being effective, and which offer the least. It is also apparent that there are potential synergies with other public health efforts to address tobacco, obesity and a range of chronic diseases.

“It is clear that a prevention agenda requires cross-sectoral, multilevel interventions that extend beyond the health sector into actions in sectors such as housing, welfare, justice, industry, employment, education, family and community service, Indigenous Affairs and communication” (Quote from submissions)

Despite the fact that there is currently a positive and growing national interest in addressing the negative aspects of alcohol use, and despite very effective reductions in drink driving, there is difficulty in moving from rhetoric to the establishment of coherent, cooperative, strategic and effective action. This situation might be compared to the place of and responses to tobacco smoking in Australia in the
1960s and 70s. Reshaping the nation’s drinking culture will therefore require long-term and multi-sectoral effort. Preventing alcohol-related harm must be a responsibility shared among all levels of government, industry and communities. The contribution of individual behavioural change in reshaping Australia’s drinking culture cannot be overlooked, nor underestimated. In March 2009, the National Health and Medical Research Council (NHMRC) published new guidelines on how individuals can reduce the health risks that arise from their alcohol consumption (for further detail, see key action area 2).

**Targets**

If its recommendations are implemented, the Taskforce aims to achieve the following targets by 2020:

- Reduce the proportion of Australians aged 14+ years who drink at short-term risky/high-risk levels at least monthly from 20.4% to 14.3%
- Reduce the proportion of Australians aged 14+ years who drink at long-term risky/high-risk levels from 10.3% to 7.2%
- Reduce the proportion of Australian secondary school students aged 12–17 years who are current drinkers and consume alcohol at harmful levels from 31.0% to 21.7%

These targets reflect the Taskforce’s long-term vision of a safer drinking culture for Australia. Achieving these targets will require substantial community effort, leadership, sustained effort and new funding.

Currently, one in five (20.4%) Australians aged 14+ years drink at short-term risky/high-risk levels at least once a month, and one in 10 (10.3%) drink at long-term risky/high-risk levels. (9) Reducing the prevalence of both short-term ‘binge’ drinking and long-term ‘regular heavy’ drinking will be important. Achieving the target of a 30% reduction in both groups, as proposed in the Taskforce Discussion Paper, would see the prevalence of short-term risky/high-risk drinking drop to 14.3% and long-term risky/high-risk drinking drop to 7.2%.

The Taskforce has also set a target for reducing the prevalence of drinking at harmful levels by Australians aged under 18 years, which is now at record levels. Alcohol consumption at harmful levels among Australian secondary school students aged 12–17 years who are current drinkers increased from 26% in 1999 to 31% in 2005. (12) Achieving the target of a 30% reduction in this category would see the prevalence of harmful drinking among Australian secondary school students aged 12–17 years who are current drinkers drop from 31% to 21.7%. In this context it is important to acknowledge that the overall proportion of 12–17-year-old Australian students who drink on a weekly basis has declined from 35% in 1999 to 29% in 2005. (12)

In order to monitor and measure progress towards the three 2020 targets, interim targets need to be set. As shown in Figure 4.1, the Taskforce has set interim targets for the years 2010, 2013, 2016 and 2019. Importantly, these interim target years coincide closely with the triennial National Drug Strategy Household Survey and the Australian School Students’ Alcohol and Drug (ASSAD) Survey, the results of which can be used to assess achievement of the interim targets. Should the monitoring of interim targets indicate that progress is not being made at the required rate, this should be a prompt for more responsive regulation in relation to the availability, pricing and promotion of alcohol.
The definitions of drinking at short-term risky/high-risk levels (at least once a month) and at long-term risky/high-risk levels that have been adopted for the above targets are based on the previous Australian alcohol guidelines. Currently, these definitions remain as the convention for describing the drinking patterns of the Australian population, notwithstanding the important changes contained in the guidelines themselves that were published in March 2009. However, in the longer term, it is anticipated that the accepted definitions for describing the drinking patterns of the Australian population will need to be modified to reflect the new NHMRC guidelines.
Key action areas

**Key action area 1:** Improve the safety of people who drink and those around them

The negative effects of alcohol consumption are far-reaching, extending well beyond accidents and diseases to a range of adverse social consequences, for both drinkers and those around them.

‘Addressing the cultural place of alcohol in the broader Australian community is critical if we are to effect longer-term change in attitudes and behaviours’ (Quote from submission).

In Australia, concern among the general public about the adverse health and social effects of alcohol is prominent. A recent survey of Australians revealed that 84% of people are concerned about the impact of alcohol on the community.(14) These consequences include harm to family members (including children), friends and workmates, as well as to bystanders and strangers. The negative impacts of drinking by individuals is felt regularly by many Australians: 13.1% of Australians report being ‘put in fear’ by a person under the influence of alcohol, and 25.4% report being subjected to alcohol-related verbal abuse.(9)

Alcohol-related disturbance and assault ranges from acts of vandalism, offensive behaviour and disruption to far more serious antisocial behaviour, which can result in violence or injury to others.(5) Hence, it is not surprising that much of the time and resources of policing in Australia are related to incidents involving alcohol. Alcohol is significantly associated with crime, with some studies suggesting that alcohol is involved in up to half of all violent crimes and a lesser but substantial proportion of other crimes. (5) There is also a link between drinking and domestic violence. In men who are already predisposed towards domestic violence,
alcohol increases the risk of violence. (5) Alcohol consumption also increases the risk of being a victim of domestic violence. (5)

In recent years there has been a significant liberalisation of state and territory liquor licensing laws, and a corresponding growth in the diversity and number of alcohol outlets, both on- and off-premises. Recent research from three states (15-19) has demonstrated consistent links between the availability of alcohol in a region and the alcohol-related problems experienced there. In particular, these studies have linked rates of violence to density of alcohol outlets. The results of this research are clear: liberalising alcohol availability is likely to increase alcohol-related problems.

This outcome calls into question the general assumption behind regulatory changes over the past two decades, made in accordance with National Competition Policy – that the number and type of alcohol outlets should be determined by market demand for the product, without primary consideration of the potential impact on local communities’ health, economy and amenity. Widespread feedback received by the Taskforce indicates that it is time for the granting, compliance and enforcement of liquor licences to be taken more seriously by governments, licensees and enforcement agencies.

The Taskforce believes that improving liquor control laws in each state and territory is a critical element in this reassessment, including refocusing the primary objective of such laws on harm minimisation. Recognising the net benefits to the Australian community that would accrue from strengthening the public health focus of liquor control legislation it would be appropriate to exempt such regulation from the constraints of National Competition Policy.

In addition to regulating the number of alcohol outlets, regulation of their opening hours must be a core component of managing the availability of alcohol. There is a substantial body of international and Australian work that has examined the impact of changes to licensed premises’ trading hours on levels of alcohol consumption and rates of related harms. (20) Most Australian studies have shown that increased trading hours have been accompanied by significantly increased levels of alcohol consumption and/or harms. There is also a question of whether particular types of outlets or their design and location tend to attract increased levels of alcohol consumption and/or violence. There is good evidence that certain premises contribute disproportionately to problems, (20) highlighting the need to further examine the types of outlets that are related to assaults. Further studies of these factors, such as alcohol sales, opening hours, capacity and venue style, could provide substantial insights into how different outlets contribute to the effect of outlet density on alcohol-related problems.

It is clear that effective law enforcement is the key ingredient to ensure the efficacy of strategies that aim to alter drinking contexts as a way of preventing harmful consumption of alcohol. While all Australian jurisdictions do have bans on serving intoxicated and underage persons, it is the extent to which these laws are adequately enforced that determines their effectiveness. Similarly, although very popular, the effectiveness of Responsible Service of Alcohol (RSA) programs is also contingent on proper enforcement. (20) Without concerted efforts by police and/or liquor licensing authorities to enforce existing liquor laws, the imposition of RSA policies and/or training has limited impact on the behaviour of servers or the intoxication levels of patrons. (20) RSA programs have the potential to raise awareness of relevant issues, and when highly publicised, the threat of substantial financial penalty has been shown to be particularly effective at motivating behaviour change among licensees. This in turn has resulted in reduced levels of alcohol-related harms, but it is not clear whether such financial penalties remain effective in the long term without frequent and highly visible examples of enforcement. (20) There is also evidence of RSA programs being effective when they include a mandatory component combined with effective enforcement. (21)
In addition to training bar staff in the responsible service of alcohol, there have also been programs designed to train staff in managing aggressive behaviour, given the reality that some patrons could already be intoxicated when they enter a bar and that some aggressive behaviour may not necessarily be alcohol related at all. There have been very few evaluations of such programs, although there is evidence that they can improve staff and patron interactions generally, but the long-term sustainability of these improvements relies on maintaining training and standards of practice.

Proactive or intelligence-led policing has been successful in some parts of the world, and has been partially adopted in some Australian jurisdictions. It involves monitoring alcohol-related incidents in and around licensed premises, combined with regular police visits to licensed premises most often linked to alcohol problems.

These approaches require resources, especially at the state level, and it is important for the business case to be developed for an increased focus on policing and enforcement of liquor licensing and liquor control laws. The business case would underpin the development of a new Council of Australian Governments (COAG) national partnership on policing and enforcement.

Since the 1970s, Australian states and territories have been world leaders in driving down rates of drink driving through mass media campaigns and a blood alcohol concentration limit of 0.05, backed by an enforcement regime of random breath testing (RBT). However, road accidents caused by alcohol continue to represent great social costs to the community, totalling more than $2.2 billion each year.

There is solid evidence that random breath testing loses much of its effect if levels of enforcement are too low or if the enforcement effort is insufficiently targeted. A recent Australian study has estimated that increased enforcement, equivalent to one test per licence holder per year, would yield benefits estimated to be in the range of $780 million to more than $1 billion.

In Australia, voluntary codes of bar practice involving alcohol beverage and related industries, such as alcohol retailers, hoteliers, licensed clubs and major event organisers, typically take the form of ‘liquor accords’. Where they are local and community-based, and involve licensees, other businesses, local government authorities, community representatives and police, such initiatives often aim to reduce alcohol-related harm in the late-night drinking environment.

Locally developed ‘accords’ have many possible components, such as RSA programs, drink discounting bans, trained security personnel, provision of food, use of safe glassware and alcohol containers, and environmental modifications to reduce conflict and thereby reduce the risk of violence.

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FOR EXAMPLE:

- The New South Wales police have adopted a system of enforcing liquor laws through the collection of data such as feedback to police about any alcohol-related crimes that have followed drinking at a specific licensed premises. Known as the Alcohol Linking Program, this intelligence-led enforcement system has been shown to reduce alcohol-related crime. Similar approaches are now being trialled and implemented in other jurisdictions.
Few accords have been formally evaluated, and among those that have, most have been unable to demonstrate effectiveness in either short- or (particularly) long-term reduction of alcohol-related harms. The appeal of accords tends to lie in the development of local communication networks, the facilitation of local input, a sense of local ‘control’ and improving public relations through open negotiations, rather than in actual reduction of harm. Even so, improved communication and participation may also be perceived as desirable and worthwhile outcomes in some circumstances. It is strongly recommended that voluntary regulation such as this is accompanied by effective law enforcement.

**PARTNERSHIP EXAMPLE:**

‘Lockouts’ are increasingly utilised as a licensing intervention in Queensland, Western Australia (Perth) and Victoria (Warrnambool, Ballarat, Bendigo and Melbourne CBD) as one method of reducing late-night migration between venues and associated anti-social behaviours. The Victorian Branch of the Australian Hotels Association (AHA), along with their local members, have been important partners in ensuring the implementation of the Ballarat lockout, citing it as the best example of the usefulness of this type of licensing intervention. The terms and conditions of the Ballarat lockout were negotiated in good faith by the affected licensees (guided by AHA (Vic)), the Mayor and executives of the City of Ballarat, and the Victoria Police Licensing Inspector for the region.

**Action 1.1**

States and territories to harmonise liquor control regulations, by developing and implementing best practice nationally consistent approaches to the policing and enforcement of liquor control laws.

**Action 1.2**

Increase available resources to develop and implement best practice for policing and enforcement of liquor control laws and regulations.

**Action 1.3**

Develop a business case for a new COAG national partnership agreement on policing and enforcement of liquor control laws and regulations.

**Action 1.4**

Provide police, other law enforcement agencies and private security staff with information and training about approaches to complying with and enforcing liquor licensing laws and managing public safety.

**Action 1.5**

Change current system to ensure local communities and their local governments can manage existing and proposed alcohol outlets through land use planning controls.

**Action 1.6**

Establish the public interest case to exempt liquor control legislation from the requirements of National Competition Policy.

**Action 1.7**

Support the above through partnerships with the alcohol beverage and related industries and data collection and monitoring of alcohol sales, policing, and health and social impacts.
Key action area 2: Increase public awareness and reshape attitudes to promote a safer drinking culture in Australia

One of the best examples of successfully shifting the drinking culture in Australia has been the introduction and enforcement of drink driving legislation, and the accompanying mass media campaigns. While this approach was first perceived to be a radical alcohol policy experiment, it has ultimately become one of Australia’s great public health success stories.

Since their introduction, there has been considerable research conducted into the effectiveness of public health and safety campaigns, both within Australian and overseas. A systematic review of evaluations of various mass media campaigns that were aimed at reducing drink driving and alcohol-related road accidents in Australia, New Zealand and North America found that campaigns which were carefully planned, well executed, attained adequate audience exposure and were implemented in conjunction with other ongoing prevention activities, such as high-visibility enforcement, have been effective in reducing drink driving and alcohol-related crashes.[27]

An Australian review[28] of several Australian road safety campaigns, which incorporated findings of two international meta-analyses of road safety mass media campaigns,[29, 30] has highlighted some of the key success factors for such campaigns. These factors include:

- Those with a persuasive orientation and which use emotional rather than rational appeals tend to have a greater effect on the relevant measure of effect. In contrast, information-based and educative approaches have been associated with less effective campaigns.

- The use of explicit theoretical models and prior qualitative or quantitative research to inform the development of mass media campaign messages and execution has been found to increase the effectiveness of campaigns.

- The use of public relations and associated publicity appears to be more important to the outcome of the campaign than the use of enforcement. However, the combination of public relations and enforcement as supporting activities shows particularly large effects.

The effectiveness of public health mass media campaigns can be enhanced not only by complimentary enforcement measures, but also by a range of other policy interventions, such as taxation. As noted in the Strategy chapter on tobacco, a study of the impact of various tobacco control policies and televised anti-smoking campaigns on adult smoking prevalence in Australia found that increases in the real price of cigarettes along with the mass media campaigns, broadcast at sufficient exposure levels and at regular intervals, have been critical for reducing population smoking prevalence.[31] The study found there was a 0.3-percentage-point reduction in smoking prevalence by either exposing the population to televised anti-smoking commercials at an average of almost four times per month – 390 Target Audience Rating Points (TARPS) per month – or by increasing the cost of a pack of cigarettes by 0.03% of gross average weekly earnings. Another Australian study, which assessed the impact of the population-based skin cancer prevention program SunSmart, found that population-based prevention programs incorporating substantial televised mass media campaigns into the mix of strategies are highly effective in improving a population’s sun-protective behaviours.[32]

Australia’s successes in public health and safety-oriented mass media campaigns provide substantial guidance and confidence to pursue similarly constructed campaigns aimed at reshaping Australia’s drinking culture. To date, a significant obstacle in the development of a well-planned, adequately resourced, coordinated and effective national alcohol
campaign has been the negative perception of previous campaigns – with the notable exception of campaigns targeting drink driving behaviour. Several past campaigns have focused solely on young people’s drinking, rather than that of adults, and have been short-term, one-off initiatives with insufficient reach and limited evaluation. If any meaningful and lasting behavioural change among Australian drinkers of all ages is to be achieved, this cycle of ad hoc, fleeting alcohol campaigns must be broken.

Recent research for the development of a new national alcohol social marketing initiative concludes that while such youth-focused campaigns can achieve positive results, they operate in a social environment where young people are exposed to a significant amount of contrary messages. Hence, a more sustainable approach would be to aim to effect wider change in societal behaviour towards alcohol. The research concludes that the best opportunity for effecting a change in Australia’s drinking culture will be in the targeting of attitudes towards intoxication, or more specifically, the perceived acceptability of intoxicated behaviour. It is recommended that the development of an alcohol social marketing campaign consider a staged approach by:

- Initially raising the consciousness of drinkers about the health and safety effects of their drinking on those around them
- Following this by targeting various segments of the population (young males, females, older people, parents) regarding the downside of intoxication (for example, shame, embarrassment and humiliation)

The target audience for a major new national alcohol social marketing campaign must be the whole community: all Australians who drink, not only those who experience alcohol dependence, as well as those who are negatively affected by somebody else’s drinking. The planned timeframe for the campaign must be at least 15 to 20 years – long enough to underpin the national alcohol strategy for the next two decades and achieve significant changes in Australia’s drinking culture.

**Action 2.1**

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

**Action 2.2**

*Embed the main themes and key messages within a broad range of complementary preventative health policies and programs*

Ensuring that future alcohol social marketing campaigns complement and support other policy interventions and programs will be critical for their success, especially in relation to particular settings where alcohol polices and programs are being implemented. Settings where there are concentrations of young people in early adulthood, such as TAFEs and universities, provide a valuable opportunity for increasing awareness and promoting safer and healthier attitudes and behaviours in relation to alcohol. Research suggests that alcohol education and prevention programs aimed at this population should target them prior to their arrival on campus, utilising web-based communications. Recently, online alcohol education and prevention programs have been trialled and evaluated in North America, New Zealand and to a limited extent in Australia, and appear to offer the potential to address the harmful drinking culture that is common among tertiary students.

Australian workplaces are a setting with great potential for targeting and assisting people who consume alcohol in harmful ways. There are at least two important rationales for workplace interventions addressing the harmful consumption of alcohol: to improve productivity, and to improve workplace safety.
In the Australian context, approaches to workplace alcohol issues are influenced by occupational health and safety laws and policies, and the creation of prevention strategies must be considered in this context. Employee Assistance Programs (EAP) provide a potential opportunity for interventions that are known to be effective, such as brief interventions for high-risk drinkers.

A recent study of alcohol consumption by Australian workers and the impact of alcohol consumption on absenteeism has pointed to the need for workplace education to influence young employees’ attitudes and behaviours regarding alcohol use. The study also suggests that there is a need to take a ‘whole of workplace’ approach when designing and implementing prevention strategies that target both ‘problem drinkers’ and workers who drink at short-term risk levels, even infrequently, because the latter have an elevated risk of alcohol-related workplace absenteeism. As discussed in Chapter 1, there is also a need to address structural factors in the workplace as a more sustainable prevention measure, including reducing stressful working conditions that may lead to health-damaging behaviour such as the harmful consumption of alcohol.

The 2009 guidelines take a new approach to developing population-health guidance, that:

- Goes beyond looking at the immediate risk of injury and the cumulative risk of chronic disease, to estimating the overall risk of alcohol-related harm over a lifetime
- Provides advice on lowering the risk of alcohol-related harm, using the level of one death for every 100 people as a guide to acceptable risk in the context of present-day Australian society
- Provides universal guidance applicable to healthy adults aged 18 years and over (Guidelines 1 and 2), guidance specific to children and young people (Guideline 3), and to pregnant and breastfeeding women (Guideline 4)

**Action 2.3**

*Introduce basic strategies in the workplace to prevent and reduce alcohol-related harm in a range of key industries.*

The contribution of individual behavioural change in reshaping Australia’s drinking culture cannot be overlooked, nor underestimated. In March 2009, the NHMRC published new guidelines on how individuals can reduce the health risks that arise from their alcohol consumption. Research since the previous, 2001 edition of the guidelines has reinforced earlier evidence on the risks of alcohol-related harm, including a range of chronic diseases, accidents and injury.
AUSTRALIAN GUIDELINES TO REDUCE HEALTH RISKS FROM DRINKING ALCOHOL

Guideline 1: Reducing the risk of alcohol-related harm over a lifetime:
For healthy men and women, drinking no more than two standard drinks on any day reduces the lifetime risk of harm from alcohol-related disease or injury.

Guideline 2: Reducing the risk of injury on a single occasion of drinking:
For healthy men and women, drinking no more than four standard drinks on a single occasion reduces the risk of alcohol-related injury arising from that occasion.

Guideline 3: Children and young people under 18 years of age:
A. Parents and carers should be advised that children under 15 years of age are at the greatest risk of harm from drinking and that for this age group, not drinking alcohol is especially important.
B. For young people aged 15–17 years, the safest option is to delay the initiation of drinking for as long as possible.

Guideline 4: Pregnancy and breastfeeding:
A. For women who are pregnant or planning pregnancy, not drinking is the safest option.
B. For women who are breastfeeding, not drinking is the safest option.

Guideline 1 is based on calculations of the lifetime risk of harm from drinking, from a chronic disease or through accident or injury, which estimates that for both men and women, the lifetime risk of death from alcohol-related disease or injury remains below 1 in 100 if no more than two standard drinks are consumed on each drinking occasion, even if the drinking is daily.

Guideline 2 is based on research showing that as more alcohol is consumed on a single occasion, skills and inhibitions decrease while risky behaviour increases, leading to a greater risk of injury during or immediately after that occasion.

There is little difference between men and women in the risk of alcohol-related harm at low levels of drinking. However, as mentioned previously, at higher levels of drinking, the lifetime risk of alcohol-related disease increases more quickly for women and the lifetime risk of alcohol-related injury increases more quickly for men. On this basis, the NHMRC has advised equivalent levels of drinking for both and men in order to remain at low risk of harm.

Key action area 3: Regulate alcohol promotions

Alcohol marketing and promotion is a global activity, with the largest corporations promoting their products across the world. Marketing strategies include an integrated mix of advertising on television, radio, the internet, print media, sponsorship of sports and cultural teams and events, point-of-sale and other promotions, product placement and product design, including the packaging and naming of alcohol beverages.

While the Australian Government currently spends approximately $10 million on alcohol-related health campaigns each year, total alcohol advertising expenditure in Australia is reported to be $119 million. Based on estimates from the United States, it is likely that two to three times this amount is spent on...
'unmeasured' advertising, such as sponsorships, point-of-sale promotions, giveaways, branded materials and special events. It is significant that the figure is exclusive of sponsorship of sports and cultural events by alcohol companies, as such events generally represent a substantial marketing investment by large alcohol companies in Australia. It also does not take account of extensive promotion for many sales outlets. A recent study found that alcohol-industry sponsorship of sports people, and in particular the provision of free or discounted alcoholic beverages, is associated with hazardous drinking.

The broader impact of advertising upon individuals can be seen as having both immediate effects, such as influencing decision making with regard to brand preference, as well as longer term effects, for instance reinforcing pro-drinking messages. In this way, both the content and context of advertising and the frequency of media exposure can have an impact on individuals' attitudes and behaviours. While the effect of alcohol advertising on young people's alcohol consumption is often disputed by advertisers and the alcohol beverage and related industries, these arguments are often based on studies that are flawed because of methodological and theoretical weaknesses.

A recent systematic review of longitudinal studies examined the impact of alcohol advertising and media exposure on adolescent alcohol consumption. The study concluded that alcohol advertising and promotion is associated with an increased likelihood that adolescents will start to use alcohol, and to drink more if they are already using alcohol. A study into the effect on young people of portrayals of alcohol consumption in television commercials and in movies found a causal link between exposure to alcohol commercials and drinking role models on acute alcohol consumption. Another recent study of the effects of ownership of alcohol-branded merchandise (ABM) by young people found that among those who had previously not drunk alcohol, ABM ownership is independently associated with increased susceptibility and initiation to drinking and binge drinking.

As discussed later, the young brain is particularly vulnerable to long-term damage from the toxic effects of alcohol when it is consumed regularly at risky/high-risk levels, at least until the age of 25.

Unlike tobacco advertising, which was banned in Australia in 1995, there are no alcohol advertising bans in Australia. Some restrictions, including advertising content controls, apply (see below). Alcohol advertising in Australia is subject to a number of different laws and codes of practice. The Australian Association of National Advertisers Code of Ethics covers general advertising issues. Other applicable laws and codes include:

- The Trade Practices Act
- State and Territory fair trading legislation
- The Commercial Television Industry Code of Practice
- The Commercial Radio Code of Practice
- The Outdoor Advertising Code of Ethics
- The Alcohol Beverages Advertising Code (ABAC)

The Commercial Television Industry Code of Practice states that alcohol advertisements can only be shown during M, MA or AV classification periods. However, on weekends and public holidays alcohol advertisements can be shown as an accompaniment to the live broadcast of a sporting event.

Alcohol advertising is covered in detail by the Alcohol Beverages Advertising Code (ABAC) Scheme. Currently voluntary, the scheme covers only certain forms of direct advertising, such as television, radio, print, outdoor and, more recently, internet advertising. The ABAC Scheme is funded and administered entirely by the alcohol industry. Australian, state and territory governments are involved through the presence of one government representative on the ABAC Management Committee.
The main aims of the scheme are to ensure that alcohol advertising presents a responsible approach to drinking, and does not have appeal to children or adolescents. Among other rules in the code, the administration of the following is often questioned by community members: ‘Advertisements for alcohol beverages must not depict the consumption or presence of alcohol beverages as a cause of or contributing to the achievement of personal, business, social, sporting, sexual or other success’ (ABAC 2008, Clause C (i)).

In 2003 the Ministerial Council on Drug Strategy (MCDS) considered a report on the effectiveness of the ABAC Scheme. Some issues of concern identified include:

- The current system does not address public health concerns about alcohol advertising and use
- The high dismissal rate for complaints about alcohol advertisements heard by the Advertising Standards Bureau does not engender community confidence in the complaint system
- The current system does not apply to all forms of advertising; for example, packaging, electronic advertising, sponsorships, point-of-sale advertising and promotions
- The effectiveness of the current system is compromised by the amount of time taken to resolve complaints

Despite the ABAC Scheme’s rule to discourage advertising that has ‘strong or evident appeal to children or adolescents’, research shows that a substantial amount of alcohol advertising is communicated to young people. For example, a recent study found that in 2007 Australian adolescents were exposed to significant levels of alcohol advertising from free-to-air television. The study found that in Melbourne, four of the 30 top alcohol beverage brands generated similar or greater exposure to 13–17-year-olds compared with those aged 18–29 years.

An international expert on alcohol advertising and public health has recently cautioned that televised promotions will become increasingly challenging for Australian regulators over the coming decade, as television channels continue to expand globally, offering advertisers even greater opportunities for reaching narrow age demographics, and as a proliferation of new digital television channels emerge in Australia. In this context, it is advised that standards for alcohol advertisers must be strengthened.

As a self-regulatory scheme, ABAC’s effectiveness largely depends on the independence of its complaints body with powers to sanction. Recent research has revealed that less than three in 10 (28%) people surveyed reported an awareness of restrictions or regulations covering the advertising of alcohol, in terms of what can be said or shown. It is estimated that only 3% of the total adult population are aware of the existing ABAC Scheme and know what it relates to. Among the 30% of people who reported being concerned about any alcohol advertising, only 2% had made a formal complaint.

Until the above issues are addressed, pressure remains to move to a more tightly regulated advertising environment with strict government controls. The World Health Organization (WHO) recently recommended that governments be supported:

- To effectively regulate the marketing of alcoholic beverages, including effective regulation or banning of advertising and of sponsorship of cultural and sports events, in particular those that have an impact on younger people
- To designate statutory agencies to be responsible for monitoring and enforcement of marketing regulations
- To work together to explore establishing a mechanism to regulate the marketing of alcoholic beverages, including effective regulation or banning of advertising and sponsorship, at the global level
In April 2009, the MCDS agreed to a series of reforms for strengthening the alcohol industry’s existing self-regulatory system that will be presented to COAG, including:

- Mandatory pre-vetting of all alcohol advertising
- Expanding the ABAC management committee to have a more balanced representation between industry, government and public health
- Expanding the adjudication panel to include a representative specialising in the impact of marketing on public health
- Expanding the coverage of the scheme to include emerging media, point of sale, naming and packaging
- Meaningful and effective sanctions for breaches of the code

The Taskforce is particularly concerned about the high levels of alcohol advertising and promotion to which adolescents and young Australians are exposed during live sport broadcasts, during other high adolescent/child viewing times, through sponsorship of sport and cultural events, such as sponsorship of professional sporting codes, and through youth-oriented print media and internet-based promotions.

**Action 3.1**

*In a staged approach phase out alcohol promotions from times and placements which have high exposure to young people aged up to 25 years.*

In recent years a number of high-profile sportsmen have reportedly been involved in alcohol-related violence and sexual violence, setting very negative examples for young Australians to follow. Despite the stated willingness of the national sporting codes to address these problems, much work remains to be done. This progress could be assisted by the development of enforceable codes of conduct with meaningful penalties.

**Action 3.2**

*Introduce enforceable codes of conduct requiring national sporting codes to take greater responsibility for individuals’ alcohol-related player behaviour.*

One of the most formidable obstacles to effective public education campaigns on alcohol is product advertising by the alcohol industry that intentionally promotes pro-drinking messages to the general population, much of which also reaches young people. In response, the governments of some countries have sponsored counter-advertising programs, which provide health advice about alcohol. These might include public services announcements, or warning messages within actual product advertisements. Counter-advertising may be a more pragmatic option than banning advertising altogether, but it is important that Given the significant shortcomings of the ABAC Scheme to date, it is appropriate to plan the future regulation of alcohol advertising in Australia along a continuum that began with self-regulation, moving towards co-regulation as indicated by the MCDS and then to independent regulation if co-regulation is found to be ineffective. This form of responsive regulation begins with the regulator attempting persuasion, escalating with greater regulation if persuasion proves to be ineffective. In summary, the Taskforce has reviewed the arguments regarding the links between advertising and alcohol consumption and alcohol-related harm, and has also taken into account submissions which disagree with this association. Having considered all the evidence to hand, the Taskforce is of the strong view that reducing the exposure of young people to alcohol promotions is an essential element in reducing alcohol-related harm in Australia. This is further reinforced by evidence that young people are highly vulnerable to the effects of alcohol up to the age of 25.
its message not be compromised. Although rare, there are examples of well-planned and implemented counter-advertising programs that have had some success, particularly in building support for public health-oriented alcohol controls. Although rare, there are examples of well-planned and implemented counter-advertising programs that have had some success, particularly in building support for public health-oriented alcohol controls. (21) There is also very strong evidence from other public health areas such as tobacco about the value of such approaches.

Warning labels on alcohol products, while not required in Australia, have a high level of public support. Evaluations of alcohol warning labels are generally limited to the US experience, where small, text-style labels were implemented in 1989. While there is some evidence of effects on knowledge and attitudes, there is as yet no evidence that warning labels, as a single policy measure, influence drinking behaviour. (55)

By contrast, the tobacco labelling experience offers strong evidence that warning labels can be effective not only in increasing information and changing attitudes, but also in changing behaviour. The successful use of tobacco warning labels suggests that alcohol warning labels should:

- Be graphic and attention-getting
- Occupy a considerable portion of the package surface, for example at least 25% of the physical space
- Involve rotating and changing messages

Perhaps most importantly, labels should complement, and be complemented by, a wider range of strategies aimed at changing behaviour.

Recently, the Australia and New Zealand Food Regulation Ministerial Council (ANZFRMC) considered a report on alcohol warning labels and the evidence of their effectiveness on risky alcohol consumption. The report was developed in response to the announcement by COAG to curb alcohol misuse and binge drinking among young people. The ANZFRMC has referred this report to the MCDS to allow a single and coordinated response to COAG as a part of its broad and comprehensive approach to reducing binge drinking. (56)

### Action 3.3

**Require health advisory information labelling on containers and packaging of all alcohol products to communicate key information that promotes safer consumption of alcohol.**

### Action 3.4

**Require counter-advertising (health advisory information) that is prescribed content by an independent body within all alcohol advertising at a minimum level of 25% of the advertisement broadcast time or physical space.**
Members of the public can make complaints about alcohol advertisements

Under the alcohol industry’s current self-regulatory system for alcohol advertising, known as the Alcoholic Beverages Advertising Code (ABAC) Scheme, alcohol advertisements in Australia must:

a. Present a mature, balanced and responsible approach to the consumption of alcohol.
b. Not have a strong or evident appeal to children or adolescents.
c. Not suggest that the consumption or presence of alcohol beverages may create or contribute to a significant change in mood or environment (and accordingly must not depict the consumption or presence of alcohol beverages as a cause of or contributing to the achievement of personal, business, social, sporting, sexual or other success).
d. Not depict any direct association between the consumption of alcohol beverages, other than low alcohol beverages, and the operation of a motor vehicle, boat or aircraft or the engagement in any sport (including swimming and water sports) or potentially hazardous activity.
e. Not challenge or dare people to drink or sample a particular alcohol beverage, other than low alcohol beverages, and must not contain any inducement to prefer an alcohol beverage because of its higher alcohol content.
f. Comply with the Advertiser Code of Ethics adopted by the Australian Association of National Advertisers.
g. Not encourage consumption that is in excess of, or inconsistent with, the Australian Alcohol Guidelines issued by the NHMRC.
h. Not refer to the ABAC Scheme, in whole or in part, in a manner which may bring the scheme into disrepute.

Anybody wishing to complain about an alcohol advertisements which they believe is in breach of the above, can do so by lodging a complaint with the Advertising Standards Bureau at www.adstandards.com.au.

Key action area 4: Reform alcohol taxation and pricing arrangements to discourage harmful drinking

The price of alcohol clearly impacts on consumption patterns. Australian and international studies confirm that when alcohol increases in price, consumption is reduced. A recent systematic review of 112 studies examined the relationships between alcohol tax or price levels and alcohol sales or self-reported drinking. The review concluded that alcohol price and tax increases are related inversely to drinking levels; in other words, policies that raise the price of alcoholic beverages are an effective means of reducing alcohol consumption.(57) In addition, studies have shown that price increases reduce problems due to alcohol, including binge drinking and a variety of alcohol-related harms (for example, motor vehicle accidents, cirrhosis mortality and violence).(58-60)

However, it should be recognised that price does not act in isolation from a range of other influences. The current National Alcohol Strategy observes that Australia’s drinking cultures are driven by a complex mix of powerful, intangible social forces. These forces include habits, customs, images, norms and other interlocking and equally powerful tangible forces relating to the social, economic and physical availability of alcohol, such as promotion and marketing, age restrictions, price, outlets, hours of access and service practices.(2) Given the complexity of the relationship between alcohol price and consumption, it is important that when alcohol taxation arrangements are being developed, the relationship between the price of individual
alcohol products and consumption amongst particular groups of drinkers is carefully modelled against known price elasticity and existing consumption patterns.

The Taskforce notes that alcohol taxation is currently the subject of a review by Federal Treasury (the Henry Review), which is considering the future of the entire tax and transfer payment system in Australia. Under Australia’s current alcohol tax system, different products – beer, wine and spirits – are all taxed differently. The result is that very different amounts of tax are payable on a standard drink, depending on beverage type, alcohol concentration, container size, size of producer and the pre-tax price of the product. From a public health perspective, some of these differences are desirable, such as the relatively low tax on low-strength beer as an incentive for the production and consumption of such products. However, some differences under the current regime are a cause for concern (see Figure 4.2 and the box below). In this context, it is also important to consider that the production costs of alcohol products vary considerably between product types (for example, spirits are relatively inexpensive to manufacture compared to beer and wine products), which in turn has a bearing on the ultimate cost price to consumers.

CASK WINE: A TAX ANOMALY

The tax on typical cask wine is only $0.05 per standard drink compared to $0.32 per standard drink of mid-strength beer, despite the vastly different alcohol volumes in these products: 12.5% alcohol by volume (ABV) compared to 3.0% ABV, respectively (see Figure 4.2). The extraordinarily low price of cask wine is due to the low rate of tax that applies to such products, and is a major contributing factor to the significant involvement of this type of alcohol in harmful drinking, particularly among people who are alcohol dependent and among those Indigenous Australians who drink at harmful levels.

During the 1990s, the Northern Territory Government applied a modest levy on the sale of cask wine, a beverage shown to contribute disproportionately to alcohol-related harm in that jurisdiction. Prior to the introduction of the levy, quarterly per capita consumption of cask wine among persons aged 15 and older was 0.73 litres. During the levy period, consumption fell to .49 litres. Following the removal of the levy, consumption rose to 0.58 litres. Imposition of the levy had no significant effect on the consumption of other beverages.
While we have a good understanding of the flaws or lack of logic in Australia’s current alcohol taxation system, and broad agreement on the principles upon which reforms should be based, our knowledge of precise solutions is limited, and more scholarly work in the area is clearly required. Even the best designed Australian studies are hamstrung by the dearth of accurate alcohol consumption data,(64) thus curtailting accurate planning, monitoring and evaluation of alternative tax models. A volumetric approach to alcohol taxation across all alcohol products is often suggested by both public health experts and some quarters of the alcohol industry as the most sound basis for alcohol taxation. However, in its simplest form, such a model is still inadequate to reduce overall alcohol consumption and the prevalence of heavy drinking. For instance, if a flat rate of tax per litre of pure alcohol was applied across all product types, the average price of spirits would drop, while the price of low-strength beer would increase.

Instead, a ‘tiered’ volumetric system is recommended by the Taskforce. This system would be inclusive of stepped increases in tax rates that provide economic incentives for the production and consumption of lower strength alcohol products, and disincentives for the production and consumption of the highest-risk alcohol products. In this way, taxation would reflect the negative externalities attributable to certain products.
Action 4.1

Commission independent modelling under the auspices of Health, Treasury and an Industry panel for a rationalised tax and excise regime for alcohol that discourages harmful consumption and promotes safer consumption.

In addition to taxation, it is also desirable to influence the price of alcohol by regulating the minimum price (floor price) of alcohol products, thereby aiming for a real shift in per capita consumption rather than just product preference. Studies have shown that pricing of the cheapest alcohol products has the most influence on overall consumption, as there is less scope for down-shifting in quality within beverage categories. A move towards regulating the minimum price of alcohol will require the establishment of a public interest case, to the satisfaction of the National Competition Council, that minimum price regulation would produce a net public benefit for the Australian community.

Action 4.2

Develop the public interest case for minimum (floor) price of alcohol to discourage harmful consumption and promotes safer consumption.

The Australian Government collected a total of $3.5 billion in 2007–08 from the excise on beer and spirits and the Wine Equalisation Tax. This raises important questions relating to the use of government revenue collected from alcohol taxation, including whether all or part of this revenue should be directed to pay for the costs of alcohol problems in the community. The Northern Territory Government’s Living with Alcohol program provides the best Australian example of such an approach.

In 1992 the Northern Territory Government used a hypothecation approach by placing a levy of 5 cents per standard drink on the sale of alcohol products with more than 3% ABV. The government then used the revenue to fund a range of alcohol prevention measures in the territory. These measures included funding for new and existing alcohol education programs and expanded treatment and rehabilitation services. Evaluations of this approach found that combining alcohol taxes with comprehensive programs and services designed to reduce the harm from alcohol were associated with significant declines in alcohol-attributable mortality in the Northern Territory.

This approach could also include using proceeds from taxation to replace alcohol sponsorship of sporting and cultural events.

Action 4.3

Direct a proportion of revenue from alcohol taxation towards initiatives that prevent alcohol-related societal harm.
Key action area 5: Improve the health of Indigenous Australians

‘No health and wellbeing issue in Australia is worse or more urgent than the impoverishment and appalling health status of Indigenous people. Aboriginal and Torres Strait Islander peoples should command high priority under preventative health programs’ (Quote from submissions).

Indigenous populations are a particularly high risk group in Australia with regard to the health and social impacts of alcohol consumption. Indigenous Australians are about twice as likely to abstain from alcohol as non-Indigenous Australians, but those who do drink may be up to six times more likely to drink at high-risk levels than non-Indigenous people.[69]

Alcohol is associated with 5% of the burden of disease and injury borne by Indigenous Australians, in particular through homicide, violence and suicide.[70] In 2002–03 the rate of hospital admission among Indigenous males for conditions related to high levels of alcohol use, such as acute alcohol intoxication, alcoholic liver disease, harmful use and alcohol dependence, was between two and seven times greater than for non-Indigenous males.

Other studies have shown that the rates of death from wholly alcohol-caused conditions among residents of Western Australia, South Australia and the Northern Territory are almost eight times greater for Indigenous males than for non-Indigenous males, and 16 times greater for Indigenous females than for other females.[71] The level of alcohol-attributable death among young Indigenous Australians (aged 15–24 years) has also been shown to be almost three times greater than for their non-Indigenous counterparts – with the divergence between the two populations apparently increasing in recent years.[72] Drinking while pregnant is also associated with Foetal Alcohol Spectrum Disorders, which are estimated as being between three and seven times as common in the Indigenous population as in the non-Indigenous.[70]

Example:
A 2007 study by Chikritzhs et al. estimated alcohol-attributable mortality for Indigenous residents in each of the 17 former ATSIC zones, and found that:

- Over the five-year period from 2000 to 2004, an estimated 1145 (nearly 5% per 10,000 population) Indigenous Australians died from alcohol-attributable injury and disease caused by drinking.
- In 2004 alcohol-attributable death rates for Indigenous people in the Central Northern Territory (14 per 10,000) and northern Western Australia (10 per 10,000) were more than double the national rate for Indigenous people (just over four per 10,000) for that year.
- Suicide (19%) and alcoholic liver cirrhosis (18%) are the two most common causes of alcohol-attributable death among Indigenous men.
- For Indigenous women, alcoholic liver cirrhosis (27%), haemorrhagic stroke (16%) and fatal injury caused by assault (10%) were the most common causes of alcohol-attributable death.
- The average age at death from the most common alcohol-attributable conditions was 35 for Indigenous men and 34 for Indigenous women.[73]
Alcohol is prominent in family and community violence in Indigenous communities. Among the total recorded homicides over the period 1999–2000 to 2004–05, 69% of Indigenous homicides involved both the victim and offender having consumed alcohol at the time of the offence; in contrast, the figure for non-Indigenous homicides was 20.4%. (73)

Indigenous people are more likely than non-Indigenous people to be victims of domestic violence. The main reason both Indigenous and non-Indigenous people sought Supported Accommodation Assistance Program (SAAP) assistance in 2005–06 was to escape domestic or family violence (31.4% of Indigenous people and 21.3% of non-Indigenous people). (73)

A recent study of the key approaches and actions required to reduce the harm from alcohol consumption in Indigenous communities recommended five specific actions, including:

1. Resourcing of interventions from the primary healthcare setting
2. Reform and increased support for treatment and rehabilitation services
3. Actions on pricing of alcohol, including a broad review of Australia’s alcohol taxation policy as part of a comprehensive approach to alcohol problems in Australia
4. Action to restrict alcohol supply, including numbers and types of licences and hours of sale, especially for takeaway licences
5. Supporting community agency and action through the establishment of local community leadership groups (70)

In addition, it is also important to build upon existing responses to the problem of alcohol consumption in Indigenous communities that are supported and known to be working effectively. Among the diverse Indigenous communities across Australia, there is now a wide range of locally conceived approaches to preventing and responding to harmful consumption of alcohol and the negative health and social consequences. Some small regional or remote communities in Australia with relatively large Indigenous populations have introduced sales bans on the alcohol products most frequently involved in harmful drinking, such as cask wine and cask fortified wine. According to evaluations of these approaches, several of the bans have resulted in reduced alcohol-related harm within the communities where they exist.

Another example of alcohol restrictions known to be effective in reducing harm in some Australian Indigenous communities are referred to as ‘dry community declarations’. (20) Some remote Indigenous communities in Western Australia, the Northern Territory and South Australia have declared themselves ‘dry’ using provisions of state/territory legislation. The key element of such dry area declarations is a combination of Indigenous community control and statutory authority, along with police enforcement for ensuring that dry community declarations reach their potential. Evidence suggests that although there are shortcomings (for example, sly grogging) and associated costs to this approach, overall there have been reductions in consumption and alcohol-related harm.

Since the 1980s, ‘sobering-up centres’ have been established in many parts of Australia, particularly Indigenous communities, as humane forms of care for publicly intoxicated individuals, and as an alternative to individuals being arrested and held in police cells and watch houses. (74) In many ways, these centres function primarily as a broad harm-reduction measure, rather than as a treatment program. Sobering-up centres are not a detoxification centre, nor are they aimed at long-term rehabilitation; rather, their role is to keep people out of police custody to reduce alcohol-related harm and to offer practical care in a safe environment for a limited time, including protection, shelter and food. (74) Nevertheless, they could provide an opportunity for interventions that can be effective.
Sometimes related to these centres are night patrols, which are a particularly common alcohol harm-reduction strategy in many Indigenous communities. Night patrols provide transport to safe locations for intoxicated persons, particularly in remote areas. Evaluations of the effectiveness of night patrols, on their own, as an intervention have been somewhat equivocal although they have been rated effective in communities where they exist in reducing alcohol-related violence and getting intoxicated people off the streets.

The National Indigenous Drug and Alcohol Committee (NIDAC), an important voice in Indigenous alcohol and other drugs policy in Australia, has endorsed the National Drug Strategy – Aboriginal and Torres Strait Islander Peoples Complementary Action Plan 2003–2009 as the basis of any approach to the reduction of alcohol-related harm among Indigenous Australians. Within this framework, NIDAC has also recommended consideration of the following key principles when developing and implementing any policies and programs aimed at preventing alcohol-related harm in Indigenous communities:

1. Indigenous people should be involved at all stages of the development and implementation of strategies to address harmful alcohol use in their communities.

2. The capacity of Indigenous communities to deliver alcohol intervention initiatives should be actively encouraged and resourced – including an expanded program of workforce development.

3. Any strategies to reduce alcohol-related harm should be evidence-based and culturally secure.

4. Strategies to specifically address harmful alcohol use should be conducted in conjunction with strategies to address the underlying social determinants of such use.

As recommended by the fourth principle above, it is important to acknowledge that universally targeted preventative health initiatives will also be highly effective among Indigenous communities. Such initiatives could include alcohol taxation, regulating the physical availability of alcohol, policing and law enforcement, placing restrictions on alcohol promotions and producing public awareness campaigns. While not diminishing the importance of developing culturally and locally appropriate adaptations of such initiatives, this acknowledgement emphasises the importance of addressing some of the underlying determinants of harmful consumption of alcohol in Australia.

**Action 5.1**

*Increase access to health services for Indigenous people who are drinking at harmful levels.*

**Action 5.2**

*Support local initiatives in Indigenous communities.*

**Action 5.3**

*Establish a reliable, regular and sustained system for the collection and analysis of population statistics on alcohol and drug use among Indigenous people.*

**Action 5.4**

*Establish and fund a multi-site trial of alcohol diversion programs.*

**Action 5.5**

*In communities that desire them and which are large enough to support them, the availability of night patrols and sobering-up shelters should be expanded.*
Key action area 6: Strengthen, skill and support primary healthcare to help people in making healthy choices

"The primary healthcare system has an important role within the whole of society, integrated approach to tackling chronic disease" (Quote from submission)

Brief interventions in primary healthcare settings for early-stage alcohol problems are consistently identified as a key ingredient in a comprehensive alcohol prevention strategy. Such interventions are regarded as relatively inexpensive, taking very little time and being able to be implemented by a wide range of health and welfare professionals. Their benefit as a preventative measure arises from their relative effectiveness in treating early-stage problem drinking, preventing the need for later, more intense and costly treatment.

Brief interventions typically involve the provision of advice and information to ‘at risk’ drinkers in the context of a consultation by a primary care physician. This information is initially conveyed verbally, usually during a primary care consultation for a different health issue. The initial screening may be complemented by a range of additional supports, including the provision of printed information, follow-up telephone calls, and drinking diaries to record and monitor alcohol consumption.

In Australia, brief interventions are as yet a relatively untapped opportunity, due in part to the need for greater recognition of the role that the primary health workforce can play. Efforts during the 1980s and early 1990s to introduce more systematic screening, early identification and potentially brief or extended responses were variously tried. These included the Coordinator of Alcohol and Drug Education in Medical Schools program (CADEMS), which supported curriculum development for undergraduate medical students; a range of general practice trials, especially in New South Wales, sometimes in association with other specific interventions including tobacco; efforts to develop a combined risk-screening instrument for a number of conditions; and studies of the use of screening instruments (especially AUDIT) in hospital settings.

Follow up has been patchy. Even where the uptake and utility under experimental conditions was promising, the longer term effort and cost required to achieve widespread involvement has not been sustained. An Australian study of the effectiveness of brief interventions in hospital emergency departments suggests they have the potential to significantly reduce subsequent alcohol-related injuries.

EXAMPLES:

- A 2007 Cochrane Database Systematic Review of the effectiveness of brief alcohol interventions in primary care populations found they consistently produced reductions in alcohol consumption.

- A 2008 Australian study examining the potential cost savings of a comprehensive program of brief interventions estimated that $5.8 billion in costs to the community could potentially be saved each year. The study emphasises that given the total estimated social costs of alcohol in 2004/05 were over $15 billion, this potential saving represents an enormous reduction in the overall costs of alcohol for the community.
interventions to become part of routine practice for doctors, nurses and other health professionals, an approach at the level of health system funding and expectations is needed. It is unrealistic to expect overstretched health service providers to implement this strategy without reimbursement or other recognition.

In addition, referral pathways may be unclear and the links between primary care practitioners and community-based alcohol and drug services need to be strengthened and promoted; for example, utilising the Headspace (youth mental health promotion) service sites.

**Action 6.1**

*Enhance the role of primary healthcare organisations in preventing and responding to alcohol-related health problems.*

**Action 6.2**

*Develop a more comprehensive network of alcohol-related referral services and programs to support behaviour change in primary healthcare.*

People with alcohol dependence combined with other psychiatric disorders have higher rates of primary healthcare service usage than those without such disorders. An Australian study, published in 2009, found that alcohol dependence combined with mental health disorders has a significant impact on GP service in Australia. High rates of service use by individuals with such comorbidities are a considerable burden for GP services. (78)

Specialised alcohol and other drug treatment and early intervention programs are essential components of a preventative approach to the harmful consumption of alcohol. In 2005–06 there were a total of 145,000 drug treatment episodes recorded in Australia, of which 56,000 (or 39%) patients were treated for alcohol problems. (79) While this figure may appear high, it is perhaps relatively low given the estimated 585,000 Australians who drink at levels considered to be high risk to health in the long term, many of whom might be considered the potential target group for treatment. (1)

While treatment and prevention are traditionally viewed as separate and sometimes unrelated activities, it is critical that specialised treatment programs are embraced as part of a legitimate approach to preventing and reducing alcohol-related harm.

Internationally, the evidence base regarding the treatment of alcohol problems is very well developed and is now at the stage of determining what is best practice rather than attempting to determine if treatment can work; this is particularly the case in Australia. (25) Effective alcohol treatment options include motivational interviewing, brief interventions, social skills training, community reinforcement approaches, relapse prevention and some aversion therapies. (25) There is evidence that mutual help programs such as 12-Step Facilitation Therapy, which encourages attendance at Alcoholics Anonymous (AA) meetings, are particularly effective for severely dependent drinkers with low levels of social support. (25) Although popular and widely used, there are also treatments which have little evidence of efficacy, including insight-orientated psychotherapy, confrontation counselling, relaxation training, general ‘alcoholism counselling’, education and milieu therapy. (25)

Pharmacotherapies for alcohol dependence include disulfiram, naltrexone and acamprosate. Reviews have found that naltrexone and acamprosate are the safest and most effective of the three pharmacotherapies in the long and intermediate terms, respectively. (25)

**Action 6.3**

*Increase access to primary healthcare services and improve health outcomes for hard-to-reach disadvantaged individuals who are at risk of alcohol-related health problems.*
Low-risk drinking guidelines have been adopted in many countries, including Australia, as a resource for health professionals. They are often the basis for advice on the health risks of alcohol consumption for the general adult population and for particular sub-groups. Guidelines potentially fulfil an important function as supporting information for other measures known to be effective, such as brief interventions in primary care, and as the basis for health promotion programs and social marketing campaigns. In Australia, new guidelines have been informed by updated estimates of the risks over a lifetime from alcohol consumption. While it has been reported that the health benefits of alcohol can be achieved with an intake of half a standard drink per day, emerging evidence indicates that previous studies claiming significant health benefits of alcohol consumption have tended to overestimate any positive effects. As a result, the new Australian guidelines advise that it should be noted that the potential benefits from alcohol can also be gained from other means, such as exercise or by modifying the diet.

**FACTORS THAT AFFECT SUSCEPTIBILITY TO ALCOHOL**

**Sex** – the same amount of alcohol leads to a higher blood alcohol concentration in women than in men, as women tend to have a smaller body size, a lower proportion of lean tissue and smaller livers than men. On the other hand, the higher level of risk-taking behaviour among men means that, over a lifetime, male risks exceed female risks for a given pattern of drinking.

**Age** – in general, younger people are less tolerant to alcohol, and have less experience of drinking and its effects. In addition, puberty is often accompanied by risk-taking behaviours. Later in life, as people age, their tolerance for alcohol decreases and the risk of falls, driving accidents and adverse interactions with medications increases.

**Mental health** – people who have, or are prone to mental health conditions (for example, anxiety and depression, schizophrenia) may have worse symptoms after drinking. Alcohol can also trigger a variety of mental health conditions in people who are already prone to these conditions.

**Other health conditions that are made worse by alcohol** – people who already have health conditions caused or exacerbated by alcohol, such as epilepsy, alcohol dependence, cirrhosis of the liver, alcoholic hepatitis or pancreatitis, are at risk of the condition becoming worse if they drink alcohol.

**Medication and drug use** – alcohol can interact with a wide range of prescribed and over-the-counter medications, herbal preparations and illicit drugs. This can alter the effect of either the alcohol or the medication and has the potential to cause serious harm to both the drinker and others.

**Family history of alcohol dependence** – people who have a family history of alcohol dependence (particularly among first-degree relatives) have an increased risk of developing dependence themselves.

Source: NHMRC 2009.
Key action area 7: Build healthy children and families

It is a reality that the most visible effects of drinking on others, particularly the spouse or partner of a drinker and their children, result from accidents and injury (including violence) during or after drinking occasions. When families have to deal with a relative’s harmful drinking, violence, injury or even death, the consequences can cause great suffering.

‘The patterns of health and illness throughout life are strongly influenced by patterns that are established early in life. Biological and environmental risk and protective factors, together with early life experiences, affect long term health and disease outcomes’ (Quote from submission)

As mentioned previously the impact on children of drinking by their parents and/or other adults is a particular concern: 13% of Australian children aged 12 years or less are exposed to an adult who is a regular binge drinker. It has been estimated that 31% of parents involved in substantiated cases of child abuse or neglect experience significant problems with alcohol use. There is also a link between drinking and domestic violence. In men who are already predisposed towards domestic violence, alcohol increases the risk of violence. Alcohol consumption also increases the risk of being a victim of domestic violence. Witnessing domestic violence, particularly violence that occurs over long periods of time at intense levels, can have a severe emotional impact on children. This impact appears to be even more profound if the children’s mother is the victim of domestic violence.

In 2002 the NSW Department of Community Services reported that up to 80% of investigated child abuse reports were associated with parental substance abuse. Similarly, the Victorian Department of Human Services reported that 65% of children in foster care presented with backgrounds of drug and alcohol misuse, and that 62% of parents with a psychiatric problem were also affected by substance misuse. In 2004 the Department for Community Development in Western Australia found that up to 50% of child protection cases involved parental substance misuse concerns. A study by the South Australian Department for Families and Communities found that parental substance misuse was associated with children’s entry into care in approximately 70% of cases.

Notwithstanding the influence of various determinants of alcohol-related harm, such as the economic and physical availability of alcohol, marketing and promotions, and wider social norms and pressures, family history is a strong predictor of developing an alcohol-related problem. Genetic factors are also a matter of importance, with evidence showing that children of alcoholic parents appear to be at significantly greater risk of dependence themselves than those of non-alcoholic parents. Drinking practices within the family environment are an important consideration because, depending upon the circumstances, they can be either a positive or negative influence on the drinking behaviour of young people. Exposure to a family culture that accepts heavy drinking may contribute to the development of dependence in the children of heavy drinkers.

‘Increase the focus on prevention aimed at addressing health risks for unborn children through maternal health services and support to parents and carers, given the importance of early interventions on lifelong outcomes’ (Quote from submission)
THE RISK OF FOETAL ALCOHOL SPECTRUM DISORDERS

Rates of drinking during pregnancy are high in Australia, with recent surveys reporting rates of 47%. Between 19% and 44% of Indigenous women drink alcohol in pregnancy, and between 10% and 19% drink at harmful levels. Maternal alcohol consumption can result in a spectrum of harms to the foetus. Although the risk of birth defects is greatest with high, frequent maternal alcohol intake during the first trimester, alcohol exposure throughout pregnancy (including before pregnancy is confirmed) can have consequences for development of the foetal brain. It is not clear whether the effects of alcohol are related to the dose of alcohol and whether there is a threshold above which adverse effects occur. This uncertainty is reflected in policy regarding alcohol use in pregnancy within Australia and overseas.

Although the risks from low-level drinking (such as one or two drinks per week) during pregnancy are likely to be low, a ‘no-effect’ level has not been established, and limitations in the available evidence make it impossible to set a ‘safe’ or ‘no-risk’ drinking level for women to avoid harm to their unborn baby. Evidence also shows that alcohol may adversely affect lactation, infant behaviour (for example, feeding) and psychomotor development of the breastfed baby.

Rates of risky drinking in Australia peak amongst young people, and alcohol-related harm are substantial for both adolescents and young adults. Drinking contributes to the three leading causes of death among adolescents – unintentional injuries, homicide and suicide – along with risk-taking behaviour, unsafe sex choices, sexual coercion and alcohol overdose. A recent study of self-reported harm found that drinkers under the age of 15 are much more likely than older drinkers to experience risky or antisocial behaviour connected with their drinking, and the rates are also somewhat elevated among drinkers aged 15–17 years.

Initiation of alcohol use at a young age may increase the likelihood of negative physical and mental health conditions, social problems and alcohol dependence. Regular drinking in adolescence is an important risk factor for the development of dependent and risky patterns of use in young adulthood. An additional risk to the health and safety of young people who consume alcohol is illicit drug use. There is a range of documented adverse outcomes from illicit use of drugs, and consuming alcohol together with illicit drugs can have dangerous or lethal consequences.

Childhood and adolescence are critical times for brain development. The brain is more sensitive to alcohol-induced damage during these stages, while being less sensitive to cues that moderate alcohol intake. The young brain is particularly vulnerable to long-term damage from the toxic effects of alcohol when it is consumed regularly at risky/high-risk levels, at least until the age of 25.

Action 7.1

Protect the health and safety of children and adolescent brain development.
According to recent research, the average age at which young Australians first consume a full standard drink of alcohol is 17 years. (1) This is despite the fact that the minimum legal purchase age for alcohol in all Australian jurisdictions is 18 years. However, new evidence suggests that average age may be best examined by age cohort. (41)

Of more concern is the fact that the prevalence of drinking at harmful levels by Australians aged under 18 years is now at record levels. Alcohol consumption at harmful levels among Australian secondary school students aged 12–17 years who are current drinkers increased from 26% in 1999 to 31% in 2005. (12) While minimum legal purchase age refers to the age at which alcohol can actually be lawfully purchased by a person, this is distinct from the age at which alcohol can be consumed, sometimes referred to as the legal drinking age. The distinction is important because while all state and territory laws in Australian prohibit a minor from purchasing alcohol, they do not necessarily prohibit consumption in certain circumstances.

Clearly, consistent enforcement of laws regarding purchase age is critical if we are to achieve a shift in the average age of initiation and an overall reduction in alcohol-related harm among young people. It must be acknowledged that consumption of alcohol by children and adolescents in the home and in certain social settings is often sanctioned by parents, often in the belief that it is relatively harmless or might be helpful in educating young people about alcohol. (88) The majority of young Australians who report drinking at home also report parents as the primary suppliers of their alcohol. (12)

In New South Wales, it is now an offence to supply alcohol to minors in a private home without the direct approval of a parent or guardian. This has often been referred to as the state’s ‘secondary supply’ law. Whilst the impact of this law upon youth drinking is not yet known, legislation of this kind has been welcomed by advocates of preventing alcohol-related harm among young people. There is currently considerable community interest in the introduction of similar laws in other Australian jurisdictions. (88)

In the United States, where minimum legal purchase age for some time ranged between 18 and 21 years, several studies have found that increasing the age limit is an effective means of reducing road crash death and injury among teenagers and young adults. Some studies have also found that a higher legal minimum drinking age is associated with reductions in alcohol consumption among young people. (20) There is, therefore, some evidence that raising the minimum legal purchase age to 21 years can reduce teenage drinking, as well as harms. A recent commentary on attempts to increase the minimum purchase age in New Zealand to 20 years demonstrates that popular debate convinced a majority of the public that raising the age would be an appropriate way to reduce young people’s harm from drinking. (89)

In Australia, Toumbourou et al. have recommended that a first step in this direction would be better monitoring of alcohol-related developmental harms, using longitudinal and other developmental research. (90) Recent Australian research on the effects of drinking during adolescence for predicting alcohol-related outcomes in young adulthood concludes that any drinking during adolescence, even at the low-risk levels, may have negative consequences for adulthood. (91)

In the interests of promoting the health and welfare of young Australians, and raising awareness of the need to reshape our drinking culture over the life course, community engagement and informed discussion on this issue is now warranted.

**Action 7.2**

_Support parents in managing alcohol issues at all stages of their children’s development through community-level approaches._
Action 7.3

Measure the impact of harmful consumption of alcohol on families and children by ensuring all population surveys that collect data to monitor drug use and drug trends across Australia collect information on parental status or childcare responsibilities of drinkers.

WHAT FAMILIES CAN DO

Sometimes parents feel they are no longer an important influence in their teenagers’ lives, and that their children’s decisions about alcohol use are beyond their control. This is not the case. While they are not the only influence in teenagers’ lives, what parents do, what they believe and what they say to their children can have an important influence on young people’s decisions. Discussions about alcohol should begin before children reach the age of 10 to 11 years. Children are never too young to start talking about the effects of alcohol and they need to know what their parents think about drinking. They also need to know what their parents expect. Starting such discussions early also encourages open conversations in future and gives parents practice in discussing the issues before they become sensitive topics. Parents and other adults are powerful role models that children copy as they grow older. Alcohol consumption is very much a part of the Australian lifestyle, and parents who drink can teach children how to use alcohol in low-risk ways by modelling responsible use such as providing alternatives to alcohol, avoiding driving after drinking and following the NHMRC guidelines on low-risk drinking. Parents need to establish and enforce clear standards for teenage behaviour. It is important that parents set an example they are happy for their teenagers to copy, and that they know what’s going on in their children’s lives and know their whereabouts. Effective communication between parents and teenagers is important and parents should take responsibility for this. Teenagers are less likely than younger children to ask for information so parents need to make time, take the initiative and talk with them about a wide range of topics. [92]

Key action area 8: Strengthen the evidence base

‘The importance of strong links between researchers and practitioners that develop understanding of how best to translate research into practice are essential’ (Quote from submissions)

It is critical that preventative health policies and programs relating to alcohol are informed by sound data on alcohol consumption and alcohol-related harm in the Australian population. [64] The WHO has recommended that public health monitoring of alcohol use should include credible estimates of per capita alcohol consumption, derived from alcohol sales data, in addition to well-conducted population surveys of drinking patterns.

There is an urgent need to collect and analyse nationally consistent data about alcohol sales, consumption, outlets and alcohol-related health and safety outcomes. This data will then inform the modelling of safer patterns of alcohol consumption in different communities and settings, and the monitoring of the impact of changes in alcohol policies, alcohol availability and other factors.

Currently, information on levels and patterns of alcohol consumption in Australia is diverse. It can be difficult to identify the key features for purposes of monitoring trends in drinking and related harm, and the possible opportunities for intervention. Unfortunately, some of the most significant and valuable data is not readily available to the public health field. For example, alcohol sales data, while it is known to be collected and analysed by the alcohol beverage industry, is not available for the purposes of the Taskforce, nor indeed is it easily accessed for public health research purposes in general. The Taskforce notes with some concern that continuation of the most accessible datasets on alcohol consumption levels in Australia, collected and compiled by the Australian Bureau of Statistics (ABS), is currently under review. Efforts are urgently required to seek the continuation of this valuable dataset.
If collection and reporting of this data were to cease, Australia would be the only Organisation for Economic Co-operation and Development (OECD) country not to collect national alcohol consumption data.

There are several important reasons why the collection of alcohol sales data in Australia should be improved rather than abandoned. (64) Such data can be used to:

- Monitor trends in per capita alcohol use, which is strongly related to adverse health outcomes such as liver cirrhosis, motor vehicle crashes and suicide

- Facilitate studies of the relationships between changes in the level of per capita alcohol consumption and both population health outcomes and social harms (for example, arrests for assault and public disorder)

- Provide a benchmark to gauge the accuracy of national alcohol consumption surveys

- Enable the sales volumes of each beverage type to be estimated at local levels

- Evaluate the effectiveness of government community initiatives to reduce alcohol-related harm and the effects of liquor licensing changes on alcohol consumption

The collection and reporting of alcohol sales data would entail only a small cost to the alcohol industry, which already provides these data to commercial market research companies. (64) The collection of a range of other datasets will also be important for appropriate planning, monitoring and evaluation of alcohol policies and programs. These include datasets on places of drinking, the duration of drinking occasion, and reasons for drinking; datasets on the harm to drinkers and harm to others, such as police datasets; child and family welfare agency datasets; health service datasets; and a range of other datasets that capture the impact of alcohol on sectors such as local government, fire services and insurance.

---

Action 8.1

*Develop a system for nationally consistent collection and management of alcohol wholesale sales data to inform key alcohol policy developments and evaluations.*

Action 8.2

*NPA to define a set of essential national indicators on alcohol consumption and health and social impacts by reviewing what is currently available and what is also required.*

Action 8.3

*Expand the collection of patterns of drinking data to include place of drinking, duration of drinking occasion, and reasons for drinking.*

Action 8.4

*Improve utilisation of key datasets on the harm to drinkers and harm to others.*
## ALCOHOL: IMPLEMENTATION PLAN

### Summary of action required and how progress will be measured

<table>
<thead>
<tr>
<th>KEY ACTION AREAS</th>
<th>RESPONSIBILITY</th>
<th>STAGED IMPLEMENTATION</th>
<th>MEASURE</th>
</tr>
</thead>
</table>
| Key action area 1: Improve the safety of people who drink those around them | Lead agency:  
  MCDS  
  Partners:  
  State and territory liquor licensing authorities  
  Police services  
  Local government  
  Alcoholic beverage and related industries  
  Health authorities | Years 1–4  
  Develop best practice approaches for liquor control legislation for implementation by states and territories. Consultation with the alcohol industry.  
 Years 5–8  
  All states and territories introduce legislation to implement best practice approaches.  
 Years 9–11 and ongoing  
  States and territories to monitor and report on enforcement of legislation. | Agreed best practice approach is introduced within two years.  
 Alcohol outlet opening times.  
 Alcohol outlet density (state/LGA region/capital city/high-risk areas).  
 Number of liquor licences issued where RSA training and accreditation completed prior to issuing licence.  
 Monitoring of type and extent of alcohol promotions. |
| 1.1 States and territories to harmonise liquor control regulations by developing and implementing best practice nationally consistent approaches to the policing and enforcement of liquor control laws, including:  
 Outlet opening times, outlet density  
 Accreditation requirements prior to the issuing of a liquor licence  
 Late-night and other high-risk outlets  
 Responsible Serving of Alcohol (RSA) and training model | Years 1–4  
  Develop best practice nationally consistent approaches to policing and enforcement of liquor control laws and regulations, relating to:  
 Optimal levels of enforcement of drink-drinking laws  
 Intelligence-led, outlet-focused systems of policing and enforcement  
 Annual review of liquor licences as part of annual licence renewal process  
 Demerit points penalty systems for licensees who breach liquor control laws, with meaningful and graduated penalties depending on severity and frequency of offence  
 Monitoring and reporting on enforcement of legislation | Reporting and monitoring framework developed as part of best practice approach for policing and enforcement.  
 Baseline measures identified and collected.  
 Annual reporting of performance measures. |                                                                 |
### Key Action Areas

<table>
<thead>
<tr>
<th>1.3</th>
<th>Develop a business case for a new COAG national partnership agreement on policing and enforcement of liquor control laws and regulations.</th>
</tr>
</thead>
</table>
| **Responsibility** | Lead agency:  
- All governments (Australian/state/territories)  
- Partners:  
  - State and territory police services and law enforcement agencies  
  - State and territory liquor licensing authorities  
  - Local government  
  - Alcoholic beverage and related industries |
| **Staged Implementation** | Years 1–4  
- Develop a business case for a new COAG national partnership agreement on policing and enforcement of liquor control laws and regulations.  
- Years 5–8  
- Implement COAG national partnership agreement on policing and enforcement of liquor control laws and regulations.  
- Legislation introduced as required.  
- Years 9–11 and ongoing  
- Continue to implement performance-based National Partnership Agreement on policing and enforcement of liquor control laws and regulations. |
| **Measure** | The business case for a new COAG national partnership agreement on policing and enforcement of liquor control laws and regulations is developed within four years. |

<table>
<thead>
<tr>
<th>1.4</th>
<th>Provide police, other law enforcement agencies and private security staff with information and training about approaches to complying and enforcing liquor licensing laws and managing public safety.</th>
</tr>
</thead>
</table>
| **Responsibility** | Lead agency:  
- State and territory liquor licensing authorities  
- Partners:  
  - State and territory police services and law enforcement agencies  
  - Local government  
  - Alcoholic beverage and related industries |
| **Staged Implementation** | Years 5–8  
- Develop training package.  
- Disseminate information and training. |
| **Measure** | Training packages developed for each jurisdiction.  
- Monitoring of the delivery of training package to all new and existing law enforcement personnel. |

<table>
<thead>
<tr>
<th>1.5</th>
<th>Change current system to ensure local communities and their local governments can manage existing and proposed alcohol outlets through land use planning controls to:</th>
</tr>
</thead>
</table>
| **Responsibility** | Lead agency:  
- All governments; MCDS  
- Partners:  
  - National Local Government Drug and Alcohol Advisory Committee  
  - Local government  
  - State and territory liquor licensing authorities  
  - Alcoholic beverage and related industries |
| **Staged Implementation** | Years 5–8  
- Consultation and development of best practice approach.  
- Implement approach in local communities and refine as necessary to ensure consistency with best practice approaches mentioned in previous actions. |
| **Measure** | Alcohol outlet opening times.  
- Alcohol outlet density (state/LGA region/capital city/high-risk areas).  
- Community opinions on issues such as outlet density, impact on neighbourhood amenity, noise levels, perceived safety, overall satisfaction with current approach.  
- Data collection and monitoring of alcohol sales, policing, and health and social impacts: e.g.  
  - Alcohol-related violence and crime  
  - Alcohol-related hospital admissions |
<table>
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<tr>
<th>KEY ACTION AREAS</th>
<th>RESPONSIBILITY</th>
<th>STAGED IMPLEMENTATION</th>
<th>MEASURE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.6 Establish the public interest case to exempt liquor control legislation from the requirements of National Competition Policy</td>
<td>Lead agency: National Competition Council, Partners: State and territory liquor licensing authorities, Local government, Alcoholic beverage and related industries</td>
<td>Years 1–4Commission the public interest case in order for liquor control legislation and other regulatory measures to be exempt from National Competition Policy.</td>
<td>Establishment of the public interest case.</td>
</tr>
<tr>
<td>1.7 Support the above through:</td>
<td>Lead agency: National Prevention Agency (NPA), Partners: State and territory liquor licensing authorities, State and territory police services and law enforcement agencies, Local government, Alcoholic beverage and related industries, Health groups</td>
<td>Years 1 – 4Establish partnerships with the alcohol beverage and related industries.</td>
<td>Partnerships established. Data collections established for alcohol sales, policing and health and social impacts – trends over time.</td>
</tr>
</tbody>
</table>

**Key action area 2: Increase public awareness and reshape attitudes to promote a safer drinking culture in Australia**

| Lead agency: National Prevention Agency (NPA) | Partners: State and territory liquor licensing authorities, State and territory police services and law enforcement agencies, Local government, Alcoholic beverage and related industries, Health groups |
|斯塔吉德实施方法 | 年份 1–4建立与酒精饮料相关行业和相关行业的合作伙伴关系。 |
| 核心行动领域2: 增加公众意识并重塑态度，以促进澳大利亚的安全饮酒文化 |

| Lead agency: NPA | Partners: MCDS, State and territory health departments and other relevant agencies, Road Safety authorities, Nationally based NGOs |
|斯塔吉德实施方法 | 年份 1–4识别有效活动信息，通过定性和国内外其他活动的分析和研究，开发第一波活动。 |
| 核心行动领域2: 增加公众意识并重塑态度，以促进澳大利亚的安全饮酒文化 |

| Percentage of target audiences (including adults, young people and low SES) who: | Have seen advertising used in recent campaigns |
|斯塔吉德实施方法 | Can name themes covered in advertising (unprompted and prompted) |
| 核心行动领域2: 增加公众意识并重塑态度，以促进澳大利亚的安全饮酒文化 |

| Correctly identify health risks and social disadvantages of harmful consumption of alcohol |
|斯塔吉德实施方法 | See such disadvantages as salient and relevant to themselves |
| 核心行动领域2: 增加公众意识并重塑态度，以促进澳大利亚的安全饮酒文化 |

<p>| Change in measures such as knowledge, attitudes, awareness, intention and behavior relating to harmful consumption of alcohol |
|斯塔吉德实施方法 | Develop and implement new phase of comprehensive, sustained social marketing strategy. |
| 核心行动领域2: 增加公众意识并重塑态度，以促进澳大利亚的安全饮酒文化 |</p>
<table>
<thead>
<tr>
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<th>MEASURE</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.2 Embed the main themes and key messages within a broad range of complementary preventative health policies and programs, such as:</td>
<td>Lead agency: NPA</td>
<td>Years 5–8 and ongoing</td>
<td>Proportion of the community who can identify health risks and social disadvantages of alcohol and see these disadvantages as potentially salient and relevant to themselves or others.</td>
</tr>
<tr>
<td>- Schools and tertiary education settings</td>
<td>Partners: State and territory education departments</td>
<td></td>
<td>Change in measures such as knowledge, attitudes, awareness, intention and behaviour relating to alcohol and risk drinking.</td>
</tr>
<tr>
<td>- Community-based sport and recreation settings</td>
<td>National, state and local sporting codes</td>
<td></td>
<td>Measures of risky alcohol use associated with participation or attendance at sporting events.</td>
</tr>
<tr>
<td>- Community-based cultural groups</td>
<td>Schools</td>
<td></td>
<td></td>
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<td></td>
<td>Local government</td>
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<td></td>
<td>Cultural organisations</td>
<td></td>
<td></td>
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<tr>
<td>2.3 Introduce basic strategies in the workplace to prevent and reduce alcohol-related harm in a range of key industries, including:</td>
<td>Lead agency: NPA</td>
<td>Years 5–8</td>
<td>Increased number of workplaces implementing health policies with a focus on nutrition, physical activity, alcohol and tobacco.</td>
</tr>
<tr>
<td>- Offering regular basic health checks for employees</td>
<td>Partners: State and territory workplace safety authorities</td>
<td></td>
<td>Increased number of workplaces with health programs.</td>
</tr>
<tr>
<td>- Development of evidence-informed workplace policies</td>
<td>Chambers of commerce and industry</td>
<td></td>
<td>Number of employees with access to healthy programs in the workplace and the proportion who use them.</td>
</tr>
<tr>
<td>- Employee assistance programs</td>
<td>Employer groups</td>
<td></td>
<td>Uptake of workplace policies and programs by public sector agencies at the Australian/state/territory and local government level.</td>
</tr>
<tr>
<td></td>
<td>Trade unions</td>
<td></td>
<td>Active transport to and from work, level of physical activity, healthy eating, risky drinking and smoking by employees.</td>
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<td></td>
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<td>Uptake of incentives by the private sector.</td>
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</table>
### Key Action Areas

<table>
<thead>
<tr>
<th>Key action area 3: Regulate alcohol promotions</th>
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</thead>
<tbody>
<tr>
<td><strong>Lead agency:</strong></td>
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<tr>
<td><strong>Partners:</strong></td>
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<tr>
<td><strong>Year 1–4</strong></td>
</tr>
<tr>
<td><strong>Year 4</strong></td>
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<tr>
<td><strong>Year 5–8</strong></td>
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<tr>
<td><strong>Year 9–11</strong></td>
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<td><strong>Year 5–8</strong></td>
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<td><strong>Year 5–8</strong></td>
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</table>

### Staged Implementation

- **Years 1–4** | Introduce a co-regulatory approach to alcohol promotions agreed by MCDS in April 2009.  |
- **Year 4** | Ban the sale of alcohol-branded merchandise.  |
- **Years 5–8** | Introduce independent regulation through legislation if the co-regulatory approaches are not effective in phasing out alcohol promotions from times and placements which have high exposure to young people aged up to 25 years.  |
- **Years 9–11** | Continue phase out of alcohol promotions from times and placements which have high exposure to young people aged up to 25 years.  |
- **Years 5–8** | Develop and implement enforceable codes of conduct.  |
- **Year 5–8** | Develop and implement enforceable codes of conduct.  |
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- **Year 5–8** | Develop and implement enforceable codes of conduct.  |
- **Year 5–8** | Develop and implement enforceable codes of conduct.  |

### Measure

- Number and type of alcohol promotion, marketing and sponsorship arrangements which are most likely to appeal to or have an impact on children and young people.
- Changes in community attitudes to alcohol: adults and young people.
### Key Action Areas

<table>
<thead>
<tr>
<th>3.3 Require health advisory information labelling on containers and packaging of all alcohol products to communicate key information that promotes safer consumption of alcohol, including:</th>
<th>Lead agency:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• The current NHMRC Australian Guidelines to Reduce Health Risks from Drinking Alcohol</td>
<td></td>
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<tr>
<td>• Text and graphic warnings about the range of health and safety risks of alcohol consumption</td>
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<td>• Nutritional data</td>
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<td>• Ingredients</td>
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<tr>
<td>• Clearly legible information on the amount of alcohol by volume and number of standard drinks</td>
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<tr>
<td>Partners:</td>
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<tr>
<td>• Food Standards Australia New Zealand (FSANZ)</td>
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<tr>
<td>• Alcoholic beverage and related industries</td>
<td></td>
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<tr>
<td>• Health authorities</td>
<td></td>
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<tr>
<td>Staged Implementation: Years 1 – 4 Introduce requirements for health advisory information.</td>
<td></td>
</tr>
<tr>
<td>Measure: Community attitudes, awareness and knowledge of warnings, labels and key messages.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>3.4 Require counter-advertising (health advisory information) that is prescribed content by an independent body within all alcohol advertising at a minimum level of 25% of the advertisement broadcast time or physical space.</th>
<th>Lead agency:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Australian Government</td>
<td></td>
</tr>
<tr>
<td>Partners:</td>
<td></td>
</tr>
<tr>
<td>• Australian Competition and Consumer Commission</td>
<td></td>
</tr>
<tr>
<td>• Health authorities</td>
<td></td>
</tr>
<tr>
<td>• Advertising industry</td>
<td></td>
</tr>
<tr>
<td>• Alcoholic beverage and related industries</td>
<td></td>
</tr>
<tr>
<td>Staged Implementation: Years 5 – 8 Specify, develop and implement the arrangements and content for the counter-advertising initiative. Develop operating principles to guide the industry. Consultation. Years 9 – 11 If required, introduce legislation to require counter-advertising and implement arrangements.</td>
<td></td>
</tr>
<tr>
<td>Measure: Awareness of counter-advertising and key messages. Change in measures such as knowledge, attitudes, awareness, intention and behaviour relating to alcohol and risk drinking. Industry compliance with counter-advertising requirements.</td>
<td></td>
</tr>
</tbody>
</table>

### Key action area 4. Reform alcohol taxation and pricing arrangements to discourage harmful drinking

<table>
<thead>
<tr>
<th>4.1 Commission independent modelling under the auspices of Health, Treasury and an industry panel for a rationalised tax and excise regime for alcohol that discourages harmful consumption and promotes safer consumption.</th>
<th>Lead agency:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Commonwealth Treasury (Henry Review)</td>
<td></td>
</tr>
<tr>
<td>Partners:</td>
<td></td>
</tr>
<tr>
<td>• Australian Government and State and Territory Health Departments</td>
<td></td>
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<tr>
<td>• Australian Tax Office</td>
<td></td>
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<tr>
<td>• Australian Customs</td>
<td></td>
</tr>
<tr>
<td>• Alcoholic beverage and related industries</td>
<td></td>
</tr>
<tr>
<td>• Individuals and organisations within public health and health economics</td>
<td></td>
</tr>
<tr>
<td>Staged Implementation: Years 1 – 4 Commission modelling.</td>
<td></td>
</tr>
<tr>
<td>Measure: Prices of alcoholic beverages differ significantly according to their alcohol content and/or their potential to cause harm.</td>
<td></td>
</tr>
<tr>
<td>KEY ACTION AREAS</td>
<td>RESPONSIBILITY</td>
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</tr>
<tr>
<td>4.2 Develop the public interest case for minimum (floor) price of alcohol to discourage harmful consumption and promotes safer consumption.</td>
<td>Lead agency: National Competition Council Partners: Alcoholic beverage and related industries Health and law enforcement groups</td>
</tr>
<tr>
<td>4.3 Direct a proportion of revenue from alcohol taxation towards initiatives that prevent alcohol-related societal harm.</td>
<td>Lead agency: Commonwealth Treasury Partners: NPA</td>
</tr>
</tbody>
</table>

Key action area 5: Improve the health of Indigenous Australians

| 5.1 Increase access to health services for Indigenous people who are drinking at harmful levels through: | Lead agency: Australian Government Partners: National Aboriginal Community Controlled Health Organisation (NACCHO) Aboriginal Community Controlled Health Organisations (ACCHO) National Indigenous Health Equality Council | Years 1–4 and ongoing Development of a coordinated implementation plan to expand alcohol treatment programs in the community as well as residential and improve coordinated care. | Availability of alcohol treatment services in public, private and NGO sectors. Access to alcohol treatment services by SES, age, ethnicity, Indigenous status etc. Evaluation of the coordinated implementation plan. |
| Providing resources to primary healthcare providers | | | |
| Training of staff, including Indigenous health workers | | | |
| Expanding both community-based and residential alcohol treatment programs | | | |
| Increasing health service capacity to facilitate coordinated case management of alcohol-dependent persons | | | |
### KEY ACTION AREAS

<table>
<thead>
<tr>
<th><strong>5.2 Support local initiatives in Indigenous communities, including:</strong></th>
<th><strong>RESPONSIBILITY</strong></th>
<th><strong>STAGED IMPLEMENTATION</strong></th>
<th><strong>MEASURE</strong></th>
</tr>
</thead>
</table>
| - Restricting the physical availability of products | Lead agency:  
- Australian Government  
Partners:  
- NACCHO  
- ACCHO  
- NIDAC  
- Indigenous organisations such as Land Councils and Housing Associations  
- State and territory liquor licensing authorities  
- State and territory police services and law enforcement agencies  
- Local government  
- Alcoholic beverage and related industries | Years 1–4 and ongoing | Level of risky drinking in Indigenous communities.  
- Alcohol outlet opening times.  
- Alcohol outlet density.  
- Community opinions on issues such as outlet density, impact on neighbourhood amenity, noise levels, perceived safety, overall satisfaction with current approach.  
- Data collection and monitoring of alcohol sales, policing, and alcohol-related health and social impacts; e.g.:  
- Alcohol-related violence and crime  
- Alcohol-related hospital admissions, road accidents, injuries etc. |

| **5.3 Establish a reliable, regular and sustained system for the collection and analysis of population statistics on alcohol and drug use among Indigenous people.** | Lead agency:  
- Australian Institute of Health and Welfare (AIHW)  
Partners:  
- NIDAC  
- Office for Aboriginal and Torres Strait Islander Health  
- NACCHO  
- AIB  
- Public health research bodies | Years 1–4  
Identify options to enhance data collections on alcohol and drug use among Indigenous people.  
Years 5–8  
Implement system. | Robust and sustained data collections and analysis of alcohol and drug use among Indigenous people is available within two years. |

| **5.4 Establish and fund a multi-site trial of alcohol diversion programs.** | Lead agency:  
- Australian Government  
Partners:  
- NACCHO  
- ACCHO  
- State and territory police services and law enforcement agencies  
- State and territory health departments | Years 1–4  
Identify trial methodology and sites, and evaluative research component.  
Years 5–8  
Implement, monitor and evaluate trial. | Trials successfully established in a range of sites with support of key partners.  
Trials evaluated and results reported. |
5.5 In communities that desire them and which are large enough to support them, the availability of night patrols and sobering-up shelters should be expanded.

<table>
<thead>
<tr>
<th>KEY ACTION AREAS</th>
<th>RESPONSIBILITY</th>
<th>STAGED IMPLEMENTATION</th>
<th>MEASURE</th>
</tr>
</thead>
<tbody>
<tr>
<td>5.5 In communities that desire them and which are large enough to support them, the availability of night patrols and sobering-up shelters should be expanded.</td>
<td>Lead agency:</td>
<td>Years 1–4</td>
<td>Availability and use of sobering-up shelters and night patrols. Indigenous community opinions on issues such as night patrols, impact on neighbourhood amenity, noise levels, perceived safety, overall satisfaction with current approach. Data collection monitoring of alcohol sales, policing, and alcohol-related health and social impacts. For example: Alcohol-related violence and crime Alcohol-related hospital admissions, road accidents, injuries etc</td>
</tr>
<tr>
<td></td>
<td>Australian Government</td>
<td>Invite expressions of interest from local communities to establish and/or expand night patrols and sobering-up shelters.</td>
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</tr>
<tr>
<td></td>
<td>Partners:</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>NACCHO</td>
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<td></td>
<td>ACCHOs</td>
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<td></td>
<td>NIDAC</td>
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<tr>
<td></td>
<td>Indigenous organisations such as Land Councils and Housing Associations</td>
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<td></td>
<td>Local government</td>
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<tr>
<td></td>
<td>State and territory police services and law enforcement agencies</td>
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<td></td>
<td>State and territory health departments</td>
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</tbody>
</table>

Key action area 6: Strengthen, skill and support primary healthcare to help people in making healthy choices

6.1 Enhance the role of primary health care organisations in preventing and responding to alcohol-related health problems by:

- Reviewing the incentive structure for alcohol-related health checks in the primary healthcare settings that are both universal and targeted at high-risk groups
- Further developing their role in coordinating collaborative initiatives such as individual and group referral programs for alcohol-related risk factors
- Increasing the uptake of pharmacotherapy treatment for alcohol dependence, by GPs and specialist alcohol and drug treatment services
- Promoting the NHMRC guidelines on low-risk drinking

<table>
<thead>
<tr>
<th>Lead agency:</th>
<th>COAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Partners:</td>
<td>Divisions of General Practice, Australian Medical Association (AMA), Royal Australian College of Physicians (RACP), Health Insurance Commission, State and territory health departments, Primary Health Services, Primary Care Networks</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>STAGED IMPLEMENTATION</th>
<th>MEASURE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Years 1–4</td>
<td>Review current incentives for alcohol-related health checks. Develop training and support for primary health workforce. Years 5–8 Implement new incentives. Evaluate progress.</td>
</tr>
<tr>
<td>Review of current incentive structure completed and reported to COAG, including recommendations. Occasions of brief alcohol-related health checks in primary healthcare services. Rates of pharmacotherapy treatment provided for alcohol dependence through primary healthcare services.</td>
<td></td>
</tr>
<tr>
<td>KEY ACTION AREAS</td>
<td>RESPONSIBILITY</td>
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<td>---------------------------------------------------------------------------------</td>
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</tr>
</tbody>
</table>
| 6.2 Develop a more comprehensive network of alcohol-related referral services and programs to support behaviour change in primary healthcare by: | Lead agency: Australian Government with the Divisions of General Practice  
Partners: AMA, RACP, Health Insurance Commission, State and territory health departments, Primary Health Services, Primary Care Networks, Drug and Alcohol Treatment Services, Australian Nursing Federation, Drug and Alcohol Nurses Association | Years 1–4  
Establish quality standards and identify referral network.  
Years 5–8 and ongoing  
Provide funding for services to achieve quality standards and implement referral networking.  
Quality accreditation. | Referrals between primary healthcare services and specialist alcohol treatment services.  
Quality accreditation system developed.  
Brief interventions for alcohol issues undertaken by practice nurses. |
| 6.3 Increase access to primary healthcare services and improve health outcomes for hard-to-reach disadvantaged individuals who are at risk of alcohol-related health problems by: | Lead agency: Australian Government with the Divisions of General Practice  
Partners: AMA, RACP, Health Insurance Commission, State and territory health departments, Primary Health Services, Primary Care Networks, Drug and Alcohol Treatment Services, Australian Nursing Federation, Drug and Alcohol Nurses Association | Years 1–4  
Identify existing barriers to primary healthcare for hard-to-reach disadvantaged individuals.  
Years 5–8  
Pilot a range of programs that increase access for hard-to-reach disadvantaged individuals. | Removal of major barriers for hard-to-reach disadvantaged individuals who require access to primary healthcare services.  
Service outcomes for hard-to-reach disadvantaged individuals at risk of alcohol-related health problems. |
<table>
<thead>
<tr>
<th>Key action area 7: Build healthy children and families</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>7.1 Protect the health and safety of children and adolescents brain development by:</strong></td>
</tr>
<tr>
<td>- Developing nationally consistent principles and practices regarding the supply of alcohol to minors without parental/guardian consent</td>
</tr>
<tr>
<td>- Promoting informed community discussion about the appropriate age for young people to begin drinking</td>
</tr>
<tr>
<td>Lead agency:</td>
</tr>
<tr>
<td>- MCDS Partners</td>
</tr>
<tr>
<td>- State and territory police services and law enforcement agencies</td>
</tr>
<tr>
<td>Lead agency:</td>
</tr>
<tr>
<td>- NPA</td>
</tr>
<tr>
<td>- Maternal and child health services</td>
</tr>
<tr>
<td><strong>STAGED IMPLEMENTATION</strong></td>
</tr>
<tr>
<td>Years 1–4</td>
</tr>
<tr>
<td><strong>MEASURE</strong></td>
</tr>
<tr>
<td>All states have consistent legislation and monitoring systems in place by 2010.</td>
</tr>
<tr>
<td>Number of complaints. Community attitudes to young people and drinking, and supply of alcohol to minors.</td>
</tr>
</tbody>
</table>

| **7.2 Support parents in managing alcohol issues at all stages of their children's development through community-level approaches including:** |
| - Broad dissemination and implementation of the NHMRC guidelines on the risks of alcohol consumption for young people aged under 18 years and for women who are pregnant or breastfeeding |
| - School-based parent networking for mutual support and information sharing |
| - Local policing programs to proactively liaise with families, schools and communities at times when alcohol may pose risks to the health and safety of young people |
| - Provision of practical advice for handling alcohol issues among children and adolescents at key life stages and settings, including commencement of secondary education, in sport settings, during periods of stress, at times of family disruption or breakdown, and in school leaving years |
| Lead agency: |
| - MCDS Partners |
| - Maternal and child health services |
| - State and territory health departments |
| - State and territory education departments |
| - Schools |
| - State and territory police services and law enforcement agencies |
| **STAGED IMPLEMENTATION** |
| Years 1–4 |
| Develop information and materials and dissemination strategy. |
| Years 5–8 |
| Disseminate information and materials. Evaluate impact. |
| **MEASURE** |
| Knowledge, attitude and awareness of NHMRC guidelines and health risks associated with alcohol use, particularly for young people. |
| Local programs established and program evaluation completed. |
| Data collected on alcohol-related health and social impacts for young people. e.g.: |
| - Alcohol-related violence and crime |
| - Alcohol-related hospital admissions, road accidents, injuries etc. |
| - Population-level surveys of young people – sources of alcohol supply and sales, levels of risk drinking, experience of alcohol-related harms |

| **7.3 Measure the impact of harmful consumption of alcohol on families and children by ensuring all population surveys that collect data to monitor drug use and drug trends across Australia collect information on parental status or childcare responsibilities of drinkers.** |
| Lead agency: |
| - AIHW |
| **STAGED IMPLEMENTATION** |
| Years 5–8 and ongoing |
| **MEASURE** |
| Data collections include this measure by 2010. |
### Key Action Area 8: Strengthen the Evidence Base

<table>
<thead>
<tr>
<th>Key Action</th>
<th>Responsibility</th>
<th>Staged Implementation</th>
<th>Measure</th>
</tr>
</thead>
</table>
| 8.1 | Develop a system for nationally consistent collection and management of alcohol wholesale sales data to inform key alcohol policy developments and evaluations that includes:  
- Funding for data collection and provision by the alcohol beverage and related industries; and  
- Funding for regular and ongoing data management, analysis and reporting by the Australian Bureau of Statistics;  
- Continuation of current accessible datasets on alcohol consumption levels in Australia, collected and compiled by the Australian Bureau of Statistics | Lead agency: NPA  
Partners: MCDS  
State and territory liquor licensing authorities  
Australian Bureau of Statistics  
Alcoholic beverage and related industries | Years 1–4  
Fund data collection.  
Years 5–8 and ongoing:  
Quarter and/or annual reporting. | Data collection funded.  
Data collected and reported. |
| 8.2 | NPA to define a set of essential national indicators on alcohol consumption and health and social impacts by reviewing what is currently available and what is also required. | Lead agency: NPA  
Partners: AIHW  
ABS  
Public health research bodies | Years 1–4  
The national alcohol indicator dataset finalised and collection commences 2011. | |
| 8.3 | Expand the collection of patterns of drinking data to include place of drinking, duration of drinking occasion, and reasons for drinking. | Lead agency: AIHW | Years 5–8 and ongoing | Data collected. |
| 8.4 | Improve utilisation of key datasets on the harm to drinkers and harm to others, including:  
- Police data including that relating to random breath testing, ignition interlock devices, and crimes against property and crimes against the person  
- Child and family welfare agency data  
- Health services data including hospitals, primary care services, ambulance services and specialist treatment services  
- Local government data on management of public space, clean-up costs, noise issues and enforcement of local laws  
- Other relevant datasets including fire services, property insurance and medical insurance | Lead agency: NPA  
Partners: AIHW  
State and territory health departments  
State and territory education departments  
State and territory police services and law enforcement agencies  
Local government  
Emergency services  
Insurance industry  
ABS  
Alcoholic beverage and related industries | Years 5–8 | Data collected and appropriate mechanisms in place to link datasets and sources to enable analysis of data on alcohol-related harm. |
References


56. Australia and New Zealand Food Regulation Ministerial Council (ANZFRMC), Joint Communiqué 1 May 2009: Canberra.


87. Room R and Livingstone M, Variation by age in the harm per drinking volume and heavier drinking occasion. 2007, AER Centre for Alcohol Policy Research, Turning Point Alcohol and Drug Centre: Melbourne.


APPENDIX 1: Preventative Health Taskforce Terms of Reference

Tasks

The Preventative Health Taskforce will provide evidence-based advice to government and health providers – both public and private – on preventative health programs and strategies, and support the development of a National Preventative Health Strategy.

The Strategy will provide a blueprint for tackling the burden of chronic disease currently caused by obesity, tobacco and excessive consumption of alcohol. It will be directed at primary prevention, and will address all relevant arms of policy and all available points of leverage, in both the health and non-health sectors, in formulating its recommendations.

The Taskforce will also:

1. Support the further development of the evidence base on preventative health, to inform what works and what doesn’t.
3. Provide advice on the most effective strategies for targeting prevention in high-risk sub-populations, including Aboriginal and Torres Strait Islander peoples and people living in rural and remote locations.
4. Provide guidance and support for clinicians, particularly in primary care settings, to play a more effective role in preventative healthcare.
5. Provide advice to government on options for better integration of preventative health practice into the Medicare Schedule and other existing government programs.

Membership

The Taskforce is appointed for a term of three years by the Commonwealth Minister for Health and Ageing.

The Taskforce is chaired by Professor Rob Moodie, Professor of Global Health at the Nossal Institute for Global Health at the University of Melbourne, former CEO of VicHealth, the Victorian Health Promotion Foundation, and internationally renowned leader in health promotion and preventative health.

Other members of the Taskforce include:

- **Professor Mike Daube**, (Deputy Chair) Professor of Health Policy at Curtin University of Technology, former Director-General of WA Department of Health, and expert in public health, tobacco prevention and alcohol policy.
- **Ms Kate Carnell** AO, CEO of the Australian Food and Grocery Council, former ACT Chief Minister, and former pharmacist.
- **Dr Christine Connors**, Director, Preventable Chronic Disease Program, Northern Territory Department of Health and Community Services.
- **Dr Shaun Larkin**, General Manager at not-for-profit health insurer HCF.
- **Dr Lyn Roberts** AM, CEO of the National Heart Foundation with wide-ranging experience in public health promotion, particularly in cardiovascular disease and cancer, and current Chair of the Australian Chronic Disease Prevention Alliance.
- **Professor Leonie Segal**, Foundation Chair in Health Economics at the University of South Australia.
- **Dr Linda Selvey**, Deputy Chief Health Officer and Senior Director, Population Health, Queensland Health.
- **Professor Paul Zimmet** AO, Professor and Director of the International Diabetes Institute, and expert in obesity and type 2 diabetes prevention.
The Taskforce will also co-opt external expertise as required, particularly including:

- **Medical and clinical expertise** from the Commonwealth’s Chief Medical Officer.
- **Nursing expertise** from the Chief Nursing and Midwifery Officer.
- Input from the **food, alcohol and medicines industries**, from stakeholders in these industries.
- **Consumer input** from health consumer stakeholder groups.
- Expertise from **outside the health portfolio**, including in areas such as transport and town planning, from stakeholders in these sectors.

**Accountability and deliverables**

The Taskforce will report to the Commonwealth Minister for Health and Ageing. The Taskforce will use a multidisciplinary approach, operate in a collaborative, open and consultative manner, and work in partnership with existing agencies and bodies working in associated areas.

The Taskforce will provide:

- Advice on the framework for the Preventative Health Partnerships between the Commonwealth and the states and territories by July 2008
- A three-year work program by September 2008
- A National Preventative Health Strategy by June 2009
- Advice on such matters as may be referred to the Taskforce from time to time by the Commonwealth Minister of Health and Ageing

The Taskforce shall be supported in its operations by the Commonwealth Department of Health and Ageing.
APPENDIX 2: Preventative Health Taskforce member profiles

Professor Rob Moodie - Chair
Professor Moodie is Professor of Global Health at the Nossal Institute for Global Health at the University of Melbourne, and former CEO of the Victorian Health Promotion Foundation since 1998. Since 1979 he has worked for Save the Children Fund, Médecins Sans Frontières, Congress (the community-controlled Aboriginal Health Service in Alice Springs), the Burnet Institute, and for the World Health Organization and UNAIDS. Professor Moodie also chairs the Technical Panel to the Gates Foundation Avahan Program in India, and the Melbourne Storm Rugby League Club.

Professor Mike Daube - Deputy Chair
Professor Mike Daube is Professor of Health Policy at Curtin University of Technology, and Director of the Public Health Advocacy Institute of WA. He was Western Australia’s Director General of Health from 2001 to 2005, and Chair of the National Public Health Partnership. He is currently President of the Public Health Association of Australia, the Australian Council on Smoking and Health and the WA Heart Foundation, and Chair of the WA Alcohol and Drug Authority. He has played a leading role in tobacco control, alcohol and other public health issues nationally and internationally for many years, and has advised governments and NGOs in some 30 countries. He has received awards for his work from organisations including the World Health Organization, the Public Health Association, the Australian Medical Association, Healthway, the Heart Foundation, Curtin University, the Australian Council on Smoking and Health, and the Australian Red Cross.

Ms Kate Carnell AO
Kate Carnell is currently Chief Executive Officer of the Australian Food and Grocery Council. She was ACT chief minister from 1995 to 2000, and received the Liberal Party’s Distinguished Service Award in 2002. Ms Carnell has been the chief executive of development at TransACT Communications in 2001, Director of NRMA Ltd from 2001 to 2002, and Executive Director of the National Association of Forest Industries. She is an Honorary Ambassador for Canberra and became the Director of the Multicultural Business Chamber of Australia Ltd in 2001. She has received the Paul Harris Award from Rotary.
Dr Shaun Larkin
Shaun Larkin joined the Hospitals Contribution Fund of Australia (HCF) in 1997 as General Manager, Strategic Development. He was appointed General Manager, Benefits Management in 2002 and in November 2007 began leading HCF’s development of a new corporate ventures function. This function is dedicated to seeking out and forming strategic and financial partnerships with innovative companies that share HCF’s commitment to improving healthcare quality, service and affordability.

Prior to joining HCF, Shaun was based in Singapore for four years where he led the establishment of a chain of ambulatory medical centres throughout Asia. Before this he worked for nine years as an executive for a large private hospital operator (Ramsay Health Care) in Australia and the United States.

Dr Lyn Roberts AM
Dr Lyn Roberts has been CEO of the National Heart Foundation of Australia since 2001. Dr Roberts has developed national cardiovascular health programs within Australia, has been extensively involved with cancer prevention programs and is regarded as an expert on tobacco control matters. She is past Chair of the Australian Chronic Disease Prevention Alliance (ACDPA; members: Cancer Council Australia, Diabetes Australia, Kidney Health Australia, National Stroke Foundation and National Heart Foundation of Australia) and is a member of a number of expert advisory committees for the government and non-government sectors. In 1997 Dr Roberts was awarded an Order of Australia (AM) for service to the community and to health, particularly in the fields of health promotion, cancer prevention awareness and lifestyle education. Dr Roberts was elected to the Board of the World Heart Federation (WHF) in 2006 and is Vice President.

Professor Leonie Segal
Professor Segal is Foundation Chair in Health Economics at the University of South Australia. Her research interests are broadly concerned, optimising the mix of health services and identifying the associated drivers and incentives that can facilitate evidenced-based resource shifts. Professor Segal’s former research interest has resulted in a large research program to develop and apply a population-based approach to priority setting, together with large-scale cost-effectiveness analysis.

Professor Paul Zimmet AO
Professor Zimmet pioneered Australia’s first institute dedicated exclusively to diabetes research, education and clinical care, becoming the Foundation Director when the International Diabetes Institute (IDI) was opened in July 1985. He was Professor of Diabetes at Monash University from 1989–1997. In 1993 he was awarded the Order of Australia (AM) for distinguished services to medicine and education, particularly in the field of diabetes. In 2001 he was honoured as an Officer of the Order of Australia (AO) for medical research of national and international significance, particularly in diabetes, and for contributions to Australia’s biotechnology development. In July 2008 the IDI merged with the Baker Heart Research Institute to establish the Baker IDI Heart and Diabetes Institute. Professor Zimmet is Director Emeritus and Director of International Research in the new institute.
AHMC NOMINATED JURISDICTIONAL MEMBERS:

**Dr Christine Connors**

Dr Christine Connors is a General Practitioner and Public Health Physician who has been working in the Northern Territory for over 20 years, providing clinical and public health services to remote Indigenous communities. Dr Connors was involved in developing the NT Preventable Chronic Disease Strategy and has been leading its implementation in the Northern Territory. She is the Director of the Preventable Chronic Disease Program for the Department of Health & Community Services. She is involved in a number of research projects with the Menzies School of Health Research and the Cooperative Research Centre for Aboriginal Health.

**Dr Linda Selvey**

Dr Linda Selvey is currently Senior Director, Population Health and Offender Health Services with Queensland Health. Previously she was Director, Communicable Diseases Unit with Queensland Health. She is a Public Health Physician and also has a PhD in Immunology. She is currently Deputy Chair of the Australian Population Health Development Principal Committee, and Chair of the Blood Borne Virus and STI Subcommittee of this Committee. She has previously been a member of the National Aboriginal and Torres Strait Islander Health Council, and a member of Australian Technical Advisory Group on Immunisation. Her special interests are primary prevention of chronic diseases, and HIV/AIDS and hepatitis C prevention and management. She has been an active environmentalist since the early 1980s and is particularly passionate about climate change. She was recently trained as a climate change presenter by former US Vice President Al Gore, who is training climate change presenters around the world as part of the Climate Project.
APPENDIX 3: Formal consultations conducted by the Preventative Health Taskforce

<table>
<thead>
<tr>
<th>DATE</th>
<th>CONSULTATION</th>
<th>LOCATION</th>
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</thead>
<tbody>
<tr>
<td>22 October 2008</td>
<td>General Consultation (morning)</td>
<td>Hobart</td>
</tr>
<tr>
<td>22 October 2008</td>
<td>General Consultation (afternoon)</td>
<td>Hobart</td>
</tr>
<tr>
<td>23 October 2008</td>
<td>General Consultation (morning)</td>
<td>Launceston</td>
</tr>
<tr>
<td>23 October 2008</td>
<td>General Consultation (afternoon)</td>
<td>Launceston</td>
</tr>
<tr>
<td>31 October 2008</td>
<td>General Consultation</td>
<td>Darwin</td>
</tr>
<tr>
<td>31 October 2008</td>
<td>Northern Territory Government</td>
<td>Darwin</td>
</tr>
<tr>
<td>31 October 2008</td>
<td>Australian General Practice Network Forum</td>
<td>Darwin</td>
</tr>
<tr>
<td>4 November 2008</td>
<td>General Consultation</td>
<td>Alice Springs</td>
</tr>
<tr>
<td>7 November 2008</td>
<td>General Consultation</td>
<td>Dubbo</td>
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<tr>
<td>17 November 2008</td>
<td>General Consultation</td>
<td>Canberra</td>
</tr>
<tr>
<td>17 November 2008</td>
<td>Thematic Roundtable: Prevention and Primary Care, including in remote and rural settings.</td>
<td>Canberra</td>
</tr>
<tr>
<td>19 November 2008</td>
<td>Thematic Roundtable: Targets, Strategies, Evidence and Evaluation</td>
<td>Canberra</td>
</tr>
<tr>
<td>19 November 2008</td>
<td>Australian Capital Territory Government</td>
<td>Canberra</td>
</tr>
<tr>
<td>24 November 2008</td>
<td>General Consultation</td>
<td>Brisbane</td>
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<tr>
<td>24 November 2008</td>
<td>Queensland Government</td>
<td>Brisbane</td>
</tr>
<tr>
<td>24 November 2008</td>
<td>Thematic Roundtable: Shaping Demand and Supply in Food</td>
<td>Sydney</td>
</tr>
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## APPENDIX 4: Submissions to the Preventative Health Taskforce

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A number of organisations provided multiple submissions, bringing the total number of submissions (as distinct for organisations) to 397.

These submissions can be found on the Preventative Health Taskforce website at www.preventativehealth.org.au. Some submissions have not been published on the website at the request of the author(s).
APPENDIX 5: Papers commissioned by the Preventative Health Taskforce


Friel S. 2009. Health equity in Australia: A policy framework based on action on the social determinants of obesity, alcohol and tobacco

Garrard J. 2009. Taking action on obesogenic environments: Building a culture of active, connected communities

Gray V. and Holman C.D.J. Deaths and premature loss of life caused by overweight and obesity in Australia in 2011-2050: Benefits from different intervention scenarios

Harris M. 2009. The role of primary health care in the prevention of chronic disease


These papers can be found on the Preventative Health Taskforce website at www.preventativehealth.org.au.
APPENDIX 6: Acknowledgements

The National Preventative Health Taskforce developed the strategy with advice from the following experts:

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Associate Professor Ted Wilkes
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**OBESITY (INCLUDING ALL MEMBERS OF THE PREVENTATIVE HEALTH TASKFORCE)**

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