

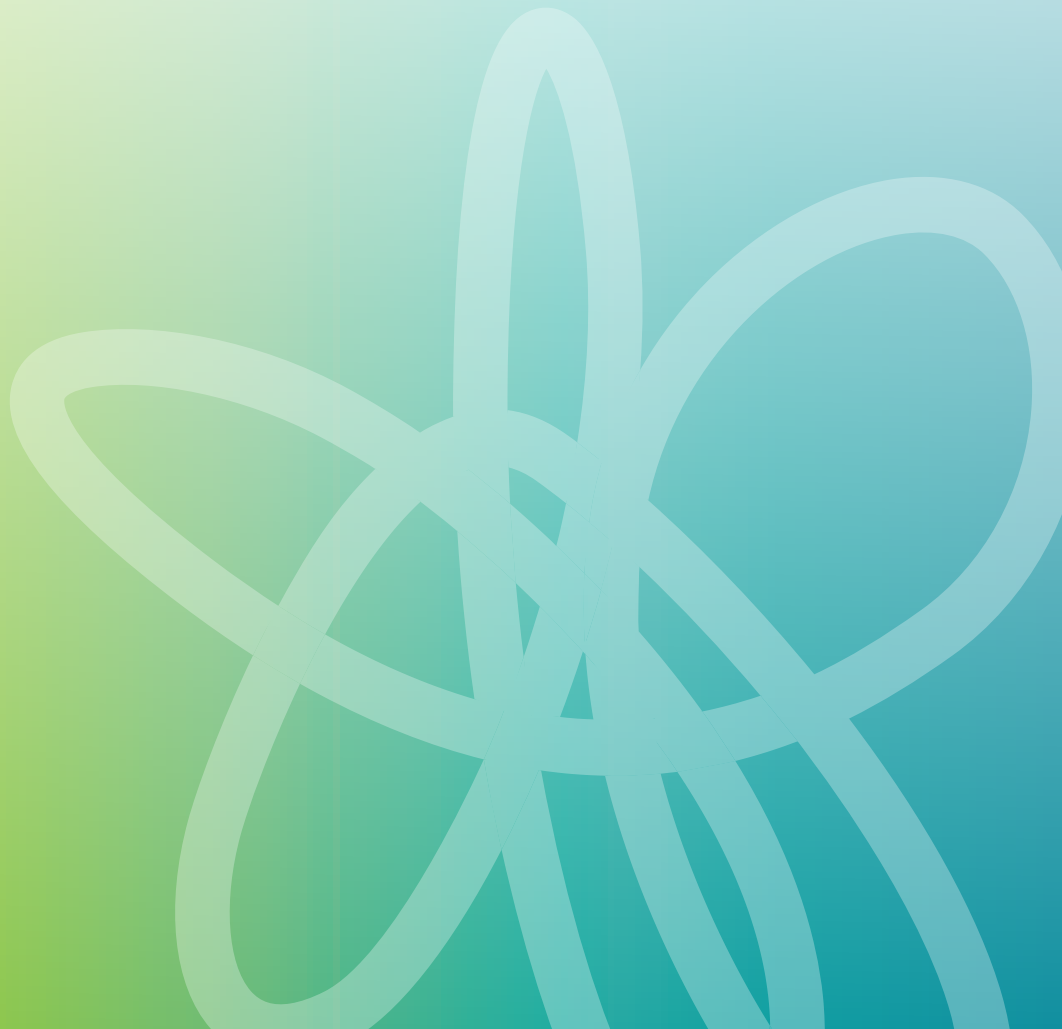


The Australian Prevention
Partnership Centre
Systems and solutions for better health

Chronic disease prevention landscape

Results of a national key informant survey

August 2015



Chronic disease prevention landscape

Results of a national key informant survey

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Introduction and objectives

The Australian Prevention Partnership Centre (Prevention Centre) engaged Inca Consulting to undertake research among health prevention practitioners, policy makers, researchers and other experts. The research was designed to help the Prevention Centre better understand, learn from and contribute to the improvement of prevention efforts across Australia.

A small project steering committee was established to provide advice on the research scope and methods, with members drawn primarily from the Prevention Centre's investigator team.

In broad terms, the project explored:

1. The status of the 2005 National Chronic Disease Strategy, in particular, its usefulness to the prevention sector and the lessons for future strategies, with a particular focus on whether applying systems thinking and approaches could add value
2. Jurisdictional responses to the cancellation of the National Partnership Agreement for Preventive Health (NPAPH), in particular, the adjustments made to prevention programs in each State or Territory and the factors that influenced decision-making.

This report is intended to provide the Prevention Centre with an insight into the prevention sector's current priorities for the planning and implementation of chronic disease prevention programs. It also intended to provide the Prevention Centre with material that could potentially be shared with jurisdictions and other players across the prevention sector.

Methods

The project was qualitative and involved two streams: one stream to canvass opinion from both jurisdictions and other informants on the National Chronic Disease Strategy (Objective 1 above); and a second stream to hear from jurisdictions about the status of their prevention programs and activities (Objective 2 above).

The project featured the following activities:

- An initial planning workshop attended by Inca Consulting and Prevention Centre representatives
- A review of key documentation including the NPAPH Healthy Children and Healthy Workers Implementation plans developed by each jurisdiction and the 2005 Chronic Disease Strategy
- The development of two discussion guides (for stream 1 and stream 2) – reviewed by the Project Steering Committee
- Face-to-face and telephone in-depth interviews with representatives of all State/Territory health jurisdictions and a variety of other advocacy and research organisations.

Prevention Centre Director Professor Andrew Wilson invited 33 individuals to take part in the research. The Prevention Centre chose invitees on the basis of their likely ability to provide an informed contribution to the study (i.e. a purposive sample was selected). Inca Consulting followed up all potential respondents to arrange a suitable time for interview.

In total, 29 people were included in the research. This included 17 of the people sent the invitation email and 12 others who responded in place of the original invitee or else alongside the original invitee. All eight health jurisdictions participated in the research, along with representatives of 10 other advocacy or research organisations.

Interviews lasted for about an hour and were conducted between 2 June and 14 August 2015.

Results: The chronic disease prevention landscape

Main achievements and legacy resulting from the NPAPH

Informants were asked to describe progress made during the NPAPH – to highlight the main achievements and enduring benefits. Care was taken to not present the line of questioning as an attempt to evaluate the achievements of each State/Territory, but rather as a means of initiating the discussion and identifying the positives that had resulted during the time of the NPAPH.

It was clear from the discussions that there were very different starting points in different jurisdictions in terms of the extent of existing prevention programs and the political and institutional support for investing in chronic disease prevention. Before the NPAPH, some jurisdictions had invested heavily in the development, implementation and evaluation of prevention initiatives of various kinds while others had a more modest suite of programs in place. Consequently, the nature of the discussion relating to 'progress' or 'achievement' differed substantially from one jurisdiction to the next.

Across jurisdictions, the discussions revealed that the NPAPH allowed jurisdictions to, to a greater or lesser extent:

- Structure thinking and the approach to prevention around settings – workplaces, schools and early learning centres in particular

"The settings approach has an enduring benefit. We'll continue to use settings as the basis for our programs."

"It allowed us to focus on workplaces for the first time. It made a huge difference on how we approach workplaces."

- Assemble a more comprehensive and layered suite of prevention activities that provided multiple opportunities for engaging at-risk target audiences

"With that money you can layer up the programs and interventions ... not take such a fragmented approach."

- Reform the approach to prevention, adopting stronger systems thinking principles

"It enabled us to reform the system ... not just boost or reorient things we were already doing. We took the opportunity to do some system transformation."

- Expand, bolster or scale up existing programs (albeit on a temporary basis) to include more ambitious targets, a wider geographical area, more schools, more workplaces and industry sectors etc

"We'd already been doing work with primary schools, and the NPAPH allowed us to expand that ... increased capacity to 75% of primary schools participating. The school canteens program pre-dated NPAPH but we only had around 29 schools involved; NPAPH took it to over 50 schools."

- Advance and/or develop new, evidence-based initiatives that had not previously been funded (for example, initiatives modelled on those developed in other jurisdictions)

"It helped us to develop approaches and programs that we knew, based on the evidence, were effective. Some we had already started, others we looked to other jurisdictions and thought they would be able to apply here."

- Trial or pilot test some innovative or new interventions, including new approaches to engaging particular target audiences

"The ability to innovate and try things that we hadn't tried before was a benefit. We could see what worked but also we were able to learn from our mistakes – we wouldn't go down the path of incentives again for example ... we could see that it just wasn't going to be sustainable from an administrative point of view. We learned a lot about how to engage particular target audiences – men, blue-collar workers etc. We can use those learnings in future programs and can be a bit more prescriptive when we're procuring services."

- More effectively communicate with, and learn from, other jurisdictions particularly through the prevention leaders forum that the Australian National Preventive Health Agency (ANPHA) facilitated

“The ability to talk and learn as a group was never there as strongly as it is now, and certainly never as strong as it was during that time [of the NPAPH].”
- Dedicate more resources to the evaluation of prevention initiatives

“The focus on evaluation was a significant thing – to have it formalised as it was in the NPAPH was very good.”
- Strengthen population health monitoring and surveillance systems and data collections

“Having access to that data is embedded now in people’s expectations. So yes, the money was useful to us in advancing our collections program.”

“[It has led to] a more systematic approach – making sure you invest in programs that have a population impact – and learning how to do that.”
- Develop new or stronger partnerships with other state government agencies, local Councils and NGOs, particularly through engaging them to deliver services and health promotion messages

“The work we did with Workplace Health and Safety, to use their infrastructure to deliver our programs – that was important. There is definitely a legacy of continued cross-government communications. The development of some personal working relationships has been a real benefit.”
- Develop stronger frameworks or principles for promoting the outcomes of prevention programs, to generate more support from departmental and political decision-makers

“We have developed a good narrative around our achievements, a more sophisticated packaging and framing of the evidence ... with the decision-making audience in mind. We thought carefully about our terminology, for example, we came up with ‘avoidable cost benefits’ that Treasury liked to hear. The academics are interested in the confidence intervals but it just creates doubt for the decision makers. It’s about melding scientific purity with the message.”
- Develop a core of expertise and an effective team of people to develop and direct the delivery of prevention programs and to ‘sell’ their achievements

“We need the financial skills, skills in inter-governmental relations, contract management skills ... a mixed, collaborative team.”

“We’ve ended up with a large workforce of people who now understand how the systems approach works and how to make it work.”

Some jurisdictions reported that the NPAPH had contributed to a stronger commitment to prevention through being able to more convincingly demonstrate the effectiveness of prevention activities in avoiding the costs of managing chronic disease. As one informant said: *“We were able to develop the traction, to make the initiatives sustainable from the point of view of ongoing political commitment. [The NPAPH] accelerated culture change, commitment to prevention.”*

However, this was not the case for all jurisdictions. Other informants noted the initiatives funded through the NPAPH were “ready to show good results”, but that the opportunity to see the full potential of the programs and to fully evaluate them was lost with its cancellation. It was further noted that the opportunity to more strongly embed prevention in a state-wide approach to chronic disease was curtailed. This was commonly reported as a major disappointment associated with the cancellation of the NPAPH. Following are some illustrative comments made by these informants:

“We got to scale. We were on track. We made all the tweaks we needed to. We had done some interim evaluation. Then the funding was cut.”

“We couldn’t see the ROI – we didn’t get the opportunity to demonstrate it.”

“We didn’t get the opportunity to embed prevention culturally in government. We were starting to demonstrate legitimacy but didn’t quite get there.”

Immediate impact of the cancellation of the NPAPH and ensuing decision-making processes

Representatives of State/Territory Health Departments were asked to describe the events immediately following the cancellation of the NPAPH. It was clear from the consultations that the decision came as a surprise and that while some changes may have been expected, the total cancellation of the agreement was not widely anticipated:

"A new government is always going to have a different philosophy around prevention. We expected some contraction but not cancellation."

"It was unceremonious – no discussion, no warning, just a letter from DoHA."

The abrupt cancellation of the NPAPH resulted in obvious disappointment on the part of those working in the prevention field and a need to quickly adapt to the situation. However, jurisdictions commonly said change was always a feature of government and that there was a fairly constant process of responding to the ebb and flow of funds for chronic disease prevention activities. It was also noted that the NPAPH was a time-limited arrangement, meaning that the programs of prevention initiatives in each jurisdiction were, in turn, time limited. In other words, there was the understanding of the need to move to a new set of funding arrangements once the NPAPH expired. The result – according to those consulted – was a fairly orderly transition, albeit a transition that was brought on more quickly than expected. Following are some indicative quotes:

"It's not like chaos ensued. The funding was always time limited and the initiatives were developed with this in mind. We always had to be able to dismantle it."

"We always knew the dollars would end so we planned for that. We were building towards identifying what was sustainable but it ended early so we didn't quite get to that point."

It was evident from the consultations that responding to the cancellation of the NPAPH was a complex process given the "web of implementation" that was in place. As one informant noted: *"We had contracts in place with NGOs to do a lot of the delivery. There was an ongoing obligation there."*

Jurisdictions reported that they used a structured process to make decisions about how to respond to the cancellation of the NPAPH. For example, some jurisdictions reported using decision-making tools or frameworks to guide this process.

Informants generally reported that the initial response was to assess the level of support within their State/Territory for chronic disease prevention and to determine what funds would be available in the absence of NPAPH funding. This was clearly an area where jurisdictions differed. Some informants reported that assurances were provided of ongoing State/Territory funds for much of the activity funded through the NPAPH, so only relatively small adjustments had to be made to prevention activity. As one informant said: *"We're privileged at the moment to have such a strong commitment to prevention."*

Representatives of other jurisdictions reported having far less support in this regard and had to move quickly to bring many of their NPAPH-funded programs to an early end. Some jurisdictions said the NPAPH cancellation coincided with the restructuring of the State/Territory health budget, bringing more pressure and complexity to decisions about future investment in chronic disease prevention.

Generally, however, each jurisdiction reported a process of assessing the entire suite of prevention programs in response to the new financial constraints arising from NPAPH cancellation. Informants reported that the following had to be considered in assessing the suite of prevention programs and making decisions about the future approach:

- The status of time-limited programs, that is, how near they were to completion
- The status of existing contracts with external agencies and the legal ramifications of different courses of action (for example, whether the program should be ceased, targets reduced, timeframes shortened or interventions scaled back)
- The status of procurement processes and whether they could be altered or aborted (several jurisdictions reported that planned procurements were aborted)
- The costs of interventions and whether there was scope to reduce costs through program redesign

- The ease or difficulty of re-scaling existing programs, such as setting more modest targets, reducing the geographic footprint, selecting different target audiences
- The degree of fit with State/Territory policy, strategic plans etc
- The degree to which programs met identified needs and priorities, for example in addressing chronic disease in particular at-risk groups
- The administrative and logistical burden associated with 'changing course' or re-scaling programs
- Whether programs were running smoothly or else proving to be problematic in terms of implementation
- The evidence of effectiveness and projected future outcomes, that is, whether programs were established and proven interventions or pilot programs yet to fully evaluated
- The population health impacts and return on investment associated with different programs (where this could be determined)
- The popularity of programs within the community and among decision-makers
- The political risks associated with discontinuing programs or reducing their scope
- The risks to stakeholder relationships associated with withdrawing funding from programs.

Several jurisdictions described a process of working with stakeholders to find a way to make programs work without NPAPH funds. This often involved a renegotiation of the financial contributions made by the State/Territory Government and partnering local governments or non-government organisations. Some programs were salvaged to a degree, not just by the contributions of State/Territory governments, but also by other organisations.

Resultant changes to prevention programs

It was evident from the consultations that, on a national basis and in very general terms, the following occurred as a result of the cancellation of the NPAPH:

- Many existing prevention programs that were expanded, enhanced or extended using NPAPH funds returned to a smaller scale, generally preserving the fidelity of programs
- Many pilot programs were discontinued with or without being fully evaluated
- Programs that were planned but had not started when the NPAPH was cancelled generally did not proceed
- The low cost but visible elements of interventions (e.g. websites) were often retained but the more costly elements (e.g. counselling) were scaled back or discontinued
- Community-based programs featuring the delivery of prevention activities by local government and NGOs were among the first programs to be discontinued, cut short or re-scaled (resulting in some damage to stakeholder relationships)
- Social marketing activity was reduced
- The scope of surveillance and monitoring systems, population health surveys and the like were usually returned to their original scales.

The cancellation of the NPAPH also resulted in a need to reduce the prevention workforce in each jurisdiction. In some jurisdictions, one or two positions were lost. In others, just half the number of positions now exist. It was also reported that there was a need to reduce staff numbers in external, contracted agencies, where positions were funded using NPAPH money.

For example, one NGO contracted to deliver a schools-based program lost nine of 11 full-time equivalent positions after the NPAPH was cancelled. Some informants lamented the loss of expertise that resulted, as the following quotes demonstrate:

"I think the sadness is that the effort and all of the investment that went into doing a whole heap of work, for that then to stop in some areas. I think that's a real sadness because you lose so much not only in terms of the human resources and those people's knowledge, but also the effort and work to actually stop and start it."

“Losing the people was the worst thing because they were people that had great skills and knowledge and capacity and made a huge contribution.”

Changing priorities for prevention

Informants were asked about the changes that resulted from the cancellation of the NPAPH, in terms of the priorities for prevention activity. Informants were also asked whether particular gaps had emerged. The discussions were fairly consistent in that informants in all jurisdictions reported a continuing focus on children and families (through schools and early learning centres) and workers (through workplaces and industry organisations). Informants also noted that the understanding of the causes of chronic disease and the community segments most at risk preceded the NPAPH – in other words, the priorities for action remained the same. As one informant put it:

“The priorities haven’t changed – they’ll never change. We just can’t do as much in the way of intervention.”

It was clear from the discussions that there was a continued focus on communities of low socio-economic status/low educational attainment. In some instances, however, the satellite programs that targeted particular groups in the community were discontinued, with those groups targeted through mainstream initiatives. As already noted, the NPAPH allowed jurisdictions to layer initiatives to ensure that the most at-risk groups had multiple opportunities to be engaged – this seems to have been diminished in recent years.

One jurisdiction reported NPAPH funding had enabled enhanced data collection, which allowed it to more precisely identify geographic areas of need, such as small geographic areas where there was a high rate of childhood obesity. This had allowed programs to be more specifically targeted on a geographic basis (i.e. suburb by suburb). With a limited budget to deliver prevention programs, this had helped make the most of limited resources.

National coordination of prevention activity and the future for national partnerships

Informants were asked about the degree of national coordination of chronic disease prevention activities, both during and after the NPAPH. Most informants believed there was a greater degree of coordination during the NPAPH, in particular through the activities of ANPHA. Informants particularly valued the ability to share information and ideas through the prevention managers’ forum that ANPHA facilitated. They said this provided a real practical benefit, as well as being the main reason that the NPAPH felt like a partnership between the Australian Government and other States/Territories. Following are some indicative quotes:

“The main thing we lost was the ability to interact directly with the Commonwealth. We have to be talking to one another.”

“We don’t have the same guidance or ability to share.”

“The national structure and the sharing that occurred under the NPAPH is a big loss.”

“The technical network was really useful ... there’s no other forum.”

“In an informal sense the network is still there, but there’s no longer a systematic sharing of information.”

It was clear from the discussions that the abolition of ANPHA, along with the cancellation of the NPAPH, had coincided with a drift back towards a situation where there was no national coordination and a lack of communication between the Australian Government and States/Territories.

Some informants provided examples of national social marketing activities that were launched without States/Territories even being advised. Following are some illustrative comments:

“It’s hard to call it a partnership when one body funds another. There’s more to partnership than that.”

“Collaboration requires trust ... There’s a culture of secrecy in the Commonwealth that makes that difficult.”

In considering the perceived lack of national coordination, informants often made the point that there was no clarity around roles and responsibilities with regard to chronic disease prevention, as the following comments demonstrate:

"There's no clarity around role and continuity. Who is running the prevention agenda? The Primary Health Networks are muddying the waters again."

"Whose space is prevention?"

"What is the Commonwealth's role here? Funder? Coordinator? It's a contested space that constantly changes."

One informant described this conundrum in terms of the different government responsibilities along the continuum from prevention to the treatment of chronic disease in the tertiary health system. While primary health care was the responsibility of the Australian Government and tertiary health the domain of the States and Territories, it was not clear who does (or who should) have overarching responsibility for prevention. Informants called for a more explicit statement about the role of the Commonwealth in chronic disease prevention.

The role of The Australian Prevention Partnership Centre

Informants were not specifically asked about the Prevention Centre's potential role but several informants offered comments, particularly when lamenting the abolition of ANPHA. Some informants may have assumed that the Prevention Centre was seeking to fill the void left by ANPHA or to identify a clearer role for itself. These issues were not explored in detail, but some pertinent comments are set out below, suggesting that a cautious approach is required:

"It's not a creature of government ... can't talk on behalf of jurisdictions. Not all states are partners. It's hard to see how it can have a national impact."

"We need to know more about its capabilities and what it can offer ... it has some competition out there."

"You need to know what's happening in jurisdictions ... need a really good understanding of the context and the political machinations. It's a fraught time for jurisdictions – there's a backdrop of significant reform."

"Rather than being helpful, you can add to the problems."

"TAPPC (the Prevention Centre) needs to think very carefully about how to position itself."

"It can do research or pull together good practice, but we're pretty well serviced to be honest. And there's no point just having documents."

Results: National Chronic Disease Strategy

Perspectives on the value of the 2005 National Chronic Disease Strategy

Informants were asked about their awareness of the 2005 National Chronic Disease Strategy, how they had used it and its centrality to the national approach to chronic disease, particularly chronic disease prevention. A couple of small jurisdictions reported that the Strategy had guided the development of their own State/Territory strategic documents or noted that there was alignment between the State/Territory strategy and the Strategy.

Most respondents, however, thought that the Strategy had served very little function and was not important in underpinning the work of policy makers and practitioners, as the following comments illustrate:

"I've given it as close to zero consideration as you can get."

"Never looked at it."

"The 2005 Strategy was virtually entirely irrelevant to our work. There was a failure to include, recognise or engage the NGO sector as providers of health services. It had no bearing whatsoever on our work."

Among those who were familiar with the Strategy, a common observation was that it was a high-level document that made no funding commitments, had no implementation plan and was not binding. While some saw value in high-level strategic statements of intent, most of those consulted thought that the Strategy served little purpose due to the lack of a funding and other infrastructure.

The following quotes are typical of the response:

"A strategy is pointless without the contribution of an infrastructure."

"How can you have a strategy without any funding?"

"The strategy was never really implemented and was not funded. It's a high level framework without resources to do anything."

"A national strategy is only as good as the dollars attached to it. It failed to provide resources, an implementation strategy, an accountability framework, and goals and targets."

"National strategies are pretty useless unless they come with financial muscle – otherwise why would the States and Territories do anything, let alone convince other portfolios to do anything."

"A great attempt at a plan but very, very poor attempt at implementation is the way that I'd actually appraise that."

"The problem was there was no implementation plan. It was simply a rehash of the same old stuff about what needs to happen. There were no reporting milestones, no clearly identified responsibilities, no funding. No process and outcomes measures."

Informants were asked about the prominence that prevention was given in the 2005 Strategy and the way that prevention was 'oriented' in the Strategy. Generally, it was acknowledged that prevention was given appropriate treatment in the document, but like other aspects of the Strategy, lacked detail and specified actions. In other words, the document 'said all the right things' about the importance of prevention but provided no clear direction (and did not earmark funds) for the pursuit of national prevention initiatives.

The need for a new chronic disease strategy

Although there was a fairly cynical view of the value of the 2005 Strategy, many informants saw value in a national strategy providing that it was developed to genuinely underpin a coordinated effort to address chronic disease. As one informant noted: *"When they're well put together, they serve as an anchor for everything that happens. It helps to prioritise research and programs – everything can be tied back to the Strategy."*

However, there was concern that the current process to develop a new national chronic disease strategy was likely to yield a similar result to the 2005 Strategy.

As one informant said:

“The risk is that the next Strategy is just a set of motherhood statements without any implementation plans. It needs to be funded, planned and coordinated with the States and Territories.”

There was also some cynicism about the Australian Government’s ability to develop an effective national Strategy that incorporated a meaningful approach to chronic disease prevention: *“The Commonwealth has been absent on health prevention and now they want to develop a national strategy?”*

It was clear that informants – whether they were practitioners, policy-makers, advocates, researchers or thought leaders – wanted a chronic disease strategy that would guide a genuine effort to address the root causes of chronic disease. In short, informants wanted to see government leadership. They wanted government to signal its preparedness to embark on the difficult process of reform and bring about the culture change required to better prevent chronic disease.

Informants commonly referred to the ‘elephant in the room’: the reluctance of government to attempt to drive environmental or systemic change – reducing the amount of sugar, salt and fat in food and drink, addressing the social acceptability of alcohol consumption etc. It was commonly noted that there had been some good wins in terms of tobacco control – such as plain packaging and widening no smoking areas – but that the same leadership had not addressed other root causes of chronic disease. It was clear from the discussions that a new national strategy would be considered to be almost worthless without some movement in this area.

Several informants said governments tended to adopt a personal responsibility approach to chronic disease prevention rather than addressing environmental or systemic factors. That is, governments often take the view that ‘people should be able to choose’ and that prevention activities should be aimed at ‘encouraging people to make healthier choices’. Prevention activity is thus usually focused on behaviour change, through social marketing, counselling and coaching. Some informants, while acknowledging the importance of these activities, saw the personal responsibility approach as fundamentally inequitable. It was noted that people were not always able to make healthy choices, whether due to their knowledge, social background, geographic location or available income. Government had an important role, it was thought, in addressing environmental factors to make it easier for people to make healthier choices.

Following are some indicative quotes:

“Strategies need to be honest about what the evidence says. Otherwise, it’s just political – it indicates government concern but there’s no preparedness to do anything about it.”

“There needs to be a food and health dialogue, a process of working with industry on nutritional content.”

“Government does whatever it can to avoid public health prescriptions – it just doesn’t want to upset the vested interests.”

“It’s important to have national strategies, but they usually don’t have a systemic foundation. They’re usually based of what people think the strategy should be.”

“It’s inequitable to simply say that individuals should take responsibility. Clearly, not everyone is equal in their ability to stay healthy.”

“You need governance, leadership to address systemic issues – unless that’s there, there’s no point.”

A systems approach to chronic disease prevention

What informants were asking for – whether they would describe it as such or not – was a stronger systems approach to chronic disease prevention and for systems thinking to be applied to the development of the new chronic disease strategy.

Respondents were specifically asked about how a stronger systems perspective could be brought to bear on a national chronic disease strategy.

There was strong interest in taking a more comprehensive and systems-based approach, in particular because it was a departure from the (flawed) traditional approach. However, among some informants, there was a lack of clarity as to how the approach would work.

In particular, the complexity of the health system made the envisaged process a little overwhelming. Following are some typical comments:

"It is preferable to the individual health consumer focus."

"It's hard to conceptualise ... there's so much that impacts our health."

"Where and how does change happen in a complex system? It would be valuable to know more about that. But it's hard to see how that can be enshrined in a national strategy."

"I'm not sure where systems thinking will take us – we should pursue it and see where it ends up."

"There's a logic to it that warrants exploration."

"Chronic disease is just the sort of issue where [systems thinking] can help."

"We need to take the Australian prevention system to the next level."

"A vehicle for working together on really tough problems."

Although it was not widespread, there was a view that systems thinking was a label given to a fairly common sense approach to problem solving. A couple of comments suggested that some people thought that there was a tendency to over-intellectualise the process and that this did not necessarily help. For example, one person said:

"I sat in on one of the workshops and I couldn't help but think 'The Emperor has no clothes'."

Among those who were more familiar with, and supportive of, systems thinking, there was a clearer idea of how a national chronic disease strategy would benefit from taking this perspective. A systems approach to developing a chronic disease strategy should feature a number of things, according to those consulted:

- Taking a long-term view of addressing the problems of chronic disease – over a generation, not over one electoral cycle
- More deeply examining the root causes of chronic disease and understanding what environmental factors contribute, using comparisons between Australia and other countries – that is, why we have particular problems when other countries do not
- Charting a pathway to a more desirable situation (i.e. a healthier Australia) rather than just focusing on defining the problems and offering 'solutions'
- Identifying and articulating the interests and the roles that can be played by all actors in the system – individuals, health professionals, governments, researchers, non-government organisations, private sector organisations etc
- Identifying areas of joint interest and alignment as a means of generating 'buy-in' from stakeholders and identifying where change can most easily be made
- Planning to establish an effective mechanism for cross-sectoral engagement and coordination
- Acknowledging and building on the work already being done by all actors to prevent chronic disease
- Identifying and making use of the expertise or capabilities of different actors (for example, the marketing expertise within the private sector)
- Considering different geographical and cultural contexts and avoiding 'one-size-fits-all' approaches
- Linking and sequencing interventions over a person's life course and thinking about the transitions from one set of interventions to the next
- Identifying how interventions can affect the system, not just individuals
- Using evidence-based interventions where possible but being willing to accept and learn from failure
- Focusing on changing social norms rather than just individual behaviour, for example in relation to healthy weight and alcohol consumption

- Establishing indicators of change in policy direction, volume of prevention activity, and social norms – not just relying on health outcome indicators to demonstrate change
- Identifying the political, financial and technical factors that facilitate and inhibit change and identifying interventions that can realistically be applied.

Several informants noted that systems thinking should be brought to bear on the process of developing a strategy and was not simply some theoretical framework to be applied. What was described was an inclusive, collaborative and open process that was carefully managed but not in an overly directive way.

It was noted that systems thinking allowed for a process where shared understanding was developed, where roles and responsibilities emerged and where joint commitment to the 'cause' was an important outcome.

Following are some comments to this effect:

"The process of developing a strategy is more important than the document itself. It's an opportunity for leaders to signal their preparedness to drive some reform."

"Don't neuter the process from the outset. Don't rule things in or out – it undermines the whole process."

"People are all correct, they just come from different angles. You need to put them together, understand their mental models then integrate them into a systems model."

Conclusions

The research with representatives of State/Territory health jurisdictions and other organisations working across the chronic disease prevention sector revealed a number of things that should inform and assist the Prevention Centre. Firstly, it is evident that the NPAPH has left an important legacy for the way chronic disease prevention programs are oriented. It was a time when some jurisdictions were able to restructure and reform the approach to prevention and to more strongly demonstrate the outcomes of a larger investment in chronic disease prevention. It was a time of funding certainty that, although cut short, allowed jurisdictions to improve or alter the way that prevention programs were organised, implemented and evaluated.

The legacy of the NPAPH took a different shape in each jurisdiction – it was highly dependent on the starting point for each jurisdiction in terms of existing investment and the underlying political and organisational support for chronic disease prevention. For some jurisdictions, the legacy of the NPAPH was not as significant in some jurisdictions as it was in others.

In the wake of the cancellation of the NPAPH, some jurisdictions have been able to continue to pursue programs using already acquitted NPAPH funds, a greater State/Territory government contribution and financial contributions from local government and the non-government sector. Programs that have been continued have often set more modest targets or adopted less comprehensive delivery models. Other programs were completed before the NPAPH was cancelled, were cut short or limited to a 'first phase', or were abandoned before implementation had started.

Across jurisdictions, a structured process was generally employed to assess how to move forward in the absence of NPAPH funds. Informants were quick to point out that government was used to making these sorts of adjustments and that although the NPAPH was ended early, it was always a time-limited arrangement. The status of existing service delivery contracts was a major factor in decision-making and jurisdictions generally elected to honour the agreements that had been made. Decisions about which programs to continue and in what form were also influenced by evidence of effectiveness, the cost-benefits of service delivery models and the political or community support for particular initiatives. What was described was basically a forced re-budgeting process, brought on by a very different set of funding constraints.

The cancellation of the NPAPH resulted in obvious disappointment for those working in the prevention sector. Importantly, it also resulted in reduced coordination and clarity about the roles of the States and the Commonwealth with respect to chronic disease prevention – something that all thought was highly necessary for an effective prevention system.

Few of the informants reported that the 2005 National Chronic Disease Strategy had any bearing on their own strategies for preventing chronic disease. While the document was thought to be structurally sound, it was commonly noted that it was not associated with any funding framework or implementation plan and was therefore not as central as it was perhaps intended to be. Despite some cynicism about the usefulness of overarching strategic documents, informants saw value in producing a new national chronic disease strategy, providing that it:

- Makes a meaningful attempt to set down a long-term approach to addressing the root causes of chronic disease
- Addresses environmental factors as well as individual behaviours, acknowledging the inequities in people's ability to stay healthy and avoid chronic disease
- Signals a commitment to investing in prevention as well as the treatment of chronic disease
- Addresses societal issues, for example, the social norms about healthy weight or alcohol consumption
- Makes use of an inclusive and appropriate process for defining problems and exploring possible interventions.

Essentially, informants saw scope for a much stronger systems approach to the development of a new national chronic disease strategy.



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