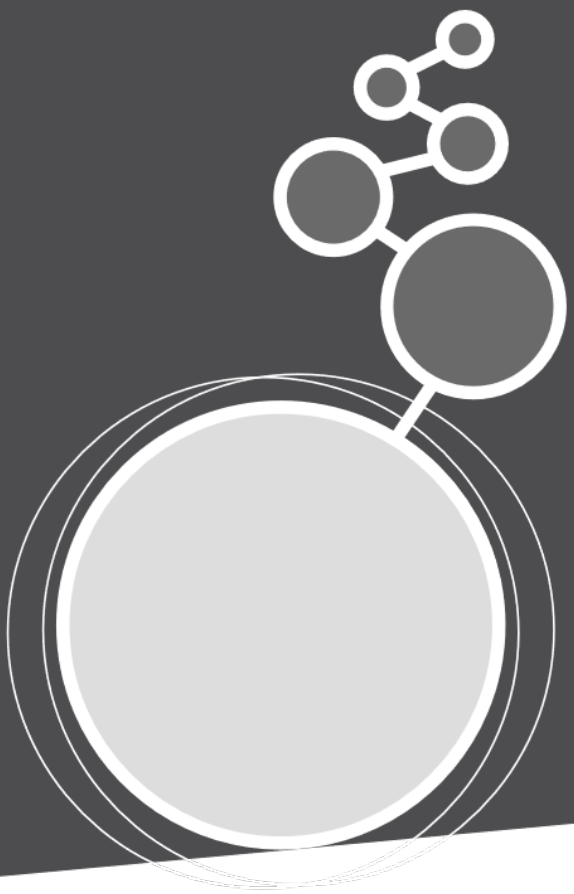
CERI
Collaboration for Enhanced Research Impact

Submission to the National Preventive Health Strategy

19 April 2021



The Australian Prevention Partnership Centre

CRE HiPP Centre for Research Excellence Health in Preconception and Pregnancy

epoch Early Prevention Of Obesity In Childhood

NATIONAL CENTRE OF IMPLEMENTATION SCIENCE

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CREWHiRL Centre for Research Excellence in Women's Health in Reproductive Life

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About the publisher

CERI is administered by The Australian Prevention Partnership Centre, which is funded by the NHMRC, Australian Government Department of Health, ACT Health, Cancer Council Australia, NSW Ministry of Health, Wellbeing SA, Tasmanian Department of Health, and VicHealth. The Prevention Centre is hosted by the Sax Institute.

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About the Collaboration for Enhanced Research Impact

The Collaboration for Enhanced Research Impact (CERI) is a joint initiative between The Australian Prevention Partnership Centre and seven NHMRC Centres of Research Excellence. CERI aims to enhance the profile and impact of chronic disease prevention research in Australia.

Established in June 2020, this novel initiative brings together some of Australia's leading prevention researchers to develop shared narratives, work together to translate new knowledge, and support early- to mid-career researchers across all member institutions.

About this submission

In June 2019, the Minister for Health, the Hon Greg Hunt MP, announced that the Australian Government would develop a 10-year National Preventive Health Strategy (the Strategy). The Strategy provides the overarching, long-term approach to prevention in Australia by working to build systemic change to ensure the best outcomes for all Australians. Areas of focus for the next 10 years are identified in the Strategy as well as evidence-based policy achievements.

In March–April 2021, the National Preventive Health Taskforce sought stakeholder and community feedback on the draft National Preventive Health Strategy. The diverse perspectives, experience and knowledge of all stakeholders and interested members of the community will contribute to the final Strategy.

This submission was prepared by members of the CERI Coordinating Group. Thank you to representatives of EPOCH CRE, NCOIS, RE-FRESH CRE and CRE HiPP for their input.

Vision of the draft Strategy

We agree with the Vision of the draft Strategy: To improve the health of all Australians at all stages of life, through early intervention, better information, targeting risk factors and addressing the broader causes of poor health and wellbeing.

We commend the broad scope of the Strategy and its recognition that the responsibility for creating positive change by 2030 is shared by all governments, the non-government sector, research and academia, the private sector, industries, communities and individuals.

The Strategy approach has been developed using the best evidence from a range of sources, including what interventions are effective (what works). However, it does not appear to have applied similar commitment to the application of evidence when identifying 'how' such interventions, policies or programs can best be implemented.

The lack of consideration and application of the science of implementation is, we believe, a considerable blind spot of the current Strategy that will curtail its capacity to achieve its objectives and improve public health.

We recommend that the Strategy seek the guidance of implementation scientists (for example, include implementation scientists in its key governance structures) and formally review and apply evidence regarding the effectiveness of implementation strategies to ensure the significant investments in the implementation of Strategy-recommended policies and programs yield the benefits to the community that they are intended to deliver.

Aims and associated targets of the draft Strategy

We strongly agree with the Aims of the draft Strategy:

Aim 1: Australians have the best start in life.

- Target: The proportion of the first 25 years lived in full health will increase by 2% by 2030.

Aim 2: Australians live as long as possible in good health.

- Target: Australians will have an additional two years of life lived in full health by 2030.

Aim 3: Health equity for target populations.

- Target: Australians in the two lowest SEIFA quintiles will have an additional three years of life lived in full health by 2030.
- Target: Australians in regional and remote areas will have an additional three years of life lived in full health by 2030.
- Target: The rate of Indigenous-specific general practitioner health checks increases 10% year-on-year across each age group.

We applaud that the Strategy recognises the value of a life-course approach which emphasises the significance of prevention in the early years.

We note, however, that this life-course approach is missing the key complementary element of the Developmental Origins of Health and Disease (DOHaD) concept, which suggests that events before birth can have life-long consequences. Hence, the Strategy's approach should begin in the preconception period, not prenatally (during pregnancy).

The preconception approach needs to be more purposeful and move beyond standard population level prevention for preconception, as despite preconception being a time people report to want to improve their health for their future child, the evidence suggests that this is not occurring. For more information, please see: www.sciencedirect.com/science/article/pii/S2451965020300855

ADDITIONAL AIM

Much of the chronic disease burden of Australia (including half of all cancer occurring today) could be alleviated if interventions known to be effective were implemented. Achieving the vision of the Strategy , therefore, could be achieved with better implementation of what we know works.

Principles of the draft Strategy

We strongly agree with the principles of the draft Strategy:

- Multi-sector collaboration
- Enabling the workforce
- Community engagement
- Empowering and supporting Australians
- Adapting to emerging threats and evidence
- The equity lens.

We support the principles for which the framework for action have been developed, including the emphasis on equity and community engagement.

When considering the equity lens, there is a clear opportunity to add weight stigma under the structural barriers that inhibit equitable access to health supporting behaviours (see 'Systemic attitudes and practices', p 14). This would ensure that weight stigma is addressed across the whole Strategy.

Enablers of the draft Strategy

We strongly agree with the enablers of the draft Strategy:

1. Leadership, governance and funding
2. Prevention in the health system
3. Partnerships and community engagement
4. Information and health literacy
5. Research and evaluation
6. Monitoring and surveillance
7. Preparedness

We agree with the enablers. However, we believe that there needs to be further consideration about how these enablers should come together to improve prevention.

Specifically, there should be consideration of how the enablers are operationalised to support the development of learning, health (or other) systems, where organisations are supported to use and produce evidence to develop, implement and improve in an ongoing way the impact of prevention policy, practice and programs. This will require the convergence of the enablers stated here within critical institutions for prevention.

Research is also urgently needed to explore the interactions between the socio-ecological determinants of health that have been outlined in this strategy so that they can be appropriately addressed moving forward. It is not enough to address these issues as silos.

Focus areas

We agree with the seven focus areas:

1. Reducing tobacco use

2. Improving access to and the consumption of a healthy diet

3. Increasing physical activity

4. Increasing cancer screening and prevention

5. Improving immunisation coverage

6. Reducing alcohol and other drug harm

7. Protecting mental health

We would make the following observations.

1. Sedentary behaviour is an important focus area that is currently missed. Sedentary behaviour (particularly as it relates to increased screen time) is a different behaviour to physical inactivity, and leads to poor health outcomes regardless of physical activity levels. Please note WHO's separate guidelines on PA and sedentary behaviour: apps.who.int/iris/bitstream/handle/10665/325147/WHO-NMH-PND-2019.4-eng.pdf and this review on the association between sedentary behaviour and health outcomes in children (independent of PA and obesity) journals.sagepub.com/doi/10.1177/1559827613498700

Based on the evidence, we would like to see sedentary behaviour included as an additional focus area.

2. We also note that the focus areas are not solely based on individual responsibility to change behaviours, but stem from an integrated approach that underpins the Strategy. This should be clearly outlined to avoid inadvertently falling into the trap of continually assigning individual responsibility for behaviours that stem from broader socio-ecological issues.

Targets for the focus areas

We are happy with the targets for the focus areas, but suggest the additions outlined below.

2. IMPROVING ACCESS TO AND THE CONSUMPTION OF A HEALTHY DIET

We broadly applaud the targets for this focus area. There are some additional considerations we would like to bring to your attention:

We would request the development of a national obesity stigma reduction strategy. Weight stigma is pervasive in Australia and increases individuals' risk of depression, anxiety, low self-esteem, poor body image, substance abuse, suicidal thoughts and behaviours and binge eating behaviours (please see www.obesityevidencehub.org.au/collections/treatment/weight-bias-and-stigma-in-health-care). Rather than a campaign, we would like this to be an underpinning obesity stigma reduction framework. It is also important that prevention strategies in other areas, such as obesity, address weight stigma.

We query the timing of support for exclusive breastfeeding to around 4 months. Introduction of solids is currently recommended at around 6 months. www.eatforhealth.gov.au/sites/default/files/files/the_guidelines/n56b_infant_feeding_summary_130808.pdf - page 3

We request specific mention of priority groups at higher risk of obesity and its complications. We need policy approaches that prioritise health equity and address the social determinants of health.

It would be helpful to include specific mention of early childhood as a critical period for support of healthy eating.

3. INCREASING PHYSICAL ACTIVITY

While we agree with the target of decreasing physical inactivity, having a single target (compared with eight under nutrition) seems to be a missed opportunity.

We suggest the targets should be expanded to include:

- Increase physical literacy in children
- Increase active transport for children and adults.

Policy achievements for the focus areas

While we broadly support the policy achievements for the focus areas, we are concerned that they are not very specific and are certainly not measurable. We recommend that the policy achievements are revised to be specific to enable them to be both actionable and monitored to ensure accountability.

While the targets for health improvements sought by the Strategy are clear, the specific intervention strategies and the approach to select them are not clear from this document. It would be helpful to either describe them or specify the approach that will identify them. We think that the specific interventions should:

1. have evidence of effectiveness/cost effectiveness

2. be amenable for implementation (at scale) within the available resource and infrastructure, and appropriate / acceptable for the target setting

3. utilise a strategy for implementation that is evidence-based

4. contribute to health equity.

Furthermore, we recommend that prioritisation of efforts should take a systems perspective to ensure that intervention targets focus on factors that may have the greatest health benefits, including other societal co-benefits (climate change, employment), and that any unintended adverse impacts can be anticipated.

Further considerations on specific policy achievements are outlined below.

2. IMPROVING ACCESS TO AND THE CONSUMPTION OF A HEALTHY DIET

- Australian Dietary Guidelines are supported by a communication and social marketing strategy

The Australian Dietary Guidelines are typically much less effective in creating change than tackling structural barriers to healthy eating, such as cost and availability and the marketing of unhealthy options. We suggest this point should be de-emphasised or deleted.

- Healthy eating is promoted through widespread multi-media education campaigns

In terms of communication of nutrition information and guidance: perhaps there should be specific mention of communications to priority groups? These should be tailored to be culturally appropriate and accessible for different levels of health and English literacy.

- Ongoing access to adequate and affordable healthy food options are available to all Australians, including older Australians

Barriers to healthy food intake include costs and availability of such foods, especially in areas experiencing social disadvantage and in rural and remote communities. Can there be a recommendation on subsidies or improved availability and access to healthy food options in such areas?

Environmental changes should explicitly address the social determinants of health. We suggest that access to healthy and affordable foods is linked with socio-economic infrastructure, for example, investment in social housing and support to employment for the most vulnerable population groups; and council development policy to restrict the number of fast-food outlets and ensure adequate access to affordable healthy foods, especially in areas with food deserts.

- Exposure to unhealthy food and drink marketing for children is restricted, including through digital media

This policy achievement may be strengthened with the inclusion of marketing AND branding. There are currently few restrictions around the use of branding of fast food chains such as McDonalds, for example.

We strongly approve the mention of digital marketing of food and drink to children. We note that it will be important to consider future forms of marketing to the child and adolescent age group, and include these in the recommendations.

We would like there to be stronger restrictions around limiting unhealthy marketing and sponsorship in the context of sport, both junior/club and elite sport, in order to protect child and adolescents. We note this is highly supported by the public.

- Relevant guidelines and policies are regularly updated using the latest scientific evidence

We agree it is important to update relevant guidelines and policies, and note that this may require specific resourcing.

- Consumer choice is guided by energy and ingredient labelling on all packaged alcoholic products

Energy and ingredient labelling needs to be easy to comprehend by broad population groups.

- Restricted promotion of unhealthy food and drinks at point of sale and at the end-of-aisle in prominent food retail environments, and increased promotion of healthy food options

We would also like to see restrictions on the price-promotion of unhealthy foods and beverages such as through multi-buys and discounts. There is evidence that unhealthy options are discounted much more frequently and by greater amounts than healthy options in Australian major supermarkets (pubmed.ncbi.nlm.nih.gov/31180614/ and https://pubmed.ncbi.nlm.nih.gov/31415196/)

3. INCREASING PHYSICAL ACTIVITY

- Physical activity action in Australia is guided by a specific national policy document

We would like the Strategy to explicitly state the need for a National Physical Activity Plan (to align Australia with other developed nations), rather than imply this in the term "national policy document".

- Mass media campaigns that link to actionable behaviour change are used to create healthier social norms and influence physical activity behaviour

Mass media campaigns are not typically useful in achieving behaviour change and could be removed.

- Pre-school, primary and secondary schools are supported to ensure that children and students are physically active

These settings are appropriate to address a range of risks beyond physical inactivity.

Also, we suggest expanding this point to read: "Early childhood education and care settings, primary and secondary schools are supported to ensure children and students are physically active across they day in indoor and outdoor environments through structured and free play opportunities".

We request the addition of the following points:

- Early childhood education and care, primary and secondary schools are supported to ensure that children and students receive formal instruction on physical literacy including fundamental movement skills.
- Early childhood education and care staff and schoolteachers receive training to equip them to facilitate physical activity and physical literacy for the children in their care.

Continuing strong foundations

It will be important to make use of existing infrastructure for prevention to provide expertise and advice on the Strategy and its implementation.

The Australian Prevention Partnership Centre and its associated CREs have existing infrastructure and key research and policy partnerships to assist the implementation of the Strategy through:

- synthesising and communicating relevant evidence for policy and practice
- providing expert guidance
- convening / connecting expertise nationally and internationally
- monitoring and evaluating
- providing communications and knowledge translation expertise
- generating evidence and facilitating knowledge / evidence translation in a policy relevant way.

Through our more than 350 prevention researchers, we are able to offer expertise that could assist with implementation and evaluation of this strategy. For example, we can provide:

- rapid reviews or evidence checks, and support for these with brokerage between researchers/content experts and policy agencies
- technical content-specific syntheses
- options papers
- evidence briefings, webinars and research seminars, etc
- simulation modelling
- complex systems mapping
- economic evaluation
- implementation and scale up
- qualitative research.

Additional comments

The draft National Preventive Health Strategy is a strong, holistic document that identifies the importance of government and whole-of-society investment in effective prevention to support a healthier population. We applaud the work that has been done to produce the draft document.

We believe the key oversights of the Strategy at present are:

1. Limited consideration of the implementation science and a lack of a detailed implementation plan. Unless this is addressed, we believe poor implementation is foreseeable, and the Strategy will fail to realise its potential

2. Little specification on specific interventions, policies or programs, and the process used to identify/prioritise these.