The Australian Prevention Partnership Centre
Systems and solutions for better health

THE AUSTRALIAN PREVENTION PARTNERSHIP CENTRE SUBMISSION

Response to the consultation paper on the role and functions of an Australian Centre for Disease Control

Submission date: 9 December 2022

Introduction

- This response is provided by The Australian Prevention Partnership Centre (the Prevention Centre) which is a national collaboration of researchers and policy partners working together to prevent chronic disease. The submission is informed by our 10 years of chronic disease prevention research, as well as consultations with policy partners from all state and territory jurisdictions, our scientific leadership executive, and selected representatives from our collaboration with NHMRC Centres of Research Excellence.
- The comments provided in this response **focus on the stated goal that the Australia Centre for Disease Control (CDC) will include within its remit the prevention of chronic disease.** In this document, we use 'prevention' to refer to the prevention of non-communicable chronic diseases, unless otherwise specified.
- Chronic diseases cause **9 out of every 10 preventable deaths** in Australia[1] and account for 85% of years lost due to ill health or early death[2], which justifies the CDC to have a commensurate focus and investment in prevention.
- There is wide and growing agreement that **wholistic, systemic strategies** are needed to address chronic disease. However, prevention research, policy and practice in Australia is fragmented and implemented through often siloed mechanisms and structures.
- There is a need for a more **harmonised national prevention system** that supports shared learning, avoids duplication, enables shared priority setting, and aligns funding for implementation of prevention strategies and data collection across Australia's many, often disparate prevention functions and agencies.
- We suggest that a national agency focused on disease prevention could provide the **connective tissue** for this national prevention and public health vision. It could provide the necessary national coordination, strategic alignment and information sharing for effective prevention implementation and research.
- The Prevention Centre has developed a substantial **evidence base** in how to support an effective prevention system, and can contribute our learnings on science communication, research-policy linkages and knowledge translation.

Recommendations

We recommend that the CDC:

- is designed to be fit-for-purpose for inclusion of prevention
- champions systems thinking, co-design and the co-benefits of prevention
- includes prevention and equity indicators in its evaluation and impact assessment
- provides mechanisms for distilling and sharing evidence, experience and learnings across, and between communicable and non-communicable disease
- provides national leadership as a trusted voice on the systemic nature of chronic disease
- bolsters data solutions for chronic disease risks factors and outcomes
- develops shared national priorities for greater investment in prevention research
- provides leadership and coordination to strengthen accountability for prevention
- includes prevention in scope for national public health workforce development.

The basis for each of these recommendations is described in more detail below.

Inclusion of prevention in the design of the CDC

- We support the inclusion of chronic disease prevention in the CDC draft mission statement. The CDC is a mechanism to bring greater **cohesion, integration and strategic alignment to the field of public health, including the prevention of chronic disease**. We note the CDC guiding principles refer to a wholistic 'all hazards' approach. We acknowledge the proposal to implement a phased process, starting with a focus on communicable disease, and with a focus on prevention of chronic disease to be implemented subsequently.
- We recommend that as part of the staged approach, the nascent CDC will include from the start a consideration of how its **purpose, structures, systems and processes will be fit-for-purpose to embed prevention as an integral national health priority**. This is to avoid misalignment and retrofitting as the remit of the CDC expands. We make this recommendation because experience demonstrates that the immediacy of health protection can divert attention and resources from the longer-term focus of chronic disease prevention. We also suggest that a 'Centre for Disease Prevention and Control' would better reflect the intended focus on prevention of both communicable and non-communicable disease.
- We acknowledge reference to the interactions between non-communicable and communicable diseases, and support the focus on 'one health' in the CDC mission and purpose. We suggest another way to bring communicable and non-communicable diseases together could be to establish an **organising framework that recognises the factors that make people vulnerable** to the impacts of both (for example, climate change, inequity, disadvantage).
- We recommend that the interactive and **inter-dependent nature of communicable and non-communicable disease is reflected in the structure and work** of the CDC. We note that the distinction between communicable and chronic disease is not absolute, with many infectious diseases having prolonged, sometime lifelong chronic elements (for example, individuals with HIV whose viral load is controlled with anti-retroviral therapy). We also note that some communicable diseases are recognised causative agents for some chronic diseases, and that some chronic diseases may in turn contribute to susceptibility to communicable disease (for example, obesity and COVID-19 morbidity and mortality).
- We note that the **prevention of communicable and non-communicable diseases share many common elements**, such as underpinning theory, evidence basis and practice, particularly when it involves individual or group behaviour change (for example, adoption and maintenance of personal protective behaviour such as masking during COVID-19 or condom use for prevention for sexually transmitted diseases, or the adoption and maintenance of healthy eating or physical activity). We recommend the CDC provides mechanisms for distilling and **sharing evidence, experience and learnings** across such domains.
- While we support the design principle to avoid replication of existing functions, we recommend that where other agencies do have the lead role, the **function of the CDC in providing enhanced support**, rather than leadership, be made **more explicit**, for example in First Nations Health.

Systems approaches to prevention

- We recommend the CDC places priority attention to developing **guidance on systemic levers for prevention**. We make this recommendation because guidance on addressing structural and economic determinants of health, the **role of public health law** and strategies to **manage unhealthy industries' influence on public policy** is less well developed than guidance on program and educational approaches to prevention.
- We recommend that in establishing the CDC's role in providing policy advice, consideration be given to mechanisms to maximise and support the **use and implementation** of best practice guidance by prevention system stakeholders.
- We recommend the CDC champion the use of **systems thinking, methods and tools**, such as causal loop mapping and simulation modelling (for example, system dynamic or agent-based modelling), that have been demonstrated to be useful aids in prevention policy and program planning and implementation. There are

many common elements to the prevention of both communicable and non-communicable disease that include complex interactions between biological and psychological factors, and social, cultural and environmental determinants of disease risk and prevention pathways. Systems-based approaches will enable the CDC to support prevention research, policy and practice to manage and address such complexity.

- We support the CDC taking a leadership role on driving positive change to the wider determinants of health. We agree with the observation that this area has been neglected or disjointed. We recognise that working closely with other sectors, such as planning, transport, climate policy, etc. can lead to systems changes with wide ranging **cross-sectoral co-benefits**. While this is increasingly understood, currently it is not well acted upon.
- We suggest the CDC could lead in establishing close partnerships among existing agencies beyond the health sector to capitalise on opportunities to **co-design initiatives** and **share knowledge and resources** aimed at addressing other portfolio imperatives while benefiting prevention of chronic disease (Case study 1).

Case study 1: Cross-sectoral initiatives: Liveability and Transport Health Assessment

Prevention Centre projects have developed a national database of indicators for the liveability domains of walkability, transport, public open spaces, food environment, alcohol environment, housing affordability and employment. These indicators have been further applied to improve understanding of relationships between built environments and people's daily activities and travel choices.

Further work is focused on adapting for Brisbane the award-winning Transport Health Assessment Tool (THAT), which was first developed for Melbourne in collaboration with the Victorian Department of Transport. Such inter-sectoral research can support a focus on preventive health and other co-benefits when working across government sectors.

- We recommend that the CDC take the lead in developing and promulgating a co-benefits approach to such partnerships, and in fostering high level **partnerships across government**. The CDC would also be well placed to advise on the establishment and ongoing development of the Australian Government **wellbeing budget**.
- The value of CDC leadership in this area will be to **assist the prevention system** to engage with other sectors and to seek shared understanding of the **mutual benefits of joint action**. The health sector has tended to use Health in All Policies or Health Impact Assessment approaches in engaging with other government departments. While there are some examples of success, there is significant opportunity for more systemic and enduring approaches.
- We recommend co-design is a principle for most CDC activity, for example, across agencies, with communities and/or research institutions. As Australia's largest centre in prevention knowledge translation and communication, the Prevention Centre's nearly 10 years of experience has demonstrated the value of co-design, including in science communication.

Evaluating the impact of the CDC

- We support the important focus on data and evidence as a basis for evaluating the functions and impact of the CDC. We recommend that the primary indicators of success for the role of the CDC in supporting preventive health is a more effective and well-funded prevention system that is able to **bend the curve on chronic disease** in Australia for all population groups, and **redress existing health inequities**.
- We recommend that, in addition to risk factor and disease surveillance, emphasis is also given to collecting evidence on **trends in public and political endorsement** of preventive health actions – particularly for **actions at the systemic level** such as for public health law and regulation to protect and promote public health. The Prevention Centre's AUSPOPS surveys provide a valuable starting point for such surveillance (Case study 2).

- We recommend the CDC also develops guidance on the mechanisms and resources required for a comprehensive **prevention surveillance system to underpin a wellbeing economy**. Such surveillance would measure the systemic impacts of public policy that are essential to cost-effective prevention, in addition to measuring and monitoring rates of disease, individual risk factors and behaviours.

Case study 2: Australian perceptions of prevention

Three national surveys conducted by the Prevention Centre in 2016, 2018 and 2021 examined Australians' attitudes and values towards government intervention for chronic disease prevention. Although people thought personal responsibility for health is important, most recognised the role of government in helping people to stay healthy.

Our research shows monitoring trends in community attitudes to government intervention can help public health regulators and advocates more accurately direct information and advocacy campaigns across different demographic areas. Understanding and informing community attitudes can also help to direct the conversation towards cost benefit, equity and vested interests in prevention.

National leadership as a trusted voice on the systemic nature of chronic disease

- We recommend that the CDC provides national leadership as a trusted voice on the systemic nature of chronic disease and **systemic changes required** for prevention to work and be cost-effective.
- We recommend this national voice also work with mainstream and social media to **reach the wider Australian public**, including communities, lobby groups, civil society and non-government organisations, industry and political decision makers and their advisors. That the intended audience trusts the CDC is paramount to its success in effectively communicating health advice.
- We note that effective public communication on prevention will support effective preventive action by transforming perceptions of 'individual choice' to an understanding that changes in systems (**legal, regulatory, economic, food, planning, transport and other systems**) are required to effectively prevent chronic disease. Such transformations are politically challenging, particularly when there is insufficient public understanding and demand for action.
- We recommend that the CDC's role should include capacity for **science communication and risk communication for prevention**. Enhanced public communication can build community demand for investment in prevention, and counter harmful industries' sophisticated approaches to influence community attitudes and political action.[3]
- We support the premise that the CDC should inform prevention policy choices through national standards and ranking evidence-informed intervention options and best buys. We suggest that the CDC could play a role in **tracking** prevention **policy and program distribution and dose** to support more widespread and equitable uptake of cost-effective interventions to improve health and reduce health inequity.
- We suggest there is significant scope to more consistently bring together preventive health research programs to **synthesise and communicate policy implications** across a broad body of work. By way of example, the Prevention Centre models the use of science communication and evidence synthesis for policy and practice, including mechanisms for research-policy linkage, coordination and exchange. The Collaboration for Enhanced Research Impact (CERI) is a relatively recent partnership between the Prevention Centre and 11 prevention-focused NHMRC Centres of Research Excellence to support the translation of prevention research for policy and practice, including shared communications and advocacy.

Data solutions for chronic disease risk factors and outcomes

- We support the need for a national data system for prevention, including more consistent, standardised, timely and secure approaches to defining, collecting, storing, linking and sharing of chronic disease risk factors and outcomes data. We recommend that prevention databases and data registries include health **economic data on the value, costs and benefits** of prevention to inform and support the business case for investment in prevention. Other key indicators to inform cross-sectoral preventive action include **place-based measures** of liveability and food retail environments.
- We support the need for national data registries that are usable across jurisdictions. The CDC should act as a conduit between the Australian Institute of Health and Welfare (AIHW), Australian Bureau of Statistics (ABS), states and territories, and support **cross-jurisdiction priority setting** to ensure that data registries' functions align with the data needed to support state, territory, and national policies and programs. We recommend the CDC play a leading role in ensuring prevention investment decisions at all levels of government flow from data and research by supporting the development of **shared platforms for data visualisation** and application. The Australian Urban Observatory provides a useful example, that includes the Transport Health Assessment Tool (Case study 1).
- We recommend the CDC is also enabled to provide strategic **policy-relevant guidance on data collection standards and methodologies**. For example, Prevention Centre research has identified how inconsistencies in measuring physical activity hamper a system-wide approach. We support better linkage between national and state and territory surveys, and greater alignment of priorities, resources and data sharing. The CDC should provide policy-led guidance on priority risk factors, disease and other outcomes, sentinel sites and sample sizes for at-risk groups. Mechanisms would also include collaborations with the AIHW.
- We recommend that particular consideration is given to the role the CDC can play in risk factor surveillance and monitoring to provide the **longitudinal data** required to **support policy scenario modelling** and prevention research. Prevention Centre research has identified significant gaps in Australian national data on chronic disease risks and outcomes. These include limited longitudinal data on trends in risk factors and risk factor data for some priority groups (Case study 3). More relevant, accurate and consistent longitudinal data are essential for timely understanding of factors influencing changes over time, to allow comparisons, and to support evidence-informed investment decisions.

Case study 3: Predictive modelling and gaps in data

The Prevention Centre has built a national dynamic simulation model of chronic disease prevention (GoHealth model) based on trends in prevalence of nine modifiable risk factors. This model has the potential to forecast the health burden and economic costs of preventable disease, and allow scenario testing to understand how best to allocate investments and actions across risk factors to achieve the greatest impacts.

The primary limitation for using this type of modelling to support national chronic disease prevention decisions is the current lack of consistent and reliable Australian data on risk factor prevalence.

Shared national priorities for investment in prevention research

- We recommend that the importance of prevention research is recognised in the charter of the CDC. While the CDC will not be a primary research entity, it must be in a position to inform and direct Australian prevention research endeavours to address the national and cross-jurisdiction prevention priority gaps and identify where further evidence is needed for policy agencies to fulfil their roles.

- We support a role for the CDC to assist with coordination across jurisdictions to identify **national prevention research priorities**, both for the routine data collection led by national and state and territory agencies, as well as through the NHMRC, Medical Research Future Fund (MRFF), Australian Research Council (ARC) and other funding schemes and special initiatives.
- We recommend prevention research priorities are identified collectively and focused on generating **solutions and their application** and implementation in real life settings. While there are known and effective prevention policies and practices, widespread adoption and implementation is uncommon. One impediment is the is limited evidence on how to **implement and scale up interventions** in different contexts.[4] A proactive strategy is needed to ensure new insights from implementation science are quickly embedded in practice.
- We recommend the CDC monitors and reports on the **scale and scope of prevention research** funded through health research programs and other schemes. Mechanisms to close evidence gaps and meet the information needs of agencies charged with implementing the National Preventive Health Strategy will be a particularly valuable function to inform future investment priorities in prevention research.

Strengthening accountability for prevention through national leadership and coordination

- We note that the design principles refer to the role of the CDC in national coordination in identified areas. We support the caveat that this would not replace or undermine existing state and territory responsibilities.
- We note that leading national issues (including climate change and health, mental health and suicide prevention, First Nations health and migrant health) and some national strategies (the National Preventive Health Strategy, National Tobacco Strategy, National Drug Strategy) are either in scope or potentially in scope. It is not clear the basis for inclusion of some strategies and not others (for example, the National Obesity Strategy and National Alcohol Strategy).
- We recommend that the CDC take a leadership role in coordinating **implementation of the multiple prevention strategies** so the opportunities and investment for implementation are understood across topic area silos.
- We recommend careful consideration be given to identify which key prevention issues are prioritised for CDC national coordination in the first instance. We suggest that priority is given to **emerging** issues (for example, e-cigarettes), areas of work where **national expertise is limited** (for example, prevention and mental health), where national, cross-sector approaches would yield **multiple benefits** (for example, climate change and health) or where there are **gaps in leadership** and coordination.
- We note that existing structures are in place to provide a focus on communicable disease (for example, the Australian Health Protection Principal Committee and its subcommittees, the Ministerial Drug and Alcohol Forum and Food Ministers Meeting), whereas **important gaps remain for prevention policy,** most notably obesity and health inequities resulting from significant discrepancies in available opportunities to be healthy between geographic areas, workplaces, and population groups.
- While national coordination in identified areas could provide benefits across the system, we recommend that mechanisms are clarified for agreeing portfolios of actions that together are likely to create change, and establishing accountability measures and processes that are **clear, minimise overlaps, duplication and conflicts between different stakeholders**. It will be important to mitigate the potential for blurring of roles, responsibilities and relationships between the CDC, the Australian Government Department of Health, other national agencies, such as AIHW, and state and territory governments.

Chronic disease prevention and national public health workforce development

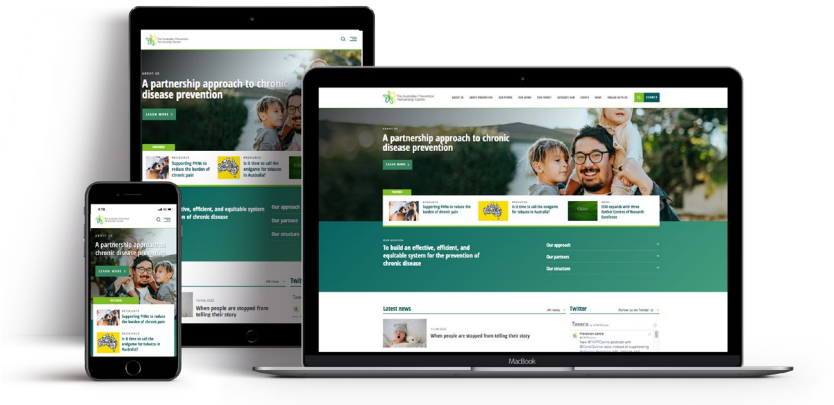
- We support the role of the CDC in building the workforce, including national public health training to **extend and federate** rather than replace existing state and territory workforce programs.
- We recommend that chronic disease prevention is **in scope for national public health training**. There is already an acknowledged gap in the chronic disease prevention workforce. To ensure this workforce is not diverted to communicable disease and emergency response, we will need to concurrently build prevention capacity at national, state and territory level.

References

1. Australian Institute of Health and Welfare 2020. Australia's health 2020 snapshots. Australia's health series no. 17. Canberra: AIHW. https://www.aihw.gov.au/getmedia/128856d0-19a0-4841-b5ce-f708fcd62c8c/aihw-aus-234-Australias-health-snapshots-2020.pdf.aspx
2. Global Burden of Disease Collaborative Network 2020. Global Burden of Disease Study 2019 (GBD 2019) Results. Seattle, United States: IHME. Accessed 20 April 2022. https://www.healthdata.org/gbd/2019
3. Howse E, Watts C, McGill B, Kite J, Rowbotham S, Hawe P, Bauman A, Freeman B. Sydney's 'last drinks' laws: A content analysis of news media coverage of views and arguments about a preventive health policy. Drug and Alcohol Review. 2022 Mar;41(3):561-74. https://onlinelibrary.wiley.com/doi/10.1111/dar.13376
4. Wolfenden L, Hawe P, Rychetnik L, Sutherland R, Barnes C, Yoong S, Giles-Corti B, Mitchell J, Bauman A, Milat AJ, Chai LK. A call to action: More collaborative implementation research is needed to prevent chronic disease. Australian and New Zealand journal of public health. 2022 Oct;46(5):549-53. https://doi.org/10.1111/1753-6405.13270

Funding partners

The Australian Prevention Partnership Centre 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 Australian Government also contributed through the Medical Research Future Fund. Queensland Health became a financial contributor in 2022. The Prevention Centre is administered by the Sax Institute.



preventioncentre.org.au