

# Baker IDI PERSPECTIVES

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## Preventing the conditions that lead to heart disease must take priority.

GARRY JENNINGS, AM

*Director, Baker IDI Heart and Diabetes Institute*

**T**he National Preventative Health strategy highlights the need for urgent, comprehensive and sustained action to address the rising incidence of preventable disease amongst Australians.

Making Australia the healthiest country by 2020 is not a nice-to-have aspiration but rather a need-to-have imperative based on the prevention of human suffering and the crippling economic burden of treating the direct and associated health consequences of alcohol, tobacco and obesity.

Tobacco, physical inactivity and obesity are responsible for a range of co-morbidities such as diabetes and renal failure, which ultimately lead to heart disease. Heart disease also happens to be one of Australia's most resource-intensive diseases to treat. Our expanded waistlines will result in an extra 700,000 cardiovascular-related hospital admissions in the next 20 years; and these highly preventable admissions will conservatively cost \$6 billion in health care (\$2.9 billion in hospital costs alone).

Given the prevalence of conditions such as obesity and diabetes that act as a precursor to heart disease, it is no coincidence that cardiovascular disease is one of the single greatest health problems facing our nation's indigenous communities.

Mortality rates in Aboriginal Australians are three times the rate of the rest of the population. With the median age of death just a fraction over 50, life expectancy is 17 years less than for non-indigenous Australians.

Cardiovascular diseases account for almost one third of indigenous deaths – the single largest contributor to the life expectancy gap.

Besides the injustice of these statistics and the tragedy of human suffering caused by cardiovascular disease, it also poses a significant economic burden on the health care system, drawing funds away from preventative health and into costly and extreme forms of treatment such as hospital admissions and surgery. If reducing cardiovascular disease is the end game in 'Closing the Gap', then preventing the conditions that lead to heart disease must take priority.

In dealing with obesity we have only just begun to scratch the surface and an even broader range of initiatives will be necessary if we are to make headway.

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What is needed is a multi-disciplinary approach, informed by research into health protection and disease management across the whole-of-life. Indeed, fostering a culture of research is one of the best ways to ensure that Australia can provide a responsive healthcare system and optimal care.

In keeping with the recommendations of the Wills review in 1998 and the Grant Review in 2004, the Taskforce have rightly identified investment in national research infrastructure as an important component of an effective preventative health strategy.

This could be supported by better use of information technology and the introduction of electronic health data systems that protect privacy but provide current health information for both treatment and monitoring purposes.

The rise in chronic disease is a problem for which there is no easy solution – not least because we are dealing with people and what motivates and informs the behaviour of one person may be very different to the next.

In responding to the Preventative Health Taskforce, we encourage the Government to consider a range of levers – discouraging poor lifestyle choices where appropriate and encouraging healthy modifications through preventative strategies where feasible.

Creating positive incentives for better health can be a powerful behavioral motivator. This could take the form of subsidised exercise programs, healthcare rebates for preventative treatments and a greater focus on the nutritional value of food served in schools, workplaces and recreational facilities.

We all have a role to play in this most pressing health crisis. As individuals, we can do more to live healthier lives by reducing our sugar, salt

and saturated fat intake and increasing our physical activity.

As consumers, we should demand that the food industry continue to take responsibility for reducing salt and sugar in everyday food items such as bread and breakfast cereals and providing us with clear food labeling information so we can make more informed decisions about the food we eat.

We need community level planning that provides greater opportunities for physically active recreation so that children can safely walk and ride to work and desk-bound workers can interrupt an otherwise sedentary day.

And of course, governments and industry have a critical role to play too in mandating clearer food labeling, making fresh and healthy foods more accessible and encouraging healthier lifestyle habits.

Australia stands poised at the crossroads of health reform. The Preventative Health Taskforce Strategy and the National Health and Hospitals Reform Commission Report have armed our Government with a raft of informed recommendations for transforming our healthcare system to ensure better outcomes for all Australians.

What is required now is a concrete political commitment to reform in the form of legislation, allocation of resources and consistent, sustainable planning and vision. Failure to capitalise on this opportunity will result in an untold collective cost in the form of pain and suffering, as well as the inevitability of higher taxes to pay for treating the health consequences – a classic case of robbing Peter to pay Paul.

*Professor Garry Jennings, AM is Director of Baker IDI Heart and Diabetes Institute.*

**‘Our expanded waistlines  
will result in an extra 700,000  
cardiovascular-related hospital  
admissions in the next 20 years.’**

# It would be a mistake to simply cherry pick the proposals which are most convenient or lacking in controversy and resistance.

There is nothing slick or glib about the title of the National Preventative Health Strategy. But look more closely, and many of the clues to Australia becoming the healthiest nation by 2020 are inherent in the label.

PROFESSOR PAUL ZIMMET, AO

Perhaps one of the most important words here is; 'Strategy'. As a member of the Taskforce who developed this broad-sweeping, comprehensive proposal, I can attest that this is neither a plan, a project nor a program.

The word 'Strategy' quite boldly and deliberately sums up the need to harness all the forces at our disposal, to take a long-term, planned and methodical approach to reaching a singular goal – that of making all Australians healthier.

Another critical clue to success is the word 'National'. This suggests a joined-up, co-ordinated and complementary approach, cutting across government departments, and social, geographic and political boundaries to deliver information and services to all Australians, regardless of their electoral boundaries or postcode.

And yet anyone following media coverage around the release of the strategy could easily be mistaken for thinking that the Taskforce's report simply presented an itemised menu of so-called 'sin taxes' – or measures designed to increase the cost of tobacco and alcohol. Nothing could be further from the truth.

In drafting the strategy, the Taskforce consulted across a wide range of interest groups; including individuals, local communities, major organisations, corporations, NGOs and governments. The strategy is the outcome of a great deal of thinking, debate and evidence gathering both in Australia and internationally.

It would be a mistake to simply cherry pick the proposals which are most convenient or lacking in controversy and resistance. And while we cannot necessarily expect the government to take up every single recommendation, it's imperative that they do address the wide range of options.

Much is at stake.

If current upward trends in overweight and obesity continue, there will be approximately 1.75 million deaths at ages 20+ years and 10.3 million years of life lost at ages 20-74 years caused by overweight and obesity in Australia from 2011 to 2050.

In order to address this issue, we need to take a full life-cycle approach to health care, starting with an infant's in utero experience. Unfortunately, being selective about which initiatives to implement – especially in relation to obesity – will not achieve the stated goal.

Simply banning junk food advertising during children's peak TV viewing time, and applying stricter marketing regulations to fatty, salty, sugar-laden foods will only address a small part of the equation. We need to go further than addressing the concerns of the "food police"!

By the same token, not all approaches can or should be introduced simultaneously. Experience with past social marketing campaigns indicates that progressive, staged and comprehensive actions have been the most successful.

We have already made some reasonable progress in preventative health care, including previous national strategies such as Acting on Australia's Weight, the National Alcohol Strategy 2006-2009 and the National Tobacco Strategy 2004-2009. And with the recent introduction into Parliament of legislation to establish the National Prevention Agency (NPA), momentum is gathering around translating policy into evidence-based preventative health programs. But there is much more to be done and several areas which present unique challenges that cannot be ignored.

Addressing maternal and child health will be critical to the success of the strategy. The need to intervene early is becoming more evident as we better understand the relationship between growth and development during foetal and infant life, and health in later years. This is particularly relevant to obesity and diabetes as science reveals the extent to which these chronic diseases are trans-generational.

We know that some communities are more disadvantaged in their access to good nutrition and health-promoting infrastructure and services. This is particularly true for indigenous Australians and recently arrived migrants.

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As well as rolling out culturally appropriate services to these groups, we need to take into account the built environment. This requires long term planning and vision to ensure new neighborhoods have adequate foot and bike paths, and consideration is given to recreational infrastructure.

Unfortunately, the national obesity epidemic is an issue for which there is no easy solution and it may take years to turn this ship around, but to sit on the sidelines is not an option.

Australia is not alone in the increasing incidence of chronic, lifestyle-related disease. Yet few countries are tackling preventative health on such a comprehensive level. Dr Ala Alwan, Assistant Director at the World Health Organisation, has called the National Preventative Health Strategy “ground-breaking” and an example for other nations.

This is very encouraging.

But translating the strategy into real outcomes for all Australians will require significant commitment from all three levels of government.

That includes a commitment to work together collaboratively; to share the responsibility for delivering

on the strategy and a commitment to keeping preventative health on the political agenda.

Establishing a lead agency such as the NPA will be critical to driving the preventative health care agenda, however, it would be a mistake to expect the authority to take sole responsibility for delivering on the strategy.

In fact, it would be a mistake to expect any one agency, level of government, political party, industry or health care provider to carry the agenda. And on this account, the strategy may present one of the biggest reform challenges since federation.

However, the need for a progressive, comprehensive and sustained preventative health strategy and the financial and health benefits of such a strategy are now indisputable. If, in light of this knowledge, we fail to act now, we will commit future generations to a shorter lifespan. As much as anything, this will be a failure because it is entirely preventable. We are fortunate to have a Prime Minister and Minister for Health who appear committed to see Australia the healthiest nation by 2020!

*Professor Paul Zimmet, AO is Director Emeritus and Director International Research of Baker IDI.*

## Indigenous representation should be embedded within the development of the plan.

**T**he health disadvantage of Indigenous Australians represents one of Australia’s most enduring social and health divides.

SANDRA EADES

The taskforce is to be commended for recognising this inequity and prioritising ‘Closing the Gap’ as one of the report’s core strategic principles. The disproportionate incidence and burden of chronic disease amongst Australia’s indigenous communities, and the contribution of obesity, tobacco and alcohol to this situation is well documented.

And while the report makes some good recommendations for addressing this situation, it is disappointing that there was no indigenous representation on the Taskforce, given the national importance and gravity of the strategy.

One of the critical success factors in efforts to improve indigenous health is the involvement of suitably qualified indigenous health people within the governance and decision making structures of relevant agencies.

Indigenous representation must be embedded within the development of the plan and afforded the opportunity to contribute to a robust and meaningful

debate about the efficacy of the strategy at the planning stages.

Unfortunately, it remains unclear how, if at all, the new National Prevention Agency will involve indigenous representatives at the strategic level. The strategy recommends 10 to 12 cross-sectoral members on the board of the new agency but does not explicitly commit to indigenous representation.

It is widely agreed that for indigenous health policy to be effective and successful, we need a more inclusive model, in contrast to the old, paternalistic paradigm which met with significant community resistance. This is a crucial factor that needs to be addressed. If it’s not in the plan, it simply won’t happen.

The NHMRC example provides a good model of indigenous representation within the governance structure. The agency now has indigenous involvement on council and each of the principle committees and in 2002 agreed to commit at least five per cent of the research budget to indigenous health initiatives.

As a result, the agency's strategic direction now takes greater account of indigenous priorities because people who have a real-world understanding of the issues can contribute to practical, effective outcomes.

Governance and representation aside, it is important to highlight that appropriate, well directed preventative health strategies do work and have a significant role to play in improving health outcomes for indigenous Australians.

Recent intervention research conducted by Baker IDI showed that 20 per cent of pregnant indigenous women in the study who smoked were able to quit and sustain their quit to the end of their pregnancy. The project tested the effect of a high-intensity, culturally specific intervention for pregnant indigenous women delivered through indigenous-specific primary health care services.

The promising message here is that prevention works. But we also know that mainstream preventative health campaigns do not translate effectively in indigenous communities, with their own unique cultural norms. The Taskforce is to be congratulated for acknowledging this fact and identifying the need for culturally specific campaigns from the outset.

To ensure success, these campaigns will need to take account of strong evidence to suggest that targeting individual behaviour-change in isolation has limited value. In order to impact and shift the cultural norms that sanction higher rates of smoking across the community, social marketing has to engage with indigenous people in group settings across the entire social spectrum – engaging the community, the household unit, community organisations, sporting teams, community opinion leaders and elders to effect successful cultural change.

Like so many good plans, the devil will be in the detail. Overall, the recommendations proposed by the Taskforce are sound and reasonable but they are generic and will require significant refinement before they can be implemented and translated into real outcomes for remote, rural and urban indigenous communities.

Critically, the inclusion of indigenous representation on the new National Prevention Agency's board and work force will be one of the first tests of the Federal Government's commitment to indigenous health and an important determinant of the success of future programs.

*Professor Sandra Eades is the Head of Baker IDI's Indigenous Maternal and Child Health Research Program.*

## In theory, a national research framework creates some unique opportunities for the research community.

Research plays a critical role in the development of preventative health programs – from early identification of risk factors to effective intervention strategies at both the individual and social level.

BRONWYN KINGWELL

However, in Australia at present, the majority of healthcare expenditure is on established disease where the evidence for benefits of treatment is most clearly seen.

The transformation required to shift the focus to early prevention and intervention is significant but not impossible, provided research is seen as an integral part of the solution.

Although much is known about the negative health impact of high-risk behaviours (alcohol, smoking, fatty foods) much less is known about effectively implementing the kind of behavioural change required to secure long term, sustainable lifestyle changes.

There is still much to discover about the social determinants of good health and how they can be replicated and translated into effective preventative healthcare.

The Preventative Health Taskforce has rightly identified a key role for research in the evaluation and delivery of healthcare with the recommendation to develop a national strategic framework for preventative health research.

The benefits of such an approach are significant, not least in the capacity for accelerated discovery and breakthrough with the potential to save lives and in the long run, reduce the costs of acute care.

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An integrated national approach, fostering collaboration through a network of research centres and database linkages would deliver greater economies of scale and minimise duplication of effort. This would also be a welcome alternative to the current ad-hoc arrangements which fail to fully leverage the expertise of specialised research groups.

In order to be truly effective, national collaboration should take account of international research. Chronic diseases such as obesity are a global problem not confined to Australia. In identifying new research opportunities, we need to look at the international experience and draw from what has already been developed to ensure we leverage our strengths to develop internationally competitive expertise and improved translational outcomes.

Of course, this will need to be complemented by research that takes account of Australia's unique health challenges such as those faced by indigenous and rural populations.

In theory, a national research framework creates some unique opportunities for the research community. In practice, however, the governance, funding, implementation and administration of such a framework will not be without its challenges.

Never far from the spotlight, research funding arrangements are contentious at the best of times. The concerns of the research community with respect to the funding of indirect costs are well-founded and widely documented. How a new research fund would complement current arrangements and whether it would illicit a fresh commitment of resources, in addition to the current allocation to research, or whether it would compromise these sources through poaching remains to be seen.

The benefits of a centralised repository, listing current research projects are significant.

But registers and networks are only effective to the extent that they are governed by clear, independent oversight at the operational level. To this end, management of these initiatives will be critical to

ensuring they deliver on the overall objectives of the strategy.

In establishing the register, due consideration will also need to be given for developing an appropriate mechanism for effectively facilitating collaboration. This will need to take account of the present barriers and disincentives that limit information sharing amongst researchers. These include the current funding environment which sees researchers competing for the same limited funds, an increased focus on commercialisation and a culture in which intellectual property is heavily guarded.

Another consideration for developing an effective research framework will be the involvement, from the outset, of all stakeholders to this strategy including Medical Research Institutes, relevant industry associations, primary healthcare representatives, universities and hospitals.

Engaging these groups at the strategic level will be an important factor in bridging the gap between competing agendas and creating a shared vision with shared ownership.

Once again, it is not inconceivable. Our own experience at Baker IDI of collaborating with researchers at the University of Queensland to develop a Healthy Lifestyle Research Centre attests to the feasibility of establishing networks with shared research interests.

Despite the considerations, there is much to be gained from a process that facilitates better collaboration between researchers. Devising a suitable framework, governed by robust guidelines that adds value, creates economies of scale and cuts down the transaction costs of delivering outcomes will be key to the success of the proposal. As we in the research community can testify, it's a fine line between creating sustainable, well governed new agencies and adding ever more complex and demanding layers of administration to the workload of already stretched investigators.

*Professor Bronwyn Kingwell is the Executive Director of Science Policy and Head of Metabolic and Vascular Physiology at Baker IDI.*

**‘Registers and networks are only effective to the extent that they are governed by clear, independent oversight at the operational level.’**

# The workplace is emerging as a critical front-line in the fight against obesity and associated complications.

Identifying the workplace as a key target setting for preventative health intervention is a significant and important milestone in the development of Australia's preventative health strategy.

DAVID DUNSTAN

There are an estimated 11 million Australians in the workplace – nearly 70 per cent of them in full time employment, representing a significant number of the population.

Increasingly, the working day of these Australians involves sitting for long stretches. This is particularly prevalent in modern office-based work environments. Indeed, for many of us, incidental movement in the office consists of moving from one chair to another – from the chair in our office to the chair in a meeting room to a chair in a lunch room.

The results of the recent Stand Up Australia study conducted by both Baker IDI and The University of Queensland in conjunction with VicHealth and Medibank Private confirmed that the average worker spends more than two thirds of their work day in sedentary time.

Given the accumulating body of evidence, linking risk factors for chronic disease and premature mortality with prolonged sitting, the workplace is rightly emerging as a critical front-line in the fight against obesity and associated complications.

But reducing sitting time in the workplace is complex and requires an integrated approach. It is not enough for individuals to be motivated to change, organisations need to support them and in turn, organisations require support from government in the form of incentives and rewards.

This is not impossible. Just over a decade ago there were still workplaces in which people smoked amongst their colleagues but once the scientific evidence was in on the harmful effects of passive smoking, this very rapidly changed. We can also take heart from this example in highlighting the critical role of science and research in shifting cultural norms.

Organisational support for new workplace practices is another critical catalyst for change. If a call centre employee is sufficiently motivated to stand up and move around while taking calls, their efforts to reduce sedentary time will fail if management insist they assume a seated position.

At the other end of the spectrum, there are some highly progressive organisations which have started to recognise the value of 'activity permissive' work environments.

Australia's own Macquarie bank has successfully implemented innovative new work practices with the redesign of their King Street Wharf office interior. The new lay-out allows greater movement and adapts to worker's daily work styles by offering a range of different work spaces to choose from.

This kind of radical innovation, backed by high level management support is what is needed if we are to tackle the effects of occupational sedentary time head-on.

The Taskforce is right to recommend grants and tax incentives as a form of recognition for employers who facilitate and support a workplace environment that is less health hazardous.

Occupational Health & Safety legislation is another lever that could be used to address prolonged sedentary time in the work place. If research can prove that sedentary time has a direct impact on ill health, then that provides greater credibility to shift the issue into the OH&S arena by identifying occupational sedentary time as an occupational hazard.

As the head of Baker IDI's Physical Activity research, I applaud and encourage the report's recommendation to: 'develop a national action research project to strengthen the evidence of effective workplace health promotion programs in the Australian context.'

Australia is leading the way in tackling sedentary time in the workplace and is one of the few countries targeting occupational sedentary time as a potential workplace health hazard.

The challenge now is to establish clear evidence that prolonged sitting leads to adverse health profiles and to use this evidence to strengthen the case for programs that reduce sedentary time in the workplace.

*Associate Professor David Dunstan is the head of Baker IDI's Physical Activity Research Program.*

# In plain terms, alcohol is the drug which kills on average more than 60 people each week and hospitalises another 1500.\*

The Australian Government's intent to reduce harmful drinking in our nation by 30 per cent by 2020, is a target well worth aiming for – but it will only happen when the entire health care system has undergone significant reform.

MR DAVID TEMPLEMAN

The Government's Preventative Health Taskforce Report provides a solid health and wellbeing platform to change the destructive drinking culture in Australia.

As the national peak body advocating on behalf of non-government organisations (NGO) across the alcohol and other drugs (AOD) sector, ADCA urges the Government to endorse all recommendations made in the Taskforce Report in the areas of obesity, alcohol and tobacco to achieve a healthier Australia.

The Taskforce says that if the targets for alcohol are reached, the proportion of Australians who drink at short-term risky/high-risk levels will drop from 20 to 14 per cent, and the proportion of Australians who drink at long-term risky/high-risk levels will drop from 10 to seven per cent.

Australia's culture of risky drinking continues to have a huge impact on our communities, with the latest research showing an alarming increase of 30 per cent in alcohol-related hospitalisations (NDRI, Sept 2009).

If the targets for reducing the alcohol harm in our communities are reached, the Taskforce estimates this will prevent the premature deaths of over 7200 Australians and 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.

In plain terms, alcohol is the drug which kills on average more than 60 people each week and hospitalises another 1500. All indications are that numbers will continue to rise – unless significant changes are made in alcohol policy, licensing laws and more is invested in frontline AOD services.

We need to see politicians at all levels of government adopt a bipartisan approach and work together to achieve the outcomes envisaged by the Taskforce Chair, Mr Rob Moodie, and his team. The graduated long-term approach from 2010 through to 2020 is one supported by ADCA.

Alcohol is not like any other common commodity, it is a drug – and its misuse has serious consequences. ADCA has been campaigning through Drug Action Week to alert the community to the fact that 'Alcohol is a Drug – TOO'! and the strong response to this grassroots campaign shows the message is being heard.

Our organisation continues to advocate for significant cultural reform regarding safety and alcohol, attitudinal change, as well as pricing and promotion reform. For the Taskforce to be successful, it will require significant intervention and resourcing at all levels of Government.

One way to achieve that is to direct the extra taxation revenue gained through the levy on ready-to-drink alcohol products to prevention measures. Over \$1 billion in additional revenue has been collected since May 2008 – re-investing this in health prevention would be a sound outcome.

Healthcare reform is critical for Australia's future. As medical science has expanded, Australians are living longer and it is anticipated that 25 per cent of the population will be over the age of 65 by 2030. This will place greater demands on our health system.

However, technological change has brought about new ways of living, working and socialising. These lifestyle changes, and changes in the way alcohol is consumed, mean that our healthcare budget will need to increase from nine per cent to 12.5 per cent of Australia's GDP to deal with the challenges of obesity, alcohol consumption, tobacco and related diseases. How we tackle this critical priority will be a major challenge nationally.

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