

Preventative Health Taskforce Consultations

Kalgoorlie General Consultation

6 February 2009

Comfort Inn Midas

Facilitators: Professor Rob Moodie and Professor Mike Daube

Thirty one participants attended the Kalgoorlie general consultation.

Professor Moodie and Professor Daube provided participants with a general overview of the work of the Preventative Health Taskforce and the discussion paper.

Participants were then provided with two challenges and the outcomes of these are listed below:

Omissions

General

Medical model is too altruistic for the delivery of primary care: primary funding systems do not allow for alternative models to be utilised. Too much focus on General Practitioner as primary care giver in strategies – for example Healthy Kids Check for 4year olds – there is an assumption that these checks are undertaken with the 4yr old immunisation, however in Western Australian most 4 year olds are vaccinated in the school system and are consequently missing out on their 4 year old GP check.

Environmental health programs probably have more impact than primary health initiatives.

Grants programs/interventions need to be long term - prevention should be treated as an essential service not a program.

Enhance the capacity to collect local data on the effectiveness of programs - consider what is happening locally and the quality of data collection.

Government

What is the willingness of government (Commonwealth/State and Territory) to be involved, especially in areas such as food industry, alcohol industry, regulation and taxation?

Review the disparity between government and non-government organisation. Funding to get to “the lands” is disproportional and is significantly less for the non – government sector.

Financial resourcing is a big problem.

Funding from the Commonwealth and State to line up – rather than reproducing the same initiatives (eg Measure Up Campaign).

- Gain funding for a number of different items that line-up, rather than getting funding from different areas for the same item – this is where National Leadership is important.

Rural / Remote

More detail is required around whether national campaigns are effective in rural and remote areas.

Need local initiatives for local levels – there should be no assumption that what works in one setting will work in all settings. Need to determine where progress is being made and further develop these areas.

Flexibility of national campaigns – most campaigns do not reach the most vulnerable groups – timing of action is crucial within these settings – need to be on the ground and aware of the situation. Allow those who are being targeted to be a part of the decision-making process and also ensure that the community is ready for implementation.

- Variability exists between communities and regions – in some circumstances similar underlying issues may need to be addressed differently.

Need to do some partnering in this area – share resources (partnerships at the local level) and develop a common purpose.

Strategy

Staging of the strategy over years is important – self regulation leading through to regulation if required.

Need to consider the generational differences within the strategy e.g. focus on generation x and y.

Need to consider gender differences.

Indigenous

Closing the Gap “very broad area” more specifics are required around actions and what can be done.

More focus around disadvantaged – Indigenous and low socio economic groups required.

Supply of food, tobacco and alcohol is money driven for business – need to know how to change this. Industry is fundamentally there to make money not to provide a healthy option.

Obesity

The reality of the situation in many instances is the supply of good quality fresh food.

Need to ensure that we do not become desensitised to the health promotion message.

Look at programs that have worked e.g. Outback Stores program which worked well with the food industry and kitchen/community gardens.

Obesity focus in schools, however school resources are already stretched. It is important that any recommendations are supported with resources.

Implementation

Incentive based funding (e.g. immunisation) to go across professions and not only available to GPs.

Practice based incentives, not practitioner need to be across all professions.

Risks need to be taken at all levels based on common sense and evidence based. Flexibility and risks need to underpin the Strategy.

Social marketing needs to be strengthened by government through regulation and legislation.

Innovation balanced accountability is important.

Provision of programs for prisoners – this also presents an opportunity to reach families (smaller communities).

Health prevention/promotion needs to become core business – not just acute medical care – need to look at how to make this part of the infrastructure to ensure funding is provided with this in mind.

Need to ensure that funding from Commonwealth is in alignment, rather than duplication – across local, state and federal levels. The level of input should match the outcomes.

Effectiveness of social marketing campaign – look to the hard approaches that worked with tobacco.

Need for increase focus on the potential impact on climate change on physical activity and food security.

Need for a more ecological focus.

Recognition of accessibility to physical activity, particularly for older persons in rural and regional areas.

Need for a stronger focus on imbedding a culture of physical activity particularly through the built environment. Increase in incidental activity.

Improve data on the actual size of the problem – which should be available.

Consider the engagement with complimentary medicine e.g. massage, herbalists and other.

Need smaller targets to track progress.

Need to focus on young population looking beyond 2020 - i.e. early intervention.

Change perception that health is not the sole responsibility of the health industry.

Integrated planning with all stakeholders supported by funding and qualified or access to qualified personnel.