

Preventative Health Taskforce Consultations

Melbourne General Consultation

10 February 2009

Facilitators: Professors Rob Moodie and Paul Zimmet

Sixty eight participants (68) attended the 10 February 2009 general stakeholder consultation session.

Professor Moodie and Professor Zimmet 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:

Challenge One: Omissions to the Discussion Paper/Innovative Ideas

Monitoring and surveillance are required such as gender and diversity socio economic analysis.

Role of local government – looking to Taskforce to show leadership – and a map of local/state/federal/community and industry actions - policy change and implementation important at all levels.

The paper is aimed at middle class and may be perceived as just more public health police work – need to watch the language in the document– look at backlash from ‘alcopops.’

Understand and address social complexity of populations and access issues.

Focus on long term evaluation (more time and resources required).

More emphasis required in more wide-stream settings including community – need more balance of up stream and down stream strategies.

Understand and be careful of the impact of labelling on people i.e. ‘Obesity’ label and ‘alcoholic’ – negative connotations.

The discussion paper looks at symptoms and should focus more on disadvantaged.

Is the existing paradigm up to this work – existing paradigm focuses on systems and needs to change to prevention – changes also are needed to structures

Coherent view of knowledge translation– what is this translation going to be – should based on fundamental issues.

There is an urgent need to implement what is in the discussion paper – can’t hang around and wait for policy to be implemented.

Hospitals need to take a lead – 80 per cent smoking rates in hospitals – lots of work to be done here.

Collaboration is required across the sectors from individual through to whole community – important to get balance right.

Positive statements should be made as points of reference throughout the Strategy.

Lifecycle stages – looking at times when people most open to change (i.e. arrival of children).

Look at children as being the motivation and putting pressure on the family.

Focus on maternal and children should expand into primary schools.
Marketing of Strategy to reach hard to reach groups – look at health literacy

Alcohol

Physical availability of Alcohol is an important lever in technical paper but falls off in the discussion paper – there is evidence to support it should be implemented.

Alcohol – improve role models.

Taxes on ready to drinks - just shift drinking habits from one area to another.

Ready to drink (RTD) tax can be seen as interfering with lifestyles.

Obesity

Future of Foods Report (published by public health association) - use as tool.

Need more emphasis on access to food – particularly at the local socio-economic levels.

Provide more options and choices for disadvantaged (that are affordable).

Provide options to engage in physical activity i.e. young kids take up sports but sports often become elitist.

Adoption needs to be clear well understood – the issues are complex – i.e., not just obesity but the obsesiogenic environment.

Need to look at how we frame obesity to make more positive i.e., healthy weight rather than obesity.

Dealing with overweight kids with issues about themselves – need to look at how to support them.

Grass roots programs are required to support participation i.e. soccer groups for disadvantaged people.

There is a need to weight the list of interventions and stage the priorities.

Workforce balance – charitable disadvantaged – when people donate they often donate unhealthy options.

Tobacco

Tobacco – taxation to encourage behaviour change.

Regulation around tobacco - implementation of regulation required.

Littering – legislation.

Recreation areas ban smoking.

Increase in tax and social marketing are the two biggest focus areas required.

Tax, keeping some to go back into programs for disadvantaged groups and to provide services to those groups that are most impacted.

Legislation and regulation are required to decrease hours and restrict licensing.

Ensure all smokers are given support – all socio economic groups are provided NRT.

Work with industry working groups to work on advertising.

Challenge Two: Implementation

General

Importance of engaging local communities to work out solutions and involve them in the solution and process - this works best in areas of disadvantaged, they can own the solution.

The built environment can create a difference – without expensive education programs, and sometimes don't require any technical solution.

Schools to become more community hubs – schools provide opportunity, try and engage children and parents in learning opportunities. Wellness centres in school that parents are invited to participate in.

There have been regulatory losses and resources losses over time that require reinvestment, particularly in relation to schools, workplaces and community settings. Need to find the ‘hooks’ to get people out of their homes - cost and time are key issues that we need to look at.

Need to champion local advocates and look at areas where we have been successful – look at water issues.

Need to encourage community dialogue and generate community outrage.

Need to get tough, need incentives and to show we need to take these things seriously.

Culture and language – researchers need to move out of their comfort zone and don’t use old frameworks to deliver new ideas.

Need preventative council that has the ability to continue to engage in alcohol, tobacco and obesity strategies.

Major focus around attitudinal change - look at attitudinal issues that have been successful, such as wearing seat belt

Obesity.

Need industry as a partner to this. Look at shift in consumption of saturated fats and the role of industry in this.

Need to encourage financial incentives to encourage healthy lifestyle over a whole continuum and range of different programs: healthy food, exercise, children toys, food, regulation on outlets, transport and roads to encourage more physical activity. Environment, carbon tax ideas – tax industries that produce unhealthy products (e.g. calorie trading scheme).

Look at leveraging from other agendas, where there is existing momentum.

Look at what is working from other parts of the world.

Tobacco model very successful, we need to look at that.

Social marketing – support for prevention activities.

Need industry as a partner to this. Look at shift in consumption of saturated fats and the role of industry in this.

Introduce financial incentives to allow women to breastfeed at their work.

Tobacco

Cigarettes the only products that will kill you – use marketing for good and not for evil. Positive marketing is required that shows healthy outcomes.

Regulation, laws and taxes are required – there is an opportunity at local level to enforce those.

Social marketing should be kept simple to understand – too many complicated messages.

Alcohol

Alcohol policy requires regulation, regulation, regulation.

More kids exposed to alcohol advertising than Humphrey B bear through watching sport on television – normalised – need to denormalise!

Challenge Three

Not addressed at this meeting.