

SUBMISSION TO NATIONAL HEALTH AND HOSPITALS REFORM COMMISSION

From the

AUSTRALIAN CHRONIC DISEASE PREVENTION ALLIANCE

The Australian Chronic Disease Prevention Alliance (ACDPA) is an alliance of five non-government health organisations who are working together in the primary prevention of chronic disease, with particular emphasis on the shared risk factors of poor nutrition, physical inactivity and overweight and obesity.

The members of the ACDPA are:

- *Cancer Council Australia*
 - *Diabetes Australia*
 - *Kidney Health Australia*
 - *National Heart Foundation of Australia*
 - *The National Stroke Foundation*
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Introduction

ACDPA welcomes the opportunity to make a submission to the National Health and Hospitals Reform Commission regarding practical reforms to address major challenges facing the Australian health system, of which the growing burden of chronic disease is one of the most significant. In particular ACDPA is supportive of the current impetus to bring a greater focus on prevention to the health system.

This submission complements and supports submissions to the Commission from the individual member organisations of the ACDPA.

Impact of chronic disease

Cancer, cardiovascular disease, diabetes and renal failure together account for nearly 45% of the total burden of disease and injury in Australia.¹ This burden is expected to grow significantly in line with the aging of the population and increasing prevalence of shared chronic disease risk factors such as overweight and obesity.

This growing burden of chronic disease poses major challenges for the Australian health system. Health care expenditure for cancer, cardiovascular disease and diabetes is projected to increase by 79% over the next 15 years, from \$12.1 billion in 2002/03 to \$21.7 billion in 2022/23.²

National Service Improvement Frameworks: Improving performance of the health system

The Commission's terms of reference, and the long-term objectives of the Government's health reform agenda, have great potential to optimise the health system's capacity to address the growing burden of chronic disease in Australia.

The Commission should recognise that nationally agreed approaches to improving health service provision for chronic disease already exist in the form of the National Service Improvement Frameworks (NSIFs) developed under the National Chronic Disease Strategy.

These frameworks were developed in consultation with a range of stakeholder groups, including leading clinicians, national, state and territory policy makers, consumers and members of non-government and other health organisations, and endorsed by all jurisdictions. Frameworks currently exist for cancer,³ heart, stroke and vascular disease,⁴ and diabetes,⁵ as well as for other chronic diseases.

Although they are disease specific, these frameworks embody common principles and approaches that provide an excellent blueprint for health reform - the delivery of more person-centred, equitable, timely, effective, affordable and cohesive health care for all Australians, which covers the continuum of care from prevention through to end of life care.

In addition, a number of the critical intervention points are common across the frameworks for cancer, heart, stroke and vascular disease, and diabetes, increasing the impact value of

these interventions. For example, all identify the establishment of national, state and territory plans to promote healthy eating, increased physical activity and healthy weight as critical intervention points to reduce the risk of developing these diseases.

The principles, critical intervention points and priority actions for change identified in the frameworks are directly relevant to items 2b to 2h of the Commission's terms of reference.

While the frameworks outline the principles and key actions required to achieve optimal care, each of the frameworks refers to the need to adopt a systematic implementation plan. However, little has been done to develop these plans or otherwise drive the implementation of these frameworks.

Consequently, the ACDPA recommends the development of comprehensive implementation plans and funding for these frameworks, in consultation with key stakeholder groups, as a top priority. These implementation plans should include clearly articulated responsibilities across jurisdictions and sectors of the health system, concrete performance benchmarks and challenging targets, regular monitoring and reporting arrangements and a commitment to adequate funding to ensure their effective implementation.

The potential impact that effective implementation and funding of the NSIFs could have on health outcomes in Australia is illustrated by the outcomes achieved by the implementation of the National Service Frameworks in the United Kingdom. The UK frameworks incorporate well articulated action plans with clear goals, challenging targets and dedicated funding and have achieved outstanding progress. The National Service Framework for Coronary Heart Disease, for example, has already achieved its national target of reducing cardiovascular disease deaths for people younger than 75 years by at least 40% by the year 2010, five years earlier than planned.⁶

Prevention

Nearly two thirds of the disease burden for cardiovascular disease and for diabetes and one third of the disease burden for cancer are attributable to modifiable risk factors, a number of which are common to all these diseases¹, as well as to chronic kidney disease. The most significant common risk factors for these diseases include overweight and obesity, physical inactivity, poor nutrition and tobacco smoking.

This submission focuses on issues relating to reducing the risk factors of overweight/obesity, physical inactivity and poor nutrition. Issues relating to reducing tobacco smoking, which is also an important shared risk factor for these chronic diseases, are addressed in detail in submissions to the Commission from individual ACDPA member organisations.

Although the prevalence of smoking is declining, levels of overweight and obesity are rising dramatically, in line with the associated factors of poor eating habits and reducing levels of physical activity. These trends are expected to result in a surge in chronic disease levels in coming years, which will place major pressure on the health system and on health system

expenditure, in addition to reducing the wellbeing and life expectancy of increasing numbers of Australians.

As modifiable lifestyle factors are important determinants of chronic disease, increasing the emphasis on prevention within the health system will be critical to slowing and reversing current trends in chronic disease. Consequently ACDPA strongly commends the increased focus on prevention embodied in the National Health Reform Agenda and in current Australian government initiatives such as the establishment of the National Health and Hospitals Reform Commission and the National Preventative Health Taskforce.

However, the current health system is primarily focused on treatment and very little is invested in the area of prevention, so the scale of change required is substantial. Only 1.5% of health system expenditure in Australia was on prevention and public health services in 2005/06.⁷ Consequently a significant re-orientation of the health system towards prevention will be required, supported by substantial funding increases for prevention strategies if any significant impact is to be made on chronic disease trends.

National Obesity Strategy and Implementation Plan

Obesity/overweight and the associated factors of physical inactivity and poor nutrition are important risk factors for cardiovascular disease, diabetes, cancer and kidney disease. In 2005, obesity alone was estimated to account for:

- 102,204 Australians with Type 2 diabetes (10.8% of all people with Type 2 diabetes);
- Over 379,000 Australians with CVD (obesity causing 14% of hypertension, 12% of CHD and 12% of stroke) and
- 20,430 Australians with cancer (obesity causing 13% of colorectal and kidney cancers, and 16% of breast and uterine cancers).⁸

The Australian Institute of Health and Welfare estimates that 54.7% of the diabetes disease burden, 19.5% of the cardiovascular disease burden and 3.9% of the cancer disease burden are attributable to overweight and obesity.¹ The total financial cost of obesity alone (not including overweight) in Australia has been estimated as \$3.767 billion.⁸

Obesity and overweight are increasingly a problem in Australia. In 2004/05, 7.4 million adults were overweight or obese, up from 4.6 million in 1989/90. On an age-standardised basis, the proportion of overweight or obese adults has increased steadily from 38% in 1989–90 to 44% in 1995, 50% in 2001 and 53% in 2004–05.⁹

Overweight and obesity rates are also rising in children. In the 10-year period from 1985–95 the level of combined overweight and obesity amongst Australian children more than doubled while the level of obesity tripled.¹⁰ More recent data indicate that almost one quarter of children aged 5–16 years were overweight or obese in 2004.¹¹

Based on past trends and without effective interventions in place, it has been estimated that 16.9 million Australians are likely to be overweight or obese by 2025.¹² This will lead to major increases in the number of Australians with cancer, cardiovascular disease, diabetes and kidney disease.

Prevention activities designed to address overweight and obesity consequently offer significant potential to reduce the future level of these chronic diseases in Australia and reduce the associated burden on the health system and society. However, the health behaviours which contribute to overweight and obesity are underpinned by a complex range of social, economic, educational and environmental factors. Our environment is increasingly “obesogenic”, characterised by access to a wide variety of cheap, energy dense/nutrient poor food and by technologies, lifestyles and environments which encourage people directly or indirectly, to avoid expending energy through physical activity.¹³

Lower socio-economic status is also a key determinant of health and the prevalence of lifestyle risk factors. Australians with lower socioeconomic status are more likely to be overweight or obese, exercise less, eat less fruit and smoke than those of higher socioeconomic status.¹⁴

The multi-faceted determinants of obesity and overweight will require a comprehensive approach and multi-level interventions to address social, cultural, behavioural, organizational and environmental factors, if any significant change in obesity trends is to be achieved. Evidence increasingly indicates that comprehensive approaches, comprising multiple interventions targeting a range of health promotion outcomes, are required to deliver and sustain the population health behaviour changes required to address overweight and obesity, physical inactivity and poor nutrition.^{15 16 17}

However, despite the scale of the problem and the implications for the future health and wellbeing of a large number of Australians and for the health system, the response in Australia so far has been insufficient to turn the tide on rates of overweight and obesity, poor nutrition and physical inactivity.

A number of strategies, frameworks and initiatives relating to chronic disease and obesity have been developed in Australia, including: the National Chronic Disease Strategy; the NSIFs for cancer, heart, stroke and vascular disease and diabetes; the action agendas for healthy weight developed by the National Obesity Taskforce and the Australian Better Health Initiative. However, as illustrated with the NSIFs, the emphasis has been mainly on developing strategies and frameworks to guide activities at national, state and community levels rather than on implementing and funding activities directly.

In order to effectively address the obesity problem in Australia, a comprehensive obesity strategy to encourage healthy weight, increased physical activity and improved nutrition is called for. This strategy should build on existing strategies and engage all spheres of government, the private sector, workplaces, communities and non-government

organisations. Rather than being just another strategy, however, it is critical that this obesity strategy be supported by:

- A clearly articulated implementation plan, with timelines
- Clearly defined responsibilities and accountabilities for implementing programs under the strategy
- Concrete measures and performance indicators, challenging targets and mandatory regular reporting and evaluation arrangements
- Dedicated and adequate funding for programs identified in the plan.

The strategy will require a comprehensive portfolio of complementary interventions across sectors including;

- **Social marketing campaigns** promoting healthy weight, increased physical activity and healthy eating.
- **Food supply and marketing reform**, such as: reducing the use of saturated fat and salt; **banning or limiting trans fat**; improving the nutritional value of food products; promoting appropriate portion size; improving nutrition information labelling; restricting junk food advertising to children.
- **Improving the built environment** and workplaces to support active living.
- **Data collection and research**, including: an ongoing commitment to the national nutrition and physical activity survey to monitor biomedical risk factors and trends in nutritional and physical activity behaviours and weight status of Australians, building on the recent national children's nutrition and physical activity survey for which results are due to be announced in mid-July; evaluation of interventions to build the evidence base on what works best to prevent obesity.
- **Program interventions** such as strengthening support for the primary care sector to provide healthy lifestyle advice (eg through an expansion of the Lifescrpts program) and improved chronic disease prevention and management services.
- **Strategies to address the needs of disadvantaged groups** such as Aboriginal and Torres Strait Islanders, lower socio-economic groups, and culturally and linguistically diverse groups.

Implementation of the obesity strategy should be built into the Australian Health Care Agreements and the National Preventative Health Partnership.

Recommendations

Implementation plans based on principles of the National Service Improvement Frameworks for cancer, heart, stroke and vascular disease and diabetes should be developed and funded as a top priority.

A comprehensive obesity strategy and implementation plan, engaging all spheres of government, the private sector, workplaces, communities and non-government organisations should be developed and implemented to reduce levels of overweight and obesity in Australia. The strategy should incorporate a comprehensive portfolio of interventions across sectors including:

- **Social marketing campaigns** promoting healthy weight, increased physical activity and healthy eating.
- **Food supply and marketing reform**, such as: reducing the use of saturated fat and salt; banning or limiting trans fat; improving the nutritional value of food products; promoting appropriate portion size; improving nutrition information labelling; restricting junk food advertising to children.
- **Improving the built environment** and workplaces to support active living.
- **Data collection and research**, including: an ongoing commitment to the national nutrition and physical activity survey to monitor biomedical risk factors and trends in nutritional and physical activity behaviours and weight status of Australians, building on the recent national children's nutrition and physical activity survey for which results are due to be announced in mid-July; evaluation of interventions to build the evidence base on what works best to prevent obesity.
- **Program interventions** such as strengthening support for the primary care sector to provide healthy lifestyle advice (eg through an expansion of the Lifescripts program) and improved chronic disease prevention and management services.
- **Strategies to address the needs of disadvantaged groups** such as Aboriginal and Torres Strait Islanders, lower socio-economic groups and culturally and linguistically diverse groups.

Implementation of the National Service Improvement Frameworks and the obesity strategy should be built into the Australian Health Care Agreements/National Preventative Health Partnership and should be supported by:

- Clearly defined responsibilities and accountabilities across sectors and jurisdictions for implementing agreed programs
- Concrete measures and performance indicators, challenging targets and mandatory reporting and evaluation arrangements
- Dedicated and adequate funding for identified programs.

References

- ¹ Begg S, Voss T, Barkett B, Stevenson C, Stanley L, Lopez AD, 2007. The burden of disease and injury in Australia 2003. PHE 82. Canberra:AIHW
- ² Vos T, Goss J, Begg S and Mann S (2007). *Projection of health care expenditure by disease: a case study from Australia. Revised version of a report used in the preparation of the 2007 World Economic and Social Survey, Centre for Burden of Disease and Cost-effectiveness, School of Population Health, University of Queensland and Australian Institute of Health and Welfare.* <http://www.un.org/esa/policy/wess/wess2007files/backgroundpapers/australia.pdf>
- ³ National Health Priority Action Council (NHPAC) 2006. *National Service Improvement Framework for Cancer.* Australian Government Department of Health and Aging, Canberra
- ⁴ National Health Priority Action Council (NHPAC) 2006. *National Service Improvement Framework for Heart, Stroke and Vascular Disease.* Australian Government Department of Health and Aging, Canberra
- ⁵ National Health Priority Action Council (NHPAC) 2006. *National Service Improvement Framework for Diabetes.* Australian Government Department of Health and Aging, Canberra
- ⁶ DH UK (United Kingdom Department of Health) (2008). *The Coronary Heart Disease National Service Framework - Building for the future (Progress Report for 2007).* http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_083060
- ⁷ Australian Institute of Health and Welfare 2007. Health expenditure Australia 2005–06. Health and Welfare Expenditure Series no. 30. Cat. no. HWE 37. Canberra: AIHW
- ⁸ Access Economics (2006). "The economic costs of obesity." Report by Access Economics to Diabetes Australia. Diabetes Australia, 2006.
- ⁹ Australian Bureau of Statistics (ABS) (2008a). Overweight and obesity in adults. 2004–05, Australia. ABS cat no. 4719.0. Canberra: ABS, 2008.
- ¹⁰ Cameron AJ, Welborn TA, Zimmet PZ, Dunstan DW, Owen N, Salmon J, Dalton M, Jolley D & Shaw JE 2003. Overweight and obesity in Australia: the 1999–2000 Australian Diabetes, Obesity and Lifestyle Study (AusDiab). *Med J Aust*
- ¹¹ NSW Schools Physical Activity and Nutrition Survey (SPANS) 2004.
- ¹² Department of Human Services (DHS) (2008). Future prevalence of overweight and obesity in Australian children and adolescents, 2005-2025. Melbourne: Victorian Government, 2008.
- ¹³ Gebel K, King L, Bauman A, Vita P, Gill T, Rigby A & Capon A 2005. *Creating healthy environments: a review of links between the physical environment, physical activity and obesity.* Sydney: NSW Department of Health and NSW Centre for Overweight and Obesity.
- ¹⁴ Australian Institute of Health and Welfare 2008. Australia's health 2008. Cat No. AUS 99. Canberra: AIHW.
- ¹⁵ Gill T, King L and Webb K 2005. Best options for promoting healthy weight and preventing weight gain in NSW. NSW Department of Health 2005
- ¹⁶ NSW Centre for Overweight and Obesity, University of Sydney 2005. A literature review of the evidence for interventions to address overweight and obesity in adults and older Australians Undertaken for the Australian Government Department of Health and Ageing for the National Obesity Taskforce.
- ¹⁷ Baker P, Young M 2006. A summary of published Cochrane and non-Cochrane systematic reviews (from Health-Evidence.ca, The Community Guide and quality assessed systematic reviews (Database of Abstracts of Reviews of Effects – DARE)