



AMA

AMA Submission: Preventative Health Taskforce
Australia The Healthiest Country

December 2008

Introduction

As the peak professional organisation representing medical practitioners in Australia, the AMA welcomes the opportunity to respond to the options for prevention of obesity, smoking and harmful alcohol use that are explored in the National Preventative Health Taskforce discussion paper – *Australia: The Healthiest Country by 2020*.

Medical practitioners engage in high quality health prevention and preventative medicine every time they consult with their patients. Prevention is an integral part of medical care, and has been since the advent of modern medicine. The AMA's response to the Taskforce is therefore informed by a deep understanding of the factors that will contribute to successful health prevention, at both an individual level, community and national level.

Doctors are also at the front line of acute care and treatment, addressing urgent medical needs in a health system with finite resources. The AMA recognises the place of prevention in Australia's health system. It also recognises the importance of a strong commitment to the resourcing of acute care and treatment. The Taskforce proposes a decade long investment in the prevention of obesity, alcohol misuse and smoking. While this is important, this must not come at the expense of treatment and acute care needs. The AMA believes that when the issue is the allocation of scarce health resources, the Taskforce's proposed 10 year investment in prevention must be a balanced one.

The Taskforce considers proposals for prevention at a population-based level and at the level of individual interactions in primary care settings. This submission comments on both, with a particular focus on the latter. The AMA is heartened that a great many of the population-level preventative measures that the Taskforce endorses are ones that have been advocated by the AMA for some time. There are still some gaps, however, and this submission includes recommendations as to how they should be addressed.

The AMA's response to the Taskforce begins with the role of doctors in health prevention, and takes two facts as its starting point:

- (i) health prevention and preventative medicine are already integrated into the medical care provided by doctors, and
- (ii) among the health professionals and service providers that may contribute to health prevention in the primary care context, doctors make a central and unique contribution.

Against this background, the AMA believes that the key issue for the Taskforce is how best to support doctors in their preventative efforts in the target areas of smoking, obesity and alcohol misuse.

The AMA fully supports the aspirations expressed in *Australia: The Healthiest Country by 2020*. Achieving them will demand a careful resource balance between prevention and care. However the balance is struck, the medical profession will be central to the solution.

Prevention in Medical Practice

The AMA believes that a comprehensive and effective national prevention strategy should place particular importance on medical practice. Doctors are multi-skilled and highly trained professionals. For example, general practitioners are the most highly trained general health professional, with a minimum of 10 to 15 years training, and have expertise in managing patients with multiple conditions. Doctors command a high level of respect and credibility in the eyes of their patients and the public, and provide high level health and medical care to all groups in society. About 88% of all Australians visit a general practitioner at least once a year,¹ giving doctors significant opportunities to address the health risks and medical problems of a very large proportion of the Australian population.

Doctors provide long-term and continuous care to many of their patients, and “often . . . develop an ongoing relationship and rapport . . . which can lead to an increased sense of respect and trust.”² They are not only aware of their patients’ medical conditions and concerns, but also very often the circumstances of their lives, and that of their families. These factors all contribute to making doctors pre-eminent in identifying the presence of risks to individuals’ health, and the particular factors in their lives that contributing to those risks.

Prevention and Doctor-Patient Consultations

Doctors already engage in preventative medicine. An estimated 29.7% of all clinical treatments provided by general practitioners (GPs) in 2007-08 involved types of health advice, education and counselling that could be considered preventative.³ In each year from 2000 to 2006, nearly 10 million patient encounters involved general practitioner advice and counselling on nutrition, weight and exercise, smoking, lifestyle and alcohol issues.⁴

Doctors, particularly GPs, routinely incorporate prevention into their patient consultations as part of providing comprehensive ‘whole-of-patient’ health and medical care. As a matter of course, doctors will actively screen and be constantly alert to risk factors for chronic conditions. Doctors recognise the importance of providing patients with timely information and advice when risk factors emerge or become apparent. Brief interventions by doctors are among the top five most cost-effective interventions for reducing the harms to young people of alcohol misuse.⁵ Similarly, doctor interventions for smoking are also widely acknowledged as effective.⁶ Doctors also have a sound understanding of when to refer, or recommend further action to their patients, to address risks early.

There is not always a sharp line between primary and secondary prevention, particularly with advice and counselling in relation to smoking, alcohol, exercise and diet.⁷ With regard to these

¹ *General Practice Activity in Australia 2007-08*. C. Bayram. H. Britt, et. al., AIHW, 2008.

² *Alcohol and Other Drug Brief Interventions in Primary Care*, Turning Point Alcohol and Drug Centre, 2008.

³ *General Practice Activity in Australia 2007-08*. C. Bayram. H. Britt, et. al., AIHW, 2008.

⁴ “Preventive Activities in General Practice”, Helena Britt, *GP Review* May 2007.

⁵ *Identifying cost-effective interventions to reduce the burden of harm associated with alcohol misuse in Australia*. Doran, C., Vos, T, et. al., Alcohol Education and Rehabilitation Foundation, 2008

⁶ *Putting prevention into practice. Guidelines for the implementation of prevention in the general practice setting*. Royal Australian College of General Practitioners, 2006.

⁷ “Preventive Activities in General Practice”, Helena Britt, *GP Review* May 2007.

behavioural risks, doctors mostly practise secondary prevention, ie., early intervention to stop emerging problems or harms from becoming worse. Through screening or observation, doctors become aware of the early signs in their individual patients of problematic drinking, or more frequent tobacco use, or excess weight, and they then determine what action or intervention will best help to turn things around early, before they become worse.⁸ Depending on the individual involved and the doctor's judgement, the intervention could take a range of forms – provision of information, advice, motivational counselling, advice on behaviour-management techniques or referral to other medical specialists or allied health professionals.

Doctors mostly engage in secondary prevention because they generally deal with people who already have health problems or concerns, and who may be exhibiting alcohol, smoking or weight risk factors. However doctors can engage in primary prevention regarding these risks during a normal consultation, or a health check, or when people are seeking advice about family members. It may be medically appropriate for a doctor, for example, to advise a pregnant non-drinker and non-smoker not to start drinking or smoking. And it may be appropriate for a doctor to provide this advice to a patient whom the doctor believes is at risk of initiating tobacco use, or excessive or binge drinking, etc..

RECOMMENDATION 1

Any strategic consideration of the place of prevention in the primary care setting must begin with recognition of the following facts:

- Doctors have a central place in the primary care setting;
- Doctors already routinely integrate prevention into their patient consultations, and doctors are integral to prevention in the health system, particularly secondary prevention.

Supporting the Role of Doctors in Prevention

The AMA believes that the key issue regarding primary care in a National Prevention Strategy will not be how doctors can or should adopt new roles or attitudes to prevention. It will be how the role that doctors already play in prevention can be better supported and further strengthened. This applies to the interventions that doctors undertake in consultations. But also, outside the doctor-patient consultation context, there are opportunities for doctors to play an enhanced role in primary prevention regarding smoking, harmful drinking and obesity.

Supporting Doctor-Patient Prevention

The proportion of patients attending general practice who exhibit smoking, alcohol and weight risk factors is significant. During 2007-08, an estimated 19.3% of the GP patient population were daily smokers (with prevalence highest in younger adult patients); 29.3% of GP patients were at-risk drinkers; and 23.5% were obese and 35.3% overweight.⁹ The patient population rates for at-risk drinking have remained the same over the last 10 years, and rates for smoking have decreased.

⁸ For a characterisation of secondary and other forms of prevention in relation to alcohol, tobacco and other drug use, see *Prevention, Alcohol and Other Drugs* Council of Australia, 2003.

⁹ *General Practice Activity in Australia 2007-08*. C. Bayram. H. Britt, et. al., AIHW, 2008.

However, the proportion of people attending GPs who are either overweight or obese has increased significantly since 1998-99.¹⁰

In 2007-08, an estimated 7% of patient encounters with GPs involved advice and counselling specific to smoking, weight or alcohol.¹¹ Given the proportions of the GP patient population noted above that are subject to these risk factors, there are still opportunities to strengthen doctors' provision of prevention specifically relating to smoking, obesity and harmful alcohol use. This is particularly so in the case of overweight and obesity, given significant increases in the proportion of patients who are overweight and obese.¹²

Maximising the role of doctor-patient prevention will be a matter of:

1. minimising the impediments to prevention that can arise in the complex circumstances of modern medical practice;
2. more support and information on best practice strategies, and
3. ensuring that the time required to undertake this work is available, enabled and properly recognised.

Minimising the barriers and impediments to doctor patient prevention

The AMA believes that doctors could significantly enhance their contribution to effective doctor-patient prevention if the following factors were addressed:

There is limited information available to doctors about best practice preventative interventions for smoking, alcohol, and obesity. Targeted screening and 'brief interventions' involving awareness raising and motivational advice and referral, are generally regarded as appropriate early intervention measures for doctor consultations.

There is a credible evidence-base concerning the forms of brief intervention that work in smoking cessation, and how well.¹³ Very brief advice from a GP to quit results in a 2-3% increase in quitters after one year, and this can be increased with active follow-up. The evidence-base for the effectiveness of brief interventions for hazardous alcohol consumption is less well-established, but nonetheless credible. There is evidence that a five minute session of advice about hazardous drinking can produce a significant reduction in alcohol consumption after 9 months (and as great a reduction as longer sessions) with longer term effectiveness sustained through follow-up sessions and continued reinforcement.¹⁴ The evidence-base relating to effective GP obesity interventions is more limited. There is some evidence of short-term effectiveness of brief GP advice (coupled with literature resources) in patients' weight reduction,¹⁵ and indications that GP advice and monitoring of exercise regimes can have some effect.¹⁶ In view of the increasing proportion of the

¹⁰ From 32.8% (1998-99) to 35.4% (2007-08) for overweight, and from 18.3% to 23.9% for obesity. *General Practice Activity in Australia 1998-99 to 2007-08: 10 Year Data Tables*. H. Britt, G. Miller, et. al., AIHW 2008

¹¹ Not necessarily as the main problem or reason for the encounter. *General Practice Activity in Australia 2007-08*. C. Bayram. H. Britt, et. al., AIHW, 2008.

¹² *General Practice Activity in Australia 1998-99 to 2007-08: 10 Year Data Tables*. H. Britt, G. Miller, et. al., AIHW 2008

¹³ *Putting prevention into practice. Guidelines for the implementation of prevention in the general practice setting*. Royal Australian College of General Practitioners, 2006.

¹⁴ "The long-term effectiveness of brief interventions for unsafe alcohol consumption: a 10-year follow-up", Wutzke, S., et. al., *Addiction* 97(6), 2002 pp. 665-675.

¹⁵ *Literature Review to Reduce the Burden of Harms from Poor Nutrition, Tobacco Smoking, Physical Inactivity and Alcohol Misuse*, Dalziel, K, et. al., 2006 Centre for Health Economics, Monash University.

¹⁶ See for example, 'Half of patients given exercise prescriptions are more active', *British Medical Journal* 337, 2008.

patient population with excess weight, it is important that the evidence-base for GP obesity interventions is developed, and best practice models are promoted widely across the profession.

The forms of brief intervention that are effective for one risk factor may not be as effective for the others. Nor might the same forms of brief intervention be effective with differing population groups (eg. cultural groups), ages, genders and individual life circumstances (eg., during pregnancy). There is a need for doctors to be updated on an ongoing basis with current evidence and information about these issues.

To be genuinely effective, brief interventions and their associated guidelines and screening protocols, need to be capable of being realistically undertaken in a busy medical practice. Where there is experience, or a perception, on the part of doctors that an intervention or guidelines are impracticable or cannot be readily applied, there will be a reluctance to adopt them.¹⁷ A safeguard against this is to include a ‘reality test process’ when developing any national guidelines regarding interventions, based on input and feedback from practising doctors. The AMA would be happy to facilitate this process through its public health and general practice committees. The uptake of brief interventions can also be enhanced by ‘packaging’ them in a readily accessible and user friendly form for doctors, such as incorporating online reminders and protocols into doctors’ software. Again, a process of ‘road-testing’ these through the AMA before finalising them would help in this regard.

The means by which information about brief interventions is disseminated to doctors is particularly crucial. WHO evidence shows that direct and active approaches to promoting and raising awareness about evidence-based interventions to GPs (such as telephoning, or face to face visits with GPs) were more successful in promoting uptake than indirect and passive approaches such as general mail outs of written information.¹⁸

RECOMMENDATION 2

The uptake and integration of brief interventions into routine medical practice across Australia should be increased through:

- Dissemination of best-practice information to doctors about
 - the most effective forms of brief intervention in a routine clinical setting for each risk factor; and
 - what is effective for different population groups, including prevention ‘target groups’ such as adolescents and youth.
- Significantly increasing the research and evaluation effort to identify brief or other interventions that doctors can apply with good effect in the case of overweight and obesity;
- Involving the AMA, in providing practice-based quality assurance on:
 - the development of prevention guidelines and protocols, to ensure their practicality in a practice context, and

¹⁷ Some studies of clinical guidelines in these risk areas indicate that they are perceived by practitioners as better suited to education and information than to practical application. See, for example, “Diagnosis and management of childhood obesity: A Survey of general practitioners in South West Sydney”, Louise Silversten, et al., *Journal of Paediatrics and Child Health* Vol 44 2008, pp. 622-629.

¹⁸ “A multi-country controlled trial of strategies to promote dissemination and implementation of brief alcohol interventions in primary health care: findings of a WHO collaborative study”, Funk, M., Mundt, M, et. al., *Journal of Studies in Alcohol*, 66 (3), 2005.

- the packaging of information and guidance on conducting brief interventions into printed and on-line resources for doctors' use in clinical settings, together with materials (eg., literature) for patient use.

Taking direct and active approaches to promoting and raising awareness among GPs of evidence-based brief interventions.

Doctors may not necessarily have all the skills to apply best-practice interventions effectively. It is one thing to know what works, it is another to know how to make it work, and when. In many cases, doctors are able to accurately identify patients who are at risk, and to initiate interventions. In other cases however, there may be difficulties in doctors identifying smokers¹⁹ as well as early stage hazardous drinking.²⁰ Even when these difficulties don't occur, doctors may often care for patients who become defensive when issues of smoking or alcohol use are raised, or who see the doctor as judgemental.²¹ Similarly, in cases of overweight and obesity, research shows that a significant proportion of overweight people do not see themselves as overweight, and many mothers do not perceive their overweight children to be different from their peers.²² Often, problems that patients have with smoking, drinking and weight management are caused by, or result in, general emotional difficulties and complex life-circumstances. Highly developed skills are required to initiate and provide brief interventions in a way that recognises patients' readiness to change, and negotiates patient sensitivities, perceptions and experiences. Initial medical training may transfer these skills to a certain extent, but further opportunities for skill development need to be available to doctors to help them deal with some of the more complex doctor-patient issues.

RECOMMENDATION 3

The implementation of brief interventions by doctors could be made more effective through:

- Stronger incorporation into medical training of brief intervention skills and techniques, including counselling and screening techniques;
- Ongoing availability to doctors of continuing professional development in this area and availability of advice to doctors on best-practice prevention screening tools, and counselling skills and techniques.

Information about, and linkages to, appropriate referral services in doctors' local areas is not always available for doctors. Referral by a GP to specialist medical practitioners or allied health professionals can have positive impacts on the effectiveness of interventions for smoking, problematic alcohol use, and weight issues. However, the referral options that are available in a local area may not always be apparent to medical practitioners, particularly referral options to

¹⁹ See, for example, "GPs confidence in and barriers to implementing smoking cessation activities: compared to dentists, dental hygienists and pharmacists", *Australian Journal of Primary Health* 12 (3), 2006, pp. 117-125.

²⁰ See for example, "Obstacles to carrying out brief interventions for heavy drinkers in primary health care: a focus group study", Aalto, M, et. al *Drug and Alcohol Review* 22 (2) 2003; "Identification of and guidance for problem drinking by general medical providers: results from a national survey", D'Amico E J, et. al., *Medical Care* 43 (3), 2005.

²¹ For studies reporting these factors, see, for example, 'In-practice management versus Quitline referral for enhancing smoking cessation in general practice: a cluster randomised trial', 2008 *Family Practice*; "Death, depression and defensive expansion: closing down smoking as an issue for discussion in GP consultations", Pilnick A, and Coleman T., *Social Science and Medicine* 62 (10), pp. 2500-2512; "Factors influencing inquiry about patients' alcohol consumption by primary health care physicians: qualitative semi-structured interview study" Aira, M. et al., *Family Practice* 20 (3), 2003, pp. 270-275

²² "Maternal concern and perceptions of overweight in Australian preschool-aged children", Campbell, M. W, et al., *Medical Journal of Australia* Volume 184, (6), 2006, pp. 274-277.

allied health providers such as dietitians, and certain options for physical activity, eg, gym programs suited to certain ages or abilities. Coordination and information exchange between these services and medical practices to facilitate referral may also not be in place.²³

The desired outcome from most forms of brief intervention for smoking, obesity and harmful alcohol use is for the patient to become sufficiently aware and motivated to self-regulate and manage their own behaviour. In seeking to do this, many people are likely to default to popular schemes and programs in the public domain, particularly for dealing with smoking and weight problems. Many of these are transient schemes, but others tend to maintain their currency (for example, the *Weight Watchers* program, the ‘Atkins Diet’, or more recently the ‘Low GI’ diet). Doctors would be in a better position to advise their patients if they had available to them evidence-based assessments of the major publicly available and promoted programs that many patients may resort to for self-management.

RECOMMENDATION 4

The potential of brief interventions to motivate patients to self-manage their risk behaviour would be enhanced if:

- Information was readily available to medical practices about programs, services and therapists in the local area that would be suitable as referral options, and
- Evidence-based evaluations were conducted of the major publicly available programs for self-managing weight, smoking, and alcohol use, and information on the evaluation outcomes was made readily available to medical practitioners.

Some of the population groups that would most benefit from early intervention are under-represented in patient populations. When it comes to smoking and alcohol use, the behaviours adopted in teenage years can influence the habits of later life. Each successive generation of Australian teenagers is starting to drink at an earlier age than the previous one. This increases their likelihood of continuing to drink in later life, including becoming dependent drinkers.²⁴ Adolescents and teenagers are an important group to target for early intervention. Despite this, and the fact that Australian youth regard health as an issue of high priority in their lives,²⁵ they are not highly represented among the patients who access GPs.²⁶ Whatever the explanations for this, targeted efforts are needed to normalise and reinforce the value of routine doctor attendance among teenagers and young adults. Those efforts could include nation-wide public awareness campaigns targeted at young people, reinforcement in the school setting of the importance of regular medical attendance, and the enhancement of existing youth outreach initiatives like the *Youth Friendly Doctor* program and *Dr Yes*.

Measures to raise public awareness around smoking, alcohol and weight can also be instrumental in breaking down psychological barriers that individuals may have to self-awareness of their risk

²³ Poor linkages with referral options and community-based support services has been identified as an impediment to the uptake of brief interventions in general practices for smoking, alcohol, nutrition and physical activity. See “Implementation of a SNAP intervention in two divisions of general practice: a feasibility study”, Harris, M., et al., *Medical Journal of Australia* Vol. 183 (10), 2005.

²⁴ *Young People and Alcohol*. National Centre for Education and Training in the Addictions, 2008.

²⁵ *National Survey of Young Australians 2008* Mission Australia, 2008.

²⁶ Patients aged 15 to 24 years accounted for only 9.5% of encounters with GPs in 2007-08 *General Practice Activity in Australia 2007-08*. C. Bayram, H. Britt, et. al., AIHW, 2008.

behaviour. With regard to alcohol, a culture which normalises excess drinking, together with limited public information about risky drinking levels, can make it easier for individuals to deny that they are engaging in risks to their health. Public awareness campaigns can go some way to addressing these perceptions, and can help ease the way for doctors to provide effective interventions to patients who may be otherwise reluctant to acknowledge their health risks. The “Measure Up” media campaign and the recent media campaigns around youth alcohol abuse are positive in this regard. Both of these campaigns could be improved through better follow-up links with doctors (see the later discussion).

RECOMMENDATION 5

To improve doctors’ access to important groups and individuals for early intervention, more public awareness and outreach measures should be implemented that are targeted to adolescents, young people and other key groups to encourage them to routinely access doctors’ services.

Realistic, flexible and efficient support for doctor-patient preventative health

In the day to day circumstances of modern, busy medical practices, doctors face many competing demands and priorities, particularly the provision of treatment and acute care to patients who are in immediate need. If doctors’ uptake of preventative interventions for smoking, obesity and alcohol misuse is to be maximised, the time required for doctors to undertake this work needs to be available and properly recognised.

There are options within the existing framework of government rebates to patients for medical services. There is no need to establish a specific prevention benefit item in the MBS, nor a prevention add-on item to standard consultations. Instead, supportive rebate arrangements should be guided by the following principles:

- arrangements should support the provision of effective forms of brief intervention for alcohol, smoking or obesity;
- arrangements should recognise, enable and support an appropriate level of time spent with patients, continuity of care and appropriate follow-up;
- arrangements should minimise red tape, administration and transaction costs;
- arrangements should allow medical practitioners the flexibility to use their practice team skill-set in the most effective way;
- arrangements should not result in the unnecessary addition of new Medicare items.

There is no ‘one-size fits all’ prevention consultation that doctors can provide to all their patients. Individuals will differ in the seriousness of their smoking, alcohol or weight risk. They will differ in their motivational state, readiness to change, level of risk awareness and in how receptive they are to advice. All of these factors are relevant to the level of skill and expertise that will be needed to provide an effective intervention. Individual patients will also differ in whether they need follow-up and continuing advice, support and care. The circumstances under which issues around smoking, alcohol and weight arise in a consultation will differ as well. Sometimes these risk issues will be the key patient concern, and will be raised early in a consultation. At other times, they will

be issues that are addressed incidentally and opportunistically in a consultation that is about another matter, perhaps toward the end.

These facts all point to the need for government to take into account the flexibility needed to ensure that interventions are provided in a way that suits individual patients' circumstances. For the doctor, this might mean extending the consultation time when a health risk is disclosed. It may also mean that a doctor, after assessing a patient's needs and motivation, decides that the patient could be referred by the doctor to a skilled practice nurse in the practice team under the doctor's supervision, who can provide an appropriate brief intervention. Or the doctor may recognise that the patient's needs are complex and require highly developed expertise, knowledge and counselling skills. In this case the doctor could decide to provide the appropriate preventative intervention, with possibly one or more follow-up sessions, or refer to another service or appropriate medical specialist.

Appropriate arrangements for recognising doctors' time should not involve latent disincentives or inefficiencies introduced in the guise of government accountability measures (for example, more than the minimal administrative processes, recording requirements, or other red tape).

The AMA believes that doctor-patient preventative interventions for alcohol, smoking and obesity can be delivered within existing, or appropriately amended, MBS fee-for-service items. However, this will require a better reflection of the time and costs involved in standard and long consultations through better indexation of patient rebates through the MBS, and more flexibility in MBS arrangements to allow patients to access a rebate for services provided by practice nurses undertaking preventative interventions within general practice. The MBS currently recognises practice nurses performing activities like immunisation, wound management, assist with health checks, assist with chronic disease management. The MBS should also recognise that they can assist, where appropriate, in providing brief interventions for patients' alcohol, smoking and weight issues, and follow-up, where appropriate.

It is important that medical practices also be supported to undertake preventative health activities in a variety of ways. While practices generally approach prevention in a one-on-one consultation environment, there is scope for practices to do more. Group educational sessions in a medical practice are an efficient way of helping patients to remain healthy, and should be supported by government.

RECOMMENDATION 6

The most appropriate funding arrangements to support patient rebates for the flexible and efficient provision of preventative interventions in medical practice (initial intervention and any follow-up) will consist of:

- Existing standard and long consultation items with improved indexation of patient rebates through the MBS to properly recognise the time spent on preventative health care;
- Improved MBS arrangements to provide patient rebates for practice nurses conducting brief preventative health interventions or follow-up 'for and on behalf of' the patient's doctor; and
- MBS arrangements that provide patient rebates for services provided by medical practices undertaking group educational and preventative health sessions.

Grants for whole-of-practice preventative care

While the right government rebate arrangements will greatly assist in supporting doctors' delivery of prevention, there are other important prevention measures at a whole-of-practice level that also warrant support. Some of these have been mentioned previously. For example, making educational material and resources on alcohol, smoking, and weight issues available for patients' use. Other potentially effective whole-of-practice prevention measures include:

- employment of 'preventative health coordinators' in medical practices to liaise with GPs, allied health providers, and other community-based providers to ensure the coordination of preventative care and pathways for patients;²⁷
- mail or phone-based outreach from medical practices to patients who may be at risk, or scheduled for a consultation to discuss the relevant risk factors;
- provision of on-line screening tools in surgery waiting rooms, for patients to fill out routinely while waiting for appointments.²⁸

In addition, individual medical practices may have specific patient population profiles and needs that would benefit from special practice-level measures (for example, group counselling programs for weight management among an elderly patient population). Grant funding should be available to medical practices for practice-level prevention measures, and for practices to develop special initiatives and programs that are specific to their patients' prevention needs. It is important that this support should involve minimal red-tape and administrative costs, unlike PIP payments.

RECOMMENDATION 7

Grant programmes for general practices should be established to support the development and implementation of whole-of-practice prevention measures and programs. These arrangements should involve a minimum of administrative and transaction costs for doctors and medical practices, and should be as available to smaller rural and regional practices as to others.

Doctors Supporting Primary Prevention Beyond the Consultation Context

There are opportunities outside of the patient consultation context where medical professionals can play an effective role in primary prevention.

Doctors are trusted, and their advice has credibility among the public. This suggests that preventative health messages in public media and education campaigns will be reinforced if provided by doctors or endorsed by a doctors' professional association, such as the AMA. In this way, the public could be assured that the campaigns are evidence-based. Similarly, media and public education campaigns such as the 'Measure Up' campaign or the recent alcohol and young people media advertising campaign, would have greater preventative effect, if part of the message being conveyed is that concerned people should contact their doctor for further advice.

²⁷ *Putting prevention into practice*, Royal Australian College of General Practitioners, 2006. This possible measure is based on the existing clinical coordinator role, and would include other possible activities such as development and implementation of prevention plans, education of practice team members, and patient follow-up.

²⁸ See, for example, "Computerised screening for hazardous drinking in primary care", Kypros Kypri, et al., *The New Zealand Medical Journal* Vol. 118, No 1224, 2005, pp. 1-10.

There are already certain doctor ‘outreach’ initiatives that would be very effective vehicles for primary prevention regarding alcohol, smoking and obesity, were they to be extended. For example, the *Dr Yes* and *Youth Friendly Doctor* programs involve doctors or medical students visiting schools to provide information and advice about a range of health issues relevant to young people, including the risks of alcohol, smoking and weight issues. Other doctors routinely visit locations frequented by at-risk groups who may not regularly visit doctors, such as middle aged men, and provide preventative health information and advice. The preventative benefits and potential of these outreach activities could be enhanced if greater support was available to doctors and doctors’ associations doing this.

RECOMMENDATION 8

- The AMA should be invited to quality assure public education and mass media campaigns regarding alcohol, smoking and obesity risks, with a view to the AMA providing professional endorsement of appropriate evidence-based campaigns;
- Public education and mass media campaigns about these risks should recommend, where appropriate, that further advice be sought from a medical practitioner, and
- A grant program should be developed to encourage and support preventative health outreach activities in the general community conducted by individual doctors, medical practices, or doctors’ professional associations.

Population-based Prevention of Obesity, Smoking and Harmful Alcohol Consumption

The AMA believes that strategic, long-term, and properly resourced population-based approaches to prevention can be effective in bringing about reductions in obesity, smoking and harmful alcohol use.

Obesity Prevention

The epidemic of obesity in Australia is sustained by a complex range of social, economic and personal factors that influence how easily individuals can make healthy choices about their diet and physical activity.²⁹ An effective response to this epidemic must be multifaceted in the ways it makes healthier choices more available to people. The AMA believes³⁰ that combating obesity is a shared social responsibility that must engage stakeholders and agencies across all sectors of society. These stakeholders and agencies include Federal, State and local governments, the corporate sector, non-government organizations, the health sector, food industries, the media, employers, schools, community organizations and individuals.

The AMA advocates a national strategic approach to preventing obesity, in which all levels of government set clear goals and targets, and employ policy, regulatory and fiscal instruments to make healthier choices easier for people. As part of such a strategy, the AMA has proposed:

- targeted regulation of food prices and distribution (including through subsidies), to make healthier food options more available and affordable, and unhealthy ones less available and less affordable;
- regulation of food marketing to ban the promotion of unhealthy foods to children, and to ensure that simple and accurate nutrient information about products is available to consumers;
- reduction in the production and sale of energy dense and nutrient poor food products by the food industry (through eg., reducing the calorie density of food items, responsible display and placement of products in retail outlets, etc.);
- national school-based initiatives, where every school's curriculum, physical environment and community relationships are modelled to promote nutritional literacy, healthy dietary choices and physical activity;
- promotion and support for sole breastfeeding of babies in the first six months of life (unless there are medical reasons against this);

²⁹ *Diet, nutrition and prevention of chronic diseases*. World Health Organisation, Geneva, 2003.

³⁰ AMA 2008, *Position Statement on Obesity*.

- incorporation of measures to promote and facilitate physical activity within urban and infrastructure planning regulations;
- adoption by employers of measures to promote and facilitate healthy options in workplaces, and
- funding of a network of local community-based pilot programmes and initiatives to address obesity.

It is encouraging that the AMA's views have been reflected in the overall strategic approach that the National Preventative Health Taskforce takes, and in the particular measures it proposes. The AMA is especially heartened that COAG, at its meeting in November 2008, has agreed on a Health Prevention National Partnership to fund measures including those proposed by the AMA regarding local community initiatives to address obesity, promotion of healthy options in the workplace, and healthy children initiatives in schools.³¹

The AMA also sees as promising the Preventative Health Taskforce proposals regarding:

- targeted social marketing campaigns;
- expansion of the national nutrition and activity survey, and
- the development of a national food strategy for Australia.

The AMA believes that there are also some key respects in which the approach to obesity prevention proposed by the Taskforce could be strengthened.

Overall goals and specific targets

The Taskforce stipulates determinate goals for alcohol prevention and smoking prevention – reducing the prevalence of harmful drinking by 30%, and the prevalence of daily smoking to 9% or less. The proposed goals for obesity prevention – halting and reversing the rise in overweight and obesity – are less specific. It is also problematic that little is indicated in the way of specific targets and objectives tied to the *particular* measures and interventions that are advocated. For example, the target effect at 2020 on fitness activity from increasing tax breaks (at a certain level) for fitness related products, or levels of behavioural change sought from regulating unhealthy food marketing to children.

RECOMMENDATION 9

Overall goals for obesity prevention should be adopted, and specific obesity-related objectives and targets should be identified for the component measures in an obesity prevention strategy.

Non-regulatory means of leveraging change

Many of the measures proposed by the Taskforce involve new regulation by government. For example, increasing taxes for energy dense foods, regulating the

³¹ COAG Communique 29 November 2008.

amount of trans fats in foods, and banning the advertising of unhealthy food to children. However, a number of proposed measures do not appear to be regulation-based. For example, ‘encourage school communities to support initiatives to enable healthy eating’, ‘encourage employers and workplaces . . .’, ‘facilitate the adoption of consistent town-planning’, and ‘curb inappropriate advertising’. It is unclear by what non-regulatory means these outcomes are to be induced. There is also no systematic justification provided as to when regulatory measures are appropriate, and when other means of achieving compliance will suffice, or what they may be (eg., government partnerships, voluntary codes, etc.).

RECOMMENDATION 10

An obesity prevention strategy should develop a clear conception of the means by which compliance with its component measures is to be secured.

Assignments of responsibility

The Taskforce provides little indication of what measures and outcomes are to be the responsibility of which level of government (federal, state or local). While this may be subject to negotiation under the emerging National Healthcare Agreements, there is still a need to provide a broad delineation as part of the development of an efficient and well coordinated obesity prevention strategy.³²

RECOMMENDATION 11

An obesity prevention strategy should incorporate a framework for assigning policy responsibilities and activities to different levels of government.

Policy priorities and target groups

Some obesity prevention measures may have a greater claim on resources than others. The AMA believes that where obesity prevention over the longer term is the concern, a significant focus should be on children and youth. It is important that this focus includes an emphasis on obesity during pregnancy, given the heightened risks this involves for both mother and child.

RECOMMENDATION 12

A particular focus should be adopted in an obesity prevention strategy on measures for children and youth, including unborn children and pregnant mothers

³² Some have argued this should be a central aspect of a comprehensive policy framework for obesity reduction. See, for example, Sacks, G., Swinburn, B., and Lawrence, M., 2008, “Obesity policy action framework and analysis grids for a comprehensive policy approach to reducing obesity”, *Obesity Reviews*, September 2008.

Data Collection and Research

To be effective in achieving its goals, an obesity prevention strategy will need to incorporate the regular collection of accurate and representative data about changes in prevalence of obesity, including in specific population groups. Data should also be routinely collected about the operation and outcomes of the strategy's initiatives. Strong research programs will also need to be maintained to ensure the strategy is informed by best practice initiatives.

RECOMMENDATION 13

An obesity prevention strategy should incorporate ongoing data collection on obesity levels and the outcomes of initiatives, and also research regarding best practice measures for obesity reduction.

Prevention of Tobacco Use

The AMA has for many years actively campaigned to bring about lower levels of smoking in Australia and improved protection for non-smokers. The AMA is encouraged that the Taskforce has also endorsed many of the views proposed by the AMA regarding tobacco use. Major among these are:

- banning all forms of promotion of tobacco products, including at the point of sale;
- increasing the taxation on tobacco products;
- prohibiting the duty-free sale of tobacco;
- tightening enforcement of legislation prohibiting tobacco sales to minors;
- restrictions on the depiction of smoking in films;
- support for plain/generic packaging of tobacco products;

The AMA also supports the following proposals made by the Taskforce:

- tighter enforcement of legislation to protect against exposure to second-hand smoke;
- the required licensing of retailers to sell tobacco;
- prohibition of the sale of tobacco products from customer operated vending machines;
- prohibition of smoking in cars carrying children;
- requirement to fully disclose tobacco product constituents, additives and emissions; and
- development of effective media and public education campaigns to reduce smoking.

In addition, there are some further issues, measures and proposals to prevent and reduce tobacco use which the Taskforce may wish to consider.

Focus on primary prevention

Despite its stated intention regarding primary prevention of tobacco use, the Taskforce appears to place a greater emphasis on smoking cessation than on discouraging smoking initiation, and halting the progression from experimental to regular smoking.

RECOMMENDATION 14

A strategy for preventing tobacco use should include a strong focus on discouraging smoking initiation, and halting the progression from experimental to regular smoking.

Overall goals and specific targets

The AMA considers it important that a smoking prevention strategy has determinate overall goals, incorporates measures robust enough to achieve these goals, and specifies targets and objectives for each type of proposed measure. The Taskforce has proposed an overall goal of reducing the prevalence of smoking to 9% of the population or less by 2020. Achieving this goal, however, will require particular and intensive efforts to increase cessation among high prevalence groups. While the overall prevalence of daily smoking may be less than 17%, prevalence is 21% or slightly higher among Australians in their 20s, 30s and 40s³³, and is even higher among certain sub-populations.³⁴ The measures proposed by the Taskforce do not sufficiently target these high prevalence groups.

RECOMMENDATION 15

A strategy for preventing tobacco use should include a strong focus on measures targeted to population sub-groups with particularly high smoking rates.

There are also a range of demand reduction and supply control measures that the AMA believes should form part of a national approach to preventing tobacco use.

Demand reduction

Tobacco promotion

The AMA supports the phasing out of all forms of tobacco promotion. This should include all emerging forms of advertising and promotion (eg., electronic and internet).

RECOMMENDATION 16

The Tobacco Advertising Prohibition Act should be reviewed to address any loopholes regarding emerging forms of advertising and promotion (such as internet advertising).

³³ 2007 National Drug Strategy Household Survey. AIHW 2008.

³⁴ Smoking prevalence of 43% has been reported in the Victorian construction industry. Tony LaMontagne, 2007, *Health Protection & Workplace Health Promotion: A Strategy for Addressing Social Gradients in Smoking and Cessation?* McCaughey Centre: VicHealth Centre for the Promotion of Mental Health & Social Wellbeing School of Population Health, University of Melbourne, http://www.mccaugheycentre.unimelb.edu.au/presentations_library/Lamontagne_VH_Nov07.pdf

It is important that graphic warnings be placed on tobacco products and that they remain effective.

RECOMMENDATION 17

Health warnings appearing on tobacco packaging should be changed regularly, and be integrated with media and education campaigns.

Prevention and youth

A major demand reduction focus in primary prevention should be on young people. Given that more than 90% of Australians who smoke begin as teenagers and new users are as young as 14, 13 and even 12 years of age³⁵, it is essential to develop consistent, comprehensive and effective strategies to discourage the uptake of smoking among children and young adults.

RECOMMENDATION 18

- Children's media literacy, and resilience skills should be strengthened through the provision of media literacy and 'life skills training' at age-appropriate levels in school;
- Targeted demand-reduction strategies should be developed for tertiary educational institutions and in workplaces where the employee population is typically teenagers and young adults.

Tobacco pricing

As suggested previously, the AMA believes that price signals can affect consumer demand.

RECOMMENDATION 19

Taxes should be applied to increase the price of tobacco by 5% each year.

Supply control

Retail Licensing

The degree to which tobacco products are available through retail outlets contributes significantly to tobacco related harms. Potential sales outlets should be reduced.

RECOMMENDATION 20

- There should be a phased reduction in the number of retail outlets, and
- The distribution of tobacco products for promotional purposes, and the sale of tobacco products via the internet and from customer operated vending machines should be prohibited.

³⁵ *National Tobacco Strategy 2004-2009*, p.10 at [http://www.health.gov.au/internet/main/publishing.nsf/Content/E955EA2B5D178432CA256FD30017A522/\\$File/tobccstrat2.pdf](http://www.health.gov.au/internet/main/publishing.nsf/Content/E955EA2B5D178432CA256FD30017A522/$File/tobccstrat2.pdf).

Current regulations make it difficult to prohibit the importation to Australia of specific categories of tobacco product, such as cigarettes with characterising flavours (such as fruit flavours). These flavoured tobacco products have the potential to be attractive to young people.

RECOMMENDATION 21

Regulations should be revised to make it easier to prohibit the importation of tobacco products with characterising flavours.

Information for policy and program development

To ensure that a strategy for preventing tobacco use adopts informed and effective policies and programs, improvements should be made in the collection and analysis of information regarding tobacco use.

RECOMMENDATION 22

- State and Territory-level tobacco sales data should be collected and reported;
- A comprehensive Australian survey which includes information about teenagers should replace the Australian Secondary Schools Alcohol & Drug Survey, and
- Detailed information about tobacco companies' promotional expenditures should be required to be provided to the Australian Government.

The tobacco industry

The costs of tobacco-related harm should not be met entirely by governments and the wider community.

RECOMMENDATION 23

A levy should be imposed on Australian tobacco company profits, and the revenue raised should be used to finance cessation initiatives.

Government support for the tobacco industry should be minimized, as should the potential influence of that industry on political decision-making.

RECOMMENDATION 24

- Government superannuation funds should be prohibited from investing in tobacco companies, and
- Political parties should be prohibited from accepting tobacco company donations in any form.

Prevention of harmful alcohol use

The AMA has for some time advocated a comprehensive set of measures to discourage excessive alcohol consumption, and early onset of drinking, which incorporates:

- volumetric taxation - applying levels of taxation on the sale of alcohol beverages according to the percentage of a beverage's volume that is alcohol;
- legislation and regulation to control the marketing and advertising of alcohol, especially to teenagers and adolescents, and the sponsorship of sporting events by alcohol manufacturers;
- examination of the pricing policies at drinking venues, to ensure that non-alcoholic drinks are not more expensive than alcoholic;
- clear and prominent warnings on alcohol products, and clearly visible 'point of sale' signage in drinking venues showing levels of risky and high risk consumption (translated in terms of standard drinks/glasses);
- carefully devised and targeted media campaigns and school-based education informing of the risks of excessive alcohol consumption;
- examination of the regulations applying to opening hours of licensed premises.

The AMA is heartened to note that the Taskforce has endorsed many of these measures as part of its proposed strategic approach to excess alcohol use. There are further measures that can be undertaken to strengthen that strategic approach.

Managing the physical availability of alcohol

The physical availability of alcohol is an important determinant of alcohol use and misuse.³⁶ For example, increased trading hours for licensed premises have been associated with increased levels of alcohol consumption or alcohol related harm.³⁷ Similarly, there is evidence of a relationship between increases in the numbers of licensed venues and increased levels of violence.³⁸ The AMA believes that the impact of regulations relating to the positioning and opening hours of licensed premises needs to be closely examined. This is particularly so in the context of existing National Competition Policy, which supports competition in the industry which could in turn lead to increases in newly licensed premises and extensions of trading hours.

RECOMMENDATION 25

National Competition Policy should be reviewed to consider the merit of exempting regulations relating to the licensing of premises to supply alcohol.
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³⁶ *Alcohol misuse: tackling the UK epidemic*. British Medical Association. 2008

³⁷ *Restrictions on the Sale and Supply of Alcohol: Evidence and Outcomes*. National Drug Research Institute, Curtin University of Technology 2007

³⁸ *Restrictions on the Sale and Supply of Alcohol: Evidence and Outcomes*. National Drug Research Institute, Curtin University of Technology 2007

90% of 18-24 year olds have drinking patterns that place them at high risk of acute harm.³⁹ The AMA believes it is also important to consider options to address the supply of alcohol to consumers under the minimum purchase age. For example, the recently introduced NSW secondary supply law makes it an offence to supply alcohol to minors in a private home without the direct approval of a parent or guardian. There may be other regulatory and non-regulatory means of controlling the supply of alcohol to underage people.

RECOMMENDATION 26

Regulatory and non-regulatory options to control the supply of alcohol to underage people should be explored and evaluated.

Managing the economic availability of alcohol

Taxation is a broad policy instrument that is cost effective and likely to impact on overall consumption levels through influences on product prices.⁴⁰

RECOMMENDATION 27

An effective way to shift consumer preferences to lower alcohol beverages is to ensure that beverage prices reflect alcohol content. This can be achieved through uniform application of 'volumetric' taxation on the sale of alcohol beverages according to the percentage of a beverage's volume that is alcohol.

Improved Enforcement of Current Legislative and Regulatory Measures.

The AMA believes that retailers have a special responsibility to reduce the incidence and consequences of excessive alcohol consumption, particularly 'binge' drinking and the unlawful supply of alcohol to teenagers.

RECOMMENDATION 28

- There should be mandatory responsible service of alcohol programs to facilitate the training of licensees, managers, and industry staff in appropriate serving practices and refusal of services to intoxicated or under-aged customers, and
- Venues should be required to adopt appropriate oversighting and enforcement of responsible service practices.

³⁹ Bonomo YA, Bowes G, Coffey C et al. "Teenage drinking and the onset of alcohol dependence: a cohort study over seven years" *Addict* 99, 2004, pp.1520-8

⁴⁰ Doran C, Vos T, Cobiac L et al. *Identifying cost effective interventions to reduce the burden of harm associated with alcohol misuse in Australia*. Alcohol Education and Rehabilitation Foundation, 2008

Data and evaluation

The AMA believes that there is a clear need for improved availability of data on alcohol consumption and harms. The World Health Organisation has recommended that public health monitoring of alcohol use should include credible estimates of per capita alcohol consumption derived from sales data in addition to well conducted population surveys of drinking patterns.⁴¹ Local level sales data could be used to evaluate the effectiveness of local community initiatives. State level data can be used to evaluate broader strategies such as lockouts, tax increases and community based restrictions.

RECOMMENDATION 29

The collection of alcohol sales data should be significantly improved in order to evaluate programs, monitor behavioural change and determine levels of alcohol related harm.

⁴¹ *International guide for monitoring alcohol consumption related harm*. Geneva: WHO 2000.

Prevention of Obesity, Smoking and Harmful Alcohol Use Among Indigenous People.

A major challenge for a National Preventative Health Strategy will be to address the very significant levels of chronic disease that many Indigenous Australians experience as a result of high levels of smoking, alcohol misuse and obesity.

As a member of the HREOC Steering Committee for Indigenous Health Equality, the AMA holds the view that enduring reductions in the prevalence of these risk factors can only be achieved through sustained improvements in the access of Indigenous people to high quality, comprehensive primary care. Access to medical practitioners is especially important. The observations made earlier in this submission about the significant preventative role played by doctors apply equally in the context of Indigenous health.

In seeking to reduce the prevalence of smoking, alcohol misuse and obesity among Indigenous people, it is important to set appropriate targets. The AMA supports the targets for closing the gap in life expectancy between Indigenous and non-Indigenous Australians that are outlined in *Close the Gap – National Indigenous Health Equality Targets*.⁴² Of particular relevance to alcohol, smoking and weight risks are the following key targets:

- the rate of smoking in Indigenous population be reduced to that of the non-Indigenous population by 2020;
- 90% of Indigenous families to have access to a standard healthy food basket at the cost of less than 25% of their available income, within 10 years;
- the per capita rate of alcohol consumption in the Indigenous population to be reduced to the national average by 2020.

As non-Indigenous prevalence rates for these risks will hopefully reduce over time, these targets for Indigenous outcomes should also.

RECOMMENDATION 30

The National Preventative Health Strategy should incorporate relevant prevention and risk-reduction targets detailed in *Close the Gap – National Indigenous Health Equality Targets*, and should adopt appropriate measures to achieve those targets.

The AMA welcomes the recent COAG agreement to an Indigenous Health National Partnership, which will contribute a total of \$1.6 billion over 4 years for programs including those to reduce smoking rates, improve uptake of MBS funded primary care services and health checks by Indigenous people, expand the primary care workforce, and establish lifestyle modification programs to manage lifestyle risk factors.

⁴² Steering Committee for Indigenous Health Equality, 2008.