



Victorian Healthcare Association

23 December 2008

Preventative Health Taskforce Secretariat  
MDP 16  
Department of Health and Ageing  
GPO Box 9848  
Canberra  
ACT 2601

## **‘The fence at the top of the cliff’**

### **The Victorian Healthcare Association Submission on:**

Australia: The Healthiest Country by 2020 –

A Discussion Paper prepared by the National Preventative Health Taskforce

The Victorian Healthcare Association welcomes the opportunity to respond to the Paper "Australia: The Healthiest Country by 2020 – A Discussion Paper prepared by the National Preventative Health Taskforce [the taskforce]" [the Paper].

#### **The Victorian Healthcare Association**

The Victorian Healthcare Association (VHA) is the major peak body representing the interests of the public healthcare sector in Victoria. Our members are public hospitals, rural and regional health services, community health services and aged care facilities. Established since 1938, the VHA promotes the improvement of health outcomes for all Victorians, from the perspective of its members.

Over the past three years, the VHA has advocated on behalf of Victoria’s public health sector for a reformed health system that prioritises:

- Prevention
- Population health approaches
- Effective management
- Quality
- Safety
- Efficiency

In preparing this submission, the VHA has consulted its members and distilled a shared position aimed at improving the health of Victorians. This submission remains the position of the VHA and does not supersede any submission or position stated by any member agency.

#### **Prefacing Comments**

The rapid acceleration of chronic disease, estimated to cause approximately 80% of the total burden of disease in Australia, can only be successfully reduced by preventative action. The VHA applauds the steps towards the development of a National Preventative Healthcare Strategy to bring a true preventative focus to the Australian health system and society, more broadly.

Australians are living longer than ever before and have experienced significant improvements in quality of life over recent decades. However, the emerging challenges of demographic change, concentration of morbidity among the elderly and widening social inequalities impact on the provision of efficient and effective health services. As noted by the Federal Minister for Health, Nicola Roxon, ‘poor health thrives on inequality, just as inequality thrives on poor health’<sup>1</sup>.

The VHA and its members are concerned about the narrow role of health services outlined within the Paper. The Paper aligns health services strongly with the concepts of health education and considered the disseminators of resources and information to assist people to make behaviour change. However, the VHA would argue that health services play a more



Victorian Healthcare Association

substantial role in operationalising the social model of health and integrating health promotion into service provision. There is widespread interest across the primary healthcare sector regarding the prospect of a system that further strengthens this approach.

The VHA calls on all areas of government to be held to account for the impacts of their policy on health outcomes, with a cross-governmental response to the determinants of health. This will require all current health reform bodies to work in coordination to achieve an integrated response. Whilst a mobilised and well-funded health sector will be able to contribute to improved health outcomes, the root causes need to be addressed. A purely disease-based approach mitigates against addressing the social determinants of health.

### **The Victorian Health System**

The VHA believes health services have a health-promoting influence, with primary healthcare principles entwined in these efforts. Illness prevention and health promotion remain a fundamental role of the Victorian health sector, which does much more than cater for those that walk through the door. Health services, driven by the governance of boards, engage with communities at the local level to build supportive environments. This is a unique strength of the Victorian approach. To make further gains, the VHA believes health service boards should be required to report on their contribution to the health outcome of the community as well as on financial and clinical outcomes. The function of the health system is to facilitate health and therefore requires evaluation. Targets for health services could include: increases in community-wide health, reductions in health inequalities and increased community wellbeing (as demonstrated by Community Indicators Victoria).

The VHA believes this local 'social contextual' approach must be incorporated into a national strategic framework for preventative health, in tandem with the economic and regulatory activities described in the Paper. Victoria's health services perform enormous amounts of cross-sectoral work in order to address health in a holistic way, forming coalitions with local government, Royal District Nursing Services, Victorian Aboriginal Health Services, Centrelink, housing services and other relevant community bodies.

Primary health services in Victoria currently use a range of existing health promoting strategies to address the social determinants of health and the issues prioritised by the Taskforce. Examples of good practice will be mentioned throughout this submission and should be incorporated into the existing body of evidence that informs the Strategy.

### **Population Health**

The VHA is concerned about the terms of reference of the Preventative Health Taskforce, that focus on the 'burden of chronic disease currently caused by obesity, tobacco and the excessive consumption of alcohol'<sup>2</sup>. Whilst the VHA acknowledges the dire consequences of these societal issues, they must be considered symptomatic of the problem and not the problem in themselves. Interventions at the risk factor level will only succeed with significant investments being made at the determinant level. Despite this, the VHA broadly supports the principles and suggestions outlined in the Paper and encourages their consideration and subsequent implementation.

Whilst access to healthcare systems is a vital determinant of health, health services can do much more than treat disease when it occurs. Research by the Social Research Centre and VicHealth identified that responsibility for population health is seen by consumers as a shared government, community and individual responsibility<sup>3</sup>. While 91% agree that 'individuals have to take full responsibility for their own health', there is also strong agreement that 'schools need to do more to educate children about health issues and healthy lifestyle choices' (84%) and that 'governments have the main role to play in promoting good health' (78%).



The rural population is of particular significance in terms of health service provision. Higher levels of avoidable mortality occur in rural and remote areas in addition to higher levels of admissions for ambulatory sensitive conditions<sup>4</sup>. In addition, rurality and the impact of climate change across Australia will continue to exacerbate the ongoing poor health outcomes for rural Australians. People most vulnerable will be the elderly, chronically ill, socioeconomically disadvantaged and those who rely on climatic conditions for their livelihood and do not have sufficient resources and capacity to adapt<sup>5,6</sup>. Health responses need to consider this particular need.

Disparate approaches to population health policy and its implementation leads to a lack of shared understanding and negates the likelihood of shared goal setting and the achievement of outcomes. Without a more homogeneous understanding and approach towards health system improvements, gains will be slower to identify and achieve. To facilitate this, the VHA believes effective planning is required at a community level to determine the most important issues (where the most need and impact is required), to ensure a long-term view to facilitate prevention and to ensure health services are pro-active rather than reactive in their service planning.

#### **Population health rather than blaming the victim**

Baum notes that whilst it is "probably true that if people were to eat less fat, exercise more, buy safer cars, lead less stressful lives and avoid violence they would be healthier. The beguiling simplicity of the logic, however, ignores many extraneous factors that make change difficult to achieve and ignores the social, cultural and economic context in which decisions are taken"<sup>1</sup>. In the population approach, public health measures are implemented to reduce the level of risk in the whole population. The VHA/Monash University "Best-practice in the use of population health approaches to address chronic disease" project will further inform this approach.

#### **Funding**

A 2008 report by the Australian Institute of Health and Welfare (AIHW) estimates Australia's total investment in "public health" activities is currently 1.8% of recurrent health expenditure<sup>7</sup>. The other 98% was spent on "hospitals, medical centres, pharmaceuticals and other treatment for people who were already sick"<sup>8</sup>. This 1.8% is both inadequate and disproportionate to contemporary health issues. Unfortunately it has remained unchanged for almost a decade.

The health sector is concerned about the "short term project driven" nature of health promotion/illness prevention funding. This limits progress, longevity, continuity and long-term examination of success. To make significant gains in prevention, long term-systemic funding is required that transcends political or planning cycles, especially when targeting the complex causes of poor health. The VHA highlights the applicability of Professor Fran Baum's notion that to end the frustrating era of "projectism", funding should be for a minimum of five years and be granted only if local agencies are committed to sustaining successful projects<sup>9</sup>.

Jennifer Doggett argues that "the best way to take the pressure off hospitals is to ensure that most people don't need to go there in the first place"<sup>10</sup>. Rebalancing health financing is an important component in health reform. The VHA welcomes the Council of Australian Governments (COAG) new funding arrangements of \$450 million into preventive programs and recommends further investment. However, there is some concern that this funding boost merely means more money to train people to work the same way as they've done for 150 years<sup>11</sup>. The VHA supports the notion in the Paper that Australian governments, at all levels, have a role to play in funding and supporting programs in community, schools and workplaces backed by leadership and evaluation.



In the context of the global financial crisis, British Prime Minister Gordon Brown recently stated *"some say that this period of global financial turbulence is a time where we will have to put our wider ambitions on hold and to retreat from plans to build a fairer and better world. There could be no worse time than this to turn back"*. Investments in disease prevention and health promotion are recognised worldwide as effective and represent the highest levels of value for the funding they attract. This is demonstrated by a Department of Health and Ageing report<sup>12</sup> of five major health promotion programs that found substantial returns to society and the government. Increased wise investment could reap further benefits.

### Person centred health

The health sector has a responsibility to facilitate access to appropriate care at the right time, in the right setting, and with a particular focus on care in the community. Community care should, ideally, be provided by (or supervised by) multi-disciplinary teams of professionals that empower individuals. The VHA supports shifting the focus holistically towards the client rather than the client's specific illness or disease at a particular point in time. People in certain socioeconomic situations do not always have the necessary control over their circumstances to change factors influencing their health or the capacity to make healthy choices.

If Australia wishes to remain committed to a socially segregated community containing extremes of wealth and poverty, it must necessarily put up with the resultant gaps in health status between rich and poor. Health is therefore not the sole responsibility of the individual and health professionals, but of society as a whole. For example, there exists good evidence that the years from conception through to age five set a pattern for the rest of life. Society plays an important role in this development.

The 2020 Summit held in Canberra in 2008 noted that the "relative benefits of strategies to improve health and wellbeing in the early years – strategies that may include improved family planning and antenatal care, better delivery of services, improved parenting, methods to improve cohesiveness of families and communities, access to high-quality early childhood education – will have the greatest impact for people with the worst health outcomes"<sup>13</sup>. For this reason, the VHA believes a one-size-fits-all approach to service delivery does not suffice. What is required is a multiplicity of approaches to care, backed by principles of equity.

### Keys to prevention

The VHA recognises that health depends on more than the healthcare system alone. Even in countries with universal access to healthcare, people with lower socio-economic status have poorer health outcomes<sup>14</sup> as a result of the social gradient<sup>15,16</sup>. Health is not equally distributed among the population with some possessing significantly worse health than others. This has ramifications for healthcare systems that can be partly solved by preventative action.

The VHA believes reducing inequalities in health both between and within populations and regions remains one of the most important challenges for society and the causes and solutions for issuing change vary between communities. Health policy impacts on all levels and areas of government, and therefore the answers require the work of these very stakeholders. The recent National Prevention Summit in Melbourne concluded that a comprehensive and sustainable approach to prevention is needed that considers both immediate risk factors as well as the social determinants of health<sup>17</sup>.

The VHA proposes the following actions to reduce the inequalities and inequities between population groups, as outlined by Oldenburg, McGuffog and Turrell<sup>18,19</sup>.

1. Changes to macro-level social and economic policies
2. Improving living and working conditions
3. Strengthening communities for health
4. Improving behavioural risk factors
5. Empowering individuals and strengthening their social networks



## 6. Improving responses from the healthcare system and associated treatment services

### The case for prevention: overweight and obesity

The prevalence of obesity is increasing at an alarming rate, with childhood obesity particularly concerning. This rising epidemic is due to the profound changes in society, with “projections so serious that public health action is urgently required”<sup>20</sup>. The VHA supports the proposals outlined in the Paper and supports comprehensive policy that ensures food is safe, secure, healthy, affordable, available and accessible and the rate of physical activity is boosted through initiatives within schools, workplaces, health services, sport and recreation facilities and organisations, the fitness industry, local government and other stakeholders. This involves modifying the physical environment to secure infrastructure to support healthier lifestyles.

#### Victorian Lifestyle and Neighbourhood Environment Study

The Victorian Lifestyle and Neighbourhood Environment Study (VicLANES) identifies that people in low socio-economic status (SES) areas are **less likely** to purchase groceries that are low in fat, high in fibre, low in salt, low in sugar and that they purchase fewer fruits. In addition, **twice as many** people purchased fast food weekly in low SES areas (14%) compared with people in high SES areas (7%).

People in low SES areas were **less likely** to be influenced by health considerations when buying food and **more likely** to be influenced by the price of food and think that healthy food choices were limited<sup>2</sup>.

#### What is a realistic target for 2020?

The VHA seeks the development of links between policies and processes in different sectors and social structural levels to “stabilise the level of obesity, reduce the incidence of new cases and reduce the prevalence of obesity”<sup>21</sup>. Whilst the VHA endorses the target of halting and reversing the rise in overweight and obesity, we emphasise that this cannot be done without comprehensive partnerships and flexible funding.

#### How can key players (for example, individuals, communities, health services, industry and governments) be engaged from the outset?

All major employers, especially hospitals and other healthcare providers, have a duty to lead by example to build a health promoting culture. This means providing healthy food options and encouraging employees to be more physically active<sup>22</sup>.

The following are areas of focus needed to prevent obesogenic environments and the rising tide of obesity:

##### 1) Access to healthy food and food insecurity

Access to safe, nutritionally adequate, culturally acceptable food from non-emergency sources is shaped by income growth, climate change, high energy prices, globalisation, and urbanisation. This requires the transformation of food consumption, production and markets<sup>23</sup>. It is, unfortunately, cheap to become obese. To reverse this trend, the VHA believes profound change is required at political, economic, and societal levels. Attempting to reduce population levels of obesity by seeking to change individual behaviour will not address population wide issues, if the economic barriers to healthier options are not also addressed.

##### 2) Healthy Promoting Settings

Health facilities are ideally placed to model healthy lifestyles to the broader community, including dietary behaviour, and act as partners in prevention. Vending machine snacks are a



prime example of convenience foods that are pervasive in community settings such as health services, train stations, schools, universities and sports facilities. Not only are vending machines widespread, the food choices are largely high in salt, fat and sugar. Limiting unhealthy choices within public settings could be a key aspect in the effort to prevent obesity and its co-morbidities. The *VHA Tackling Obesity: Healthy Food Labelling in Victoria's Health Services* position statement<sup>24</sup> calls for a simple colour-coded nutritional guide for all food and drinks sold at public hospital and health service cafeterias and vending machines.

### 3) Advertising of unhealthy food

The pervasive nature of food marketing and product placement within society should not be underestimated, nor should it undermine the goal of good health. Food advertisers invest heavily in researching what prompts certain groups of people to buy particular food items, and subsequently use this information to advertise in ways likely to appeal to consumers<sup>25</sup>.

The Public Health Association of Australia states *"there are no effective controls on the promotion of junk food. Junk food promotion is everywhere, ruthlessly aimed at kids and parents. The voluntary codes are feeble and poorly enforced, and do nothing to curb the industry's massive investment in targeted advertising and sports sponsorship"*. The VHA supports the Taskforce's specific recommendation to curb inappropriate advertising and promotion during children's viewing hours and expresses disappointment at the Senate committee's rejection of the *Protecting Children from Junk Food Advertising (Broadcasting Amendment) Bill 2008*.

### 4) Labelling of nutritional information

Many people feel overwhelmed by the choices available to them and even anxious about what a healthy diet contains<sup>26</sup>. The VHA believes the nutritional content of snacks and beverages must be evaluated and colour-coded based on a quantitative methodology. The 'traffic light' system as endorsed by Zimmet<sup>27</sup> and the Obesity Policy Coalition<sup>28</sup> has merit in simplifying food labels to enable the population to quickly identify healthier snacks and beverages from the less healthy options. This results in consumer empowerment.

### 5) Ensuring healthy public policy

Equally important to health and wellbeing is the role of physical activity in energy balance and weight maintenance<sup>29</sup>. The VHA recommends the continual evaluation and investment in *Go for your life* and also in local programs in community health centres. Healthy societies "balance economic, social and environmental concerns through the ongoing development of community capacity – achieved through a fusion of programs, policies and investments"<sup>30</sup>. In 2005, Japan enacted the Basic Law on Shokuiku (Food Education) to tackle concerns about diet-related disease and poor eating behaviours such as irregular meals, poor body image, and the erosion of traditional food culture by globalisation<sup>31</sup>. This approach demonstrates how governments can facilitate healthier populations without imposing paternalistic or 'nanny state' approaches.

#### Eroding Obesogenic Environments

The Be Active, Eat Well four-year pilot project<sup>3</sup> that began in 2002, compared the growth of 1,800 Colac children aged 2-12 years against sample groups from Victoria's south-west. Reductions were seen in weight and waist growth at a population-wide level, which included children across the socio-economic spectrum.

Without comprehensive social policy and rebalanced health investment, Australia will struggle to redress the obesity epidemic. The Be Active, Eat Well project eroded the obesogenic environment in Colac by enabling healthy settings in schools, recreation and sporting facilities, health services and fast food outlets across the town.



### **What is the best combination of 'learning by doing' and, at the same time, building the evidence base?**

Ensuring that healthcare is of high quality, efficient and effective requires evidence. Substantial data about the health system is collected, but it is difficult to analyse it in a useful and meaningful way. Australian studies that address the cost-effectiveness of health promotion strategies should apply a greater proportion of the research funding pool to informing the Strategy.

Determining the effectiveness of interventions is too often disregarded. While the educative and agenda setting components of health promotion are understood, other aspects of the health promotion agenda, such as advocacy for social change and infrastructure and community building, are less well understood<sup>32</sup>. Fundamental to the success of preventative activity is the integration of evaluation within projects from their commencement.

The VHA position statement '**Planning for optimal health outcomes: improving access to data**' calls for the establishment of a national health data 'portal' to integrate data from various sources and make it publicly available. This site should incorporate Geographic Information System mapping capabilities.

To integrate a preventative approach into health policy, it is imperative that data feeds into aligned planning cycles. Anecdotal evidence within Victoria highlights that Primary Care Partnerships (PCPs), local government and health services currently plan separately as a result of funding and reporting guidelines based on divergent data and varied planning cycles. This results in duplication despite a common focus to meeting the needs of the community. Only structural change can remove these barriers and ensure plans and requirements align.

Planning across health services and local government aims to empower local communities and facilitate cooperation between services on key health issues. This is based on monitoring and evaluating health and wellbeing. Common planning cycles would facilitate funds pooling and effective resourcing, and thus reduce duplication.

The VHA purports that the alignment of these processes, locally and nationally, would benefit the health system through efficiency gains and produce a more cohesive data system and information set to guide development.

### **What can individuals and families do to be physically active eat well and maintain healthy body weights?**

Cornell University's Jeffrey Sobal argues that global food systems and mass media are the underlying causes of increases in global obesity with corporations establishing almost constant 24 hours a day/7 days a week/365 days a year consumer access to virtually unlimited volumes of relatively inexpensive calorie dense foods to all people in all places at all times<sup>33</sup>.

The problem of overweight and obesity cannot be tackled by focusing solely on the individual. It is not merely a product of poor individual choices, but is influenced by a person's social, physical and economic environment. A myriad of environmental, social and manufacturing factors ensure that it is a 'product' of the system to become overweight or obese.

The Paper (pg 16) discusses the need to embed physical activity and healthy eating in every day life, highlighting schools, workplaces and communities as key settings. The Paper notes health services have a role in community programs. Whilst the VHA support this, it is crucial to note that health services also have a large role to play in school and work based programs.



### **Workplace Settings**

'Towards a Healthy Heart' is a structured primary prevention program developed by Portland District Health to address the risk factors for heart disease in men, with the aim of reducing the total risk factors for heart disease for men within the high-risk age group of 30-60 years. **Towards a Healthy Heart** is unique in that it links partners in health, sport, industry and local government to bring about sustained change in this hard to reach group. The program consists of four risk factor assessments (pre, post, 6 months and 12 months), twelve weeks of group education, twelve weeks of physical activity sessions and individualised health coaching (where necessary) to promote sustained behaviour change. The program is based on a workplace settings model involving floor staff, middle and top management with the employer contributing to the program by allowing workers to attend in work time.

### **In what ways can high-risk groups be supported?**

#### **Open Space for All**

A recent study by Mitchell and Popham<sup>34</sup> shows the health gap between rich and poor can be halved with the help of green spaces. Simply, green spaces should be available on health and wellbeing grounds rather than merely on the basis of neighbourhood amenity and environmental considerations. This research, coupled with research by Townsend<sup>35</sup> highlights that open spaces promote physical activity, can be psychologically and physiologically restorative. They can contribute to reduced blood pressure and stress levels and possibly promote faster healing in patients after surgical intervention.

#### **Regulation**

Whilst labelling is one form of intervention, reforms within the manufacturing and production level are another form of intervention that the VHA supports. For example, regulation through Food Standards Australia New Zealand (FSANZ) of the use of trans fats has the potential for improving food intake. The VHA also endorses further research on the role of preservatives, additives and other 'fillers' present in processed foods.

North Yarra Community Health in partnership with the City of Yarra has developed a community gym program where local agencies can purchase a gym membership and allow it to be shared by a number of high risk, vulnerable people. This program is considered an enormous success with a large number of previously disenfranchised or isolated people now using the local leisure centre.

### **Are the priorities for action appropriate? If you do not think they are appropriate, or have other suggestions, what would you propose we do as a nation to halt the toll of early deaths and disease caused by overweight and obesity?**

Australian estimates suggest that increasing rates of fruit and vegetable consumption by just one serve per day would save between \$8.6 million and \$24.4 million in healthcare costs associated with breast, colorectal, prostate and lung cancer in Australia<sup>36</sup>.

Page 17 of the Paper calls for reshaped urban environments that encourage health, however health services are not noted as a stakeholders in this area. MonashLink Community Health Service in partnership with Monash Council and the Department of Human Services recently opened a centre in Clayton. The \$24.2 million Community Centre was designed to be an important 'community hub' for the area which contains the 'Clayton Public Library, the Clayton Aquatics and Health Club, a theatrette, pre-school, occasional care, youth and family services,



maternal and child care services, café, meeting rooms and MonashLink community health services. The VHA believes this is an important example of how health services can play a vital role in reshaping urban environments to facilitate health and community wellbeing.

## The Case for Prevention: Tobacco

Australia is at the forefront of the battle to control the social consequences of tobacco through the use of regulation, denormalisation of smoke-friendly venues and anti-smoking campaigns. There is, however, a strong social class factor evident among smokers, with the less educated and less well remunerated over-represented in this population<sup>37</sup>.

A recent review of the effects of population tobacco control interventions (an intervention applied to a population, group, area, jurisdiction or institution with the aim of changing the social, physical, economic or legislative environment to make them less conducive to smoking) demonstrates that population-level tobacco control interventions have the potential to benefit more disadvantaged groups and thereby contribute to reducing health inequalities<sup>38</sup>.

Australians now expect smoke-free environments as a result of legislation and cultural change and this has modified social norms. The VHA supports this proactive prevention policy into the future to create healthy settings for people to live, work and play.

Tobacco is the only legally available consumer product which kills people when it is used entirely as intended<sup>4</sup>. Every cigarette contains more than 4,000 chemicals, 200 known poisons, at least 69 known or suspected carcinogens in every cigarette, and over 50 diseases can be caused by smoking<sup>5</sup>.

**There is clear and unequivocal evidence that two actions by government will decrease the number of Australians who die early because they smoke:**

- **increasing the price of tobacco products**
- **sustained, well-funded, hard-hitting public education campaigns**

The cure for this devastating epidemic is not dependent on medicines or vaccines, but on the concerted actions of government and civil society<sup>39</sup>.

**Do you support our government taking the following actions, which in combination could halve smoking rates?**

- **progressively increasing the tax on tobacco products to the levels in places such as Ireland, Scandinavia and the UK, and reaching \$20 for a packet of 30?**

The pricing of cigarettes has long been utilised as a major method of reducing consumption.

Increases in taxation rates for tobacco may not be as effective a method of reducing consumption within lower-income groups as has been assumed. It is suggested that these taxation policies penalise 'low-income smokers', as a disproportionately large amount of their income is spent on tobacco compared to higher-income groups. Specifically, 'tobacco taxes can contribute to financial hardship among low socio-economic status populations where smoking persists<sup>40</sup>. This, in turn, results in a reduction in this group's access to resources and exacerbates economic hardships<sup>41</sup>. The VHA recommends placing more focus on reducing the cultural attractiveness of tobacco products, eroding the capacity of the tobacco industry and placing particular emphasis on reducing smoking uptake through the removal of cues and lures to smoking.

Raising prices is often used as a disincentive to alter people's behaviour. Much can be gained by reversing this notion to encourage healthy choices. Lowering prices for some products and services can be an incentive for healthy behaviour. Simply, if price can act as a driver for



people to reduce smoking, price can be an enabler to facilitate health behaviours. Examples include, subsidising the cost of access to gyms for people most at risk (e.g. public housing estates) and lowering the cost of healthier foods.

- **investing \$40–50m a year in public education – less than 1% of revenue from tobacco tax**

There have been an abundance of smoking education programs trialled globally with varied of success. Most benefit from quitting coming earlier in life as opposed to later in life<sup>42</sup>.

Whilst the majority of the population are aware that smoking is harmful, research demonstrates that many people are unable to personalise the threat due to the 'lag time' between the commencement of smoking and the manifestation of disease. Because the associated harms do not lie in the immediate future, Borland argues that it is not emotionally salient and tends to be more easily dismissed<sup>43</sup>.

The VHA highlights the need for caution about the role of public education. Some participants in the Social Research Centre and VicHealth research note that people feel the market is saturated, there are mixed messages and also that certain tactics become 'background'<sup>44</sup> information in thought processes.

Individual behaviours are often complex and having more knowledge is no guarantee of change. Whilst behavioural approaches have some demonstrated benefit and have a role to play, the VHA believes they must remain one component of an overarching strategy that encompasses social change, empowerment, personal skill development and supportive environments. This includes clinicians and practitioners, who may require guidance to shift to a preventative model.

Whilst health services have an important role to play in devising education programs for their communities of interest, they also act as agents of social change, enabling communities to manage and improve their general wellbeing.

**If you do not support these actions and investment, or have other suggestions, what would you propose we do as a nation to halt the toll of early deaths and disease caused by smoking?**

- **Should we prohibit all remaining forms of promotion of tobacco products and mandate plain packaging?**

The VHA submission to the Victorian Tobacco Control Strategy 2008- 2013 Consultation argues that point-of-sale displays normalise the purchase of tobacco and in-turn smoking behaviours<sup>45</sup>. The VHA endorses further legislative requirements on tobacco packaging, such as plain packaging and a table detailing the amount of toxic substances found in that particular brand of cigarette (as seen in Canada).

Preventing children from commencing smoking relies on a healthier society with healthier norms. Banning tobacco point-of-sale displays will also assist 'quitting'. Recent research by Wakefield demonstrates that 40% of smokers who tried to quit experienced an urge to purchase cigarettes as a result of seeing tobacco product displays<sup>46</sup>. Point-of-sale retail displays *promote smoking initiation, impede cessation attempts and promote relapse among quitters*<sup>47</sup>. Therefore, the VHA supports a complete ban on tobacco point-of-sale displays resulting in tobacco products being stored in a way that prevents consumers from seeing them prior to purchase.

Examples of **acceptable** alternatives found worldwide include:

- Overhead containers that ensure tobacco products are visible only to staff



- Below-the-counter drawers or cabinets that ensure tobacco products are visible only to staff
- Slim drawers that open in sections and expose the spine only of cigarette packages

Signs referring to the sale of tobacco must only detail tobacco products sold and the product price with black text against a white background. There should be no visual identification of a brand of tobacco or tobacco-related product.

In addition, the VHA argues that the text of a sign must not be visible from outside the retail establishment and recommends a maximum of two signs per retailer. A time frame of between 3-6 months to implement these changes is appropriate but the end result, of reformed tobacco point-of-sale displays is paramount.

- **Should we move by 2020 to a system where cigarettes are sold only through a limited number of specially licensed outlets?**

Tobacco is an anomaly as a public product, as it is equally or perhaps more widely available than basic commodities such as milk and bread, being available from milk bars, petrol stations, supermarkets, news agencies, convenience stores, vending machines, alcohol retailers and duty free stores<sup>48</sup>.

The influence of 'ease of retail access' to cigarettes on smoking activity or on attempts to quit has received limited attention in the literature<sup>49</sup>. However, research has demonstrated the link between high retail tobacco outlet density and smoking uptake<sup>50,51</sup>, being disproportionately located in neighbourhoods characterised by social and economic disadvantage<sup>52,53</sup>.

In addition, 'specialist tobacconists' should be defined by a measure of gross operating revenue. At least 60% of gross operating revenue should be associated with sale of tobacco or tobacco products. This is the definition that has been used in many other jurisdictions. In addition, these retailers should not be able to sell products designed for children, confectionary, or products of convenience such as milk, newspapers or transport tickets.

The other area the VHA recognises as important is in relation to banning cigarette vending machines and associated advertising in areas frequented by teenagers and young people. In addition, tobacco products should not be sold in cafes or kiosks located at, or in connection to leisure facilities or public spaces.

The Philip Morris tobacco company announced a new campaign to market slim pink cigarettes to women called Super Slim implies a link between cigarettes and weight loss for girls and women, who are already known to be very concerned about body image<sup>6</sup>.

The VHA believes the Minister for Health's capacity to ban particular tobacco products and packaging should be based on criteria such as; the intention to unduly target non smokers, the intention to unduly target children, the intention to unduly target adolescents, and the intention to target those who have not initiated smoking behaviours.

- **What more can we do to protect children and adults from exposure to second-hand smoke?**

The uptake of smoking by young people is of particular concern as the earlier the initiation of smoking, the earlier the risk of smoking-related disease and addictive behaviour setting. This will impact on the future needs of the health system.

Children are especially vulnerable to Environmental Tobacco Smoke (ETS) smoke.



When adults smoke in the enclosed, confined interiors of cars small children, who are passengers, are involuntarily exposed to prolonged, concentrated volumes of ETS<sup>11</sup>. A growing body of scientific evidence has concluded that ETS significantly harms the health of non-smokers<sup>54</sup> and that smoking in cars, even with the window down, produces at least as much harmful ETS smoke as the smokiest bar<sup>55,56</sup>.

A poll by Action on Smoking (ASH) Australia and Pfizer Australia found that 73 percent of smokers support banning smoking in cars carrying children, with 90 percent of Australians in favour of smoke-free cars. The VHA supports the Cancer Council's proposal that calls for bans on smoking in cars with children<sup>57</sup>, coupled by appropriate levels of enforcement.

As stated in the *NSW Protecting Children from Tobacco*<sup>58</sup> document, banning smoking in cars where children are present would:

- Reduce exposure to ETS in a common, confined setting
- Send a powerful message to parents about the detrimental health effects of children being exposed to environmental tobacco smoke
- Protect children from involuntary exposure to environmental tobacco smoke
- Further contribute to making smoking not a social norm

Physically and biologically, the human body is still developing between the ages of 16-18. Therefore, the VHA encourages the alignment of policy across Australia to ensure that those aged under 18 are not susceptible to avoidable ETS or specifically marketed to, implicitly or explicitly.

### **Additional comments**

The VHA supports tobacco control being placed firmly back on the agenda.

Recent experience (in several jurisdictions and organisations) suggests that policies to directly erode tobacco industry power may contribute to the effectiveness of comprehensive tobacco control programs<sup>59</sup>. The VHA calls for political commitment to erode industry power and optimise health outcomes. Examples include truth campaigning<sup>60,61</sup> and the continued reductions in tobacco brand visibility. The VHA believes these strategies should be further developed in both reach and scope.

Smoking became popular well before the health risks of smoking were established and published, with the first evidence appearing in the early 1950s<sup>62</sup>. Cultural change is required to reverse the trends that are embedded in social norms.

With regard to Indigenous outcomes, Vos et al argues that 17 per cent of the health gap between Indigenous and non-Indigenous populations is due to smoking<sup>63</sup>. Smoking may play a role in ensuring social cohesion, reinforcing family relationships and friendships, and affirming cultural identity; not smoking may, in fact lead, to social isolation<sup>64,65,66</sup>. The VHA supports the Close the Gap campaign and appreciates that these social considerations are being incorporated into Indigenous smoking prevention programs.

### **The Case for Prevention: Alcohol**

Whether we drink is not the issue. It is how we drink and our attitude towards getting drunk that is the problem<sup>67</sup>.

Whilst personal responsibility is a key determinant of alcohol misuse, drinking behaviour is strongly influenced by organisational, economic, environmental, and social factors<sup>68</sup>. The VHA supports an approach in Australia that prevents and reduces alcohol related harm and promotes a healthier and safer drinking culture across all social and cultural groups.



There is strong evidence that approaches that combine educational with other behavioural, environmental, policy and organisational changes are likely to be the most effective compared to those to bring about change in drinking behaviour through education alone<sup>69</sup>.

Many preventable presentations to health services are as a result of the negative effects of alcohol. These include injury, violence, loss of income, unplanned pregnancies, liver disease, cancer, hypertension and heart problems. Specifically, within Victoria, alcohol contributes to 24,714 hospitalisations, 8000+ emergency department presentations, 759 alcohol-related deaths, 13,000 seeking treatment for alcohol problems, 10,000+ people arrested for public drunkenness and 1,500+ assaults in licensed premises<sup>70</sup>.

Conversely, settings like emergency departments, ambulance services, client intake and dental chairs should be considered as appropriate environments for brief interventions. Non-clinical points of contact such as youth workers, community elders, youth mentoring programs and police programs are opportunities for engagement.

Rural areas have high levels of assaults, alcohol-related motor accidents and high levels of licensed outlets per capita. The Sustainable Farm Families program has also identified high levels of alcohol consumption in the farm family participants particularly in number of drinks per occasion. People living in rural and remote zones have less access to services compared with those living in the metropolitan zones and therefore innovative programs are required.

#### **Sustainable Farm Families**

The VHA award winning Sustainable Farm Families Program initiated by the Western District Health Service, Hamilton, draws on health promotion, primary prevention and community development to address the health, wellbeing and safety of farm families. Sustainable Farm Families meets many of the actions suggested by Oldenburg, McGuttag and Turrell

- By improving both the living and working conditions - farms are homes and workplaces so 'double bang for the buck'
- Strengthening communities – all workshops are conducted in local communities and mix industry, health, and farmer groups together, as well as supporting local infrastructure and capacity
- Improved behavioural risk factors - which are evidence based and proven by the published evaluations and reports
- Improved social networks - due to the capacity building and cross sectoral collaboration in each community
- Health service providers report improved engagement with farm families who have previously been recognised as hard to engage and stoic

#### **Do you support a focus on the suggested priorities?**

**If you do not support these actions, or have other suggestions, what would you propose we do as a nation to halt the toll of early deaths and disease caused through alcohol-related harm?**

Over time, population-based public health approaches have been neglected in favour of approaches oriented to the individual that tend to be more palliative than preventative<sup>71</sup>. Research by Hill argues that most mass media health promotion campaigns on alcohol and other drugs can increase knowledge but appear to have little impact on actual behaviour<sup>72</sup>. This evidence is compounded by the recent review of alcohol policy research sponsored by WHO which gave a low rating for all education and persuasion strategies that target individual behaviour<sup>73</sup>.



The VHA endorses efforts in the following areas:

**Drinking Culture:** As noted in the Paper, cultural change is not instant and requires time. The VHA endorses further promotion and supports effective program in schools about how to address the decision making processes aligned with alcohol and the encouragement of responsible alcohol use. These sessions need to facilitate empowerment and skill development rather than victim blaming or authoritative 'one-way' lines of communication.

**Venues:** Staff of licensed premises must be trained to manage alcohol related problems that may occur, especially those that result from intoxication. In addition, the VHA call for stronger measures to discourage promotions within licensed premises that encourage excessive or irresponsible drinking.

**Consumer:** Those who decide not to drink should feel comfortable that this is an acceptable option. Health services have particular knowledge of their communities of interest, and therefore have capacity to inform the debate regarding how certain groups will address alcohol-related harm and determine particular priorities. Targeting drinkers in isolation will affect demand, but fails to address the ingrained culture of supply at high volume and thus must be only one component of a prevention strategy.

**Enforcement:** Enforcement activities must primarily target supply control. This necessitates targeting suppliers of alcohol, particularly on-premise supply and the promotions used to lure customers that have flow-on affects for demand reduction and problem limitation. Supply control strategies have an important role to play in reducing alcohol-related harm by restricting the availability of alcohol. However, this requires stronger enforcement, particularly relating to identification checks for liquor purchasing by suspected minors.

**Industry:** The alcohol industry plays a pivotal role in determining cultural norms of alcohol consumption and must be engaged in efforts to prevent alcohol misuse. The Paper discusses changes to the current taxation regime that stimulate the production and consumption of low-alcohol products. Australia is already far ahead of other countries with its variety and access to low alcohol beverages but more can be done, such as ensuring every venue offers a light-beer option on tap. The VHA supports the removal of tax deductibility for advertising and the development of a staged approach to restrict alcohol advertising, as noted in the Paper.

### **What are the most important issues that can engage support from individuals, communities, industry and governments and drive cultural change?**

Strategies such as changing the drinking culture by de-emphasising alcohol's role within society are important steps to drive necessary cultural change, particularly changing the 'drink to excess' mentality. Harm-reduction methods include reducing alcohol outlet density, promoting the use of opportunistic brief interventions and increasing the support for alcohol-free events.

In combating the harm associated with excessive alcohol consumption, institutions can adopt strategies that include:

1. Reducing alcohol availability
2. Reducing alcohol outlet density near key public facilities
3. Promoting host responsibility strategies
4. Supporting treatment and prevention services
5. Encouraging a 'health-promoting setting'

The VHA strongly agrees with the importance the Paper places on addressing the cultural aspect of alcohol. The media and celebrity culture play a significant role in shaping drinking habits, particularly for young people. Therefore, broadcasting standards related to the



promotion of intoxication and risky drinking practises must be considered, with breaches to the code resulting in educative tactics rather than punitive action. This results in organisations becoming partners in the prevention process.

### **What prevention strategies work best for high-risk groups, particularly among young people and in Indigenous communities?**

Demonising young people and their alcohol consumption will result in disenfranchisement of young people. Parents must be a primary target of alcohol reduction strategies. There is strong evidence that children of parents with alcohol problems have more drug involvement, plus related mental health and behavioral problems<sup>74</sup>. Similarly, children's early experiences with alcohol are associated with exposure to socialisation factors that promote risk taking<sup>75</sup> and specifically alcohol consumption is a learned behaviour from adult role models. A study by Ary et al demonstrates that parental attitudes towards youth alcohol use and parent modelling of alcohol use were strongly related to change in adolescent alcohol use. This suggests that parents can influence the future use of alcohol by their children<sup>76</sup>. Therefore, interventions to ensure parents are positive role-models of alcohol behaviours are needed.

Weintraub and Chen investigated how parental reinforcement of media messages is associated with alcohol-related beliefs and behaviors and found that anti-alcohol campaigns that included parents as a target had potentially beneficial results<sup>77</sup>.

Alcohol consumption during pregnancy has been shown to jeopardise the safety of the unborn foetus. Consuming more than one drink per day has been associated with a number of adverse health effects such as the risk of miscarriage, low birth weight, cognitive defects and congenital abnormalities<sup>78</sup>. The VHA supports the taskforce's proposal to improve screening, advice and programs for pregnant women and recommends further involvement of consumers in developing appropriate strategies.

There have been some promising results about presenting information for young people in culturally-appropriate ways through a range of mediums. This incorporates the internet, SMS and through role-model led advertising. This is worthy of further research as noted by Wyn et al<sup>79</sup>.

## **Supporting Prevention**

### **Do you support the development of a National Prevention Agency to lead and guide coordinated action for prevention?**

Communities locally, nationally and globally are striving to determine how to contribute to a truly healthy population. This is a significant challenge for all stakeholders. Many communities are achieving gains through evidence-based approaches that tackle disadvantage, promote health, prevent illness and create environments in which health flourishes. The VHA believes the concept of a National Prevention Agency is worthwhile to overcome and repeal the problems of inadequate funding, ad hoc 'projectism' and siloed approaches and is an essential complement to the overall health continuum.

The VHA supports strengthening the prevention agenda within all forms of government and call for all government ministries and departments to **commit** to the prospective Preventative Health Strategy. In 1993, the Swedish Parliament adopted the *Public Health Objectives* bill, which requires that the public health impacts of all political decisions be considered. This bill binds the government to more structured follow-up and reporting of public health endeavours. The VHA believes a similar bill has merit in the Australian sphere.

Research by Deakin University has established that Health Impact Assessments (HIA) are a valid method to determine the potential risks to human health of an action (policy, strategy, program or project). Health impact assessment offers an approach to ensure that governments



programs and policy initiatives align, or are congruent with agreed health goals<sup>80</sup>. The VHA endorses this tool to add value to, the policy-making process.

**Is the suggested approach adequate? If not, or if you have other suggestions, what else should be considered?**

This platform from the National Prevention Summit<sup>81</sup> outlined the following as paramount for action:

1. **Prevention-orientated healthcare system** that delivers quality preventive care, health promotion and primary health care.
2. **A whole-of-system for health approach** which enables prevention and health promotion strategies to operate effectively and sustainably across all levels and sectors of society

Australia has a highly medicalised healthcare system within which many health problems will not be solved. Medical care treats one person at a time and medical interventions often come late. It is therefore important that primary prevention and changing conditions at the community level are considered of paramount importance. The VHA supports all approaches that seek to increase the capacity of the health system and other stakeholders to prevent illness and promote health.

This should be undertaken by providing support to more vulnerable individuals or groups, and by supporting equal health at the population level. Work aimed at the population is done by reporting causes of health inequalities to the surrounding world, as well as by cooperating with other key participants in health promotion and preventative efforts.

## **Choosing performance indicators**

**Are these measurements appropriate? If not, what would you propose?**

The VHA supports and applauds the taskforce for setting measurable targets for improving the health of Australians. Despite this, the current dollar allocation to prevention activities is insufficient to meet these targets and therefore, astute new investments and realignment of current investment is required.

The VHA also believes a target should be set for funding designated to preventative activities and recommends an increase in funding for prevention. This could potentially include an increase to 10% of the national health budget by 2015, as proposed by Oldenburg and Harper<sup>82</sup>.

In addition, the VHA recommends further development of equity targets, as demonstrated by the Close the Gap campaign.

## **Conclusion**

Many of the concepts and concerns within this Paper are not new. However, they will have a more profound impact on the population when exacerbated by the impacts of climate change, an ageing population, the current financial crisis, persistent social inequality and a growing burden of chronic disease. This will manifest in poorer health outcomes that place more pressure on health services in Victoria and nationally. Therefore, the VHA applaud the development of a National Preventative Health Strategy but stipulates the need for substantial funding, authority and accountability to be associated with the strategy.

The current attention on health is welcome. It provides an opportunity for policy makers to take actions that will result in sustainable, cost-effective and prevention-focused approaches to



Victorian Healthcare Association

health. All of government needs to take responsibility for their actions on the health outcomes of communities. Only with a true whole-of-government approach will we see the creation of environments and societies that achieve optimal health outcomes in which the health system is the fence at the top of the cliff rather than the ambulance down in the valley.

#### Key points:

1. A national health data 'portal' should be established which integrates data from various sources in a publicly available domain. This site should incorporate Geographic Information System mapping capabilities (Page 7)
2. The balance of healthcare expenditure needs to be redressed with a greater proportion of the national healthcare budget allocated to prevention (Page 3 & 4)
3. Strict education or behaviour change is limited. Social action, encompassing bottom-up and top-down approaches that bring about changes in the physical, social or economic environments are the best option to promote health (Page 2 & 3)
4. All governments and government departments should be responsible for actions to promote health equity, sustainably fund preventative activities and modify legislation, norms and values to promote healthier structural environments (Page 16)
5. Flexible funding structures must be in place to allow preventative action to be underpinned by the complex determinants of health rather than short term projects (Page 3)

Kind Regards

A handwritten signature in black ink, appearing to read 'Trevor Carr', with a long horizontal flourish extending to the right.

**Trevor Carr**  
Chief Executive Officer



## References

- <sup>1</sup> Roxon N (2008) *24th Annual Light on the Hill Address*. Paper presented at the Chifley's Light on the Hill Address. 20 September 2008,
- <sup>2</sup> Preventative Health Taskforce (2008) *Preventative Health Taskforce Terms of Reference*. Retrieved from <http://www.preventativehealth.org.au/>
- <sup>3</sup> Social Research Centre, VicHealth (2007) *Public Attitudes to Health Promotion and Disease Prevention*. Victoria
- <sup>4</sup> Department of Human Services (2005) *Your Health*. Melbourne: Department of Human Services
- <sup>5</sup> Victorian Council of Social Service (VCOSS) (2007) *Climate Change and Drought Policy: context and recommendations* Melbourne
- <sup>6</sup> Rowe R, Thomas A (2008) *Climate Change Adaptation: A Framework for Local Action*. Melbourne Southern Grampians and Glenelg Primary Care Partnership/McCaughey Centre Policy Signpost #3
- <sup>7</sup> Australian Institute of Health and Welfare (2008) *National public health expenditure report 2005-06*. Canberra: AIHW
- <sup>8</sup> Australian Institute of Health and Welfare (2008) *National public health expenditure report 2005-06*. Canberra: AIHW
- <sup>9</sup> Baum F (2008) Health Promotion Dreaming: 6th Eberhard Wenzel Memorial Oration. *Health Promotion Journal of Australia*;19(3):174-178
- <sup>10</sup> Doggett J (2007) *A New Approach to Primary Care for Australia*. Centre for Policy Development
- <sup>11</sup> Menadue J (2008) COAG's billions are a wasted opportunity for health. *Centre for Policy Development*.
- <sup>12</sup> Department of Health and Ageing (2003) *Returns on Investment in Public Health: An Epidemiological and Economic Analysis* Canberra: Department of Health and Ageing,
- <sup>13</sup> Australia 2020 Summit (2008) *A long-term national health strategy*.. Canberra
- <sup>14</sup> Pincus T, Esther R, DeWalt DA, Callahan LF (1998) *Social Conditions and Self-Management Are More Powerful Determinants of Health Than Access to Care*. *Am Coll Physicians*
- <sup>15</sup> Adler NE, Boyce T, Chesney MA, Cohen S, Folkman S, et al. (2002) Socioeconomic status and health: The challenge of the gradient. *Foundations in Social Neuroscience*;
- <sup>16</sup> Marmot M (2005) Social determinants of health inequalities. *The Lancet*;365(9464):1099-1104
- <sup>17</sup> Australian Institute of Health Policy Studies and VicHealth (2008) *A Platform for Advancing the Health and Wellbeing of all Australians*. National Prevention Summit 2008
- <sup>18</sup> Oldenburg B, McGuffog ID, Turrell G (2000) Socioeconomic determinants of health in Australia: policy responses and intervention options. *Medical journal of Australia*;172(10):489-492
- <sup>19</sup> Oldenburg BF, McGuffog ID, Turrell G (2000) Making a difference to the socioeconomic determinants of health: policy responses and intervention options. *Asia Pac J Public Health*;12:S51-4
- <sup>20</sup> WHO (2000) *Obesity: prevention and managing the global epidemic*. Geneva: WHO
- <sup>21</sup> WHO (2000) *Obesity: prevention and managing the global epidemic*. Geneva: WHO
- <sup>22</sup> Dixon J (2008) Making inroads into obesity. *HealthMatters*.
- <sup>23</sup> von Braun J (2007) *THE WORLD FOOD SITUATION: New Driving Forces and Required Actions*. Washington: International Food Policy Research Institute
- <sup>24</sup> Victorian Healthcare Association (2008) *Tackling Obesity: Healthy Food Labelling in Victoria's Health Services*. Melbourne: Victorian Healthcare Association
- <sup>25</sup> Tansey G, Worsley T, Rogers P (1995) *The Food System: A Guide*. Earthscan
- <sup>26</sup> Robinson Y, Booth S (2004) Promoting health eating: challenges and opportunities for local action. In: Moodie R, Hulme A, eds. *Hands-on Health Promotion*. Melbourne: IP Communications
- <sup>27</sup> Zimmet PZ, James WPT (2006) The unstoppable Australian obesity and diabetes juggernaut. What should politicians do? *MEDICAL JOURNAL OF AUSTRALIA*;185(4):187
- <sup>28</sup> Obesity Policy Coalition (2007) *Obesity Prevention: priorities for action*. Retrieved from [http://www.opc.org.au/downloads/positionpapers/OPCpriorities\\_for\\_action.pdf](http://www.opc.org.au/downloads/positionpapers/OPCpriorities_for_action.pdf)
- <sup>29</sup> Robinson Y, Booth S (2004) Promoting health eating: challenges and opportunities for local action. In: Moodie R, Hulme A, eds. *Hands-on Health Promotion*. Melbourne: IP Communications
- <sup>30</sup> Baum F (2008) Social Capital: Feature Article. VHA HealthMatters.
- <sup>31</sup> Dixon J (2008) Making inroads into obesity. *HealthMatters*.
- <sup>32</sup> Social Research Centre, VicHealth (2007) *Public Attitudes to Health Promotion and Disease Prevention*. Victoria
- <sup>33</sup> Sobal J (2001) *Commentary: Globalization and the epidemiology of obesity*. IEA



- <sup>34</sup> Mitchell R, Popham F (2008) Effect of exposure to natural environment on health inequalities: an observational population study. *The Lancet*;372(9650):1655 - 1660
- <sup>35</sup> Townsend M (2006) Feel blue? Touch green! Participation in forest/woodland management as a treatment for depression. *Urban Forestry & Urban Greening*;5(3):111-120
- <sup>36</sup> Devine A (2008) *Vegetables and Fruit for Health and Healing*. WA: School of Exercise, Biomedical and Health Sciences, Edith Cowan University
- <sup>37</sup> Gray NJ (2007) The modern cigarette, an unregulated disaster. *Medical journal of Australia*;187(9):502
- <sup>38</sup> Thomas S, Fayter D, Misso K, Ogilvie D, Petticrew M, et al. (2008) Population tobacco control interventions and their effects on social inequalities in smoking: systematic review. *Tob Control*:tc.2007.023911
- <sup>39</sup> WHO. (2008). WHO REPORT ON THE GLOBAL TOBACCO EPIDEMIC, . Geneva: World Health Organization.
- <sup>40</sup> Wilson N, Thomson G (2005) Tobacco taxation and public health: ethical problems, policy responses. *Social Science & Medicine*;61(3):649-659
- <sup>41</sup> Marsh A, McKay S (1994) *Poor Smokers*. Policy Studies Institute
- <sup>42</sup> Wakefield M, Hill D (2004) Tobacco control. In: Moodie R, Hulme A, eds. *Hands-on Health Promotion*. Melbourne: IP Communications
- <sup>43</sup> Borland R (1997) What do people's estimates of smoking related risk mean? *Psychology & Health*;12(4):513-521
- <sup>44</sup> Social Research Centre, VicHealth (2007) *Public Attitudes to Health Promotion and Disease Prevention*. Victoria
- <sup>45</sup> Hoek, J., Gifford, H., Pirikahu, G., Thomson, G., & Edwards, R. Smokers'and Former Smokers' Responses to Tobacco Retail Displays.
- <sup>46</sup> Wakefield, M., Germain, D., & Henriksen, L. (2008). The effect of retail cigarette pack displays on impulse purchase. *Addiction*, 103(2), 322-328.
- <sup>47</sup> Hoek J, Gifford H, Pirikahu G, Thomson G, Edwards R Smokers'and Former Smokers' Responses to Tobacco Retail Displays.
- <sup>48</sup> Wakefield M, Hill D (2004) Tobacco control. In: Moodie R, Hulme A, eds. *Hands-on Health Promotion*. Melbourne: IP Communications
- <sup>49</sup> Clark L, Burton S, Bollerup J (2008) Environmental Influences on Tobacco Consumption by Smokers Intending to Quit.
- <sup>50</sup> Novak SP, Reardon SF, Raudenbush SW, Buka SL (2006) Retail Tobacco Outlet Density and Youth Cigarette Smoking: A Propensity-Modeling Approach. *Am J Public Health*;96(4):670-676
- <sup>51</sup> Pokorny SB, Jason LA, Schoeny ME (2003) The Relation of Retail Tobacco Availability to Initiation and Continued Smoking. *Journal of Clinical Child and Adolescent Psychology*;32(2):193-204
- <sup>52</sup> Novak SP, Reardon SF, Raudenbush SW, Buka SL (2006) Retail Tobacco Outlet Density and Youth Cigarette Smoking: A Propensity-Modeling Approach. *Am J Public Health*;96(4):670-676
- <sup>53</sup> Laws MB, Whitman J, Bowser DM, Krech L (2002) Tobacco availability and point of sale marketing in demographically contrasting districts of Massachusetts. *Tob Control*;11(90002):ii71-73
- <sup>54</sup> U.S. Department of Health and Human Services (2006) The Health Consequences of Involuntary Exposure to Tobacco Smoke, A Report of the Surgeon General. *Atlanta: US Department of Health and Human Services, Centres for Disease Control and Prevention*;
- <sup>55</sup> Rees VW, Connolly GN (2006) Measuring Air Quality to Protect Children from Secondhand Smoke in Cars. *American Journal of Preventive Medicine*;31(5):363-368
- <sup>56</sup> Edwards R, Wilson N, Lecturers S, Pierse N (2006) Highly hazardous air quality associated with smoking in cars: New Zealand pilot study. *Journal of the New Zealand Medical Association*;119(1244)
- <sup>57</sup> The Cancer Council Victoria (2008) *Calls for nationwide ban on smoking in cars with children* Retrieved 17 September.
- <sup>58</sup> NSW Health (2008) *Protecting Children from Tobacco*. NSW,
- <sup>59</sup> Thomson, G., & Wilson, N. (2005). Directly eroding tobacco industry power as a tobacco control strategy: lessons for New Zealand. *NZ Med J*, 118(1223), 118-1223.
- <sup>60</sup> Thrasher, J. F., Niederdeppe, J., Farrelly, M. C., Davis, K. C., Ribisl, K. M., & Haviland, M. L. (2004). The impact of anti-tobacco industry prevention messages in tobacco producing regions: evidence from the US truth (R) campaign. *Tobacco Control*, 13(3), 283.
- <sup>61</sup> Zucker, D., Hopkins, R. S., Sly, D. F., Urich, J., Kershaw, J. M., & Solari, S. (2000). Florida's" truth" campaign: a counter-marketing, anti-tobacco media campaign. *J Public Health Manag Pract*, 6(3), 1-6.
- <sup>62</sup> Wakefield M, Hill D (2004) Tobacco control. In: Moodie R, Hulme A, eds. *Hands-on Health Promotion*. Melbourne: IP Communications
- <sup>63</sup> Vos T, University of Queensland Centre for Burden of D, Cost E (2007) *The Burden of Disease and Injury in Aboriginal and Torres Strait Islander Peoples 2003*. Centre for Burden of Disease and Cost-Effectiveness, School of Population Health, University of Queensland
- <sup>64</sup> Briggs VL, Lindorff KJ, Ivers RG (2003) *Aboriginal and Torres Strait Islander Australians and tobacco*. BMJ



- 
- <sup>65</sup> Roche AM, Ober C (1997) Rethinking Smoking Among Aboriginal Australians: The Harm Minimisation-Abstinence Conundrum. *Health Promotion Journal of Australia*;7:128-133
- <sup>66</sup> Johnson IL, Ashley MJ, Reynolds D, Goettler F, Lee-Han H, et al. (2004) Prevalence of smoking associated with pregnancy in three Southern Ontario Health Units. *Can J Public Health*;95(3):209 - 13
- <sup>67</sup> Alcohol Advisory Council of New Zealand (ALAC) (2005) *New Zealand and its drinking culture: A programme of change*. ALAC
- <sup>68</sup> WHO (2004) *Global status report: Alcohol policy*. Geneva: WHO
- <sup>69</sup> Howat P, Sleet D, Maycock B, Elder R (2005) *Effectiveness of Health Promotion in Preventing Alcohol Related Harm*,
- <sup>70</sup> Victorian Government (2008) *Victoria's Alcohol Action Plan: Restoring the balance*. Melbourne,: Victorian Government
- <sup>71</sup> Room R, Babor T, Rehm J (2005) Alcohol and public health. *The Lancet*;365(9458):519-530
- <sup>72</sup> Hill L (2004) *Alcohol health promotion via mass media: The evidence on (in)effectiveness*. Paper presented at the Eurocare "Bridging the Gaps" Conference. Warsaw, 16-19 June 2004
- <sup>73</sup> Babor T, R. Caetano, S. Casswell et al. (2003) *Alcohol: No ordinary commodity: Research and public health*. Geneva: Oxford University Press/World Health Organisation.
- <sup>74</sup> Obot IS, Wagner FA, Anthony JC (2001) Early onset and recent drug use among children of parents with alcohol problems: data from a national epidemiologic survey. *Drug and Alcohol Dependence*;65(1):1-8
- <sup>75</sup> Jackson C, Henriksen L, Dickinson D, Levine DW (1997) The early use of alcohol and tobacco: its relation to children's competence and parents' behavior. *Am J Public Health*;87(3):359-364
- <sup>76</sup> Ary DV, Tildesley E, Hops H, Andrews J (1993) The Influence of Parent, Sibling, and Peer Modeling and Attitudes on Adolescent Use of Alcohol. *Substance Use & Misuse*;28(9):853-880
- <sup>77</sup> Austin EW, Chen YJ (2003) The Relationship of Parental Reinforcement of Media Messages to College Students' Alcohol-Related Behaviors. *Journal of Health Communication*;8(2):157-169
- <sup>78</sup> Young A, Powers J (2005) *Australian Women and Alcohol Consumption 1996-2003*. Canberra: Commonwealth of Australia
- <sup>79</sup> Wyn J, Cuervo H (2005) *Young people, wellbeing and communication technologies*. Melbourne, Youth Research Centre, The University of Melbourne
- <sup>80</sup> Ratner PA, Green LW, Frankish CJ, Chomik T, Larsen C (1997) Setting the stage for health impact assessment. *J Public Health Policy*;18(1):67-79
- <sup>81</sup> Australian Institute of Health Policy Studies and VicHealth (2008) *A Platform for Advancing the Health and Wellbeing of all Australians*. National Prevention Summit 2008
- <sup>82</sup> Oldenburg BF, Harper TA (2008) Investing in the future: prevention a priority at last. *Med J Aust*;189(5):267-8

## Box References

- <sup>1</sup> Baum F (2003) *The new public health*. Oxford University Press Oxford, UK
- <sup>2</sup> Kavanagh A, Thornton L, Tattam A, Thomas L, Jolley D, et al. (2007) *Place does matter for your health: A report of the Victorian Lifestyle and Neighbourhood Environment Study*. University of Melbourne
- <sup>3</sup> Sanigorski AM, Bell AC, Kremer PJ, Cuttler R, Swinburn BA (2008) Reducing unhealthy weight gain in children through community capacity-building: results of a quasi-experimental intervention program, Be Active Eat Well. *International Journal of Obesity*;(current)
- <sup>4</sup> Wilkenfeld JP *Saving the World from Big Tobacco: The Real Coalition of the Willing*.
- <sup>5</sup> Raloff J (1994) What's in a Cigarette? *Science News*;145(21):330-331
- <sup>6</sup> American Cancer Society Cancer Action Network, American Heart Association, American Lung Association, American Medical Association, Campaign for Tobacco-Free Kids (2008) Deadly in Pink: Philip Morris' New Look for Virginia Slims Cigarettes Shows Contempt for Women's Health. *October 30, 2008*.