

Submission from the Australian Government to WHO on multisectoral action and partnerships for Non-Communicable Diseases (NCDs) - 19 April 2012

Introduction

Australia is pleased to note the progress being made by WHO in moving forward the work requested in the *political declaration* of the United Nations General Assembly High Level Meeting (UNGA HLM) on non-communicable diseases (NCDs) in September 2011.

This submission incorporates the views of the Australian Government Department of Health and Ageing, the Australian Agency for International Development (AusAID) in the Department of Foreign Affairs and Trade, the Australian National Preventive Health Agency and the Department of Prime Minister and Cabinet.

Australia offers the comments below on the two WHO discussion papers on multisectoral action titled: 1. *Effective approaches for strengthening multisectoral action for NCDs* and 2. *Lessons-learned from existing multisectoral partnerships that may inform the global response to NCDs*.

Australia's feedback covers the following areas:

- priority setting is important to ensure resources are allocated to the highest-need areas
- it would be helpful for the WHO to clarify its expectations of Member States regarding the role of private sector and civil society
- there needs to be recognition that there are existing arrangements and plans in many Member States on multisectoral action
- it will be important not to create vertical structures which do not integrate programs and outcomes.

Australia agrees that multisectoral action is complex and that, despite this, many Member States are involved in partnerships to address NCDs. The outcomes from multisectoral action are hard to measure, though some successes can clearly be seen, such as with tobacco in Australia. That said, Australia also agrees that partnerships can be resource intensive and therefore need to be focused on agreed priorities and on delivering against specific outcomes.

The WHO papers raise questions on page 5 of Discussion Paper 1 and page 9 of Discussion Paper 2. This submission provides comments against these questions.

More broadly, Australia notes that it would be helpful for the WHO to outline the expected process for advancing this work on multisectoral action, and that a consultative process will help to ensure that Member States have the opportunity to understand, engage and influence, any options that are developed.

Discussion Paper 1

Priority setting

Priorities

The multisectoral papers ask what priority setting should occur. Inherently, this acknowledges that gains are usually more achievable when there is targeted effort on specific health concerns rather than addressing multiple issues at the same time. In

setting priorities, recognition needs to be given to the different approaches to public health within countries.

The papers emphasise the extent of cross-sectoral contribution to NCD risk factors, however, they may unintentionally make the issues look very complex, and do not recognise that much action is already underway. The papers would benefit from consideration of the need to prioritise cross-sectoral action on the issues where there is evidence of the potential effectiveness of interventions, and that these top priorities may be different in different countries.

Issue 1: Achieving whole of government action

Multisectoral action in Australia

The WHO papers acknowledge that many countries already have in place multisectoral action, and Australia is pursuing this approach. For example, there are a number of National Partnerships in place between the Australian government and the eight states and territories which define funding arrangements with specified frameworks for monitoring progress, that span a number of sectors such as:

- National Partnership Agreement on Preventive Health which aims to address the rising prevalence of lifestyle-related chronic diseases by implementing programs and activities that promote healthy living, particularly in workplaces, educational settings and communities.
- National Partnership Agreement on Closing the Gap in Indigenous Health Outcomes which aims to improve health life expectancy and reduce child mortality through efforts in housing, education, employment as well as in health care settings.
- National Partnership Agreement on Indigenous Early Childhood Development provides funding for early childhood education and mothers' and babies' programs to improve the outcomes for Indigenous children in their early years. This partnership also aims to provide improvements to the current programs through quality early learning, child care, parent and family support.

Other examples include:

- On tobacco, the Australian Government has employed a number of policy levers across sectors to reduce the number of people taking up smoking and to assist those already smoking to quit including legislation on advertising, social marketing campaigns, subsidising of drugs and increasing taxation on tobacco products.
- Partnerships between the Australian Government and industry in areas such as food and alcohol policy.
- The Australian Government has a national urban planning policy which aims to promote active public transport across most of Australia's capital cities. For example, establishing networks of bicycle paths.

(Detail is provided in [Attachment 1](#).)

The examples described are just some of the activity that is occurring, and are not comprehensive. In any document calling for activity on multisectoral approaches, it would be useful to recognise the breadth and depth of work that is already occurring in Member States.

Issue 2: Political leadership

Governance arrangements

- **For Member States**

The multisectoral papers call for action from governments through developing national plans, establishing cross-ministry NCD working groups, undertaking health impact assessments, introducing innovative financing instruments for NCDs and a number of other governance techniques.

Some Member States already have a variety of these governance arrangements in place. Such governance arrangements generally develop over a long period of time and evolve as a result of country-specific factors. It may not be necessary to introduce new governance, but rather recognise opportunities to focus existing structures on cross-sectoral approaches where appropriate.

Australia requests that any future work acknowledge such governance arrangements and that they have evolved as a result of factors specific to individual country's needs.

- **For Civil Society and the Private Sector**

As noted above, the Australia Government is involved in partnerships with the private sector in a number of areas including food and alcohol policy. These partnerships create an enabling environment where change which promotes healthy living is encouraged. These types of partnerships have produced useful outcomes and should continue to be fostered.

The role of the WHO versus Member States to facilitate/drive/resource the proposed actions directed at civil society and the private sector needs to be clarified in further documents on this issue.

Issues 3, 5 and 6: Stewardship, workforce, access to medicines and diagnostics

All these issues are receiving ongoing attention as part of managing the Australian health system. In particular:

- The Australian government has well developed guidelines and protocols for engaging with stakeholders;
- The Australian Government's financing strategies are reviewed frequently to ensure that funding is sustainable and focused on cost effective purchases;
- health workforce issues are considered across government, with engagement of the employment and education sectors; and
- the underlying principle for access to medicines and diagnostics is that they are affordable for all Australians which is assisted through strategies such as higher subsidies for people on lower incomes.

Issue 4: Sustainable financing for addressing NCDs – proposed actions for Member States

The first dot point on page 17 proposes that Member States commit to implementing WHO thresholds for tobacco excise taxation (70 per cent of retail price) and consider allocating a proportion of such taxes for NCDs and for health. The dot point is not supported as currently drafted.

The first aspect of the dot point is not supported as it exceeds the Framework Convention on Tobacco Control (FCTC) Parties' obligations under Article 6 of the

FCTC. Broadly, Article 6 states that, ‘without prejudice to the sovereign right of the Parties to determine and establish their taxation policies’, Parties should adopt measures ‘that may include’ tax policies aimed at reducing tobacco consumption. A more acceptable formulation would be for the dot point to propose Member States *consider* implementing WHO thresholds.

The second aspect of the first dot point is not supported, as earmarking a proportion of tax for NCDs or health may not be appropriate or effective in many countries. A more acceptable formulation would be for the dot point to state that parties should consider allocating revenue generated from tobacco taxation for public health purposes.

Australia believes that the second dot point should not go beyond its current formulation where it states that countries should ‘consider allocating’ a proportion of tobacco tax revenue to an international tobacco solidarity fund.

Issue 7: Promote development and use of impact assessment methods to monitor and evaluate multisectoral action

Assessment of multisectoral action

Assessment of multisectoral action can occur at a number of stages including:

- before a program is implemented to determine if it should be introduced;
- while the program is in place to determine if it should be altered (formative evaluation); and
- when the program is reaching an end to determine if it should be continued/changed (summative evaluation).

Multisectoral work, such as that implemented through the partnership agreements, has involved large investments by the federal and state/territory governments. Thus, significant efforts were in place at each stage of the agreements. For example, strong monitoring frameworks exist for these agreements including multiple performance benchmarks and indicators to check that they are on-track for delivering on their intended outcomes.

Evaluations of the agreements are planned. Such evaluations are complex for a number of reasons:

- It can be difficult to identify causal links between a program’s initiatives and its outcomes.
- Techniques for assessing the effectiveness of the processes are not well developed and do not have a common metric.
- It can be difficult to disaggregate the effect of an individual initiative when a suite of initiatives have been implemented.
- Valid and reliable data collections are not always readily available in some areas.

Health Impact Assessments (HIA) are a means of assessing the health impacts of policies, plans and projects in diverse economic sectors using quantitative, qualitative and participatory techniques. HIAs are a useful tool, however, they can be expensive and time consuming, thereby imposing a heavy administrative burden on government/industry.

HIAs are not the only technique for assessing health impacts. For example, Social Return on Investment is a principles-based method for measuring extra-financial value (i.e., environmental and social value not currently reflected in conventional financial accounts) relative to resources invested. It can be used to evaluate the impact of policy on stakeholders, identify ways to improve performance, and enhance the performance of investments.

For these reasons, Australia would request that further consideration be given to the issue of assessments of health impacts of policies including around appropriate priority setting mechanisms to assist in determining when such assessments would be of value, i.e. ensuring the cost and administrative impost are not too burdensome.

Discussion Paper 2

Global response

a) What gaps and challenges should global partnerships target as priorities?

In identifying priorities, recognition needs to be given to the different approaches to public health and the prioritisation of issues that can occur within countries. As noted earlier, gains are usually more achievable when there is targeted effort on specific health concerns rather than addressing multiple issues at the same time. Thus, priorities will legitimately differ across nations.

As noted above, the Australia Government is involved in partnerships with the private sector in areas such as food and alcohol policy. These partnerships have yielded substantial benefits by changing, for example, food formulations to healthier alternatives. These types of partnerships should continue to be fostered. Thus, defining an appropriate role for the private sector is an important objective. Strengthening civil society, especially in developing countries is also important.

Given the WHO has limited mechanisms to change behaviours for the private sector and civil society, there would appear to be an expectation that this would occur through government action. It would be helpful for the WHO to clarify its expectations in this area.

b) What form should these partnerships take to optimise effectiveness, to overcome the fragmentation that has historically characterized the global response to NCDs, and to manage potential conflicts of interest?

Australia maintains the position that no new health architecture should be established in the response to NCDs. The global response to NCDs, including any strengthening and facilitating multisectoral action through partnership, should work within the existing health aid architecture and focus on strengthening health systems as a whole rather than establishing new vertical approaches.

Australia agrees with the need to ensure a positive impact on national health systems and avoiding fragmentation, vertical approaches and overburdening of health systems in the global response to NCDs. Australia will work to keep the NCD global agenda focused on cost-effective prevention in low-income settings and encourage stakeholder accountability through representation at global and regional meetings.

c) What should the role of the WHO be in convening, coordinating and supporting new global partnerships?

Australia supports the WHO as the lead UN specialised agency for health and, in that capacity, the WHO should convene, coordinate and support the global NCD response. Australia agrees that while the NCD challenge requires new ways of thinking and enhanced collaboration, this should be achieved within existing health architecture and the WHO, with its mandate for all people to achieve the highest attainment of health, is the most appropriate body to do this.

National Response – examples which could be replicated in other countries

As noted, Australia is currently pursuing a number of multisectoral actions to address NCDs. More detail on the actions is provided in [Attachment 1](#).

Australia agrees with the WHO approach of using multiple policy levers to target priority issues as well as involving multiple sectors. While particular strategies have worked in Australia at a point in time, countries face differing circumstances and only broad guidance would be able to be developed which would be applicable across countries. As noted above, in drawing out the lessons on multisectoral action across countries, the WHO should reflect on the need to prioritise cross-sectoral action on the issues where there is the most clear and strong causal relationship, and that these top priorities may be different in different countries.

Consultation process to gain understanding and support for multisectoral policies

Australia notes that the multisectoral papers have been developed as a tool to stimulate debate by Member States around multisectoral action. Given the complexity around this area, Australia would welcome a process which involves a highly consultative approach to ensure that Member States have the opportunity understand, engage and influence the outcomes any resolutions. Thus, it may be too early for highly specific options to be considered and agreed to at the World Health Assembly in May 2012.

Summary

Australia welcomes the progress the WHO is making on multisectoral action. It notes that such action will need to account for country-specific factors. Australia further notes that a consultative process will achieve good engagement across Member States.

Multisectoral Action in Australia

Multisectoral arrangements to address NCDs have been a feature of the Australian health system over many years. Multisectoral action to improving health outcomes occurs in a number of ways in Australia including with interaction occurring:

- across various federal government departments
- across various levels of government (federal, state/territory and local government)
- between the public and private sectors.

Through a multisectoral approach, the Australian Government has implemented a range of programs and activities that promote healthy outcomes in the daily lives of Australians through non-health settings, such as communities, early childhood education and care environments, schools and workplaces.

Examples of these include:

- National Partnership Agreement on Preventive Health, which aims to address the rising prevalence of lifestyle related chronic diseases by implementing programs and activities that promote healthy living. This is an agreement between the federal and state/territory governments which has initiatives for improving the health of children, workers and communities by:
 - funding states/territories/other organisations to deliver programs;
 - developing partnerships with industry and NGOs to encourage changes in practices;
 - raising awareness of public health issues through social marketing campaigns; and
 - developing ‘enablers’ such as surveys, research, a workforce strategy and a preventive health agency to provide assistance to all sectors to promote health and reduce health risk and inequalities in the Australian community.
- National Partnership Agreement on Closing the Gap in Indigenous Health Outcomes, which aims to improve access for Indigenous Australians to effective health care services essential to improving health and life expectancy and reducing child mortality. This is an agreement between federal and state/territory governments which focuses not only on preventive, primary and hospital care but also on:
 - workforce strategies to improve the cultural security of services by increasing Indigenous participation in health care training and the workforce;
 - and by expanding diversionary activities within the juvenile justice system; and
 - improving service delivery coordination for families that have a high level of contact with child protection, juvenile justice and housing services.
- National Partnership Agreement on Indigenous Early Childhood Development, which provides funding for early childhood education and mothers’ and babies’ programs to improve the outcomes for Indigenous children in their early years. This is an agreement between the federal and state/territory governments which aims to provide:
 - expanded children and family centres in areas with high Indigenous populations;

- at these centres, provision of early learning, child care and parent and family support services; and
- increased antenatal care, sexual and reproductive services and maternal and child health services for Indigenous peoples.

On tobacco, the Australian Government has employed a number of policy levers across sectors to reduce the number of people taking up smoking and to assist those already smoking to quit. This interconnected suite of tobacco control measures include:

- the world-first plain packaging legislation, which will take effect from 1 December 2012;
- a new graphic health warning Information Standard, requiring warnings and graphics to cover 75 per cent of the front and 90 per cent of the back of cigarette packs from 1 December 2012;
- record investments in anti-smoking social marketing campaigns;
- subsidisation of nicotine replacement therapies and smoking cessation support drugs;
- significant investments to support Aboriginal and Torres Strait Islander communities to reduce smoking rates;
- a 25 per cent increase in the tobacco excise implemented from April 2010; and
- legislation to restrict internet advertising of tobacco products, to support existing stringent restrictions on tobacco advertising.

The Australian Government has partnerships with industry in a number of areas. For example, in the area of food policy, the Australian Government has established a mechanism called the Food and Health Dialogue (the Dialogue) where it works collaboratively with the food industry to improve dietary intakes. A voluntary food reformulation program has been established under the Dialogue to target the reduction of risk-associated nutrients, including sodium, sugar and saturated fat, in commonly consumed foods. To date, reformulation targets have been reached for bread, breakfast cereal, simmer sauces, processed meats and soup sectors. More work will be done in 2012 with the sector which deals with processed foods.

The Australian Government also has a partnership with the alcohol industry. In particular, involves working with the alcohol industry in pursuing voluntary and collaborative approaches to responsible alcohol advertising and labelling.

The Australian Government has a national urban planning policy which takes account of multiple priorities when determining how to plan community infrastructure. Australia's urban planning aims to facilitate and support preventive health approaches by incorporating parks, fitness tracks, swimming pools, clubs, community centres and easy access to health care facilities.