In the *Healthy Weight, Healthy Lives* strategy (England), an equality impact assessment is being used to identify the possible impact of the strategy on equality, and the policies it sets out, on people according to their age, disability, race, religion and beliefs, gender and sexual orientation. It aims to assess whether the strategy is likely to have adverse effects on any of these groups. In New Zealand, the Reducing Inequalities framework guides the design and implementation of the *Healthy Eating-Healthy Action* program. This means that the program must take full account of four key concerns:

- Structural – tackling the root causes of health inequalities, that is, the social, economic, cultural and historical factors that fundamentally determine health.
- Intermediary pathways – targeting material, psychosocial and behavioural factors that mediate the impact of structural factors on health.
- Health and disability services – undertaking specific actions within health and disability services.
- Impact – minimising the impact of disability and illness on socioeconomic position.

Monitoring and evaluation of implementation and outcomes

All of the integrated programs stress the need for rigorous and ongoing evaluation and monitoring. Plans note goals and/or actions for the development/implementation of evaluation and monitoring systems to support continuous program improvement.

The OECD countries reviewed all had national agencies/institutions for supporting the evaluation of interventions. England, for example, has introduced an impact assessment process with it's *Healthy Weight, Healthy Living* strategy which monitors the impacts of its policies upon the public, private and tertiary sectors. This acknowledges the multi-sectoral nature of the interventions. In addition the impact on equality, including race, disability and gender is monitored through an Equality Impact Assessment. Research has also been bolstered through the commissioning of an obesity observatory that operates within a system of geographically based public health observatories.

SECTION 5. LESSONS FOR AUSTRALIA

In this section of the report, we identify a number of findings and lessons arising from this rapid stocktake (see Part B) which require further consideration and analysis with respect to building and enabling sustainable systems for prevention in Australia in the future. Selective examples – called EXHIBITS - that were identified during the review are used to illustrate some of these potential lessons for Australia. These findings and lessons are discussed in two sub-sections: (1) systems underpinning the strategies and programs and (2) strategies and programs for primary prevention and health promotion.

5.1 The systems underpinning strategies and programs

Lesson 1. Establishment of a high-level government or equivalent committee with appropriate inter-sectoral partners is necessary to champion primary prevention of chronic disease and ensure high-level political commitment and accountability.

The highest status committee is a Cabinet Committee (and equivalents) that had cross-portfolio representation. In New Zealand, a recent review of the Healthy Eating-Healthy Action program has recommended that a Ministerial Committee, chaired by the Minister of Health, be established to provide high-level, whole-of-government leadership that focuses on improving obesogenic environments. The Ministerial Committee will also work alongside a steering group to set agreed targets. The group will include non-government organisations, academics, Maori and Pacific representatives and the food and advertising industries.

In England, a Sub-Committee on Health and Wellbeing has been established.

EXHIBIT - SUB-COMMITTEE ON HEALTH AND WELLBEING

Terms of Reference:

"To consider policy on health and wellbeing, including the prevention of ill-health, the promotion of healthy and active lifestyles and the reduction of health inequalities; and report as necessary to the Ministerial Committee on Domestic Affairs."

Membership:

Minister for the Cabinet Office; and Chancellor of the Duchy of Lancaster (Chair)
Secretaries of State for: the Home Department; Health; Environment, Food and Rural Affairs; Business, Enterprise and Regulatory Reform; Work and Pensions; and Secretary of State for Wales; Transport; Communities and Local Government; Children, Schools and Families; Innovation, Universities and Skills; Culture, Media and Sport
Chief Secretary to the Treasury
Secretary of State for Innovation, Universities and Skills
Minister of State, Scotland Office
Minister for the Olympics and Minister for London (Paymaster General)
Minister of State, Northern Ireland
Parliamentary Under Secretary of State, Government Equalities Office
Parliamentary Secretary, Cabinet Office (Gillian Merron)

Obesity

Remit includes tackling obesity and promoting healthy weight. The Cabinet Committee on Families, Children and Young People monitors progress with respect to child weight problems.

Reporting to the new committee is a new cross-Government obesity unit based in the Department of Health (DOH) but led jointly by the DOH and the Department for Children Schools and Families, and includes staff and resources from across Government. The major responsibilities of the new unit will include: taking forward the commitment outlined in this strategy; producing the annual report; leading across Government in developing further proposals as necessary to fulfil our ambition to reverse the rising tide of obesity and overweight; acting as the focal point for knowledge on healthy weight in Government; managing relationships between Government, industry and other stakeholders. The unit is supported in its responsibilities by: 1. an Expert Panel of academics, building on the Foresight science advisers 2. a Delivery Reference Group composed of experienced representatives from across the delivery chain and across the country.

The Government will assess the impacts, through the Impact Assessment process, including the health impacts, of its policies upon the public, private and third sectors. Additionally the Government will assess the impact on

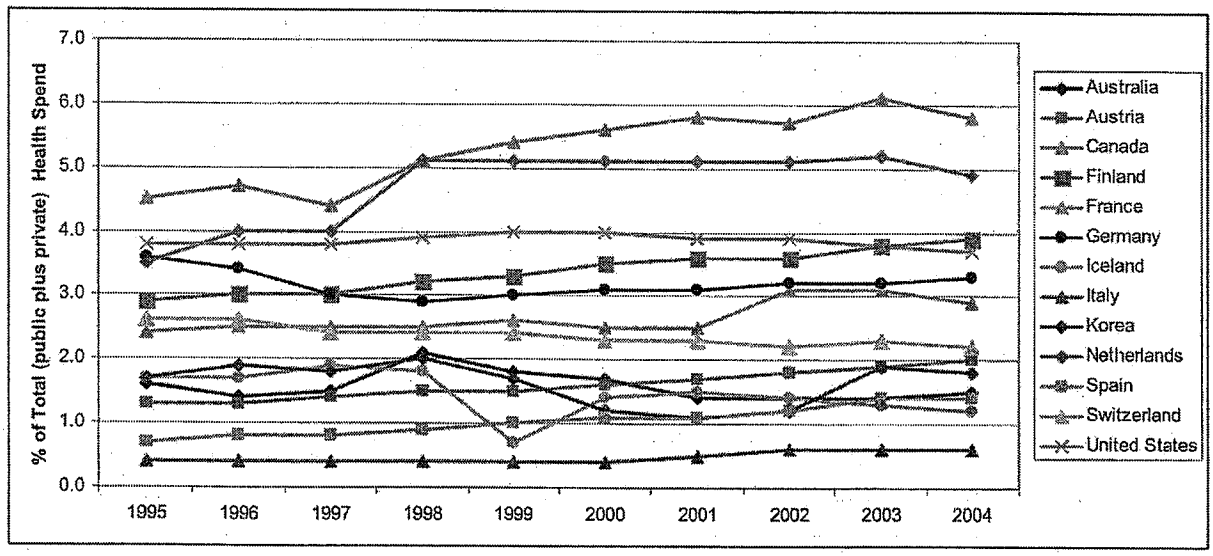
equality, including race, disability and gender and has undertaken an Equality Impact Assessment. Full impact assessments on these policies will be carried out as these policies are taken forward. The new unit will also work to align policies with the forthcoming Cross-Government Global Health Strategy.
The Government aims to 'support stakeholders in business and the third sector in engaging with each other on how they can meet the challenge of tackling excess weight in the population by building a Coalition for Better Health, which would: reach agreements on joint programmes; disseminate knowledge on what works, and what doesn't; challenge each other to go further.

Swinburn (2008) has outlined the roles of government in relation to obesity prevention, which has implications for the more general role for government in primary prevention of chronic disease. (**Appendix 5**).

Lesson 2. New approaches to long-term funding for primary prevention of chronic disease need to be developed and recognise the limited approaches of the past and the need for more innovative and sustainable financing models in the future.

A recent AIHW Report has estimated that Australia's total investment in 'public health' by all Australian health jurisdictions is currently 1.8% and unchanged in almost a decade (AIHW 2008), which is low compared to a (still inadequate) OECD average of about 3 per cent for 'prevention' (OECD 2000). The spending on prevention and health promotion is only a proportion of this 1.8%. OECD trend data on prevention and public health programs for Australia, Canada, Finland and the US appear in **Figure 5.1**.

Figure 5.1 Trend in percentage of total health expenditure accounted for by prevention and public health programmes in selected OECD countries 1995 to 2004.



Source: OECD System of Health Accounts, October 2006

Relying on a very small proportion of funding from a national health budget to provide adequate, sustainable financing of a long-term and well organised chronic disease prevention and health promotion program has proven to be insufficient in most countries because of the inherent pressures on such funds from the health care delivery system. It also reflects a narrow understanding of what actions are needed and the roles of a wide range of stakeholders. Some innovative national financing models – such as the one in Thailand – have been developed in recent years (**Appendix 6**). The funding arrangements of the new obesity strategy in England could also be further explored to gain insight into the financing arrangements of a cross-portfolio initiative. This is an area that needs closer scrutiny and analysis. Health England (a national reference group for health and wellbeing) is currently

investigating prevention financing, and has to date engaged an expert advisory group on prevention financing to examine an initial set of questions.

Lesson 3. Strengthened system components are needed for developing and implementing an effective chronic disease primary prevention strategy and related programs.

Lack of integration among the jurisdictions and between programs has long been a criticism of the Australian situation and clearly, this will be a challenge for developing and implementing a more nationally coordinated approach to prevention and health promotion in the future (Willcox 2006; AIHPS & VicHealth 2008; Lin et al 2008).

Some of the specific elements that have been introduced internationally to strengthen the effectiveness and accountability of the system supporting chronic disease prevention are population health targets, workforce development and mechanisms to ensure continuous system learning. Elements within systems are being strengthened in different ways across countries. Ideally, new infrastructure and resources enable each system to operate as an **integrated whole**, capable of being adaptive to emerging issues and resilient to stresses on the system such as changes in participation of particular sectors in action. Further analysis is required to examine innovations across countries that are building a more integrated and coordinated system.

Lesson 4. Establishment of measurable targets for primary prevention and health promotion is critical for long term monitoring and evaluation of implementation and outcomes.

Most countries have some form of national health targets that also include chronic disease. These need to include not only measurement of the disease conditions and the behavioural risk factors, but also the more upstream determinants and influences on these. Advocates of health targets propose that they will help to direct cross-sectoral efforts involving multiple settings, players and levels, without being prescriptive of how to achieve the targets. In the US, a rolling program of national public health objectives and targets under the Healthy People initiative has existed since 1979. It is based on the notion that setting objectives and monitoring progress can motivate action at different levels. The role of the States is particularly important in that context. The targets have been reviewed for the next chapter of the program – Healthy People 2020 (Blakey et al 2006).

In Sweden's case, public health targets reflect the trend in health policy towards more emphasis on determinants of health and societal interventions (less on individuals). While there is debate about their value in supporting governance with targets (Lager et al 2007) the targets initiative represents a bold move to orient sectors, systems and activities to cooperatively developing the social conditions needed to ensure good health for the whole population. The process of formulating targets successfully raised awareness among policy makers and civil servants of the broad social and economic determinants of health problems such as chronic disease and the role of other sectors, such as transport (preventing road injury) and housing (secure, healthy homes) in contributing to health. An intersectoral committee designed the 11 targets (**Appendix 7**) thus producing agreement at the highest political levels of the intersectoral approach to health. Implementation remains an issue: "A major block is that some ministries do not consistently address health considerations in their policies. Inter-sectoral rhetoric is not the same as inter-sectoral action. …I fear also that

sometimes issues regarding socioeconomic determinants of health are simplified, and their complexity is not recognised. A better link between research and policy is necessary." [4]

Lesson 5. Establishment of sustainable infrastructure that facilitates the production, dissemination and use of evidence and learning is essential if strategies and programs are to be effective.

To continue improving the health and wellbeing of the population, reliable and relevant evidence on the most effective ways of protecting people from disease, preventing illness and promoting good health is required. This information can only come from research (including ongoing evaluation of strategies and programs).

Countries examined in this review have recognised the complexity of primary prevention interventions (especially for healthy eating and physical activity) and have, or are, implementing integrated research and surveillance agendas to align efforts nationally to effect change, and to ensure that:

- Policy and program decisions are based on timely, regular and meaningful data.
- There is coordination and integration of investments in research, policy and practice.
- Communities have easy, efficient, timely access to the knowledge they need, in usable form, to inform decisions.
- Researchers are better able to conduct research to address policy and practice.
- The existing research is synthesized and translated for use by population and public health organisations.
- Key intersectoral stakeholders at all levels collaborate in the various phases of the knowledge development and exchange cycle, to create the ability to "learn as we go" – what works, and in what context.
- Research, surveillance and evaluation are integrated with policy and program development.

Mechanisms that allow for ongoing cross-strategy/program learning at national and international levels are needed so that measures adopted to address the same issues in other jurisdictions or different issues in a variety of jurisdictions can be instructive in developing efforts to prevent chronic disease. According to Yach et al (2003) in regard to tobacco:

The accumulation of experience from many countries means that it is now much clearer what works and what does not. It confirms the wisdom of the early adopters: Be comprehensive; keep the debate alive, interesting, and provocative in the media; incrementally tighten laws as public support and demand for action increases; move to make smoking an unacceptable and antisocial behaviour; and globalise action to counter the global reach and strategies of tobacco companies – particularly their marketing and investment practices.

While learning is important, McLaren reminds us that uncritical translation of programs from one context to another (such as the North Karelia project in Finland) carries the risk of failure (McLaren 2006).

5.2 Strategies and Programs

Clearly, Australia continues to make a very significant contribution internationally to the development, implementation and evaluation of effective strategies and programs for preventing chronic disease and promoting health.

[4] Interview with Commissioner Denny Vagero, Sweden
http://www.who.int/social_determinants/commissioners/interview_vagero/en/index.html

Lesson 6. Strategies and programs should incorporate an integrated approach and a life-course perspective.

Chronic disease prevention initiatives have traditionally taken their starting point from specific diseases such as heart disease, diabetes, chronic obstructive pulmonary disease and some cancers. This has given rise to vertical programs that aim to bring about change in relation to a number of the same risk issues. With growing evidence and increasing recognition that these diseases share a number of the same behavioural risk factors – e.g. tobacco use, unhealthy diet and sedentary lifestyle - as well as social risk factors – e.g. inequalities - there is a major opportunity to reconceptualise a national framework for chronic disease prevention initiatives in Australia in terms of a much more integrated approach. There are now a number of examples of OECD countries which have developed such an approach.

In addition, the life-course approach to chronic disease prevention has been advocated internationally in recent years, reflecting the emergence of research that tracks associations between exposures and outcomes at the individual and population levels.
Public health strategies that target individual chronic diseases have often operated without reference to one another. There is also research which demonstrates that this 'narrow' approaches leads to limited program effectiveness and efficiency (Robinson et al 2007). However, a systematic review of research on more integrated approaches to the prevention of excess weight and chronic disease in populations has also demonstrated an equivocal picture. It showed that some non-integrated (single component) strategies were quite effective and that the same mixed outcomes were apparent for more vertically and horizontally integrated strategies (Shiell, 2004).

What the evidence does suggest is that because of the multi-faceted, multi-level, multi-sector and population-wide nature of risk factors (proximal and distal) an integrated approach is more likely to:

- ensure greater alignment, coordination and direction for all sectors;
- provide a national context and reference point for all sectors, governments and Aboriginal organisations to measure the success of their own strategies and interventions;
- provide a forum for multiple players to align efforts and to work collaboratively to address common risk factors;
- ensure stakeholders are better and more broadly informed, thereby facilitating greater synergy and improved identification of opportunities across sectors public;
- overcome any inconsistencies or confusion of multiple "messages"; and
- lead to an increase in large scale efforts in knowledge development and exchange.

Requirements identified to support integrated chronic disease prevention and healthy living initiatives include:

- multi-level and multi-sector partnerships;
- policy development;
- flexibility in financing across different levels of government and organisations;
- capacity building (e.g. knowledge and resource development); and
- a combination of surveillance and information dissemination (Robinson et al 2007).

Exhibit - The Sydney Declaration
Partners making up the Oxford Health Alliance (2008) proposed four fronts for action that by nature represent one form of an integrated approach to primary prevention of chronic disease:

- Healthy places – designing towns, cities and rural areas, which are smoke-free, and where it is easy to walk, cycle and play, with unpolluted open spaces and safe local areas that foster social interaction.
- Healthy food – making healthy food affordable, and available to all.
- Healthy business – engaging business in the agendas promoting healthy people, healthy places, healthy planet and making good health good business.

- Healthy public policy – formulating comprehensive, innovative and 'joined-up' legislation and social and economic policies that promote health.
- Healthy societies – addressing equity and socio-economic disadvantage.

Source: Oxford Health Alliance (2008)

Potential barriers to integration may include:

- the lack of financial resources that span multiple-disease strategies and competing priorities (e.g., acute care and public health crises that divert policy attention and resources);
- issues for individual agencies of territoriality and perceived "loss of glory" (i.e., sharing credit for achievements) that may affect fundraising;
- resource costs involved in creating partnerships and slow progress in making things happen;
- problems integrating programs that have varied policies, service frameworks, and practices (i.e., silo effect); and
- difficulty protecting under-funded programs when integrating them with programs that have adequate resources.

Lesson 7. Strategies and programs need to be adequately supported and funded to demonstrate their effectiveness.

An important observation from the impact of public health policy and systems integration on chronic disease health outcomes is that considerable time is required for full implementation to occur and changes in determinants of the problem to be realised. Coordinated funding for capacity development is required and this takes time as well. Reliable implementation over an extended period of time (10 years or more) is essential and the means for the positive effects of programs to be sustained need to be considered. This requires significant levels of leadership, considerable investment in all aspects of program development, delivery, research and knowledge exchange into policy and practice.

Lessons 8. Strategies and programs need to be well designed using the best available evidence and implemented using multi-level and multi-sectoral approaches.

The evidence informing integrated programs and strategies consistently points toward multi-faceted interventions that are:

- addressing the fundamental behavioural and social causes of chronic disease
- using multiple approaches simultaneously – laws, communication (social marketing and education), social and community support/capacity building, and economic incentives and disincentives.
- operating at multiple levels: individuals, families, schools, workplaces, communities, and nation.
- designed to account for the special needs of specific target risk groups such as children, seniors, ethnic groups or at-risk communities.
- being long in duration because change takes time and needs to be constantly supported for each subsequent generation.
- engaging with a variety of sectors that are not traditionally associated with "health", such as business, transport, engineering, law, media and others.
- implementing a nationally comprehensive communications and social marketing campaign that provides clear and consistent messages.

In British Columbia, Canada, the integrated health strategy was based on 'four E's'; namely:

EXHIBIT - THE 4-E'S FOR MAINTAINING HEALTH

Education: campaigns that give populations and individuals the facts about specific health issues or behaviours, stressing the harms and the actions needed to avoid them. The education process must be multi-faceted, ongoing, and creative. It must use multiple settings, multiple variations of the message, and multiple avenues of communication - such as media, schools, and government campaigns.

Environmental supports: are design and social developments that support behavioural change. They might include nicotine patches, drug treatments, or cessation programs for tobacco use; comfortable, effective seatbelts or helmets to help injury reduction; vending machines stocked with healthy choices of food; pedometers used to measure daily activity; bike lanes or trails to promote cycling or walking.

Economic levers: are financial incentives and disincentives to discourage an unhealthy behaviour. Raising taxes, such as on tobacco, can discourage use. Removing taxes or providing tax deductions from other items, like sporting activities or exercise equipment, can encourage their use. Fines, tolls or other levies act as disincentives for unhealthy or risky actions, while rebates, price cuts, subsidies can support healthy actions and choices. Economic disincentives have been used very effectively to discourage tobacco use.

Enforcement: involves implementing legislation such as banning smoking in workplaces and public spaces, imposing age restrictions for cigarette purchases, and introducing helmet and seatbelt laws. It is usually the final step that comes after the groundwork has been done by the activities under the three other "Es".

Lesson 9. Addressing inequalities and the health gap between different population subgroups needs to be a critical dimension of all strategies and programs.

Countries' efforts to address health inequalities and the health gap between different population subgroups demonstrate that this requires a whole-of-system response that addresses both the proximal and more distal influences of the inequalities. Work from New Zealand on ensuring that inequalities are always addressed through programs is instructive and stems from the Treaty of Waitangi (**Appendix 8**). The following exhibit sets out how England is approaching the issue of health inequalities. The approach used in England illustrates many of the themes arising from the review in terms of what constitutes useful ways forward in this complex and politically challenging area. For instance, setting targets helps to ensure accountability to the public for actions and support the monitoring and evaluation of progress.

EXHIBIT - TACKLING HEALTH INEQUALITIES IN ENGLAND

History	A programme of addressing inequalities in health was initiated in England by the Acheson report "Independent inquiry into inequalities in health": http://www.archive.official-documents.co.uk/document/doh/ih/ih.htm, which triggered a series of key policy documents that brought health inequalities forward as a cross-government priority. Government-wide targets known as PSA or Public Service Agreement targets, aimed for faster improvement in health outcomes in a fifth of areas with the worst health and deprivation indices (in life expectancy, death from heart disease and stroke, and cancers).
Context	England along with all UK countries recognised the need to tackle health inequalities through a common approach, and working with regional and local structures of government as necessary. The approach involves a focus on both health (health care and health behaviour) factors, and on the wider, social determinants in health that achieve a sustainable reduction in health inequalities. All UK countries share a commitment to tackling health inequalities through addressing the wider, social determinants of health, as well as with targets; although the targets are framed slightly differently in each country.
Policies and action	The national health inequalities strategy for England is set out in the *Programme for Action* (2003) covering around a third of the population, not just socially excluded groups. It outlines a twin track approach with a national target to: *reduce health inequalities by 10% as measured by infant mortality and life expectancy at birth by 2010.* This approach combines action to achieve a long-term, sustainable reduction in health inequalities through the National Health Service (NHS), and through other government departments. The strategy identified 77 commitments from 12 government departments. The aim is to improve the health of people in disadvantaged groups and areas faster than the rest of the population. This includes reversing the 'inverse care law' where those with

	greatest health needs have least access to services. Action is on a broad front and is reflected in the strategy themes: • supporting families, mothers and children • engaging communities and individuals • preventing illness and providing effective treatment and care • addressing the underlying determinants of health Delivery involves action at local, regional and national level. Local government in England has new responsibilities for the health and well being of their communities as well as responsibility for a range of services covering the wider determinants such as education and housing. Working with local NHS bodies also helps deliver this strategy. A different focus has been deployed to deliver the 2010 target part of the strategy. On reducing the life expectancy gap, the specific interventions required are • reducing smoking in manual social groups • preventing and managing other risk factors, such as diet, and obesity, physical inactivity and high blood pressure • improving environmental health, including housing conditions and reducing accidents • targeting the over-50s –among whom the greatest short-term impact will be made, as well as • UK action also includes reductions in suicide rates and teenage pregnancy.
Targets	The UK Government's Public Service Agreement (PSA) to reduce health inequalities The single overall target: • Reduce health inequalities by 10% by 2010 as measured by infant mortality (from a 1997-99 baseline) and life expectancy at birth (from a 1995-97 baseline). The single target is supported by the following two specific targets: • Starting with children under one year, by 2010 to reduce the gap in mortality by at least 10% between "routine and manual" groups and the population as a whole. • Starting with Local Authorities, by 2010 to reduce by at least 10% the life expectancy gap between the fifth of areas with the worst health and deprivation indicators and the population as a whole. Supporting Targets: • Substantially reduce mortality rates by 2010 from heart disease and stroke and related disease by at least 40% in people under 75 with a 40% reduction in the inequalities gap between the fifth of areas with the worst health and deprivation factors (Spearhead areas) and the population as a whole. • Substantially reduce mortality rates by 2010 from cancers by at least 20% in people under 75 with a reduction in the inequalities gap of at least 6% between the fifth of areas with the worst health and deprivation indicators (spearhead areas) and the population as a whole. • Reduce adult smoking rates to 21% or less by 2010, with a reduction in prevalence among routine and manual groups to 26% or less.
Key strengths of the strategy	• An independent, scientific review on the evidence of health inequalities • A strategic approach that encompasses the social determinants of health underpinned by a cross government partnership • National targets to galvanise action at all levels, supported by an outcomes based performance framework and focus on delivery
Challenges	A Department of Health/Treasury review concluded that to achieve the desired targets it will be necessary to ensure: • a clear local plan and timescale for delivering the target • the engagement of key players in health and local government • greater clarity about the actions needed to address health inequalities, including an assessment of the impact of different interventions • action to address the low expectations about their health by people living in disadvantaged groups and areas, and • a clear performance management framework focused on outcomes and tracking delivery. In January 2006, the NHS in England announced that tackling health inequalities is to be one of the top six priorities for the service.

Policy Link	Social Exclusion A three phase initiative commenced in 1997. 1997-2001 – dedicated Social Exclusion Unit (SEU) in Cabinet Office directly accountable to Prime Minister. Focus was on developing new policies for selected 'socially excluded groups and areas'. 2001-2006 - SEU transferred to the Office of the Deputy Prime Minister with a focus on mainstream services of central and local government being changed to better meet the needs of disadvantaged groups. Spring 2007 to 2008 - SEU abolished and a Social Exclusion Task Force established back in the Cabinet Office with a narrower focus on 'deep' exclusion i.e. 'those experiencing entrenched and deep-seated exclusion [who] are often harder to reach and harder to engage'.

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Section 7. Appendices

Appendix 1. Statement of Requirement

This review was commissioned by the National Preventive Health Taskforce on behalf of the Australian Government, with the following Statement of Requirement:

Statement of Requirement

International Prevention Strategies/Programs – Requirements

The Department requires a background paper on the organisation and design of preventative health strategies/programs internationally, and from international organisations, which can inform the deliberations of the National Preventative Health Taskforce and the development of a new Preventative Health Strategy for Australia. The scope of the work is broadly to be focused on chronic disease prevention, and will not need to encompass health protection strategies.

Content Requirements
In particular, the background paper should identify and describe national, and (where appropriate) sub-national strategies/programs focusing on broad chronic disease prevention, tobacco, alcohol, diet, physical activity and obesity, which may offer lessons for Australia. It is likely that these will primarily be located in selected OECD countries; however, where there are important lessons to be learnt from innovative strategies in middle-income countries (for example, the work of Thai Health Promotion Foundation) these may also be appropriate for inclusion.

The paper will need to answer practical, policy-relevant questions in relation to the selected strategies: for example, what is the policy framework, what is the budget, how is the initiative financed, what is the timeframe, what targets have been set (if any), what are the human resource commitments in managing the strategy, what is the lead institution, what are the critical partnerships, how is the strategy being implemented and by whom, how are disparities being addressed, what empirical studies or models have informed the choice of strategy, what are the monitoring and evaluation arrangements?

Where appropriate, the paper will indicate how a particular strategy articulates into a broader policy context; for example, is there an overarching prevention strategy which has given rise to sub strategies targeting particular risk factors; how frequently is this renewed; what are the accountabilities – for example, is there reporting to parliament; what are the major drivers: for example, economic productivity, reducing demand on hospitals, population ageing?

Presentation
The paper should be presented in two parts. The first part will provide a summary analysis of strategies/programs chosen from the selected countries, together with an analysis of organisational and financing arrangements. It will provide a critical review of current and recent practice internationally, identify what, in the author's opinion, comprise the major strengths and weaknesses; what initiatives are proving, or are likely to prove, successful; and what are the key lessons that Australia might learn.

The second part, or appendix, would include details of the strategies/arrangements as a tabulated 'stocktake'.

Appendix 2. Policy responses by key players to the burden of chronic diseases

Table 1. Policy responses by key players to the burden of chronic disease

Key players	Policy responses	
	Of general nature	Specific to chronic disease
International organizations: WHO	• Resolutions of WHA and Regional Committee for Europe on the Regional health for all (HFA) policy framework • European Region strategy for attaining HFA by the year 2000 • Health21	• WHA resolutions on integrated prevention and control of noncommunicable diseases • WHA resolutions on risk factors for chronic disease (tobacco, diet, physical activity, alcohol) • WHO Regional Office for Europe Action Plans for Tobacco-free Europe, Food & Nutrition Policy, Alcohol • Positioning CINDI to meet the challenges: a WHO CINDI policy framework for noncommunicable disease prevention (1993) *(5)* • WHO Framework Convention on Tobacco Control • WHO Global Strategy on Diet, Physical Activity and Health • WHO Move for health initiative • Food and Health in Europe: a new basis for action, WHO Regional Office for Europe (2004)
EU	• Community action in public health (programme for 1997–2002) • Public health programme for 2003–2008	• Subprogramme areas on tobacco, alcohol, cardiovascular disease and cancer • Determinants of health • Information systems for health • Promoting heart health - a European consensus (under the Irish Presidency of EU)
NGOs	• Capacity building initiatives by the Association of Schools of Public Health in the European Region (ASPHER)	• European Heart Network (EHN): Tobacco use - priorities for action (1998) • EHN Expert Group on Physical Activity (1999) • EHN Nutrition Expert Group. Food, nutrition and cardiovascular diseases in the European Region: challenges for New Millennium (2002) • Third Joint Task Force of European and other Societies on Cardiovascular Diseases Prevention in Clinical Practice (2003)
Heads of State	• G8: Recognition that "health is the key to prosperity" and "poor health drives poverty"	• However, little commitment to chronic diseases except some support to the Framework Convention on Tobacco Control
Ministries of Health	• National health policies of European Member States	• Specific policies for selected chronic diseases; however, inadequate capacity and budgets in most of them
Academic and research institutions	• General recognition of the problem and research advocated	• Support and assistance in developing policies for selected chronic diseases with no provision of adequate funding
Private sector	• Little interest in primary prevention	• Considerable investments in secondary prevention
Media	• Lack of interest in primary prevention and long-term strategies	• Chronic disease low on the scale of interest compared with acute infections and sensations

Appendix 3. Overview of Program and Strategies

Programs	Finland	USA #	England	NZ	Canada	Thailand
Integrated Notes: Program in **bold text** is a major integrated program for chronic disease prevention. A more detailed description is provided for each in Appendices. CINDI (Country-wide Noncommunicable Disease Intervention) - a pan-regional initiative by WHO - is not represented in this analysis. WHO's **global survey on assessing the progress of national chronic diseases prevention and control** is likely to be a source of useful data but was not available at time of report preparation	**Development Programme for the Prevention and Care of Diabetes in Finland DEHKO 2000-2010** Programme for the Prevention of type 2 Diabetes in Finland 2003-2010 (FIN-D2D)	**Nutrition and Physical Activity Program to Prevent Obesity and Other Chronic Diseases (CDC-NCCDPHP)** Steps Program: Preventing Chronic Diseases Through Local Community Action REACH - Racial and Ethnic Approaches to Community Health New Delivery Sites and New Starts in Programs Funded Under the Health Centers Consolidation Act 21st Century Community Learning Center *The Coordinated Approach to Child Health (CATCH)*	**Healthy Weight, Healthy Lives** Healthy Living Centres (most disadvantaged areas) Young people's health demonstration sites National Child Measurement Programme NICE guidance program Reference Guide of Physical Activity Programs for Older Adults: A Resource for Planning Intervention X-Pert Programme (Type 2 diabetes) Choosing a better diet: a food and health action plan	**Healthy Eating - Healthy Action – HEHA**	**Pan-Canadian Healthy Living Strategy: Community Action Program for Children** **Aboriginal Head Start program** Canadian Field Epidemiology Program Building Canada National Native Alcohol and Drug Abuse Program	Health Promotion in Communities Plan Health Literacy Plan Health Promotion in Organizations Plan
Physical activity (also see Integrated)		National Youth Sports Program Fund *Activity Community Environment* *Washington Active Bodies Active Minds (WAABAM)* *VERB Summer Scorecard* *School-based physical activity* *The Sports Play and Active Recreation for Kids (SPARK)* *Carol M. White Physical Education Program*	Choosing Activity: A Physical Activity Action Plan (March 2005) Local Exercise Action Plans (LEAP) NICE guidance program Reference Guide of Physical Activity Programs for Older Adults: A Resource for Planning Intervention	*Mission On* *Push Play* *Green Prescription (GRx)* *Project Energize* *He Orange Poutama: Mapri Healthy Lifestyles Programme* *KiwiWalks* *SPARC and The Cancer Society*	SummerActive WinterActive ParticipACTION (public awareness campaign) The Children's Fitness Tax credit National Sport Policy Canada's Physical Activity Guides to Healthy Active Living	Health Risk Factors Control Plan Physical Exercise and Sports for Health Plan

Italicised programs are examples of state-level programs that are funded through a national program

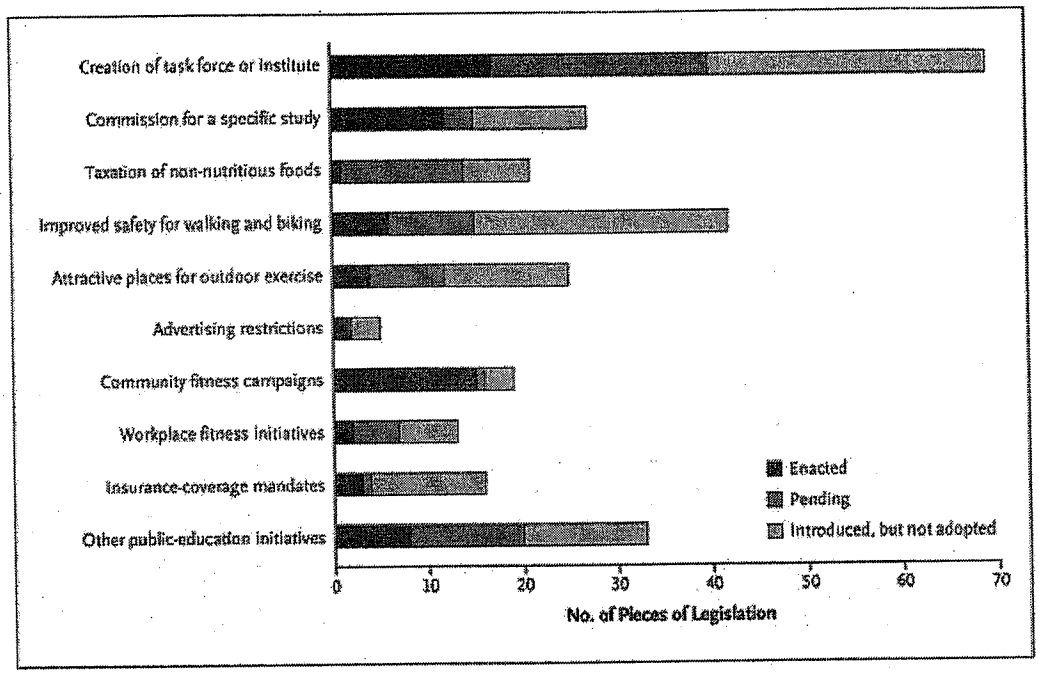
Programs	Finland	USA #	England	NZ	Canada	Thailand
Diet (also see Integrated)		5 A Day for Better Health *Fresh Initiative* *The Access to Healthy Foods Coalition* *Food Stamp Program* *Healthier Options in School Cafeterias* *Nutrition Program for Women, Infants, and Children* Promoting Fruit and Vegetable Consumption in Schools	Food in schools programme Food and Health Action Plan Choosing a better diet: a food and health action plan	Live Smart 5+ a Day Pick the Tick (Tick Approval) School based nutrition programes Food labelling Food advertising restriction	Canadian PreNatal Nutrition Program Canada's food guide	
Physical activity and diet OR Obesity (also see Integrated)	JALOIN programme (2001-2004)	National Diabetes Education Program (DHHS, NIH, CDC) (primary, secondary) National School Lunch Program *Healthier Vending Machine Project* Prevention and Treatment of Childhood Obesity in Primary Care Children, Youth, and Families at Risk State Strengthening Projects	Guidance on setting goals for child obesity Guidance for Local areas	Strategy for Prevention and Control of Diabetes (primary, secondary) Waitemata Beverage Project	Canadian Heart Health Initiative ParticipACTION and VITALITY Investing for the future – Governmental action plan for the promotion of healthy lifestyle and prevention of weight-related problems 2006-2012	
Diabetes (also see Integrated)	Development Programme for the Prevention and Care of Diabetes in Finland DEHKO 2000-2010 Programme for the Prevention of type 2 Diabetes in Finland 2003-2010 (FIN-D2D)	National Diabetes Education Program Community-Based Diabetes Management	Diabetes National Service Framework 1999 X-Pert Programme (Type 2 diabetes)	Let's Beat Diabetes (LBD) http://www.letsbeatdiabetes.org.nz/page/diabetes_5.php	Canadian Diabetes Strategy Eat well. Be active. Have fun. – you can Prevent Type 2 Diabetes. Aboriginal Diabetes Initiative	
Tobacco (also see Integrated)	European Network on Young People and Tobacco ENYPAT (includes participation by Finland) QUIT & WIN - Global program (includes participation by Finland)	2-minute tobacco cessation intervention Medicare coverage of quit counselling for smokers diagnosed with smoking-related illnesses	Tobacco – new strategy in development	Healthy Eating - Healthy Action (primary) Smokefree and physical activity actions within the workplace	National Native Alcohol and Drug Abuse Program	Tobacco Consumption Plan

Italicised programs are examples of state-level programs that are funded through a national program

Programs	Finland	USA #	England	NZ	Canada	Thailand
Alcohol (also see Integrated)			Safe. Sensible. Social. The Next Steps in the National Alcohol Strategy	Awareness of the harmful effects of alcohol Tied alcohol tax Warning labels on alcohol products Alcohol advertising	National Native Alcohol and Drug Abuse Program	Alcoholic Beverage Consumption Plan
Other risk factors for major chronic diseases – CVD, cancers		WISEWOMAN - national screening program for low-income and uninsured women	Cancer Reform Strategy 2007 Coronary Heart Disease National Service Framework	Carcinogenic compounds legal framework SunSmart	Canadian Strategy for Cancer Control Renewed Canadian Breast Cancer Initiative Centre for Chronic Disease Prevention and Control - Cancer	Cervical Cancer Screening programs

Italicised programs are examples of state-level programs that are funded through a national program

Appendix 4. US State Legislative Initiatives to Combat Obesity in the Community, 1998–2005



Source: Mello M, Studdert DM and Brennan TA (2006)

Appendix 5. Roles of government in obesity prevention

Action area	Description	Rationale	Examples
Leadership	Providing a visible lead Reinforcing the seriousness of the problem Demonstrating a readiness to take serious action	All societal change needs strong leadership The role of governments is central, powerful and carries sufficient authority to stimulate a sustained multisector response Government voices speak loudly about problems Government actions speak louder about solutions	Being visible in the media Role modeling healthy behaviours (at an individual level) Role modeling healthy environments (at a government agency level) Creating mechanisms for a whole-of government response to obesity Lifting the priority for health (versus commercial) outcomes
Advocacy	Advocating for a multi-sector response across all societal sectors (governments, the private sector, civil society, and the public)	Solutions will need to involve many sectors within governments and all sectors outside government Authoritative mechanisms will be needed to achieve cross-sectoral collaboration and coordination	Advocating to the private sector for corporate responsibility around marketing to children Creating a high-level taskforce to oversee and monitor multisector actions Encouraging healthy lifestyles for individual and families
Funding	Securing increased and continuing funding to create healthy environments and encourage healthy eating and physical activity	Changing environments requires funding Social marketing and programs require funding Supporting actions (eg training, research, evaluation, monitoring) require funding Public good funding comes mainly from government sources	Establishing a health promotion foundation (eg using an hypothecated tobacco tax) to fund programs and research Moving from project funding to program and service funding for obesity prevention Creating centres of excellence for research, evaluation and monitoring
Policy	Developing, implementing, and monitoring a set of policies, regulations, taxes, and subsidies that make environments less obesogenic and more health promoting	Most behaviours are heavily influenced by environmental factors (physical, economic, policy, socio-cultural) Changing environments often requires policy drivers Education-based approaches are weak without supportive environments	Banning the marketing of unhealthy foods to children Subsidising public transport and active transport more than car transport Requiring 'traffic light' front of pack labeling of food nutrient profiles Restricting the sale of unhealthy foods in schools

Source: Swinburn B (2008)

Appendix 6.

SYSTEM UNDERPINNING CHRONIC DISEASE PREVENTION IN THAILAND

GOVERNANCE

ThaiHealth is one small organisation of the larger Ministry of Public Health and its service agencies, which employ a workforce of more than 200,000. It also articulates with the Ministry of Transport on issues associated with reducing traffic accidents.

It is described as a 'catalyst' in the system to accelerate the development towards the Ministry of Public Health's goals and objectives (ThaiHealth, 2008).

The Thai Health Promotion Foundation Act specifies that, in addition to supporting national public health policies, ThaiHealth should help coordinate activities by state and private agencies. ThaiHealth acts as the secretariat to the national taskforce for implementing the 'Healthy Thailand' campaign (540 million baht over 3 years). The national taskforce includes state agencies, academics, and private organizations.
The areas that ThaiHealth support include: office secretariat to coordinate activities; coordination between partner organizations; development of model projects; research and development necessary for implementing the 'Healthy Thailand' policy; and communication for policy implementation.
ThaiHealth has two boards. Besides the Governing Board (21 members) which the Prime Minister chairs, ThaiHealth has an independent Evaluation Board (7 members). The two Boards maintain equal authority with the Royal Thai Cabinet appointing both. ThaiHealth has 80 staff and is consists of nine sections classified according to their working approaches and related-work responsibility.

Operational divisions in ThaiHealth
Section 0 - **Office of the Manager**: Responsible for overall administration.
Section 1 - **Health Promotion and Primary Risk Factor Reduction**: Oversees the Tobacco Consumption Control, Alcohol Consumption Control, and Traffic Accident Prevention plans.
Section 2 - **Health Promotion and Secondary Risk Factor Reduction**:
Oversees the Health Risk Factors Control, Health Literacy, and Health Promotion in Organizations plans.
Section 3 - **Community-Based Health Promotion**: Oversees the Health Promotion in Communities and Integrated National Public Health Policy ("Healthy Thailand") plans.
Section 4 - **Health Promotion in Organizations**: Oversees the Health Promotion in Organizations plan.
Section 5 - **Social Marketing**: Oversees the Physical Activities Promotion, and Social Marketing plans.
Section 6 - **Open Grants**: Oversees the Supporting General and Innovate Projects plan.
Section 7 - **Knowledge Management and Social Capital**: Oversees the Health Promotion through Health Care Delivery System and Developing Social Capital and Supportive System plans.

There is also a unit responsible public relations.

MANDATE

ThaiHealth was established under the Health Promotion Foundation Act, B.E. 2544 in 2001 as a statutory public organization. It's primary funding is from 2% earmarked taxation (a surcharge) from tobacco and alcoholic beverages. It is responsible for encouraging, supporting, and funding a variety of health promotion activities for public health. ThaiHealth aims not only to reduce tobacco and alcohol consumption, but also to improve the people's state of "total well-being" by fully applying the holistic meaning of 'health' as defined by World Health Organization.

ThaiHealth is a national body and under Section 5 of the Act, the Foundation is mandated with the following objectives:

- to promote and encourage health promotion in the population of all ages in accordance with the national health policy;
- to create awareness of hazardous behaviour from the consumption of alcoholic beverages, tobacco or other health-deteriorating substances and to create belief in health promotion amongst people of all classes;

- to support campaigns for the reduction in the consumption of alcoholic beverages, tobacco and other health-deteriorating substances, and create public awareness of the relevant legal provisions;
- to conduct studies and research, or encourage the conduct of the study and research, training or organization of meetings with regard to health promotion;
- to develop the ability of a community in fostering health promotion by the community or private organization, public benefit organization, Government Agencies, State enterprises or other State Agencies; and

to support campaigns for health promotion by various activities as a means by which members of the public can improve their health, spare time fruitfully and reduce their consumption of alcoholic beverages, tobacco and other health deteriorating substances.

INFRASTRUCTURE-RESEARCH AND SURVEILLANCE

ThaiHealth's health promotion strategies are based on the WHO Ottawa Charter and observe a holistic view of health. They aim to develop social movements and the health system to increase the well-being. The principle strategies are as follows:

Social Mobilization - involving collaborations between different groups.
System Development - to improve the structure of the Thai health system, including policies, laws and management practices.
Healthy Communities Development – supporting good health promotion practices in communities, cities, schools and workplaces throughout the country.
Social capital - to build the social infrastructure required for effective health promotion including

- leadership
- information systems and networks
- knowledge management systems
- resource management system

A multi-strategy and multi-level approach for interventions is adopted, focusing on the following: issues (such as risk factors); settings; area (geographic and local communities) and target populations (underprivileged, ThaiMuslims etc).

LEADERSHIP AND INTEGRATION

The focal points for integrating activites include: target populations; area based initiatives; and support systems for knowledge management and information system development. To this end a master plan for integration involves the development of:

- National public health policy integration plan
- Area and community health development plan
- Social marketing plan
- Developing Support System and Mechanism for Health Promotion Plan

Target populations plan

BUDGET AND FINANCING

The law secures ThaiHealth's annual revenue of approximately **US $55 million**, which comes from a 2% surcharge on tobacco and alcohol taxes. The annual budget amounts to approximately 0.75 per cent of the nation's spending on health care and close to 0.17 per cent of the annual government budget.

Table 2 : Summary of Spending Budget

	2005		2006		2007		2008	
	m baht	%	m baht	%	m baht	%	m baht	%
Supporting national health policy plans								
Tobacco Consumption Control Plan	120	3.7	150	4.4	160	4.7	180	5.3
Alcohol Consumption Control Plan	310	9.6	315	9.2	325	9.5	330	9.6
Traffic Accident Prevention Plan	260	7.8	270	7.8	280	8.2	280	8.2
Physical Exercises and Sports for Health Promotion Plan	190	5.9	200	5.8	200	5.8	200	5.8
Health Learning Process Plan	210	6.6	310	9.0	310	9.0	305	8.9
Social Marketing Plan	400	12.4	405	11.8	415	12.1	415	12.1
Integrated National Public Health Policy ('Healthy Thailand') Plan	200	6.2	180	5.2	170	5.0	160	4.7
	1,690	52.1	1,830	53.2	1,860	54.2	1,870	55
Health promotion plans								
Health Risk Factors Control Plan	350	10.9	365	10.6	365	10.6	375	10.9
Health Promotion in Organizations Plan	80	2.5	95	2.8	95	2.8	90	2.6
Health Promotion in Communities Plan	370	11.5	300	8.7	270	7.9	270	7.9
Health Promotion through Health Care Delivery System Plan	220	6.8	220	6.4	230	6.7	205	6.0
Supporting General and Innovative Projects Plan	200	6.2	220	6.4	240	7.0	260	7.6
Developing Supportive System and Mechanism for Health Promotion Plan	325	10.1	410	11.9	370	10.8	355	10.4
	1,545	47.9	1,610	46.8	1,570	45.8	1,555	45.4

Appendix 7. Swedish Public Health Policy

"An important strategic crossroads has been reached with the new public health policy. Where objectives had previously been based on diseases or health problems, health determinants were now chosen instead. Health determinants are factors in society or in our living conditions that contribute to good or bad health.

The benefit of using determinants as a basis is that the objectives will then be accessible for political decisions and can be influenced by certain types of societal measures. If we set objectives in terms of disease, e.g. to reduce the number of heart attacks, they do not provide any guidance as to what measures may be effective in achieving them. It is impossible to say, for example, whether a reduction in the number of heart attacks is due to improved public health or to other reasons.
It is important to clarify how a determinant impacts health. There is a relationship between greater economic inequality and poorer public health, but the mechanisms behind this relationship have not been particularly well clarified. This means in turn that the public health argument does not carry quite so much weight in the public debate as for example economic arguments do. Formulating public health objectives in terms of health determinants requires public health work to be very much knowledge-based.
Using health determinants as a basis means the vast majority of public health work must take place outside the medical care service. Most of the factors that impact health are to be found outside the spheres of medical competence and knowledge. When it comes to influencing unemployment figures, social security, housing segregation and alcohol habits, decisions taken in municipal assemblies and other democratic bodies play a much more important role than efforts made in the medical care sector.

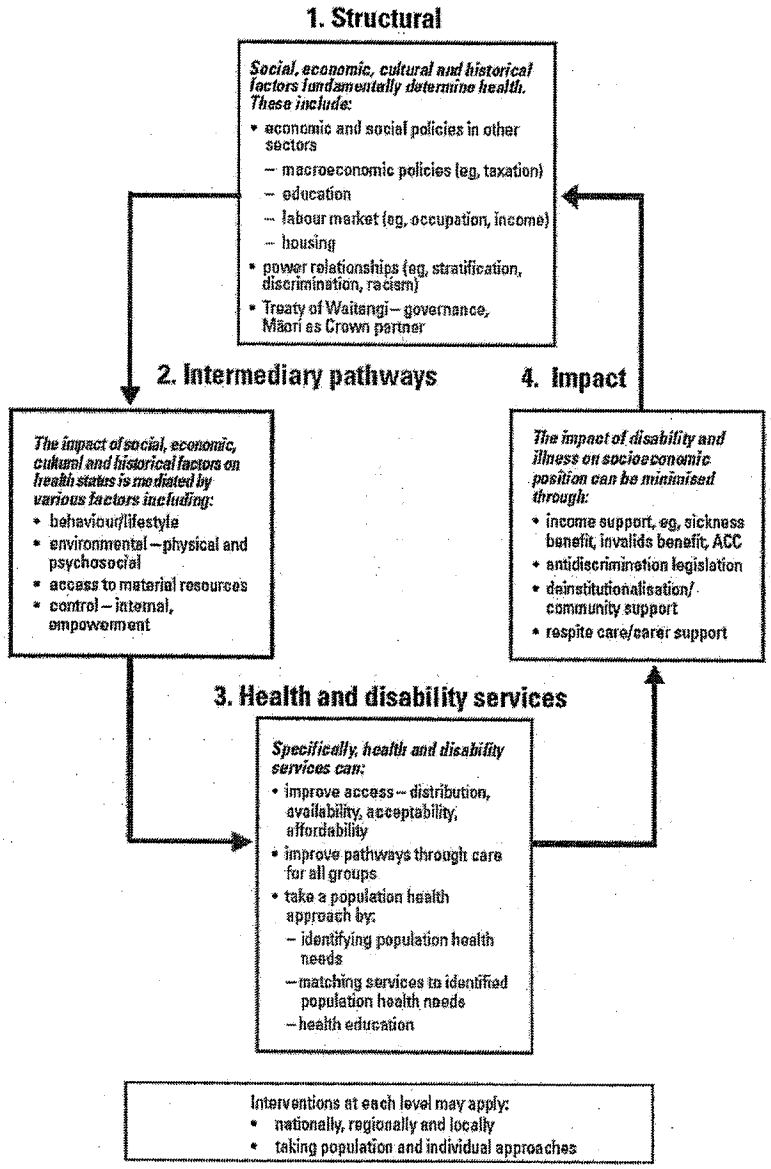
Eleven general objectives for public health work

Swedish public health policy is based on eleven objectives containing the most important determinants of Swedish public health. The overarching aim is to create the conditions for good health on equal terms for the entire population. These eleven objectives are as follows:

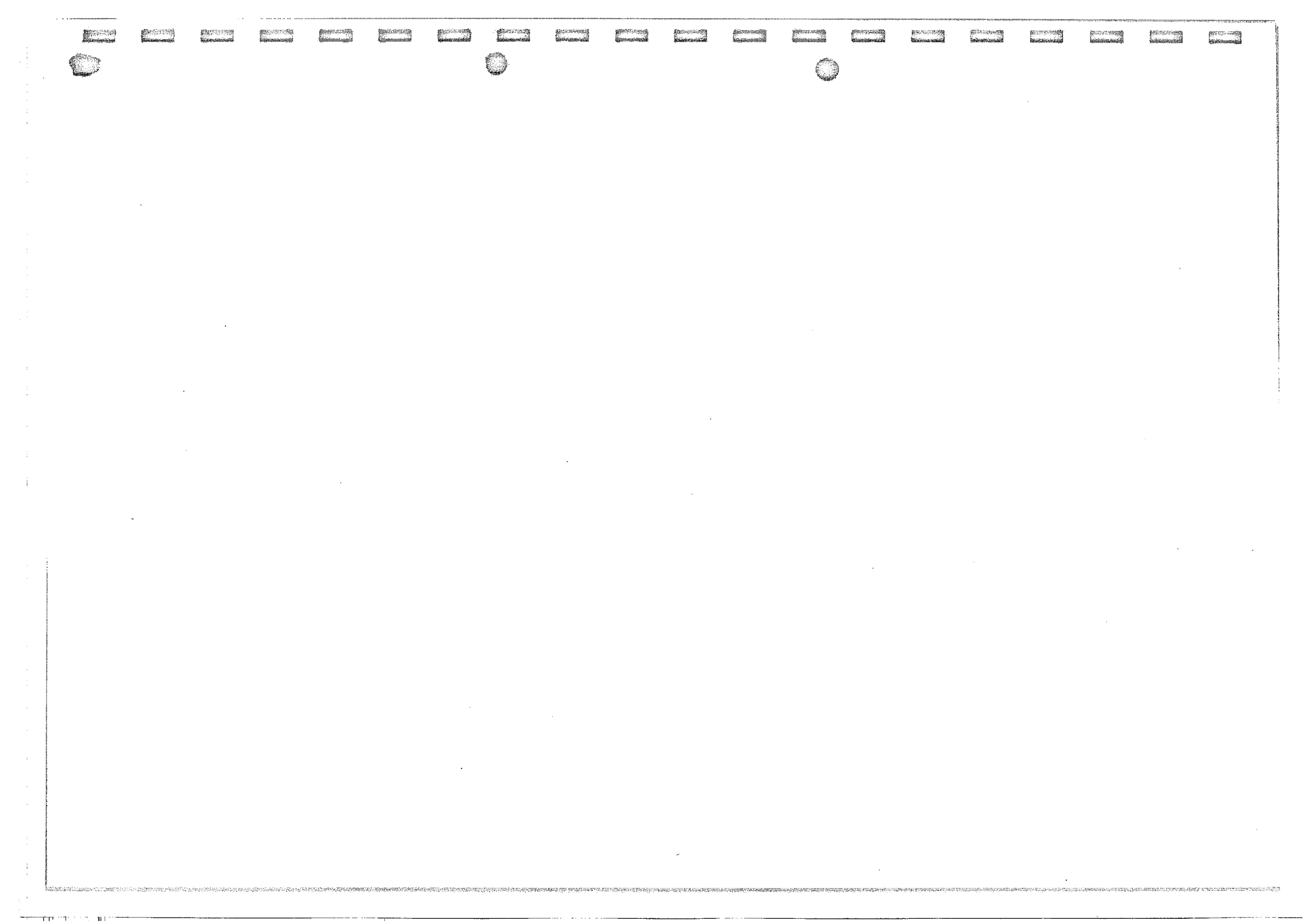
1. Participation and influence in society
2. Economic and social security
3. Secure and favourable conditions during childhood and adolescence
4. Healthier working life
5. Healthy and safe environments and products
6. Health and medical care that more actively promotes good health
7. Effective protection against communicable diseases
8. Safe sexuality and good reproductive health
9. Increased physical activity
10. Good eating habits and safe food
11. Reduced use of tobacco and alcohol, a society free from illicit drugs nd doping and a reduction in the harmful effects of excessive gambling

Source: Swedish Public Health Policy
http://www.fhi.se/shop/material_pdf/newpublic0401.pdf

Appendix 8. Intervention Framework to Improve Health and Reduce Inequalities: New Zealand



Source: Ministry of Health. 2004. Healthy Eating – Healthy Action: Oranga Kai – Oranga Pumau. Implementation Plan: 2004–2010. Wellington: Ministry of Health. www.moh.govt.nz/moh.nsf/0/CD182E2C03925C09CC256EBD0016CF4B/$File/healthyeatinghealthyactionimplementationplan.pdf



A rapid review of chronic disease prevention strategies and programs in selected OECD countries

Stocktake documentation

PART B

TABLE OF CONTENTS

Part B

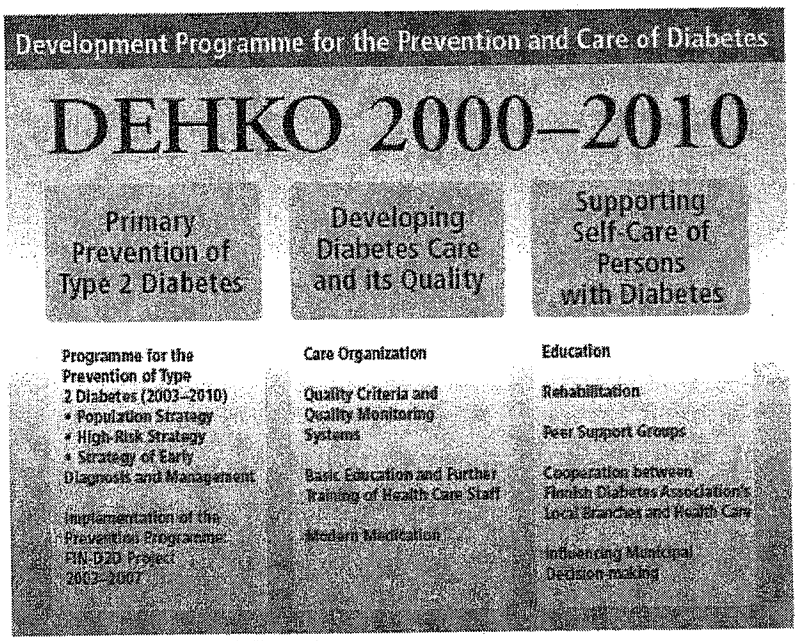
INTEGRATED – DIABETES

STRATEGY/ PROGRAM

Development Programme for the Prevention and Care of Diabetes in Finland (DEHKO)

POLICY FRAMEWORK

Aims to prevent type 2 diabetes and diabetes-related complications to improve the quality of diabetes care and to support the self-care of people with diabetes. DEHKO constructs new action models for health care which are implemented throughout Finland



ORGANISATION

Diabetes Association of Finland

LEVEL

National

BUDGET

Data not available at time of writing

FINANCING

DEHKO is financed by Finland's Slot Machine Association (RAY), the Finnish Diabetes Association and diabetes-related companies, which, together with RAY, have committed themselves from the very outset to the long-term funding of the programme.

TIMEFRAME

2000-2010

TARGETS

DEHKO has clear goals to be achieved by 2010 and 25 concrete recommendations for action. Many of the recommended actions have already been carried out.

The objectives concerning health outcomes targeted for 2010 are as follows:
The glycemic control of people with diabetes will have improved so that at least 50 percent of people with diabetes have optimal glycemic control and at least 30 percent have adequate glycemic control.
The incidence of cardiovascular disease among people with diabetes drops by at least one-third.
The complications related to diabetes will decrease according to the objectives of the European St. Vincent programme:
- leg amputations at least by one-half
- diabetic retinopathy at least by one-third
- diabetic nephropathy at least by one-third

There will be a quality system of diabetes care in each care unit, a natural part of which is regular and comprehensive diabetes training within primary healthcare. Measures aimed at the prevention of type 2 diabetes will be a permanent function of primary healthcare.

	There will be a computerized diabetes registry in each care unit and in each district, as well as a national diabetes registry. The care organisation for people with diabetes will be based on smooth-running care chains, shared responsibility for care between primary healthcare and specialized medical care, and flexible consultation practices. Each person with type 1 diabetes will have access to individual, high-quality self-care. All people with type 2 diabetes will receive sufficient education in self-care, and their cardiovascular risk factors will be treated along with their hyperglycemia. People with diabetes will have the skill required for self-care and have a high level of satisfaction with their care. The cooperation between the healthcare system and the diabetes associations in supporting self-care will become established as a permanent form of activity.
HR	Data not available at time of writing
LEAD INSTITUTION	DEHKO is coordinated by the Finnish Diabetes Association, which is responsible for the national sub-projects of DEHKO. DEHKO is the first national programme in the world also to include and implement the prevention of type 2 diabetes.
PARTNERSHIPS	This is a partnership project between the Finnish Diabetes Association, primary health care, specialised medical care, occupational health care providers and the National Public Health Institute (KTL)..
IMPLEMENTATION	Finnish Diabetes Association has been responsible for initiating, preparing, financing and coordinating the implementation of DEHKO since DEHKO was accepted as Finland's national diabetes programme for 2000–2010 in the consensus meeting in 2000. Already during DEHKO's preparation stage, Finnish Diabetes Association created a cooperation network. An estimated hundred diabetes researchers, practical care professionals, people with diabetes and other partners were involved in building Dehko. Once the implementation of DEHKO began, authorities, government institutes, organizations and various experts were invited to take part in the programme. The cooperation network has grown bigger year after year, particularly during the preparation of type 2 diabetes prevention programme and the implementation of population strategy. Key cooperation partners of DEHKO are the Ministry of Social Affairs and Health, the Ministry of Education, National Public Health Institute, National Research and Development Centre for Welfare and Health, Social Insurance Institution in Finland, and from nongovernmental organizations Association of Finnish Local and Regional Authorities, Finnish Heart Association as the strategic partner, Finnish Association for Organ Transplant and Kidney Patients, Finnish Federation of the Visually Impaired, Stroke and Dysphasia Federation in Finland, Association of Finnish Pharmacies, Association of Finnish Diabetes Nurses, Finnish Association of Podiatrists and several other professional health care organizations. The Ministry of Social Affairs and Health and the main sponsor, Finnish Slot Machine Association, as well as the pharmaceutical companies which act as DEHKO's main sponsors, sponsors and supporters, are regularly informed of DEHKO's progress. The strong commitment of financial supporters is an essential prerequisite for implementing DEHKO.
INEQUALITIES	Data not available at time of writing
MODELS/EVIDENCE	Data not available at time of writing
MONITORING	The programme is regularly monitored and assessed by the DEHKO Direction and Monitoring Group

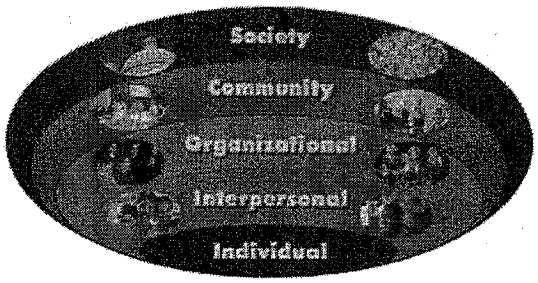
INTEGRATED – NUTRITION & PHYSICAL ACTIVITY (HEALTHY WEIGHT)

STRATEGY/ PROGRAM

Nutrition and Physical Activity Program to Prevent Obesity and Other Chronic Diseases (CDC-NCCDPHP)

The Nutrition and Physical Activity Program to Prevent Obesity and Other Chronic Diseases (NPAO) is based on a cooperative agreement between the Centers for Disease Control and Prevention's Division of Nutrition, Physical Activity and Obesity (DNPAO) and 28 state health departments.

The program was established in fiscal year 1999 to prevent and control obesity and other chronic diseases by supporting states in developing and implementing nutrition and physical activity interventions, particularly through population-based strategies (e.g., policy-level changes, environmental supports).



POLICY FRAMEWORK

Linked to Healthy People 2010

Designed to help states prevent obesity and other chronic diseases by addressing two closely related factors — poor nutrition and inadequate physical activity. The program supports states with developing and implementing science-based nutrition and physical activity interventions. States fund activities that are based on the social-ecological model to address all levels of influence within a community to help people make behavior changes.

Linked to other policy frameworks:
- Physical Activity and Health: A Report of the Surgeon General;
- Healthy People 2010;
- Community Guide to Preventive Services.
- SmallStep.Gov;
- Steps to a HealthierUS Partnerships;
- President Bush's HealthierUS initiative;
- The President's Council on Physical Fitness and Sports;
- Fitness.gov;
- The President's Challenge (The new President's Challenge allows individuals to track weekly fitness activities, and receive Presidential fitness awards for achieving defined fitness goals)

ORGANISATION

Centers for Disease Control and Prevention's (CDC's) Division of Nutrition and Physical Activity (DNPA) and the health departments of funded states.
http://www.cdc.gov/nccdphp/dnpa

LEVEL

National program that funds state-level activities

BUDGET

In fiscal year 2006 - program leveraged about $1.7 million;
In 2005–2006 - 21 states were funded at $400,000 to $450,000 for capacity building. Seven states were funded at $750,000 to $1.3 million for basic implementation, bringing the total number of funded states to 28
In fiscal year 2008 - funding of $38 million

FINANCING

Federal Government funded states' activities via CDC

TIMEFRAME

2010

TARGETS

In a new funding announcement FY 2008, newly funded states will address the

following six target areas:
1. Increase physical activity.
2. Increase consumption of fruits and vegetables.
3. Decrease consumption of sugar-sweetened beverages.
4. Increase breastfeeding initiation and duration.
5. Decrease consumption of high energy-dense foods.
6. Decrease television viewing.

States that received funded provide evidence of:
Policies, environmental supports, and legislative actions that were initiated (introduced), modified, or enforced (enacted) for the prevention or control of obesity and other chronic diseases;
Outcomes/impacts of at least one intervention that evaluates nutrition and physical activity strategies to prevent or control obesity and other chronic diseases;
At least one community that implemented a nutrition and physical activity plan for the prevention and control of obesity and other chronic diseases;
A quality, comprehensive state nutrition and physical activity plan to prevent and control obesity and other chronic diseases; this plan would promote coordination of activities across all relevant state and community programs, in which relevant partners are identified in substantive roles;
Strategic planning activities at the state level to develop a comprehensive nutrition and physical activity plan to prevent and control obesity and other chronic diseases

HR

Data not available at time of writing

LEAD INSTITUTION

CDC's Division of Nutrition, Physical Activity and Obesity (DNPAO)

PARTNERSHIPS

States governments; National Fruit and Vegetable Alliance; Center of Excellence for Training and Research Translation; public health experts in government and academia; the Physical Activity Policy Research Network (PAPRN)

CDC is the federal health authority for the National Fruit and Vegetable Program and a founding member of the National Fruit and Vegetable Alliance. The alliance works to increase access and consumption of all forms of fruits and vegetables to improve public health. DNPAO supports this target area through scientific, partnership, and programmatic efforts. The programmatic efforts are integrated into the NPAO program.

IMPLEMENTATION

Programs have been implemented since fiscal year 1999. The implementation including **capacity building** and **basic program implementation**:

Capacity building:
- Establish state infrastructure;
- Plan obesity prevention and control efforts;
- Identify data sources to monitor the burden of obesity;
- Collaborate and coordinate with public and private partners; and
- Begin implementing interventions.

Basic implementation: In 2006, state interventions addressed the following five levels of the social-ecological model:
- Societal level: 20 interventions;
- Community level: 39 interventions;
- Organizational level: 54 interventions;
- Interpersonal level: 52 interventions;
- Individual level: 65 interventions as well as
- **Increase physical activity**: 65 interventions;
- **Increase consumption of fruits and vegetables**: 66 interventions;
- **Decrease consumption of sugar-sweetened beverages**: 24 interventions;
- **Decrease television viewing**: 21 interventions;

Examples of state programs implemented:

Activity Community Environment
State Department of Health, working collaboratively with the Dept of Community Trade and Economic Development, Dept of Transportation and Regional Transportation Planning Organizations supported the development of Active Living Task Forces in communities around the state. Active Living Task Forces assisted the local Regional Transportation Planning Organizations to consider appropriate policy and environmental changes that will support an active community environment (ACE). An ACE is a place where people of all ages and abilities can easily enjoy walking, bicycling and other forms of recreation.

Healthier Vending Machine Project:
The Department of Health and Senior Services (DHSS) initiated a healthier vending project at their office buildings where approximately 800 state employees work to provide the healthier foods.
Fresh Initiative
An innovative public-private partnership with one of the largest fresh fruit and vegetable distributors that delivered high-quality fresh fruits and vegetables directly to the worksite and sold them to employees at significant discounts.
Washington Active Bodies Active Minds (WAABAM) - provide online resources that professionals and families can use to help limit screen time and encourage physical activity for preschool children.
The Access to Healthy Foods Coalition is a statewide group that works to improve the availability of healthful foods for all Washington residents.
VERB Summer Scorecard – a community-based prevention marketing program works with businesses, faith-based groups, and public organizations to encourage physical activity among children ages 9-13 through free or reduced-price activities – e.g., free dances at libraries, swimming at public pools, black-light volleyball at the YMCA, and two-for-one roller skating
Healthier Options in School Cafeterias
"Rock on Café" is a community collaborative effort to provide healthier meals and food options in school

Other activities:

- School-based physical activity
- Social support interventions in community settings
- Creation of or enhanced access to places for physical activity combined with informational outreach activities
- The Sports Play and Active Recreation for Kids
- (SPARK)
- The Coordinated Approach to Child Health (CATCH)
- National School Lunch Program;
- Food Stamp Program;

INEQUALITIES

Inequalities are addressed through programs in a variety of ways.
Initiatives to combat inequalities within the realm of physical activity programs exist at Federal, State, and local levels in many different and innovative forms.

For example:

REACH 2010 (Racial and Ethnic Approaches to Community Health 2010) is a collaborative Federal initiative aimed at eliminating disparities in health status experienced by select populations.
The VERB campaign targeted American Indian or Alaska Native adolescents and Hispanic adolescents with multicultural media messages about physical activity.
"I Can Do It, You Can Do It!" is an initiative supported by the HHS Office on Disability, the President's Council on Physical Fitness and Sports, the National Institutes of Health, and numerous community and nonprofit organizations to improve and evaluate the activity and nutrition of people with disabilities.
The National Blueprint: Increasing Physical Activity Among Adults Aged 50 and Older identifies organizations and strategies to help combat inactivity and improve the quality of life for older Americans
CDC's Paediatric Nutrition Surveillance System (PedNSS) was designed to monitor the nutritional status of low-income infants, children, and women in federally funded maternal and child health programs.

MODELS/EVIDENCE	State -programs must be evidence based. The operational definition of an intervention used by the Nutrition and Physical Activity Program to Prevent Obesity and Other Chronic Diseases is *"an activity with the main purpose of changing existing obesity-, nutrition- or physical activity-related behaviors and/or practices."* At a minimum, interventions that funded states implement must contain all of the following components: • Grounded in theory; • Intervention design decisions can be linked to knowledge and understanding of the target audience; • Defined purpose with clearly stated goals and objectives; • Expected outcomes (to include BMI/BMI for age when appropriate); • Defined intervention methodology (where, when, and how); • Strategy for implementation (to include collaboration with partners); • Target population(s) segment(s) that relate to populations identified in the state plan; and • Defined evaluation design and methodology.
MONITORING	Program activities evaluated based on a set of performance measures in the original Request for Applications (RFA). CDC's framework for preventing and controlling chronic diseases is supported by surveillance, which involves collecting data to better understand the extent of risk behaviors, to monitor the progress of prevention efforts, and to help public health professionals and legislators make more timely and effective decisions. For example: Behavioral Risk Factor Surveillance System; Health-Related Quality of Life (HRQOL), National Health and Nutrition Examination Survey (NHANES), a survey is designed to assess the health and nutritional status of adults and children in the United States. Paediatric Nutrition Surveillance System (**PedNSS**) and Pregnancy Nutrition Surveillance System (**PNSS**), CDC facilitates the collection, analysis, and interpretation of key indicators of child nutritional status and behavioral and nutritional risk factors for low-income pregnant women. An interactive CDC Web site trains people to use these systems

INTEGRATED - DIET/PHYSICAL ACTIVITY/OBESITY

STRATEGY	**Healthy Weight, Healthy Lives: A cross-government strategy for England.** Focus on: the healthy growth and development of children; promoting healthier food choices; building physical activity into our lives; incentives for better health; personalised advice and support. 5 key elements: • Healthy growth and development of children • Promoting healthier food choices • Building physical activity into daily lives • Creating incentives for better health (healthy workplaces and personal incentives) • Personalised advice and support •
POLICY FRAMEWORK	Whole of population; lifecourse perspective; multi-level; multi-strategy; across sectors/portfolios; integrated approach across risk factors. Linked to *NHS Operating Framework* and *Children's Plan*
ORGANISATION	Department of Health - Public Health http://www.dh.gov.uk
LEVEL	National
BUDGET	Base unknown. In 2008 an additional 375 million pounds - 75 million in evidence-based marketing plan; 30 million in healthy towns. 1.3 billion in school fund, sport and play; 140 million for Cycling England. 240 million school lunches; 150 million capital fund for school kitchens; 20 million cooking classes in schools.
FINANCING	Consolidated revenue and lottery funding
TIMEFRAME	2008-11
TARGETS	By 2020 reduce the proportion of overweight and obese children to 2000 levels; a third of England walking at least 1,000 more steps
HR	
LEAD INSTITUTION	Department of Health -The Department of Health is responsible for overall policy on obesity and is jointly responsible with the Department for Children, Schools and Families (DCSF) for tackling child obesity. Across government leadership/integration is by a new Cabinet Committee on Health and Well-being. Their remit is tackling obesity and promoting health weight and membership includes all lead departments. Linked also to the Cabinet Committee on Families, Children and Young People who will monitor progress on child weight problems.
PARTNERSHIPS	Department of Schools and Families; Sport England; strategic health authorities; primary care trusts; local authorities and citizens and business (citizen juries). To support stakeholders in business and the third sector in engaging with each other on how they can meet the challenge of tackling excess weight in the population, the Government will seek to work with stakeholders on how to strengthen existing arrangements. Our aim is to build a Coalition for Better Health, which would; • reach agreements on joint programmes • disseminate knowledge on what works, and what doesn't • challenge each other to go further
IMPLEMENTATION	Current - commenced January 2008
INEQUALITIES	Strategy for * Early identification of at risk families and plans to make breastfeeding the default option for mothers. An equality impact assessment is used to identify the possible impact of Healthy Weight, Healthy Lives, and the policies it sets out, on people according to their age, disability, race, religion and beliefs, gender and sexual orientation. Aims to assess whether the strategy is likely to have adverse effects on any of these groups.

MODELS/EVIDENCE	Foresight (2007) Tackling Obesities: Future Choices – Project Report. Government Office for Science HM Government (2007) PSA Delivery Agreement 12: Improve the health and well-being of children and young people. HM Treasury. www.hm-treasury.gov.uk Whitaker R.C., Wright J.A., Pepe M.S., et al (1997) Predicting obesity in young adulthood from childhood and parental obesity. The New England Journal of Medicine; 337:869–73 5. Obesity Reviews; 8 (s1): 13-17 6. Field AE, Coakley EK, Must A, Spadano JL, Laird N, Dietz WH, et al (2001) Impact of overweight on the risk of developing common chronic diseases during a 10-year period. Arch Intern Med; 161: 1581–1586 Targher G (2007) Zaninotto P, Wardle H, Stamatakis E, Mindell J, Head J (2006) Forecasting Obesity to 2010. National Centre for Social Research Royal Commission on Environmental Pollution (2007) Twenty-sixth Report: The Urban Environment: Royal Commission on Environmental Pollution 13. Department for Transport – National Travel Survey www.dft.gov.uk Childwise (2007) The Childwise Monitor Trends Report 2007. Childwise Blenkinsop S, Bradshaw S., Cade J, Chan D, Greenwood D, Ransley J, Schagen S, Scott E, Teeman D and Thomas, J. (2007). Further Evaluation of the School Fruit and Vegetable Scheme. Department of Health Schagen S, Blenkinsop S, Schagen I, Scott E, Teeman D, White G, Ransley J, Cade J. and Greenwood D. (2005) Evaluation of the School Fruit and Vegetable Pilot Scheme: Final Report. Big Lottery Fund. Department for Children, Schools and Families (2007) School Sports Survey 2006/07. Department for Children, Schools and Families Department for Children, Schools and Families (2007) The Children's Plan: Building Brighter Futures. Department for Children, Schools and Families Department for Transport (2005) Sustainable travel demonstration towns www.dft.gov.uk Wesley H (2007) Thin Living. British Medical Journal; 335–1236–1237
MONITORING	Impact Assessment process, including the health impacts, of its policies upon the public, private and third sectors. Additionally the Government is assessing the impact on equality, including race, disability and gender and has undertaken an Equality Impact Assessment. To fill current gaps the Government will explore a number of options, including: • using existing data on maternal weight to identify at-risk families • weighing and measuring children in the first two years of life where there is parental or professional concern regarding a child's growth • collecting height and weight data on young people and adults • obtaining better information from primary care on obese and overweight patients • other cost-effective methods of collecting height and weight data on adults • participation in the WHO European childhood obesity surveillance initiative to provide internationally comparable data • making full use of data from the Expenditure and Food Survey, and the National Diet and Nutrition Survey.

INTEGRATED – NUTRITION/ PHYSICAL ACTIVITY (HEALTHY WEIGHT)

STRATEGY

Healthy Eating – Health Action

Five key priorities for action are identified in the strategy:
1. lower socioeconomic groups
2. children, young people, and their family and whänau (including older people)
3. environments
4. communication
5. workforce

Within each priority area, objectives, suggestions and action are developed based on the Ottawa Charter: develop healthy policy, create supportive environments, strengthen community action, develop personal skills, reorient services and
programs, and monitor, research and evaluate.

The strategy emphasises the need for partnerships outside the health sector, and offers guidance for intersectoral action with other central and local government agencies, non-governmental organisations and industry. *Healthy Eating – Healthy Action* also recognises the importance of addressing environmental modification as well as behavioural change to improve nutrition, increase physical activity and reduce obesity. The principles of the **Treaty of Waitangi** and directions for reducing inequalities in health are fundamental elements of this strategy.

The strategy aims to:

- Develop and implement a comprehensive communication plan to ensure consistent nutrition and physical activity messages.
- Promote nutrition, physical activity and obesity issues in preschools and schools including Kohanga Reo and Kura Kaupapa Ma'ori.
- Identify and develop activities for promoting nutrition and physical activity in primary health care settings.
- Investigate options for improving food security in low-income families with children.
- Initiate development and implementation of a range of social marketing strategies to facilitate behavioural changes supporting healthy eating, healthy action and healthy weight.
- Develop and expand community action programs for high-need groups.
- Develop and implement a strategy to increase capacity and capability of trained Ma'ori and Pacific health professionals and community health workers.
- Encourage the food and physical activity industries to implement the HEHA Strategy.
- Develop a monitoring plan.

POLICY FRAMEWORK

New Zealand Health Strategy
Healthy Eating Healthy Action
Healthy Eating – Healthy Action: Oranga Kai – Oranga Pumau Implementation Plan: 2004–2010
Healthy Eating - Healthy Action. Oranga Kai – Oranga Pumau: A strategic framework

Links to other policies:
Hillary Commission. 1998. *Physical Activity Taskforce Report: More People, More Active, More Often.*
Ministry of Health and Ministry of Sports, Fitness and Leisure. 1998. *Physical Activity: a Joint Policy Statement by the Minister of Sport, Fitness and Leisure and the Minister of Health.*
Ministry of Health. 1999. *Taking the Pulse. The New Zealand Health Survey 1996–97.*
Ministry of Health. 1999. *Our Health, Our Future: Hauora Pakari, Koiora Roa – The Health of*
New Zealanders 1999.
Ministry of Health. 2003. *Healthy Eating – Healthy Action, Oranga Kai – Oranga Pumau: A strategic framework.*

	Ministry of Health. 2003a. *Healthy Eating – Healthy Action, Oranga Kai – Oranga Pumau: A background.* National Health Committee. 1998. *Active for Life: a call for action. The health benefits of physical activity.* Public Health Commission. 1995. *National Plan of Action for Nutrition: the Public Health Commission's advice to the Minister of Health 1994/95.*
ORGANISATION	MoH and SPARC
LEVEL	National
BUDGET	At the time of the launch, existing funding for nutrition and physical activity (approximately $10.0 million GST exclusive in 2004/05) was realigned to meet actions mentioned in the HEHA Implementation Plan. The funding received from the CCAP amounted to $7.2 million (GST exclusive) and funded four work areas: the Fruit in Schools program, the District Health Board/PHO Innovations Fund, the public awareness campaign, and research into the primary prevention of cancer (including HEHA and tobacco). A further $19.033 million (GST exclusive) per year ongoing funding was approved in April 2006 for the further implementation of HEHA, and a significant amount of work has been done as a result of this new funding. The Ministry has also established a $1.6 million/year HEHA DHB evaluation fund
FINANCING	**The Nutrition Fund** is part of the Government's agreement with the Green Party and will support the implementation of the Ministry of Education's Food and Nutrition guidelines for schools and early childhood education services. The Fruit in Schools program is funded through the Cancer Control Action Plan and HEHA implementation plan. **The Innovations Fund** has been developed to support community action to improve nutrition, increase physical activity and reduce obesity in high needs groups. The Fund offers opportunities for DHBs and primary health organisations (PHOs) to work within their communities and alongside other providers to implement innovative public health interventions to progress the goals of HEHA. There are currently 20 innovative initiatives from 13 DHBs; 16 are funded through the Cancer Control Action Plan and four through HEHA funding
TIMEFRAME	2004–2010
TARGETS	▪ Increased awareness of the nutrient value of foods ▪ Increased awareness of the importance of breastfeeding ▪ Increased exposure to advertising for low fat, salt and sugar products ▪ Reduced exposure to advertising for high fat, salt and sugar products ▪ Reduced availability of high fat, salt and sugary products ▪ Increased availability/affordability of low fat, salt and sugar products ▪ Increased awareness of the importance of being active ▪ Increased access to physical activity options
HR	DHBs, local government, NGOs, industries groups
LEAD INSTITUTION	In recognition of this strategy, the Ministry of Health's Public Health Directorate is forming an Inter-agency Steering Group on Healthy Eating – Healthy Action. The Steering Group will support the work of the district HEHA inter-agency groups being set-up as part of HEHA implementation. DHBs have recently been funded by the Ministry of Health as lead agencies to provide district leadership and co-ordination in the delivery of the Strategy.
PARTNERSHIPS	• DHBs • provider groups • SPARC and the physical activity sector • Agencies for Nutrition Action and non-government organisations • food industry • fitness industry; and

	• Ministries of Pacific Island Affairs, Education and Transport, Social Development, Local Government New Zealand and the Energy Efficiency Conservation Authority.
IMPLEMENTATION	• **Push Play**: a brand that includes a mass-media campaign to get all New Zealanders to include physical activity as part of their everyday lives. It involves television commercials as well as promotion through brand merchandise (t-shirts, drink bottles, mugs, caps) and National Push Play Day. Media activity is supported by ongoing activities at a regional level. Program start 1999. • **Green Prescriptions:** written physical activity advice by a health professional as part of a patient's health management. An evaluation of Green Prescriptions is currently under way in the Waikato. Program start 1999 • **He Oranga Poutama**: Māori healthy lifestyles program since 1997. • **KiwiWalks:** a series of free walks throughout New Zealand which are easily accessible to a person wearing leisure footwear, are of no more than one hour in duration, are suitable for most ages and fitness levels, and are on maintained tracks. • **SPARC and The Cancer Society** are producing two pamphlets on physical activity and cancer risk reduction, and cancer prevention.
INEQUALITIES	Data not available at time of writing
MODELS/EVIDENCE	Data not available at time of writing
MONITORING	Evaluation and monitoring have three basic elements: • monitoring the overall rollout of the Plan (process monitoring) • monitoring whether the actions made a difference – surveys (outcome monitoring) • evaluation of individual initiatives (formative, process, impact and outcome evaluation). Short term: awareness of campaigns; participation rates in organised events or programs; number of green prescriptions prescribed; evaluation of programs to determine effectiveness. Intermediate term: to reduce the couch potato index, with more New Zealanders being more active more often. Long term: decline in physical inactivity-related cancer rates. Surveys: i.e. The New Zealand Health Survey; The Hillary Commission New Zealand Sport and Physical Activity Surveys, www.sparc.org.nz.

INTEGRATED – NUTRITION & PHYSICAL ACTIVITY (HEALTHY WEIGHT)

STRATEGY	**Pan Canadian Healthy Living Strategy**
POLICY FRAMEWORK	Linked to prevention of chronic disease. Population health and settings approach. Focus on determinants of health within specific life stages and across the life span The goal of this initiative is to build a healthier nation, reduce health disparities and contribute to the efficiency and sustainability of the health system in Canada by providing Canadians information and opportunities to make healthier decisions that will lead to a better quality of life. Initially, the Strategy will emphasize nutrition and physical activity, and their relationship to healthy weights.
ORGANISATION	Public Health Agency of Canada
LEVEL	National
BUDGET	$300 million over 5 years (2006-2011) *A $3.5 million social marketing campaign to focus on healthy eating, physical activity and sport participation.*
FINANCING	Data not available at time of writing
TIMEFRAME	2015
TARGETS	By 2015, 20% increase in the proportion of Canadians who are physically active, eat healthy food choices and are at healthy body weights. Linked to 10 percentage point, year 2010 physical activity target These targets are to link with broader Public Health Goals and accompanied by measures of disparities and disparities reduction.
HR	Data not available at time of writing
LEAD INSTITUTION	The Public Health Agency of Canada, in partnership with the provinces and territories, is working with other levels and sectors of government, community groups, volunteer organizations, non-governmental organizations, Aboriginal peoples, the private sector, academia, consumer organizations, and others with an interest in healthy living to develop an Integrated Pan-Canadian Healthy Living Strategy.
PARTNERSHIPS	With provinces and territories, across other levels and sectors of government, community groups, volunteer organizations, non-governmental organizations, Aboriginal peoples, the private sector, academia, consumer organizations
IMPLEMENTATION	Four strategic directions: 1. Leadership and Policy Development 2. Knowledge Development and Transfer 3. Community Development and Infrastructure 4. Public Information To support the intersectoral development of the Strategy, the Coordinating Committee of the Intersectoral Healthy Living Network was established in September 2004, led by three chairs representing federal, provincial/territorial governments, and the non-government sector. Comprising representatives of regional networks, governments, the private and voluntary sectors, and national Aboriginal organizations, the Coordinating Committee acts as an engine to move the Pan-Canadian Healthy Living agenda forward. A number of working groups were formed, consisting of members of the Coordinating Committee and experts drawn from across the Network, to advise and support the implementation of the "action" areas identified by the F/P/T Conference of Deputy Ministers and by F/P/T Ministers of Health in September 2003. These included the development of: • healthy living priorities and targets for the Strategy; • an integrated research and surveillance agenda, including best practices; and • a public information campaign and social marketing program.

	A parent / educator program is being developed to complement advertising activities and Health Canada funded a TV public service announcement. [check]
INEQUALITIES	Federal leadership role includes identifying and addressing the systemic barriers to physical activity which are particularly apparent among Canadians with a disability, girls and women, older adults, and Aboriginal Peoples
MODELS/EVIDENCE	Data not available at time of writing
MONITORING	On-going monitoring and periodic evaluations Health Canada's Food Directorate and Office of Nutrition Policy and Promotion work with their federal, provincial and territorial partners on a variety of food and nutrition surveillance activities including: Collecting data on what Canadians are eating. Measuring contaminant levels in some foods. Developing methodological and data collection tools and standards. Providing guidance on interpreting surveillance data. Analysing and interpreting data to inform programs and policies.

SYSTEM UNDERPINNING CHRONIC DISEASE PREVENTION IN ENGLAND

MANDATE

The Department of Health (DOH) is responsible for health protection, health improvement and health inequalities issues in England, including pandemic influenza, seasonal flu, patient safety, tobacco, obesity, drugs, sexual health, and international health.

Within the DOH the Health Improvement branch tackles obesity, STDs, alcohol and substance misuse and smoking. *Health Challenge England – Next Steps for Choosing Health* (DH, December 2007) sets out the next steps in the Department of Health's strategy to support the changes that everyone needs to make in their lives to enjoy the best possible health.

The DOH leads the integration of health and well-being into wider government policy, working with other sectors and systems, as well as integrating wider public policy into health and care services. DOH also takes the lead internationally on some health issues for the UK.

The nature of the work on leading health and well-being for Government includes: working with the wider public sector, the third and private sectors on issues such as health protection or lifestyle choices, including integrating health and well-being with other Government agendas at regional level through our regional teams; and working with international partners, including the European Union (EU), World Health Organisation (WHO) and the Organisation for Economic Co-operation and Development (OECD).

INFRASTRUCTURE-RESEARCH AND SURVEILLANCE

The new **Public Health Research (PHR) Programme** was established by the National Institute for Health Research (NIHR) to evaluate a wide range of public health interventions. These may include social marketing for the promotion of safe sex, to the prevention of obesity in children, and speed bumps for the prevention of road traffic accidents.

The funding will rise over three years to reach £10 million a year. The research programme has been designed to provide new knowledge on the benefits, costs, acceptability and wider effect of non-NHS interventions.

The NIHR Public Health Research (PHR) programme forms part of a coordinated approach to health research by the National Institute for Health Research and the Medical Research Council. The programme was established in response to the 2007 Comprehensive Spending Review in support of Best Research for Best Health, and the Cooksey review recommending the need for more public health research.

The NIHR PHR Programme will mainly work in responsive mode, taking applications for both primary and secondary research and assessing them at regular intervals. The programme will look to fund primary research at all phases but especially pragmatic evaluation studies. The first call for research proposals will be taking place in November 2008 (see http://www.phr.nihr.ac.uk).

The NIHR Public Health Research (PHR) programme - purpose

1. The development of modern, evidence-based and politically credible public health practice depends on a better understanding of what public health interventions are worth pursuing and in what contexts.
2. This is needed both for the implementation of successful action at local level and the development of national policy and guidance. Many agencies involved in the improvement of health are potential users of such knowledge. Many agencies involved in the improvement of health are potential users of such knowledge and have a particular need for reliable evidence to underpin its guidance on public health interventions.
3. Recognising the importance of improved knowledge in this area, the 2006 national health research strategy Best Research for Best Health included public health research as a target for investment and emphasised the contribution it could make to improving health.

Operations of the NIHR Public Health Research (PHR) Programme

1. The NIHR Public Health Research (PHR) Programme will have two modes

of operation. Most funding will be in response to applicants' proposals, but there will also be commissioning capacity to advertise prioritised topics, themed calls and linked research projects.

2. The NIHR PHR programme will be managed by the NIHR Evaluation, Trials and Studies Coordinating Centres (NETS-CC), based at the University of Southampton alongside other NIHR Programmes including the world-class NIHR Health Technology Assessment Programme.

3. The National Institute for Health Research provides the framework through which the research staff and research infrastructure of the NHS in England is positioned, maintained and managed as a national research facility. The NIHR provides the NHS with the support and infrastructure it needs to conduct first-class research funded by the Government and its partners alongside high-quality patient care, education and training. Its aim is to support outstanding individuals (both leaders and collaborators), working in world class facilities (both NHS and university), conducting leading edge research focused on the needs of patients. Information about the National Institute for Health Research is available on its website at: http://www.nihr.ac.uk.

4. The HTA programme produces research information about the effectiveness, costs, and broader impact of health technologies for those who use, manage and provide care in the NHS. More information about the HTA programme is available on its website at: http://www.hta.ac.uk

LEADERSHIP AND INTEGRATION

Tackling obesity

Tackling child obesity is a national priority for primary care trusts (PCTs) from April 2008, and set out in the NHS Operating Framework for 2008-09 (DH, December 2007).

Healthy Weight, Healthy Lives: A Cross-Government Strategy for England was launched on 23 January 2008, and is the first step in a sustained programme to support people to maintain a healthy weight.

To provide leadership across Whitehall the Government has established a new Cabinet Committee on Health and Well-being. The remit of this committee includes tackling obesity and promoting healthy weight, and the membership includes all of the lead departments. The Cabinet Committee on Families, Children and Young People will also monitor progress with respect to child weight problems. Reporting to the new committee is a new cross-Government obesity unit. This is based in the Department of Health but led jointly by the Department of Health and the Department for Children Schools and Families, and includes staff and resources from across Government. The major responsibilities of the new unit will include:

- taking forward the commitment outlined in this strategy
- producing the annual report
- leading across Government in developing further proposals as necessary to fulfil our ambition to reverse the rising tide of obesity and overweight
- acting as the focal point for knowledge on healthy weight in Government
- managing relationships between Government, industry and other stakeholders – the unit will act as the secretariat to the new stakeholder groups; and
- • building the evidence base on tackling obesity

The unit is supported in its responsibilities by:

- An Expert Panel of academics, building on the Foresight science advisers
- A Delivery Reference Group composed of experienced representatives from across the delivery chain and across the country.

A new Obesity Observatory has been established to research the causes and consequences of the rise in unhealthy weight, and the evidence of what works.. Established in December 2007 as part of the wider Public Health Observatory family, it will work alongside the existing research and

development infrastructure. The Obesity Observatory will be commissioned to:

- provide an authoritative source of data and evidence on obesity, overweight and their determinants
- •co-ordinate surveillance on obesity and overweight, including working towards the commitment to monitoring made in the WHO European Charter on Counteracting Obesity
- analyse surveillance and indicator data and reporting on progress against the new ambition
- provide guidance on assessing and evaluating pilots and demonstration sites in England
- gather information on international best practice and develop links to the International Obesity Task Force, WHO, and other supranational bodies – including the new EU nutrition and physical activity strategy
- provide technical support to the Expert Panel.

One of the first tasks of the Obesity Observatory will be to assess the strengths and weaknesses of using the International Obesity Task Force cut-offs for defining BMI against the 1990 UK Growth Reference Standards currently used.

The *Healthy Start* scheme provides nutritional support and encouragement for breastfeeding and healthy family diet to around half a million pregnant women and under four-year-olds across the UK. The scheme was implemented across all of the UK from 27 November 2006

Leadership for physical activity
The *Choosing Health White Paper* in November 2004 and *Choosing Activity: A Physical Activity Action Plan* (DH, March 2005) set out a series of projects aimed at increasing levels of physical activity.

Sport England
Sport England is the Government agency responsible for advising, investing in and promoting community sport to create an active nation (and contributing to reducing obesity and increasing respect). Sport England **is a non-departmental public body and National Lottery distributor**, committed to creating a world leading community sports development system and increasing participation in sport. Their goal is to get two million people more active in sport by 2012 – and to make sure that participation is sustained.

Sport England works with and through:

- Community sports activities
- Sports clubs
- Coaches and officials
- Player pathways
- Volunteering
- Sports facilities.

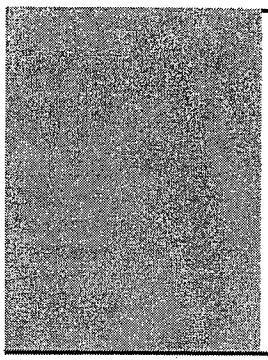
And work with a range of partners, including:

- The Government
- London Organising Committee of the Olympic Games
- Youth Sport Trust
- UK Sport
- Greater London Authority

Their primary group are the people who play sport – or those who might play given the right encouragement, environment or opportunities.

People are reached through the Sport England's Supply Chain – the Delivery System for Sport. The Delivery System connects those involved with sport at national, regional, sub-regional and local levels to help ensure appropriate targeting of investment, time, energy and other resources into initiatives that will really make a difference to levels of participation. It brings together national governing bodies of sport (NGBs), regional sports boards (RSBs), county sports partnerships (CSPs), community sports networks (CSNs) and the coaches, clubs and volunteers who are making sport happen, every day, across the whole of England.

Sport England is one of three national agencies involved in the delivery of



sport in England. The Youth Sport Trust is primarily responsible for improving the quality and quantity of school sport. Sport England is responsible for sustaining and increasing participation in community sport. UK Sport is responsible for elite sport and world-class events.

Alcohol
In June 2007, published i *Sensible. Social. The Next Steps in the National Alcohol Strategy.*

The Department and the Home Office are jointly leading a cross-government programme of work, together with the Department for Children, Schools and Families, the Department for Culture, Media and Sport, the Ministry of Justice and the Department for Transport.

SYSTEM UNDERPINNING CHRONIC DISEASE PREVENTION IN CANADA

GOVERNANCE

The Government of Canada provides national leadership and coordination, improving surveillance, helping to build capacity in communities, continuing to support knowledge development and exchange, providing information to the public and monitoring and evaluating interventions and innovations.
The key roles comprise:

- Leadership, coordination and strategic policy development; and
- Knowledge development, exchange and dissemination
- Surveillance
- Community-based programming and community capacity building
- Public Information
- Monitoring and evaluation

MANDATE

Health Canada is the federal department responsible for helping the people of Canada maintain and improve their health. In 2004, The Public Health Agency of Canada was established as part of a new federal strategy for public health, and absorbed all aspects of the former Population and Health Branch of Health Canada

The Public Health Agency of Canada (PHAC), as part of the federal health portfolio, mission is to promote and protect the health of Canadians through leadership, partnership, innovation and action in public health. The PHAC is mandated to work in collaboration with its partners, to mobilize pan-Canadian action in preventing disease and injury, and to promote and protect national and international public health.

INFRASTRUCTURE-RESEARCH AND SURVEILLANCE

PHAC Organisational Branches – Directorates

Health Promotion and Chronic Disease Prevention Branch (HPCDP) is responsible for developing policies and programs that enhance and strengthen PHAC's strategic objectives of health promotion and chronic disease prevention.

Centre for Chronic Disease Prevention and Control (CCDPC) is the national focal point for chronic disease prevention and control. Program activities are centred around three key strategic priorities: knowledge generation and dissemination; program development; and surveillance.

CCDPC activities focus on:

- **building** and disseminating the evidence based on best practices and lessons learned to support policies and programs for chronic disease prevention and control;
- **facilitating** the development of prevention, screening and early detection programs for chronic diseases by provinces/territories;
- **providing** project funding to community and support groups;
- **contributing** to the development and implementation of pan-Canadian integrated and disease-specific strategies;
- **maintaining** and enhancing an integrated surveillance system to assist in developing chronic disease policy; and
- **providing** a stimulus for international links in the area on chronic disease prevention and control.

Centre for Health Promotion (CHP) is responsible for implementing policies and programs that enhance the conditions within which healthy development takes place. Through action founded on the principles of population and public health, CHP seeks to address the determinants of health and facilitate successful movement through the life stages. The Centre acts through programs addressing:

- healthy child and adolescent development;
- healthy communities, families, including family violence;
- healthy aging;
- physical health and injury prevention;
- work with the voluntary sector; and
- public information and education.

Strategic Policy, Communications and Corporate Services Branch (SPCCS) supports the Agency in its day-to-day operations as well as around long-term planning and policy development. The Branch provides a senior-level

focus on the provision of integrated and coordinated strategic direction and communications advice.

The SPCCS Branch's responsibilities include: the provision of strategic policy advice and coordination; managing policy partnerships and development with stakeholders including provinces and territories and international organizations; managing the Agency's communication plans and strategies; delivering comptrollership functions (including planning and reporting) to assure probity, value for money and compliance with applicable federal legislation and policies; providing human resources advice and services, information management and information technology expertise and leadership, and asset management services (including safety and security).

Public Health Practice and Regional Operations Branch (PHPRO) is responsible for providing strategic advice and direction **to support cross-jurisdictional** human resources capacity, effective dissemination of knowledge and information systems, and a public health law and policy system that evolves in response to changes in public needs and expectations. In addition, the branch is responsible for building the regional capacity of PHAC.

Office of Public Health Practice (OPHP) collaborates with internal and external partners to support effective Public Health Practice on the development, maintenance and use of health surveillance information, tools and skills to increase the capacity of public health professionals and decision makers across Canada. The Office provides coordination and strategic vision for the development of workforce capacity and public health law policies in Canada and develops, maintains and strengthens relationships with local/regional, provincial/territorial and federal governments as well as non-governmental organizations and academia. With its partners, the Office jointly **addresses cross-cutting issues** in public health practice in Canada and internationally.

LEADERSHIP AND INTEGRATION

The PHAC objectives are delivered through **leadership and partnership**. Through work with provinces and territories, the Agency translates public health skills and knowledge into action across the public health spectrum, including promoting health, preventing infectious and chronic disease, and preparing for health-related emergencies.

The PHAC is made up of four Branches, including two Laboratories, and has more than **1,600 staff** contributing to the achievement of the Agency's mission who are located in six regions.

PHAC's main areas of focus are:

- **prevention** of disease and injury and the promotion of health;
- **federal leadership and accountability** in managing public health emergencies;
- **sharing** Canada's expertise with the rest of the world, and applying international research and development knowledge to Canada's public health programs;
- **strengthening intergovernmental collaboration** on public health and facilitating national approaches to public health policy and planning; and
- **playing a role in Aboriginal public health issues** along with Health Canada.

Leadership for **systemic change in policy integration** in the area of chronic disease is provided through the **Canadian Health Services Research Foundation (CHSRF) and the Centre for Chronic Disease Prevention and Control (CCDPC)**. These centres demonstrate an approach for establishing and fostering linkages between decision-makers and researchers to ensure the exchange of knowledge in effort to enable evidence-based decision-making. The focus of these centres remains practical in order to meet the needs of decision-makers to ensure information is actually accessible, applicable and able to influence priority setting, but also to foster relationships and mutual understanding of the cultural differences between researchers and decision-makers.

RESEARCH AND SURVEILLANCE

Canadian Health Services Research Foundation (CHSRF) supports the evidence-informed management of Canada's healthcare system by facilitating knowledge transfer and exchange - bridging the gap between research and healthcare management and policy. The Foundation is governed by up to 14 trustees, including an ex-officio representative (the deputy minister of Health Canada) and others representing researchers, decision makers, and their organizations in the health sector. Trustees oversee the approximately $110-million endowment and an annual operating budget of $15 to $16 million, and they set policies and program directions for the Foundation. Trustees are elected for three-year renewable terms by the ordinary members of the Foundation

Canadian Integrated Public Health Surveillance (CIPHS)
CIPHS brings together a strategic alliance of public health and information technology professionals working collaboratively to build an integrated suite of computer and database tools specifically for use by Canadian public health professionals.

Chronic Disease Infobase
Provides current cardiovascular disease statistics and risk factor prevalence in Canada as well as for other major non-communicable diseases.

Disease Surveillance On-Line
Disease Surveillance On-Line is a tool providing four applications to visitors to PHAC's Web site which allow them to access data on cancer, cardiovascular disease and notifiable diseases over a range of years, and to customize the data for their specific need

Geographic Information Systems (GIS) for Public Health Practice
GIS (Geographic Information Systems) are used in many fields to create, store, analyze, and display data with a spatial component (i.e. location information). In recent years, the use of GIS by public health professionals has expanded rapidly.

Policy Observatory on Non-Communicable Diseases in Partnership with Pan-American Health Organization: The Observatory promotes the expansion of effective systematic NCD policy development and implementation using both qualitative and quantitative methodologies. The Observatory also fosters strong international and pan-sectoral NCD-prevention collaborations and shares its findings through a variety of channels including publications, websites and international policy dialogues and conferences. **World Health Organization Collaborating Centre on Chronic Disease Policy (WHO CC)** supports chronic disease policy development and implementation activities in Canada and with other WHO Member countries, in particular the Americas and Europe. The WHO CC is expert in chronic disease policy development and implementation and provides **strategic leadership in developing integrated policies for the prevention and control of chronic diseases in Canada**. The Centre works in partnership with provinces and NGOs.

BUDGET AND FINANCING

The **Population Health Fund** supports time-limited projects sponsored by Canadian voluntary not-for-profit organization and educational institutions. The goal of the Population Health Fund is to increase community capacity for action on or across the determinants of health. The projects develop and disseminate community-based models for applying the population health approach, increase the knowledge base for program and policy development on population health and increase partnerships and intersectoral collaboration to address the determinants of health. The Public Health Agency of Canada establishes priorities for funding based on identified program needs and life stages.

The Fund is administered through Health Canada Regional Offices (for provincial, territorial, regional or local projects) and the National Office in Ottawa (for national projects).

POLICY

A Population Health approach underpins Canadian public heath strategies which covers the conceptual framework for thinking about health; decisions informed by evidence; a framework for taking action; actions targeted at the societal, community, structural or system level; and requirements of collaboration between multiple sectors.

PROGRAMS AND STRATEGIES

Obesity has been framed increasingly as a global threat to health and an "epidemic" and identified as a major policy issue in Canada. The evidence and policy discourse suggest an increasing recognition of the complexity of the issue and the need for the coordinated involvement of a range of policy actors across sectors and settings to link independent policies and processes.

With regard to the policy analysis conducted, a large number of policy responses were identified in relation to obesity and the environment, but relatively few have been systematically tested.

Healthy Living
The PHAC, through their **Healthy Living Unit**, supports national active transportation initiatives, both financially and informatively.
This Unit promotes physical activity among Canadians in order to improve their health and well-being.

The Canadian Heart Health Initiative
The Canadian Heart Health Initiative is a countrywide multi-level strategy for the prevention of cardiovascular disease (CVD).
It adopts an integrated approach to the control of the multiple risk factors responsible for CVD.

Breast Cancer
The Renewed Canadian Breast Cancer Initiative (1998-2003) is a departmentally-led initiative that works in partnership with key stakeholders from the provincial and territorial governments, health professionals, care providers, associations, researchers, educators, consumers and support groups, the private sector, and women affected by breast cancer.

The Renewed Initiative works through five linked components: the Canadian Breast Cancer Research Initiative; Prevention, Early Detection and Quality Screening; Surveillance and Monitoring; Enhancing Quality Approaches to diagnosis, Treatment and Care; Community Capacity Building; and Evaluation and Coordination. **Canadian Breast Cancer Screening Database (CBCSD)** is a national breast screening surveillance system designed to facilitate monitoring and evaluation of organized screening programs across Canada. Established in 1993, it is operated and maintained by the Chronic Disease Management and Control Division, and Chronic Disease Surveillance Divisions in the Centre for Chronic Disease Prevention and Control.

Canada Prenatal Nutrition Program (CPNP) Description: Canada's Prenatal Nutrition Program (CPNP) is a program which funds community-based coalitions and agencies to establish, deliver or enhance services for at-risk pregnant women in order to improve birth outcomes. CPNP is targeted at pregnant women most likely to have unhealthy babies because of poor health and nutrition.

Canadian Field Epidemiology Program (CFEP) responds to requests for epidemiologic assistance by provinces, territories and other federal partners. Field Epidemiologists assist in investigations of risk factors, aetiologies and effectiveness of control measures for communicable and non-communicable diseases, environmental health and chronic disease.
Field Epidemiologists also evaluate surveillance systems to assess the capacity to translate data into public health action. Such evaluations are done within the jurisdiction of their placements, and the data generated and/or evaluated remain the custody of the workplace. The Program also offers training modules for public health professionals at all levels of public health practice in Canada.

Chronic Disease Knowledge Exchange is a program that focuses on the development of various chronic disease information products combining, synthesizing and packaging knowledge for end-users that are both understandable and usable. Types of activities include evaluations, environmental scans, needs assessments, literature and structured reviews. Key to this process are ongoing consultations with provinces and territories, non-government and professional organizations, research agencies and other key organizations relevant to chronic disease and public health.

Chronic Disease Prevention Division is a member of the Chronic Disease Prevention Alliance, an alliance of nongovernmental organizations and

government agencies, who share a common vision for an organized, coordinated system of chronic disease prevention for Canada. The division also participates as a member of the Primary Prevention Action Group of the Canadian Strategy for Cancer Control. This group's mandate is to promote the creation of a national/provincial/ territorial and local community primary prevention system to address population-based risk factors for cancer and other chronic diseases by collaborating with chronic disease constituencies. The division also leads on an intra-departmental working group on nutrition, physical activity and healthy weights for the prevention of chronic disease that seeks to maximize collaborative efforts in the areas of chronic disease prevention.

Chronic Disease Risk Assessment program focuses on identifying, generating, collecting, evaluating, synthesizing, translating and sharing the evidence on established and emerging risk factors, protective factors and determinants for chronic disease, as well as their burden in the Canada population. The program contributes to the information-base for the development of policies, programs and strategies aimed at preventing chronic diseases and reducing their burden. Studies of key chronic diseases are conducted using various primary and secondary data sources. The program also conducts systematic reviews and or meta-analyses of key risk factors when needed to obtain best agreed upon measures of risks. An inventory of evidence on chronic disease risk factors is being developed for use by practitioners and policy makers.

National Collaborating Centres for Public Health: There are six National Collaborating Centres (NCCs) for Public Health in Canada. The over-arching mission for these Centres is to build on existing strengths and create and foster linkages among researchers, the public health community and other stakeholders to ensure the efficiency and effectiveness of Canada's public health system.

The National Collaborating Centres will facilitate the sharing of knowledge and help put it into practice at all levels of the public health system across Canada. The six NCCs will be established in regions across the country; each one specializing in a different priority area of public health as follows: environmental health (British Columbia); infectious disease (Winnipeg); public health methodologies and tools (Ontario); public policy and risk assessment (Quebec); health determinants (Atlantic) and Aboriginal health (British Columbia). Although located regionally, these Centres will provide national focal points for knowledge translation in key priority areas of public health and contribute to the development of a pan-Canadian public health strategy. Each National Collaborating Centre will draw on regional, national and international expertise and complement/collaborate with the contributions of other organizations in the pan-Canadian public health system, including the Public Health Agency of Canada, the provinces and territories, academia and non-government organizations.

Policy Research Unit (PRU) Program works to strengthen and promote evidence-based decision-making by providing leadership and expertise in the development and synthesis of population and public health information. The PRU contributes to framework development, acts as a liaison on policy-oriented research and science needs, builds and transfers knowledge on the burden of illness, the relative importance of health issues and their determinants, and on the effectiveness of community intervention approaches. Four key areas of work include: The Economic Burden of Illness in Canada (EBIC); Population Health Impact of Disease in Canada (PHI); The Effectiveness of Community Interventions Project (ECIP); Knowledge Flow between Policy Research and Practice. To support program activities, the PRU maintains non-identifying record level data obtained from outside sources, including Statistics Canada, CIHI and the provinces/territories.

Physical Activity and Healthy Eating – Federal Contributions
A revised Canada's Food Guide, which provides useful information to Canadians on healthy eating, and the first-ever version tailored to the needs of First Nations, Inuit and Metis. The Food Guide also emphasizes the importance of combining regular physical activity with healthy eating.
$5 million to help fund the renewal of ParticipACTION. This funding will support a renewed national public awareness campaign to encourage

Canadians to maintain an active lifestyle.

The Children's Fitness Tax Credit. As of January 1, 2007, parents have been able to claim a tax credit on up to $500 of eligible expenses from sport and physical activity programs for each child under the age of 16, promoting physical fitness, including sport, among children.

Investments through "Building Canada," a $33 billion infrastructure plan announced in Budget 2007 aimed at providing long-term, predictable and reliable funding to help provinces, territories and municipalities meet their infrastructure needs. The plan includes funding to support sports infrastructure and active transportation projects such as bike and rollerblading paths. Municipalities benefit from a 100 per cent GST rebate, which they can apply to any infrastructure project, including those promoting a healthy lifestyle.

In partnership with provincial and territorial governments, Canada's Federal Government, through the Knowledge Development and Exchange component of the federal Healthy Living and Chronic Disease Initiative, makes significant investments in important FPT initiatives, including:

- $875,000 in the Physical Activity and Sport Benchmarks/Monitoring Program.
- Supporting the annual *WinterActive* and *SummerActive* initiatives, which encourage Canadians to get involved in community-based healthy living activities across Canada.
- Canada's Physical Activity Guides, including guides to help children and youth improve their health through regular physical activity.
- A website, www.healthycanadians.gc.ca provides Canadians with a one-stop shop for healthy living information.

Canadian Strategy for Cancer Control

Aim of Initiative Cancer control aims to **prevent** cancer, cure cancer, and increase survival and quality of life for those who develop cancer, by converting the knowledge gained through research, surveillance and outcome evaluation into strategies and actions.

Since 1999, the Canadian Cancer Society (CCS)/National Cancer Institute of Canada (NCIC), the Canadian Association of Provincial Cancer Agencies (CAPCA), and Health Canada have led the development of the national cancer control strategy. In addition, over the last three years, over 700 experts contributed their time and knowledge by participating in working groups, preparing reports that covered the cancer control continuum, and providing input during consultations.

SYSTEM UNDERPINNING CHRONIC DISEASE PREVENTION IN THAILAND

GOVERNANCE

ThaiHealth is one small organisation of the larger Ministry of Public Health and its service agencies, which employ a workforce of more than 200,000. It also articulates with the Ministry of Transport on issues associated with reducing traffic accidents.

It is described as a 'catalyst' in the system to accelerate the development towards the Ministry of Public Health's goals and objectives (ThaiHealth, 2008).

The Thai Health Promotion Foundation Act specifies that, in addition to supporting national public health policies, ThaiHealth should help coordinate activities by state and private agencies. ThaiHealth acts as the secretariat to the national taskforce for implementing the 'Healthy Thailand' campaign (540 million baht over 3 years). The national taskforce includes state agencies, academics, and private organizations.
The areas that ThaiHealth support include: office secretariat to coordinate activities; coordination between partner organizations; development of model projects; research and development necessary for implementing the 'Healthy Thailand' policy; and communication for policy implementation.
ThaiHealth has two boards. Besides the Governing Board (21 members) which the Prime Minister chairs, ThaiHealth has an independent Evaluation Board (7 members). The two Boards maintain equal authority with the Royal Thai Cabinet appointing both. ThaiHealth has 80 staff and is consists of nine sections classified according to their working approaches and related-work responsibility.

Operational divisions in ThaiHealth
Section 0 - **Office of the Manager**: Responsible for overall administration.
Section 1 - **Health Promotion and Primary Risk Factor Reduction**: Oversees the Tobacco Consumption Control, Alcohol Consumption Control, and Traffic Accident Prevention plans.
Section 2 - **Health Promotion and Secondary Risk Factor Reduction**
Oversees the Health Risk Factors Control, Health Literacy, and Health Promotion in Organizations plans.
Section 3 - **Community-Based Health Promotion**: Oversees the Health Promotion in Communities and Integrated National Public Health Policy ("Healthy Thailand") plans.
Section 4 - **Health Promotion in Organizations**: Oversees the Health Promotion in Organizations plan.
Section 5 - **Social Marketing**: Oversees the Physical Activities Promotion, and Social Marketing plans.
Section 6 - **Open Grants**: Oversees the Supporting General and Innovate Projects plan.
Section 7 - **Knowledge Management and Social Capital**: Oversees the Health Promotion through Health Care Delivery System and Developing Social Capital and Supportive System plans.

There is also a unit responsible public relations.

MANDATE

ThaiHealth was established under the Health Promotion Foundation Act, B.E. 2544 in 2001 as a statutory public organization. It's primary funding is from 2% earmarked taxation (a surcharge) from tobacco and alcoholic beverages. It is responsible for encouraging, supporting, and funding a variety of health promotion activities for public health. ThaiHealth aims not only to reduce tobacco and alcohol consumption, but also to improve the people's state of "total well-being" by fully applying the holistic meaning of 'health' as defined by World Health Organization.

ThaiHealth is a national body and under Section 5 of the Act, the Foundation is mandated with the following objectives:

- to promote and encourage health promotion in the population of all

ages in accordance with the national health policy;
- to create awareness of hazardous behaviour from the consumption of alcoholic beverages, tobacco or other health-deteriorating substances and to create belief in health promotion amongst people of all classes;
- to support campaigns for the reduction in the consumption of alcoholic beverages, tobacco and other health-deteriorating substances, and create public awareness of the relevant legal provisions;
- to conduct studies and research, or encourage the conduct of the study and research, training or organization of meetings with regard to health promotion;
- to develop the ability of a community in fostering health promotion by the community or private organization, public benefit organization, Government Agencies, State enterprises or other State Agencies; and

to support campaigns for health promotion by various activities as a means by which members of the public can improve their health, spare time fruitfully and reduce their consumption of alcoholic beverages, tobacco and other health deteriorating substances.

INFRASTRUCTURE-RESEARCH AND SURVEILLANCE

ThaiHealth's health promotion strategies are based on the WHO Ottawa Charter and observe a holistic view of health. They aim to develop social movements and the health system to increase the well-being. The principle strategies are as follows:

Social Mobilization - involving collaborations between different groups.
System Development - to improve the structure of the Thai health system, including policies, laws and management practices.
Healthy Communities Development – supporting good health promotion practices in communities, cities, schools and workplaces throughout the country.
Social capital - to build the social infrastructure required for effective health promotion including
- leadership
- information systems and networks
- knowledge management systems
- resource management system

A multi-strategy and multi-level approach for interventions is adopted, focusing on the following: issues (such as risk factors); settings; area (geographic and local communities) and target populations (underprivileged, ThaiMuslims etc).

LEADERSHIP AND INTEGRATION

The focal points for integrating activites include: target populations; area based initiatives; and support systems for knowledge management and information system development. To this end a master plan for integration involves the development of:
- National public health policy integration plan
- Area and community health development plan
- Social marketing plan
- Developing Support System and Mechanism for Health Promotion Plan

Target populations plan

BUDGET AND FINANCING

The law secures ThaiHealth's annual revenue of approximately **US $55 million**, which comes from a 2% surcharge on tobacco and alcohol taxes. The annual budget amounts to approximately 0.75 per cent of the nation's spending on health care and close to 0.17 per cent of the annual government budget.

Table 2 : Summary of Spending Budget

	2005		2006		2007		2008	
	m baht	%	m baht	%	m baht	%	m baht	%
Supporting national health policy plans								
Tobacco Consumption Control Plan	120	3.7	150	4.4	160	4.7	180	5.3
Alcohol Consumption Control Plan	310	9.6	315	9.2	325	9.5	330	9.6
Traffic Accident Prevention Plan	250	7.8	270	7.8	280	8.2	280	8.2
Physical Exercises and Sports for Health Promotion Plan	190	5.9	200	5.8	200	5.8	200	5.8
Health Learning Process Plan	210	6.5	310	9.0	310	9.0	305	8.9
Social Marketing Plan	400	12.4	405	11.8	415	12.1	415	12.1
Integrated National Public Health Policy ("Healthy Thailand") Plan	200	6.2	180	5.2	170	5.0	160	4.7
	1,680	52.1	1,830	53.2	1,860	54.2	1,870	55
Health promotion plans								
Health Risk Factors Control Plan	350	10.9	365	10.6	365	10.6	375	10.9
Health Promotion in Organizations Plan	80	2.5	95	2.8	95	2.8	90	2.6
Health Promotion in Communities Plan	370	11.5	300	8.7	270	7.9	270	7.9
Health Promotion through Health Care Delivery System Plan	220	6.8	220	6.4	230	6.7	205	6.0
Supporting General and Innovative Projects Plan	200	6.2	220	6.4	240	7.0	260	7.6
Developing Supportive System and Mechanism for Health Promotion Plan	325	10.1	410	11.9	370	10.8	355	10.4
	1,545	47.9	1,610	46.8	1,570	45.8	1,555	45.4

SOURCES USED TO INFORM THE REVIEW

Canada

Strategies and Programs

Centre for Chronic Disease Prevention and Control (CCDPC) Public Health Agency of Canada.
http://www.phac-aspc.gc.ca/centres_e.html#ccdpc

HealthEvidence Canada
http://www.health-evidence.ca/

Healthy Living Unit
www.phac-aspc.gc.ca/pau-uap/fitness/active_trans.htm

Preventing Strategies: An Overview Programs, Action and Plans.
http://www.phac-aspc.gc.ca/cncdpolicy/pdf2/CAN_INSPQ06_
PreventingObesityOverviewProgramsActionPlansStrategiesPolicies.pdf

The Population Health Fund - National (PHFN)
http://www.phac-aspc.gc.ca/ph-sp/phdd/funding/rfp_2004/index.html

National Native Alcohol and Drug Abuse Program
http://www.hc-sc.gc.ca/fniah-spnia/substan/ads/nnadap-pnlaada-eng.php

Policy documents and relevant websites

Canadian Institute Health Information
http://secure.cihi.ca/cihiweb/dispPage.jsp?cw_page=statistics_a_z_e

Info Source
http://www.infosource.gc.ca

Health Canada & Public Health Agency of Canada
http://www.phac-aspc.gc.ca

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http://www.phac-aspc.gc.ca/hl-vs-strat/pdf/hls_e.pdf

New Zealand

Strategies and Programs

Green Prescription (GRx)
http://www.sparc.org.nz/getting-active/green-prescription/overview

Healthy Eating - Healthy Action (primary)
http://www.moh.govt.nz/healthyeatinghealthyaction

Let's Beat Diabetes (LBD)
http://www.letsbeatdiabetes.org.nz/page/diabetes_5.php
Live Smart
http://www.livesmart.org.nz/

Mission On
http://www.sparc.org.nz/news/mission-on

Project Energize
http://www.projectenergize.org.nz/

Push Play
http://www.sparc.org.nz/pushplay/overview

SunSmart
http://www.sunsmart.co.nz

Waitemata Beverage Project
http://www.arphs.govt.nz/publications/Submissions/

Policy documents and relevant websites

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http://www.moh.govt.nz/healthyeatinghealthyaction

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http://www.moh.govt.nz/

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http://www.moh.govt.nz/moh.nsf/pagesmh/3172?Open

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England

Strategies and Programs

Department of Health - Public Health. Healthy Weight, Healthy Lives: A Cross-government strategy for England.
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_082378

Public Health, Health Improvement, Department of Health.
http://www.dh.gov.uk/en/Publichealth/Healthimprovement/index.htm

THE X-PERT PROGRAMME
http://www.xpert-diabetes.org.uk/

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USA

Strategies and Programs

Centers for Disease Control and Prevention's (CDC's) Division of Nutrition and Physical Activity (DNPA) and the health departments of funded states.
http://www.cdc.gov/nccdphp/dnpa

Childhood Obesity Program of the Robert Wood Johnson Foundation.
http://www.rwjf.org/childhoodobesity/index.jsp
Steps Program Preventing Chronic Diseases through Local Community Action.
http://www.cdc.gov/steps/

REACH - Racial and Ethnic Approaches to Community Health.
http://www.cdc.gov/reach/

WISEWOMAN - Improving the Health of Low-Income and Uninsured Women.
http://www.cdc.gov/WISEWOMAN/

Policy documents and relevant websites

Guide to Community Preventive Services.
http://www.thecommunityguide.org/

Healthy People 2010.
http://www.healthypeople.gov/

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http://www.cdc.gov/pcd/issues/2007/apr/toc.htm

The Federal consumer health information (website)
http://www.healthfinder.gov

U.S. Department of Health & Human Services
http://www.hhs.gov/

Thailand

Strategies and Programs

Thailand Health
http://www.thaihealth.org/
Thai Health Promotion Foundation
http://www.thaihealth.or.th/

Policy documents and relevant websites

Ministry of Public Health Thailand (2007). ThaiHealth Strategic Master Plan 2007-2009, Bangkok
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Finland

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Action Programme for Implementing National Nutrition Recommendations.
http://wwwb.mmm.fi/ravitsemusneuvottelukunta/Toim_ohj_ENG.htm

FINBALT Health Monitor
http://www.ktl.fi/portal/english/research__people___programs/health_promotion_and_chronic_disease_prevention/projects/finbalt/roskaa/finbalt_health_monitor

Fineli: The national food composition database
http://www.fineli.fi/index.php?lang=en

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International

Centre for Reviews and Dissemination (UK).
http://www.york.ac.uk/inst/crd/

Evidence for Policy and Practice Information and Coordinating Centre (UK).
http://eppi.ioe.ac.uk/

Evidence Network (UK)
http://www.evidencenetwork.org/

Oxford Health Alliance (UK)
http://www.oxha.org/initiatives/evidence/evidence

The Campbell Collaboration
http://www.campbellcollaboration.org