

Submission to the National Health and Medical Research Council
public consultation:

‘Preventive healthcare and strengthening Australia’s social and
economic fabric’

The Cancer Council Australia

The Cancer Council Australia is Australia’s peak non-government national cancer control organisation. Its member bodies are the eight state and territory cancer councils, whose views and priorities it represents on a national level.



The Cancer Council Australia has a formal partnership with Australia’s federal government through the National Cancer Control Initiative and also contributes to federal government policy through a number of committees and joint initiatives.

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Introduction

The links between cancer, preventive health and socioeconomic disadvantage are compelling and inextricable. They are particularly relevant to Australia, where cancer is the No.1 cause of death; where high incidence rates in relation to mortality rates show that we are much better at treating cancer than we are at preventing it (despite half the cancers currently diagnosed being preventable); and where cancer is markedly more prevalent among vulnerable groups.

Despite the clear and unacceptable connection between preventable cancer and socioeconomic status, not enough is known about the reasons for the link and effective ways to balance social equity in terms of cancer outcomes.

Cancer kills more Australians than any other cause¹ and is increasing in incidence, with 88,398 new cases (excluding non-melanoma skin cancers) and 36,319 deaths in 2001, compared with 65,966 new cases and 30,928 deaths in 1991².

Yet up to half the cancers diagnosed each year could be prevented or treated successfully through early detection using currently available methods and technology.

The available evidence on cancer and socioeconomic status clearly shows that people in disadvantaged groups have markedly higher cancer mortality rates³, largely attributable to reduced access to health promotion information and consequent higher-risk behaviours. (Existing research shows that health promotion aimed at reducing the impact of preventable illness favours people already socioeconomically advantaged⁴.)

On behalf of its many thousands of stakeholders, including vulnerable Australians who bear an inequitable proportion of the cancer burden, The Cancer Council Australia welcomes the NHMRC's commitment to reducing knowledge gaps in the link between socioeconomic disadvantage and poorer health outcomes and researching measures that may help to reduce inequalities.

For the purposes of this consultation The Cancer Council Australia is focusing on three of the most stark, but under-researched areas, where socioeconomic disadvantage leads to significantly higher rates of preventable cancer incidence and death: nutrition and physical activity; smoking; and cancer in Indigenous communities.

1. Nutrition and physical activity

Australia faces a potential social and economic crisis, with the human cost largely borne by vulnerable groups and the economic cost by taxpayers, if we do not arrest the trend towards obesity/overweight through targeted public health programs.

A national survey of Australians' diet and exercise habits should be conducted every five years, to provide baseline data to inform effective interventions aimed at addressing the crisis.

Overview

The prevalence of illness associated with poor diet, physical inactivity and obesity is Australia's most rapidly growing health problem. Almost 60 per cent of Australians aged 25 and over are obese or overweight – a doubling of rates in the past 20 years⁵. Poor nutrition and physical inactivity are the reasons for the obesity epidemic⁶ and are a key cause of cancer and other major diseases in Australia⁷.

The available evidence indicates that the chronic health problems associated with poor diet and inadequate physical activity are significantly more prevalent among people in vulnerable and disadvantaged groups^{8,9,10}.

Australia's skyrocketing overweight/obesity problem is placing enormous but potentially avoidable pressures on the health system. Physical inactivity currently accounts for 7 per cent of the total burden of disease, overweight and obesity 4.3 per cent and poor intake of fruit and vegetables around 2.7 per cent¹¹.

The links between chronic, preventable disease, nutrition and physical activity, and socioeconomic disadvantage are clear, but there is a dearth of up-to-date, detailed information. A regular national survey of Australians' diet and exercise habits is essential to informing an effective public health response to this potential crisis.

In the context of NHMRC key research themes

1. The social and economic fabric

Nutrition and physical activity are essential to good health from birth to old age, and therefore form a critical element of a nation's social and economic fabric. They contribute to physical and mental health and wellbeing, and help to prevent disease and disability^{8,9,10,12}. A well-nourished and healthy population is essential to economic development and social cohesion⁸.

Based on current trends, and the fact that the health problems of poor diet and physical inactivity preponderate among the disadvantaged, there is a risk that the escalating problem of obesity/overweight could widen the divide between rich and poor in Australia.

Income losses caused by health problems linked to poor diet and physical inactivity will increasingly be borne by groups already marginalised by socioeconomic disadvantage, while taxpayers may have to bear the associated medical costs. This is particularly relevant to cancer, which will impose a greater burden on the health system as our population ages.

2. Communities of place

Disadvantaged people tend to coexist geographically and culturally, and share barriers to health advice such as poorer literacy. (It is widely understood that poor general literacy equates to poor health literacy¹³⁻²⁰.)

The evidence suggests that particularly vulnerable groups, such as people on low incomes and Indigenous people, have restricted communal access to healthier foods, to safe and desirable areas for physical activity²¹, and to information about preventive health measures¹³⁻²⁰.

There is also growing evidence that a community's physical planning environment contributes to its inhabitants' diet and exercise habits, and consequently their health status²²⁻²⁵.

Communal barriers to good diet and physical activity faced by disadvantaged groups also make it more difficult to gather comprehensive data on the problem, compounding the challenge of improving their overall health outcomes.

3. Autonomy, poverty and health

Key problems in the context of "social fabric" and "communities of place" also apply to disadvantaged communities' capacity to exercise autonomy in making healthy dietary and physical activity choices.

Poverty; lack of education and information; uncondusive urban (and in some cases rural and remote) infrastructures; and associated psychosocial and behavioural issues combine to reduce the target groups' ability to make autonomous choices.

The absence of up-to-date national research on nutrition and physical activity in Australia means it is impossible to identify the areas where lack of autonomy translates to unhealthy choices made specifically by disadvantaged groups. However, we do know that health promotion is competing with the high-budget, sophisticated marketing of fast food products (generally high in fat, salt and sugar, and low in nutrition), the supply of which has grown dramatically in Australia since the 1970s²⁶⁻³¹.

New baseline research is required to ensure that health promotion messages are targeted to the groups most in need: those in lower socioeconomic brackets and other disadvantaged groups⁴.

4. Promoting change

Of the research themes identified in *Preventative healthcare and strengthening Australia's social and economic fabric*, The Cancer Council Australia is primarily interested in theme 4, "Promoting change". However, the evidence suggests that before strategies for influencing change in diet and physical activity choices can be explored, current baseline measurements of dietary intake, physical activity levels and anthropometric data must be collected.

The most recent national nutrition survey (which collected data on demographic variables, dietary intake and anthropometric measurements) was conducted 10 years ago. A report of the bridging study undertaken to compare results of the 1983, 1985 and 1995 national nutrition surveys recommended that future nutrition surveys allow changes in dietary intake to be monitored for selected age groups, ethnicities and regions in the Australian population³².

The report also stated that in future, population samples will need to be large enough to account for demographic change due to population ageing and migration patterns³².

Attempts to find differences in dietary intake data from the 1995 national nutrition survey according to income, education and socioeconomic status revealed differences in food variety, with people from higher socioeconomic groups likely to eat a greater variety of foods^{33,34} and more fruits and vegetables³⁵.

No recent national data on the dietary intake, physical activity levels, anthropometric measurements (eg body-mass index, waist circumference) and demographic characteristics of the Australian population has been collected, and this information is urgently required.

In order to measure changes and improvements over time, regular national nutrition and physical activity surveys focusing on high-risk groups are essential.

The Cancer Council Australia also recommends that high-risk groups, such as people of lower socioeconomic status, Indigenous people and those from diverse cultural backgrounds, be "over-sampled" to ensure an adequate sample size that produces statistically significant results.

Nutrition and physical activity surveys should be conducted at least every five years, allow changes in dietary intake and exercise to be regularly monitored for selected socioeconomic and age groups.

Once baseline nutrition, physical activity, anthropometric and demographic data has been collected, it will then be possible to take an informed approach to developing public health measures to reduce the unacceptable rates of preventable disease prevailing in disadvantaged groups.

Research questions

Questions should be designed to determine in accurate detail what Australians are eating and how physically active they are, with data filtered according to subjects' socioeconomic status and cultural background.

Given that "Promoting and maintaining good health" is a National Research Priority, it is essential to conduct national surveys of diet and physical activity at least every five years, to enable health promotion organisations to monitor trends, guide development of interventions, and assess the effect of interventions.

Questionnaires from previous national nutrition and physical activity surveys could be adapted in consultation with health promotion organisations, ensuring comparisons can be made with previous findings.

Research is also required into what may motivate people in disadvantaged groups to take greater control of their health and wellbeing, in terms of diet and physical activity.

2. Tobacco control

There is no more stark example of the inextricable link between preventable death and disease and socioeconomic status in Australia than smoking. Any attempt to strengthen Australia's social and economic fabric through research and health promotion in a preventive healthcare context must make a priority of reducing the unacceptably high levels of tobacco use among people in disadvantaged groups.

The development of research and interventions to reduce smoking in vulnerable communities must involve individuals in the target groups, particularly those who have autonomously made healthy lifestyle choices.

Research is also necessary on a larger scale and should focus on both adolescent and adult health literacy, attitudes and behaviours.

Overview

The total societal costs of tobacco use in Australia each year, including healthcare costs, are estimated to be over \$21 billion. In 1998-99 over 19,000 deaths and 965,000 hospital bed-days were attributed to tobacco use, with healthcare costs in excess of \$1 billion³⁶.

According to the latest figures, 21.1 per cent of Australian males and 18 per cent of Australian females smoke on a daily basis³⁷. While smoking rates in Australia are low compared with many other nations, relative tobacco use remains significantly higher among the most vulnerable groups, including people on low incomes, Indigenous people and people with mental illnesses³⁸⁻⁴⁰.

There is emerging evidence that more than one-third of the inequalities in health outcomes between socioeconomic groups in Australian men can be attributed to smoking. Similar differentials are likely to exist between women⁴⁶.

The potential to reduce the burden of smoking in Australia directly accords with the aims and objectives of the NHMRC's *Prevention* project.

In the context of NHMRC key research themes

1. The social and economic fabric

There is abundant evidence that social disadvantage, smoking and consequent death and disability coalesce in Australia³⁸⁻⁴⁰. More than one in three male blue-collar workers smokes, compared with around one in four white-collar workers and fewer than one in five professionals. The same pattern applies to Australian women, with 29.4 per cent of blue-collar workers smoking, 21.2 per cent of white-collar workers and 14 per cent of professionals⁴⁰.

Moreover, smoking prevalence is directly associated with the “Index of relative socioeconomic disadvantage”, a measure which includes income, education, household composition, and English fluency⁴¹.

Preponderant smoking rates in lower socioeconomic groups coexist with a wide range of other social and health problems. Efforts to improve infrastructure and overall social cohesion in vulnerable communities must include improved tobacco control in a coordinated, targeted way.

2. Communities of place

Smoking rates are significantly higher where vulnerable people coexist and commune, be it geographically, culturally or in terms of other commonalities such as mental illness³⁸⁻⁴¹.

However, it is encouraging to note that, with the exception of Indigenous communities (where smoking rates can be as high as 80 per cent⁴⁵), there is no single socioeconomic group where the majority of people smoke. This suggests that many disadvantaged individuals have taken control of their own preventive healthcare, despite the wide-ranging barriers they face (see theme 3, below).

A separate approach to Indigenous communities is clearly needed (see Indigenous cancer section), given the extremely high smoking rates and the complex problems of health and wellbeing specific to Aboriginal and Torres Strait Islander peoples.

3. Autonomy, poverty and health

Existing research indicates that the problems of “poverty” extend well beyond a lack of material wealth, and include poor education; social exclusion; absence of goals and structures in life; substance abuse and gambling; and higher rates of mental illness.

People facing any number of these problems are more likely to take up smoking and less likely to quit. It is therefore essential to factor all these coexistent problems into measures aimed at enabling people in disadvantaged groups to take greater responsibility for their own preventive healthcare.

It is also essential for researchers to involve individuals in the target groups who have learned to take control of their health and wellbeing in developing the research questions and consequent interventions required to reduce inequalities in health outcomes.

The Cancer Council Australia also recommends that the links between disadvantage and smoking be studied on a more wide-ranging basis in both adolescence and adulthood. We enthusiastically endorse the submission lodged independently by Drs Ron Borland and Mohammad Siahpush, which puts forward more detailed proposals in this context.

4. Promoting change

Measures aimed at influencing people to quit smoking or to avoid taking it up should be targeted at individuals and groups at key developmental stages of life. (As stated, The Cancer Council Australia supports the two-staged, rolling cohort approach proposed by Drs Borland and Siahpush in their separate submission.)

The evidence indicates a strong link between smoking prevalence and a number of other high-risk behaviours among people in disadvantaged groups. Opportunities to coordinate smoking avoidance and cessation with other preventive healthcare measures within a community setting should be explored.

To ensure community participation and encourage autonomy, people from the target groups need to be actively involved in every step of the process.

Ongoing review and measures to track what is and what is not working are also essential elements of the process.

Research questions

The “big” question that needs to be answered is:

How can positive behaviours in terms of preventive healthcare become “institutionalised” in disadvantaged communities in the same way high-risk behaviours are?

Obviously this is too broad a question in a population-health research context. However, as stated, in-depth consultation with disadvantaged communities on what has empowered many individuals to take control of their preventive healthcare is required before specific research questions are devised. A process should be in place to enable such individuals to have direct input into the development of strategic researchable questions.

Given the relevance of smoking to the objectives of *Preventive healthcare and strengthening Australia’s social and economic fabric*, it is hoped that a number of tobacco control advocates will respond and that smoking will be a priority outcome from the exercise.

Many of Australia’s leading authorities on tobacco control and population health operate in the VicHealth Centre for Tobacco Control, the state Quit organisations, and population health faculties. It is therefore recommended that these groups and individuals be invited to contribute to the development of new research into ways in which the burden of smoking on vulnerable groups can be reduced.

3. Cancer in Indigenous communities

In terms of population health, cancer in Indigenous communities is one of the most serious yet under-researched topics in Australia. Indigenous cancer patients die at twice the rate of non-Indigenous cancer patients, in many cases from preventable cancers. Yet little is known about our failure to prevent the unacceptably high incidence rates of more lethal cancers in Indigenous peoples.

Government research into cancer in Indigenous Australians is urgently required and should be undertaken in direct consultation with Indigenous organisations such as the Cooperative Research Centre for Aboriginal Health, and the National Aboriginal Community Controlled Health Organisation.

Reduction in smoking rates in Indigenous communities is a particularly high priority.

Overview

There is no national data set on cancer incidence and mortality among Aboriginal and Torres Strait Islander peoples, and only South Australia, Western Australia and the Northern Territory collect Indigenous cancer registry data.

The information extrapolated from the limited data available presents an appalling picture, with Indigenous people diagnosed with cancer twice as likely to die from the disease than non-Indigenous people⁴².

The Cancer Council Australia convened Australia's first national discussion forum on cancer in Indigenous communities in Darwin in August 2004, which drew Australia's leading Indigenous cancer epidemiologists and Indigenous people with direct experience of cancer. From the information presented at the forum, the imbalance in cancer mortality can in part be attributed to:

- Indigenous people developing comparatively higher rates of more lethal cancers, such as lung cancer⁴³;
- Unhealthy lifestyles, due to poverty, coexisting disease, 50 per cent smoking prevalence⁴⁴ (and in some communities 80 per cent⁴⁵) and poor nutrition⁸;
- Reduced access to cancer screening and early detection services;
- Diagnoses being made at a later stage and Indigenous people presenting with more advanced and less-treatable cancers⁴³.

These issues were underscored by a number of other, more complex, barriers to preventive healthcare relating to language, culture, attitudes and the myriad problems of dispossession and institutionalised racism.

Promoting change

The Cancer Council Australia makes no specific recommendations on how to address the problems of preventable cancer in Indigenous communities, as we acknowledge that our understanding is limited and that Indigenous organisations are best able to provide advice in this area.

We are, however, aware of the magnitude of the problem in a statistical context. And, as Australia's peak non-government cancer control agency representing all Australians, we have a duty to address the inequities in cancer outcomes between Indigenous and non-Indigenous Australians.

A consistent theme throughout discussions at our national forum in Darwin last year was the importance of more directly involving Indigenous groups in the development and implementation of programs to improve their healthcare. We therefore recommend that new research into cancer in Indigenous communities be undertaken in collaboration with Indigenous organisations such as the Cooperative Research Centre for Aboriginal Health and the National Aboriginal Community Controlled Health Organisation.

Reducing the appallingly high level of smoking in Indigenous communities is a particularly urgent research priority and one that should be addressed in consultation with organisations such as the VicHealth Koori Health Research and Community Centre for the Study of Health and Society.

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