AUSTRALASIAN SOCIETY OF LIFESTYLE MEDICINE

COMPLETE HEALTH AND WELLBEING FOR AUSTRALIANS

2022 FEDERAL ELECTION PRIORITIES

Australasian Society of Lifestyle Medicine

CONTENTS

THE CHALLENGE

A bold vision is required to support optimal health and wellbeing for all Australians. As defined by the World Health Organisation (WHO), "*health is a state of complete physical, mental and social wellbeing and not merely the absence of disease*[1]". However, 52% of the total burden of disease comes from Australians living with chronic diseases, of which 49% could be avoided or reduced by modifying preventable risk factors[2].

There are various sectors of our society disproportionately experiencing this burden of disease, with the main causes of this inequity a result of social inequality and disadvantage[3].

The gap between the life expectancy and health of Aboriginal and non-Aboriginal people highlights this inequality and disadvantage. The Australasian Society of Lifestyle Medicine (ASLM) sees the higher rate of disease burden and lower life expectancy for Aboriginal and Torres Strait Islander people as a failing within Australia to act to improve the economic inequality and disadvantage that result from ongoing colonisation. Aboriginal and Torres Strait Islander people have a significantly higher rate of burden of disease (at 64%) than the non-Aboriginal community[4].

Other groups within our society experiencing disproportionate burden of disease include but are not limited to:

- culturally and linguistically diverse (CALD)
- rural, regional and remote
- people of low socioeconomic status
- lesbian, gay, bisexual, transgender, queer or questioning, intersex, asexual and/or other sexuality and gender diverse people (LGBTQIA+)
- people with mental illness
- people with disability

Australia's current model of care must change from a reactive, treatment-based model, where one size fits all, to a preventive and integrative model, as recognised by the National Preventive Health Strategy 2021-2030[5]. This is especially true considering the impacts of the COVID-19 pandemic which have led to additional threats in healthcare alongside the already-growing prevalence of chronic disease cases.

In Lifestyle Medicine (LM), we understand the importance of disease prevention through health promotion, behaviour change, and intervention of modifiable risk factors (i.e., nutrition, stress, sleep, physical activity, and social connectedness). We acknowledge other social determinants of health such as health equity, environment, socio-economic factors, cultural diversity, and the importance of the health of our healthcare workforce and the general population. A shift from an overburdened primary care system to an interdisciplinary care team approach, with a focus on prevention, health promotion and disease remission will require government attention and policy action; not only in the field of health, but in a systemic 'Health in All Policies' (HiAP) synergistic approach[6].

In this document, ASLM will outline solutions to three current challenges in primary care in Australia.

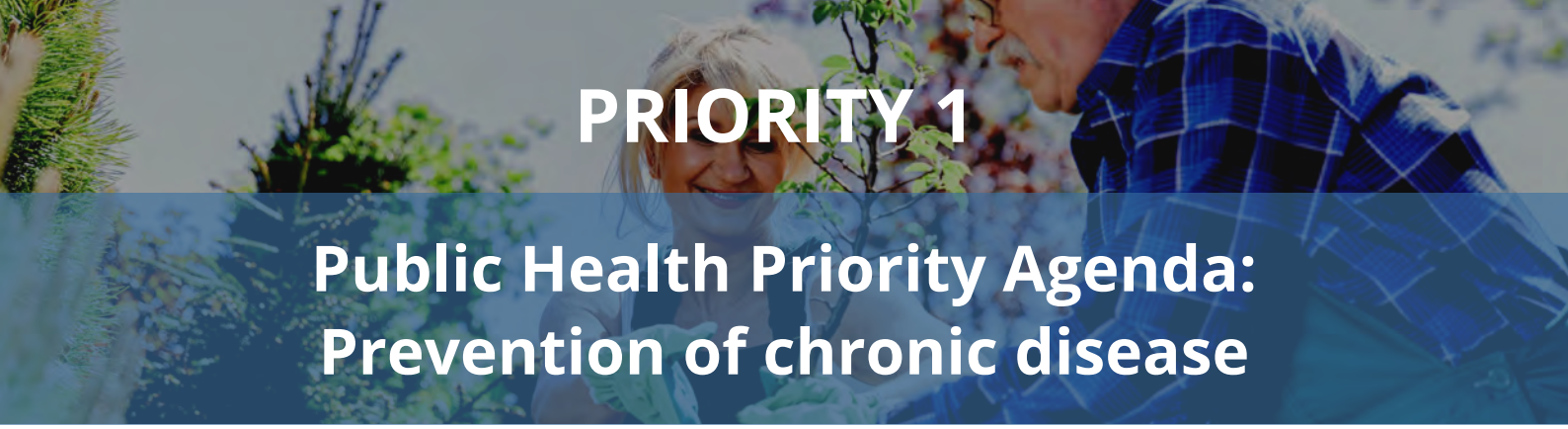
"We currently have a once-in-a-generation opportunity to reimagine life and health in Australia. The global coronavirus pandemic has highlighted many public health issues, bringing public attention and a sense of priority to protecting and promoting wellbeing[7]".

These solutions take into consideration preventing and better managing chronic disease, adopting innovation in the primary care model (particularly aimed at removing barriers to access for our most vulnerable populations), and supporting the health workforce to enable delivery of the new models. These are bold yet achievable solutions to influence innovative, sustainable, and collaborative change.

They support the incoming government to achieve key strategies including the Long-Term National Health Plan[8], the National Preventive Heath Strategy, Primary Health Care Ten-Year Plan, the 2030 Mental Health Vision, and the National Obesity Strategy[9].

The National Aboriginal and Torres Strait Islander Health Plan 2013–2023 established the overarching health goal of '*achieving equality of health status and life expectancy between Aboriginal and Torres Strait Islander people and non-Indigenous Australians by 2031*'. According to the Plan, one of the main ways in which this goal would be reached is through making services accessible, affordable, appropriate and acceptable (i.e. culturally competent and non-discriminatory)[10].

The time to act is now. When we look back at re-imagining health for all Australians in a post-pandemic world, what will your party be most proud of?



PRIORITY 1

Public Health Priority Agenda: Prevention of chronic disease

THE PROBLEM

Chronic disease is the leading cause of death, illness, and disability in Australia. Chronic disease contributes to loss of productivity, social and mental health implications, increased absenteeism, and a rise in reliance on the welfare system. It is estimated that the economic burden caused by productivity impacts of lifestyle-related risk factors, such as obesity, tobacco use, excess alcohol, physical activity, and diet is $48.4 billion[11]. In 2018, for the first time in history, more Australians were living with non-fatal chronic diseases (52%) than were dying of premature death (48%). In 2017-18, 1 in 2 Australians, or 47%, had one or more chronic conditions[2].

In 2018-19, **17% of Indigenous adults reported having diabetes or high blood sugar levels**, compared to 6.1% of non-Indigenous Australians, **and are four times as likely to be hospitalised**[12].

At present, the healthcare model does not support overall health and wellbeing for all Australians due to a range of factors, including lack of cultural awareness and acceptance of cultural expression, accessibility and education on lifestyle-related interventions.

A lack of culturally aware, safe, and responsive services and information is cited as a major barrier to culturally and linguistically diverse (CALD) and Aboriginal and Torres Strait Islander groups[4]. In Indigenous populations around the world – of which there are estimated to be up to 500 million across 90 countries - social and emotional wellbeing can include concepts beyond mental health and illness such as the importance of connection to land, culture, spirituality and ancestry[13].

As previously mentioned, 49% of diseases are preventable by decreasing or avoiding exposure to modifiable risk factors. ASLM commends the Expert Steering Committees and the Australian Government for releasing both the National Preventive Health Strategy 2021 – 2030 (NPHS) and the National Obesity Strategy, which recognise the vital role prevention plays in reducing chronic disease in all population groups. Recognition must also be given for the acknowledgement of the needs of vulnerable populations and the subsequent establishment of stronger targets for these cohorts. Whilst the current government has taken some measures in releasing the National Preventive Health Strategy, ASLM has significant concerns with the plan and timelines for implementation.

Below, we have described three key strategies to ensure improved chronic disease prevention and management is supported for a healthier future for all Australians.

THE SOLUTION

As part of a public health priority agenda, ASLM advocates for lifestyle and social determinants of health being a priority consideration in all government discussion and policy. ASLM makes three key recommendations:

1. **Ensure lifestyle and social determinants of health are a priority consideration in all government discussion and policy**
2. **Increase the prevention budget by 1% each year for the next three years to fast-track arrival at the 5% expenditure of the health budget on prevention**
3. **Create and implement a detailed outcomes framework to enable the full implementation of the NPHS**

While spending on prevention has remained at less than 2% of the total health budget for many years[14], ASLM strongly supports an increase in expenditure to 5% under the recommendation of the NPHS 2021-2030[5]. However, we believe it is both possible and necessary for this expenditure to be fast-tracked. In particular, a failure to fast-track the prevention budget, will significantly jeopardise the NPHS's ability to address inequality in health and ensure that those vulnerable groups in our community, who experience poorer health outcomes compared to the rest of the population have "greater improvements in health"[5].

In order to meet ALL of the targets in the NPHS, incremental increases should be made to achieve 3% by 2023, 4% by 2024, and 5% by 2025. This will ensure adequate time and resources are available to achieve the other seven targets of the NPHS, therefore better supporting all Australian communities, regardless of race, ethnicity, sexual orientation or ability.

Along with increasing the prevention budget urgently, ASLM recommends development and delivery of a robust outcomes framework for the "Blueprint for Action"[5]. This framework should be co-designed with industry leaders and reported against annually. These industry leaders must be chosen from organisations and communities with a focus on the most vulnerable and at-risk sectors of the Australian population. Tracking progress and implementation will support accountability, and help identify when, how, and with whom the outcomes are to be met.

ASLM presents this recommendation as a mechanism for avoiding past mistakes when it comes to implementation of prevention policy. Historically, the removal of funding resulted in stagnated implementation whereby only one of the 27 recommended actions had been fully completed 10 years later[15]. With almost 1000 general practitioners, allied health professionals and research members, **ASLM is the leading organisation in promoting evidence-based lifestyle approaches to prevent and manage chronic disease, and has a strong focus on finding solutions that work with vulnerable communities.** We would welcome the opportunity to work alongside the government or provide trusted input towards the proposed outcomes framework.

PRIORITY 2

Supporting innovation in the current model of care

THE PROBLEM

It is time for meaningful change in the current model of primary care to improve the health of our community. Our population is ageing, our health professionals are under increasing pressure, a substantial number of health professionals are seeking other professions, and our most vulnerable Australians are not served by the current homogenous, metro-centric health delivery model. Greater emphasis needs to be placed on enhanced primary care teams including diverse workforce input (interdisciplinary), self-management support programs (e.g., digital therapies, health coaching support), increased integration with community organisations (e.g., effective social prescribing), and enhanced collaboration between disciplines such as across primary care and between primary and tertiary care.

As explained in "Designing and scaling up integrated youth mental care", when designing an effective mental health care model, attention must be given to several ever-evolving factors[16]. **The system designed for the 21st century must align with one's culture, emphasise the importance of community, and be built on a clinical staging approach**. Key principles therefore include prevention and early intervention, patient and community participation, respect, empowerment and co-design, community engagement, education, and consultation, family engagement and support, and more. An integrated model of care accounts for factors influencing one's health potential, which extend beyond the basic care model.

ASLM supports RACGP's notion that **a health system should empower individuals and communities, equip them with autonomy, and expand their knowledge and capacity for self-care and self-management of health in culturally-responsive and acceptable ways**[17].

The provision of primary care has changed inadequately since the inception of Medicare. The prevalence of chronic mental and physical disease points to the need for innovation to plan, translate, evaluate, and scale a modern model of primary care.

However, without acknowledging the need for a more responsive, accessible, and interdisciplinary approach, vulnerable populations are continuously excluded from the model.

THE SOLUTION

In considering an integrated team and community care model, ASLM recommends a four-pronged approach, which includes:

1. **Primary Care innovation funding**
2. **Health coaching and/or Lifestyle Medicine provider workforce**
3. **Shared Medical Appointments**
4. **Proactive "community-based" programs**

PRIMARY CARE INNOVATION FUNDING

Instead of only investing in existing programs, the next Government budget could diversify and invest in new evidence-based, collaborative and emerging programs that integrate with existing models. **The current Government funding approach should be tiered to include a simpler and more accessible funding stream for small NGOs and start-ups that require less funding.** This would facilitate greater innovation and diversity in the health care ecosystem, creating initiatives and culturally responsive services that can be meaningfully and effectively embedded and integrated into the modern health care systems.

ASLM supports the integration of models such as Inala Primary Care (QLD), Osana (NSW), Iora and Oak Street Health (USA), the King's Fund (UK). Another international example is Te Tumu Waiora (NZ) which received $455m in government funding to develop new frontline primary mental health services through general practice, in collaboration with health coaches and community agencies[18].

HEALTH COACHING AND/OR LIFESTYLE MEDICINE PROVIDER WORKFORCE

ASLM proposes existing healthcare practitioners adopt health coaching and Lifestyle Medicine educator practices to support patients with holistic behaviour change. Health coaching involves health education and promotion, both of which our healthcare practitioners know, understand, and have influence over, especially with some suggestions for upskilling as outlined in Priority 3 below. By implementing health coaching in practice, and in communities most in need, evidence shows patients are better able to prevent and manage their chronic conditions, reducing pressure on healthcare workers.

When patients understand the root cause of disease and how lifestyle choices affect them, they can better manage and/or prevent the very conditions they see practitioners for.

Based on international evidence and local co-design, these new models of care provide rapid, targeted intervention to vulnerable people and connects them quickly to the social and primary care supports they need.

SHARED MEDICAL APPOINTMENTS: PEER-PEER BASED GROUP VISITS

Shared medical appointments (SMAs) support social connection and healthier lifestyle interventions, increase healthcare accessibility, and **decrease the burden on general practitioners and healthcare expenditure.**

By 2014, there were over 400 peer-reviewed journal articles on the effectiveness of SMAs.

SMAs allow for management of large groups of patients with shared conditions, such as type 2 diabetes, cardiovascular disease, mental health challenges, chronic pain, menopause, and weight management, through peer-to-peer education and facilitated medical appointments.

ASLM is at the forefront of pioneering SMAs, conducting pilot trials, training practitioners, and advocating for recognition within the Medicare Benefits Scheme.

SMAs, named "medical yarn ups" by Aboriginal communities, support individuals in choosing and practising healthier lifestyle behaviours learned through healthcare interventions[19].

They have been shown to improve cultural safety and access to health services. Led by Aboriginal health workers and supported by ASLM, medical yarn ups offer a unique opportunity for the 'true' co-designing of health programs that privilege Aboriginal knowledge and sovereignty which, we are told by our First Nations partners, is a key ingredient to closing the gap.

Research shows patients who participate in shared medical appointments experience a reduction in pain medications and fewer emergency department visits. Patients also report better quality of life and improvements in symptoms of depression because of these appointments[20].

By implementing more SMAs, as an adjunct practice, general practitioners could practice more efficiently and effectively, supporting a larger number of patients to increase their health literacy and modify behaviours to improve their wellbeing.

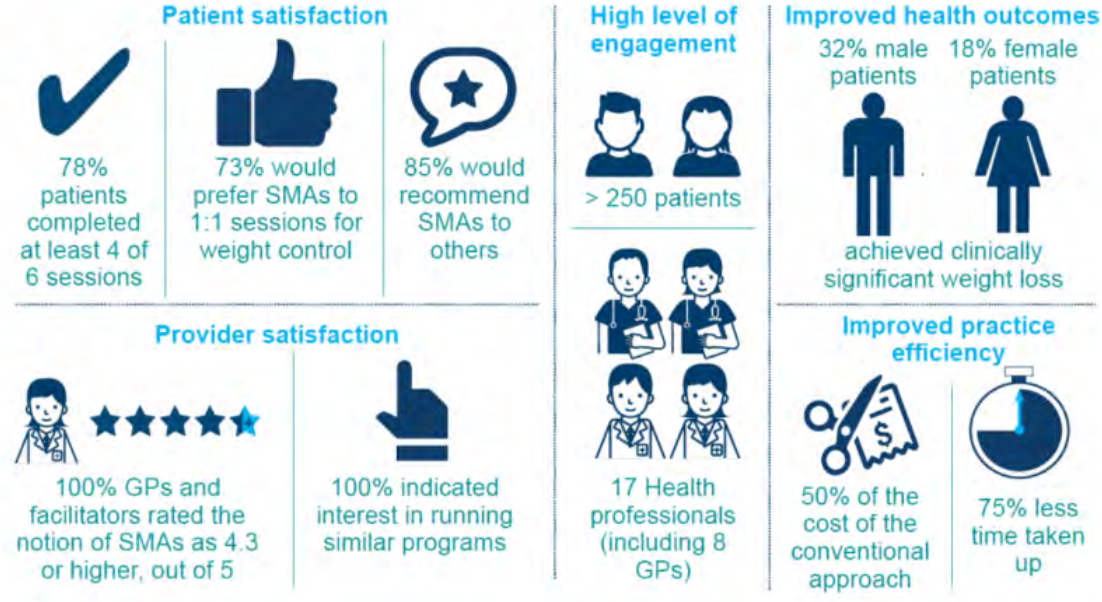


Figure 1: Outcomes of shared medical appointments[21]

PROACTIVE "COMMUNITY-BASED" HEALTH PROGRAMS

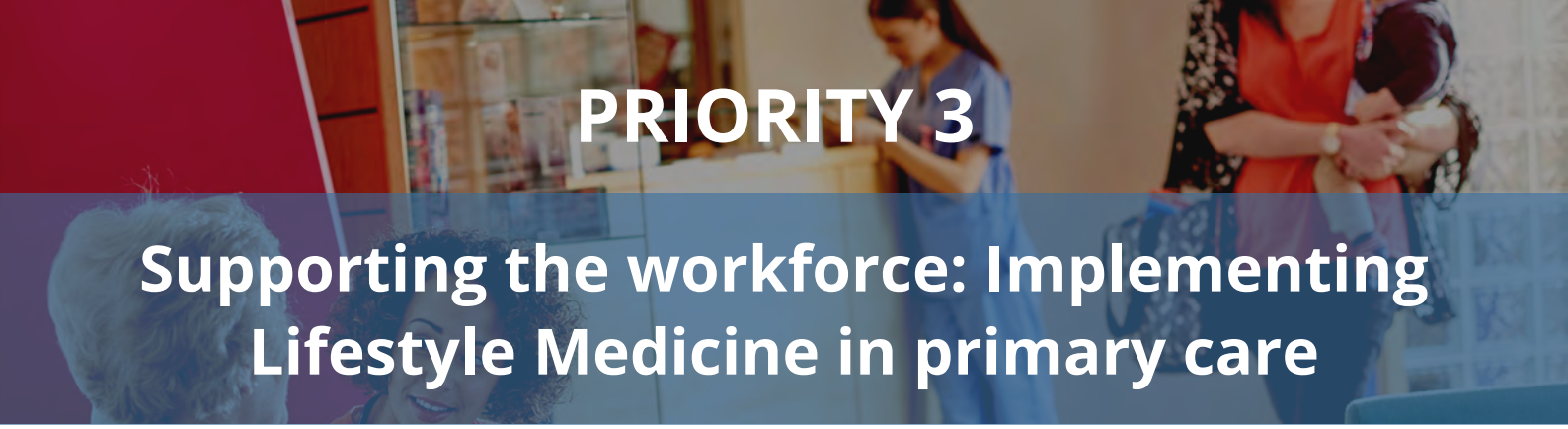
Coordinated local teams of individuals and professional groups can very effectively engage in health promotion and prevention activities to support prevention of chronic disease. These teams can include healthcare professionals (including nurses and allied health professionals), community workers, social workers, local community members, and other stakeholders such as civic communities, schools, and workplaces. Furthermore, increasing access to health services and providing ongoing support, education, and continuum of care throughout a patient's journey to health significantly increases successful health outcomes when compared to GP-centric and hospital models alone[22].

Community-based models also address the social determinants of health, health equity, and cultural appropriateness particularly in Aboriginal and Torres Strait Islander and culturally and linguistically diverse populations that unfairly experience poorer health access and outcomes. For these communities, trust is necessary to developing open therapeutic relationships that allow people from culturally diverse backgrounds to inform and work with their health care team on culturally grounded support mechanisms as both supportive and involved positive resources (e.g., community members, spiritual settings, practices, groups) and for harm-minimization reasons (e.g., to avoid potentially dangerous practices).

Genuine understanding of the local culture – or culture of origin - and concepts of health and wellbeing will strengthen provider-service user relationships, reduce stigma, make lifestyle-based approaches more personalized and relevant (e.g., connection to land, "green prescriptions" and mindfulness), and inform and improve the health service itself. A meta-analysis of 48 studies on community-based programs and their effectiveness on cardiovascular risk factors tells us this form of care has led to considerable decreases in several factors. These included decreases in systolic blood pressure, diastolic blood pressure, total cholesterol, and more[23].

By implementing innovation in healthcare as appropriate to the culture and environmental settings of the population, **we can improve risk factors for chronic diseases.**

The cost of inaction is now urgent considering the burden of chronic disease on individuals, communities, society, and the economy. Adopting an interdisciplinary, cultural and community focussed approach and an integrated model of care, as outlined above, will support us in achieving overall health for all Australians, irrespective of culture, ability, or identity.



PRIORITY 3

Supporting the workforce: Implementing Lifestyle Medicine in primary care

THE PROBLEM

Along with transforming to a more interdisciplinary approach in the Australian healthcare system, ASLM supports a substantial shift in focusing more heavily on the mental and physical health of our healthcare workers.

By better supporting health professional self-care initiatives and spreading responsibility across more healthcare professionals outside of general practitioners, **we will be better able to achieve improved workforce health and retention.**

This will positively affect workers' ability to better promote healthy lifestyle choices as a way of preventing and/or managing chronic disease.

Healthcare workers are particularly subject to mental illness, many times due to burnout and stress, which is only heightened in the years following the COVID-19 pandemic[24]. In a 2020 study of Australian healthcare workers, researchers found 59.8% reported mild to severe anxiety, 70.9% reported mild to severe burnout, and 57.3% reported mild to severe depression[25]. Globally, mental illness accounts for 32% of years lived with a disability. The result of the mental health burden healthcare workers face includes lack of appropriate care for the population, decreased happiness, adverse physical health effects, and a shortage of workers in health care, due to either poor health or decisions to leave the sector.

The challenges in our health workforce and in particular the implementation of innovative models of care are further aggravated by the current structure of the primary healthcare system. There is considerable evidence to suggest that, whilst our GP workforce is stretched (particularly in rural areas), there is significant capacity within the nursing and allied health professions to work within a Lifestyle Medicine framework[14].

THE SOLUTION

In considering the over-burdened state of our healthcare workers, ASLM suggests two solutions:

1. **Self-care interventions for healthcare professionals**
2. **Utilising the full capacity of the health workforce**

SELF-CARE INTERVENTIONS FOR HEALTHCARE PROFESSIONALS

Provision of Lifestyle Medicine (LM) self-care interventions tailored specifically to healthcare professionals is an urgent need. Implementing these interventions in primary care would see our workforce recognising the impacts of mental health, social connection, stress management, quality sleep, and environmental impacts (amongst other factors) on their overall health.

By implementing LM interventions in primary care and recognising how LM interventions support the prevention and management of chronic disease, we can better look after the workforce and the population for which they are caring.

UTILISING THE FULL CAPACITY OF THE HEALTH WORKFORCE

As outlined in priority two, **the current healthcare system is overly reliant on General Practitioners to deliver care, whilst other primary care workers have latent or under-utilised capacity.**

For example, nurses, diabetes educators, Aboriginal Health workers and various allied health practitioners have knowledge and capabilities that expand beyond their current roles in the Australian system.

In practice, this may look like nurse practitioners delivering health coaching, allied health professionals taking more responsibility of client overall health, community leaders providing coaching and support services facilitating SMAs, and all healthcare practitioners working together in a teams-based approach.

By capitalising on the broader range of capabilities of healthcare practitioners, we can help our society learn better prevention and management behaviours, and increase access to culturally responsive care, which will reverse the upward trend of chronic illness while lessening the burden on healthcare workers.

Shifting to an interdisciplinary, teams-based model that specifically addresses chronic disease prevention (such as that outlined in Priority 2) would support the wider healthcare workforce to ease the burden on general practitioners and the hospital system, as well as increase workforce satisfaction and utilise each profession to the full scope of their practice.

ABOUT ASLM

The Australasian Society of Lifestyle Medicine (ASLM) is a not-for-profit organisation working towards improved prevention, management, and treatment of chronic, complex, and lifestyle-related conditions. 'Lifestyle-related' includes environmental, societal, behavioural, and other factors.

At ASLM, we support an interdisciplinary approach to health and healthcare; shifting away from siloed practice to create a genuinely collaborative means through which complex problems can be solved.

Not one health discipline or profession alone can meet our health needs. Instead, we must work together, embracing practitioners from all fields for the value of their expertise and input. We advocate for wellbeing, which includes the absence of disease, but also health equity, social justice, corporate responsibility, and environmental sustainability.

ASLM is a leading member of a global network of multidisciplinary societies and medical colleges, all working to establish Lifestyle Medicine as central to health and wellbeing, medicine, healthcare, and health policy.

ASLM members support and utilise Lifestyle Medicine approaches in practice, and include GPs, medical specialists, allied health practitioners, public health physicians, nurses, educators, scientists, researchers, and healthcare executives.

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Australian Toll Free: 1300 673 643 | International: +61 3 7020 6996 | info@lifestylemedicine.org.au

ABN: 73 606 875 227