

Framing prevention: Response to Fry, Gleeson and Rissel

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In a recent HPJA article, Fry et al.¹ responded to commentary that we had published earlier in this Journal on the role of secondary prevention of diabetes in health promotion.² We were encouraged that our paper stimulated constructive debate, and in this spirit we reply.

The premise of the Fry et al. paper is to challenge our supposed assertion that health promoters should conduct secondary prevention programs at the expense of primary prevention. Rather, we caution the field not to ignore secondary prevention at a time when prevention has attracted more than a billion dollars of investment through the Council of Australian Governments (COAG).³⁻⁵ We argue: "By not engaging, health promoters run the risk of not having a seat at the policy table and ... increase the chance that secondary prevention programs draw resources away from primary prevention".^{2(p.87)} We do not state that health promoters should divert efforts away from primary prevention, rather that the field should influence the strategic development of secondary prevention to ensure these investments are not wasted through poor design, targeting and rollout.

Framing prevention and the policy making process

Fry et al. contend: "Milat et al. state that the view that social determinants are the only valid health promotion response is not without its risks. This seems to imply that awareness of social determinants of health is one possible health promotion response of many that could be selected. We believe the social determinants of health are central to understanding how health is created."^{1(p.88)}

We agree with these sentiments, but feel it naive to think that the social determinants 'frame' is universally understood or accepted by those who have influence over health, social and economic policy in Australia.

The field is ill-advised to apply a single 'frame' to health advocacy. To illustrate, when asked about health advocates former federal Health Minister Michael Wooldridge stated: "In many cases public health advocates feel so passionately about the correctness of their cause that they just can't understand why others can't see the justice of their case... Perhaps because of this, the number of public health people who have had a major influence on me is quite small."^{6(p.20)} A more flexible approach that applies many different 'frames' to health promotion action can indeed yield results. For instance,

recent increases in prevention funding through COAG³⁻⁵ were in large part driven by notions that preventing chronic disease can result in improved workforce participation and productivity.^{7,8} Ironically, an 'economic rationalist' frame has driven unprecedented investment in prevention.

The risk-factor frame

Fry et al. cite: "Many practitioners remain structured and socialised within the risk-factor domains of the late 1970s."^{11(p.291)} Despite a greater focus on social determinants, the risk-factor frame remains the predominant frame used by politicians, governments and funding bodies as demonstrated by current national health priorities,⁹ recent COAG reforms³⁻⁵ and issues covered by the proposed National Preventative Health Agency.¹⁰

Addressing social determinants needs a paradigm shift in how government does business, requiring 'joined up' government,^{12,13} which can only be adopted when key influencers are convinced of its merits. To illustrate, Minister Wooldridge said of effective advocates: "... they all made their advocacy in positive terms rather than negative terms ...health advocacy seems largely focused on making people feel bad. It's not particularly successful".^{6(p.20)} What this quote illustrates is that to have influence health promoters should where possible use positive and targeted advocacy, otherwise advocacy can potentially be counter productive. The challenge for the field and research community is to provide examples of rigorously evaluated effective social determinants interventions and to appropriately frame a call to action that can be practically implemented by government.

Finally, an outright rejection of the risk factor paradigm as implied by Fry et al. could result in a misalignment of health promotion activity and funding streams and a loss of political capital. By effectively implementing evidence-based equity-focused programs, health promoters gain credibility and are better placed to raise social determinants of health in whole of government, industry and community fora through which broader societal changes can be debated and adopted.

References

1. Fry D, Gleeson S, Rissel C. Health promotion and secondary prevention: Response to Milat, O'Hara and Develin. *Health Promot J Austr.* 2010; 21(2):86-91.
2. Milat AJ, O'Hara B, Develin L. Concepts and new frontiers for development – what role should health promoters play in lifestyle-based secondary prevention programs in Australia? *Health Promot J Austr.* 2009;20(2):86-91.
3. Department of Health and Ageing. *Australian Better Health Initiative: Promoting Good, Health, Prevention and Early Intervention* [factsheet on the Internet]. Canberra (AUST): Commonwealth of Australia; 2006. [cited 2010 Aug 2]. Available from: <http://www.health.gov.au/internet/abhi/publishing.nsf/Content/factsheet-abhi>
4. Council of Australian Governments. COAG: Meeting Outcomes Human Capital Reform, [communiqué on the Internet]. Canberra (AUST): COAG Unit, Department of the Prime Minister and Cabinet; 13 April 2007 [cited 2010 Aug 2]. Available from: http://www.coag.gov.au/coag_meeting_outcomes/2007-04-13/index.cfm#nra

5. Population Health Division. National Partnership Agreement on Preventive [report on the Internet]. Canberra (AUST): Commonwealth Department of Health and Ageing; 2008 [cited 2010 Aug 2]. Available from: <http://www.health.gov.au/internet/main/publishing.nsf/Content/phd-prevention-np>
6. Hawks D. Not a single vote: The politics of public health: An interview with Michael Wooldridge. *Health Promot J Austr.* 2002;13 (2):19-22.
7. Department of Premier and Cabinet. *The History of the National Reform Agenda* [report on the Internet]. Melbourne (AUST): State Government of Victoria; 2007 [cited 2010 Jun 7]. Available from: <http://www.dpc.vic.gov.au/>
8. Productivity Commission. *Potential Benefits of the National Reform Agenda* [commission research paper]. Canberra (AUST): Commonwealth of Australia; 2007.
9. Australian Institute of Health and Welfare. *National Health Priority Areas* [subject areas on the Internet]. Canberra (AUST): AIHW; [cited 2010 Aug 2]. Available from: <http://www.aihw.gov.au/nhpa/index.cfm>
10. National Preventative Taskforce. *Australia: The Healthiest Country by 2020 – National Preventative Health Strategy*. Canberra (AUST): Commonwealth of Australia; 2009.
11. Wise M. The social determinants of health: How can a radical agenda be mainstreamed? *Can J Public Health.* 2009;100(4):291-3.
12. Kickbusch I, Buckett K, editors. *Implementing Health in All Policies*. Adelaide (AUST): State Government of South Australia; 2010.
13. Mulgan G. Joined-up government now and in the future. *Public Health Bulletin South Australia.* 2008;5(1):8-12.

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Recruiting hard-to-reach populations: lessons from a study of women living in socioeconomically disadvantaged areas of Victoria, Australia

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Women living in socioeconomically disadvantaged areas are at heightened risk for physical inactivity, an important modifiable risk factor for a number of preventable diseases.¹ To best promote physical activity, we need to understand influences on physical activity and the feasibility of physical activity promotion strategies among this target group. However, those of lower socioeconomic position (SEP) are under-represented in research studies.^{2,3} Limited literature detailing effective strategies for recruiting low SEP populations exists. This letter outlines the strategies we employed in an attempt to recruit 25 women aged 18-45 years living in socioeconomically disadvantaged urban and rural areas of Victoria, Australia, into a qualitative study involving participation in a 30-60 minute interview. We hope that this letter stimulates discussion and debate about methods for recruiting populations of low SEP. Three urban and three rural socioeconomically disadvantaged neighbourhoods were purposefully selected. During December 2009 – January 2010, recruitment brochures were delivered to households in three areas (5,288 households). Brochures described the study and encouraged eligible women to register interest via telephone, e-mail or the study website. To supplement recruitment, advertisements were placed in the 'Volunteers' section of local newspapers, a media release resulted in three local newspaper articles, and flyers/posters were distributed to local neighbourhood houses, libraries and community centres. These approaches resulted in eight women registering interest in the study, four of whom met inclusion criteria and three of whom subsequently participated.

In an attempt to address the low response rates resulting from the initial recruitment attempts, our second strategy involved amending the brochures to include a statement indicating that all participants would receive a compensatory \$20 gift voucher. After delivery to the remaining neighbourhoods (6,500 households) in February 2010, nine women registered interest, seven of whom met the inclusion criteria and six subsequently participated. A summary of the final response is detailed in the table. A further two women were recruited via snowballing techniques.