PUBLIC ATTITUDES TO HEALTH PROMOTION AND DISEASE PREVENTION

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PREPARED FOR:

VICTORIAN HEALTH PROMOTION FOUNDATION
15-31 PELHAM STREET
CARLTON SOUTH
VICTORIA, 3053

PREPARED BY:

MR DARREN PENNAY
MS JENNA BATEMAN
THE SOCIAL RESEARCH CENTRE
LEVEL 1, 262 VICTORIA STREET
NORTH MELBOURNE VIC 3051

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Disclaimer

This report presents the views of the authors only and does not necessarily reflect the position VicHealth or the Victorian Government.

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Table of contents

List of figures

List of tables

Executive summary

This report presents findings from research commissioned by VicHealth aimed at better understanding community knowledge of, attitudes towards, and support for, health promotion and disease prevention.

To the best of our knowledge this is the first time research of this nature has been undertaken in Australia.

This study comprised two discrete phases – a qualitative research phase and a general community survey. While the main focus of this report is on presenting the findings from the community survey, relevant findings from the qualitative research are also included. The survey comprised telephone interviews with 1,000 Victorians aged 18 years and over in November / December 2006.

Understanding of health promotion and disease prevention

Eighty five per cent of those interviewed think 'health' should be the top government spending priority. Responsibility for population health is seen as a shared government, community and individual responsibility. While 91% agree that 'individuals have to take full responsibility for their own health', there is also strong agreement that 'schools need to do more to educate children about health issues and healthy lifestyle choices' (84%) and that 'governments have the main role to play in promoting good health' (78%).

When asked about health promotion campaigns and activities, the concept people have in mind is generally limited to health promotion *advertising*. By and large, health promotion is seen as social marketing and awareness raising with advertising the most visible component. While the educative and agenda setting aspects of health promotion are appreciated, there is limited awareness of other health promotion activities such as advocacy for social change and infrastructure and community building. The most commonly mentioned health promotion campaigns and activities included those relating to physical exercise / Go For Your Life (19%), Smoking / QUIT (18%), cancer screening (15%), obesity (9%) and diet / nutrition (9%).

Disease prevention, while seen as part of the broader health promotion continuum, is viewed somewhat differently. A distinction is made between health promotion (which is seen as health promotion *advertising*) and disease prevention which is seen as having a clinical intervention and a more tangible outcome. The community tend to view disease prevention more so as health protection, with particular emphasis on screening and immunisation programs.

Top of mind recall of disease prevention activities was dominated by cancer related activities (39% overall) and in particular breast cancer / mammograms (18%), cancer screening generally (15%), cervical cancer / Pap smears (9%), prostate cancer (8%) and skin cancer (6%). Immunisation also figures prominently in public perceptions of disease prevention (15%).

Support for health promotion and disease prevention

Over nine in ten survey participants (91%) support the spending of public money on health promotion and 85% regard health promotion as effective. Considerably fewer (44%) are of the view that the government is doing enough in the area of health promotion.

The level of support for disease prevention component of health promotion is even higher with 98% approval for the spending of public money on disease prevention and 97% of the view that disease prevention is effective. Again, less than half of the community (45%) felt that the government was doing enough in the area of disease prevention.

Population health issues

The survey also measured community perceptions in relation to the perceived seriousness of specific health determinants / risk factors. Based on mean scores on a 10 point scale, the most serious health determinants were seen as:

- Whether a person smokes (8.4)
- The type of food a person eats (7.9), and
- The amount of physical activity a person does (7.8).

Comparatively lower ratings were given in relation to 'a person's financial circumstances' (6.7) and their genetic make-up (6.6).

The same approach was also used to measure perceptions regarding the seriousness of selected population health issues. On this basis cancer is seen as the most serious population health issue (8.4), followed by heart disease (7.9) and childhood obesity, diabetes and mental health (all 7.6).

Support for specific health promotion / disease prevention proposals

A specific focus of this research was to measure support for a range of health promotion initiatives targeting childhood obesity. Of the options put to respondents those that attracted the highest levels of support were 'increasing the amount of physical activity in the school curriculum' (92%), 'building more cycling and walking paths' (90%), 'removing soft drinks from school canteens' (81%) and 'banning television advertising of high fat and high sugar content foods during children's viewing hours' (79%). Less support was evident for 'making the food industry reduce the portion sizes of fast foods' (64%) and 'banning the television advertising of high fat and high sugar content foods altogether' (61%)[1].

In terms of support for other health promotion initiatives:

- 85% support the taxing of environmental pollution to limit harmful emissions[2]
- 48% support placing additional taxes on high fat and high sugar content foods to limit their consumptions
- 43% support banning all television advertising of alcohol, and
- 43% support placing additional taxes on alcoholic drinks to reduce their consumption.

Sources of health information

To assist with the targeting of health promotion activities, the survey included questions in relation to the main sources of health information used by people. These results show that the most widely used source of health information is newspapers and magazines (49%), followed by television (40%) with General Practitioner / Doctor ranked third (30%). For lower income and older persons, however, the General Practitioner / Doctor was their primary source of health information.

The internet serves as a source of health information for almost a quarter (23%) of adult Victorians. Not unexpectedly, use of the internet as a source of health information decreases with age and increases in line with household income.

[1] Interviewing commenced approximately 2 weeks after the launch of he second phase of the Victorian Government's *Go For Your Life* campaign.
[2] The phrasing of this question most likely led respondents to consider industrial pollution more so than domestic or personal emissions.

Challenges for health promotion and population health professionals

Despite the very widespread support for health promotion and disease prevention this research does reveal some risks to the high standing and esteem afforded to health promotion and disease prevention. In part this is attributable to the rather narrow view of health promotion as advertising – as a result of which there are some associated negative connotations.

It is also apparent that health promotion activity is taking place in a very cluttered and competitive market space and there is some risk of reduced cut through, message erosion and target audience fatigue.

For this reason it is suggested community attitudes to health promotion and disease prevention continue to be monitored. It is hoped that this research proves to be a useful first step along this path.

A more detailed discussion of these findings now follows.

1 Introduction

Background

VicHealth commissioned this research to explore what the Victorian community understands about health promotion and disease prevention.

There can be significant savings to government expenditure through investment in prevention activities. For example, in 1998, an estimated 17,400 premature deaths were avoided due to the tobacco control efforts of the previous thirty years. As a result, there was an estimated saving of AUS$12.3 billion through lower health care costs, improved productivity and longevity[3].

Whilst it makes good economic sense to invest in prevention, the health promotion and prevention agenda struggles for new resources. The benefits of health promotion work are often not seen for many years, making the political gains from increasing health promotion investment less tangible for the government of the day. Politicians and senior bureaucrats are heavily pressured by community groups about the need for shorter hospital waiting lists and better access to health services and treatment. These factors may reduce resolve for a well financed health promotion agenda, especially when the demand for clinical services is ever-increasing and the pressure of emergent communicable diseases, such as avian flu and SARS, capture the community's attention.

Promoting health and preventing illness relies on the efforts of government agencies, partner organisations, communities and individuals. While people benefit from health promotion and disease prevention policies, there is limited understanding of what resources are required to implement this type of work. In the UK, a recent survey (2004) undertaken by the Kings Fund demonstrated strong support for health promotion and disease prevention activity[4]. Yet, in the US a survey conducted in 1999 showed that most people don't understand the role of health promotion[5]. To our knowledge, no such work has been undertaken in Australia.

Research aims and objectives

Given the above, the aim of this research is to arrive at a better understanding of the Victorian community's understanding of health promotion and disease prevention.

In doing so this report examines a number of issues. These include:

- Government's spending priorities
- Community understanding of health promotion and disease prevention
- Whose responsibility is population health
- The main population health issues concerning the public today, and
- Support for selected health promotion and disease prevention initiatives.

3 Applied Economics, 2003.
4 Kings Fund, 2004
5 Morbidity and Mortality Weekly Report 2000, 1999

A two-stage research design was used for this study. An initial qualitative research phase (comprising desk research, key opinion leader interviews and general community discussion groups) followed by a general community telephone survey. While the focus of this report is on presenting the findings from the community survey, it also draws on the findings from the earlier qualitative research.

Qualitative research phase

The qualitative research was undertaken with a view to better understanding community perceptions of, and attitudes towards, health promotion and to inform the design of the quantitative survey instrument.

The qualitative research comprised a literature review, fourteen key opinion leader interviews and eight group discussions with participants from a range of metropolitan and non-metropolitan areas across Victoria. Participants were selected so as to include individuals of in varying degrees of health and across various age groups and socio-economic backgrounds.

This phase of the research was undertaken by the Wallis Consulting Group in March 2006[6].

Survey phase

The development of the survey questionnaire drew on recommendations from the qualitative research and was a collaborate exercise between VicHealth and Social Research Centre.

A test/re-test pilot test methodology was used to finalise the design of the questionnaire. An initial pilot test of 22 interviews held on 18 October 2006 and, after subsequent review, a further 8 confirmatory interviews were conducted on 31 October. The final survey instrument, with an average interview length of 19 minutes, is provided as Appendix 3.

The in-scope population for the survey was persons aged 18 years and over in private dwellings across Victoria. The main survey, comprising 1,000 telephone interviews, was undertaken over the period 15 November to 19 December 2006. A disproportionate stratified random sample design was used such that 600 interviews were undertaken in metropolitan Melbourne and 400 across the rest of Victoria. Further details about the conduct of the survey are provided in Appendix 2 – About the Survey.

About this report

The results presented in this report are based on “weighted” survey data. That is, the survey results have been adjusted so as to reflect the age, sex and regional (Melbourne / Rest of Victoria) distribution of the Victorian population aged 18 years and over. The impact of this weighting is to correct for the disproportionate stratified sample design and to adjust for any variations in response patterns across the target population.

[6] Wallis Consulting Group, 2006.

This report has been structured in such a way as to address VicHealth's main research objectives. Section 2 provides an overall context for the analysis which follows by looking at public perceptions of government spending priorities, defining health promotion and disease prevention and briefly examining public perceptions of health promotion and disease prevention. Section 3 looks at the relative importance of specific determinants of population health and gauges public perceptions with regard to the perceived seriousness of selected health issues. Section 4 looks at the level of public support for selected health promotion and disease prevention initiatives and Section 5 examines main sources of health information.

Some overarching comments regarding the implications of these findings for health promotion and disease prevention in Victoria are provided in Section 6.

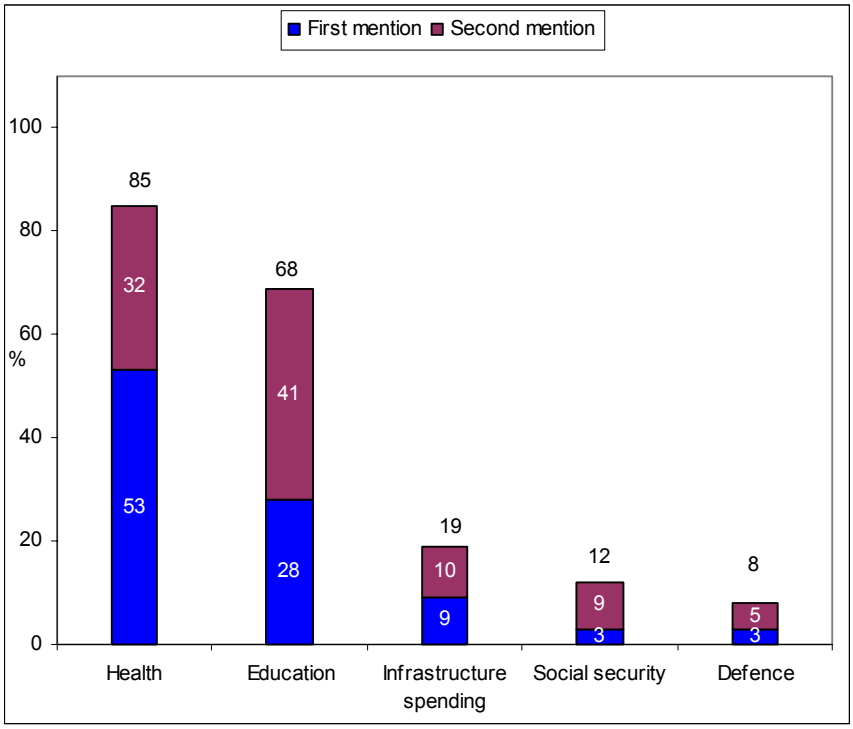
While the focus of this report is on presenting the findings of the community survey, findings from the qualitative research are also used.

2 Perceptions of health promotion and disease prevention

Spending priorities

An examination of public perceptions of government spending priorities helps provide an overall context from which to view these survey results. Respondents were read a list of five broad areas of government spending and asked which area they thought should be the top priority, and the next priority, for government spending. A spending priority other than one of the five provided could also be nominated. The five areas of spending were education, health, defence, social security and infrastructure spending (including roads, rails, ports, etc.). 'Health' was the most commonly mentioned spending priority with 53% of respondents mentioning health as their top priority for government spending and 32% as their second priority. This was followed by education (total mentions of 68%), infrastructure spending (19%), social security (12%) and defence (8%). Outside of the 5 options put to respondents the environment / water security attracted the most support (total mentions of 4%).

Figure 2.1: Government spending priorities.



Base: Total sample (n=1,000).

The spending priorities indicated above are broadly consistent with the findings reported in the qualitative research[7].

> *"Health* is an important topic to Australians. It is frequently raised as a key issue in the public opinion polls. For example, the latest NEWSPOLL published in The Australian[8] suggested that *health* remains the number one issue with 85% of Australians rating it as 'very' important. AC Nielsen's Consumer Confidence Poll in 2002[9], found the biggest concerns to be job security, followed by a worsening economy, then health.
>
> A recent Morgan Poll[10] asked voters to nominate the three most important things the government should be doing something about. The most mentioned item was health (62%) nationally, although this was slightly lower in Victoria (57%) and slightly behind education (59%)."

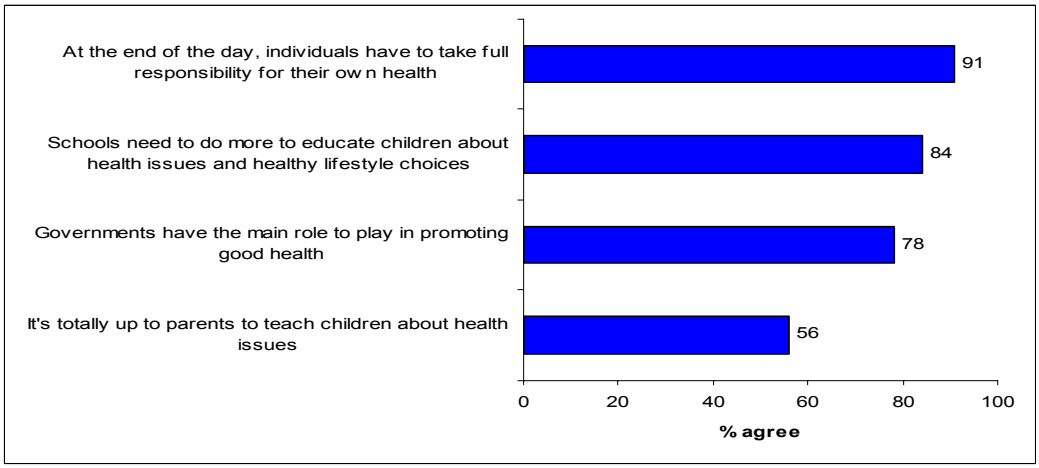
Whose responsibility is population health?

The data presented in Figure 2.1 suggest that while the community regards individuals as being *ultimately* responsible for their own health (a view held by 91% of those interviewed), individuals are not seen as being *solely* responsible for their health. The government and schools are widely acknowledged as having important (supportive) roles to play. To wit:

- There is 84% agreement that schools need to do more to educate children about health issues and healthy lifestyle choices, and
- 78% agreement that government's have the main role to play in promoting good health.

By contrast, the level of agreement with the assertion that 'it is totally up to parents to teach children about health issues' is considerably lower (56%).

Figure 2.2: Whose responsibility is population health?



Base: Total sample (n=1,000).

7 Wallis Consulting Group, August 2006.
[8] NEWSPOLL and The Australian, 2006
[9] AC Nielsen, 2002
[10] Roy Morgan Research, 2002.

The overall thrust of these findings suggests that population health is seen as a *partnership* between individuals, communities and government.

This view of that population health (and therefore health promotion) as a shared responsibility accords with key aspects of the Ottawa Charter for Health Promotion (1986). The relevant points of which in this context include:

- Promoting *shared community responsibility* for improving health
- Developing and supporting partnerships for health
- Increasing the community's skills and resources to promote healthy behaviours and empowering individuals to make informed decisions, and
- Developing personal knowledge and skills.

Public perceptions of 'health promotion'

As noted in the qualitative research report, *"the public define health promotion as any health message including:*

- *Health promotion campaigns from government and NGOs – QUIT, "get off the couch", "Heart Health" etc.*
- *Messages from commercial organisations including, Low Sugar, Low GI, "healthy" food alternatives – McDonald's, Coca-cola, Nestle, Kraft etc, and*
- *Messages from organisations about wellbeing and activity including Health and Fitness Centres, dietary supplements etc."*

The qualitative research findings show that, on the whole, 'health promotion' is equated with 'health advertising'. This perspective is no doubt reinforced by the sheer pervasiveness of advertising based around 'good health' messages. It is apparent from both the qualitative research and the survey results that other key aspects of health promotion such as capacity building, community development and infrastructure development do not form part of the general communities' understanding of health promotion.

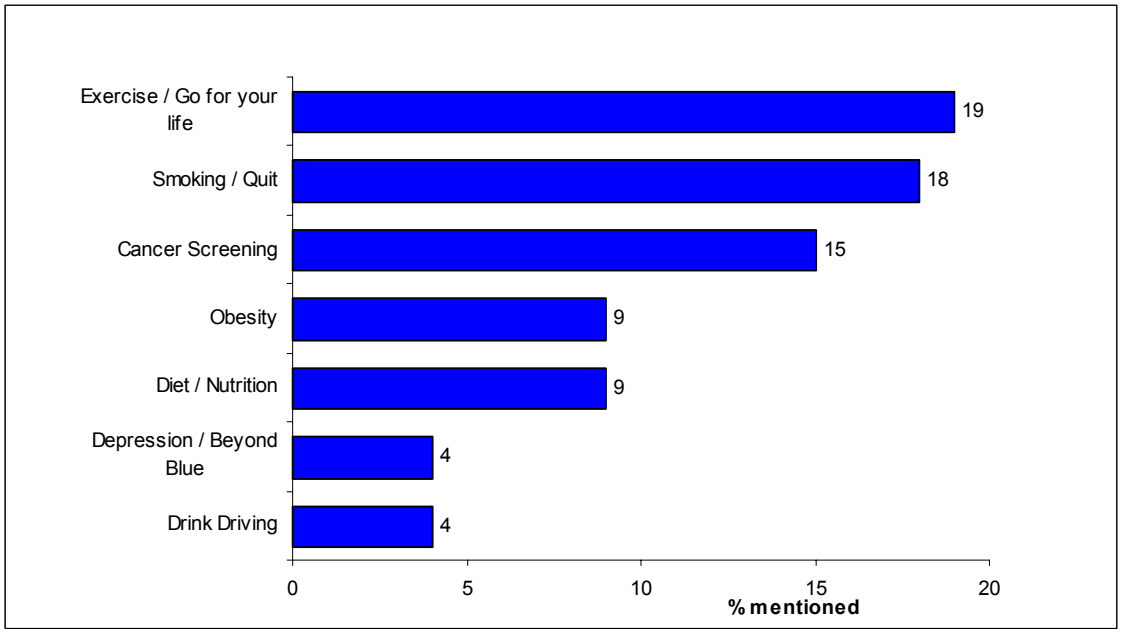
What do people think of when asked about health promotion campaigns and activities?

Given the above, in order to quantify community perceptions of health promotion survey respondents were asked, *"When thinking about health promotion campaigns and activities, what are the main things that come to mind for you?"*

The top-of-mind health promotion campaigns and activities mentioned by the public at this time (November / December 2006) are shown below (Figure 2.3). Campaigns relating to physical activity, smoking, cancer screening, obesity, diet and nutrition, mental health and drink driving were prominent in the public consciousness.

Generally speaking there seems to be a reasonable concordance between the top-of-mind recall of health promotion campaigns, and VicHealth's programs[11].and the National Health Priorities.[12]

Figure 2.3: Top of mind health promotion campaigns and activities.



Base: Total sample (n=1,000).

There were many more campaigns and activities mentioned than those presented in Figure 2.3 (the final number totalling over 30 different health promotion campaigns and / or health issues). The volume of health issues and health promotion campaigns recalled by survey participants suggests considerable clutter in this market space. As a consequence there is a risk that 'genuine' health promotion campaigns may struggle to achieve cut though and that audience fatigue could lead to a diminution of health promotion messages.

[11] Smoking and Tobacco Control, Physical Activity, Healthy Eating and Sun Protection
[12] Arthritis and Muscoskeletal conditions, Asthma, Cardiovascular health, Diabetes, Injury Prevention and Mental Health – particularly depression.

As one participant in the qualitative research noted …

> *"Initially you take notice of them, but after numerous advertisements it just becomes background. We don't do anything about it, but we are aware of it. We do take notice of it when we first see them, but after a while it goes in and out…"*

This observation was further reinforced by a key opinion leader interviewed for the qualitative research …

> *"We're in danger of saturation. Tobacco had a clear field. Now there's heaps of NGOs pushing their own messages and everyone's saying different things".*

Selected attitudes to health promotion

Having identified the top-of-mind campaigns and activities the public associate with health promotion, respondents were read a definition of health promotion and asked whether or not they approved of spending pubic money on health promotion, whether health promotion is an effective way of improving population health and whether the government is doing enough in the area of health promotion.

The definition of health promotion used for these purposes was …

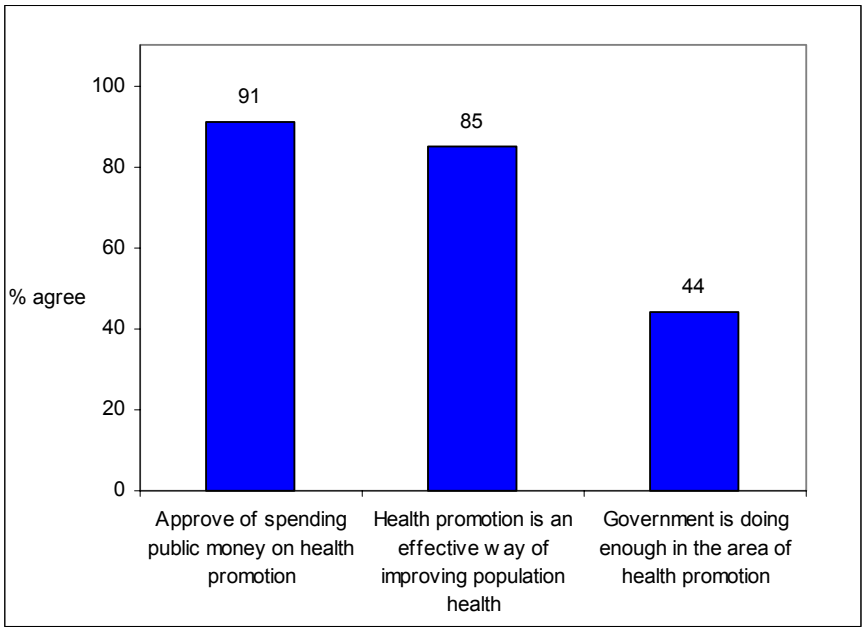
> *"Health promotion often involves media campaigns promoting healthy lifestyle choices. It also includes things like improving the number of walking or cycling paths, increasing access to healthy foods, or introducing tobacco regulations".*

Reference to Figure 2.4 shows over nine in ten survey participants (91%) approved of the spending of public money on health promotion and 85% were of the view that health promotion is an effective way of improving population health. By way of contrast, 44% were of the view that the government is doing enough to promote population health. These findings suggest that despite an environment in which health promotion messages are competing for attention, the public have an underlying appreciation of the value of health promotion.

A breakdown of these findings across various population sub groups is provided in Appendix 1, Table 1. High levels of support for health promotion are apparent across all major demographic and socio-economic groups.

- Support for spending public monies on health promotion support does not fall below 84% (those on a household income of less than $20,000 per year) and goes as high as 95% for 18 to 24 year olds and 45 to 54 year olds.
- There are no significant variations in the extent to which health promotion is seen as effective (ranging from 81% for overseas born persons to 91% for 18 to 24 year olds and persons with household incomes of between $40,000 and $80,000 per annum).
- The level of agreement with the view that the government is doing enough in the area of health promotion ranges from 37% among those with a gross annual household income of between $60,000 and $80,000 per year to 49% for those with an annual household income of between $40,000 and $60,000 per annum.

Figure 2.4: Selected attitudes to health promotion.

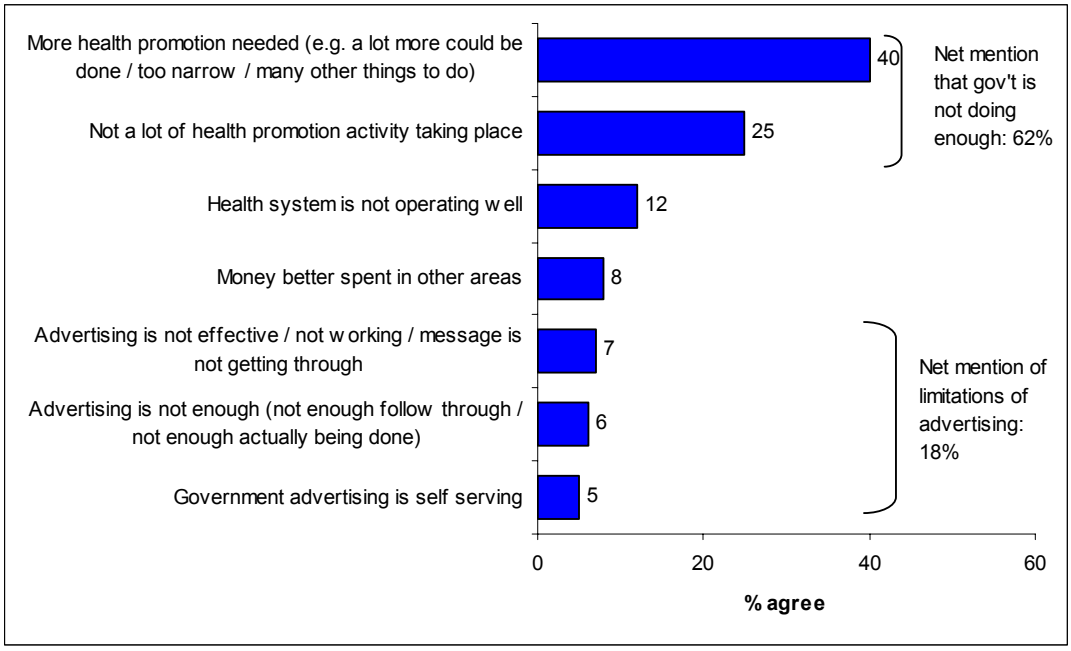


Base: Total sample (n=1,000).

The reasons given for thinking that the government is not doing enough in the area of health promotion are provided in Figure 2.5. These include:

- The simple observation that more needs to be done (as mentioned by a total of 62% of this group). This includes 40% who are of the view that the current focus is too narrow and that there are other things that need to be done and 25% who feel as though there isn't a lot of health promotion activity at the moment.
- 12% do not see a tangible result from health promotion efforts in terms of the operation of the health care system (i.e. the health system is not operating well)[13]
- 8% feel the money would be better spent in other areas, and
- A total of 18% feel that there are limitations in using advertising for health promotion (including 7% who think that advertising is not effective, 6% who feel that advertising is not enough and 5% who feel that government advertising is self-serving).

Figure 2.5: Reasons for thinking the government is not doing enough in terms of health promotion.



Base: Disagree government is doing enough health promotion (n=473).

[13] Those of this view are perhaps not distinguishing between health promotion spending and spending on the primary health care system.

The strong levels of public support for health promotion apparent from the survey findings are further reinforced by the qualitative research which showed emphatic support for continuing strong efforts in the area of health promotion. This support was based on:

- A belief that "people need to be reminded (of health promotion messages) all the time"
- A strong adherence to the creed that *prevention is better than cure*, and
- An appreciation of the demands that will be placed on the health system as a result of ill-health and an ageing population.

It also seems that the 'success' of campaigns such as QUIT enable the public to see the benefit of effective health promotion.

At the end of the day, the health promotion message is seen as compelling in that *…"Everyone wants to feel better – to eat healthier, lose weight and live longer."*[14]

In short, health promotion is seen as important because health is important.

Public perceptions of 'disease prevention'

Whereas for the bulk of the general public it seems that 'health promotion' is largely viewed as health promotion 'advertising', disease prevention is more specifically understood in terms of screening and immunisation programs and, to a lesser extent as research into the causes and prevention of disease.

By and large, the distinction between health promotion and disease prevention stems from the fact that disease prevention is seen as having a more tangible result, and generally requires a clinical intervention (e.g. a vaccination, a mammogram, etc.), whereas health promotion does not.

Figure 2.6 shows the health factors mentioned in response to the question *"… when thinking about programs to detect or prevent diseases, what sort of things come to mind?"* Almost four in ten respondents (39%) made mention of cancer-related issues / topics when asked to think about disease prevention activities. Almost one in five (18%) mentioned breast cancer and/or mammograms, almost one in six (16%) specifically mentioned cancer screening activities, 9% mentioned cervical cancer / pap smears, 8% prostate cancer and 6% skin cancer / Sun Smart.

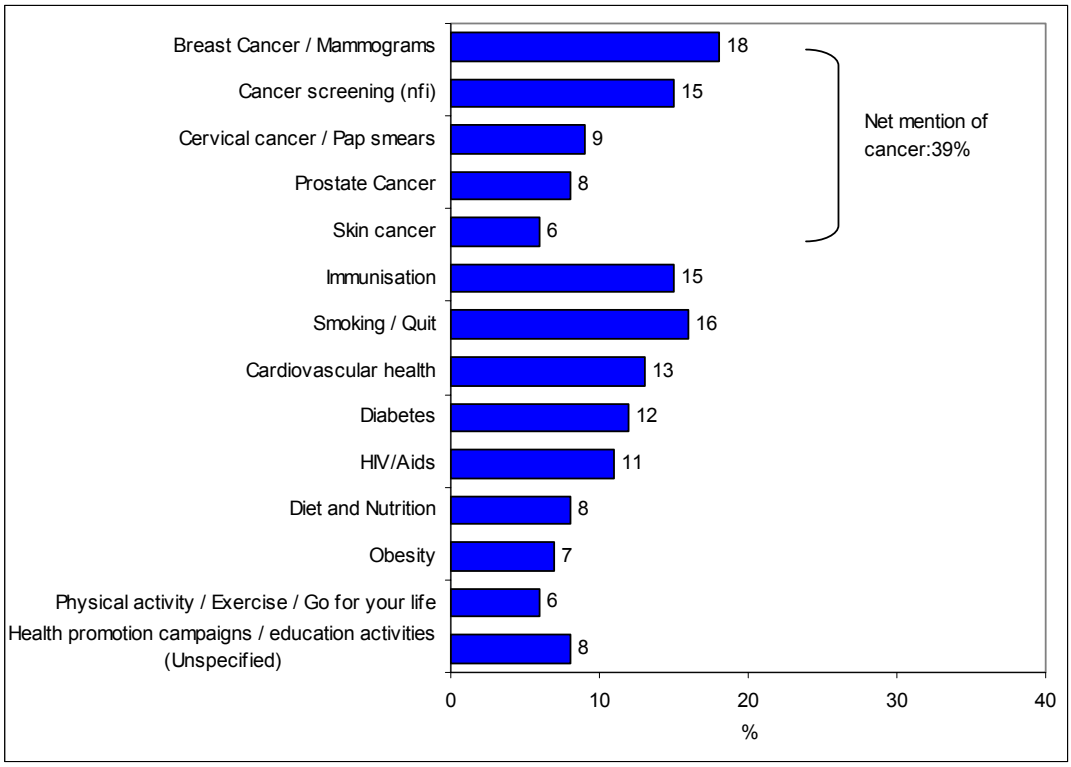
Immunisation also figures prominently in public perceptions of disease prevention activities (as spontaneously mentioned by 15% of respondents).

The main population health issues mentioned under the banner of 'disease prevention' included Smoking / Quit (16%), Cardiovascular health (13%), Diabetes (12%), HIV / Aids (11%), Diet and Nutrition (8%), Obesity (7%) and Physical Activity (6%).

[14] Quote from a Key Opinion Leader interviewed as part of the qualitative research.

Almost one in ten respondents (8%) made mention of general health promotion / education activities when asked about disease prevention.

Figure 2.6: Spontaneously mentioned disease prevention activities.



Base: Total sample (n=1,000).

A review of the verbatim responses to this question shows some appreciation of the educative, awareness raising and agenda setting component of disease prevention (particularly in school settings) but little appreciation of the social determinants of health and disease prevention such as educational attainment, income and environmental factors.

This is borne out in quotes like the following …

"More programs at school- a lot of young kids don't understand disease and they don't care. That should be enforced in schools and at the home."

"They should be promoting in schools a more healthy lifestyle. Starting in primary schools."

"Education. You have to educate the public and it starts from home.

Both the qualitative research findings and the survey results suggest that disease prevention is seen as part of the health promotion continuum, that is, the practical follow up to what is perceived as health promotion 'advertising' campaigns. However, disease prevention is seen more in a medical paradigm, and disease focused. While cancer screening and immunisation are the most visible components, disease prevention is also seen to include things like '*regulating the school lunch menu'* and *'putting limits on what companies can advertise to young kids*[15]*.'*

"Health promotion should not just be advertising – it should be practical."[16]

Support for disease prevention activities

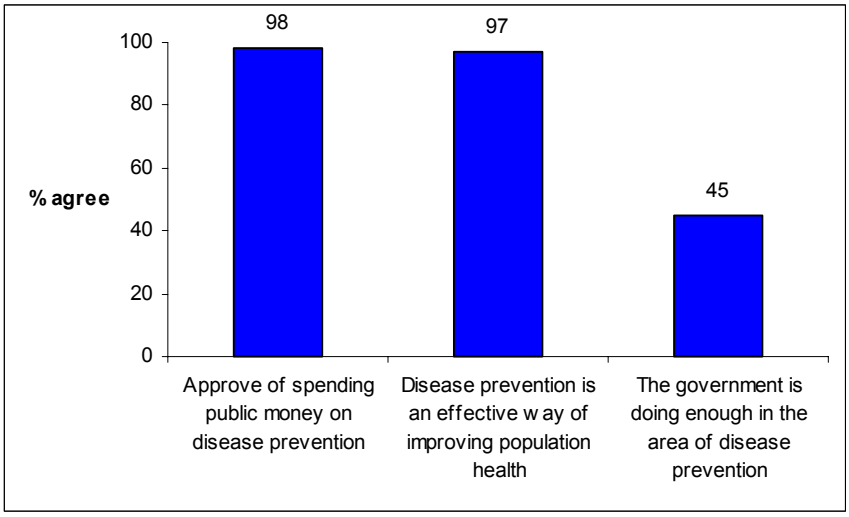
Having identified the public's top-of-mind understanding of what disease prevention entails, a definition was then provided to respondents in order to assess their level of support for disease prevention (as indicated by their perceptions with regard to spending public money on disease prevention, the effectiveness of disease prevention and whether the government is doing enough in the area of disease prevention).

The definition used for this purposes was …

"By disease prevention I mean things like the early detection of disease, immunisation and screening programs".

As was the case with 'health promotion', disease prevention activities enjoy a very high level of general community support. In fact, the level of support for the spending of public money on disease prevention (98%) and the perceived effectiveness of disease prevention activities (97%) are significantly higher than the level of support for health promotion on its own.

Figure 2.7: Support for disease prevention activities



Base: Total sample (n=1,000).

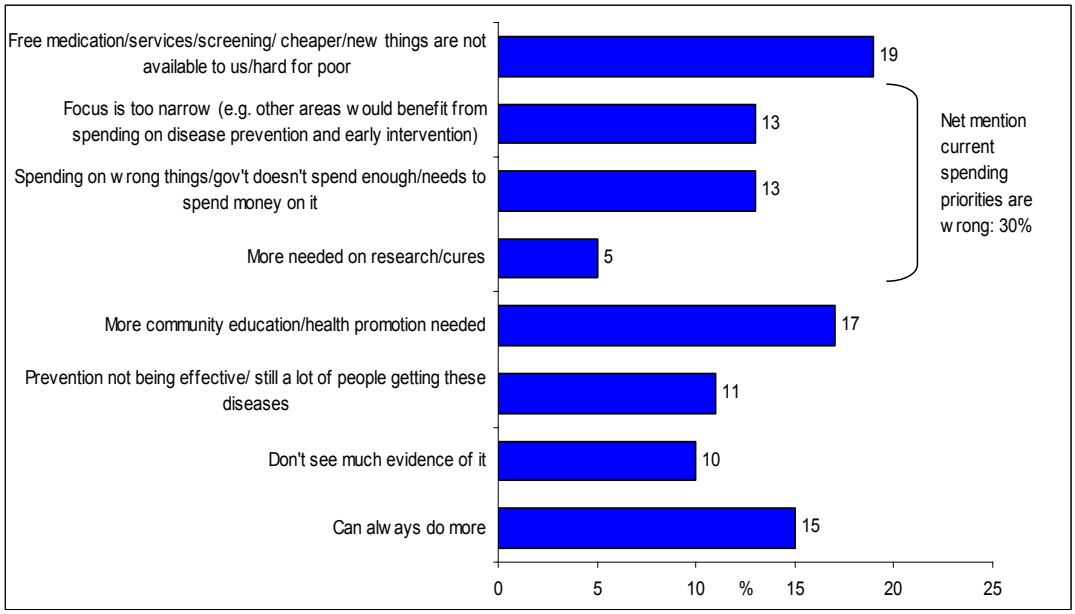
[15] The Wallis Group, August, 2006.
[16] Ibid.

The proportion of community of the view that the government is not doing enough in the area of disease prevention (45%) is almost identical to that relating to health promotion (44%). As was the case with health promotion, there is very little variation in the level of support for disease prevention activities (see Appendix 1, Table 2).

The underlying factors as to why people think the government is not doing enough in the area of disease prevention include (see Figure 2.8):

- The perception that more needs to be done to reduce the costs associated with accessing preventative services and treatments (19%)
- The view that there is a need for more community education / health promotion (17%)
- A perception that the current spending priorities are wrong (30%)
- A lack of awareness of current efforts (i.e. don't see much evidence of it) (10%), and
- The view that the current interventions are not effective enough having the desired impact, that is, are not preventing disease (11%).

Figure 2.8: Reasons for thinking the government is not doing enough in terms of disease prevention.



Base: Disagree government is doing enough in terms of disease prevention (n=411).

The distinction between what is largely perceived as advertising based health promotion and the somewhat more practically focussed disease prevention is further borne out by the findings which show:

- 95% of those who feel it isn't appropriate to spend public money on heath promotion nonetheless support the spending of public money on disease prevention, and
- 87% of those who don't think health promotion is effective nonetheless think disease prevention is effective.

These findings show that the vast majority of those members of the community that don't support health promotion (as conceptualised by campaigns and social marketing), still support the broader health promotion / disease prevention agenda.

3 Population health issues

The Public Attitudes to Health Promotion and Disease Prevention Survey also looked at a range of population health issues. These included the perceived seriousness of specific health determinants / risk factors on a person's health and the perceived seriousness of selected population health issues.

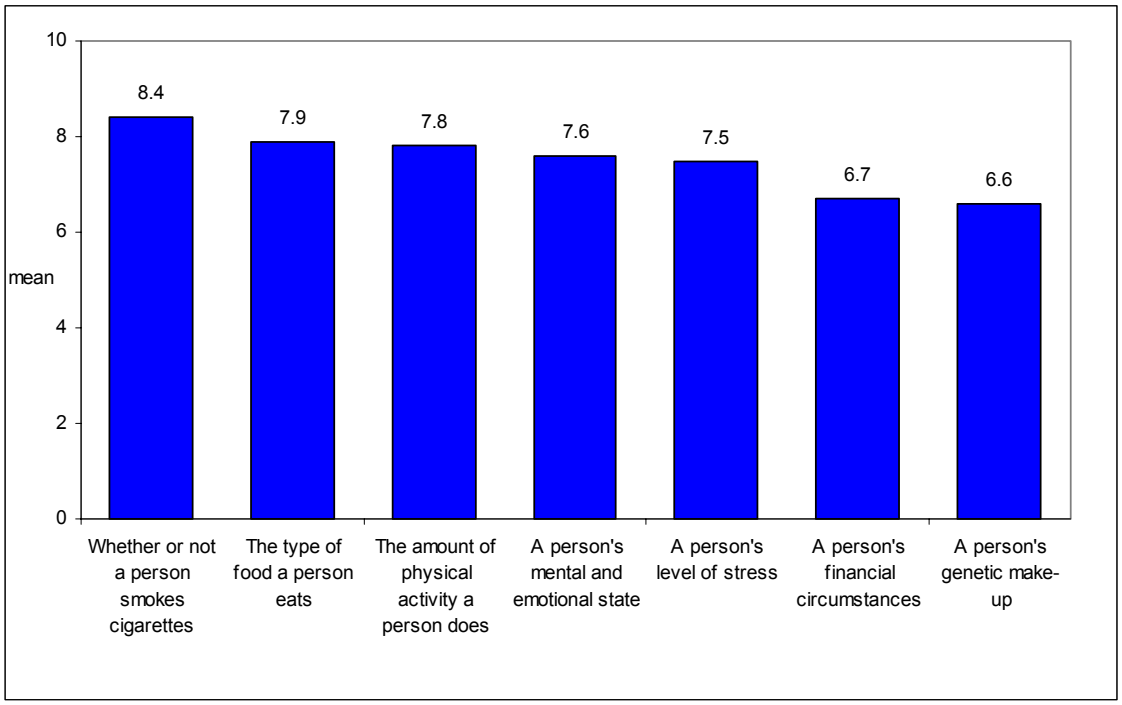
Health determinants

Figure 3.1 shows the mean score out of 10 given in response to the question *"How big an effect on a person's health is … on a scale from 1 to 10 where 1 is no effect at all and 10 is a very large effect?*

On this basis, the public view smoking as the most important determinant of a person's health (mean rating 8.4). Diet and physical activity (7.9 and 7.8, respectively) rate similarly as do mental and emotional state (7.6) and stress level (7.5). Those factors with the lowest perceived impact on a person's health were their financial circumstances (6.7) and their genetic make up (6.6).

The survey data does not show strong links between holding a view that a certain factor is a major determinant of personal health and spontaneous mention of a related health promotion campaign or activity. The notably exception is physical activity. Those persons that rated physical activity highly in terms of its effect on a person's health (i.e. a rating or 9 or 10 on the 10 point scale) were significantly more likely (24%) than those who did not (16%) to make spontaneous mention of a physical activity related campaign when asked about health promotion campaigns or activities.

Figure 3.1: Perceived seriousness of specific health determinants on a person's health.



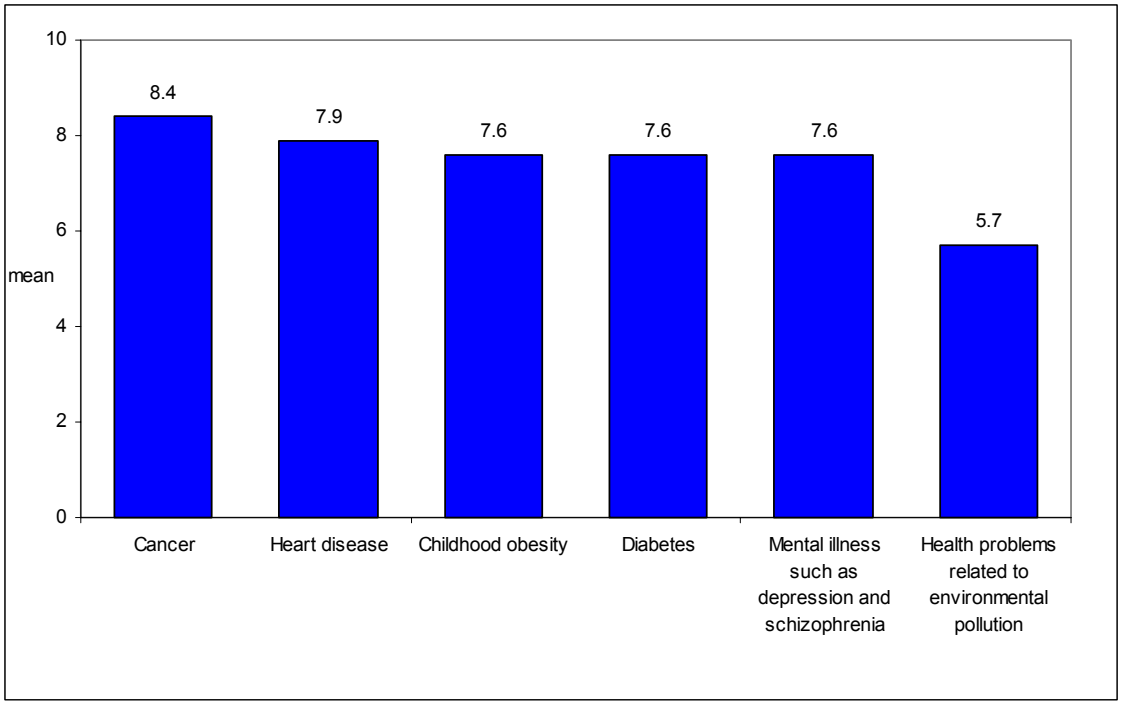
Base: Total sample (n=1,000).

There is a degree of alignment between the public's ratings of the health impacts of these issues and the major risk factors as reported in the Victorian Burden of Disease Study: Mortality and Morbidity, 2001.[17]. The twelve major risk factors and their percentage contribution to the overall burden of disease as measured by Disability Adjusted Life Years (DALYs) are; tobacco consumption (8.1), obesity and overweight (8.0), high blood pressure (7.3), high blood cholesterol (4.1), physical inactivity (4.1), insufficient fruit and vegetables (3.3) intimate partner violence (3.2% of the burden of disease amongst women) alcohol intake (1.5), illicit drug use (1.5), occupational hazards (1.5) and unsafe sex (0.4).

Perceived seriousness of selected health issues

In a similar vein to the above, respondents were also asked to rate the perceived seriousness of selected population health issues on a 10 point scale where 1 is not at all serious and 10 is extremely serious. The mean scores for each health issue are shown in Figure 3.2. When these mean scores are sorted by rank order we see that cancer is seen as the most serious population health issue (8.4), followed heart disease (7.9). Childhood obesity, diabetes and mental illness (including depression) all rate 7.6 and health problems associated with environmental pollution 5.7. Again, these findings generally reflect Victorian burden of disease information which shows that cancer accounts for about 21% of the burden of disease in Victoria (as measures in disability adjusted life years), cardiovascular disease (18%) and mental health disorders (15%).

Figure 3.2: Perceived seriousness of selected health issues



Base: Total sample (n=1,000).

[17] Victoria Department of Human Services, 2001

4 Support for specific health promotion / disease prevention proposals

Support for possible measures to tackle childhood obesity

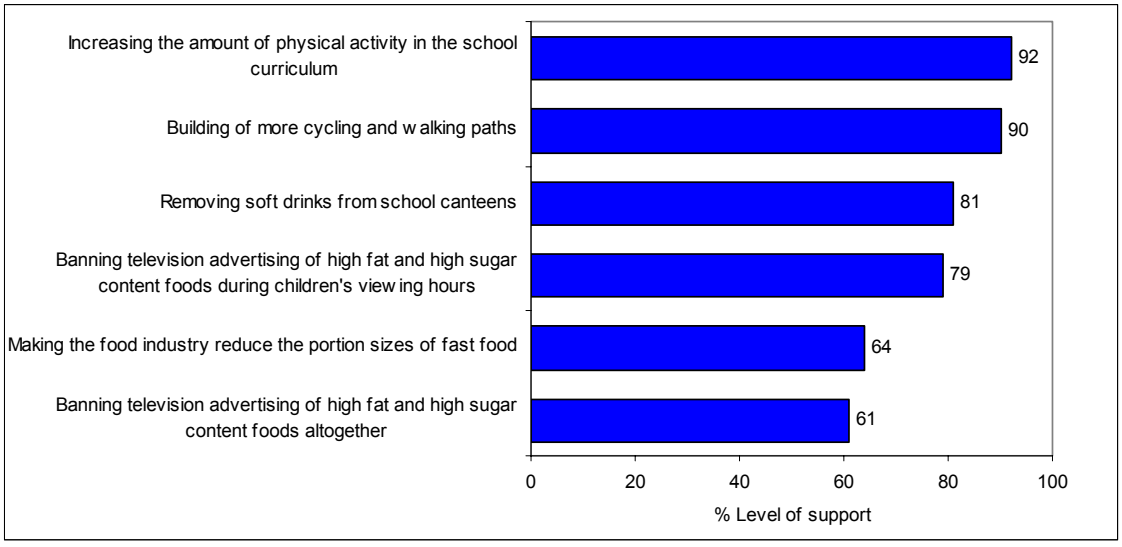
A particular focus of this research was to measure community attitudes towards a range of specific health promotion initiatives targeting childhood obesity.

It is important to note the context within which these questions were asked, in particular that the second phase of the Victorian Government's *'Go For Your Life'* campaign was launched on 3 November 2006, just prior to the commencement of interviewing on this survey. While *Go For Your Life* is a wide ranging campaign targeting diabetes and obesity, school-based nutrition and physical activity initiatives are a central component of the overall campaign strategy (and attracted a deal of media attention during the data collection period).

Within this context, Figure 4.1 shows the level of support for a range of suggestions for tackling childhood obesity. Those options that attracted the highest level of support both had a physical activity component – 92% support for increasing the amount of physical activity in schools and 90% for building more cycling and walking paths.

The other options put to respondents as possibilities for tackling childhood obesity focussed on reducing access to / consumption of 'unhealthy' foods. Of these, the most favoured option was removing soft drinks from school canteens (81%). This was followed by the banning the television advertising of high fat and high sugar content foods during children's viewing hours (79% support) in preference to banning the television advertising of high fat and high sugar content foods altogether (64% support). The least supported option was making the fast food industry reduce the portion sizes of fast foods (61%).

Figure 4.1: Support for possible measures to tackle childhood obesity



Base: Total sample (n=1,000).

Generally speaking (Appendix 1, Table 3) there is little variation across population sub groups in terms of the level of support for these various initiatives. Some noteworthy differences include:

- The relatively high level of support amongst females (88% compared with males 73%) for banning the sale of soft drinks in school canteens
- The relatively low level of support amongst 18 to 24 year olds for a total ban on TV advertising of high fat and high sugar content foods, and
- The high level of support amongst families with children for the building of more cycling paths (93%).

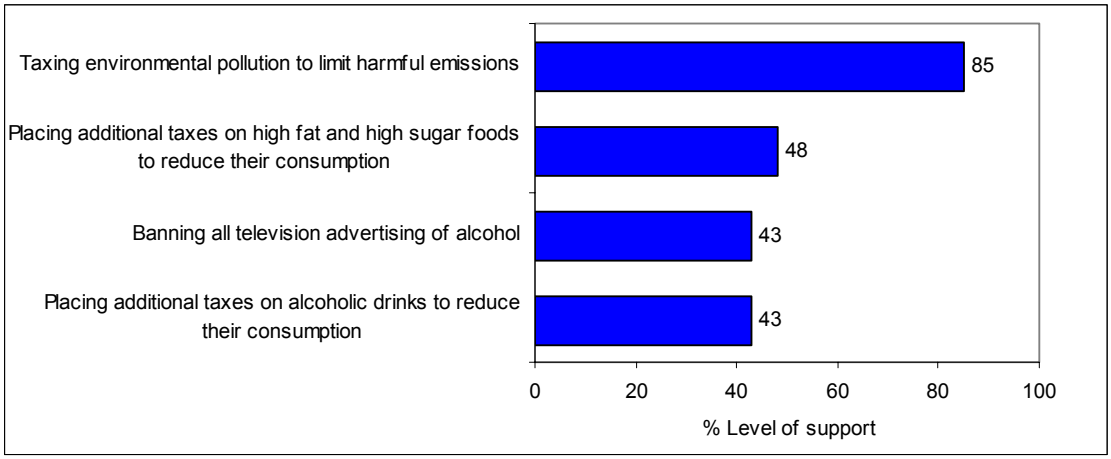
Attitudes to the advertising of food to children showed some variation by types of media mainly consumed. For example, 73% of Herald Sun readers supported banning television advertising of high fat and high sugar content food during children's viewing hours compared with 84% of Age readers and 57% of Herald Sun readers favoured a ban on the advertising of high fat and high sugar content foods altogether compared with 70% of Age readers.

The data presented in Table 3 also show a considerable difference in the levels of support for the various health promotion initiatives by whether or not people feel as though health promotion is effective. Those who think health promotion is effective are significantly more likely to support banning television advertising of high fat and high sugar content foods during children's viewing hours (81%), banning television advertising of high fat and high sugar content foods altogether (63%), making the food industry reduce the portion sizes of fast foods (66%) and building more cycling and walking paths (93%).

Support for other possible health promotion measures

The survey also included questions designed to measure the level of public support for a range of other health promotion initiatives. As reference to Figure 4.3 shows, the concept of taxing environmental pollution to limit harmful emissions attracts public support to a greater extent (85%) than does placing additional taxes on high fat and high sugar content food (48%) and placing additional taxes on alcoholic drinks (43%).

Figure 4.3: Support for other possible population health measures



Base: Total sample (n=1,000).

The inference from these figures is that the public are less supportive of health promotion measures where they are required to bear the *direct* costs (i.e. via increased taxes / increased point of sale costs) and more supportive of measures where the costs is *seemingly* borne by others (i.e. polluters).

The variations in the level of support for these initiatives across various populations groups is shown in Appendix 1,Table 4.

The support for the placing of additional taxes on alcohol to reduce its consumption is the most variable. Support for this proposition is higher amongst overseas born persons, older persons and retirees and those on an annual household income of less than $20,000. In terms of media consumption habits, a ban on the television advertising of alcohol was supported by 40% of Herald Sun readers and 49% of those who did not read the Herald Sun. Again, those that regard health promotion as effective are significantly more likely to support these health promotion initiatives than those who don't.

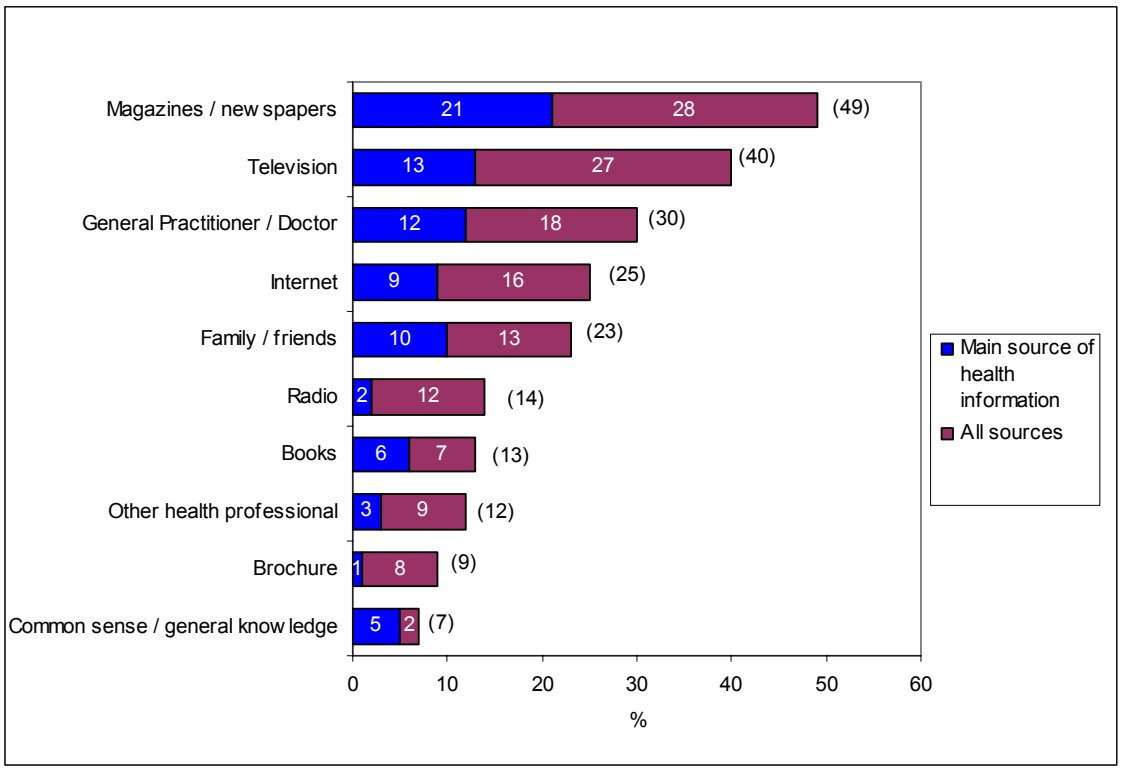
Regardless of whether or not they supported or opposed additional taxes on high fat and high sugar content foods, alcohol or environmental pollutants, respondents were asked whether, if such taxes were introduced would they prefer the money to go into general revenue or be allocated to health promotion and disease prevention. The survey shows overwhelming support (91%) for any such revenues being directed towards health promotion and disease prevention.

5 Sources of health information

Identifying the main sources health information used by the public is an obvious area of interest for social marketers and health promotion professionals. The public's main sources of health information were ascertained by asking *"Where do you get information about staying healthy?* and *"What is your main source of information about staying healthy?".*

On this basis the most widely used source of health information is magazines and newspapers. Almost half of the in-scope population (49%) cite magazines and newspapers as one of their sources of information about staying healthy and 21% as their main source. Other major sources of health information include - television (40%), Doctor / GP (30%), the internet (25%) and family / friends (23%).

Figure 5.1: Sources of health-related information.



Base: Total sample (n=1,000).

The extent to which various population sub groups use these sources of health information is shown in Appendix 1, Table 5.

Amongst other things, this shows tertiary qualified persons and persons under 45 years of age are more likely than their older counterparts to use the internet for health information (peaking at 41% amongst 18 to 24 year olds). Persons with an annual household income of less than $40,000 are less likely to use the internet as a source of health information and more likely to rely on their Doctor / GP than any other group (41%).

These findings regarding the use of the internet as a source of health information correspond with what is known about the take up and use of the internet in general. The Australian Bureau of Statistics has found that internet use decreases with age and increases in line with both personal and household income. Also, households with children under 15 years are more likely to have home internet access (76%) that are households without children under 15 years (53%)[18].

Overall the use of Doctors / GPs as a source of health information ranks third behind newspapers / magazines and television. However, the Doctor / GP assumes greater prominence as a provider of health information for older persons and low income earners. The Doctor / GP is the most often used source of health information for persons with a household income of less than $20,000 (41%) and for those who do not regard health promotion as effective (35%).

A series of questions was included in the survey to help researchers better understand the links between main sources of health information and media consumption.

Of those who use magazines and newspapers as a source of health information (49% of adult Victorians):

- Almost half (48%) read the *Herald Sun* on regular basis (i.e. at least twice a week)
- 39% read *The Age* regularly, and
- 18% regularly read regional dailies.

In terms of regular magazine readership (i.e. at least once a month) 26% of this group read Women's Magazines and 22% read Home, Health and Lifestyle magazines.

The free to air television stations usually watched by those who rely on television as a source of health information (40% of Victorians aged 18 years and over) are as follows:

- The ABC (63%)
- Channel 9 (61%)
- Channel 10 (56%)
- Channel 7 (53%), and
- SBS (45%).

[18] Australian Bureau of Statistics, 2006.

WIN and Prime (both between 9%and 10%) are the most commonly watched regional stations amongst those who use television as a main source of health information.

Finally those who rely on the radio as a source of health information (14%) tend to most regularly listen to

- Music radio (58%)
- Talkback (51%),and
- News Radio (38%).

6 Concluding remarks

As mentioned at the outset, to the best of our knowledge this survey represents the first time in Australia that an attempt has been made to measure community understanding of, and support for, health promotion and disease prevention.

The survey results reinforce the findings from the preceding qualitative research in that 'health promotion' is largely seen as being about social marketing and awareness raising on health issues. Advertising is the most visible component of health promotion.

Disease prevention is seen as part of the broader health promotion continuum but is seen more so as health protection (in particular as screening and immunisation programs).

While the educative and agenda setting components of health promotion are understood, other aspects of the health promotion agenda such as advocacy for social change and infrastructure and community building are not well understood.

The survey shows widespread community support for the health promotion and disease prevention and also widespread agreement that health promotion and disease prevention are an appropriate and effective use of public money.

The results highlight that health promotion takes place in a very cluttered and competitive market space and there is some risk of reduced cut through, message erosion and target audience fatigue. For this reason it is suggested that periodic surveys of community attitudes to health promotion and disease prevention be undertaken.

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Appendix 1: Detailed tables

Table 1: Selected attitudes to health promotion – subgroup analysis.

	Sample base n	Approve of spending public money on health promotion %	Health promotion is effective %	Gov't. is doing enough in the area of health promotion %
Total	**1,000**	**91**	**85**	**44**
Gender				
Male	384	91	83	43
Female	616	91	87	45
Age Group				
18 – 24 years	58	95	91	41
25-34 years	148	92	89	47
35-44 years	217	91	83	42
45-54 years	208	95	86	45
55-64 years	*175*	87	82	41
65 years and over	*194*	87	83	45
Location				
Melbourne	599	91	85	43
Rest of Victoria	401	91	86	46
Birthplace				
Australia	787	91	86	43
Overseas	213	91	81	45
Educational Attainment				
Year 10 or less	216	86	82	40
Years 11or 12	283	92	89	47
Trade Certificate / Diploma	199	90	85	45
Tertiary qualifications	294	94	84	43
Household Type				
Family with dependent children	390	93	87	45
Other	607	89	84	43
Employment Status				
Employed	605	93	86	43
Retired	217	88	83	43
Other not in labour force	182	88	84	47
Household Income				
Less than $20,000	136	84#	82	38
$20,000<$40,000	162	87	86	43
$40,000<$60,000	176	94	91	49
$60,000<$80,000	135	94	91	37
$80,000 or more	249	94	83	46

# Denotes statistical significance at the 95% confidence level between the sub group result and the total result.

Table 2: Selected attitudes to disease prevention – subgroup analysis

	Sample base n	Approve of spending public money on disease prevention %	Disease prevention is effective %	Gov't. is doing enough in the area of disease prevention %
Total	**1,000**	**98**	**97**	**45**
Gender				
Male	384	98	97	45
Female	616	98	97	46
Age Group				
18 – 24 years	58	100	93	46
25-34 years	148	99	98	49
35-44 years	217	98	97	48
45-54 years	208	98	97	48
55-64 years	175	97	97	33
65 years and over	194	98	97	44
Location				
Melbourne	599	98	96	45
Rest of Victoria	401	99	97	46
Birthplace				
Australia	787	98	96	46
Overseas	213	98	98	44
Educational Attainment				
Year 10 or less	216	99	97	43
Years 11or 12	283	98	95	50
Trade Certificate / Diploma	199	99	98	44
Tertiary qualifications	294	98	97	44
Household Type				
Family with dependent children	390	98	97	50
Other	607	98	96	42
Employment Status				
Employed	605	98	96	45
Retired	217	98	98	43
Other not in labour force	182	99	97	47
Household Income				
Less than $20,000	136	98	93#	40
$20,000<$40,000	162	98	98	47
$40,000<$60,000	176	98	97	49
$60,000<$80,000	135	98	97	43
$80,000 or more	249	99	97	47

# Denotes statistical significance at the 95% confidence level between the sub group result and the total result.

Table 3: Support for possible measures to tackle childhood obesity – subgroup analysis.

	Sample base n	Ban tv food ads in kids viewing hours %	Total ban on tv food ads %	Make the fast food industry reduce portion sizes %	Increase physical activity at school %	Ban soft drinks from school canteens %	Build more cycling and walkin g paths %
Total	**1,000**	**79**	**61**	**64**	**92**	**81**	**90**
Gender							
Male	384	78	60	55	94	73#	89
Female	616	80	63	72#	91	88#	91
Age Group							
18 – 24 years	58	73	47#	66	98	70	93
25-34 years	148	82	56	65	94	83	92
35-44 years	217	78	58	59	89	81	90
45-54 years	208	84	73#	66	93	84	93
55-64 years	*175*	*76*	*69*	*67*	*94*	*80*	*86*
65 years and over	*194*	*77*	*61*	*63*	*89*	*80*	*85*
Location							
Melbourne	599	78	61	63	93	80	89
Rest of Victoria	401	82	64	65	89	82	91
Birthplace							
Australia	787	79	60	62	92	79	89
Overseas	213	80	66	67	93	86	92
Educational Attainment							
Year 10 or less	216	71#	56	62	91	73#	91
Years 11or 12	283	78	60	63	95	80	89
Trade Certificate / Diploma	199	83	65	60	92	82	89
Tertiary qualifications	294	82	65	67	91	85	91
Household Type							
Family with dependent children	390	79	63	63	92	82	93#
Other	607	79	60	64	92	80	87
Employment Status							
Employed	605	80	62	63	93	80	89
Retired	217	78	63	62	92	81	89
Other not in labour force	182	76	59	69	89	83	92
Household Income							
Less than $20,000	136	81	63	64	91	76	89
$20,000<$40,000	162	78	63	66	92	82	91
$40,000<$60,000	176	80	62	69	95	80	92
$60,000<$80,000	135	76	64	59	89	81	88
Health Promotion is Effective							
Yes	849	81	63	66	93	81	93
No	81	69*	52*	49*	88	79	74*

# Denotes statistical significance at the 95% confidence level between the sub group result and the total result.
*Denotes statistically significant differences between sub groups.

Table 4: Support for other possible population health measures – subgroup analysis.

	Sample base	Banning all television advertising of alcohol	Additional taxes on alcoholic drinks	Additional taxes on high fat / high sugar content food	Pollution tax
	n	%	%	%	%
Total	**1,000**	**43**	**43**	**48**	**85**
Gender					
Male	384	35#	38	45	84
Female	616	50#	47	52	86
Age Group					
18 – 24 years	58	29#	38	42	87
25-34 years	148	36	39	46	89
35-44 years	217	42	38	41	81
45-54 years	208	52#	45	54	88
55-64 years	175	42	48	53	85
65 years and over	194	48	51#	54	85
Location					
Melbourne	599	41	43	47	85
Rest of Victoria	401	49#	43	51	86
Birthplace					
Australia	787	40	40	46	85
Overseas	213	54#	54#	56	87
Educational Attainment					
Year 10 or less	216	46	44	48	81
Years 11 or 12	283	41	43	47	82
Trade Certificate / Diploma	199	38	40	45	86
Tertiary qualifications	294	46	44	52	89
Household Type					
Family with dependent children	390	44	41	48	84
Other	607	42	44	49	86
Employment Status					
Employed	605	40	38	46	85
Retired	217	50#	55#	56	86
Other not in labour force	182	46	48	48	85
Household Income					
Less than $20,000	136	57#	54#	55	83
$20,000<$40,000	162	43	47	47	80
$40,000<$60,000	176	41	46	53	90
$60,000<$80,000	135	43	46	48	86
$80,000 or more	249	36	33#	42	86
Health Promotion is Effective					
Yes	849	44	45#	50	88
No	150	39	29	36	72

# Denotes statistical significance at the 95% confidence level between the sub group result and the total result.

Table 5: Use of selected media for health information – subgroup analysis.

	Sample base n	Radio %	TV %	Mags/ Papers %	Internet %	Doctor / GP %
Total	**1,000**	**14**	**40**	**49**	**25**	**30**
Gender						
Male	384	16	40	46	28	25
Female	616	12	41	52	22#	34
Age Group						
18 – 24 years	58	4#	45	30#	41#	29
25-34 years	148	14	44	42	35#	31
35-44 years	217	16	42	50	31#	24
45-54 years	208	17	47	56	28	28
55-64 years	175	13	38	54	12#	35
65 years and over	194	10	29#	51	6#	34
Location						
Melbourne	599	14	41	50	27	30
Rest of Victoria	401	13	39	45	18#	29
Birthplace						
Australia	787	14	41	48	23	29
Overseas	213	12	38	52	31#	31
Educational Attainment						
Year 10 or less	216	8	42	43	11#	28
Years 11 or 12	283	11	39	44	21	32
Trade Certificate / Diploma	199	17	43	51	29	32
Tertiary qualifications	294	18#	40	55#	34#	28
Household Type						
Family with dependent children	390	13	43	51	29	26
Other	607	14	39	48	22	32
Employment Status						
Employed	605	16	42	49	30#	27
Retired	217	11	31#	51	8#	35
Other not in labour force	182	8	44	44	23	35
Household Income						
Less than $20,000	136	9	23#	37#	12#	41#
$20,000<$40,000	162	14	35	46	10#	34
$40,000<$60,000	176	11	46	49	30	26
$60,000<$80,000	135	17	43	45	28	24
$80,000 or more	249	18	44	58#	31#	27
Health Promotion is Effective						
Yes	849	14	42	50	26	29
No	150	13	31#	41	19#	35#

# Denotes statistical significance at the 95% confidence level between the sub group result and the total result.
*Denotes statistically significant difference between sub groups.

Appendix 2: About the survey

The in-scope population for the survey was persons aged 18 years and over in private dwellings across Victoria. The survey comprised 1,000 telephone interviews over the period 15 November to 19 December 2006. A disproportionate stratified random sample design was adopted such that 600 interviews were undertaken in metropolitan Melbourne and 400 interviews across the rest of Victoria.

Analysis of call results

A breakdown of all the telephone calls made during the course of the survey is provided in below (Table A1).

This shows a total of 26,603 calls made to enumerate the sample. 'No answer' outcomes accounted for over two fifths of all call attempts, answering machines almost a fifth and contact with out of scope households accounted for 1.5% of all calls. An interview was obtained with an in-scope sample member about 1 in every 27 calls.

Table A1: Total call results.

	N	%
Total Calls	**26,603**	**100.0**
Unusable numbers		
Telstra message, number disconnected	2,172	8.2
Not a residential number	662	2.5
Subtotal unusable number	*2,834*	*10.7*
No contact		
Engaged	846	3.2
Answering machine	4,651	17.5
No answer	11,595	43.6
Fax/Modem	539	2.0
Not contactable within call cycle (i.e. 6 calls)	232	0.9
Subtotal	*17,863*	*67.1*
Out of scope		
No-one over 18 in household	6	0.0
Claims to have done survey	3	0.0
Too old / frail / deaf / unable to do survey	88	0.3
Selected respondent away for duration	208	0.8
Language difficulty	94	0.4
Subtotal	*399*	*1.5*
Contacts		
Interviews	1000	3.8
Selected respondent temporarily unable to continue	814	3.1
Appointments	2,425	9.1
Household refusal	1,315	4.9
Respondent refusal	136	0.5
Terminated mid survey	8	0.0
Remove number from list	7	0.0
Wrong number / selected person not known	34	0.1
Subtotal in-scope contacts	*5,379*	*21.6*

Base: Total Calls (n=26,603).

Table A2 (below) shows the final call outcome for the 7,209 records to which a telephone call was made. This shows that about two thirds of the numbers called (60.7%) were eligible working numbers, a further 19.6% were considered out of scope as no contact could be established over the call cycle and 5.5% were considered to be out of scope on the basis of needing to be interviewed in a language other than English, not having a household member over 18 years of age or considering themselves to be too old or frail to participate in the survey.

The final achieved response rate for the survey, calculated as interviews / interviews and refusals 45%. The response rate for the 25% of the RDD sample that were sent a primary approach letter 52% and 35%.

Table A2: Final call status.

	N	%
Final Call Attempts	**7,209**	**100.0**
Unusable numbers		
Telstra message, number disconnected	2,172	30.1
Not a residential number	662	15.1
Subtotal unusable number	*2,834*	*45.3*
No contact		
Engaged	27	0.4
Answering machine	197	2.7
No answer	649	9.0
Fax/Modem	539	7.5
Not contactable within call cycle (i.e. 6 calls)	232	3.2
Subtotal	*1,412*	*19.6*
Out of scope		
No-one over 18 in household	6	0.1
Claims to have done survey	3	0.0
Too old / frail / deaf / unable to do survey	88	1.2
Selected respondent away for duration	94	1.3
Language difficulty	208	2.9
Subtotal	*399*	*5.5*
Contacts		
Interviews	1000	13.9
Selected respondent temporarily unable to continue	12	0.2
Appointments	52	0.7
Household refusal	1,083	15.0
Respondent refusal	136	1.9
Terminated mid survey	8	0.1
Remove number from list	7	0.1
Wrong number / selected person not known	34	0.5
Subtotal in-scope contacts	*2,332*	*35.6*

Base: Total Eligible numbers (n=4,375).

Sample profile

The profile of those interviewed (based on unweighted data) is shown below. The following observations can be made about the unweighted sample distribution, all of which are typical of telephone-based survey approaches.

- The sample under represents young people (6% of the unweighted sample aged 18 to 24 years old compared with 13% of the population and over represents persons aged 55 years and over (37% of the achieved sample and 30% of the Victorian population)
- Males are under represented relative to their population incidence (38% compared with 49%).
- Overseas born persons are under represented relative to their prevalence in the population (20% compared with around 24%), and
- Those with tertiary qualifications are over represented relative to their population incidence (29% compared with around 20%).

Again, this sort of sample distribution is typical for surveys of this nature. The extent to which the sample varies from the population in terms of age, sex and region has been adjusted for the by the use of weighted estimates (see below).

Table A3: Unweighted sample characteristics.

	Unweighted %		Unweighted %
Total		**Educational Attainment**	
Gender		Year 10 or less	22
Male	38	Years 11or 12	28
Female	62	Trade Certificate / Diploma	20
Age Group		Tertiary qualifications	29
18 – 24 years	6	**Household Type**	
25-34 years	15	Family with children	39
35-44 years	22	Other	61
45-54 years	21	**Employment Status**	
55-64 years	18	Employed	61
65 years and over	19	Retired	22
Location		Other not in labour force	18
Melbourne	60	**Household Income**	
Rest of Victoria	40	Less than $20,000	14
Birthplace		$20,000<$40,000	16
Australia	79	$40,000<$60,000	18
Overseas	21	$60,000<$80,000	14
		$80,000 or more	25

Weights

The results presented in this report are based on "weighted" survey data. That is, the survey results have been adjusted so as to reflect the age, sex and regional (Melbourne / Rest of Victoria) distribution of the Victorian population aged 18 years and over based on ABS 2004 Estimated residential Population figures. The impact of this weighting is to correct for the disproportionate stratified sample design and to adjust for any variations in response patterns across the target group. Please note that the age by sex by region weighting of the survey data does not necessarily ensure that the socio-economic status of the sampled population reflects that of the wider community.

The population figures shown used for this weighting are shown below.

Males	**18-24 years**	**25-34 years**	**35-44 years**	**45-54 years**	**55-64 years**	**65 years and over**	**Total**
Non Metro	57,927	80,623	95,991	96,948	77,177	94,729	**503,395**
Metro	190,327	280,304	274,054	235,512	178,689	198,318	**1,357,204**
Total	**248,254**	**360,927**	**370,045**	**332,460**	**255,866**	**293,047**	**1,860,599**
Females							
Non Metro	54,217	81,399	99,675	96,726	76,309	116,015	**524,341**
Metro	186,834	284,941	279,000	244,313	180,687	254,487	**1,430,262**
Total	**241,051**	**366,340**	**378,675**	**341,039**	**256,996**	**370,502**	**1,954,603**
Persons							
Non Metro	112,144	162,022	195,666	193,674	153,486	210,744	**1,027,736**
Metro	377,161	565,245	553,054	479,825	359,376	452,805	**2,787,466**
Total	**489,305**	**727,267**	**748,720**	**673,499**	**512,862**	**663,549**	**3,815,202**

Derived variables used in this report

The composition and structure of the derived variables used in this report is shown below.

Table of derived variables.

Variable Name	Questionnaire Reference	Comments
Location		
Melbourne		Based on ABS capital city / Rest of State postcode concordances
Rest of Victoria		
Educational Attainment	**F6**	
Year 10 or less		Primary school up to Y10 (Codes 1-3)
Years 11 or 12		Code 4 and 5
Trade Certificate / Diploma		Trade apprenticeship /Other trade or technical certificate / Diploma (Codes 6-8)
Tertiary qualifications		Bachelors Degree or post graduate (9-10)
Household Type	**F9**	
Family with children		One parent or couple family with dependent children (Codes 2 & 4)
Other		All others
Main employment status	**F7**	
Employed		Employee or self employed (Codes 1 -2)
Retired		Retiree (Code 6)
Other not in labour force		Home duties, student, unable to work (Codes 4,5 and 7)
Health Promotion is Effective	**B2a**	
Yes		B2a is 1 or 2
No		B2a not 1 or 2

Appendix 3: Survey questionnaire

PR0284 – VicHealth public attitudes to health promotion and disease prevention
Questionnaire for Main Study V1

INTRODUCTION

Good morning/afternoon/evening. My name is <SAY NAME> and I am calling on behalf of VicHealth (The Victorian Health Promotion Foundation) from the Social Research Centre.

EXPLAIN IF NECESSARY: VicHealth was established by the Victorian parliament in 1987 to work in partnership with organisations, communities and individuals to promote good health and prevent ill-health.

We're conducting an important study on attitudes towards health promotion and disease prevention. The results from the survey will be used to try and improve the health of Victorians.

1. Continue
2. Stop interview, make appointment (RECORD NAME AND ARRANGE CALL BACK)
3. Household refusal (GO TO RR1)

*PROGRAMMER NOTE: IF LETTERED SAMPLE (LETTER=1) INCLUDE <Most households will have received a letter from VicHealth about the study. As the letter says> IN QUESTIONNAIRE STEM

S1 (Most households will have received a letter from VicHealth about the study. As the letter says) to help with this important study we'd like to arrange a short interview with the person aged 18 or over who is going to have the next birthday.

May I speak to that person please?

1. Selected respondent (GO TO S3)
2. Change respondents (GO TO S2)
3. Stop interview, make appointment (RECORD NAME AND GENDER AND ARRANGE CALL BACK)
4. Wants a copy of the letter before proceeding (GO TO ALET)
5. Household refusal (ATTEMPT CONVERSION / RECORD REASON) (GO TO RR1)
6. HH LOTE
7. Queried about how telephone number was obtained (DISPLAY ATELQ)
8. No one in household over 18 (GO TO TERMINATION SCRIPT)

*(SELECTED RESPONDENT)
S2 REINTRODUCE IF NECESSARY: Good morning/afternoon/evening. My name is <SAY NAME> and I am calling on behalf of VicHealth from the Social Research Centre. We're conducting an important study on attitudes towards health promotion and disease prevention. The results from the survey will be used to try and improve the health of Victorians.

IF NECESSARY: This call is for public health research and is NOT a sales call. Any information provided is protected by strict Commonwealth and State privacy laws.

1. Continue

*(SELECTED RESPONDENT)
S3 I'm mostly going to ask about your general opinions, but I'm also going to ask you a couple of questions about your health.

All responses will be confidential and any information provided is protected by strict Commonwealth and State privacy laws. You are free to not answer any questions or to end the interview at any time. This interview should take around 15 minutes depending on your answers. I'll try and make it as quick as I can. Are you happy to continue?

1. Continue (GO TO S4)
2. Stop interview, make appointment (RECORD NAME AND GENDER AND ARRANGE CALL BACK)
3. Wants a copy of the letter before proceeding (GO TO ALET)
4. Respondent refusal (ATTEMPT CONVERSION / RECORD REASON) (GO TO RR1)
5. QR LOTE
6. Queried about how telephone number was obtained (DISPLAY ATELQ)

TERMINATION SCRIPT:
Thanks anyway, but for this survey we need to speak to people aged 18 or more. Thanks for being prepared to help.

*(WANTS TO RECEIVE A COPY OF THE LETTER)
ALET RECORD ADDRESS DETAILS TO SEND COPY OF LETTER

(RECORD NAME AND VERIFY ADDRESS DETAILS FROM SAMPLE / COLLECT ADDRESS DETAILS)

*PROGRAMMER NOTE RE ALET: WILL NEED TO BE ABLE TO TRACK INTERVIEWS RESULTING FROM SENDING A COPY OF THE LETTER]

*(QUERIED HOW TELEPHONE NUMBER WAS OBTAINED)
ATELQ Your telephone number has been chosen at random from all possible telephone numbers in your area. We find that this is the best way to obtain a representative sample of all Victorians for our study.

1. Snap back to S1 / S3

*(REFUSED)
RR1 OK, that's fine, no problem, but could you just tell me the main reason you do not want to participate, because that's important information for us?

1. No comment / just hung up
2. Too busy
3. Not interested
4. Too personal / intrusive
5. Don't like subject matter
6. Letter put me off
7. Don't believe surveys are confidential / privacy concerns
8. Silent number
9. Don't trust surveys / government
10. Never do surveys
11. 15 minutes is too long
12. Get too many calls for surveys / telemarketing
13. Too old / frail / deaf / unable to do survey (CODE AS TOO OLD / FRAIL / DEAF)
14. Not a residential number (business, etc) (CODE AS NOT A RESIDENTIAL NUMBER)
15. Language difficulty (CODE AS LANGUAGE DIFFICULTY NO FOLLOW UP)
16. Going away / moving house (CODE AS AWAY DURATION)
17. Asked to be taken off list (add to do not call register)
18. Other (Specify)

*(REFUSED)
RR2 RECORD RE-CONTACT TYPE

1. Definitely don't call back
2. Possible conversion

*(ALL)
S4 This call may be monitored for training and quality purposes. Is that OK?

1. Monitor
2. Do not monitor

MODULE A: GOVERNMENT SPENDING

*(RANDOMISE CODES 1 to 6)
*(ALL)
A1 I'm going to start with a few questions about government spending priorities. Which one of the following do you think should be the top priority for government spending at the moment? (READ OUT)

1. Education
2. Health
3. Defence
4. Social security
5. Infrastructure spending (e.g. including roads, rail, ports, etc.)
6. Something else (specify)
7. (All of these) AVOID THIS CODE IF POSSIBLE GO TO PREA3
8. (Don't know) GO TO PREA3
9. (Refused) GO TO PREA3

*(PROGRAMMER NOTE: DO NOT DISPLAY CODE MENTIONED IN Q1)
*(KEEP CODES IN SAME ORDER THEY APPEAR IN Q1)
*(GAVE A VALID ANSWER AT Q1)
A2 And which one should be the next priority for government spending at the moment? (READ OUT IF NECESSARY)

1. Education
2. Health
3. Defence
4. Social security
5. Infrastructure spending (e.g. including roads, rail, ports, etc.)
6. Something else (specify)
7. (All of these) AVOID THIS CODE IF POSSIBLE
8. (Don't know)
9. (Refused)

PREA3 IF A1 OR A2=CODE 2 (MENTIONED HEALTH AS A PRIORITY) CONTINUE. OTHERS GO TO B1
*(MENTIONED HEALTH AS A PRIORITY)
A3 You mentioned health as a priority for government spending, what sorts of things do you have in mind?

1. Response given (specify)
2. (Don't know)
3. (Refused)

MODULE B: HEALTH PROMOTION AND DISEASE PREVENTION

***Health promotion**

*(ALL)
B1 When thinking about health promotion campaigns and activities, what are the main things that come to mind for you? Anything else? (ACCEPT MULTIPLES)

1. Smoking/Quit
2. Diet and nutrition
3. Obesity
4. Exercise/Go For Your Life
5. Drink Driving
6. Domestic Violence
7. HIV/AIDS
8. Cancer Screening
9. Communicable diseases/Measles (MMR), Rubella
10. Depression/Beyond Blue
11. Other (Specify)
12. (Don't know)
13. (Refused)

*(ALL)
B2 I'm going to read out a definition of 'health promotion' and then ask you about your attitudes.

Health promotion often involves media campaigns promoting healthy lifestyle choices. It also includes things like improving the number of walking or cycling paths, increasing access to healthy foods, or introducing tobacco regulations.

In general, do you approve or disapprove of spending public money on health promotion? (PROBE: Is that strongly approve / disapprove or approve / disapprove)

1. Strongly approve
2. Approve
3. (Neither approve nor disapprove)
4. Disapprove
5. Strongly disapprove
6. (Don't know)
7. (Refused)

*(ALL)
B2a To what extent do you agree or disagree that health promotion is an effective way of improving population health? (PROBE: Is that strongly agree / disagree or agree / disagree)

1. Strongly agree
2. Agree
3. (Neither agree nor disagree)
4. Disagree
5. Strongly disagree
6. (Don't know)
7. (Refused)

*(ALL)
B3 Do you agree or disagree that the government is doing enough in the area of health promotion? (PROBE: Is that strongly agree / disagree or agree / disagree)

1. Strongly agree (GO TO B4o)
2. Agree (GO TO B4o)
3. (Neither agree nor disagree) (GO TO B4o)
4. Disagree
5. Strongly disagree
6. (Don't know) (GO TO B4o)
7. (Refused) (GO TO B4o)

*(DISAGREES GOVERNMENT IS DOING ENOUGH)
B3a Why do you say that?

1. Response given (specify)
2. (Don't know)
3. (Refused)

***Disease prevention**

*(ALL)
B4o Now a few questions about disease prevention, when thinking about programs to detect or prevent diseases, what sorts of thing come to mind? Anything else? (PROBE FOR SPECIFICS)

1. Response given (specify)
2. (Don't know)
3. (Refused)

*(ALL)
B4 I'm now going to read out a definition of disease prevention and then ask you about your attitudes.

By disease prevention, I mean things like the early detection of disease, immunisation and screening programs.

Do you approve or disapprove of spending public money on disease prevention? (PROBE: Is that strongly approve / disapprove or approve / disapprove)

1. Strongly approve
2. Approve
3. (Neither approve nor disapprove)
4. Disapprove
5. Strongly disapprove
6. (Don't know)
7. (Refused)

*(ALL)
B4a To what extent do you agree or disagree that disease prevention is an effective way of improving population health? (PROBE: Is that strongly agree / disagree or agree / disagree)

1. Strongly agree
2. Agree
3. (Neither agree nor disagree)
4. Disagree
5. Strongly disagree
6. (Don't know)
7. (Refused)

*(ALL)
B5 Do you agree or disagree that the government is doing enough in the area of disease prevention? (PROBE: Is that strongly agree / disagree or agree / disagree)

1. Strongly agree (GO TO B6)
2. Agree (GO TO B6)
3. (Neither agree nor disagree) (GO TO B6)
4. Disagree
5. Strongly disagree
6. (Don't know) (GO TO B6)
7. (Refused) (GO TO B6)

*(DISAGREES GOVERNMENT IS DOING ENOUGH)
B5a Why do you say that?

1. Response given (specify)
2. (Don't know)
3. (Refused)

*(ALL)
B6 I'm going to read you a few statements and I'd like to tell me if you agree or disagree with each one. (PROBE: Is that strongly agree / disagree or agree / disagree)

(STATEMENTS)
a) Governments have the main role to play in promoting good health
b) At the end of the day, individuals have to take full responsibility for their own health
c) Schools need to do more to educate children about health issues and healthy lifestyle choices
d) It's totally up to parents to teach children about health issues
e) Australia would be a healthier place if we could reduce poverty
f) Environmental factors such as air and water quality are a major influence on population health

(CODE FRAME)
1. Strongly agree
2. Agree
3. (Neither agree nor disagree)
4. Disagree
5. Strongly disagree
6. (Don't know)
7. (Refused)

*(ALL)
B7 When governments make decisions, which of the following should be a priority …

1. Health considerations
2. Economic considerations, or
3. Both
4. (Don't know)
5. (Refused)

MODULE C: HEALTH ISSUES

*(RANDOMISE STATEMENTS)
*(ALL)
C1 Now, I'm going to read a list of diseases and conditions and I'd like you to rate how serious you think each of these is in terms of their impact on population health. Please use a scale from 1 to 10 where 1 is not at all serious and 10 is extremely serious.

In Victoria today, how serious a problem are the following (READ OUT) …

(STATEMENTS)
a) Childhood Obesity
b) Diabetes
c) Heart disease
d) Cancer
e) Health problems related to environmental pollution
f) Mental illnesses such as depression and schizophrenia

(CODE FRAME)
*PLEASE PRESENT AS A DOUBLE COLUMN
1. 1 – Not at all serious
2. 2
3. 3
4. 4
5. 5
6. 6
7. 7
8. 8
9. 9
10. 10 – Extremely serious
11. (Don't know)
12. (Refused)

(RANDOMISE STATEMENTS)
*(ALL)
C2 Still thinking about the sorts of things that can affect people's health, how big an effect do you think the following factors have. Please use a scale from 1 to 10 where 1 is no effect at all and 10 is a very large effect.

In Victoria today, how big an effect on a person's health is … (READ OUT)

(STATEMENTS)
a) The type of food a person eats
b) A person's genetic make-up
c) A person's level of stress
d) The amount of physical activity a person does
e) A person's financial circumstances
f) A person's mental and emotional state
g) Whether or not a person smokes cigarettes

(CODE FRAME)
*PLEASE PRESENT AS A DOUBLE COLUMN
1. 1 – No effect
2. 2
3. 3
4. 4
5. 5
6. 6
7. 7
8. 8
9. 9
10. 10 – A very large effect
11. (Don't know)
12. (Refused)

(RANDOMISE STATEMENTS, BUT PLEASE COUPLE STATEMENTS A AND B)
*(ALL)
C3 Now I'd like you to think about childhood obesity. I'm going to read out a number of ideas for reducing obesity and I'd like you to tell me whether or not, in general terms, you support or oppose each suggestion. (PROBE: Is that strongly support / oppose or support / oppose?)

(STATEMENTS)
a) Banning the television advertising of high fat and high sugar content foods during CHILDREN'S VIEWING HOURS
b) Banning the television advertising of high fat and high sugar content foods ALTOGETHER
c) Making the food industry reduce the portion sizes of fast foods
d) Increasing the amount of physical activity in the school curriculum
e) Removing soft drinks from school canteens
f) Building of more cycling and walking paths

(CODE FRAME)
1. Strongly support
2. Support
3. (Neither support nor oppose)
4. Oppose
5. Strongly oppose
6. (Don't know)
7. (Refused)

MODULE D: POPULATION HEALTH ISSUES

*(ALL)
D4 I'm now going to read out some suggestions that people have made in order to try and improve population health. Please tell me whether or not, in general terms, you support or oppose each suggestion. (PROBE: Is that strongly support / oppose or support / oppose?)

(STATEMENTS)
a) Placing additional taxes on alcoholic drinks to reduce their consumption
b) Placing additional taxes on high fat and high sugar content foods to reduce their consumption
c) Taxing environmental pollution to limit harmful emissions

(CODE FRAME)
1. Strongly support
2. Support
3. (Neither support nor oppose)
4. Oppose
5. Strongly oppose
6. (Don't know)
7. (Refused)

*(ALL)
D4a If additional taxes were placed on high fat and high sugar food, alcohol or environmental pollution, would you prefer the money to go into general revenue or spent on health promotion and disease prevention?

1. General revenue
2. Health promotion and disease prevention
3. (Neither)
4. (Don't know)
5. (Refused)

*(ALL)
D5 In general terms, do you support or oppose a ban on all television advertising of alcohol? (PROBE: Is that strongly support / oppose or support / oppose?)

1. Strongly support
2. Support
3. (Neither support nor oppose)
4. Oppose
5. Strongly oppose
6. (Don't know)
7. (Refused)

MODULE E: SOURCES OF HEALTH INFORMATION

*(ALL)
E1b Now some questions about obtaining health-related information. Where do you get information about staying healthy? (ACCEPT MULTIPLES)

1. Radio
2. Television
3. Magazines/newspapers
4. Internet
5. Brochure
6. Family/friends
7. General Practitioner/Doctor
8. Other health professional
9. Other (please specify)
10. None
11. (Don't know)
12. (Refused)

*(PROGRAMMER NOTE: ONLY DISPLAY CODES MENTIONED IN E1B)
*(IF GAVE MULTIPLE SOURCES IN E1b)
E1a And what is your MAIN source of information about staying healthy? (SINGLE RESPONSE)

1. Radio
2. Television
3. Magazines/newspapers
4. Internet
5. Brochure
6. Family/friends
7. General Practitioner/Doctor
8. Other health professional
9. Other (please specify)
10. Nothing
11. (Don't know)
12. (Refused)

PREE2 IF E1A OR E1B IS CODE FOR 4 (INTERNET) GO TO E3 OTHERWISE CONTINUE

*(NOT MENTIONED INTERNET AS SOURCE OF INFORMATION)
E2 Do you have access to the internet?

1. Yes
2. No GO TO PREF1
3. (Don't know) GO TO PREF1
4. (Refused) GO TO PREF1

PREE3 IF E1A OR E1B IS CODE FOR 4 (INTERNET) OR E2=CODE 1 CONTINUE. OTHERS GO TO PREF1

*(HAVE INTERNET ACCESS)
E3 Do you use the internet to look for health information?
1. Yes
2. No
3. (Don't know)
4. (Refused)

MODULE F: DEMOGRAPHICS

*(ALL)
PREF1 Now just a few questions to help us analyse the results. Some of these are about your health – please let me know if you're not happy answering them.
1. Continue

*(ALL)
F1a Do you now smoke cigarettes ... (READ OUT)
EXPLAIN AS NECESSARY: By cigarettes we mean factory-made or roll-your-own cigarettes
1. Daily GO TO F2
2. At least weekly GO TO F2
3. Less often than weekly, or GO TO F1c
4. Not at all
5. (Can't say) GO TO F2

F1b Have you ever smoked cigarettes on a regular basis?
1. Yes
2. No GO TO F2
3. (Refused) GO TO F2

PREF1b IF F1a=CODE 3 OR F1b=CODE 1 CONTINUE. OTHERS GO TO F2

*PROGRAMMER NOTE: IF F1a=CODE 3 (CURRENTLY SMOKES LESS THAN WEEKLY) INSERT <on a weekly basis> INTO QUESTION STEM

*(DOES NOT SMOKE CIGARETTES ON AT LEAST A WEEKLY BASIS)
F1b Did you stop smoking cigarettes (on a weekly basis) more than one year ago, less than one year ago or have you never smoked regularly?
1. Quit less than one year ago
2. Quit one year ago or longer
3. Never smoked
4. (Refused)

*(ALL)
F2 In general, would you say your health is (READ OUT) (DO NOT PRESS RESPONDENT FOR ANSWER)?
1. Excellent
2. Very good
3. Good
4. Fair
5. Poor
6. (Don't know)
7. (Refused)

*(ALL)
F5a How old were you last birthday?

1. Age given (RECORD AGE IN YEARS (RANGE 18 TO 99) (GO TO F6)
2. (Refused)

*(REFUSED AGE)
F5b Which of the following age groups are you in?
READ OUT

1. 18 - 24 years
2. 25 - 34 years
3. 35 - 44 years
4. 45 – 54 years
5. 55 – 64 years
6. 65 – 74 years, or
7. 75 + years
8. (Refused)

*(ALL)
F6 What is the highest level of education you have completed?

1. Primary school
2. Year 7 to Year 9
3. Year 10
4. Year 11
5. Year 12
6. Trade/apprenticeship
7. Other TAFE/Technical Certificate
8. Diploma
9. Bachelor Degree
10. Post-Graduate Degree
11. Other (please specify)
12. (Refused)

*(ALL)
F7 Which of these best describes your current employment status? Are you (READ OUT)

1. Self employed
2. Employed for wages, salary or payment in kind
3. Unemployed (GO TO F9)
4. Engaged in home duties (GO TO F9)
5. A student (GO TO F9)
6. Retired, or (GO TO F9)
7. Unable to work (GO TO F9)
8. Other (Specify) (GO TO F9)
9. (Don't know) (GO TO F9)
10. (Refused) (GO TO F9)

IF F7=CODES 1 OR 2 CONTINUE OTHERWISE GO TO F9

*(WORKING)
F7a What's your (main) occupation? (PROBE IF REQUIRED; JOB TITLE AND MAIN DUTIES)

1. Manager/Administrator (senior managers, government officials, farmers and farm managers)
2. Professional (architects, lawyers, accountants, doctors, scientists, teachers, health professionals such as optometrists, dentists & registered nurses, professional artists)
3. Associate professional (technical officers, technicians, enrolled nurses, medical officers, police officers, computer programmers, scientific officers)
4. Trades persons (building, electrical, metal, printing, vehicle, horticulture, marine trades persons)
5. Advanced clerical or service (bookkeepers, library assistants, flight attendants, secretaries / personal assistants, payroll clerks)
6. Intermediate clerical, sales or service (sales reps, child care workers, waiters, driving instructors, nursing assistant, teaching or nursing aids)
7. Intermediate production and transport (road, rail, machine, mobile or stationary plant operators/drivers)
8. Elementary clerical, sales or service (check out operator, mail / filing clerk, courier, telemarketer, security guard, parking inspector)
9. Labourers & related workers (cleaner, process worker, tradesmen's assistants, farm labourers, construction and mining labourers, *food handling*)
10. Unsure
11. (Refused)

*(ALL)
F9 Which of these BEST describes your household? (READ OUT)
NOTE: IF HOUSEHOLD DOES NOT READILY FIT CODES – PUT INTO OTHER

1. Couple only
2. Couple with dependent children
3. Couple with non-dependent children
4. One parent family with dependent children
5. One parent family with non-dependent children
6. Group household, or
7. One person household
8. Other
9. (Don't know)
10. (Refused)

*(ALL)
F5b Are you of Aboriginal or Torres Strait Islander origin?

1. No
2. Yes, Aboriginal
3. Yes, Torres Strait Islander
4. Yes, both Aboriginal and Torres Strait Islander
5. (Refused)

*(ALL)
F10 Were you born in Australia or overseas?

1. Australia
2. Overseas
3. (Refused)

*(ALL)
F11 What language do you usually speak at home?

1. English
2. Arabic
3. Australian Indigenous Languages
4. Cantonese
5. Mandarin
6. Croatian
7. Greek
8. Hindi
9. Italian
10. Macedonian
11. Spanish
12. Turkish
13. Vietnamese
14. Other (Specify)
15. (Don't know)
16. (Refused)

*(ALL)
F12 Which of the following do you usually do? (READ OUT) (ACCEPT MULTIPLES)

1. Read daily newspapers
2. Read lifestyle and homemaker magazines
3. Watch TV
4. Listen to radio
5. Watch pay TV
6. (None of these)
7. (Don't know)
8. (Refused)

PREF13 IF F12=CODE 1 (READS NEWSPAPERS) CONTINUE. OTHERS GO TO PREF14

*(READS NEWSPAPERS)
F13 Which of the following newspapers do you read at least twice a week? (READ OUT) (ACCEPT MULTIPLES)

1. Herald-sun
2. The Age
3. The Australian
4. Financial Review
5. Regional daily
6. Other
7. None
8. (Don't know)
9. (Refused)

PREF14 IF F12=CODE 2 (READS MAGAZINES) CONTINUE. OTHERS GO TO PREF15

*(READS MAGAZINES)
F14 Do you read any of the following types of magazines on a regular basis, by that I mean around once a month? (READ OUT) (ACCEPT MULTIPLES)

1. Womens' magazines
2. Men's health and lifestyle magazines
3. Home health and lifestyle magazines (eg Better Homes and Gardens)
4. None of these
5. (Don't know)
6. (Refused)

PREF15 IF F12=CODE 3 (WATCHES TV) CONTINUE. OTHERS GO TO PREF16

*(WATCHES TV)
*(ROTATE CODE FRAME)
F15 Which free to air TV channels do you usually watch? (READ OUT) (ACCEPT MULTIPLES)

1. The ABC
2. SBS
3. Channel 7
4. Channel 9
5. Channel 10
6. WIN
7. PRIME
8. Other (specify)
9. None
10. (Don't know)
11. (Refused)

PREF16 IF F12=CODE 4 (LISTENS TO RADIO) CONTINUE. OTHERS GO TO F8

*(LISTENS TO RADIO)
F16 What types of radio stations do you usually listen to? (READ OUT) (ACCEPT MULTIPLES)

1. Music Radio
2. Talkback radio
3. News radio, or
4. Something else (specify)
5. (None of these)
6. (Don't know)
7. (Refused)

*(ALL)
F8 Roughly, what is your household annual income before tax, is it…? (READ OUT)

1. Less than $10,000
2. $10,000 – less than $20,000
3. $20,000 – less than $40,000
4. $40,000 – less than $60,000
5. $60,000 – less than $80,000
6. $80,000 and over
7. (Don't know)
8. (Refused)

*(ALL)
F19 POSTCODE - AUTOMATIC RECORD

*(ALL)
F20 RECORD SEX

1. Male
2. Female

CLOSE On behalf of VicHealth and the Social Research Centre I'd like to thank you for taking part in this study. Your views count and I'm very glad you made them known to me.

If you have any queries about this survey you can call the Australian Market and Social Research Society's free survey line on 1300 364 830.

*(INTERVIEWER TO ENTER ONCE INTERVIEW IS COMPLETE)
INT1 Type of interview

1. Normal
2. Refusal Conversion

Interviewer Declaration
I certify that this is a true, accurate and complete interview, conducted in accordance with the briefing instructions, the IQCA standards and the MRSA Code of Professional Behaviour (ICC/Esomar). I will not disclose to any other person the content of this questionnaire or any other information relating to the project.

Interviewer name: Interviewer I.D:

Signed: Date