National Prevention Summit

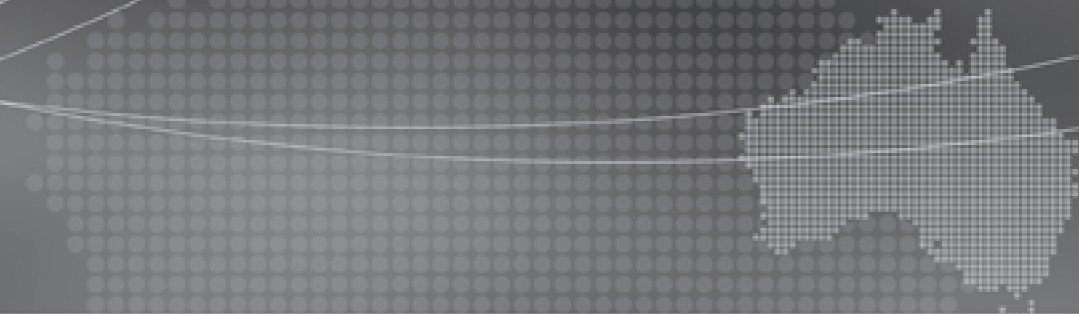
Investing in Australia's health and wellbeing

A VISION FOR PREVENTION IN AUSTRALIA

Discussion Paper

AUSTRALIAN INSTITUTE OF HEALTH POLICY STUDIES

VicHealth



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EXECUTIVE SUMMARY

The challenge

Australia is facing a number of major challenges. These include: reducing social and economic disadvantage; increasing business competition; fighting inflation; tackling climate change; securing water; increasing workforce participation and productivity; enabling equitable access to education and training; and delivering modern infrastructure to all Australians.

A number of trends will have a significant and progressive impact on the health and wellbeing of Australians and our health system over the next 20 years:

- growing health and other disparities between different population groups, most particularly, Aboriginal and Torres Strait Islander peoples
- the ageing of the population
- increasing levels of disability, chronic illness and injury, and
- pandemics (such as influenza), biological threats, natural disasters and communicable diseases.

In addition, new and unpredictable challenges will arise from time to time.

The "health system" has borne the responsibility for health in developed countries in the 20th-century, and has received very substantial government funding. However, we recognise increasingly that the achievement of good health and wellbeing for all Australians requires an integrated and cross-sectoral approach that also embraces prevention.

This approach must also recognise the crucial influence and importance of cultural, social, economic and environmental factors on the health of individuals, communities and populations.

Finally, this approach also needs to recognise that social and economic disadvantage leads to some population groups having much poorer health compared to the rest of society.

To date, many have argued that prevention and health promotion have been given insufficient attention in Australia, and yet, the current and future challenges already outlined, demand that a new approach and new ways of thinking about prevention must be developed in response to these.

We need a new agenda to elevate prevention to a national priority and to fund it appropriately.

This national prevention agenda needs to be accompanied by the development of good working relationships between a range of existing and new players, including the public, who are the ultimate beneficiaries of investments in health.

Momentum for change

Two factors have increased the momentum for a seachange in health in this country: the National Reform Agenda of 2006 and the change of national government in late 2007.

Initiated by the Council of Australian Governments (COAG), the Reform Agenda identified the crucial link between the health of the population and economic productivity, and this has opened the way for a new, future-oriented and whole-of-government approach to health.

COAG moved health promotion onto the national agenda with a grant of $500 million through the Australian Better Health Initiative (ABHI). This initiative aims to refocus the health system onto promoting good health and reducing the burden of chronic disease by funding activities to improve health outcomes along the spectrum — from the well population to people with advanced chronic conditions.

Priority will be given to promoting healthy lifestyles, supporting early detection of risk factors and chronic disease, supporting lifestyle and risk modification, encouraging patients to manage their chronic conditions, and improving communication and coordination between services.

In its 2008 work program COAG identified seven important areas, including Health and Ageing.

A Preventive Health Care Partnership, with particular emphasis on children and Indigenous Australians, and a National Health and Hospitals Reform Commission (NHHRC) have also recently been established.

A national prevention agenda

The two basic goals of an agenda for prevention should be:

1. To create a _system for health_ that enables prevention and health promotion strategies to operate effectively and sustainably across all sectors and at multiple levels of Australian society.

2. To enable the _health care system_ to play its role in prevention and health promotion by ensuring that it is driven by four important, inter-connected principles:

- It is person-centred, equitable, efficient, high quality and acceptable
- It is accessible and affordable for all Australians
- It is well coordinated and integrated, and
- It places the care of individuals and the community at its centre.

These new systems will need to have:

- The capacity to withstand the pressures and tensions that arise from tackling complex tasks;
- Techniques to identify problems through new models of monitoring and surveillance;
- Strategies for rapidly reorganising structures, functions and resources; and
- A capability to harness commitment and participation from a diverse range of actors.

These new systems will also need to have the required investment and funding, an appropriately trained workforce and to have the appropriate relationships with those existing agencies and organisations that already provide strong supports for Australia's health and well-being.

The value of prevention

Prevention benefits the population in a number of important ways:

1. Prevention can reduce the personal and community burden of disease, injury and disability.

2. It can facilitate better use of finite health system resources.

3. It generates substantial economic benefits, which although not immediate, are tangible and significant over time

4. Australia's economic performance and productivity are contingent on a motivated, skilled and healthy workforce.

Achieving these goals will require the adoption of a serious, long-term systems perspective in planning, evaluation and research. To fulfil their responsibilities, national, state and local governments will need to work towards a whole-of-government approach to prevention and health promotion.

Improving our performance

Australia's record in prevention has been generally good in areas such as road and traffic trauma, tobacco control, immunisation, HIV/AIDS and prevention of heart disease. In all of these areas over the last 30 years, we can observe the benefits of long term political will underpinned by adequate funding, a skilled workforce, evidence and program delivery structures, focus and commitment, investment in infrastructure and resources, bipartisan support, community engagement and action.

However, not all Australians have benefited in these ways, for example, Indigenous Australians have certainly not, and there is compelling Australian evidence that health inequalities have increased in Australia over the past 20 years.

Chronic diseases, obesity, mental disorders and some non-communicable diseases such as strokes, some cancers and neurological conditions, are also on the rise.

The paper identifies five levers for shifting the focus of the health system to more emphasis on prevention and health promotion:

1. Leadership and coordination
2. Sustainable financing
3. Infrastructure and resources
4. Integration of evidence, policy and practice
5. Engagement of all levels of society

1. Leadership and coordination. Because of fragmentation between sectors, levels of government, disciplines and professional groups, we need to support the Australian Government in the delivery of the National Prevention Taskforce, the National Preventive Health Care Partnership and the National Preventive Health Strategy.

The leadership within prevention and health promotion will need to be strengthened. A **national body** such as an institute of public health/health improvement should be established to coordinate policies, programs, expertise and services across sectors.

2. Financing. Problems in financing prevention have included inadequate funding, compartmentalisation, short-term thinking and ad hoc responses, but innovative funding arrangements are emerging.

This Paper canvasses other alternatives such as broad-banding several programs, mainstreaming prevention within clinical services, providing bonuses and incentives to achieve specific targets, pooling resources across traditional budgetary boundaries, taxation, price signalling and disincentive clauses in insurance schemes.

Another possibility is the establishment of a new entity whose role would be to secure adequate and sustainable financing, perhaps along the lines of the Pharmaceutical Benefits Advisory Committee. It could collaborate with the National Preventive Programs Taskforce.

3. Infrastructure and resources. Infrastructure and resources include workforce, institutions and organisations that carry out a range of functions, and information and knowledge management systems. While many of the key elements are already in place in Australia, investment is necessary to improve system performance.

Because of the varied nature of the prevention workforce across the country, **capacity-building initiatives** are needed. The national Public Health Education and Research Program (PHERP), already does this to some degree, but there is scope for a more nationally coordinated public health training scheme, building on the experiences of the New South Wales and Victorian programs and the inputs of the range of professional groups that have completed training. All this could be supplemented by **professional education programs** on priority issues.

It is not clear what the new organisational arrangements will be for the new Strategy, Partnership and Taskforce initiatives in prevention, but **well-conceived structural change is essential**. There may be a need for new institutions to stimulate change and to target areas where previous programs have failed.

Because gaps exist in information and knowledge management, **data collection** needs to be tailored to prevention and health promotion, and **surveillance** may need to be reconfigured. The introduction of population health **observatories** could enable the surveillance system to go beyond traditional models of disease surveillance.

4. Evidence, policy and practice. Not only is a larger investment in public health research required, but it is also essential that practice, policy and research be fully integrated and research efforts across shared priorities be well coordinated.

A National Preventive Programs Advisory Committee, independent of government and possibly modelled on the US Preventive Services Taskforce and Taskforce on Community Preventive Services, could be established to generate evidence. It would need to represent a diverse range of perspectives and interests — from government, through non-government organisations, research institutions, industry, professional organisations to the public.

5. Engagement of all levels of society. The entrenched view that prevention and health promotion is the exclusive domain of governments, particularly the ministries of health, needs to be countered. Government leadership and resolve are vital for engaging a kaleidoscope of actors with diverse interests, expertise and influence and involving them in sustained, coordinated action.

Social engagement strategies are needed to engage key players, citizens and communities at different levels.

These could include advisory committees for health services research and development; the committee supporting the development of the Health Regulations Act; strategies to equip consumers to take their place at the table in research, policy and programs such as those initiated by Breast Cancer Network Australia; engagement mechanisms that brings sectors together in high-level discussions such as the Business-Higher Education Roundtable, which is concerned with workforce, education, training, research and social enterprise; and citizens juries.

A strong, influential constituency will be needed to mobilise commitment to, ongoing support for, and active participation in prevention and health promotion.

Input and leadership will also be required from different societal interests and disciplines and different levels in the prevention enterprise and health care services.

INTRODUCTION

The health of our population is a reflection of our values and the way in which Australian society operates: it is a precious asset that only an unwise society would take for granted. Good health is integral to a high quality of life and economic productivity in 21st-century Australia.

The concept of positive health was succinctly captured in the World Health Organisation's 1948 constitution in the following way, and has since been used as a definition in international programs and advocacy (WHO, 1948):

Health is a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity.

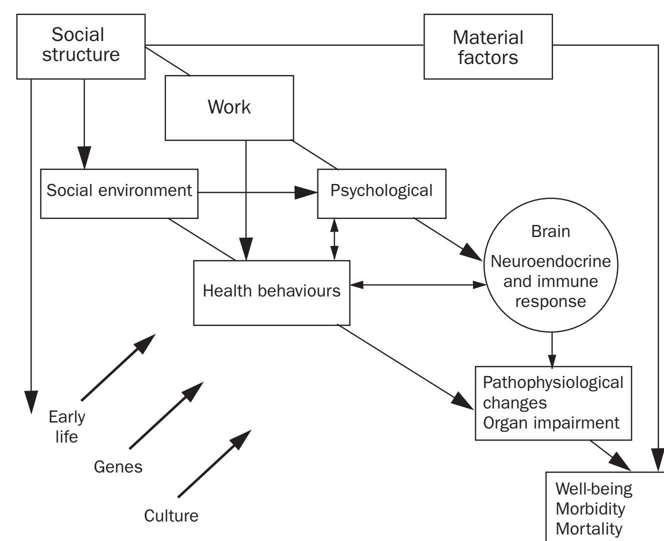
For individuals and communities, the concept of health has multiple, interrelated dimensions, although considerations of physical health have tended to dominate health system policy, activity and research priorities. Health, however, is more than physical wellbeing: it is intrinsically concerned with mental, social and spiritual realms of being. It is a dynamic state, shaped by a broad set of interacting determinants — social environment, physical environment, lifestyle or health behaviours, health care and genetics.

Conceptual models depicting relationships between these determinants and health are useful in making explicit the possible points at which policy and other interventions may play a part in preventing illness and enhancing health.

Brunner, Marmot and Wilkinson's model (Figure 1) was used recently to inform early conceptual development work for the WHO Commission on the Social Determinants of Health, due to report in 2008. It emphasises the link between social and economic factors to health and disease via different pathways, while recognising the important roles of genetics, early life and culture.

The Commission's recommendations will be based on this thinking and will lay the foundations for global and national action on the "causes of the causes" of illness and inequity (WHO CSDH, 2005).

Figure 1: Links between social structure, health & disease



Source: WHO Commission on Social Determinants of Health 2005

Although medical modalities play pivotal roles in diagnosing and helping individuals to recover from or manage illness, they play only marginal roles in securing conditions and practices for healthy living.

Sectors that influence the upstream determinants of health have more substantial roles in preventing the emergence of disease and causes of injury and in health promotion.

Health promotion is an integral part of the prevention effort, and focuses on harnessing the health-creating properties of the upstream determinants of population health, such as employment, education, transport, housing, and food security.

As an approach to public health action, it emphasises the intrinsic value of making it possible for citizens or communities to take control over these determinants, working alongside government and others to bring about improvements. It initiates broad-based policy development, community action and partnerships for action (WHO, 1986; Harper, 2008).

The Australian health system: Capable but reactive

Throughout the twentieth century in Australia and other modern societies, the health system bore the responsibility for all matters relating to health. However, its focus on the causes of and remedies for health problems has meant that personal, family, social and environmental factors shaping health problems have received much less emphasis, resulting in the growth of pharmacological and medical solutions to health problems.

The current Australian health system has generally focused on detecting, diagnosing and treating the health problems of people attending general practitioners, dental surgeries, primary health care centres and hospital emergency departments.

However, this emphasis on waiting for health problems to develop needs to be complemented by a system that is more preventive, proactive and life course in its focus.

To date, it is not surprising that prevention and health promotion have tended to operate at the margins of the health system and have, as a result, received much less emphasis than will be necessary for the health and wellbeing of all Australians in the future.

The expectation that Ministries of Health at federal and state/territory levels can single-handedly manage the protection and promotion of health and the prevention of disease and injury is clearly unrealistic, given the wide range of influences on health.

In one way or another, health is a key dimension of the far-reaching and well-recognised economic and social challenges facing Australia today; these include reducing social and economic disadvantage, tackling climate change, securing water supplies, increasing workforce participation and productivity, enabling equitable access to education and training, and delivering modern infrastructure to all Australians.

All areas of government and all sectors of society therefore need to have health on their strategic agendas and be involved in developing pro-health policies and action. Indeed, it may be argued that it is in their own interests to be as fully engaged as possible in acting to prevent illness, injury and disability.

But neither governments nor markets can deliver a national prevention agenda. What is needed are functional relationships among a range of existing and new players, including the ultimate beneficiaries of investments in health — the public.

Emerging health challenges for Australia: A mix of the familiar and the new

A number of well established trends will exert a very significant impact on the health and wellbeing of Australians and our health system over the next 10 to 20 years. These include:

- **Growing disparities between the health status and opportunities of population groups.** These already significantly affect Indigenous Australians and people living in remote and rural communities, recent immigrants, those on limited incomes, and people with low levels of education (Harper, 2008) (see Case Scenario 1).
- **The ageing of the population.** This will have significant implications for health services usage and labour force participation.
- **Increasing levels of disability, chronic illness and injury.** These will continue to increase and challenge health services, workplaces, communities and families.
- **Pandemics (such as influenza), biological threats, natural disasters and communicable diseases.** These will pose real potential risks to population health and will challenge our thinking about how to balance investments between staying prepared and responding to day-to-day demands for services.

The litany of emerging health challenges is sufficiently serious to hold our attention, but the "seeds" of many future health challenges are also evident, although it is not clear how they will interact to shape trends, conditions and events over the longer term.

We should heed the example of the Scandinavian countries and the Netherlands, who have already recognised that it is in their nations' long-term interests to anticipate and prepare for future novel, complex health challenges.

Public health problems are increasingly complex and the means of preventing them are not usually self-evident and not easy to resolve.

One thing is clear, however; to address them, governments and the health system will have to develop upstream policy interventions across sectoral boundaries and to forge common ground and commitment between governments, business and the population. To achieve this, new forms of leadership and "health diplomacy" will be needed.

Case Scenario 1: Disadvantage and poor health

Health inequalities are the differences in health status or in the distribution of health determinants between different population groups.

In Australian society today, the scale of unnecessary and avoidable health inequalities rates among the most significant health, social and political issues we face.

Trends indicate that the problem is not going to improve in the short term – as long as there is variation in exposure by unborn babies, children and adults to adverse material conditions and psychosocial risks, health inequalities will continue to mark the health landscape of Australia.

Statistics tell a convincing story about the need to prioritise action that reduces health inequalities.

- Compared with non-Indigenous Australians, Indigenous populations have a 17 to 20 year lower life expectancy and infant mortality is three times higher. They have higher rates of a number of communicable diseases (such as chlamydia, bacteriological intestinal disease, tuberculosis) and non-communicable diseases (such as diabetes, cardiovascular diseases, some cancers, dental diseases).
- People in lower socioeconomic groups have higher levels of many causes of preventable deaths, including heart disease, chronic obstructive pulmonary disease, diabetes, asthma and road traffic accidents. Oral health outcomes are almost four times worse for adults on low incomes, with 27.9 per cent having severe problems with teeth, mouth and dentures impacting on quality of life and health, compared with 7.5 per cent of high income adults with similar severity. Years of life lost due to premature mortality in the most disadvantaged quintile is 41 per cent higher for males and 26 per cent higher for females than in the least disadvantaged quintile.
- People in rural and regional areas of Australia have a higher prevalence of many chronic disease risk factors such as smoking (11 per cent higher) and excess weight (7 per cent higher). Correspondingly, they have higher death rates for coronary heart disease, chronic obstructive pulmonary disease, and diabetes.
- People living in the most disadvantaged areas of Australia have higher levels of smoking, physical inactivity and obesity; experience higher prevalence of diabetes, asthma, heart disease and arthritis; and have higher mortality across most chronic conditions.
- Refugee populations experience relatively poor health as a result of their exposure to extreme material deprivation, war and conflict, and human rights abuses in their countries of origin and/or their asylum experience. They have been shown to have higher levels of mental health problems, parasitic and communicable diseases, oral health problems, nutritional deficiencies, chronic illnesses and child developmental problems.

Explicitly addressing equity objectives that align with community values and expectations is a core dimension of prevention and health promotion. It obliges us to look at the 'causes of the causes' of health inequalities and adopt a whole-of-

government and whole-of-society approach as well as addressing them specifically in health system reform. At federal, state and local levels in Australia, a number of strategies have been developed for addressing health inequalities, though at this stage, they remain largely untested.

Australian Bureau of Statistics and Australian Institute of Health and Welfare, *The Health and Welfare of Australia's Aboriginal and Torres Strait Islander Peoples, 2005*, ABS cat. no. 4704.0, Commonwealth of Australia, Canberra, 2005.

Increasing momentum to improve health, prevent ill-health and disability and reduce health inequalities

The National Reform Agenda initiated by the Council of Australian Governments (COAG) in 2006 (COAG, 2006a) and the change of government at the federal level in 2007 have given prevention and health promotion a new momentum.

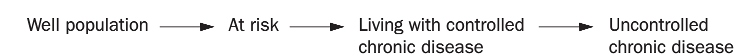
COAG aims to achieve economic growth through a human capital reform approach — that is, by increasing workforce participation and productivity.

The critical link between the health and well-being of the population, participation, and productivity and economic productivity is the prevention of chronic disease. Recognition of this link presents an invaluable opportunity for a future-oriented, whole-of-government approach to health.

COAG moved prevention and health onto the national agenda for the first time by launching the $500-million Australian Better Health Initiative (ABHI)(COAG, 2006b). It funds activities to improve health outcomes along the spectrum — from the well population to people with advanced chronic conditions (Figure 2). Priority areas for action are:

- Promoting healthy lifestyles
- Supporting early detection of risk factors and chronic disease
- Supporting lifestyle and risk modification
- Encouraging patients to manage their chronic conditions, and
- Improving communication and coordination between services (Lin, Glover, Silburn et al, 2007).

Figure 2: Australian Better Health Initiative: Conceptualisation of priority areas



Source: ABBHI Evaluation framework (2007)

Stating that his government will focus on the future and invest in the productive capacity of the economy, the newly elected Prime Minister, Mr Rudd, has asserted that (The Australian, 2007):

There are deep systemic questions concerning long-term funding and concerning the long-term delivery of health and hospital services in Australia, and this therefore must constitute agenda item one.

At its 2007 meeting COAG agreed to continue the National Reform Agenda, and identified seven important areas, including Health and Ageing, in its 2008 work program.

Prevention is a key plank of the health reform process, and a Preventative Health Care Partnership, with particular emphasis on children and Indigenous Australians, and a National Health and Hospitals Reform Commission (NHHRC) have recently been established.

The NHHRC will be responsible for advising on a framework for the next Australian Health Care Agreement and reporting on a long-term reform plan to improve the performance of the health system.

One of the NHHRC's major goals will be "providing a greater focus on prevention in the health system" (COAG, 2007c).

The health of Indigenous peoples will receive particular attention over the next five years. In his Sorry Day speech on 13 February 2008 (Rudd, 2008), the Prime Minister announced that his government will give reducing health inequalities between Indigenous and non-Indigenous Australians the highest political priority. A broad promise was made to introduce prevention and primary care initiatives in all Indigenous communities as a matter of urgency.

Overall, the new Commonwealth Government's interest in and support of preventive health care and COAG's continued reform efforts provide strong impetus to the broader national prevention agenda being pursued by AIHPS and VicHealth.

THE VALUE OF PREVENTION

The short- and long-term value of prevention and health promotion and the reasons for immediate action in Australia are not just economic in nature; it is also social, ethical and political. Prevention also:

- reduces the personal and community burden of disease, injury and disability among Australians;
- facilitates better use of finite health system resources;
- generates economic benefits as a result of investments in public health programs; and
- produces a healthier workforce, which in turn, boosts economic performance and productivity.

Benefits to society as a whole

Increasing life expectancy, ensuring that babies across all social and economic groups thrive, and enabling people to participate in the full range of opportunities and activities on offer throughout their lives are all benefits arising from national efforts to promote health and prevent disease.

Good health makes it possible for people to fulfil the myriad roles that make up a well-rounded life — as family members, parents, workers or members of community, sporting and other teams.

A well-functioning and sustainable society requires a healthy population. The destructiveness of unchecked disease and the potential for particular diseases to threaten social stability and economic productivity are exemplified by the widespread and deep social impacts of HIV/AIDS in African countries.

The persistent health inequalities between Indigenous and non-Indigenous Australians illustrate the need for the health of all people in a society to be of equal concern.

But health is not just an asset: it is a right. The 1948 WHO Constitution stated that (WHO, 1948):

The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without the distinction of race, religion, political belief, economic or social condition.

The UN Declaration of Human Rights outlines the civil, political, economic, social and cultural rights that many consider to be the foundation for health of individuals and the population: the right to life, liberty and security; the right to an education; the right to participate fully in cultural life; freedom from torture or cruel, inhumane treatment or punishment; and freedom of thought, conscience and religion.

Links between health and human rights elevate responsibility for health development from the health portfolio to the highest levels of government. Prevention of human rights violations, such as violence against women, abuse of children and neglect of people with chronic mental illnesses, are increasingly recognised as issues that require action across government portfolios and sectors.

Economic benefits through investments in public health programs

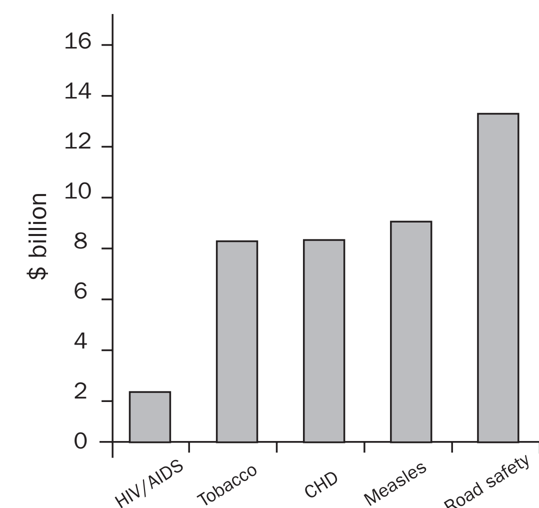
Recent studies have clearly indicated that investments in prevention generate substantial economic benefits to the community. The Organisation for Economic Cooperation and Development (OECD) concluded, in 2006, that:

An increased focus should be placed on preventive health measures to minimise future growth in health care costs and reduce long term fiscal pressures (OECD, 2006).

In Australia, the Department of Health and Ageing's study of five major public health programs — *Returns on Investment in Public Health. An Epidemiological and Economic Analysis* (also known as the Abelson Report)(Applied Economics, 2003) — conclusively demonstrated the substantial economic benefits to society of these public health programs and, importantly, that tobacco control and measles immunisation had generated savings for government.

Over the last 30 to 40 years, society has benefited by $8.4 billion from tobacco control programs that have enabled people to live longer, healthier lives and lowered health care costs; by $8.5 billion from coronary heart disease programs; by $9.1 billion from measles immunisation; by $13.4 billion from road safety programs; and by $2.5 billion from HIV/AIDS programs (Willcox, 2006).

Figure 3: Returns on investment in public health



Source: DoHA (2003). Returns on Investment in Public Health: An Epidemiological and Economic Analysis

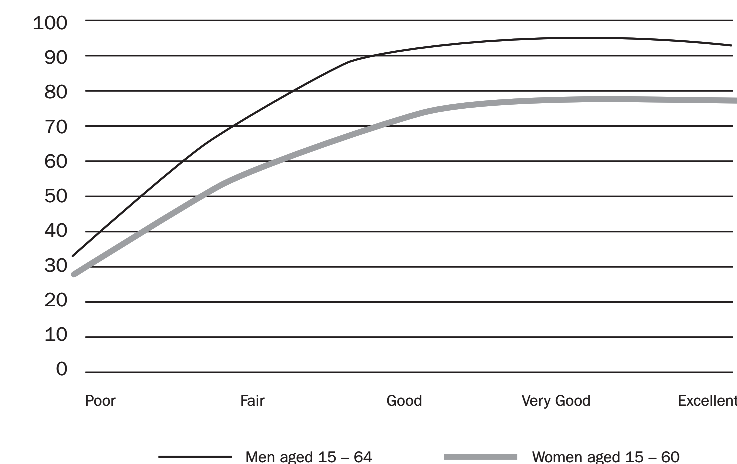
The benefits accruing to society from investing in public health programs are tangible but not immediate, as the Australian Institute of Health and Welfare's Burden of Disease report pointed out:

Australia is likely to benefit from further efforts towards expanding the range of effective prevention and treatment strategies for all causes of burden, while recognising that the returns for these efforts can take time to be realised.

A healthier workforce boosts economic performance and productivity

There is a strong link between health status and labour force participation, and Australia's economic performance and productivity are contingent on a motivated, skilled and healthy workforce. In Australia in 2004-05, 3.6 million days were lost from work through illness, injury or caring for someone who was unwell, which in turn reduced productivity (Willcox, 2006).

Figure 4: Labour force participation rate by health status



Source: Victorian Department of Premier and Cabinet (2005). A Third Wave of National Reform. A New National Reform Initiative for COAG.

Ageing of the population will also have a significant impact on labour force participation and economic productivity. Over the next four decades, the proportion of Australians aged over 65 is forecast to increase from 13.4 per cent in 2003-04 to more than 25.8 per cent in 2041-42 and will be accompanied by a decrease in the proportion of people of working age (15 to 64 years).

As shown by the Australian Bureau of Statistics, nearly one-third of Australians aged 50 to 59 years and a fifth of those aged 60 to 64 years who leave the workforce do so reportedly because of illness or disability, usually caused by one of the common chronic diseases or conditions.

The interdependence of health and economic performance was one of the driving forces behind the establishment by the World Health Organisation's Commission on Macroeconomics and Health. The Commission found that:

…countries with higher levels of health grow faster and, indeed, improvements in health may account for a significant fraction of the rapid economic growth of much of the world in the 20th century (WHO CMEH, 2001).

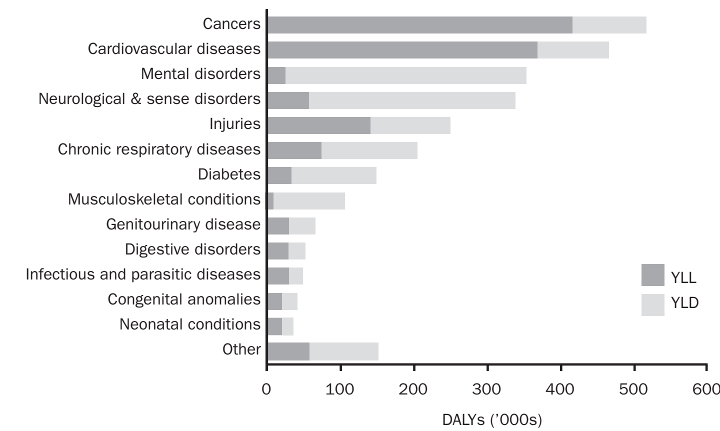
Reducing the personal and community burden of disease, injury and disability

About 1.28 million years of life were lost from premature mortality in 2003, and 1.4 million years of healthy life were lost from disability linked to non-fatal disease.

According to AIHW, approximately 70 per cent of the total burden of disease in Australia and almost 78 per cent of all deaths can be attributed to six disease groups — cancer, cardiovascular disease, mental disorders, injury, diabetes and asthma.

Accounting for an estimated 40 per cent of total health expenditure (Willcox, 2006; VicHealth, 2008), these disease groups have been targeted by Australian Health Ministers for special action under the National Health Priority Areas initiative.

Figure 5: Australian burden of disease, 2003



Source: S. Willcox: Purchasing Prevention: Making Every Cent Count

Note: YLL = Years of Life Lost; YLD = Years of Healthy Life Lost due to poor health or disability; DALY = Disability Adjusted Life Year

A proportion of each of these six health priority groups can be prevented, or their impact reduced, through more substantial investments in prevention and health promotion.

Prevention strategies can address the proximal risk factors common to a number of these conditions: smoking, nutrition, physical activity and alcohol consumption.

Health promotion can engage communities and the wider society in focusing on upstream determinants of these diseases or conditions, such as social and economic exclusion that result in poverty, stress, and lack of access to material resources for healthy living. The WHO Commission on the Social Determinants of Health refers to these factors as "the causes of the causes".

As well, health promotion can strengthen the factors that protect people from a number of these diseases or conditions, such as health literacy and social connectedness.

Ultimately, individuals, families and populations will benefit from avoiding, delaying and/or limiting disease, injury and disability; reducing the progression of disease and disability; and improving function and quality of life.

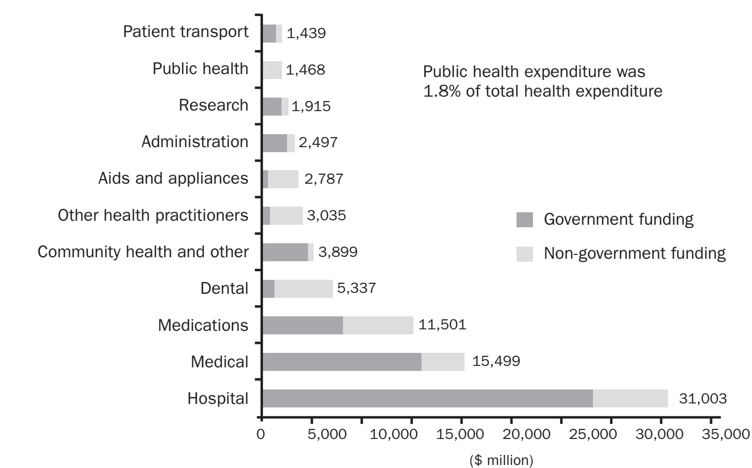
Better use of health system resources

In Australia, most of the health budget is spent on hospitals and associated resources such as medications, whereas significantly less is spent on community and public health.

According to the Australian Institute for Health and Welfare (AIHW), over $30 billion was spent on public and private hospitals in 2005-06, whereas a fraction of this amount was spent on community health programs.

Reducing the use of hospital services through prevention and health promotion initiatives would produce significant financial benefits, and the community would also benefit from a healthier citizenry.

Figure 6: Total health expenditure in Australia by areas of expenditure and source of funds 2005-06 ($million)



Source: AIHW (2008)

The AIHW estimated that a large number of hospitalisations — over 650,000 (considered to be ambulatory care sensitive conditions) across Australia, or about 9 per cent of all admissions — could have been prevented by timely and adequate health care outside hospitals.

Furthermore, poor management of chronic health conditions has the potential to increase hospitalisation and exacerbate workloads in hospitals and health services. For example, around 200,000 preventable hospital admissions were related to diabetes in 2004-05 (Willcox, 2006).

Primary care settings such as general practices and community health centres are well placed to deliver prevention, early intervention and health promotion programs at the local level. Intensive scaling-up of their role in these programs could reduce the use of highly specialised, expensive, tertiary resources.

Increasing emphasis on prevention will also benefit other parts of the health system, such as community pharmacies and community mental health services.

OVERVIEW OF OUR PERFORMANCE IN PREVENTION

Australia's performance in prevention has been mixed. It has been generally effective in areas where political and technical leadership have produced targeted, sustained efforts underpinned by adequate funding, workforce, evidence and program delivery structures, focus and commitment, investment in infrastructure and resources, bipartisan support, community engagement and action.

An analysis of our immunisation program reveals the factors that lead to success in public health action — bipartisan government commitment, well-articulated policy at all levels, adequate funding and resources for program delivery (such as vaccines, staff), monitoring of policy implementation (using a linked national register), and community support and action.

Other suitably notable successes have been achieved at both national and state levels across a range of areas:

- Populations have been well protected from communicable diseases and various environmental hazards such as food or water-borne diseases, and radiation.
- There have been major achievements from action on specific issues in maternal and child health, road safety, and screening and early detection of cardiovascular risk factors, some cancers and other health problems. These have been made possible through the combined efforts of health and non-health sectors.
- Many coordinated early intervention and health promotion initiatives associated with chronic diseases such as diabetes and cardiovascular diseases have operated through local-level providers such as general practitioners and have been successful in preventing the development of ill-health or disability or further deterioration in health.
- Local authorities have worked alongside state and federal governments to implement coordinated prevention programs in areas such as immunisation, and many have used urban planning responsibilities to protect health, for instance by minimising exposure to pollutants in air, water and soil.

On the other hand, past prevention policies and policy implementation approaches have not been as effective in other areas. For example, some population groups, particularly Indigenous Australians, have much poorer health status and life chances — and inequalities in health between other population groups are also increasing.

As well, the prevalence of chronic diseases such as diabetes, arthritis and asthma, which disproportionately affect older people, continues to increase.

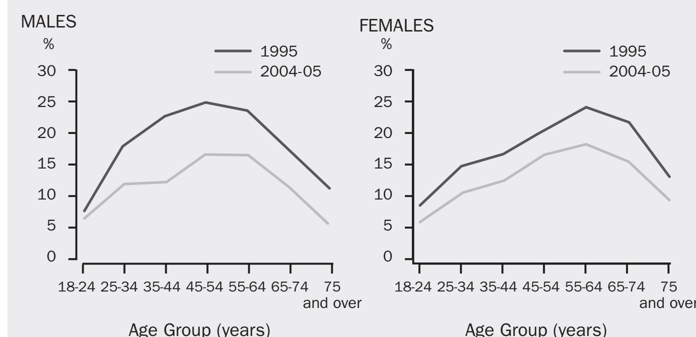
Levels of obesity and associated health problems among children and adults have been steadily increasing and show no sign of reversing (see Case Scenario 2).

Also on the increase are chronic mental disorders, particularly depression, anxiety and other stress-related disorders. As well, there has been a substantial growth in non-communicable diseases and injuries such as strokes, cancers, dental disease and neurological conditions.

Case Scenario 2: Obesity – A case for a multifaceted approach

With statistics portraying Australian children and adults as among some of the most overweight in the world, obesity has grabbed the attention of policy makers, the media, business, educators and the community. The issue is important for a number of reasons, but prominent among them is that overweight and obesity pose major risks to population health over the longer term by increasing the risk of chronic illnesses. Common health problems associated with overweight and obesity are musculoskeletal problems, cardiovascular disease, some cancers, sleep apnoea, type 2 diabetes and hypertension. Overweight and obese children face many of the same problems as adults and may be particularly sensitive to the effects on self-esteem. Taken together, the associated health problems exert substantial burdens on individuals, families and communities. The economic impact is felt by the wider society: it has been estimated that obesity cost Australian society and governments in the order of $21 billion in 2005.

The rate of overweight and obesity among Australian adults (over 18 years) has increased for both men and women across all age groups. In 2005, 7.4 million people aged 18 years and over (54 per cent of the adult population) were classified as overweight or obese, compared with 5.4 million adults, or 45 per cent of the adult population, in 1995.



Source: ABS 1995 & 2004 – 05 National Health Surveys

Overweight and obesity affect males and females of all ages and social groups. But as they are more prevalent among certain population groups, it is important that equity be considered when assessing strategies to reduce these conditions and sustain lower levels of prevalence. The ABS has produced this statistical snapshot of inequalities in relation to obesity.

Country of birth. In 2004–05, the overall adult obesity rate was 18 per cent. People born overseas who arrived before 1996 had a slightly lower age-standardised rate of obesity (15 per cent), while the rate was even lower (11 per cent) for more recent arrivals (between 1996 and 2005).

Education. Adults with a degree, diploma or higher qualifications were less likely to be obese than those with other or no post-school qualifications. In 2004–05, around one-fifth (21 per cent) of those without a non-school qualification, and 19 per cent of those with other non-school qualifications (trade certificates), were classified as obese. By comparison, 13 per cent of those with a degree/diploma or higher qualification were classified as obese.

Income. While equal proportions (53 per cent) of people in low-income and high-income households were overweight or obese in 2004–05, those in low-income households were more likely to be obese. Around one-fifth (21 per cent) of adults in low income households were obese compared with 15 per cent of adults in high income households.

Disadvantage. The Socio-Economic Indexes for Areas (SEIFA) Index of Disadvantage summarises various attributes such as the income and unemployment rate of an area in which a population lives. In 2004–05, adults living in

areas of greatest relative disadvantage had a higher age standardised rate of obesity (22 per cent) compared to adults living in areas with the lowest relative disadvantage (13 per cent).

Aside from socio-economic differences between areas in terms of education, income and employment, some areas may also offer greater opportunities for physical activity and greater access to healthy food options.

Remoteness. In 2004–05 the rate of obesity in outer regional/remote/very remote areas was 23 per cent, while in major cities and inner regional areas the rates were 17 per cent and 19 per cent respectively. The rate of overweight was similar across the remoteness areas (36 per cent in outer regional/remote/very remote areas), compared with 35 per cent in major cities.

The picture portrayed by this data is that simple interventions such as health education programs for groups at risk of becoming overweight or obese are unlikely to make a difference when the problem itself is so complex. Recognition of the links between overweight and obesity and the myriad factors contributing to the issue, particularly socioeconomic disadvantage, is fundamental to preparing strategic public health interventions that make a difference in the longer term.

Sources: Linacre, S. (2007) *Australian Bureau of Statistics. Australian Social Trends 2007. Overweight and Obesity.* Catalogue No. 4102.0. ABS: Canberra

Healthy Weight for Adults and Older Australians. A National Action Agenda to Address Overweight and Obesity in Adults and Older Australians. 2006-2010

Factors contributing to performance in prevention

An analysis of our performance in preventing health problems and enhancing health reveals some key targets for system reform.

No matter what population health issues are being addressed, three major aspects of the public health system reflect and contribute to government policy and investment decisions and influence the effectiveness of our responses (Lin, Smith and Fawkes, 2007):

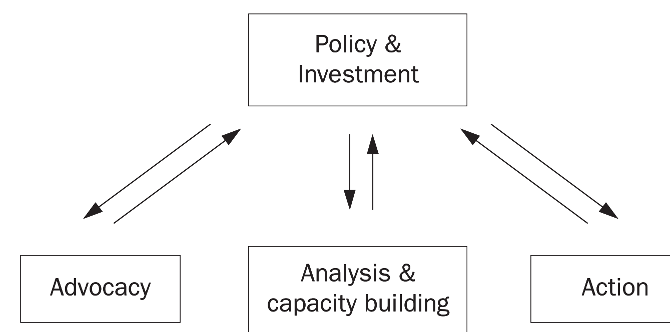
- Analysis and capacity building
- Advocacy
- Action

These “3A’s” influence the system’s overall ability to set priorities, goals and objectives, develop strategies and implement actions.

Underpinning the system’s ability to implement actions and achieve successful health outcomes is a framework that ensures accountability and measures performance through monitoring and evaluation, negotiated agreements, goals and targets and benchmarks. Government and others play key roles in this process by making decisions about policy and investment.

Significant threats to health such as HIV/AIDS or obesity have tested the resilience and adaptability of the public health system and have revealed both strengths and weaknesses in a number of the its basic functions.

Figure 7: A conceptual model of the public health system



Analysis and capacity building

As prevention and health promotion practices rely on sound knowledge and a skilled workforce, the analytical and capacity-building functions of prevention and health promotion must be adequately funded and carefully coordinated for action to be effective. Both health and non-health sectors have key roles to play in analysis and capacity building.

Universities are one of the foremost players in the research and analysis activities required for the production of knowledge. They also play the major role in skilling the workforce through undergraduate and postgraduate training programs, which are often run in partnership with institutions and community organisations.

The funders of prevention and health promotion research are also key players, with substantial influence over what receives attention and support. While government is a major funder, for example through the National Health and Medical Research

Council and the Australian Research Council, a variety of non-government organisations and philanthropic bodies also fund research.

Advocacy

Research, evidence and information are often not very strong drivers of health policy. Indeed, a wide range of stakeholders and others have considerable sway over the policy agenda through consistent, influential representation.

In the case of issues such as obesity and road trauma, stakeholders have ranged over groups of citizens, NGOs, professional and community groups, and business and industry lobbies. The Australian media have been visible players in health advocacy, mediating relationships between the community, government and other players.

Action

As effective action relies on a workforce with a mix of skills and the involvement of a diverse range of organisations, sectors and settings, prevention and health promotion need to involve people and organisations from outside the government-defined health care and public health systems.

In addition, there needs to be strong leadership, an articulated, agreed vision of what needs to be achieved, and sufficient resources and appropriate infrastructure for implementing and monitoring strategies.

Australia’s tobacco control strategies have shown how to achieve success. Smoking patterns in Australia have changed over recent years through the cooperation of community-based facilities, primary care and community health services, schools, workplaces, retail and recreational settings and media. Well-honed skills in public education, political advocacy, legislative reform and change management have been essential to the development and implementation of policy at all levels.

IMPROVING OUR PERFORMANCE

There is potential to strengthen our performance in prevention and health promotion, to benefit current and future generations, by applying leverage to the five key drivers shaping the performance of the system:

1. Leadership and coordination
2. Financing
3. Infrastructure and resources
4. Integration of evidence, policy and practice, and
5. Engagement of all levels of society.

1. Leadership & coordination

In Australia, a plethora of programs, services and activities have been developed over the last two decades to prevent particular forms of disease, injury or disability and to promote health.

Although a number of initiatives have led to measurable improvements in specific areas of health — tobacco control and road safety, for example — numerous others have struggled to achieve their objectives and make optimal use of resources because of failures in leadership and coordination.

Fragmentation, often reflecting historical relationships, has been evident between sectors, levels of government, disciplines and professional groups. It has thus proven difficult to establish and sustain the types of partnerships and working relationships needed in prevention and health promotion. One of the major enduring challenges is our federal system of government, legislated in the Constitution Act.

Without the strong leadership necessary to draw together and manage all the disparate elements of national, state and local initiatives, effective coordination and sustained effort have been difficult to achieve. To plan and implement programs and services as effectively and efficiently as possible, it is essential to **strengthen the leadership of the Australian Government.**

A key leadership challenge for strengthening prevention and health promotion is to **secure its political currency among policy makers and funders.** To date, it has had a relatively weak political voice and has attracted only ambivalent support from the public, particularly when compared with medical and pharmaceutical interests.

Numerous factors account for this situation. For example, the benefits to the public from investments in acute health services —such as relief from pain and suffering — are much more immediate and tangible than benefits from investments in prevention and health promotion. The benefits from prevention and health promotion may only arise over the longer term, making the links between interventions and effect less clear.

Political "champions" are needed to rectify the low public visibility and under-developed political support for prevention and health promotion and garner high-level commitments within the health sector and other sectors, including business.

A further leadership challenge is to develop a **critical mass of technical capability** for prevention and health promotion. At present, technical skills in this area are distributed widely — across universities, governments, health organisations, non-government organisations and community-based groups — and are not always brought together in sufficient quantity to resource and sustain national prevention and health promotion efforts.

Additionally, **technical leadership** is necessary to ensure that initiatives are grounded in evidence, are effectively implemented and evaluated, and are capable of demonstrating effectiveness.

Leadership will be required for the **successful implementation of the recently announced Australian Government initiatives** — the National Preventive Health Strategy, the National Preventive Health Care Partnership and the National Prevention Taskforce.

These are key planks in a broad platform to re-focus health priorities from treating disease, ill-health and injury onto promoting health and well-being, and represent not only a shift in the way we think about health in Australian society, but also about who is involved in the health enterprise.

Their success will depend, in large part, on the following: the availability of a clear vision of the types of structural changes and interventions required, high-level skills to engage and influence a wide variety of actors and to design programs, and managerial ingenuity to overcome the tensions and potential for fragmentation inherent in federalism.

Given the importance of change management in developing a national system for prevention and health promotion, there is scope in Australia to run **nationally coordinated leadership development programs** using models typified in public health leadership development.

These would need to draw on the best available evidence of how people from very different backgrounds can be brought together and trained in the interests of a common agenda, one that may not be familiar to all participants.

Models for this type of diverse development program are the Williamson Community Leadership program in Victoria and the rural leadership programs run by the Australian Government Rural Industries Research and Development Corporation.

Complementary innovations may be required. For instance, training will be needed for people within and outside the health sector to give them the skills to lead prevention and health promotion.

New institutional arrangements could help bring together the high-level technical skills, expertise and evidence required for prevention and health promotion while addressing fragmentation and weaknesses in coordination.

International models exist: Centres for Disease Control in the USA with a centralised organisation providing a coordinating capability, for example, and the Public Health Agency of Canada, which uses a "distributed" leadership model with regional representation in all provinces and territories.

2. Financing

Fundamental to all efforts to strengthen prevention and health promotion in Australia is the issue of financing.

It requires intense examination and our best thinking. Getting the financing issue right has important ramifications for achieving the objectives of prevention and health promotion.

Some of the key issues are:

- **Inadequate funding.** Funding is inadequate across the range of system requirements such as research and development including intervention studies, funding to scale-up successful pilot and locally-developed programs, and sustainable infrastructure and resources.

- **Compartmentalisation.** Financing arrangements are compartmentalised between and within governments, which gives rise to a lack of coordination, inability to move funds between programs, and separate accountability processes and performance incentives. Examples include maternal and child health, community health, hospitals' post-acute care programs and home-based services.
- **Short-term thinking**. Financing of programs is often short-term, driven by the imperatives of electoral cycles, and this prevents them from achieving sufficient reach, coverage and continuity to enable population-level health benefits. This approach also leads to ad hoc and opportunistic, rather than planned, responses by organisations.

A number of **innovative approaches** to generating more funding have been introduced in recent years. While in the past there has been a reliance on governments to fund prevention — the "common good" argument — other ideas have been emerging. For instance, the Transport Accident Commission in Victoria has provided significant funding for the prevention of road trauma and the promotion of road safety by joining with VicRoads, commercial, university and other partners.

Specific financing options to boost investment in illness prevention and health promotion may include reallocating public funding over time from existing sources to health promotion ("creeping commitment"); deriving new sources of funding from taxes or surcharges applied to products associated with community harm (tobacco, alcohol and some foods); and creating links between investment in health promotion and the problem it intends to address — e.g., expenditure for prevention and health promotion set at 10 per cent of the cost of preventable chronic disease to the health care system.

Other financing possibilities have been suggested, such as the broad-banding of several programs, mainstreaming prevention within clinical services, providing bonuses and incentives to achieve specific targets, and pooling resources across traditional budgetary boundaries.

Bearing in mind that financing can come from the demand as well as the supply side, taxing individuals could be part of the overall mix of strategies, although it raises ideological opposition in some quarters. Price signalling is known to affect consumption patterns; for example, rises in the cost of tobacco and alcohol have been shown to lower consumption.

Private insurance companies could manipulate incentives/disincentives in their schemes to encourage consumers to better manage their health.

One of the critical issues for developing a balanced system is the availability of **thorough economic evaluation** of investments in alternative interventions. As shown in the Wanless review in the UK, adequate investment is needed to produce such analyses in order to justify where to invest for health gain.

To secure adequate and sustainable financing for prevention and health promotion, **a new entity** could be established to evaluate evidence about financing and propose mechanisms on a sustainable basis. Other financing models could be examined — the Pharmaceutical Benefits Advisory Committee, the Medical Services Advisory Committee and the United Kingdom's National Institute for Clinical Excellence, for example.

Such an entity could collaborate with and work on recommendations emerging from the National Preventive Programs Taskforce, particularly in areas relating to financing and economic justifications for making choices between investment options.

3. Infrastructure & resources

Dedicated and sustainable infrastructure and resources are the essential building blocks of effective prevention and health promotion. Indeed, weaknesses in these fundamentals, rather than poor design, have caused many programs to fail.

Infrastructure and resources include workforce, institutions and organisations that carry out a range of functions, and information and knowledge management systems.

While many of the key elements are already in place in Australia, investment is necessary to improve system performance.

An appropriately trained and motivated workforce is one of the key building blocks of a system for prevention and health promotion (see Case Scenario 3). Without it, implementing the Agenda will fail or move ahead only in a stop-start fashion. Moreover, if not developed on an ongoing basis, the workforce will fail to grow its skill base and expertise.

At present, the character of the prevention workforce varies across states/territories as a result of the different contexts, histories and demography. This is one of the realities with which workforce development initiatives must continually contend.

Case Scenario 3: A workforce fit for prevention & health promotion in the 21st century

In broad terms, there are three main workforce groupings relevant to prevention and health promotion:

- People whose primary job concerns prevention
- People working in the health care system, and
- People working in other sectors.

Weaknesses and gaps in each of these three areas have given rise to fragmentation, ineffectiveness and inefficiency. One of the hallmarks of an effective and efficient system will be a flexible and adaptive workforce; that is, one that is equipped to operate in different environments and work across different issues, and that is capable of coping with change and operating in a complex institutional and professional environment.

Capacity-building initiatives, together with the existing and emerging workforce for prevention and health promotion, offer a good foundation on which to build further schemes. The program with most direct relevance to population health is the national Public Health Education and Research Program (PHERP), through which the Masters of Public Health (MPH) degrees are resourced via universities in each state.

MPH programs offer training in core public health competencies, and have brought together professionals from a mix of backgrounds such as primary health care, environmental health, hospitals, legal services and architecture.

Public health training is also available through Vocational Education and Training and in the undergraduate sectors. Professional development, where it exists, tends to be occasional rather than continual.

There is scope to introduce **a national public health training scheme,** building on the experiences of a number of jurisdictions using different approaches as well as the inputs of the range of professional groups that have completed training.

Professional education programs on priority issues also offer potential pathways to strengthening the skill base of people working on prevention and health promotion initiatives.

As well as developing and deploying a skilled workforce, **well-conceived structural change** is essential. Although the new Strategy, Partnership and Taskforce initiatives in prevention have been announced, it is not clear what the new organisational arrangements will be. There may be a need for new institutions to stimulate change from within the existing system and to target areas where programs have failed in the past.

The field of **information and knowledge management** is ripe for development, with some significant gaps needing to be filled. Data collection has been relatively good over many years, especially in hospitals, but some important measures are needed to tailor it to prevention and health promotion.

Changes to surveillance systems is one example. For decades, Australia's surveillance systems have been critical to providing information about the health of the population. They have served the nation well, especially in regard to communicable disease outbreaks, but surveillance may need to be reconfigured to better serve the goals of prevention and health promotion. Moreover, the system could also gather "strategic intelligence" and lessons from the field.

The **introduction of population health observatories** could strengthen its ability to identify patterns, networks and adaptive behaviour, and go beyond traditional models of disease surveillance. They could function as a form of "natural experiment" and provide information that would not otherwise be accessible.

Observatories have been used in the UK and Canada to learn about interventions and apply their lessons, sometimes in highly specialised, neglected or priority fields such as health impact assessments, obesity, social exclusion, chronic diseases and policy.

Because the system needs to be future-aware — that is, capable of anticipating problems and identifying emerging threats to and opportunities for health development — observatories could also carry out more substantial strategic surveillance. They could look for weak signals of change in social, technological, economic, environmental and political domains that may be looming at the outer edges, signals that may be missed through more traditional horizon scanning activities.

Another innovation is **an institution or organisation that strengthens mechanisms for coordinating policies, programs, services and research.** Its perspective and work priorities would call on a systems perspective, and ensure that research or programs created links between key players and programs rather than silos. It could bring together, in novel ways if required, the technical expertise necessary for prevention and health promotion and generate new trans-disciplinary fields of knowledge, expertise and research that might better reflect the complexity of present and emerging health issues.

Given the impact of the tyranny of distance in Australia for professionals and others working in rural and remote areas, the entity could facilitate widespread access to knowledge and advice at the global cutting edge of knowledge.

4. Evidence, policy & practice

At the heart of policy is the availability of high-quality, strategic, applicable and timely information and evidence that is relevant to the context and enables choices to be made between alternatives.

However, the enduring chasm between evidence, policy and practice has been the subject of much international debate and research in recent years. In Australia, there have been many calls for knowledge generated through practice to be captured in evidence, and for evidence to be translated into policy and applied more systematically to practice.

Research in Australia has played a pivotal role in expanding our knowledge and understanding of issues by identifying problems and proposing approaches to address them.

Research projects with major implications for preventive practice, for example into cardiovascular, communicable and chronic diseases, have attracted significant funding in the last two decades, but this research has tended to have a biomedical orientation (disease processes and pharmaceuticals). Public health research into prevention and health promotion and health systems research have traditionally been weaker cousins to biomedical research.

One strategy would be to **tap into the community health sector.** A potentially rich field for research, it has been largely unrecognised and unsupported in Australia. Building in the systematic practice of reflection and research at the local level has the potential to produce a substantial array of insights into what works and conditions for implementation failure and success, while contributing to the evidence base for preventive and health promotion practice. This would benefit the whole system by improving effectiveness.

But an emphasis on local-level research is not enough, to generate structural change; **feedback loops would also have to be established** between the national and local levels in order to harmonise practice and policy.

For prevention and health promotion to be effective in Australia, not only is a larger investment in public health research required, but it is also essential that practice, policy and research be fully integrated and research efforts across shared priorities be well coordinated.

The concept of "knowledge brokerage" and the model of "policy entrepreneurs" may be effective means of linking evidence, policy and practice; of encouraging partnerships between researchers and policymakers; of developing a shared understanding of each other's culture, perspectives and priorities; and of facilitating effective communication.

At the national level, a **National Preventive Programs Advisory Committee** could be established to generate the evidence needed for prevention and health promotion initiatives.

This could be modelled on the roles and functions of the United States' Preventive Services Taskforce (AHRQ, 2008) and Taskforce on Community

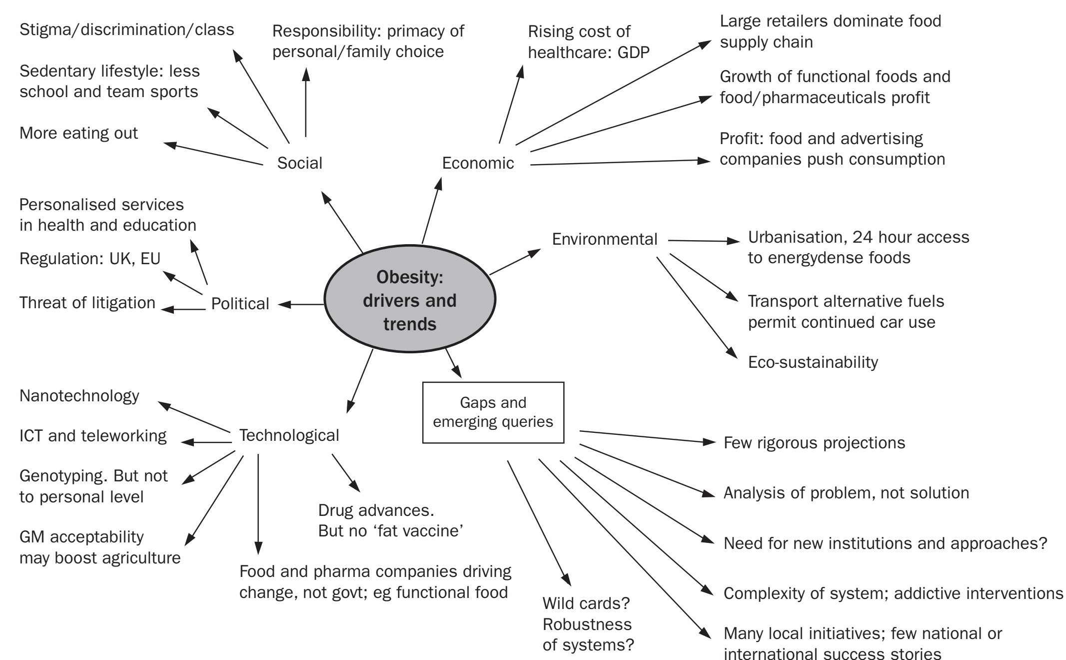
Case Scenario 4: Obesity – the result of past policies

The determinants of overweight and obesity in our society can be found in the past policies and practices of a diverse range of sectors. Lang and Rayner point to:

the rise of car culture and other advances marginalising daily physical activity; widening distances between homes and work or shops; the over consumption of food accompanied by its unprecedented, plentiful availability; the culture of clever and constant advertising flattering choice; the shift from meal-time eating to permanent grazing; the replacement of water by sugary soft drinks; the rising influence of large commercial concerns framing what is available and what sells.

Foresight research undertaken in the United Kingdom identified drivers of overweight and obesity in that country (Figure 8). The diagram shows the wide range of forces, most of which are outside the control of individuals and families, that interact to shape patterns of overweight and obesity. Implicit in the diagram is the message that taking action on overweight and obesity at a population level demands strong leadership and the intelligent coordination of myriad efforts across public and private policy spheres over the long term.

Figure 8: Obesity: Trends & drivers in the UK



Source: Trends and drivers of obesity: A literature review for the Foresight project on obesity.

Solutions to the problem must ensure that actions do not exacerbate health inequalities and that a variety of sectors play their part in addressing the problem. As Zimmet and Jennings (2008) assert:

Our path to eliminating obesity is clear, albeit challenging, and involves strong leadership by our politicians, and partnerships involving government departments of health, sport, education, agriculture, urban planning and transport, the pharmaceutical industry, the media and the food industry.

The media play a potent role in framing public debates about causes and solutions. To date, however, the news media have tended to frame obesity as gluttony and sloth, which places responsibility in the hands of affected individuals rather than as an environmental, cultural and political problem that needs to be addressed as structural levels. Social marketing campaigns may be needed to alter the representation of the issue.

This case highlights what we need to do to address complex health issues with multiple determinants — namely, adopt a prevention and health promotion approach that engages all levels of society.

Source: P. Zimmet & G. Jennings, "Curbing the obesity epidemic." The Age, 22 February 2008

Preventive Services (CDC, 2008) and the United Kingdom's National Institute for Health and Clinical Excellence (NICE, 2008).

It could have a technical role, with responsibility for evaluating evidence and developing best practice guidelines, and could ensure that efficiency and equity issues were given due consideration.

Such an Advisory Committee would be independent of government and have the necessary authority and transparency to operate effectively. It would need to represent a diverse range of perspectives and interests, such as government, non-government organisations, research institutions, industry, professional organisations and the public.

5. Engagement of all levels of society

In recent years, complex population health issues have revealed the necessity for all levels of society engage in developing an understanding patterns and determinants of health problems and to work out roles and responsibilities in addressing them.

Obesity is such a problem. Its determinants can be found in the past policies and practices of a number of diverse sectors, from trade to urban and regional/rural development. Within this context, the health system has a key leadership role in mediating among different interests and advocating for policy directions that support better health.

The problem of obesity also shows how we might change the way we think about preventing disease and enhancing health (see Case Scenario 4).

Government leadership and resolve are vital underpinnings of efforts to engage a kaleidoscope of actors with diverse technical skills and social influence. It is also essential for involving them in sustained, coordinated action that spans cross-sectoral policies, and for the development of environments supporting health, community ownership of action, skill enhancement and prevention-oriented health care.

The entrenched view that prevention and health promotion is the domain of governments, particularly the Ministry of Health, needs to be countered if various sectors are to be acknowledged as central actors in the prevention agenda.

The public's trust is a particularly important asset. Trust must also be developed between the different levels and players to avoid the breakdown of communication and the emergence of counter-productive actions. There also needs to be trust in the ways issues are framed and addressed, especially when local-level action is necessary or leadership needs to shift from government to non-government sectors.

It should be possible to empower and educate communities by using social engagement strategies that involve key players, citizens and communities.

These should aim at making a tangible difference to decision-making around prevention and health promotion.

There are a number of examples of how broader interests such as business, citizens and communities can be brought into the discussion, decision-making and action at different levels. These include: advisory committees for health services research and development; the committee supporting the development of the Health Regulations Act; strategies to equip consumers to take their place at the table in research; policy and programs such as those initiated by Breast Cancer Network Australia; engagement mechanisms that brings sectors together in high-level discussions such

as the Business-Higher Education Roundtable, which is concerned with workforce, education, training, research and social enterprise; and citizens juries.

While specific examples of social engagement strategies such as these appear to work well, other approaches often lack authenticity, are implemented in a piecemeal fashion, are poorly resourced and are not fully enough embedded in other organisational processes to ensure they make a real difference.

In reorienting the national policy agenda to prevention and health promotion, it is essential that a strong, influential constituency be developed across society to mobilise commitment to, ongoing support for, and active participation in prevention and health promotion.

How such a constituency should be built is problematic, however, because it is not identifiable individuals who are perceived to benefit from prevention but rather a "faceless" public. This lack of a recognisable beneficiary poses challenges for mobilising and sustaining support for political decision-making favouring prevention.

Representing population group interests is intractably difficult, but tracking public opinion on prevention and health promotion may be a way to integrate the public voice into policy making and the development of initiatives.

A constituency for championing change and mobilising action also needs to be created. It should include different interests and disciplines, different levels in the prevention enterprise and health care services, and players in the health system in leadership and advocacy roles. Other sectors of society which could be mobilised include:

Government: commonwealth, state/territory and local	Community: individuals, families, workplaces, wider community
Non-government organisations and peak organisations	Academic Institutions
Business, including media	Professional associations

A VISION FOR PREVENTION IN AUSTRALIA

If all Australians are to enjoy better health throughout their lives, from the early years right through to the older years, then the values and structures shaping Australian society — and the health system — need careful recasting.

At the heart of change is the need to value health and equity as a core social and economic asset and to elevate prevention and health promotion to the level of national policy priorities.

Modern structures need to be designed to support coordinated prevention and health promotion and enable population health goals to be achieved.

When good intentions give way to action, we will see unequivocal political will on the part of the Australian Government and its state and local counterparts driving prevention and health promotion, and societal institutions, communities and the business sector playing their part in implementing effective polices and programs.

The health system also needs to be transformed from a reactive system focusing on treating illness into a system geared to promoting health. Just like the practice of prevention, health promotion or medicine, the process of organisational and system reform will need to draw on the best available evidence and the engagement of stakeholders, it if is to succeed.

The system will also need the resilience to respond to new challenges.

The need for resilience

Deliberately building the resilience of a health system — by developing its function, structure and feedback mechanisms — is an important objective linked to securing Australia's resilience as a nation.

As biological and social systems both illustrate, resilience is what enables a system to respond effectively to change and produce novel responses to stressful conditions.

Over the last two decades, issues such as HIV/AIDS, mental health and obesity have tested the resilience of Australia's health system, exposing strengths and weaknesses in our health care arrangements, as well as in our political, social and economic systems.

Into the future, health inequalities and complex health issues such as those identified in burden of disease studies (e.g. cancers, trauma, chronic diseases) will challenge the health system's ability to detect and react to the multiple drivers and underlying determinants of these issues.

Getting a fix on the means of developing resilience is not a simple task, but efforts are underway across a variety of sectors.

For instance, Australia 21's 2007 roundtable on resilience (Australia 21, 2007) identified numerous trends and processes that will increase our capacity to deal constructively with future challenges including those related to health.

They nominated the increasing role of women in decision making; rapid sharing of information; a strong convergence of thinking on resilience across many sectors and disciplines, which provides an opportunity for cross-sector collaboration; increasing sophistication in using markets as tools to achieve change; advances in defining and measuring human wellbeing; and, perhaps surprisingly, the ageing of the population, which some see as a positive force for change.

Identifying the qualities that constitute resilience may help us secure them. For example, some of the

assets that allowed us to respond successfully to international health crises such as SARS would help build the resilience of an Australian system to both slow- and fast-developing problems.

Some of these are: techniques for effectively anticipating and identifying problems through new models of monitoring and surveillance; strategies for rapidly re-organising structures, functions and resources; methods for training and mobilising skilled workers as required; and a capability to harness commitment and participation among a diverse range of actors.

In a recent analysis, Professor Glyn Davis (Davis, 2008) observed that the Australian higher education system would need two crucial attributes in order to endure.

First, it would need a mechanism to "respond to changed circumstances", such as "an intermediary body between institutions and the government to monitor key indicators, report on their implications, and recommend any necessary action." Secondly, it would require a change to financing arrangements to give universities more power to raise their own revenues.

Applying these ideas to health, one could argue that a stable but flexible system would require new institutional structures and mechanisms to facilitate timely actions, efficient use of resources and local innovation.

A number of obstacles stand in the way of developing a flexible, resilient system for health: federalism, confusion about what constitutes public health, modes of financing, gaps in leadership of complex systems, an insufficient workforce (numbers/ skills), and social expectations of the role of the health system in prevention and health promotion, to name a few.

Goals of a prevention agenda

The two basic goals of an agenda for prevention should be:

1. To create a system for health that enables prevention and health promotion strategies to operate effectively and sustainably across sectors and at multiple levels of society.

2. To enable the health care system to play its role in prevention and health promotion by ensuring that it is driven by these important, inter-connected principles:

- It is person-centred, equitable, efficient, high quality and acceptable
- It is accessible and affordable for all Australians
- It is well coordinated and integrated, and
- It places the care of individuals and the community at the centre of all its decisions and activities.

Achieving these goals will require the adoption of a serious, long-term systems perspective in planning, evaluation and research.

In fulfilling its responsibilities, government (federal, state and local) will also need to work towards a whole-of-government approach to prevention and health promotion. Remedies for discrete parts of the system will ultimately prove insufficient and possibly a waste of resources if they are not part of a whole-systems development strategy.

This paper has identified five important levers with significant potential to shift the system's focus to prevention and health promotion. They are framed with an explicit concern for anticipating and meeting future health and other challenges. The fundamental basis for the development of prevention and health promotion is the commitment and engagement of all levels of society.

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Appendix

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Dr David Hill	Director	The Cancer Council (Victoria)
Mr Jim Hyde	Director	Public Health, Department of Human Services (Victoria)
Mr Mitch Messer	Chair	AIHPS & Consumers Health Forum of Australia
Mr Tony Pensabene	Associate Director	Economics & Research, Australian Industry Group (Melbourne)
Ms Prue Power	Executive Director & Board Member	Australian Healthcare and Hospitals Association (AHHA) & Australian Health Care Reform Alliance (AHCRA)
Dr Lyn Roberts	Chief Executive Officer	National Heart Foundation (Australia)
Professor George Rubin	President & Director	Australian Faculty of Public Health Medicine & Centre for Health Services and Workforce Research
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Professor Richard Southby	Executive Emeritus Dean	George Washington University Medical Center
Mr John Walsh	Senior Partner	PriceWaterhouse Coopers (Australia)

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