Victorian Public Health and Wellbeing Plan 2011–2015

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Strengthen the prevention system

Keep people well

Priority settings for action and engagement

Healthy people, resilient communities

Strengthen preventive healthcare

Continue to protect the health of Victorians

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Foreword

Health is important – to each of us as individuals, to our families and to the Victorian community. Good health also contributes to workforce productivity and participation, and a strong economy.

To be as healthy as we can be, we need a strong focus on prevention. We need to ensure Victorians are better informed about healthier lifestyles, and that programs and services are available to assist individuals and families to take the steps they need to take to stay well.

It is not the role of government to tell people what to do to follow a healthy lifestyle – people themselves have to take that responsibility – but governments can and do work hand in hand with the community to encourage healthy habits.

We are proud of Victoria's history of innovative and effective initiatives to prevent disease and promote health. We also recognise there are preventable health problems, and that future challenges demand our attention and preparation.

The government is seeking to position Victoria as a world leader in prevention. An effective prevention system, along with a strong and responsive healthcare system, can help reduce the growing burden of chronic disease and injury we are now facing, and support people to enjoy a greater sense of wellbeing.

The long-term planning and development priorities for Victoria's health system are articulated in the *Victorian Health Priorities Framework 2012–2022*. Consistent with the *Public Health and Wellbeing Act 2008*, the framework states that the government will produce the *Victorian Public Health and Wellbeing Plan 2011–2015* – a prevention strategy that is cross-government and cross-sector.

This first *Victorian Public Health and Wellbeing Plan* articulates the core elements of an approach to prevention that will help build on current strengths, and, at the same time, provide a solid

foundation to meet the challenges of the future. The aim is to achieve lasting improvements in the health of all Victorians, with a particular emphasis on the needs of those who are worse off and experiencing poorer health than others in our community.

Drawing on recommendations of the World Health Organization, the plan envisages building a Victoria-wide prevention system complementary to the healthcare system that will be more effective, better coordinated, more responsive and sustainable over the longer term.

It is clear from the evidence, and stated in the Public Health and Wellbeing Act, that partnership approaches are central to contributing to the prevention of illness and disability. Building on partnership work is a major focus of this plan. Victoria has had success in encouraging organisations to work together to coordinate prevention and health promotion efforts around the needs of local communities. Through partnerships, many organisations and programs are planning and integrating prevention and health promotion programs together.

The Act delineates the roles and responsibilities of local and state government and aligns municipal planning for public health and wellbeing with state planning. As well as local government a wide range of agencies and organisations in the non-government, voluntary, and private sectors play a role in public health. It is therefore important that this plan puts a significant emphasis on partnerships. Improving health really is everybody's business.

The development of the plan has been informed by extensive reviews of the latest evidence, and by consultations with a range of experts and representatives from the sector. In addition, the feedback we have received on the *Victorian Health Priorities Framework 2012–2022* has reinforced the view that the sector has a strong commitment to prevention and health promotion as a fundamental component of our health system.

A centrepiece of the plan is community engagement. This is to ensure the prevention programs and services provided by government are responsive to the needs and concerns of local communities, and that differences between areas are acknowledged and respected.

Your responses to this plan will be an important step in the development of a progressive and responsive prevention strategy. I encourage you to provide feedback so we can best shape the future of prevention in Victoria together. Your comments, ideas and suggestions will help inform the implementation of the government's vision for our state's preventive health system.

The Hon David Davis MP
Minister for Health

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Overview

This first *Victorian Public Health and Wellbeing Plan 2011–2015* (the plan) has been developed to meet the requirement under the *Public Health and Wellbeing Act 2008* (the Act) that a plan to identify public health priorities for the state be developed every four years.

For the first time in Victoria, the plan provides an opportunity to take a comprehensive and high-level view of the scope of preventive health activity undertaken in this state. In doing so, it illustrates that prevention is really everybody's business, and that effective approaches to promoting and maintaining health and wellbeing, require far more than the services provided by the healthcare sector, important as these are. The plan identifies contributions across, and by, all levels of government, by the private and voluntary sectors, by communities, families, individuals and others.

By taking a whole-of-government, whole-of-system, and whole-of-life approach, the plan provides the basis for resources to be used more efficiently, and for improved outcomes for individuals, the healthcare system, and the wider economy and society.

The plan is intended to be a companion document to *Victorian Health Priorities Framework 2012–2022* (the framework).

This plan, as required under section 49 of the Act, has been developed to:

a. identify the public health and wellbeing needs of the people of the State;
b. include an examination of data relating to health status and health determinants within the State;

c. establish objectives and policy priorities for:
    i.   the promotion and protection of public health and wellbeing in the State
    ii. the development and delivery of public health interventions in the State.
d. identify how to achieve the objectives and policy priorities referred to in paragraph (c) based on available evidence;
e. specify how the State is to work together with other bodies undertaking public health initiatives, policies and programs to achieve the objectives and policy priorities referred to in paragraph (c).

The plan's goal, derived both from the Act and from the framework, is:

> *to improve the health and wellbeing of all Victorians by engaging communities in prevention, and by strengthening systems for health protection, health promotion and preventive healthcare across all sectors and levels of government.*

The Act identifies the principles of the primacy of prevention, collaboration and evidence-based decision making as key to future directions in public health and wellbeing. In particular, the principle of collaboration asserts that public health and wellbeing can be enhanced through collaboration between all levels of government and industry, business, communities and individuals.

The plan is structured in three main parts.

Part I identifies the health and wellbeing needs of the people of the state and includes an examination of data relating to health status and health determinants within the state. The positive and negative trends that are likely to have health implications are outlined. While some gains are noted (for example, in the reduction in the number of Victorians smoking), a number of adverse trends in lifestyle-related behaviours and risk factors are also reported. Unless addressed, these adverse trends are expected to add to Victoria's growing burden of chronic disease. This section also explores broader social and environmental trends, including the increasingly sedentary nature of many jobs, the ageing of the population, developments in technology, and the rise of environmental risks and challenges.

Part I also describes the important role played by the many different participants in the prevention sector.

Part II establishes objectives and policy priorities for the promotion, protection and delivery of public health in Victoria, and identifies how partners within the state will work together to achieve those objectives based on the available evidence. Nine strategic directions for prevention in Victoria to 2015 are identified. Listed below, these are drawn from two broad, interrelated areas of reform and action: systems and settings, and interventions in established public health practice – that is, health protection, health promotion and preventive healthcare.

– Build prevention infrastructure to support evidence-based policy and practice.

– Develop leadership and strengthen partnerships to maximise prevention efforts across sectors.

– Review financing and priority-setting mechanisms to ensure available resources are based on population need and potential for impact.

– Develop effective modes of engagement and delivery of evidence-based interventions in key settings.

– Strengthen local government capacity to develop and implement public health and wellbeing plans.

– Improve health service capacity to promote health and wellbeing.

– Integrate statewide policy and planning to strengthen public health and wellbeing interventions.

– Increase the health literacy of all Victorians and support people to better manage their own health.

– Tailor interventions for priority populations to reduce disparities in health outcomes.

Part II outlines opportunities for progress to be taken over the next four years that will help bring the strategic directions to life. In each case, the strengths of existing arrangements are recognised, as are the major successes in protection and prevention that have served Victoria well to date. The aim of the plan is to build on and strengthen these. However, it is also designed to address those areas where it is well established that gaps exist or improvements are needed.

Two broad interrelated areas (systems and settings, and interventions) are proposed as focal points for reform and action to 2015.

Systems and settings
How – strengthening the prevention system

This section of the plan proposes that preventive health requires a system through which interventions can be sustained, coordinated and effectively supported, in the same way that healthcare requires a comprehensive and integrated system to manage illness. The system must encompass:

– governance and leadership
– information systems
– financing and resource allocation
– partnerships
– workforce development.

Where – priority settings for action and engagement

It is well established that, to be effective, strategies to improve health require the support and engagement of those affected. This is often best achieved in the settings where people live, learn, work and play, or seek healthcare for themselves or their families. This section of the plan proposes four priority settings as a major focus for action over the life of the plan:

— **local communities** – building on the strong tradition of community participation in Victoria, with a major focus on the role of local councils in municipal public health and wellbeing planning, as well as the Prevention Community Model developed under the Council of Australian Governments (COAG) National Partnership Agreement on Preventive Health (NPAPH)

— **workplaces** – building on investment to date in workplace health promotion, and the contribution of agencies such as VicHealth, and programs such as WorkHealth and the NPAPH Healthy Workers Initiative

— **early childhood and education settings** – building on the recommendations of the parliamentary inquiry into the potential for schools to become a focus for promoting healthy community living, and new initiatives under the NPAPH Healthy Children Initiative

— **health services** – building on Victoria's strong community health system; increasing opportunities for health promotion across the continuum of care; and the wider contribution of health services beyond direct service delivery such as through health promoting hospital initiatives.

Interventions
What – interventions in established public health practice

This section provides details of the opportunities for progress in improving health and wellbeing across the traditional domains of public health: health protection, health promotion and preventive healthcare, and sets out opportunities for progress for each issue:

— **continue to protect the health of Victorians** (health protection) – including environmental health and communicable disease control

— **keep people well** (health promotion and primary prevention) – focusing on lifestyle-related risk factors such as smoking, diet and physical activity

— **strengthen preventive healthcare** – including cancer screening, newborn screening, and early detection and intervention.

Taken together, these areas of reform and action aim to ensure that appropriate health improvement opportunities, underpinned by evidence of effectiveness, are provided at all stages of the life course: from the early years of life, through childhood and adolescence, adulthood, and into older age. There will also be a strong emphasis on the needs of higher risk and vulnerable population groups.

Part III briefly outlines monitoring and review arrangements for the plan.

The overall structure of the plan is provided in Figure 1.

Figure 1: Structural outline of the *Victorian Public Health and Wellbeing Plan 2011–2015*

WHY →	**Goal:** *To improve the health and wellbeing of all Victorians by engaging communities in prevention and by strengthening systems for health protection, health promotion and preventive healthcare across all sectors and levels of government*	**Part I** Chapters 1, 2

WHO →	**Partners in prevention** – State and local government – Health sector, non-government organisations, researchers, private sector and others – Individuals and families	Chapter 3

	Strategic directions 2011–2015 – Build prevention infrastructure to support evidence-based policy and practice – Develop leadership and strengthen partnerships to maximise prevention efforts across sectors – Review financing and priority-setting mechanisms to ensure available resources are based on population need and potential for impact – Develop effective modes of engagement and delivery of evidence-based interventions in key settings – Strengthen local government capacity to develop and implement public health and wellbeing plans – Improve health service capacity to promote health and wellbeing – Integrate statewide policy and planning to strengthen public health and wellbeing interventions – Increase the health literacy of all Victorians and support people to better manage their own health – Tailor interventions for priority populations to reduce disparities in health outcomes	**Part II**

HOW →

Strengthen the prevention system

Governance and leadership	Information systems	Financing and resource allocation	Partnerships	Workforce development

Chapter 4

WHERE →

Priority settings for action and engagement

Local communities and environments	Workplaces	Early childhood and education settings	Health services

Chapter 5

WHAT →

Interventions

Continue to protect the health of Victorians	Keep people well	Strengthen preventive healthcare
– Communicable disease prevention and control – Immunisation – Environmental health – Food safety – Incident and emergency response	– Healthy eating – Physical activity – Tobacco control – Oral health – Alcohol and other drug use – Sexual and reproductive health promotion – Mental health promotion – Injury prevention – Skin cancer prevention	– Cancer screening – Newborn screening – Early intervention

Chapters 6, 7, 8

Monitoring and review	**Part III** Chapter 9

Overall, this plan seeks to establish a world-leading prevention system that will ensure more effective, better coordinated activity across government and communities. It articulates the core elements of an approach to public health that will help build on current strengths, and at the same time provide a solid foundation to meet the challenges of the future. The aim is to achieve lasting improvements in the health of all Victorians.

PART I   PUBLIC HEALTH IN VICTORIA

1. Background

Keeping Victorians as well as they can be is important for individuals, families and the community. It is also crucial for a strong economy and a healthy, productive workforce.

Victoria has a long history of world-leading developments and successes in prevention and health protection. By international standards, Victorians enjoy excellent health status and longevity, and this is generally predicted to continue.

However, as the life expectancy of people increases, the likelihood of individuals experiencing age-related diseases and disability also increases. As in many developed societies, Victoria is faced with a simultaneous trend of lower death rates, and an increasing number of people requiring management and treatment for chronic illness and disability.

Concurrently, while many of the risks to our health, such as the number of people smoking, have decreased, some risk factors, such as the prevalence of obesity, have increased. Moreover, many of the health gains experienced by the population as a whole have not been shared evenly and some groups continue to experience a disproportionate burden of disease and injury.

Effective prevention can reduce the significant economic burden of disease in addition to improving the length and quality of people's lives. Improved health status supports greater workforce participation, improved productivity and lower healthcare costs, whereas ill-health and associated risk factors impose significant costs on

the economy, both in the form of additional direct costs and lost potential (Business Council of Australia 2011b).

Encouraging people to lead healthier lives – and building environments that help them do so – is challenging. Our modern way of life often makes it hard for us to make good choices. Unhealthy behaviours are frequently enjoyable or adaptive, at least in the short term. Similarly, fostering an environment that protects and promotes the wellbeing of communities is a complex yet critical priority.

To meet these further challenges effectively, we need to build on past successes and overcome some of the limitations of our current ways of working. We need to be confident that cost-effective measures that we know can help people to stay healthy and reduce the burden of chronic disease are reaching the people who need them, where and when they need them. This requires strengthening coordination across the system to maximise efficient delivery of the public health initiatives that can achieve measurable benefits for Victorians.

This plan outlines the directions the government will follow to meet these challenges.

1.1   Policy context

This plan recognises a number of important developments occurring in the context of the prevention effort in Victoria, at both the state and national levels.

Victorian Families Statement

The government released the *Victorian Families Statement* (the statement) in February 2011 (Department of Premier and Cabinet 2011). The statement recognises the diversity of families in Victoria and our common needs – the need for: accommodation; secure income; a manageable budget; a strong economy; reliable, affordable and safe road and transport systems; quality education, health and disability support services; safe and friendly neighbourhoods; and an understanding and open community where services and opportunities do not depend on where we live. All of these factors contribute to our health and wellbeing.

The statement highlights that leading a healthy and active lifestyle is an important part of keeping families strong and notes that although government cannot make people exercise more or eat better – people themselves have to take that responsibility – it can play an important role in encouraging healthy habits.

Victorian Health Priorities Framework 2012–2022

The framework sets out the government's aspiration for the future of Victoria's healthcare system (Department of Health 2011c). It is part of a suite of documents including the Rural and Regional Health Plan 2012–2022, and the Health Capital and Resources Plan 2012–2022, both of which will be released by the end of 2011.

A major goal of this plan is to contribute to the aims, objectives and outcomes of the framework, which include improving every Victorian's health status and health experiences, and delivering a system that is responsive to people's needs. The intended outcomes of the framework include that people are as healthy as they can be (optimal health status) and that people are managing their own health better.

This plan details approaches to achieve key actions and outcomes specified in the framework including:

– individuals and families consistently receiving the information and skills training that are necessary for health literacy, and thus gaining an enhanced ability to maintain their health and to make decisions that improve their health status and reduce their risk of ill-health

– developing a comprehensive metropolitan community engagement, development and experience plan to enable effective partnership approaches to healthy communities by supporting the implementation of municipal public health plans for metropolitan municipalities

– identifying population groups in metropolitan municipalities that are vulnerable to poor health, and development of interventions that address their health needs.

Other features of the framework

The framework identifies some of the major challenges facing Victoria's health system:

– many people do not have optimal healthcare outcomes
– there are not enough services when and where they are needed
– hospital utilisation could be better managed
– demand for health services is increasing rapidly
– rising health costs need to be well managed
– the health workforce is not prepared for future needs
– people need to be better informed about their health.

To cope with the challenges ahead, and especially with the demand anticipated due to population growth, ageing, and the rise of chronic and complex conditions, the framework identifies seven priority areas for the development and operation of the Victorian health system for the future:

– developing a system that is responsive to people's needs
– improving every Victorian's health status and experiences
– expanding service, workforce and system capacity
– increasing the system's financial sustainability and productivity
– implementing continuous improvements and innovation
– increasing accountability and transparency
– utilising e-health and communications technology.

The framework notes that there is a clear case for significant improvements in the current health system in Victoria to ensure health services become more responsive to people's needs, better coordinated, more efficient, and more rigorously informed and informative. Among other areas for improvement, it also proposes that the system needs greater capacity to deliver prevention, primary care and early intervention.

National context

There are a number of recent national developments that have implications for the prevention effort in Victoria. These include: the COAG health reform agenda; the commencement of the rollout of Medicare Locals; and the establishment of the Australian National Preventive Health Agency, which commenced operations in January 2011.

Australian National Preventive Health Agency

The Australian National Preventive Health Agency (the agency) was established by the *Australian National Preventive Health Agency Act 2010*. The role of the agency is to support the COAG and the Australian Health Ministers' Conference (AHMC) in grappling with the increasingly complex challenges associated with preventing chronic disease. It will provide evidence-based advice to the Commonwealth and to all health ministers developing national guidelines and standards to guide preventive health activities. The agency is responsible for a number of programs, including national social marketing programs relating to tobacco and obesity. It will also manage a preventive health research fund.

1.2 Legislative and regulatory context

Legislation has been a key tool for achieving public health outcomes since the first Victorian health Act was enacted in 1854.

Today, in addition to the current Public Health and Wellbeing Act, many Acts and regulations contribute to protecting and promoting the health of Victorians. These include, but are not limited to, the *Food Act 1984*, the *Tobacco Act 1987*, the *Child Wellbeing and Safety Act 2005*, the *Radiation Act 2005*, the *Safe Drinking Water Act 2003*, the *Health (Fluoridation) Act 1973* and the *Drugs, Poisons and Controlled Substances Act 1981*, as well as the regulations made under these Acts.

Legislation establishes frameworks designed to control well-known risks to health and to authorise or mandate specific population-wide interventions to protect and promote public health. They provide a strong legislative basis for the reform of Victoria's prevention system. Prevention of disease, including protection of the community from hazards to health, has long been recognised as a fundamental role of the modern state.

Example: Public health legislation

The enactment of the Tobacco Act is of particular significance because it broadened the scope of Victorian public health legislation to include an explicit focus on health promotion through the establishment of the Victorian Health Promotion Foundation (VicHealth).

The Act protects the Victorian population by establishing and increasing the range of smoke-free settings to reduce smoking and exposure to environmental tobacco smoke, and restricting the way tobacco is sold and marketed. Examples include smoke-free workplaces, point-of-sale display restrictions in tobacco retail outlets and bans on smoking in cars carrying children.

Legislative reform has played a major part in: reducing the uptake of smoking among Victorians; increasing the number of smokers making attempts and succeeding in quitting; and protecting more Victorians from harmful exposure to environmental tobacco smoke. Smoking prevalence in Victoria has continued to decline, with regular smoking prevalence reducing from 21.2 per cent in 1998, to 16.9 per cent in 2009 (The Centre for Behavioural Research in Cancer 2010).

However, not all legislation of significance to prevention sits within the health portfolio. Many other Acts administered by other portfolios play an equally important and complementary role in protecting and promoting health, and preventing injury across a variety of settings. Successful prevention efforts require a whole-of-government approach and hence this broader regulatory environment forms part of Victoria's integrated prevention system.

Examples: Cross-government regulation to promote healthy living

Legislation designed specifically to prevent injury includes road safety and workplace safety laws, consumer protection laws, laws governing the use and transport of dangerous goods in industry and various laws designed to ensure the safety of essential community infrastructure such as the *Building Act 1993*, the *Bus Safety Act 2009* and the *Electricity Safety Act 1998*.

The *Transport Integration Act 2010* includes an objective to support social and economic inclusion through minimising barriers to transport system access; and objectives to promote safety, health and wellbeing through minimising the risk of harm arising from the transport system, and promoting forms of transport with greatest benefit for health and wellbeing.

The *Environment Protection Act 1970* imposes specific controls to prevent or minimise air, water, soil and noise pollution and plays an important role in protecting human health and ecosystems. Section 14 of the *Climate Change Act 2010* requires the Department of Health and local councils to have regard to climate change in state and municipal public health and wellbeing plans (MPHWPs).

The *Planning and Environment Act 1987* provides the state's framework for residential and industrial development. Planning law and policy shapes the design and liveability of neighbourhoods, suburbs, cities and regions. The review of the planning system, supported by the recently established Victorian Planning System Ministerial Advisory Committee, will provide the opportunity to enhance the links between health and wellbeing objectives common to both the planning and health portfolios.

Laws governing the protection and care of children, support for families, liquor control, sex work, family violence, community safety and public order are all important elements of a whole-of-government prevention strategy. A well-educated population tends to be a healthier population. Since the 19th century Victoria has had laws providing for free and compulsory school education. The *Education and Training Reform Act 2006* continues to provide for free and compulsory school education, and also provides a framework to ensure a high standard of post-school education and training.

1.3   The Public Health and Wellbeing Act

The Public Health and Wellbeing Act is the main piece of Victoria's suite of public health legislation. It reinforces that the state has a significant role to play in promoting and protecting both the public health and the wellbeing of Victorians. The Act, under which this plan is prepared, also sets a new context for public health in Victoria. It requires that a state-based public health and wellbeing plan be developed every four years, with the first prepared in 2011. This document delivers on the specific requirements of the Act,
as well as setting longer term strategic directions for prevention in Victoria.

The objective of the Act is to achieve the highest attainable standard of public health and wellbeing for all Victorians by:

– protecting public health and preventing disease, illness, injury, disability and premature death

– promoting conditions in which people can be healthy

– reducing inequalities in the state of public health and wellbeing.

Section 49 of the Act requires the preparation of a state-based public health and wellbeing plan that is designed to:

a. identify the public health and wellbeing needs of the people of Victoria;
b. include an examination of key data relating to the health status and health determinants within the State;
c. establish objectives and policy priorities for:
   i.   the promotion and protection of public health and wellbeing in the State;
   ii. the development and delivery of public health interventions in the State;
d. identify how to achieve the objectives and policy priorities referred to in paragraph (c) based on available evidence;
e. specify how the State is to work together with other bodies undertaking public health initiatives, policies and programs to achieve the objectives and policy priorities referred to in paragraph (c).

Other features of the Act

The term 'public health' is defined in the Act to include the absence of disease, illness disability or premature death, as well as the collective state of public health and wellbeing.

The Act establishes a number of the key institutional frameworks for public health in Victoria. It specifies the role and functions of the Secretary of the Department of Health, the Chief Health Officer of Victoria and local councils in protecting, improving and promoting health. It confers specific obligations on the Department of Health and councils. These include obligations to conduct public health planning at both state and municipal levels, and duties on councils to employ environmental health officers so there is a qualified workforce to support local government's public health role. It also imposes obligations on medical practitioners and laboratories to report notifiable conditions or organisms to the Department of Health in a timely manner. This enables the Department of Health to conduct public health surveillance and investigate outbreaks of illness.

When public health incidents and emergencies arise, delayed action can result in widespread avoidable serious illness and deaths, particularly of vulnerable people. The state has traditionally had strong powers under public health legislation to control outbreaks of infectious diseases. The Act provides many of the key powers to support intervention by health authorities to investigate, manage or control various risks to health. These include specific powers vested in the Chief Health Officer to take action when public health risks are identified and in emergencies.

The Act sets out the following principles to guide public health efforts in the state:

— **evidence-based decision making** – the best available relevant and reliable evidence should be used to inform decisions regarding use of resources and selection of interventions that promote and protect public health and wellbeing

— **precautionary principle** – where a health risk poses a serious threat, lack of full scientific certainty should not be used as a reason to postpone measures to prevent or control the health risk

— **primacy of prevention** – that the prevention of disease, illness, injury, disability and premature death is preferable to remedial measures

— **accountability** – decisions relating to the Act should be made in transparent, systematic and appropriate ways that include promoting a good understanding of public health issues to Victorians, and providing the opportunity to participate in policy and program development

— **proportionality** – decisions made and actions taken relating to the Act should be proportionate to the identified health risk sought to be prevented, minimised or controlled

— **collaboration** – public health and wellbeing, in Victoria and at national and international levels, can be enhanced through collaboration between all levels of government and industry, business, communities and individuals.

1.4 This 2011–2015 plan

This first plan is based on evidence that illustrates how most effectively to confront the health and wellbeing challenges we already, and will increasingly, face. While the plan is structured to meet the requirements of the Act, it is also intended to complement the framework and to align with other key policies that underpin the government's intentions for safeguarding and improving the future health of Victorians.

Reflecting the above, the overall aim of this plan is to improve the health and wellbeing of Victorians by engaging communities and strengthening systems for health protection, health promotion and preventive healthcare across all sectors and levels of government.

Scope

> *'Public health is what we, as a society, do collectively to assure the conditions in which people can be healthy. Public health focuses on prevention, promotion and protection rather than on treatment, on populations rather than individuals, and on the factors and behaviour that cause illness and injury.'*
>
> (Department of Health 2011c)

This plan is designed to reflect the breadth of the public health effort in Victoria. The plan's major emphasis is on the primary prevention of disease and the promotion of wellbeing, in the context of a population perspective on health needs. It takes a cross-sector, cross-government perspective, and its remit extends well beyond the boundaries of the healthcare system.

The plan is therefore complementary to other health plans and reforms focused on individual treatment and care. For example, the Victorian Primary Health Care Plan (currently in development) will focus on the care that people receive at their first point of contact with the health system. Together with the framework, this series of plans will cover the full spectrum of Victorians' health needs, from supporting communities and individuals to be and stay well, through to treating early, complex and late stages of illness.

Figure 2 illustrates the major focus of this plan in the context of the continuum of care. Definitions of primary, secondary prevention and early intervention as used in this context are provided below the figure.

An area of overlap between the plans is in the area of early detection and early intervention. A number of important public health strategies, based on an analysis of population health needs and designed to improve outcomes at the population level, are delivered to individuals by healthcare providers. Historically, the leading example of this has been immunisation, but organised screening programs (for example, for breast or cervical cancer) also fall into this category. In addition, some interventions in healthcare settings, such as brief interventions on smoking, may be part of wider, population-based prevention strategies.

Figure 2: Focus of the *Victorian Public Health and Wellbeing Plan 2011–2015*
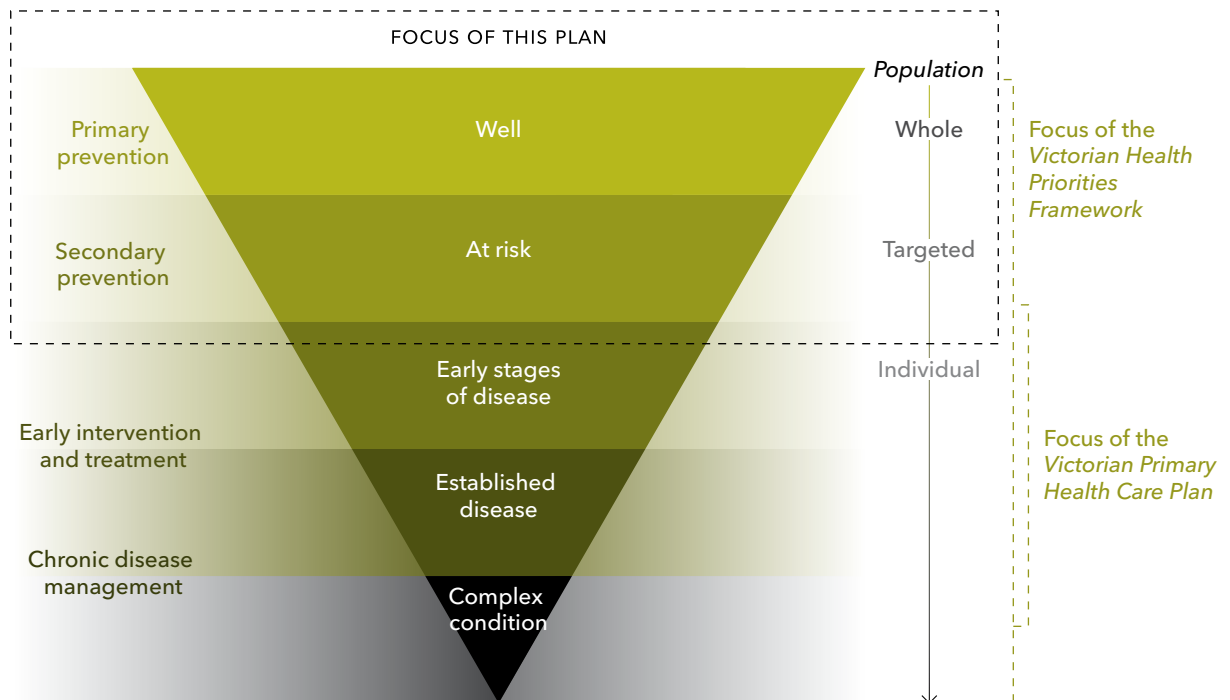
Levels of prevention

Primary prevention refers to activities that aim to prevent health problems in whole populations before they occur (reduce incidence), for example, tobacco control regulation, health promotion campaigns, fluoridation and immunisation.

Secondary prevention refers to population-based activities that aim to identify precursors to, and early signs of, illness when treatment can be most effective and supported by clear referral pathways, for example, using screening programs to test healthy but high-risk populations to identify individuals who have a disease but do not yet have any symptoms.[1]

Early intervention refers to efforts that are aimed at responding to early signs of disease and preventing worsening of the disease so that people stay as well as possible, for example, opportunistic testing for impaired glucose tolerance in people at risk of diabetes and working with those people to better manage their glucose levels (along with managing lifestyle risk factors).

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1.   In some clinical contexts 'secondary prevention' is used to refer to measures taken when disease is present to prevent further problems or complications. For example, in cardiovascular disease control secondary prevention is commonly used to refer to prevention of a second heart attack.

2. The public health and wellbeing needs of Victorians

A comprehensive view of the public health and wellbeing needs of Victorians requires information on health outcomes that captures and integrates the determinants of health. Monitoring changes over the life course and over time provides both feedback on the effectiveness of public health efforts and highlights areas in need of greater attention.

Victoria has access to a broad range of health and wellbeing indicators, which are summarised in existing reports such as the Victorian Population Health Survey, Chief Health Officer's Report, State of Victoria's Children, and technical papers supporting the *Victorian Health Priorities Framework 2012–2022*. Information is also available online through interactive sites such as Community Indicators Victoria.

2.1 Determinants of health and wellbeing

Our health and wellbeing are determined (or influenced by) a wide range of factors including individual, social, cultural, economic and environmental (Commission of Social Determinants of Health 2008). Individual factors include genetic make-up, early life experiences, age, gender, ethnicity and the cumulative effect of health-related behaviours over the life course (Bacon et al. 2010). Social and environmental factors include: employment and housing; schools and education; social connections; conditions of work and leisure; and the state of housing, neighbourhoods and the environment. Further, exposure to environmental hazards and infectious agents also play a direct role. Access to quality healthcare and treatments can help to restore health or make a condition manageable.

The classic World Health Organization (WHO) definition of health is that health is a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity. Implicit in this definition is that people can feel healthy and enjoy wellbeing even with a health condition or disability (WHO 1946).

'Wellbeing' has different meanings for different people. The Australian Bureau of Statistics (ABS) has suggested that wellbeing relates to 'the desire for optimal health, for better living conditions and improved quality of life' (ABS 2001). It also depends on many factors, including our family and social connections.

While individual choice is important in shaping our health and wellbeing, to a certain extent the choices we make for ourselves and our families are themselves subject to our social, cultural and environmental contexts.

Taking account of the wider context of an individual's health-related decisions and behaviours recognises that interactions influencing health and wellbeing are complex, and that individual choices alone may not lead to long-term changes in population health status.

2.2 Health through the life course

Health and wellbeing is the consequence of interactions between individual, social and economic influences that change as a person develops and ages. There are critical periods of development that provide opportunity for significant preventive impact over the life course – for example, infancy and early childhood, adolescence, and periods of transition (such as from early childhood education and care to primary school, primary to secondary school, new parenthood and retirement).

Investment in positive early childhood development is highly cost-effective as it provides children with cognitive and social skills (Doyle et al. 2009). This supports the development of resilience and the ability to make positive health choices. Furthermore, these skills can help delay the initiation of risk behaviours such as smoking and alcohol use (Bond et al. 2004). Given many chronic conditions stem from these behavioural choices, this is likely to result in a lower burden of disease in these illnesses across the life course.

Health promotion is also important for older Victorians. It is never too early nor too late to adopt a healthy lifestyle, the benefits of which can often be seen quickly (PMSEIC 2003).

2.3 Health status and trends

Common challenges to our good health

Australia ranks first of seven Organisation for Economic Co-operation and Development (OECD) countries for living long and healthy lives (Davis et al. 2010). Victorian health outcomes reflect these excellent nationwide results.

Overall, predictions show the health of Victorians, and of Australians as a whole, will continue to improve over time. However, the Australian Institute of Health and Welfare (AIHW) reports that as the number of people living longer increases, the chance of living long enough to experience age-related diseases and disability also increases (AIHW 2010a).

A review of the latest data trends and projections on major health issues is provided in the appendix. In some cases adverse trends are observed; in others, while the trend is favourable, the avoidable burden of disease remains unacceptably high.

Figure 3 shows the projected changes in prevalence of major chronic diseases from 2008 to 2022. The projections show a rising prevalence for all but one major chronic disease.

Figure 3: Projected prevalence of selected chronic diseases in Victoria 2022
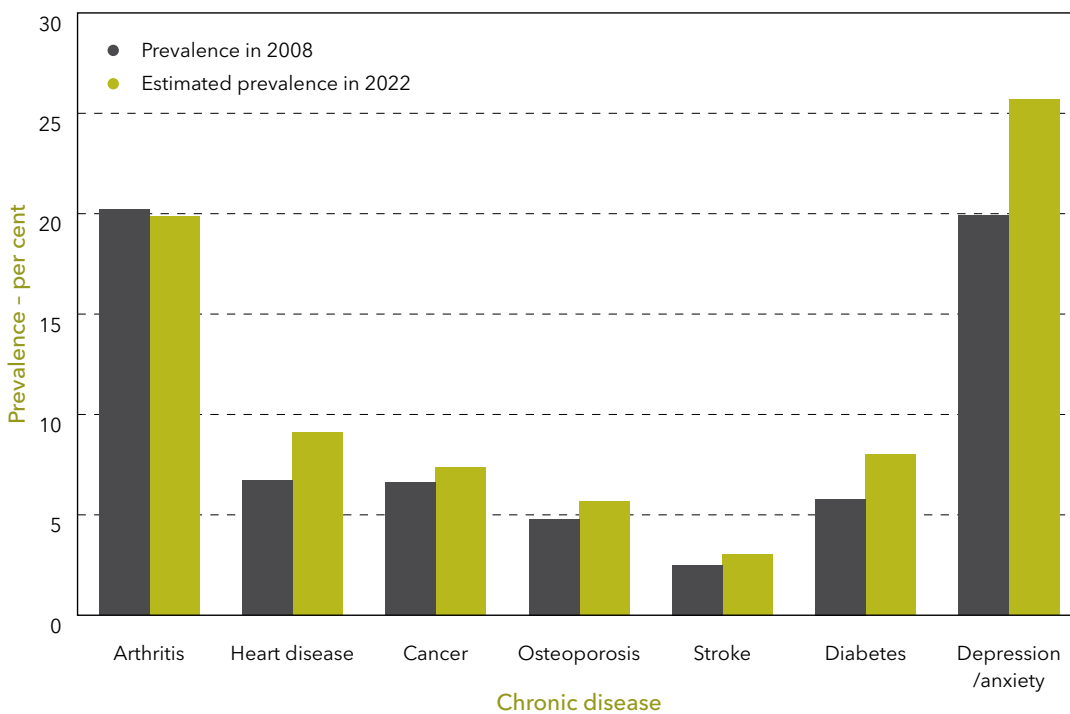
Figure 4 shows the relationship between the conditions projected to cause the highest burden of disease in Victoria, individual risk factors and selected determinants of health. The relationship between these risk factors, conditions and determinants is complex. For example, the risk factors do not necessarily operate independently but may have a combined or cumulative impact. In addition, there are relationships between conditions; for instance, diabetes is a risk factor for cardiovascular disease (CVD), and low levels of physical activity can be linked with poor mental health (McGee & Ashby 2010).

A number of the major risk factors identified in Figure 4 are considered in more detail in the appendix.

Preventable diseases are on the rise

Thanks largely to the successful application of health protection principles and activities over many decades, there is a significantly reduced risk of diseases caused by infectious agents such as polio and tuberculosis. However, the ongoing threat to health posed by communicable diseases, including new and re-emerging conditions, continue to pose challenges, and requires ongoing vigilance regarding areas such as food and water safety, and the control of environmental hazards.

Figure 4: Links between conditions, associated risk factors and determinants

FACTORS/ DETERMINANTS	CONDITIONS						
	CVD	DIABETES	CANCER	RESPIRATORY DISEASE / ASTHMA	MENTAL HEALTH	MUSCULOSKELETAL CONDITIONS / ARTHRITIS	INJURY
Tobacco use	√	√	√	√	+	√	
Alcohol misuse	√	√	√		√ +	√	√
Hypertension	√	+			+		
High cholesterol	√	+					
Nutrition	√	√	√	?	+	√	
Physical activity	√	√	√		√	√	√
Excess weight	√	√	√		+	√	?
Chronic stress	?	?	?	?	√		
Social support	√	?			√		
Depression	√	? +	+	+	√		√
Early life (incl. low birthweight)	√	√	?	√	√		?
Low socioeconomic status	√	√	√	√	√		√

NOTE: √ Established; + Associated/comorbidity; ? Possible.

Reductions in infectious diseases, along with improved healthcare treatments, have enabled Victorians to achieve greater longevity – on par with the world's highest life expectancy. Consequently the number of people with largely preventable chronic conditions appears likely to grow; this is associated with both ageing and risk factor prevalence. Chronic disease already dominates the burden of disease in Victoria, with cancer, CVD and mental disorders accounting for more than half of the disease burden in the state (Department of Human Services 2005).

While the overall decline in smoking rates is positive, trends in many risk factors and preventable diseases are rising and are projected to rise further. Some examples are provided below.

— Alcohol-related harms are increasing, and heavy drinking among young adults is rising significantly – from approximately 25 per cent in 2002 to over 40 per cent in 2009 (Victorian Drug and Alcohol Prevention Council 2010).

— Poor dietary choices are reflected in the declining percentage of people who consume the recommended volume of fruit and vegetables – only 7.9 per cent of Victorians met the guidelines for vegetable intake in 2008 compared with 12.3 per cent in 2002 (Department of Health 2010f).

— Despite a very safe food supply, food-borne illness continues to be a significant cost to the community. Nationwide there are an estimated 5.4 million cases of food-borne illness each year, costing an estimated $1.2 billion (OzFoodNet 2009).

— Obesity is increasing, with 25 per cent of children now reported as overweight or obese. Based on past trends and in the absence of effective interventions, by 2025 this figure in predicted to increase to 33 per cent (Department of Human Services 2008a; Haby et al. 2011).

— Prevalence rates for poor mental health are high. In Victoria's most recent population health survey, 24.5 per cent of women and 15 per cent of men reported they had been diagnosed with anxiety or depression (Department of Health 2010e).

— Some sexually transmissible infections, including chlamydia and gonorrhoea, continue to increase in Victoria. From 2008 to 2010, reported cases of chlamydia increased from 12,374 to 16,539, and gonorrhoea from 922 to 1,757 (Department of Health 2011b).

— Victorian rates of hospital admission and emergency department presentations due to injury increased significantly (by 65 per cent and 72 per cent respectively) between 1996 and 2009 (VISU 2011c).

— The number of people with cancer is expected to continue to increase, with the number of new diagnoses predicted to increase faster than the rate of population growth (Department of Human Services 2008b). Yet approximately one third of all cancer deaths in Australia are attributed to known, avoidable risk factors (AIHW 2002).

— The number of people living with CVD in Australia is estimated to increase by 40 per cent over the next 20 years (Access Economics 2005).

— In 2011 there are an estimated 69,000 people with dementia in Victoria, increasing from an estimated 47,500 people in 2002. By 2020 there will be an estimated 98,000 people in Victoria with dementia (Access Economics 2010). Evidence is emerging that healthy diet and prevention of diabetes and depression may be able to reduce the incidence of dementia (Alzheimer's Australia 2007; 2010).

The population is growing

Population growth projections indicate that Victoria's population will increase to more than 7.7 million by 2036 (Department of Planning and Community Development 2011). Population growth does not occur in a geographically even way. The population of Melbourne is predicted to rise to over 5.7 million by 2036, with strong population growth also projected for regional centres, coastal and other rural areas (Department of Planning and Community Development 2011). The mix of population groups within and between different geographic regions is also changing.

Population density presents particular risks to health and wellbeing. It can adversely affect air quality, which can be shown to have a range of health effects. In addition, it poses particular challenges with urban encroachment around industrial facilities, and legacy contaminated land sites. Managing the environmental, social and health impacts of population growth requires integrated planning to ensure socially, environmentally and economically sustainable communities. New developments need to be well planned so that people are not socially isolated, and have equitable access to services important for health, such as education and transport.

The population is ageing

The ageing of the population is a success story for effective public health action in lengthening our lifespan; however, it is also a challenge, as the size of the older population increases and has changing health and wellbeing needs.

Victoria's population is projected to grow and age at the same time as there is reduced growth of the working age population. In fact, the workforce will shrink in proportional terms from five working age people to every person over 65 in 2010, to 2.7 working age people to every one over 65 in 2050 (Commonwealth of Australia 2010).

Furthermore, nearly a third of retirees in Australia in 2008-09 retired from the paid labour force due to poor health (ABS 2009c). By improving the health of paid and unpaid working Victorians we may be able to minimise the number of workers leaving the workforce due to poor health.

The impact of ageing on health is significant because diseases such as stroke, cancer and dementia become more prevalent as a population ages. For example, in 2003, dementia ranked 11th among the top 20 contributors to the burden of disease and injury among males; and if current projections eventuate by 2023, it will move to fourth place (Begg et al. 2007). Ageing contributes to increased vulnerability to pathogens in many older people, particularly those in residential care facilities. In 2003 more than half of all people aged over 65 years had at least one form of disability lasting at least six months that restricted everyday activities (AIHW 2007; 2009). Disability rates increase with age from 39 per cent of those aged 60-64 years to 82 per cent of those aged 85 years and over (AIHW 2005; 2009).

In 2005 Australians aged over 65 years in the lowest income quartile were over 80 times more likely to have had all their teeth extracted than those in the highest income quartile (37.6 per cent compared with 0.5 per cent) (Australian Research Centre for Population Health 2009).

The impact of ageing is also affected by gender and diversity. For instance, more than 62 per cent of people aged 80 and over are women, with differing needs and disease patterns to be addressed (Office of Senior Victorians 2010).

Our lifestyles are changing

Sedentary lifestyles: Over the past 50 years, our lifestyles have shifted from being largely physically active to being predominantly sedentary. For example, significantly fewer Australians are now employed in jobs requiring any form of manual labour and many are working longer hours.

Eating out: Fast food is now a part of the Australian lifestyle. Based on dollar value, consumption of fast food has doubled in Australia over the 10 years from 1999 to 2009, and Australians now spend $42 a week on eating out-of-home (ABS 2006; NSW Health 2010). Foods eaten away from home have been shown to be more energy dense (up to 65 per cent more), have larger portion sizes, and are often higher in saturated fat and salt than meals prepared at home (Diliberti et al. 2004; Prentice & Jebb 2003; Rolls et al. 2004; Young & Nestle 2003).

Community participation: The demands of modern life are changing the way in which Victorians participate in their communities. The percentage of Victorians who belong to a sports or recreational club has dropped from 28 per cent in 2003 to 26 per cent in 2010, and the percentage participating in any form of organised physical activity has dropped from 45 per cent to 41 per cent over the same period period (Standing Committee on Recreation and Sport 2003; 2010). Although the percentage of the Victorian population who volunteer increased from 20 per cent to 33 per cent between 1995 and 2006, the amount of time donated by each volunteer has decreased (ABS 1996; 2007; Department of Planning and Community Development 2009). Of those who have access to the internet at home, 11 per cent used the internet for voluntary or community purposes, which highlights the way volunteering opportunities are changing as community and technology evolve (ABS 2009b).

Our world is changing

Digital media: In recent years, the way in which people communicate and obtain information has changed dramatically. The digital media environment has important implications for social interactions, health communication and health behaviours. The internet has made health information (of variable quality) more available and accessible, and the health consumer is now more informed, which in turn affects health behaviours and interactions with health providers.

New and emerging industries and technologies: Rapid advancements in biomedical research have opened up options for treatment, cure and even genetic modification that were once regarded as inconceivable. However, the availability and possibility of such interventions may influence public attitudes to taking personal responsibility for health.

Furthermore, developments in some industries may pose new challenges and potential hazards to public health. Strong collaboration with industry, consumer, environmental protection and planning regulatory bodies will be essential to maintaining population health.

Global movement creates new risks: Today's highly mobile, interdependent and interconnected world provides myriad opportunities for the rapid spread of communicable diseases such as severe acute respiratory syndrome (SARS) and new strains of influenza. In addition, new strains of highly resistant organisms, highly virulent strains of well-recognised organisms, as well as new viruses, are all emerging at a steady rate. Infectious diseases are now spreading geographically much faster than at any time in history. An outbreak or epidemic in one part of the world is only a few hours away from becoming an imminent threat somewhere else (WHO 2007b).

Food safety faces new challenges: The global movement of goods has expanded as trade between nations has grown. Our lifestyles have changed creating increased demand for convenience foods and for fresh produce to be available year round. Food products are imported into Victoria from a larger variety of locations than ever before. Economic pressures, differing regulations and production processes in some of these areas mean that the Victorian public health system must maintain constant vigilance on food-related risks to health.

Potential weather and climate related impacts: The preamble of Victoria's Climate Change Act recognises the 'scientific consensus that human activity is causing climate change'. Severe weather events present environmental, economic and health challenges. Some people will be at higher risk of health problems related to weather and climate change impacts, including children, older people, people with existing medical conditions, people who work outdoors, and those who live in areas most likely to be affected, such as rural and coastal communities.

2.4   At-risk population groups

Viewed in aggregate, Victorians typically enjoy excellent health. However, the burden of disease is disproportionately shared across our population, with certain groups and regions in Victoria having significantly worse health outcomes than others. In some instances, serious differences persist or are worsening. It is important to note that although population health and life expectancy have improved overall, the gap between the least and the most disadvantaged people has not narrowed. For example, nationally the life expectancy for Aboriginal men is 11.5 years less than non-Aboriginal men; Aboriginal women experience a 9.7 year difference (ABS 2009a). Aboriginal children also have a higher risk of disease, injury and mortality than other Australian children. Health outcomes vary in relation to socioeconomic status, education, gender and geographic location.

Health disparities are strongly associated with geographic location. The difference between the highest and lowest male life expectancy in Victorian local government areas (LGAs) for the period 2003-2007 was 7.5 years; for women, it was 7.3 years (Department of Health 2010f). Avoidable mortality is a simple, practical population-based method of counting untimely and unnecessary deaths from diseases for which effective public health and medical interventions are currently available. The relationship between disadvantage and avoidable mortality is clear – avoidable mortality rates are significantly higher among people in disadvantaged areas, as illustrated in Figure 5.

Figure 5: Avoidable mortality rates by quintiles of disadvantage, 1997–2001 to 2002–2006

Source: (Department of Health 2010c)
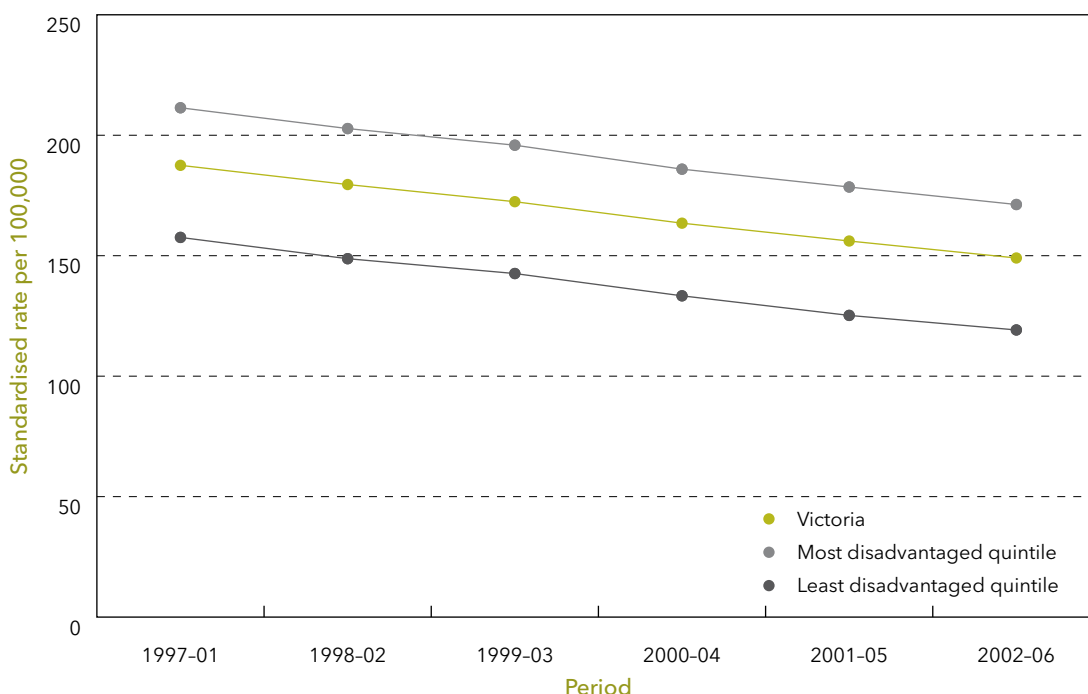
Differences such as this are often exacerbated in groups for whom discrimination, social inclusion and access to services continue to be concerns. This includes Aboriginal people, those from refugee or migrant backgrounds, people with an intellectual disability and people with a mental illness. The complex drivers for health disparities among people with severe mental illness include poverty, social isolation, unhealthy lifestyle and poor living conditions. These socioeconomic stressors affect the individual's capacity to care for their own health. People with mental illness are almost twice as likely to be smokers compared with other Australians, and they smoke 16 per cent more heavily (Access Economics 2007). For those who are homeless or living in insecure housing, these issues are compounded significantly.

The *Victorian Population Health Survey 2008* report, clearly shows that socioeconomic status is highly correlated with poor health outcomes.

As household income increases, rates of preventable health conditions decrease for both males and females (see Figure 6).

Health outcomes also vary by gender, with men having higher rates of diabetes, smoking, alcohol-related harm, poor nutrition and being overweight, while women face higher rates of psychological distress, depression and anxiety (Department of Health 2010f).

It is important to highlight that many chronic conditions causing significant burden of disease in adulthood actually start in adolescence, for example, tobacco or alcohol use, depression and anxiety. Therefore, there is a strong rationale to concentrate prevention efforts early in life to prevent or delay the onset of chronic disease, thereby preventing long-term morbidity.

Figure 6: Proportion of males and females who had ever been diagnosed by a doctor with diabetes mellitus (excluding gestational diabetes), by household income, 2008
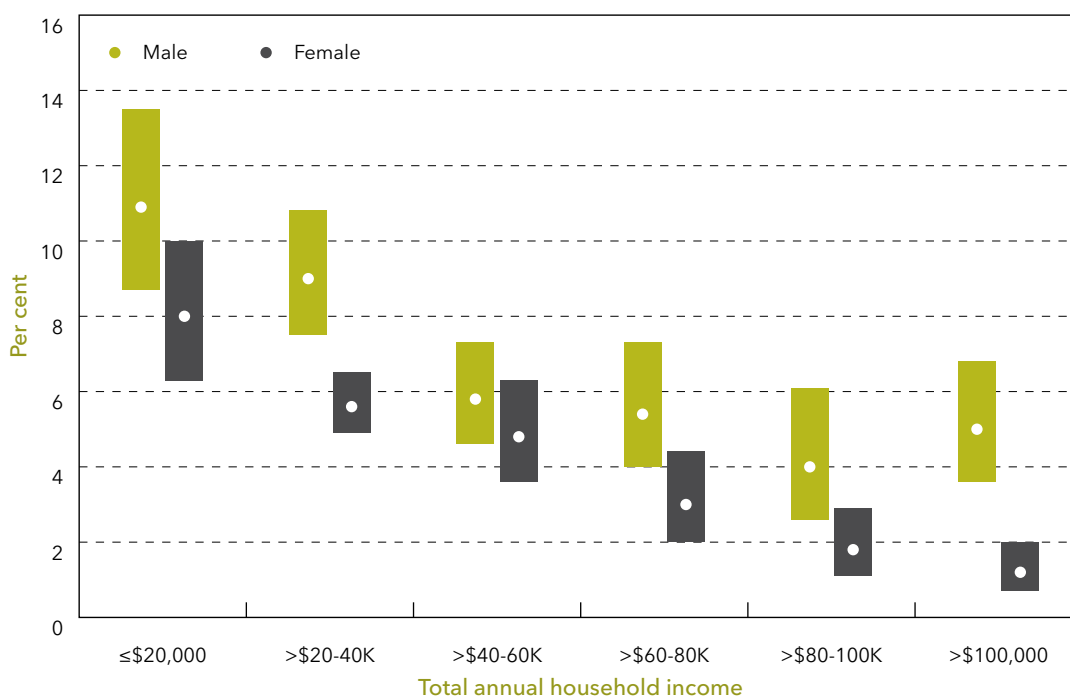
Source: (Department of Health 2010f)
Graph includes type 1 and type 2 diabetes. Only 10–15 per cent of diabetics have type 1 diabetes. There is currently no known cause of type 1 diabetes (Diabetes Victoria 2008).

3. Partners in prevention

3.1   The prevention sector in Victoria

The public health and prevention sector in Victoria comprises a wide range of organisations operating at state, regional and local levels. The main participants in the sector are outlined below.

State government

Many government departments and agencies work to influence the determinants of health, or focus on the health needs of particular populations. Successful prevention initiatives aimed at the determinants of health require collaboration across government departments.

—   The Department of Health has lead responsibility for many traditional public health functions, including immunisation, environmental risk assessment and food safety regulation, administered through local government. The department also provides, funds and manages a wide range of preventive healthcare, health promotion and disease prevention programs, and screening initiatives.

—   The Department of Human Services is responsible for planning, funding and delivering services that both address determinants of health (such as housing) and work with particular populations including young people, women and people with disabilities.

—   The Department of Education and Early Childhood Development ensures a high-quality and coherent birth through adulthood learning and development system to build the capability of every Victorian. In addition to influencing the determinants of health through access to education, the department is responsible for a number of services that promote health and wellbeing, including the maternal and child health service, primary and secondary school nursing, primary welfare coordinators, student support service officers and the School Focused Youth Service.

—   The Department of Planning and Community Development has functions and programs that support communities to become more liveable, including urban planning and programs that promote social inclusion. Within the department, Sport and Recreation Victoria, aims to increase Victorians' participation in sport and recreation. The department is also the coordinating point for whole-of-government activity directed to improving health, education and labour market outcomes for Aboriginal Victorians.

—   The Department of Justice holds responsibility for a number of functions that promote and protect the health and safety of Victorians. In addition to regulatory functions, such as liquor control, the department supports campaigns and programs that promote healthy behaviours such as responsible gambling.

—   The Department of Transport, in conjunction with VicRoads and other transport agencies, supports planning for and delivery of an integrated and sustainable transport system. The transport portfolio supports, funds and manages a number of transport initiatives related to preventive health outcomes aimed at improving the safety and accessibility of transport.

—   The Department of Sustainability and Environment leads the Victorian Government's efforts to manage water resources and catchments, climate change, bushfires, parks and other public land, forests, biodiversity and ecosystem conservation.

—   The Department of Primary Industries is responsible for agriculture, fisheries, earth resources, energy and forestry in Victoria, and supports programs that promote health for particular populations such as Sustainable Farm Families (a health check and education program for farmers, farm workers and family members).

– The Transport Accident Commission (TAC) has a key role in preventing injury and promoting road safety in Victoria. Working closely with Victoria Police and VicRoads, the TAC develops campaigns that increase awareness of issues, change behaviour and ultimately reduce the incidence of road trauma.

– WorkSafe Victoria, in addition to its legislatively defined role in occupational health and safety, is currently piloting the WorkHealth initiative, with a specific focus on promoting the links between preventive health, workplace safety and improved return to work.

Local government

Under section 24 of the Public Health and Wellbeing Act, councils are required to protect, improve and promote public health and wellbeing within their municipality and, under section 26, are mandated to prepare a MPHWP every four years.

Victorian councils provide a large number of services to Victorian communities, with the varying nature of municipalities governing the extent and range of services provided to individual communities. Councils have a broad role in health promotion, the provision of health services (for example, immunisation, early childhood and home and community care services) and other services (such as libraries). Councils are also responsible for: a range of planning activities; management of the environment and public spaces within their jurisdiction; public and social infrastructure such as roads; and public services such as emergency management.

Local government is therefore ideally placed to develop, lead and implement local policies to influence many determinants of health. These policies include actions in areas such as transport, roads, parks, waste, land use, housing and urban planning, recreation and cultural activities, and creating safe public places.

Health sector

As well as government departments with responsibility for health service functions, the health sector includes private sector providers, community and women's health agencies, and government-funded agencies.

Many health promotion and screening initiatives are implemented through community and women's health services and through statewide agencies. Screening, early detection and intervention services are delivered in partnership by various organisations. For example, cancer screening services are delivered by BreastScreen Victoria, PapScreen Victoria (within Cancer Council Victoria), the Victorian Cytology Service and the Victorian Cervical Cytology Register, working in partnership with the primary care sector, private and public pathology and medical imaging providers, and the Commonwealth Government.

The Victorian Government also funds ambulatory care services through specialist clinics (some located in community settings) and community health centres throughout Victoria. These provide a range of primary healthcare services such as community nursing, allied health, community development, chronic disease management and health promotion services. These services complement the primary healthcare services funded by the Commonwealth Government.

The Commonwealth and Victorian Governments fund a wide range of additional health services that have preventive components, including mental health, screening, dental health, rural and Aboriginal health programs, and health services for war veterans.

The Victorian Government also provides funding for VicHealth, a statutory authority with an independent chair and board of governance that works both collaboratively with, and independently of, the government to promote good health across the population. This key and widely recognised role in promoting healthy individuals and communities has provided a unique model for supporting health promotion in Australia.

Victoria has a strong and diverse non-government organisation (NGO) health sector that works together across the prevention spectrum, and encompasses many health conditions and population groups.

NGOs such as the Heart Foundation, Cancer Council Victoria, Diabetes Australia-Victoria and the Victorian AIDS Council focus on prevention of particular health issues, while other organisations such as Aboriginal Community Controlled Health Organisations, the Multicultural Centre for Women's Health and Women's Health Victoria work with particular population groups.

Private sector

Both the private health sector and the non-health sectors make an important contribution to preventive healthcare. Private healthcare includes general practice services and private allied health including oral health, psychology and physiotherapy services. Private health insurers are also playing a more significant role in prevention. For example, the Medibank Private Community Fund is supporting the trial of a new strategy aimed at harnessing the authority of healthcare professionals to refer individuals and groups to participate in tailored activity sessions in parks, in partnership with the Parks Victoria Healthy Parks, Healthy People initiative.

More broadly, the private sector plays a key role in our community, for example, through employer-led workplace health initiatives, the food industry's role in providing healthy food products and consumer information, and the private sport and recreation sector's role in promoting healthy physical activity.

Local communities

Whether self-organised or supported by government agencies or NGOs, community-led action promotes good health at a local level. Consultation and public input is a key feature of most planning processes, providing communities an opportunity to have a say about their local environment and neighbourhood. Ensuring disadvantaged groups are actively engaged in these partnerships may need further effort. A wide range of social, cultural, sporting, religious, artistic and special interest groups and clubs offer people opportunities to lead physically active and socially meaningful lives. These organisations foster reduced isolation, and improved health and quality of life. The role of volunteers in these community-led activities is especially important.

Research community

Effective prevention requires comprehensive health data collection and thorough evaluation of interventions. The Department of Health manages the Victorian Population Health Survey and the Victorian Health Monitor; the Department of Education and Early Childhood Development manages the Victorian Child and Adolescent Monitoring System; and the Department of Planning and Community Development prepares Victoria in Future outlining population and household projections; all of which provide important statewide data and trends.

Prevention research activity is also funded in collaboration with research partner organisations such as the Centre for Excellence in Rural Sexual Health, and the Victorian Injury Surveillance Unit (VISU) at the Monash University Accident Research Centre. Other important Victorian research efforts include the McCaughey Centre: VicHealth Centre for the Promotion of Mental Health and Community Wellbeing, and the research capacity of Cancer Council Victoria.

Recently, the Department of Health initiated the development of a concerted prevention research effort through establishing the Centre of Excellence in Intervention and Prevention Science and a program of rapid evidence reviews.

3.2 Planning and coordination

Given the wide range of contributors, mechanisms for coordinated planning, policy alignment and program implementation across the sector are important. Such mechanisms help to minimise duplication and maximise use of resources.

Victoria has established mechanisms for collaborative local, regional and statewide planning and coordination such as Primary Care Partnerships (PCPs), regional management forums, MPHWP, and numerous issue-specific statewide partnerships. However, if planning is to occur across the continuum (both vertically and horizontally), then arbitrary funding and governance barriers will need to be overcome. In addition, greater collaboration and planning for prevention across health and other community sectors, the private sector and with Commonwealth programs, will need to occur.

Some existing mechanisms include the following.

- **At the national level:** Victoria partners with the other jurisdictions and the Commonwealth to develop and implement national policy and programs. This includes participating in national governance and committee structures established under COAG, the AHMC and the Australian Health Ministers' Advisory Council. Victoria is an active participant in a number of partnership agreements, such as the Closing the Gap, National Partnership Agreement on Preventive Health and Essential Vaccines.

- **At the state level:** The Prevention and Population Health Advisory Board, chaired by the Department of Health Secretary, provides an opportunity for the development of coordinated approaches across a number of portfolios, the Municipal Association of Victoria (MAV), VicHealth and some of the leading health NGOs.

- **At the regional level:** Regional management forums that bring together chief executive officers of local government and senior representatives from state government departments operate in eight regions and are chaired by Secretaries of government departments. Forums initiate projects that find ways to link state departments and local government authorities in a place-based approach to local issues. Some forums have established health and wellbeing committees to focus attention on improving liveability and tackling social, economic and environmental disadvantage.

- **At the sub-regional level:** PCPs are alliances of health and community services that play an important role in facilitating, planning and coordinating health promotion and primary healthcare. In addition to local government, members include primary health and other health services, aged care services, disability services, ethno-specific services, divisions of general practice, sporting agencies, land care agencies, schools, neighbourhood houses, police, community groups and consumers. Through PCPs, Victorian Government services have links to divisions of general practice, and to other medical and allied health professionals in private practice. The PCP strategy is delivering strengthened links between community health, and other services and local government. Local government and community health have different roles and responsibilities. Through this partnership more domains of the health promotion framework can be influenced and acted upon.

— **At the community level:** The primary strategic planning mechanism for prevention efforts is the MPHWP, as mandated under the Public Health and Wellbeing Act. The Act provides a strong platform for an enhanced planning role for local government. It aligns the planning cycle of MPHWPs with council plans so that population health becomes a shared goal across all parts of the council.

To achieve real improvements in health outcomes, especially among higher risk population groups a more coherent, aligned approach to population-based prevention planning across all of these levels and sectors is required. This approach must be based on sophisticated planning tools, up-to-date evidence, and agreed roles and responsibilities.

PART II ACHIEVING OUR OBJECTIVES: THE NEXT FOUR YEARS

The goal of this plan is to improve the health and wellbeing of Victorians by engaging communities and strengthening systems for health protection, health promotion and preventive health services. For Victorians, a number of important changes will be evident, both in the way that public health is practised across our communities, and in the health experiences that they, as individuals, may experience.

By 2015 significant progress will have been made in the following areas:

– building prevention infrastructure to support evidence-based policy and practice

– developing leadership and strengthening partnerships to maximise prevention efforts across sectors

– reviewing financing and priority-setting mechanisms to ensure available resources are based on population need and potential for impact

– developing effective modes of engagement, and delivering evidence-based interventions in key settings

– strengthening local government capacity to develop and implement public health and wellbeing plans

– improving health service capacity to promote health and wellbeing

– integrating statewide policy and planning to strengthen public health and wellbeing interventions

– increasing the health literacy of all Victorians and supporting people to better manage their own health

– tailoring interventions for priority populations to reduce disparities in health outcomes.

Systems and settings

Victoria is already experiencing negative impacts from many of the challenging health trends outlined in Part I. Without a clear plan to mitigate these and future costs, there will be an increasing burden on individuals, communities, the health system and our economy. Well targeted, evidence-based prevention programs and policies can be cost-effective, reduce avoidable demand on healthcare services and improve productivity.

There is increasing recognition that a system is needed that delivers responsive, integrated and coordinated prevention (based on the best available evidence) at local, regional and statewide levels, across a range of settings such as schools, workplaces and communities.

Without changing how we deliver and fund prevention we will be unable to effectively meet the challenges of managing the increase in chronic health conditions driven by lifestyle choices and the ageing population. In moving to a better and more effective system for prevention and health promotion, it is also essential that efforts and investment in health protection are maintained and, where necessary, strengthened.

Responding to these complex trends goes beyond the capacity of any one organisation to address fully. It demands whole-of-government and whole-of-sector approaches that may include large-scale behaviour or cultural change and associated policy and environmental changes (Australian Public Service Commission 2007).

Currently, many prevention programs and organisations (government and non-government) delivering prevention interventions and services operate in isolation from one another, resulting in duplication of effort, and an inefficient use of available staffing and funding resources. In some cases the translation of statewide initiatives to the local level is not responsive to the local context, or is not sustained long enough to have an effect. At the state level, not enough has been made of the opportunities to align approaches across government departments in areas that could deliver health benefits such as in planning, environmental design, transport and active living.

What is becoming clear is that preventive health requires the same comprehensive and integrated system that healthcare requires to manage illness; a system through which interventions can be sustained, coordinated and supported, and where use of limited resources is optimised. Focusing only on specific health risks and problems is likely to have a limited long-term effect on improving population health and reducing health disparities.

Strategic directions

- Build prevention infrastructure to support evidence-based policy and practice

- Develop leadership and strengthen partnerships to maximise prevention efforts across sectors

- Review financing and priority-setting mechanisms to ensure available resources are based on population need and potential for impact

- Develop effective modes of engagement and delivery of evidence-based interventions in key settings

- Strengthen local government capacity to develop and implement public health and wellbeing plans

- Improve health service capacity to promote health and wellbeing

Action areas
Strengthen the prevention system

- Governance and leadership
- Information systems
- Financing and resource allocation
- Partnerships
- Workforce development

Priority settings for action and engagement

- Local communities and environments
- Workplaces
- Early childhood and education settings
- Health services

4. Strengthen the prevention system

Victoria has a world-class healthcare system but needs an infrastructure for delivering preventive health across the state, particularly in terms of a local prevention workforce. In addition, the existing infrastructure – workforce, financing, research, partnerships and networks – is not yet optimally connected to maximise efficiency and effectiveness.

Growing evidence worldwide suggests that continuing with single-issue programmatic or 'vertical' approaches to prevention, particularly in relation to complex challenges such as obesity, is likely to have a limited long-term effect in improving population health and reducing health disparities.

Consistent with WHO recommendations, the approach to developing the prevention system focuses on five major 'system building blocks' or enablers. These are:

– governance and leadership
– information systems
– financing and resource allocation
– partnerships
– workforce development.

These enablers serve three purposes. First, they allow a definition of desirable attributes – what a prevention system should have the capacity to do in terms of, for example, providing sustainable financing for programs that may take a number of years to show an effect. Second, they provide one way of defining priorities for the development of the prevention system. Third, by setting out the overall prevention system architecture, they provide a means for identifying gaps in current arrangements.

In order to ensure that the total prevention effort (including strategies focused on specific risk factors or threats to health, and activities across the priority settings) is delivered in a comprehensive, coordinated and effective manner, the plan proposes the development and strengthening of a prevention system.

A systems approach aims to ensure that all of the components of a system work together such that the whole is greater than the sum of its parts. A major objective of this plan is to bring the often disparate and disconnected prevention activities across government and the sector into better alignment to enable a more optimal use of resources, and a more effective focus on policy priorities.

Hence, work is underway on several significant reforms and policy initiatives that will see the development of a Victorian prevention system that maximises the potential of preventive health interventions to improve the health status of all Victorians.

New initiatives developed under the plan will allow for more sophisticated research and evaluation support through the newly established Centre of Excellence in Intervention and Prevention Science.

4.1 Governance and leadership

Leadership and governance involve ensuring that strategic policy frameworks exist and are combined with effective oversight, coalition building, regulation, attention to system-design and accountability.
(WHO 2009)

Recognising that many of the important influences on health are beyond the responsibility of any single organisation, the Victorian Prevention and Population Health Advisory Board has been established to bring together senior executives from state government departments, local government, research organisations and prevention-focused NGOs. The board provides high-level strategic advice and recommendations to the Department of Health on prevention efforts in Victoria, with the aim of strengthening Victoria's prevention effort. Advisory board members' networks across the government and non-government sectors will help to identify partnerships, provide specialised advice and ensure knowledge is shared.

Within the framework of the advisory board, there may be additional opportunities to improve the alignment of planning for prevention across government and with the broader sector. For example, the relationship between the advisory board and other cross-sector advisory mechanisms could be strengthened.

Opportunities for progress in 2011–2015 include:

– establish a statewide interagency prevention leadership forum to be chaired by the Minister for Health to support collaboration across NGOs, statewide health promotion agencies and other partners

– identify and explore the capacity of existing cross-government forums, such as regional management forums, to provide regional governance and leadership in prevention

– support local government to incorporate best practice, integrated planning and implementation for public health and wellbeing into council activities.

4.2 Information systems

There are a number of data sources that provide detailed information to guide and monitor prevention efforts in Victoria at statewide, regional and local levels. Some data sources and reports provide broad health and wellbeing data, such as the Victorian Population Health Survey series and the Victorian Health Monitor, while others provide detailed information about specific health issues such as the Notifiable Infectious Diseases Database, the Smoking Prevalence and Consumption in Victoria report or the Australian Secondary School Alcohol and Other Drug Survey. Government departments, NGOs, academic institutions and research centres all play a role in generating and disseminating this information.

The primary healthcare sector (public and private services) hold rich data about the health and health behaviours of their client populations yet there is no agreed, consistent set of data that is collected, there is no consistent classification system and there is no systematic way to access data that is held.

Victoria has a strong research and evaluation community and tradition and, together with national and international studies, there is a well-developed evidence base for effective prevention interventions, which continues to be developed. To further enhance the generation and synthesis of policy and program-relevant evidence, the Department of Health has established the Centre of Excellence in Intervention and Prevention Science to:

— advance and promote the science and practice of research in preventive health interventions

— foster and enable partnerships for research on contemporary preventive health directions and challenges

— lead and work with government in the development of systems, processes and mechanisms to enable evidence-informed policy decision making for a leading preventive health effort in Victoria.

Centre of Excellence in Intervention and Prevention Science (CEIPS)

CEIPS was established to generate and promote evidence about the effective implementation of preventive health interventions. This evidence will underpin the delivery of improved population health gains, reducing the impact of chronic diseases such as diabetes, obesity, heart disease and cancer.

The centre will lead the evaluation of the Victorian implementation of the COAG National Partnership Agreement on Preventive Health. This work will provide important support to the state government's commitment to promote and protect the health of all Victorians.

The centre will foster partnerships for research on contemporary preventive health directions and challenges. Potential partners include VicHealth, the Department of Education and Early Childhood Development, and the Department of Planning and Community Development, and close links to the Australian National Preventive Health Agency.

In conjunction with government, CEIPS will contribute to the development of systems, processes and mechanisms to enable evidence-informed policy decision making for a leading preventive health effort in Victoria.

However, gaps still exist in both the types of evidence generated, and in linking research and effective policy and practice. Support to understand the evidence, and its implications for program design and delivery, is often needed. Similarly, support is required to build high-quality evaluations.

Opportunities for progress in 2011–2015 include:

– promote access to and use of existing data to guide and evaluate prevention efforts

– continue the Victorian Population Health Survey time series

– build capacity of researchers, practitioners and policymakers to work together to facilitate knowledge co-creation and transfer by creating opportunities for joint appointments, research and implementation

– build on current efforts to create and use syntheses of the research evidence that are useful for policy and practice such as rapid reviews and evidence summaries

– improve the number and quality of evidence-based evaluations of new and existing public health interventions, including policies and programs.

4.3   Financing and resource allocation

Achieving results in prevention requires sustained and significant investment in effective activities, interventions and infrastructure over the long term.

Deciding what to fund and by how much is a difficult but essential role of good governance. The government is accountable for making investment decisions on behalf of the community, in order to maintain a strong healthcare system and support people so they can live healthy lives.

Funding models should enhance partnerships and collaboration between government and the community sector, as well as removing impediments to achieving good outcomes. Funding models should support population-based interventions that are integrated and improve population-level health and wellbeing.

It is important that funds are allocated to priority areas and are used to implement evidence-based interventions. Setting priorities in relation to prevention and health promotion should be informed by the combined inputs of economic and epidemiological analysis.

There are a growing number of Victorian, national and international studies providing quality economic analysis of preventive interventions which can inform priority setting. A recent example is the *Assessing cost-effectiveness in prevention* (ACE-Prevention) project (Vos et al. 2010), the results of which suggest there is now sufficient evidence to make the tough but necessary allocation of funding towards best practice prevention activities. The authors also argue for continued efforts in evaluation research to contribute to the evidence base of prevention, particularly for policy initiatives and community-based interventions that have the potential to have large health impacts.

Implementation of the Prevention Community Model (outlined in chapter 5.1) will help lead the transition from the existing, mainly small-scale interventions and projects, to an integrated, whole-of-community model of intervention aimed at improving population health and wellbeing outcomes.

Opportunities for progress in 2011–2015 include:

– investigate options for establishing criteria for resource allocation according to priorities in prevention and health promotion

– review and realign existing funding arrangements to ensure they reflect the directions in this plan

– consider options for consolidating statewide or regional funds in order to maximise prevention outcomes.

4.4 Partnerships

'The health sector needs to engage systematically across government and with other sectors to address the health and well-being dimensions of their activities. The health sector can support other arms of government by actively assisting their policy development and goal attainment'
(WHO 2010a)

Partnerships are integral to effective measures to improve population health and wellbeing. Victoria has a strong foundation of collaborative local, regional and statewide partnerships that have a focus on health and wellbeing promotion and support.

Many councils and PCPs recognise the benefits of combining efforts to collect and share data, produce community profiles and undertake collaborative priority setting. There are a number of examples where partnerships between PCPs and local government are maturing and delivering coordinated and integrated responses to the health and wellbeing needs of local communities.

Effective prevention is not something that government can do alone. In tackling complex problems, the engagement of a wide range of disciplines, sectors and institutions can help in understanding and informing solutions, and developing innovative strategies. Partnering with communities in intervention design and implementation can ensure acceptance and support of new programs and help sustain improvements in individual and community wellbeing (National Prevention Health Promotion and Public Health Council 2011).

Partnerships provide an opportunity to bring together the diverse skills and resources of agencies with a common purpose to maximise their collective impact on population health. Strategic partnerships can help overcome duplication of effort, ensure better coordination of activities, and identify gaps in programs and services. Building and sustaining quality partnerships or consortia arrangements among the many organisations contributing to prevention is therefore a key aim of this plan.

Partnerships vary in formality, degree of commitment and level of resource sharing. For organisational partnerships to work, they need to be supported – by boards, by senior managers, by staff, by funding bodies and by consumers. Partnerships grow and develop according to the effort, work and shared commitment invested by all partners.

Chapter 3 has outlined the many different partners who can play a role in improving health, including a wide range of government agencies, the private sector, non government organisations, planners, researchers, communities and families. Harnessing the talents, policies, resources and aspirations of all these partners, and aligning and coordinating efforts across the Victorian community, will be central to the success of this plan.

Examples of existing partnerships at the local, regional and statewide levels follow.

– Victoria's PCPs have operated successfully for more than a decade. PCPs typically include hospitals, community health services, local government, aged care assessment services, disability services and divisions of general practice. Over time they have also increasingly engaged with non-health agencies, including police, schools, and community and welfare groups.

— Consultation and partnerships are an integral part of local council municipal public health and wellbeing planning processes.

— The TAC has worked in partnership with Victoria Police and VicRoads, to successfully promote road safety over many years. TAC develops campaigns which, together with enforcement and safety measures, help change behaviour and ultimately reduce the incidence of road trauma.

— VicHealth has supported and worked in partnership with the sports sector in Victoria for more than 20 years to encourage more people to participate in sport for physical, mental health and wellbeing benefits, and to promote a healthy sports culture and environments.

— The Department of Health has worked closely with the Department of Education and Early Childhood Development on the design of school-based initiatives under the NPAPH.

— The success of the Quit campaign in Victoria has been underpinned by the strong partnership between two leading health NGOs – Cancer Council Victoria and the Heart Foundation – VicHealth and the Department of Health.

— The Municipal Association of Victoria, local governments, academics and the Department of Health have worked together on the development and implementation of the Environments for Health Framework to support local planning for health.

— The Department of Transport has worked with the Department of Health in the development of strategies to increase walking as a mode of transport for Victorians.

While the strengths of existing and effective prevention partnerships must be maintained, new relationships and approaches will also be necessary in order to achieve the level of sustained coordination and scale of effort needed. There will need to be action at multiple levels; and in many instances, opportunities for collaboration will need to be supported by and align with new governance structures and financing and accountability mechanisms. This will ensure that where partnerships are needed, siloed funding and reporting arrangements do not act as a barrier to effective collaboration.

This plan recognises that the quality of partnerships between agencies is important. Effective cross-agency or cross-sector partnerships in prevention generally have the following characteristics:

— a defined mandate and mission, and agreed partnership strategies and objectives
— clear partnership leadership and governance arrangements
— good planning processes
— clearly defined roles and responsibilities
— partnership resources, capabilities (for example, staff skilled in collaborative ways of working) and commitment.

Opportunities for progress in 2011–2015 include:

- review the current configuration of the prevention sector and map activity to clarify roles, and address duplication and gaps in light of this plan

- establish a statewide interagency prevention leadership forum to be chaired by the Minister for Health to support collaboration across NGOs, statewide health promotion agencies and other partners

- funding arrangements could encourage partnerships, joint planning and pooling of resources (where appropriate) among agencies to enhance prevention efforts and remove disincentives to collaboration

- collaborative planning for population health at all planning levels of the health system (statewide, regional, hospital networks, PCPs, community health services, local government)

- encourage community partnership and engagement opportunities provided by interactive internet technology and digital media

- develop a whole-of-government prevention web portal which captures the range of initiatives across government to improve health and wellbeing, and which provides evidence-based guidance and ideas for the role of other sectors and institutions in prevention and partnership development

- develop tools to enhance collaborative planning capacity and establish shared learning networks

- further strengthen the state/local government partnerships through leadership development and workforce planning.

4.5   Workforce development

Workforce shortages have been a longstanding concern across the health sector. The increasing policy emphasis on prevention is now highlighting the limitations in the size, distribution and capacity of the prevention workforce.

Non-health workforces contribute significantly to prevention but are not introduced to public health and prevention theory, thinking or practice. Investment in skills development and reform across disciplines may provide opportunities to engage a broader range of workers to deliver prevention based on demand requirements. As work in prevention develops, there may be opportunities to develop new roles or functions that will contribute to further development of career structures.

Victoria's prevention workforce is supported by a strong university sector that offers undergraduate and graduate programs, and a range of training organisations providing a number of short courses. However, many stakeholders have argued there is not a sufficient supply of workers with the skills required. New initiatives such as the NPAPH will place additional demands on workforce capacity.

The National Preventative Health Taskforce proposed that strategies to build the prevention workforce need to take account of six key factors: identification; supply needs; core competencies; education, training and accreditation; models and scope of practice; and support mechanisms (Preventative Health Taskforce 2009). Participation in national workforce initiatives, such as the Health Workforce Australia agency, will be important while maintaining a focus on developing the existing and building the future Victorian and local workforce.

Now and in the future, Victoria needs workers with a strong understanding of public health issues at many levels and roles in government, non-government and private sectors.

> **Opportunities for progress in 2011–2015 include:**
>
> – seek a grant, should it become available, from the Australian National Preventive Health Agency to provide workforce development opportunities in prevention for health and other workers
>
> – identify and address key competencies in prevention, including the use of and generation of evidence.
>
> – explore ways to build the capacity and role of health and other professionals in best practice prevention.

5. Priority settings for action and engagement

Health and wellbeing are influenced by the places in which people live, learn, work and play. Engaging with individuals and families in these settings is often one of the most effective ways to enable people to make decisions that improve their health status and reduce their risk of ill-health.

A major focus for action over the life of this plan is a coordinated and strategic approach to implementation activities across priority settings.

While it is recognised that preventive health activities occur in a wide range of settings, four priority settings have been selected based on a substantial body of evidence for their contribution to health improvement. The settings are:

– local communities and environments (including homes and neighbourhoods)
– workplaces
– early childhood and education settings
– health services.

These are key locales for preventive interventions for individuals and families at all stages of life. These settings provide opportunities both to create environments that support healthy choices, and also to link health advice to key life-transition stages (such as beginning school or joining or leaving the workforce).

A settings approach to public health and wellbeing is flexible – it can address a variety of health concerns appropriate to the needs and capabilities of different population groups in different communities. Health information can be provided in flexible settings including libraries, the internet (such as the Better Health Channel website) and social media, and be adapted to support development of relevant health literacy skills.

Recognising the differences between communities, working in partnership with communities, and the importance of local planning are central to a settings approach. This reflects the emphasis placed on MPHWPs in the Public Health and Wellbeing Act, and partnership work led by PCPs.

A settings approach is complementary to issue-specific national and statewide campaigns and programs, such as those targeting smoking or healthy weight. It is also consistent with the COAG NPAPH, which provides funding for activities targeting healthy communities, healthy children and healthy workers. These activities are supported by enabling infrastructure, such as health surveys and social marketing campaigns. Social marketing can play an important role in influencing individual behaviour change through raising public awareness and providing health information.

Each setting is considered in more detail on the following pages.

5.1   Local communities and environments

Recent meta-reviews of community health programs, along with emerging international evidence such as from France's EPODE program, have reinforced lessons in Victorian demonstration projects. The evidence confirms that a high investment in community engagement, leadership, partnerships and workforce can lead to real improvements in hard-to-change health risks and behaviours such as unhealthy weight (The Centre for Allied Health Evidence 2009; Wandersman et al. 2008).

Public health and wellbeing in local communities: an overview

The role of local government as a major partner in contributing to prevention of illness and disability is one of Victoria's particular strengths. Victorian local government is acknowledged as a national leader in the planning and provision of health and human services, including Home and Community Care (HACC) services, public health and emergency management, and community support and recovery. While MPHWPs have been in place for some years, the Public Health and Wellbeing Act now offers an opportunity to widen and enhance local government's role in fostering healthy communities.

Over the past decade the department's investment in local government health planning has been guided by the *Environments for health municipal public health planning framework* (Department of Human Services 2001).

Victoria also has a longstanding tradition of supporting community health services with strong links to local communities. PCPs and alliances of health and community services (including local government) bring together different organisations with different roles, responsibilities and expertise to plan, implement and evaluate health promotion. By working in partnership, diverse organisations can promote health to individuals and populations.

PCPs deliver three-year integrated health promotion (IHP) plans, which describe health promotion priority areas, strategies to deliver a mix of interventions, target groups, timeframes and expected contributions for partners.

PCPs have also been key partnership brokers, linking a diverse range of organisations to work in a coordinated and integrated way around the needs of local communities. More recently, place-based renewal projects and community-based demonstration programs, such as Best Start and Colac's 'Be Active, Eat Well', have shown the potential of whole-of-community interventions.

Planning and environmental design affects the everyday life of all Victorian communities. It influences the location and performance of buildings and homes, the location of shopping centres and community facilities, as well as the location of transport infrastructure and recreation space.

Looking ahead

The implementation of the NPAPH, complemented by state resources, will see significant and targeted investment at the community level. The Prevention Community Model has been developed under the NPAPH and will inform the funding decisions of around 12 local prevention areas to improve health, reduce chronic disease risk and reduce health disparities in identified high-needs areas. As part of the NPAPH there will be an initial focus on addressing smoking, fruit and vegetable consumption, physical activity and alcohol use.

Also within the community setting, the government has committed to tackling the underlying causes of homelessness and reducing the number of homeless people in Victoria. In addition, building respectful and non-violent communities will be supported through new initiatives such as Preventing Violence Against Women in our Community, a whole-of-community approach to be delivered through selected local government clusters.

The NPAPH and the Prevention Community Model – key facts

Local action will be driven by local government, community health agencies and other local partners in a 'prevention partnership' with the Department of Health. This partnership model will be based on agreements with the selected communities, which have been tailored to reflect existing infrastructure, networks, programs and local planning processes.

Existing health promotion efforts will be strengthened in each community to build a local prevention system and access to:

– community-level prevention efforts and networks

– resources and workforce

– local participation and partnerships for health

– tailored interventions at the community level, for example, local mass media and 'healthy living' programs

– health-promoting families, schools, communities and workplace initiatives

– new community-level innovation in community engagement and social marketing.

The targeted investment in the Prevention Community Model sites is complemented by investment in statewide initiatives including:

– the CEIPS to generate and promote evidence about the implementation of preventive health interventions

– establishment of a Victorian Healthy Eating Advisory Service to provide healthy eating and nutrition advice to early childhood services, primary and secondary schools, hospitals and a number of workplaces

– recognition and award programs to support good practice in workplaces, and early childhood and education settings

– statewide social marketing efforts to reinforce healthy living messages.

The NPAPH represents the first stage of investment in the Prevention Community Model; more communities will follow if they choose to adopt a similar approach within existing resources, or should new resources become available. Combining aspects of the NPAPH model with enhanced health planning by local councils and local partners offers further opportunities to strengthen healthy community initiatives, and to build a comprehensive approach to community engagement

For all communities, the primary strategic planning mechanism for public health and wellbeing efforts is the MPHWP. Opportunities exist for further alignment between PCPs and local government to better integrate PCP IHP plans and MPHWPs.[2]

To build on the *Environments for health* framework as the next wave of municipal health and wellbeing planning occurs, local government leadership will be important over the life of this plan. Many opportunities exist to further expand and strengthen the focus of municipal plans. For example, it is anticipated that there will be important lessons and recommendations arising out of the Parliamentary Inquiry into Environmental Design and Public Health, which will report in 2012.

The development of a Metropolitan Planning Strategy will identify infrastructure and transport needs, and consider ways to link planning and development for better outcomes for health, wellbeing and the economy. Better safety, improved public amenity and greater opportunities for transport and activity will be supported through place-based approaches such as urban renewal, neighbourhood improvement programs and growth area planning.

Other opportunities include building on the experience of the Office of Senior Victorians, the MAV, and the Council of the Ageing's Positive Ageing in Local Communities Project, consistent with WHO's *Age-friendly cities guide* (WHO 2007a). The 2011–2013 Improving Liveability for Older People initiative in 12 regional shires will provide further evidence in support of local government's role in improving quality of life for older people.

2   A number of examples of good practice are emerging. For example, in Wellington the PCP and shire continue to work to improve physical activity in the community. The aim is to have one plan across the catchment by June 2012 to identify partners' roles and responsibilities in the delivery of a mix of interventions required to increase opportunities for physical activity.

Opportunities for progress in 2011–2015 include:

– support local communities to take action on their health through the Prevention Community Model (significant enabling infrastructure and ongoing support will be provided to a number of Victorian communities to enable effective and sustainable delivery of interventions)

– revitalise the *Environments for health framework* and strengthen strategic partnerships with local government to enhance municipal public health and wellbeing planning, implementation and evaluation

– work to better align planning between local government, PCPs, primary health agencies, and other providers of health promotion and prevention

– develop interventions through the health planning process to address the needs of population groups (including the ageing population and those who are vulnerable to poor health) to support overall community health and wellbeing, and address specific health needs

– invest in the Victorian Population Health Survey to produce population health status estimates for each local government area in Victoria every three years

– work with other state bodies to supply local government with information and appropriate resources to support them in planning as part of the review of their MPHWPs

– participate in coordination and consultation mechanisms with other state government bodies with policy responsibilities for planning and environmental design that impact on the health of communities and initiatives with local government

– sustain commitment towards greater use of parks and open spaces to encourage active living

– recognise communities that promote health and wellbeing through awards, forums and leadership programs.

5.2 Workplaces

Public health and wellbeing in workplaces: an overview

Nearly three million Victorians are in full- or part-time work (ABS 2011). With employees spending about one third of their total hours at work, the workplace provides significant opportunities for promoting health and wellbeing.

The benefits of a healthy paid and unpaid (volunteer) workforce reach far beyond individual workers. Improvements in workers' health behaviours and attitudes towards health have the capacity to influence the health of families and communities, and deliver significant social, business and economic benefits. The full-time workforce and productivity could increase by 10 per cent if chronic disease was eliminated (Business Council of Australia 2011a). It is estimated that the loss to the labour force from people suffering from chronic disease (or their carers) is 537,000 full-time person years and 47,000 part-time person years (Business Council of Australia 2011a). The cost of absenteeism amounts to $7 billion per annum, and presenteeism between $18–25 billion per annum (Business Council of Australia 2011a).

The evidence for effective workplace health programs shows benefits both for employees and employers (WHO 2010b). Studies have shown an up to a 35 per cent decrease in sick days among participants in comprehensive workplace health promotion programs (PriceWaterhouseCoopers LLP 2008). Improving the health of the working population will assist in lifting productivity and workforce participation, and in reducing workplace injury, sick leave and unnecessary turnover. It will also help minimise the effects of the projected shortfall in supply of workers and the declining participation rates of older workers.

Victoria's WorkHealth initiative, delivered by WorkSafe Victoria since 2008, is a program that has broken new ground in developing partnerships and communicating with employers and employees about the relevance and benefits of preventive health in a workplace context.

WorkHealth – key facts

The WorkHealth initiative is a five-year pilot program, that delivers free, voluntary and confidential health checks in Victorian workplaces, assessing individuals' risk of type 2 diabetes and CVD. The health checks are supported by interventions that facilitate individual and organisation-wide behaviour change.

More than 300,000 WorkHealth checks delivered across the state have revealed a range of concerns about the health of the workforce including disturbing rates of inadequate fruit and vegetable consumption and physical inactivity across all workers. Sixty-six per cent of those tested were found to be at risk of developing type 2 diabetes or CVD (WorkHealth 2011).

Importantly, 84 per cent of workers with the highest risk of CVD or type 2 diabetes rated themselves as being in good health, meaning many workers are unaware that they have significant health risks (WorkHealth 2011).

Looking ahead

There is a strong rationale to expand and enhance efforts in workplace health promotion, and to continue to strengthen the partnerships with employers and employees to improve health in a wide range of industries. As a lead agency in workplaces, WorkSafe is well positioned, in partnership with others, to continue to drive preventive health programs and deliver health messages to Victorian workplaces.

An aligned and coordinated approach across various partners with interests in workplace health in the state – including the Department of Health, VicHealth, NGOs, local health services and private sector groups – could further strengthen the opportunities to improve the health and wellbeing of the Victorian workforce.

Victoria's approach to implementing the NPAPH Healthy Workers Initiative will involve both statewide and community-level activities to support the next phase of a best practice approach to workplace health promotion. This will be complemented by national activities under the NPAPH, such as the Joint Statement of Commitment signed by peak employer and union bodies, and a National Quality Framework to specify standards for workplace-based prevention programs.

For greatest population effect further action needs to consider workplaces as health promotion settings and workers as potential providers of health promotion interventions.

Opportunities for progress in 2011–2015 include:

— further drive health awareness in the workplace, increase business investment in health and wellbeing, boost worker participation in lifestyle programs to reduce health risks, and evaluate the various WorkHealth interventions (this work includes improving referral pathways to primary care providers and to lifestyle change programs such as the Life! Diabetes and Cardiovascular Disease Prevention Program)

— build on successes to date by developing a statewide, long-term workplace preventive health approach to guide Victoria's efforts in workplace preventive health and wellbeing incorporating the connection between workplaces, workforces and the community

— ensure workplace and workforce strategies are coordinated, complementary and comprehensive, drawing on worker population health data and a range of effective interventions spanning organisational leadership, wellbeing planning, local policy development, healthy environments creation, social marketing and healthy living programs

— support employers and employees to develop skills, leadership and knowledge to take action on health

— establish a Workplace Health and Wellbeing Partnership chaired by the Department of Health to advise and oversee the rollout of the NPAPH – Healthy Workers Initiative

— link the Workplace Partnership to a series of prevention consortia to oversee significant programs of preventive health work such as social marketing, healthy living programs, a prevention workforce to support action for workers and a Victorian prevention awards program

— continue to lead the establishment of industry partnerships and deliver coordinated preventive health messages to Victorian businesses and working Victorians

— explore appropriate ways to link Victorian employers and employees to the online national Healthy Workers Portal being developed to support the implementation of healthy living programs in workplaces as part of the NPAPH Healthy Worker Initiative

— through the NPAPH Prevention Community Model, support comprehensive local approaches to healthy workplaces and workers, coordinated by workplace health promotion officers (local approaches will provide expertise and intensive support for workplaces, as well as enable smaller and medium-sized enterprises to access programs offered in the local community)

— work to develop a voluntary industry recognition program that aligns with existing industry awards programs offered through WorkSafe and other agencies

— develop approaches to tackle workplace stress in partnership with organisations such as beyondblue, VicHealth and WorkSafe Victoria

— through the new Victorian Healthy Eating Advisory Service, support workplaces to implement healthy eating policies and provide and promote healthier foods

— continue to support research, community initiatives and events that promote healthy behaviours and raise awareness of health in the context of work such as ride/walk to work days

— establish immunisation advice mechanisms to support employers to provide workplace immunisation.

5.3 Early childhood and education settings

Public health and wellbeing in early childhood and education settings: an overview

Good health is a prerequisite for good learning. Advances in neuroscience have identified the importance of influences on brain development during the early years, extending through childhood and adolescence to early adulthood. The evidence is clear that supporting and nurturing all children's learning and development from birth is crucial to long-term health, educational, social and economic outcomes (Schweinhart et al. 2005; Shonkoff et al. 2009; Shonkoff & Philips 2001). Likewise, better health has important benefits for optimal development and educational attainment (Suhrcke & de Paz Nieves 2011). As children and young people develop the knowledge, skills and behaviour for lifelong health and wellbeing, preventive efforts focused early in life are likely to be effective and long-lasting.

The 2010 Victorian Parliamentary Inquiry into the Potential for Developing Opportunities for Schools to Become a Focus for Promoting Healthy Community Living explored the concept of health-promoting schools. The inquiry's report recommendations provide a broad framework for how the Victorian health-promoting schools approach could be supported through Victorian government, Catholic and independent schools (Education and Training Committee 2010).

The State of Victoria's Children report provides collated data from a variety of children's health data sources and also shows some of the developmental determinants of adult onset disease. The 2010 report will provide baseline information against which impacts of this plan will be assessed.

The universal maternal and child health (MCH) service provided by local government supports all families and their children. It emphasises parenting, prevention, health promotion, developmental assessment, early detection and referral, social support, and links to the community. The enhanced MCH service provides more targeted, intensive support to identified vulnerable families.

Services for children and families within community health are based on evidence that identifies the significance of the early years. Through supporting early identification and treatment of health and developmental problems, community health services are well placed to respond to the needs of young children and their families. Child health teams provide multidisciplinary care with a focus on the provision of early interventions, as well as improving the capacity of parents and families to understand and manage the health and development needs of their child.

Groundbreaking projects and programs from Victoria over the past several years have demonstrated success in working with schools and early years settings on health promotion topics such as physical activity, healthy eating, oral health promotion and mental health promotion. An opportunity exists to build on and improve the programs and projects that have happened to date, and create a cohesive initiative focused on promoting the physical health, and social and emotional development of children and young people.

Looking ahead

The 2011 four-year investment in the NPAPH Healthy Children Initiative will support Victoria's new Prevention Community Model (outlined in chapter 5.1). Victoria's approach to implementing NPAPH's Healthy Children Initiative will build the capacity of early childhood and education settings to promote healthy lifestyles in children and young people.

Through this initiative the Department of Education and Early Childhood Development and the Department of Health are working together on a statewide policy to guide health promotion for children and young people, on a recognition and award program to support developing and good practice, and collaborating on a range of child health and wellbeing surveillance improvement efforts. These actions will be supported by a new Victorian Healthy Eating Advisory Service which will provide healthy eating and nutrition advice to early childhood services, primary and secondary schools.

It is also important to support and strengthen existing platforms that provide valuable support to children and families. The Early Home Learning Study, currently being trialled through the MCH service, aims to provide a positive home learning environment to optimise child development. The findings, when released in the next two years, will have significant implications for health-promoting activities in early childhood.

The evidence of the benefits of breastfeeding for lifelong health is clear. According to the National Health and Medical Research Council (NHMRC), the total value of breastfeeding to the community makes it one of the most cost-effective primary prevention measures available and well worth the support of the entire community (NHMRC 2003b).

Opportunities for progress in 2011–2015 include:

– through the new Victorian Healthy Eating Advisory Service, expand support for early childhood and education settings to implement their relevant nutrition policies, such as school canteen policies, and provide and promote healthier foods

– establish local prevention teams in selected communities, including healthy children positions that will provide support to early childhood and education settings to participate in health promotion in partnership with their local community

– establish a range of Healthy Living Programs in selected communities to provide opportunities for parents and families to engage in local community activities and access state-of-the-art information and resources for promoting good health

– provide a tailored community education and social marketing initiative that engages parents, families and the broader community in preventive health (healthy living messages and ideas for taking action on health will be provided over the coming four years)

– support health-promoting approaches in other family and children's settings including recreation facilities and junior sport for example: promoting healthy eating in sporting events such as Auskick and promoting mental health through partnerships such as beyondblue

– support and strengthen the universal MCH service platform through a continued focus on quality provision of service, and support the findings of the Early Home Learning Study when available

– promote and support breastfeeding practice through a range of supportive social and educational initiatives

– continue to support the ongoing work of the Victorian Child and Adolescent Monitoring System (VCAMS), which provides an outcomes communication framework to report the population effectiveness of prevention and health promotion efforts across Victoria

– strengthen the Victorian child surveillance of impact measures such as overweight/ obesity, physical activity and healthy eating to better support and inform policy

– establish a Victorian Prevention and Health Promotion Achievement Program to support developing and good practice for schools, early childhood settings and other children's settings to work towards meeting relevant benchmarks in health promotion achievement (this will be part of a comprehensive whole-of-community and state prevention awards program; categories will include healthy schools, childcare settings, workers/workplaces and communities)

– develop new health promotion guidelines for children and young people to establish best practice for promoting the physical health and social and emotional development of children and young people (the new approach will be a cohesive policy that is easier for early years services, schools and other children's settings to implement).

5.4   Health services

The role of health services in prevention: an overview

In addition to their role in delivering preventive healthcare, health services also contribute to prevention in many other ways. Many health services employ health promotion staff who may have an outreach role. In addition, many health services also have a focus on the health of their own workforce, contribute to healthy environments (for example, as part of facility design), take a population approach to service planning, engage with their local communities, are leaders and role models, and are partners with other services and organisations. Some services are affiliated with WHO's International Network of Health Promoting Hospitals.

Evidence-based preventive services delivered by healthcare providers, including general practitioners, practice/community nurses and allied health professionals, are effective in reducing death and disability, and are cost-effective or even cost-saving. Preventive services are delivered to individuals, either as part of organised programs or opportunistically in the context of clinical consultations. They may include measures (including counselling and medications) that prevent disease, detect health problems early, delay onset or moderate disease severity, or provide people with the information they need to make good decisions about their health.

Preventive services include those that provide for early detection (for example, Pap smears and blood pressure checks) and preventive care (for example, immunisation, pregnancy/infant care, family planning services and counselling), and approaches that support individuals and their families to self-manage long-term conditions and disabilities and participate in meaningful activities (continuing care and rehabilitation). Health promotion in the form of client education and lifestyle advice to individuals is a fundamental component of preventive healthcare.

Brief interventions in primary care, such as advice on smoking, can be highly effective in some situations. However, in many instances, better outcomes can be achieved by referrals either to well-designed group or individual interventions delivered by providers with special training or expertise in lifestyle modification, or to community programs that provide supports and motivation for behaviour change.

With chronic disease, the prevention goals are to prevent or delay the development of complications and disability, and to maximise health-related quality of life. There are two key differences between a preventive approach in the clinical setting and treatment based on a reactive approach to specific episodes of illness: a systematic approach to management, and a context of client empowerment. Services provided by specialist clinics (for example, diabetes centres) can therefore also be seen to contribute to prevention. Significant health gains could be achieved by ensuring that people with biological risk factors (such as hypertension or high cholesterol) achieve and maintain control of their conditions consistent with clinical guidelines.

In Victoria community health services represent an extensive network of organisations delivering care in every LGA across the state. They provide a strong platform for delivering services and programs across the care continuum, underpinned by the social model of health. Funding supports local community health services to work in partnership and develop flexible models of care that meet the needs of their communities, particularly vulnerable groups at risk of poorer health. Community health services will be a key partner in the Prevention Community Model and will provide many of the lifestyle modification interventions.

PCPs have a key role to play in enabling linkages and referral pathways in networks of preventive health and community services.

Looking ahead

A systematic approach to preventive services can be extended to the whole of a practice population (that is, to all individuals attending a service) and applied across the continuum of care. Practitioners would then have more opportunities both to embed best practice clinical care within a broader population health context, and to assess their practice against population health targets (for example, the proportion of women in the practice population who have had Pap smears).

Community programs can also play a role in promoting the use of preventive health services and assisting clients to overcome barriers (for example, transportation, childcare or client navigation issues). Many more people will receive the preventive care they need if logistical, financial, cultural and health literacy barriers to care are removed, and if information and decision supports are available to clinicians and service providers. Furthermore, quality of outcomes are improved if clinical, community and complementary services are integrated and mutually reinforcing.

Over the life of the plan, priorities for community health services include preventing ill-health, improving the health and wellbeing of populations, reducing health disparities and intervening early to reduce the impact of chronic conditions.

Furthermore, PCPs, which include divisions of general practice as key members of their partnerships, will work with local primary care practitioners to strengthen the primary health service system. In this area, significant opportunities exist to enhance existing practice to achieve better outcomes for those at medium to high risk of lifestyle-related conditions.

Opportunities for progress in 2011–2015 include:

— promote referral pathways and access from general practice and other private providers to services that support healthy living

— support the active service model in strengthening person-centred capacity building and restorative care approaches to delivering HACC services among older people, people with disabilities and their carers in Victoria

— support the delivery of healthy living programs for children and their families (particularly those at risk of poor health), that aim to increase physical activity and healthy eating such as the MEND program

— explore ways to increase the capacity of primary health practitioners to deliver preventive health services to high-needs populations such as refugees, and use reports such as the *VCAMS refugee status report* (Department of Education and Early Childhood Development 2011) to monitor progress

— support the routine use of evidence-based screening tools (such as the diabetes risk assessment and absolute risk tool) within community health, and the development of effective referral systems and pathways for people identified as being at risk

— continue to build the capacity of community health services and other primary care providers to provide high-quality early intervention services

— strengthen the capacity of community health services to deliver early, evidence-based, multidisciplinary assessment and care to children and their families (for conditions such as developmental delay)

— within clinical care provided by community health services, continue to support the delivery of health education and support for behaviour change in addressing health risks

— develop Victorian guidelines for health-promoting health services

— as part of the COAG National Health Reform Agreement, the Victorian and Commonwealth Governments will develop a joint plan for general practice and other primary healthcare services. This will include a focus on prevention and early intervention. This may include strategies that strengthen the role of general practice (including GPs and practice nurses) and other private providers in risk factor and illness prevention and early intervention, for example, building on the Lifescripts initiative.

Interventions

Public health activities are diverse. They include surveillance, health education, lifestyle advice, organised immunisation programs, risk-factor monitoring, regulation, fiscal measures and response and control activities.

The major components of public health practice are health protection, prevention and promotion. Its aims are to:

— **continue to protect health** (health protection) including environmental health and communicable disease control

— **keep people well** (health promotion/ prevention), with a focus on lifestyle-related risk factors such as smoking, diet and oral health

— **strengthen preventive healthcare** including cancer screening, health checks, early detection and early intervention, counselling and lifestyle advice.

Strategic directions across a range of priority interventions are proposed opposite.

Strategic directions

– Integrate statewide policy and
 planning to strengthen public health
 and wellbeing interventions

– Increase the health literacy of all Victorians
 and support people to better manage their
 own health

– Tailor interventions for priority populations
 to reduce disparities in health outcomes

Action areas
Continue to protect health

– Communicable disease prevention and control
– Immunisation
– Environmental health
– Food safety
– Incident and emergency response

Keep people well

– Healthy eating
– Physical activity
– Tobacco control
– Oral health
– Alcohol and other drug use
– Sexual and reproductive health promotion
– Mental health promotion
– Injury prevention
– Skin cancer prevention

Strengthen preventive healthcare

– Cancer screening
– Newborn screening
– Early detection and
 early intervention

6. Continue to protect the health of Victorians

Health protection activities ensure that risks to the health of Victorians are identified, investigated and controlled without delay.

Outbreaks of new and re-emerging infectious diseases in recent years, such as SARS and avian flu, as well as recent natural disasters, have served as salient reminders of the critical – although often invisible – role that the health protection system plays in maintaining our health and wellbeing.

The risks to health from communicable diseases, food safety issues and environmental hazards require sustained efforts and constant vigilance in the face of new and emerging challenges.

Communicable disease

Communicable disease control is an important health priority both in Australia and internationally. Strengthening surveillance capacity, developing and delivering evidence-based prevention, ongoing control of current and emerging diseases, and fostering partnerships and collaboration are key actions for communicable disease management.

Immunisation

Immunisation remains one of the most effective and cost-effective interventions to reduce the incidence of vaccine-preventable diseases, protecting not only the individual but the wider community. It is important to maintain and increase vaccination coverage, particularly for populations with low coverage.

Environmental health

Preventable environmental health hazards (including physical, chemical, biological and radiological hazards) contribute to the burden of disease and illness in Victoria. Proactive management of these hazards requires a strong emphasis on health risk assessment, and the integration of multiple strategies including policy development and review, regulation, education, communication, advocacy, monitoring and surveillance.

Food safety

Sustained effort is required to maintain the high degree of public confidence in the safety of food in Victoria. This involves responding to contemporary trends in food trade, technology and consumption patterns that create the potential for significant food safety risks.

Incident and emergency response

Public health incidents and emergencies, including adverse affects of fire, flood and contamination, require a coordinated response to both meet community need arising from incidents and emergencies and to plan for new and emerging threats.

6.1 Communicable disease prevention and control

Communicable diseases remain a significant public health priority both in Australia and internationally. The problems facing Australia today are diverse: food-borne diseases, emergence of antimicrobial-resistant bacteria, sexually transmissible infections, vector-borne diseases and some vaccine-preventable diseases. Also, we must continue to be prepared for the intentional release of a biological agent.

The arrival of pandemic influenza 2009 (pH^{1}N^1) in Australia was a timely reminder of the importance of communicable diseases planning and preparedness.

In order to monitor and control communicable diseases in Victoria, the Public Health and Wellbeing Act requires the notification of certain conditions, and specifies the manner and timing of their notification. In 2010, 119,021 notifications were received, which represented 50,141 cases and 579 outbreaks (Department of Health 2011a).

Current priorities in communicable diseases in Victoria include increases in *Salmonella*, pertussis, tuberculosis and sexually transmissible infections. There were 2,260 notifications for *Salmonella* infections in 2010; an increase of 43 per cent on the previous five-year average (Department of Health 2011a). There was also an increase in the number of *Salmonella* outbreaks requiring investigation by the Department of Health. There were also 3,022 notified cases of pertussis in 2010, which was an increase of 300 per cent since 2008 (Department of Health 2011a). Notified cases of tuberculosis increased by 18 per cent on the previous five-year average to 435 cases in 2010 (Department of Health 2011a).

Opportunities for progress in 2011–2015 include:

– strengthen our high-quality surveillance systems through enhanced data collection, analysis and reporting

– continue to provide timely, targeted public health interventions based on best practice to manage current and emerging communicable diseases affecting individuals and the broader community

– enhance preparedness and operational capacity to respond to new and emerging diseases and public health emergencies, including rapid response to outbreaks in the Victorian community

– strengthen public health action to control notifiable diseases according to impact and in line with national and state protocols, with particular attention to tuberculosis, pertussis, *Salmonella* and sexually transmissible infections

– work in partnership with local government to ensure collaborative and effective polices and operating procedures are in place for public health priorities.

6.2 Immunisation

Immunisation is widely acclaimed as one of the world's most effective and cost-effective public health interventions, protecting not only the individual but the wider community. Global immunisation programs have brought nine major diseases under varying degrees of control. Victoria's comprehensive program, including the legislative aspects, has contributed to high levels of immunisation in the community.

Immunisation coverage for children in Victoria at 30 June 2011 was:

– at 12 months – 92 per cent
– at 24 months – 93 per cent
– at five years – 91 per cent (Australian Childhood Immunisation Register 2011).

Immunisation coverage in young people and adults varies according to the specific program. For example,

– 76.1 per cent of eligible young women (aged 12–15) were vaccinated for human papillomavirus in 2009 (Department of Health and Ageing 2011)

– 75 per cent of Victorians aged 65 years or older were vaccinated against seasonal influenza in 2009 (AIHW 2011a).

Maintaining and increasing vaccination coverage, particularly for populations with low coverage, is a priority.

Opportunities for progress in 2011–2015 include:

– continue to implement key action areas of the *Victorian immunisation strategy 2009–2012* (Department of Human Services 2008c) including addressing high-risk groups and service quality

– work with key partners to increase opportunities for timely immunisation of Aboriginal and Torres Strait Islander children and increase uptake in areas of low coverage

– meet the four performance benchmarks of the *National Partnership Agreement on Essential Vaccines* (COAG 2009b), which means maintaining or increasing vaccination coverage for four-year-olds, Aboriginal Australians and people living in areas of low immunisation coverage, as well as maintaining or decreasing wastage and leakage of vaccines

– continue to advocate to the Commonwealth for inclusion of additional target populations in the National Immunisation Program (for example, pertussis containing vaccine for new parents).

6.3 Environmental health

The most challenging up-and-coming preventable environmental health issues include:

— land-use conflicts resulting from rapidly growing populations and emerging technologies

— outdoor air quality from industry, motor vehicles, bushfires and wind-blown dust

— appropriate management of use of all water resources and preventing illness from inappropriate exposure to alternative water sources

— the rapid growth in the collective radiation dose to the population arising both from the increasing use of ionising radiation diagnostic medical imaging procedures and from higher dose X-ray technology, particularly computed tomography (CT) scanning.

Victorians expect environmental health hazards to be proactively managed according to best practice. This requires a strong emphasis on early hazard identification, health risk assessment and hazard management through the application of multiple skills including policy, regulation, education, communication, advocacy, monitoring and surveillance. In many cases, the regulatory responsibilities are carried out in partnership with other state agencies and by devolving operational regulatory responsibilities to local government. In other cases the regulatory responsibilities are carried out by the Department of Health. For example, the regulation of cooling tower systems and water delivery systems to minimise the impact of legionnaires' disease on the Victorian community is administered solely by the Department of Health.

Along with workforce shortages faced by many industries and service sectors within Australia (including health), the environmental health workforce is currently experiencing capacity challenges. This is, in part, due to recent increases in the number and severity of natural disasters, and increasing complexity of managing environmental health issues and the expectations of the public.

These challenges impact on the government's ability to deliver best practice, timely environmental health programs and services.

Opportunities for progress in 2011–2015 include:

– work with municipal public health and wellbeing planners and health service providers to adapt and reduce health impacts of heatwaves on vulnerable communities and implement the requirements of the relevant Acts

– ensure population health considerations are incorporated into policy, state, regional and community planning including planning for major housing and industrial developments, and other land use planning and design processes

– protect and enhance the health and wellbeing of Victorians in relation to all uses of water through maintaining and improving the integrity of drinking water supplies, water fluoridation coverage and implementing an effective regulatory framework for the use of alternative water supplies for non-drinking purposes. In addition, the *Living Victoria, Living Melbourne Roadmap* (Department of Sustainability and Environment 2011) aims to establish Victoria as a world leader in liveable cities and integrated water cycle management

– explore workforce development options to increase the capacity of the environmental health workforce to protect the Victorian community from hazards in the environment

– further develop radiation safety efforts to continue to protect Victorians from the harmful effects of radiation, while continuing to enjoy the benefits that radiation brings to many areas ranging from medical to industrial uses. This could encompass regulation, risk communication, emergency preparedness, the long-term management of radioactive waste and the protection of high-consequence radioactive material from misuse by terrorists.

6.4   Food safety

Victoria has been a leader in implementing systems to manage food safety risk. Victorians enjoy a high degree of public confidence in the safety of food (Campbell Research & Consulting 2005). Nonetheless, food-borne illness is a perennial problem that requires sustained effort and attention to prevent and manage risks to public health. It remains a significant contributor to the burden of disease, and to health system and lost productivity costs, with an estimated 5.4 million cases of illness Australia-wide costing an estimated $1.2 billion each year (OzFoodNet 2009). Many of these cases of illness are preventable. A major food safety incident can have serious public health and economic ramifications, including negative impacts on industry viability and jobs, trade and investment.

Today's food products often contain multiple ingredients sourced from around the globe. Local economic or environmental pressures can lead to sub-optimal food production practices, creating food safety risks. Complex global supply chains for foods and their ingredients is making investigating outbreaks of food-borne disease increasingly difficult. Improvements in the traceability of foods and all their ingredients throughout the supply chain are required so that rapid targeted action can be taken to protect the public whenever risks to health are detected.

Rapid product innovation to satisfy the growing demand for convenience foods and the use of new technologies in food processing can also give rise to benefits and risks for food safety. Data suggests a growing number of food allergy and anaphylaxis sufferers, this will require additional emphasis on systems to protect their health (Department of Human Services 2009). At the local level, there is significant scope to improve food safety outcomes through increasing community understanding of food safety risks and how to manage them.

Food safety and regulation involves all three levels of government. Victoria works with a range of partners and stakeholders to identify and manage food safety risks, promote effective food regulation, and improve food safety knowledge and practices.

Opportunities for progress in 2011–2015 include:

–   continue working with partners and stakeholders to ensure effective implementation of the 2009 amendments to the Food Act and to embed the operational and cultural changes required to continuously improve the consistency, accountability and effectiveness of food regulation

–   strengthen food surveillance and the capacity for evidence-based public health and regulatory interventions by progressively building a robust Food Act data collection process (supplemented by periodic surveys of food handler knowledge and stakeholders' experiences) and by developing tools to assist in measuring effectiveness

–   work to reduce the incidence of food-borne *Salmonella* infections through collaboration with business, local government and food premises

–   improve public awareness of food safety issues and compliance with food laws by developing innovative new education and compliance tools, building on the success of the *dofoodsafely* initiative

–   enhance compliance and enforcement of food regulation by developing an enforcement policy framework, working with stakeholders to deliver specific compliance strategies and programs

–   develop a strategic approach to food safety and food regulation in consultation with key partners and stakeholders.

6.5 Incident and emergency response

The Department of Health currently has responsibilities that include responding to small-scale incidents associated with core business activities, as well as broader incident control responsibilities.

Under Victoria's emergency management arrangements, the department is the control agency for public health emergencies that involve:

– human disease
– biological materials
– radioactive materials
– food/drinking water contamination.

Under current legislation and regulations, the control authority ultimately rests with the Chief Health Officer to undertake actions in relation to incident control.

The management of public health emergencies requires cooperation and communication between the various divisions of the department, the department's regions, the Department of Human Services, emergency services organisations, local government, non-government agencies, industry and, ultimately, the community.

A joint agency and an all-hazards approach is generally preferred for managing emergencies, including those with public health impacts. The Department of Health also performs a crucial role in the provision of timely public health information and warnings to the community and support agencies.

The department does not exercise control responsibilities for other emergency events, however, under Victoria's emergency management arrangements, the department may be called on by other control agencies to provide support during any other emergency.

Responding to community needs arising from incidents and emergencies, and planning for new and emerging threats, are priorities.

Opportunities for progress in 2011–2015 include:

– continue to work with other government, emergency services, non-government organisations and industry so that Victoria is appropriately prepared to respond to and meet community needs arising from incidents and emergencies

– develop the capacity of the public health workforce to protect the Victorian community from public health hazards and emergencies

– work to improve protection from adverse health impacts of emergency events

– evaluate and undertake planning for new and emerging threats and consider the health impacts of incidents and emergencies.

7. Keep people well

Escalating rates of chronic disease place a huge burden on the Victorian community, yet many of these conditions are able to be prevented. Research following 20,000 people between 1993 and 2006 showed that those having four healthier behaviours (not smoking, drinking in moderation, being physically active and having a healthy diet) had a mortality risk equivalent to being 14 years younger, compared with those with none of these good behaviours. Put simply, multiple poor behaviours multiply the health risks that people face (Khaw et al. 2008).

The influences on health are many and complex, operating at individual, societal and systemic levels, and at different stages of wellbeing. For example, whether or not an individual is obese or suffers from stress may arise from factors as diverse as income and behaviour, and whether obesity and stress develop into CVD and mental illness may in turn be determined by physical activity and involvement in a supportive community.

Health can be promoted by both increasing the factors that build our wellbeing and protect our health, and reducing the factors that put us at risk of illness and expose us to threats to our wellbeing. Both health and non-health sector organisations play an important preventive and restorative role in the health and wellbeing of the community. For instance, programs that maintain social networks, reconnect isolated people into their community, facilitate maintenance or re-entry into paid or unpaid work, and encourage councils and organisations to consider accessibility and age-friendly environments, all contribute to individual health and wellbeing.

Supporting healthy lifestyle choices – for example, encouraging participation in physical and social activity, and reducing excess consumption of unhealthy food, alcohol and other substances – can contribute not only to the reduction of illness, but also to improved physical and mental wellbeing.

Maintaining the health of Victorians entails providing individuals with the information and skills required to make healthy choices, coupled with supporting communities to facilitate living a healthy lifestyle. These approaches may be tailored to meet the specific needs of particular communities, for example the *Life is health is life, Taking action to close the gap* (VicHealth 2011) resource provides a health promotion framework for Victorian Aboriginal communities.

This chapter highlights the priority issues for promoting the health of Victorians:

–   increasing healthy eating
–   increasing physical activity
–   controlling tobacco use
–   improving oral health
–   reducing misuse of alcohol and drugs
–   promoting sexual and reproductive health
–   promoting mental health
–   preventing injury
–   preventing skin cancer.

None of these issues stand alone. The opportunities for progress are identified in the context of the development of new plans (including strategic directions in Aboriginal health, refugee health and wellbeing, alcohol and drugs, child and paediatric services, healthy ageing, and plans for managing cardiac, renal, and chronic and complex conditions) and by reviewing existing plans (for example, plans for: cancer, oral health, women's and men's health and wellbeing, and gay, lesbian, bisexual, transgender and intersex people's health).

7.1   Healthy eating

Healthy eating is the foundation of a healthy population and a productive workforce. Better nutrition can significantly improve the health and wellbeing of individuals and the population, as well as decrease chronic disease and associated healthcare costs for society. Many diet-related chronic diseases such as CVD, type 2 diabetes and some forms of cancer are the major cause of death and disability among Australians (AIHW 2010c). Food- and drink-related risk factors are estimated to contribute 10 per cent to the total burden of disease in Australia (Begg et al. 2007; Catford 2000).

The prevalence of overweight and obesity is rising and affects nearly half of all Victorians (48.6 per cent) (Department of Health 2010f). Australia's adult obesity rate is fifth highest among OECD countries (OECD 2007).

A key factor impacting on overweight/obesity and diet-related disease is the increased consumption of food and drinks high in fats, salt and sugar, served in larger portion sizes and of greater energy density. Consumption of these extra foods now contributes 36 per cent and 41 per cent of the total energy intake of Australian adults and children respectively; increasing (11–15 per cent) in a single decade for 10–15 year-old boys (Cook et al. 2001).

Some subgroups of Victorians experience particular nutritional issues, for example, deficiency of some nutrients such as iodine, folate, iron and vitamin D. Nearly six per cent of Victorians experienced food insecurity in 2008, with some geographic areas experiencing rates of up to 12.6 per cent (Department of Health 2010f). All Victorians should all be able benefit from regular supply of and access to nutritious foods.

For children and adolescents, healthy eating is essential for optimum growth and cognitive development. In particular, breastfeeding is an important factor for both maternal and child health and wellbeing. While 73.1 per cent of women initiate breastfeeding in Victoria, the rate drops to 36.9 per cent by six months (Department of Education and Early Childhood Development 2010). This is well below the 2003 NHMRC Dietary Guidelines recommendation of a 90 per cent initiation rate and 80 per cent breastfed at the age of six months (NHMRC 2003a; b).

Opportunities for progress in 2011–2015 include:

– support local councils and urban planners to enhance supply of and access to nutritious food in municipalities through promoting the uptake of existing tools (for example, the Victorian Local Governance Association's Municipal food security scanning tool and the Heart Foundation's Food-sensitive planning and urban design)

– implement policies and programs to support settings (early years services, schools, hospitals and workplaces) to promote healthy eating across the life course

– promote and support breastfeeding practice through a range of supportive social and educational initiatives

– develop strategies that facilitate an environment and culture where healthy choices are the easy choices for all Victorians, potentially including nutrition disclosure schemes for food outlets, healthy food outlet award/accreditation schemes, extension of current healthy food provision and procurement policy and guidelines

– support to improve healthy food supply and access by development and implementation of specific strategies to address identified nutrition issues for subpopulation groups and regional locations, especially vulnerable populations

– encourage a culture of healthy eating, through multi-strategy community-based programs and social marketing such as regional healthy cooking classes, healthy cooking grants, urban gardens, food rescue and distribution programs, and launch of an interactive health application on the Better Health Channel to support these initiatives

– implement the Prevention Community Model in 14 LGAs and implement health promotion initiatives for early childhood services and schools (see chapter 5.3) that support healthy eating, as well as implementing healthy workplace programs (see chapter 5.2) that include initiatives to encourage healthy eating

– develop healthy eating and nutrition approaches for Victoria and support the implementation of the *Victorian Aboriginal nutrition and physical activity strategy 2009–2014* (VACCHO 2009) in order to achieve a secure, accessible and sustainable supply of healthy food choices for all Victorians to consume and enjoy.

7.2 Physical activity

Physical inactivity is associated with an increased risk of ill-health and death, and has been linked to increased rates of overweight and obesity, CVD, some cancers, and depression (AIHW 2008; 2011c; National Heart Foundation of Australia 2009). Yet 32.7 per cent of Victorians aged over 18 years do not undertake sufficient levels of physical activity to meet the national guidelines (which includes incidental activity as well as physical exercise) (Department of Health 2010f).

Twenty-five per cent of children are overweight or obese, a significant increase from five per cent in the 1960s (Preventative Health Taskforce 2008). Based on past trends and in the absence of effective interventions, by 2025 this figure is likely to increase to 33 per cent (Department of Human Services 2008a; Haby et al. 2011).

Regular physical activity is a key factor in supporting a healthy population. Good urban design is focused on creating places which encourage public activity and through improved walkability, provide quality alternatives to car use. People in communities with access to parks, sporting grounds and open spaces are more likely to be physically active (Bauman & Bull 2007; Davison & Lawson 2006; Humpel et al. 2002; Sallis et al. 2006). Green spaces also contribute to enhanced mental health and wellbeing, and help to strengthen a sense of community by providing venues for relaxation, community celebrations and sporting competition (AIHW 2011c; Maller et al. 2008).

Opportunities for progress in 2011–2015 include:

– Get more people, more active, more often, through implementation of:
  - the Active Places program to help communities with low levels of physical activity to participate more frequently in sport and recreation
  - the Premier's Active Families Challenge to encourage Victorian families to undertake regular physical activity
  - the Ride2School program, supporting schools and assisting young people to incorporate physical activity into every day by choosing active modes of transport to and from school

– coordinate efforts across state and local government with policy and planning responsibilities for physical activity initiatives such as walking infrastructure, parks and open space for example:
  - the Department of Planning and Community Development – Sport and Recreation Victoria – community programs that encourage more people to be physically active and that support local government and local sport and recreation clubs to improve access to sporting and recreational facilities
  - coordinating the resources available to local government to support planning for walkability, open space, active transport and local transport solutions to make it easier for people to take part in community life

– implement the Prevention Community Model in 14 LGAs and implement health promotion initiatives for early childhood services and schools (see chapter 5.3) that support active play and physical activity, as well as implementing healthy workplace programs (see chapter 5.2) that include initiatives to reduce sedentary behaviour

– investigate a comprehensive statewide approach to promote physical activity and support the implementation of the *Victorian Aboriginal nutrition and physical activity strategy 2009–2014* (VACCHO 2009).

7.3 Tobacco control

Progress has been made in reducing the overall prevalence of smoking among Victorians, however smoking remains the leading avoidable cause of cancers, respiratory, cardiovascular and other diseases (Collins & Lapsley 2006). Smoking in Victoria costs approximately 4,000 lives and $5 billion annually (Department of Human Services 2008d). Its adverse effects are not evenly felt, but are concentrated in some communities and population groups, in both metropolitan and regional Victoria.

The government's considerable investment in tobacco control is primarily focused on actions to ensure a continuing reduction in smoking rates in the whole population, with specific actions to address smoking in low socioeconomic and priority populations with high smoking prevalence.

Significant decreases in the prevalence of regular smokers have been observed among almost all demographic groups; however, the general population trend tends to obscure markedly higher rates of smoking in some subgroups. Action to address these gaps is required.

For example, smoking prevalence is appreciably higher among Victorians living in low socioeconomic areas in comparison with those living in high socioeconomic areas. This disparity has been the focus of much on the state's investment in social marketing and is beginning to show signs of a positive impact in reducing the number of young people and adults living in these areas taking up smoking.

Aboriginal smoking rates are substantially higher than in the general population. For instance, Aboriginal smoking rates in pregnancy are nearly five times higher than for non-Aboriginal women in the last month prior to birth (Department of Health 2009). This is an area that requires sustained focus to achieve positive outcomes, and is included as a priority in the *National Partnership Agreement on Closing the Gap in Indigenous Health Outcomes* (COAG 2009a).

Other subgroups with high smoking prevalence include prison populations, homeless people and people living with a mental health condition.

An ongoing reduction in the involuntary exposure to second-hand smoke by non-smokers, including children, is also a key priority.

Opportunities for progress in 2011–2015 include:

– limit and reduce the exposure of Victorians to the harmful effects of tobacco smoke by initiating and supporting actions informed by evidence to: denormalise and discourage smoking uptake, especially by young people; promote the benefits of living without smoking and smoke-free environments; and support smokers' efforts to quit.

– support anti-smoking initiatives and provision of quit smoking services, as well as action to reduce smoking in the key target groups of pregnant smokers and Aboriginal smokers

– maintain, monitor and enforce compliance with the Tobacco Act including addressing issues of noncompliance in retailer display bans, smoking bans in specified events and locations, and prohibited products

– monitor the emergence of council by-laws concerning the banning of smoking in public areas such as at beaches and playgrounds

– develop advice and options for possible legislative change.

7.4 Oral health

All Victorians should be able enjoy good oral health that allows them to eat and socialise without pain, discomfort or embarrassment. It is increasingly recognised that oral health is a significant health issue. Tooth decay is Victoria's most prevalent health problem, with more than half of all children and almost all adults affected (AIHW Dental Statistics and Research Unit 2009; Roberts-Thomson & Do 2007). All age groups retaining their natural teeth (although often heavily restored) longer than previous generations will create different needs for care and treatment in future.

Moderate or severe gum disease is the fifth most common problem, affecting over a third of Victorian concession card holders and over a quarter of non-cardholders (AIHW Dental Statistics and Research Unit 2009; National Advisory Committee on Oral Health 2004; Roberts-Thomson & Do 2007). Gum disease also becomes more of a problem in older age – 61 per cent of Australians 75 years and over with some natural teeth have moderate or severe gum disease (Roberts-Thomson & Do 2007).

Preventable dental hospitalisation is the highest cause of preventable hospitalisations in people aged under 20 (Victorian Health Information Surveillance System 2011). In addition, oral disease is the second most expensive disease group, with direct treatment costs in Victoria of over $2 billion annually (AIHW 2010b).

It is a priority to reduce the disparities in oral health including between people living in rural and metropolitan areas. Oral diseases are a key marker of disparity, with people in low-income households having over three times the impact of poor oral health on their quality of life compared with those in high-income households (AIHW Dental Statistics and Research Unit 2006). There are 370,000 Victorians who receive a reticulated water supply that is not fluoridated (Department of Health 2006).

Opportunities for progress in 2011–2015 include:

– include oral health promotion approaches in the update of Victoria's oral health plan and in health promotion plans at local, state and national levels; for example, Smiles4Miles

– increase oral health literacy through integrating oral health information with other health information and including oral health in school curricula, supported by the research, development and consistent use of evidence-based oral health approaches

– introduce oral health policies and practices in key settings (including healthy food and drink policies and daily oral healthcare where required – such as in residential care)

– target high-risk populations with prevention programs

– maximise the benefits of water fluoridation to all Victorian communities

– strengthen early detection of oral disease and early intervention

– utilise health and welfare workers such as MCH nurses and family and children's services workers as oral health promoters (including integrating oral health into well person's visits). This includes implementing the early intervention oral health program Healthy Families, Healthy Smiles to build the capacity of health workers working directly with young families.

7.5 Alcohol and other drug use

The consequences of risky drinking on health, productivity and public safety in Victoria are pronounced. In 2006 there were 765 alcohol-related deaths in Victoria (Turning Point Alcohol & Drug Centre 2011). The rate of alcohol-related Victorian emergency department presentations and hospitalisations has more than doubled since 1999–2000 (Turning Point Alcohol & Drug Centre 2011).

Of adult Victorians, 24 per cent of males and 20 per cent of females drink at risky levels at least once a year (Department of Health 2010f). Heavy drinking among young Victorians aged 16–25 has increased from approximately 25 per cent in 2002 to over 40 per cent in 2009 (Victorian Drug and Alcohol Prevention Council 2010). Consequently, efforts to decrease the current rates of risky drinking and delay youth uptake of consuming alcohol are paramount.

Yet while one third of current Victorian drinkers try to reduce their consumption each year, only 13 per cent of those seek help or information (ABS 2008). Hence it is important to increase access to early intervention options for risky drinkers.

Illicit drug use and pharmaceutical drug misuse are also of growing concern within the community. Emerging trends such as analogue drugs (chemical and herbal products that mimic the psychoactive effects of illegal drugs) and increases in cocaine, hallucinogen and cannabis use highlight the significance of drug related issues nation wide (AIHW 2011b).

The *National Drug Strategy Household Survey 2010* found that 9.4 per cent of the Victorian population aged 14 years and over reported recent use of cannabis, making cannabis the most widely used illicit drug in Victoria over the previous 12 month period (AIHW 2011b). In 2010, cannabis use was highest among those aged 18–29 years in Victoria, with 20.4 per cent of this population group having used cannabis at least once during the previous 12 months (AIHW 2011b).

There are also increased risks to mental health from cannabis use, with research indicating that cannabis use is associated with increased risk in the development of mental health problems, even without a family history of mental illness (Lubman et al. 2007).

Opportunities for progress in 2011–2015 include:

– develop a communication and education project targeting parents and teenagers in order to:
  • inform the community of recent amendments to the *Liquor Control Reform Act 1998* banning the supply of alcohol to minors in a private residence without parental consent
  • increase awareness among parents about the risks associated with excessive or unsupervised drinking by young people and educate families about why young people should delay drinking

– develop an online alcohol intervention tool aimed at reducing risky drinking in young Victorian adults (via the Better Health Channel website)

– improve alcohol and drug education in schools

– ban the display and sale of water pipes used to smoke cannabis in Victoria, and prohibit emerging drugs of concern, such as synthetic cannabis-like substances

– explore ways to educate young people and parents on the harms and risks associated with cannabis use

– develop a whole-of-government alcohol and drug strategy to reduce the incidence and impact of drug and alcohol abuse on individuals, families and the community.

7.6   Sexual and reproductive health promotion

Sexual health needs change across the life span and are influenced by a range of factors including: gender; sexual health literacy; social and community attitudes to sexuality and sexual relationships; freedom from coercion, discrimination and violence; and access to information, services and support.

Not all Victorians enjoy the same level of sexual and reproductive health. There have been a number of changes in social and sexual behaviour in Australia over the past decades that demand new responses and approaches.

Age of first sexual intercourse has reduced with the median age being 16 years for both women and men (Rissel et al. 2003); and contraceptive use at first intercourse has increased significantly from less than 30 per cent in the 1950s to over 90 per cent in the 2000s (Australian Research Centre in Sex Health & Society). This means young people are sexually active for a longer period of time with a higher number of sexual partners prior to committing to a life partner. Although contraceptive use has increased, sexually active young people face the risks of unplanned pregnancy and sexually transmissible infections (STIs) (Sexual and Reproductive Health Strategy Reference Group 2008).

Notifications of many STIs have increased in Victoria. For example, the number of notified cases of chlamydia increased 403 per cent between 2001 and 2010 with young people aged 15–29 accounting for 78 per cent of chlamydia notifications in Victoria in 2010 (Department of Health 2011a); there continues to be more than 200 new HIV infections in Victoria every year with 85 per cent of these cases occurring among gay and homosexually active men (Department of Health 2010b).

Efforts to prevent STIs, including HIV, need to include focused attention to those most at risk. The *Second national sexually transmissible infections strategy 2010–2013* (Department of Health and Ageing 2010a) and *Sixth national HIV strategy 2010–2013* (Department of Health and Ageing 2010b) identify a number of populations as priorities for prevention efforts, including: young people; Aboriginal and Torres Strait Islander peoples; gay men and other men who have sex with men; transgender people; sex workers; people living with HIV; people from (or who travel to) high-prevalence countries; people in custodial settings; and people who inject drugs.

Contraceptive use is high amongst sexually active adults however some methods are fallible and unplanned pregnancy is possible (Richters et al. 2003). The prevalence of unintended or unwanted pregnancy in Victoria is currently unknown, as data is not routinely collected. However, given the impact of unintended pregnancy, further prevention effort is needed to minimise risk. This will require a long-term approach, incorporating multiple health promotion and service system responses.

Opportunities for progress in 2011–2015 include:

- support efforts to reduce the transmission of and morbidity and mortality caused by STIs (including HIV), and minimise the personal and social impacts of these infections

- support affected communities to participate in STI (including HIV) prevention, health promotion and education strategies

- improve young people's sexual health literacy through quality school-based sexuality education (with continued support of the active partnership between the Department of Health and the Department of Education and Early Childhood Development)

- support collaborative workforce development for health, education, prevention, policy and research practitioners working in sexual health

- support health services working with Aboriginal communities to improve sexual health outcomes for Aboriginal Victorians

- improve access to sexual and reproductive health services across Victoria, particularly for at-risk populations

- collaborate with relevant agencies to work toward reducing, over time, the number of unplanned pregnancies.

7.7   Mental health promotion

About one in five Victorians live with a mental illness, with anxiety and depression the most common disorders. Mental illness is the largest single contributor to the disability burden in Victoria, and accounts for 70 per cent of the disease burden in young people (The Boston Consulting Group 2006). The estimated cost of mental health problems to Victorian society is $5.4 billion a year, of which $2.7 billion relates to lost productivity and workforce participation (The Boston Consulting Group 2006). Those living with mental illness frequently suffer the additional burden of stigma, prejudice and discrimination, which can further hinder social participation and recovery.

Mental health is a complex issue that has multiple causes and influences; however, particular risk factors contribute to a greater risk of developing a mental illness. These include violence against women, race-based discrimination, socioeconomic status, poor body image, trauma and workplace-related stress. People's mental health can also be protected by a range of factors such as the extent to which they are included in society (employment, housing), are connected to others and are resilient.

Addressing the differences in mental health status within population groups is a priority; those with low socioeconomic status and Aboriginal Victorians both report above average levels of psychological distress (Department of Health 2010a). In addition, nationally, suicide rates are up to five times higher for some Aboriginal populations (ABS and AIHW 2008). Moreover, for all Victorians, suicide is a leading cause of injury-related death, even ahead of traffic accidents (VISU 2010).

Opportunities for progress in 2011–2015 include:

– strengthen protective factors and reduce risk factors for mental health through a collaborative approach to mental health promotion in key areas (this will include tackling stress in the workplace, preventing violence against women, and promoting acceptance of diversity and social inclusion to build resilient and connected communities)

– target mental illness and suicide prevention measures to at-risk populations including Aboriginal Victorians, young Victorians and those with a low socioeconomic status

– develop resources to support best practice mental health promotion in a range of key settings including local communities, workplaces and early childhood services and schools

– support Victorians to maintain good mental health through increasing understanding of the actions individuals and communities can undertake to protect their mental health and build resilience

– develop a suicide prevention strategy for Victoria in collaboration with communities, local government and NGOs, including investment in a gay, lesbian, bisexual, transgender and intersex youth suicide prevention initiative.

7.8 Injury prevention

Injury and its residual effect represents a significant health challenge for Victoria. Overall, injury has the sixth highest burden of disease in terms of healthy years of life lost in Victoria (Department of Human Services 2005). In 2009 there were 109,939 hospital admissions and 285,860 emergency department presentations as a result of injuries, costing the state over $500 million in direct hospital costs (VISU 2011b).

Injury is usually categorised as either intentional (inflicted by self or another) or as unintentional (accidental). In Victoria in 2009, 2,223 people died a result of injuries, with 1,394 being the result of unintentional injury (VISU 2011b). Falls were the leading cause of injury admissions and emergency department presentations, accounting for more than one third of all hospital treated injury cases in 2009 (VISU 2011c). The direct hospital costs associated with treating falls in 2009 was over $200 million (VISU 2011b). Sporting-related injuries also appear to be increasing: in the eight year period from July 2002 to June 2010 the frequency of hospital-treated sports injury rates increased by an annual estimate of six per cent, and 60 per cent overall (VISU 2011a). In addition to the direct costs of treatment, the effects of sports injuries and the fear of injury are also significant barriers to increasing participation in sport and physical activity.

Injury prevention focuses on identifying the causes of injury and either eliminating or reducing exposure to these causes. Injury prevention activity includes making the built environment safer, promoting safety devices, and addressing factors that influence individual behaviour (National Public Health Partnership 2005). Responsibility for injury prevention rests with a number of government departments, statutory authorities and the community and business sectors, emphasising the need for intersectoral collaboration.

Opportunities for progress in 2011–2015 include:

– promote safe environments and reduce the rate of unintentional injuries through a comprehensive and coordinated approach to injury prevention across the state which would involve establishing injury prevention priorities, and facilitating government and inter-sectoral cooperation, coordination and data sharing

– facilitate the inclusion of evidence-based injury prevention interventions into municipal plans

– promote the adoption of evidence-based injury prevention interventions throughout the broader community and injury prevention sector.

7.9   Skin cancer prevention

Skin cancer places a significant burden of disease on the Victorian community. The main types of skin cancer are basal cell carcinoma (67 per cent of skin cancers), squamous cell carcinoma (31 per cent) and malignant melanoma (two per cent) (Cancer Council of Victoria 2010a). While malignant melanoma is the least common form of skin cancer, it is the most deadly. In 2009, 2,396 new cases of melanoma were diagnosed in Victoria, and 317 people died from the disease (Cancer Council of Victoria 2010b).

Sun exposure is the cause of approximately 99 per cent of non-melanoma skin cancers and 95 per cent of melanomas in Australia (Armstrong 2004; Armstrong & Kricker 1993). UV-emitting tanning devices are also carcinogenic to humans, with the risk of cutaneous melanoma increased by 75 per cent when the use of tanning devices starts before age 30 (The International Agency for Research on Cancer Working Group 2007).

Victoria is a leader in skin cancer prevention, achieved through the success of the SunSmart program, and policy and legislation reform such as solarium regulations.

Opportunities for progress in 2011–2015 include:

– continue to support VicHealth activity that aims to reduce harm from UV exposure (as outlined in the 2009–2013 strategic framework (VicHealth 2009)) and that provides funding for SunSmart initiatives delivered by the Cancer Council Victoria

– continue to monitor and evaluate the impact of strengthened solarium regulations in Victoria

– explore a comprehensive approach to skin cancer prevention, including evidence-based approaches for children, adolescents and young adults, and other priority populations.

8. Strengthen preventive healthcare

Detecting illness early and providing access to early care and treatment primarily benefits the individual, but it also has wider benefits when a sufficient proportion of the population is screened and treated.

Screening aims to find precursors to or early stages of disease before it causes symptoms, and therefore when treatment can be most effective. Screening is offered to people who may have an increased risk of a particular disease because of their age, gender or other factors. There are three different approaches to screening:

− **targeted** – testing of selected groups of people in high-risk categories, for example, genetic screening of people with a strong family history of breast cancer.

− **opportunistic** – tests offered to screen individual people when they attend a healthcare provider as part of a routine medical check-up.

− **population-based** – a test offered to all people within a target group (usually defined by age) as part of an organised program. The group is targeted because there is strong scientific evidence that they are at most risk of getting the disease and will get the most health benefit from screening. For a successful population screening program, a sufficient proportion of the population must participate in the program, and there must be evidence that early diagnosis and treatment increases the chance of successfully treating or managing the disease.

Early intervention requires individuals and health professionals to recognise symptoms early and provide access to treatment early in the progression of a disease to improve health outcomes.

Increasing people's participation in screening programs, improving their knowledge of the early warning signs of particular conditions, and ensuring access to and seamless transitions into early care, lead to better outcomes for individuals and for the population as a whole.

Development of the proposed Victorian Primary Health Care Plan will support a stronger primary healthcare system with a greater capacity to deliver primary healthcare, including prevention and early intervention.

As part of the National Health Reform Agreement, the Victorian Government has agreed to work together on system-wide policy and statewide planning for general practice and primary healthcare. This plan will also support a more effective primary healthcare system.

8.1 Cancer screening

In Victoria, cancer incidence continues to rise and has a significant impact on the Victorian community. Action to reduce mortality from breast, cervical and bowel cancer through evidence-based population screening is an important approach to cancer control.

Breast cancer is the most common cancer in Victorian women. In 2009, 3,294 Victorian women were diagnosed with breast cancer and 700 died from the disease (Cancer Council of Victoria 2010b). Finding breast cancer early offers women the best chance of successful treatment and recovery.

Cervical cancer is largely preventable through regular screening. In 2009, 166 Victorian women were diagnosed with cervical cancer and 48 died from the disease (Cancer Council of Victoria 2010b). In Victoria at least 85 per cent of women who develop cervical cancer have either never had a Pap test or have not followed the recommended two-yearly screening in the 10 years prior to diagnosis (Victorian Cervical Cytology Registry 2010).

Bowel cancer is the second most common cancer in people living in Victoria. In 2009, 3,619 Victorians were diagnosed with bowel cancer and 1,365 died from the disease (Cancer Council of Victoria 2010b). The National Bowel Cancer Screening Program offers one-off testing via faecal occult blood testing (FOBT) to people turning 50, 55 and 65. FOBT looks for blood in the bowel motion, but not for bowel cancer itself.

Opportunities for progress in 2011–2015 include:

– continue to deliver effective cancer screening programs to eligible Victorians and develop collaborative approaches to screening service recruitment, delivery and data collection

– deliver the Digital Mammography Project in partnership with BreastScreen Victoria (the project will transition all breast screening services in Victoria to digital systems by 2013 and enable changes to improve service efficiency, sustainability and capacity in Victorian breast screening services)

– contribute to a planned renewal process for the National Cervical Screening Program that considers the impact of human papillomavirus immunisation on cervical screening, and will assess the new and emerging science and screening technologies, and the feasibility and acceptability of any proposed changes to the program

– continue to work with the Commonwealth Government to expand the National Bowel Cancer Screening Program to additional cohorts, including 60-year-olds and re-screening

– develop coordinated strategies aimed to increase cancer screening in communities that have lower than average participation rates, including Aboriginal and Torres Strait Islander and culturally and linguistically diverse communities.

8.2 Newborn screening

In Victoria there are two population-based screening programs available for newborns: the Newborn Screening Program (NBS) and the Victorian Infant Hearing Screening Program (VIHSP).

NBS is an important public health program that facilitates the early identification and management of babies at risk of having rare but serious medical conditions that can affect normal development.

NBS has been available to all babies born in Victoria since the late 1960s. Screening is a quick, safe and effective way to identify newborns at risk of having a rare but serious medical condition. Early identification allows for early intervention (usually with diet and/or medication) and can lead to a significant reduction in morbidity and mortality for affected infants.

Screening is conducted using a small blood sample obtained by pricking the baby's heel, 48–72 hours after birth. Conditions that can currently be identified through newborn screening include phenylketonuria, congenital hypothyroidism, cystic fibrosis and approximately 22 other metabolic conditions that affect fat or protein metabolism.

The VIHSP screens the hearing of newborn babies while they are still in hospital or at an outpatient appointment in the first weeks of life. Early detection through screening is a critical component of early intervention, promoting optimal outcomes for children with hearing impairment.

The program started screening in Victoria in 2005. Since then, more than 1,300 babies have been referred for further audiological assessment and 183 babies have been diagnosed with permanent bilateral hearing impairment (Victorian Infant Hearing Screening Program 2011).

Many of these babies were diagnosed at less than one month of age. The program now operates in 73 hospitals in Victoria – all public maternity services and 16 private maternity services – and will achieve statewide coverage in 2011–2012.

Opportunities for progress in 2011–2015 include:

– continue to work towards improving the NBS program through implementing the requirement for written consent to strengthen the process of giving information to parents, as well as promoting choice in relation to screening and the use of stored samples for research

– support quality improvements in the NBS program through education and compliance monitoring of blood sample collection and proper recording of processes within maternity services

– continue to work towards universal coverage for infant hearing screening to ensure infants with hearing impairment have the best possible start in life.

8.3 Early detection and early intervention

In order to detect conditions and intervene early, people need to be enabled to monitor and manage their own health, with the support of an effective primary healthcare system.

Public community health services have a particular focus on providing early intervention and proactive care to people with chronic disease. The various chronic disease initiatives seek to build new and innovative models of care that intervene early for those newly diagnosed with disease, and build people's capacity to manage their health and engage in health-promoting behaviours. Promoting positive health behaviours also occurs through the active service approach to services provided to frail older people and people with disabilities through the HACC program.

Child health services within community health aim to promote children's positive development and to intervene early to address child health and developmental problems. The service also supports parents' active participation in their child's early learning and development.

Opportunities for progress in 2011–2015 include:

– continue to support community health services and other primary healthcare providers to provide high-quality early intervention services

– continue to promote new models of care that provide prevention and health promotion to older people and younger people with disabilities through the HACC program

– support the routine use of evidence-based screening tools (such as the diabetes risk assessment and absolute risk tool) within community health, and development of care pathways for people identified at risk; for example, there is a current partnership project with the Heart Foundation (Victoria) piloting the implementation of a CVD absolute risk assessment approach within community health

– develop a screening tool for risk factors for chronic and complex conditions to facilitate early intervention (in areas such as homelessness, problem gambling, tobacco, alcohol and other drug misuse, nutrition, physical activity)

– encourage PCPs to continue to develop referral pathways across the service system to enable people with chronic disease, or at risk of disease, to have access to improved services and prevention.

A targeted approach to early detection and early intervention is required in order to reach those populations most at risk. Examples of early detection and intervention approaches for CVD and type 2 diabetes, and vision impairment are highlighted on the following pages.

Highlighting: Life! – taking action on CVD and type 2 diabetes

In Victoria there are more than 900,000 people with a long-term cardiovascular condition, and some 11,000 lose their life to the disease each year (Heart Foundation (Victoria) 2011). Australia-wide, the burden of type 2 diabetes is increasing and it is expected to become the leading cause of disease burden by 2023 (AIHW 2010a). However, there may be signs that the prevalence of diabetes is plateauing in Victoria.

A large and increasing proportion of the population is now in the high-risk categories for type 2 diabetes and CVD. As both chronic diseases are largely preventable, early detection of risk in individuals provides an opportunity to manage risk factors through lifestyle changes and appropriate medication (for CVD) to prevent or delay their onset.

A particular benefit of risk testing and screening processes for type 2 diabetes is identifying people with undiagnosed diabetes. It is estimated that for every person diagnosed with diabetes, another person is unaware they have it (Australian Diabetes Council 2010). People tested and found to have existing diabetes can be referred for appropriate diabetes management care, improving their health and reducing the risk of more severe complications or comorbidities.

The recent *Assessing cost-effectiveness in prevention* (ACE-Prevention) report found good evidence for the cost-effectiveness of screening programs for pre-diabetes and for lifestyle treatments recommended for high-risk people (Vos et al. 2010).

Type 2 diabetes and CVD have a number of modifiable risk factors in common:

– overweight and obesity
– physical inactivity
– poor dietary intake.

Additional risk factors for CVD are:

– high blood pressure
– high cholesterol
– tobacco smoking.

A significant proportion of the Victorian adult population have one or a combination of these risk factors. Results from 300,000 WorkHealth checks conducted in Victoria since the start of the program reveal that 70 per cent reported inadequate physical activity, nearly a quarter (24.4 per cent) had elevated blood pressure and more than 90 per cent of workers are not eating enough fruit and vegetables (WorkHealth 2011).

Opportunities for progress in 2011–2015 include:

– provide individual, tailored support for high-risk people through the Life! Diabetes and CVD prevention programs

– explore the feasibility of providing support for people at high risk of diabetes or CVD through the workplace setting

– tailor early detection programs to meet the needs of low-income and other identified sections of the Victorian population at high risk.

Highlighting: Vision Initiative

Seventy-five per cent of vision loss is preventable or treatable, and this rises to 94 per cent in Aboriginal and Torres Strait Islander communities for whom blindness is 6.2 times higher and vision impairment 2.8 times higher in comparison to the general community in Australia (Centre for Eye Research Australia 2004; Hugh et al. 2009).

Eye health is a critical issue for Victoria's ageing population. A recent report by Access Economics estimated that in 2009 vision loss affected nearly six per cent of Victorians aged over 40 (145,370 people), and 11 per cent (or 16,940) of these individuals were blind. By 2020, without appropriate intervention, it is projected that this number will increase to 201,000 Victorians over 40 experiencing vision loss, of which 26,400 are blind (Vision 2020 Australia 2010).

The Victorian Burden of Disease Study estimates that the loss of wellbeing attributable to neurological and sensory disorders is 12 per cent of the total burden of disease in Victoria, behind cancer, cardiovascular diseases and mental disorders. Vision loss is also associated with other morbidity and mortality impacts through falls, hip fractures, other accidents and depression. Indirect costs are also associated with earlier entry into supported accommodation or aged care facilities, impacts on carers and productivity losses as vision affects people's ability to work (Department of Human Services 2005).

This will impact on demand and costs for eye health and vision care services. According to a 2009 report prepared for Vision 2020 by Access Economics, the direct health costs of treating eye disease in Victoria in 2009 was estimated at $652 million, $222 million of which accounts for hospital costs, and these are projected to almost double to $412 million by 2020, mainly due to the ageing demographic (Vision 2020 Australia 2010).

In November 2005, AHMC endorsed the *National Framework for Action to Promote Eye Health and Prevent Avoidable Blindness and Vision Loss*. The National Framework was developed in response to World Health Assembly resolution WHA 56.26 which calls on all member countries to develop national vision plans to eliminate avoidable blindness by the year 2020 (Eye Health Working Group 2008).

Opportunities for progress in 2011–2015 include:

– The Vision Initiative forms part of Victoria's public health response to the National framework to promote eye health and prevent avoidable blindness and vision loss, and its objectives include:
  - to communicate the importance of regular eye tests to prevent and treat eye disease and vision loss particularly to those over 40 and in other at-risk groups
  - to improve the understanding and awareness of health and community professionals about eye health and vision issues and referral pathways, and
  - to ensure a platform for collaboration and sustainable partnerships between Victorian eye health and vision care providers, government and other organisations.

PART III MONITORING AND REVIEW

9. Monitoring and review

The Public Health and Wellbeing Act requires a plan
to be developed every four years, with the first being prepared
in 2011. Progress towards the directions established in this
plan will be monitored over the 2011–2015 period.

The government is committed to providing greater transparency and detail in reporting on health system performance through the budget process. Performance measures relating to prevention and public health, reported in the budget, are being reviewed to strengthen accountability and support monitoring of the plan. This process is ongoing.

Progress will be used to inform priorities for the next plan, due in September 2015.

9.1 Governance

The Prevention and Population Health Advisory Board, chaired by the Secretary of the Department of Health, provides direction and high-level strategic advice and recommendations in relation to prevention. The board will oversee the plan's implementation, monitor its impact and contribute to the development of future plans.

Existing governance, management and planning bodies, such as regional management forums, councils, and PCPs, will contribute to leading prevention efforts locally and across the state.

9.2 Monitoring public health and wellbeing and its determinants

A number of key data sources and reports will be used to monitor over time the overall health and wellbeing of Victorians, and the factors that influence health.

Health-specific information is available in administrative and condition-specific data collections, and collated in key reports, including:

— Victorian Population Health Survey reports. Established in 1998, the survey provides quality information at the state, regional and LGA levels about the self-rated health, lifestyle and wellbeing of adult Victorians aged 18 years and over. Information collected includes overall self-rated health status, level of psychological distress, body mass index (to determine weight status), the presence of chronic diseases, nutrition, physical activity, smoking and alcohol consumption. Information is also collected on participation in screening for bowel cancer, cervical cancer, breast cancer, high blood pressure, cholesterol and high blood sugar in addition to community participation, levels of social support and connections with others.

— *Your health: The Chief Health Officer's report 2010*. Under the Public Health and Wellbeing Act, the Chief Health Officer is required to publish a comprehensive report on public health and wellbeing in Victoria every two years (Department of Health 2011d).

– State of Victoria's Children report. Produced annually, this report provides a comprehensive picture of how Victorian children, young people and their families are faring across the domains of health, safety, learning, development and wellbeing.

Data and intelligence from other government portfolios will also be used to monitor the determinants of and contributions to health, including information about educational attainment, employment, active transport, environment, housing, sustainability of new developments and community connection.

Research will also contribute to understanding the health and wellbeing of Victorians. The Department of Health will continue to actively engage in a partnership approach to research that will inform policy and practice.

9.3   Evidence translation

Support and guidance for improved evaluation efforts across the prevention sector will build evidence of the effectiveness of prevention and health promotion interventions. This, and other research evidence, needs to be translated into formats that can influence practice.

The Department of Health currently produces a range of evidence guides to promote good practice in prevention and health promotion; this includes rapid reviews and evidence summaries (see <http://www.health.vic.gov.au/prevention/evidence.htm>). The Centre of Excellence in Intervention and Prevention Science (detailed in chapter 4) will play a key role in enhancing the generation and synthesis of policy and program-relevant evidence.

The translation of evidence into policy and practice will be critical to the effectiveness of this and future plans.

9.4   Program reporting

Funding provided to support prevention initiatives by the Department of Health will continue to be monitored, with improvements made to funding criteria as noted in chapter 4. These will ensure that programs are informed by the best available research evidence and evaluated appropriately.

Outcomes and targets

The Victorian Government is party to a number of agreements with the Commonwealth Government that set performance targets including NPAPH, Closing the Gap, the *National Partnership Agreement on Essential Vaccines* and cancer screening programs. Examples of the outcomes or targets set by these agreements include:

National Partnership Agreement on Preventive Health
– increase in mean number of daily serves of fruits and vegetables consumed by children by at least 0.2 for fruits and 0.5 for vegetables from baseline for each state by 2013; 0.6 for fruits and 1.5 for vegetables by 2015

– increase in proportion of adults participating in at least 30 minutes of moderate physical activity on five or more days of the week of five per cent from baseline for each state by 2013; 15 per cent from baseline by 2015

– reduction in state baseline for proportion of adults smoking daily commensurate with a two percentage point reduction in smoking from 2007 national baseline by 2011; 3.5 percentage point reduction from 2007 national baseline by 2013.

Closing the Gap in Indigenous Health Outcomes
- reduced smoking rate

- reduced burden of tobacco related disease
  for Indigenous communities

- increased sense of social and
  emotional wellbeing

- reduced uptake of alcohol, tobacco and
  illicit drugs

- reduced rates of sexually transmissible
  infections

- reduced hospitalisations for violence and injury

- improved access to targeted early detection
  and intervention programs by high-need
  Indigenous families.

Progress against these and other targets are
reported in publically available documents such
as the Report on Government Services and COAG
Reform Council reports.

Appendix: Health status and trends

The following data identifies trends for some of the major risk factors and conditions that may impact on the current and future health of Victorians.

Alcohol

In 2006 approximately 765 people died as a result of alcohol misuse and there were around 26,500 alcohol-related hospitalisations (Turning Point Alcohol & Drug Centre 2011). According to the ABS, 14.4 per cent of Victorian adults drink at risky or high-risk levels (ABS 2010b). The impacts of alcohol misuse are significant, and are borne by the drinker, by others, and by society as a whole.

While overall consumption is relatively stable, hospital admissions, emergency department and ambulance data show that alcohol-related harms are increasing. Evidence suggests that the risky use of alcohol is causing increasing acute health consequences in key population groups such as young women (see Figure A1).

In particular, heavy drinking among young adults is rising significantly – from approximately 25 per cent in 2002 to over 40 per cent in 2009 (Victorian Drug and Alcohol Prevention Council 2010).

These consequences extend beyond the individual drinker, with passive drinking adversely impacting others through, for example, increased exposure to domestic and other violence, and fetal alcohol syndrome.

Figure A1: Alcohol-caused hospital separations per 1,000 population, females
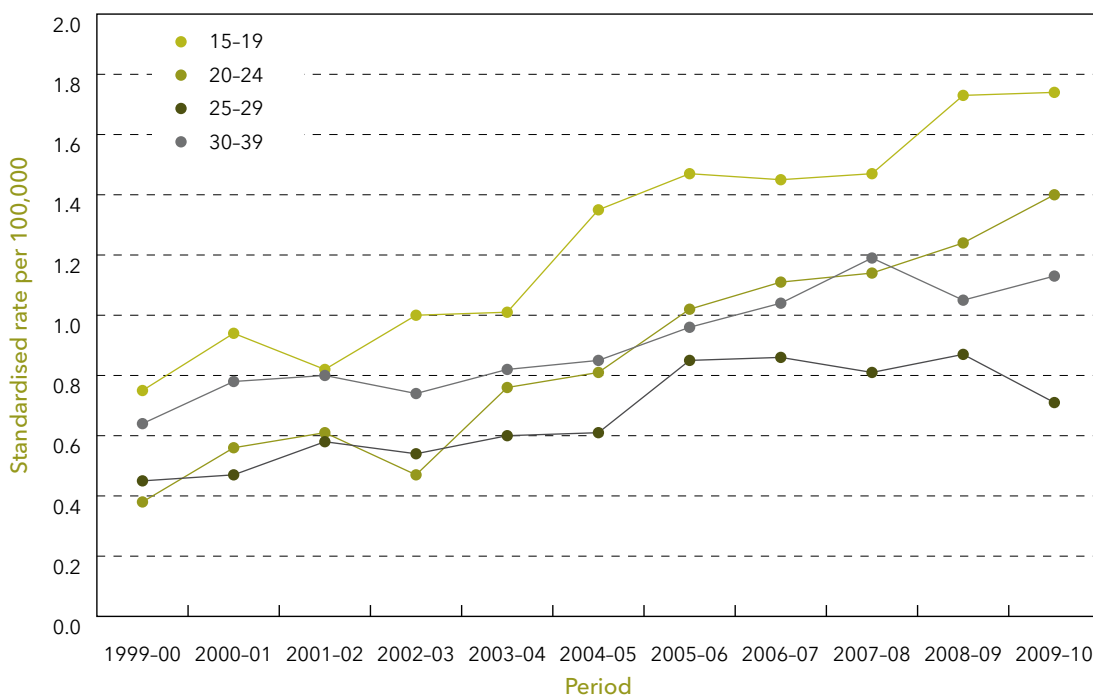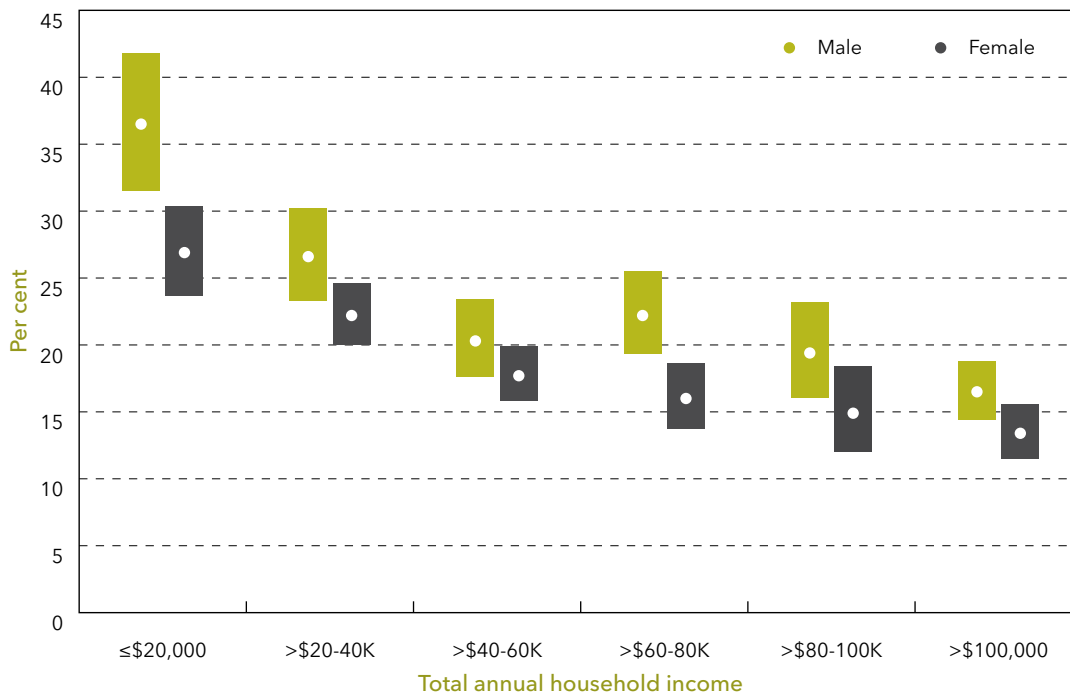

Source: (Department of Health 2010a)

Developed from data in the Victorian Admitted Episode Dataset.

This is an unpublished graph.

Smoking

Every year smoking causes around 4,000 deaths in Victoria (Department of Human Services 2008c). Smoking also causes the most significant proportion of avoidable chronic illness and hospitalisation from conditions such as cancer, cardiovascular disease and chronic obstructive pulmonary disease (Department of Human Services 2005).

The past two decades have seen a significant decline in smoking in Victoria, driven by a range of policy and legislative changes implemented over the period. Challenges for the future include reducing prevalence in groups that have significantly higher smoking rates than the general population such as Aboriginal Victorians and people from low socioeconomic areas (Department of Human Services 2008c) (see also Figure A2).

Figure A2: Proportion (95 per cent confidence interval) of male and female current smokers, by household income, 2008

Unhealthy weight, diet, and physical activity

The rate of overweight or obesity in Victorian adults is rising and is predicted to reach just over half of the adult population by 2013 if the current trend continues (Department of Health 2010c).[3]

Twenty-five per cent of children are overweight or obese, which represents a large increase from five per cent in the 1960s (Preventative Health Taskforce 2008). By 2025 this figure is likely to increase to 33 per cent (Department of Human Services 2008a). Overweight and obese children are more likely than children of healthy weight to be overweight or obese as young adults (Magarey et al. 2003; Whitaker et al. 1997; Wright et al. 2010).

Victorians have an extremely low intake of vegetables and fruit. Only 7.9 per cent meet the guidelines for vegetable intake and only 47.4 per cent met the guidelines for fruit intake (Department of Health 2010c). This is lower than vegetable and fruit consumption in other states of Australia. High levels of salt and saturated and trans fats consumption are also of concern. On average, Australians eat 5–10 times more than the 1–2 grams per day of salt required for health (Australian Division of World Action on Salt and Health), and Australians and New Zealanders consume 14–16 per cent of their total daily energy intake from trans fat and saturated fat combined, well above the National Health and Medical Research Council (NHMRC) guidelines of 8–10 per cent (Food Standards Australia New Zealand 2009; National Health and Medical Research Council and Department of Health and Ageing 2005).

Australian research has found a direct correlation between uninterrupted periods of sedentary time (primarily sitting) and weight and waist circumferences (Healy et al. 2008). Research is also confirming an important association between sedentary behaviour and type 2 diabetes, cardiovascular disease and musculoskeletal problems (Bassuk & Manson 2005; Katzmarzyk et al. 2009; Parkinson & Harris 2010; Thorp et al. 2010).

Mental illness and psychological distress

The prevalence and debilitating effects of poor mental health are important concerns for public health. In Victoria's most recent population health survey, 24.5 per cent of women and 15 per cent of men reported they had been diagnosed with anxiety or depression (Department of Health 2010b).

In addition, a significant proportion of Victorians report a high to very high level of psychological distress (Department of Health 2010c). People who are socially and economically disadvantaged, including Aboriginal and Torres Strait Islanders, refugees and people in vulnerable or traumatic circumstances, generally experience worse impacts of poor mental health. Mental health is also affected by gender (VicHealth 2007).

The costs associated with mental illness and psychological distress are borne not just by the individual, but also by families, communities, industry and governments. These costs include the economic costs of reduced workforce participation and productivity, as well as social costs such as suicide, crime and the impacts on carers and communities (VicHealth 2007).

3   Based on self-reported height and weight used to calculate body mass index (BMI) for the determination of weight status. Self-reported BMI underestimates the true proportion of overweight and obese persons because people typically overestimate their height and underestimate their weight.

Sexual health and blood-borne diseases

Trends in sexually transmitted infections and blood-borne disease continue to change over time. For example, while the sharp rise in incidence of syphilis in the years 2005–2007 has now decreased, certain sexually transmissible infections, including chlamydia and gonorrhoea, continue to increase in Victoria. Similarly, the incidence of HIV infection, which increased from 2000 to 2006, stabilised from 2006 to 2009 and decreased slightly in 2010, illustrates that fluctuations in infections can occur within short timeframes (Department of Health 2011).

Even though more people are choosing to have regular sexual health check-ups, some population groups use sexual health testing and treatment services less frequently. Strategies to target these populations, including young women, people living in rural communities and people from culturally diverse backgrounds, should be enhanced.

Injury

Injury (intentional and unintentional), including road trauma, is a major cause of morbidity and disability. Overall, injury has the sixth highest burden of disease in terms of years of life lost in Victoria (Department of Human Services 2005). Notably, intimate partner violence – including physical, emotional and sexual violence – is the leading contributor to death, disability and ill-health in Victorian women aged 15–44 (VicHealth 2004).

The causes of injury resulting in hospitalisation or death change across the lifespan. Injury-related deaths in children are most likely to be caused by transport accidents, drowning, choking and poisoning. In adolescents and young adults injury-related deaths are predominately due to suicide and transport accidents. In older adults, falls are the leading cause of injury-related hospital admissions, emergency department presentations and death (VISU 2010; 2011b).

Injuries resulted in the deaths of 2,223 people in 2009, with 1,394 categorised as unintentional (accidental). In addition, 285,860 emergency department presentations and more than 100,000 hospital admissions were attributed to injury in 2009 (VISU 2011a). Victorian rates of hospital admission and emergency department presentations due to injury increased significantly (by 65 per cent and 72 per cent respectively) between 1996 and 2009 (see Figure A3) (VISU 2011b), and estimates suggest an even greater number of injuries are attended to by primary care, ambulatory and rehabilitation systems, or are self-treated at home, school or work.

Figure A3: Trend in the frequency of injury hospital admissions, Victoria 1996–2009
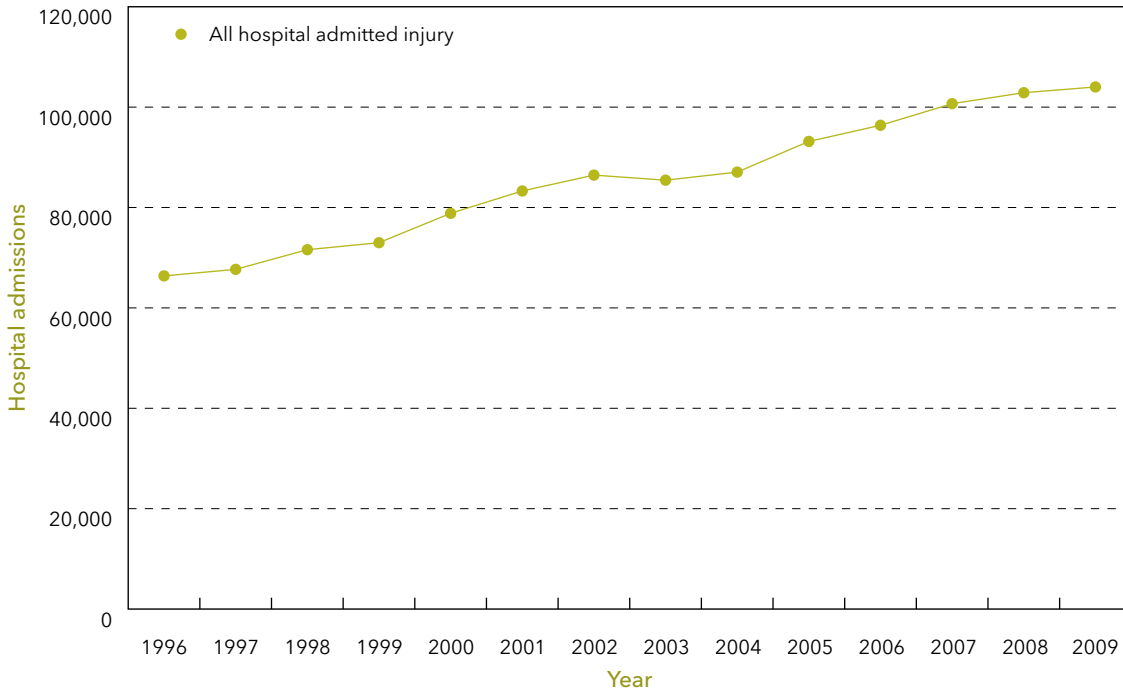
Cancer

Cancer is the leading cause of death in Victoria, affecting one in three Victorians up to the age of 75. Around 500 Victorians are diagnosed with cancer every week (Department of Human Services 2008b).

The number of people with cancer is expected to continue to increase, (see Figure A4) with the number of new diagnoses predicted to increase faster than the rate of population growth. Yet approximately one third of all cancer deaths in Australia are attributed to known, avoidable risk factors (AIHW 2002).

Many cancers are now preventable and survival rates are improving. A considerable body of evidence shows modifiable risk factors associated with several common forms of cancer, including:

– tobacco use
– unhealthy diet
– excess body weight

– physical inactivity
– alcohol consumption
– over-exposure to the sun.

These modifiable risk factors account for a substantial number of cancers diagnosed each year. It should therefore be possible to prevent many cancers by either reducing the number of people exposed to substances that increase cancer risk, or by improving cancer-protective behaviours. Early detection through participation in organised screening programs is also critical because early treatment improves survival rates significantly.

While Victoria has one of the highest participation rates for cancer screening in the country, many population groups, including Aboriginal and Torres Strait Islander and culturally and linguistically diverse communities, have lower than average participation rates. Within these groups, cancers are often diagnosed later, resulting in poorer survival rates.

Figure A4: New diagnoses of cancer compared with the rate of population growth
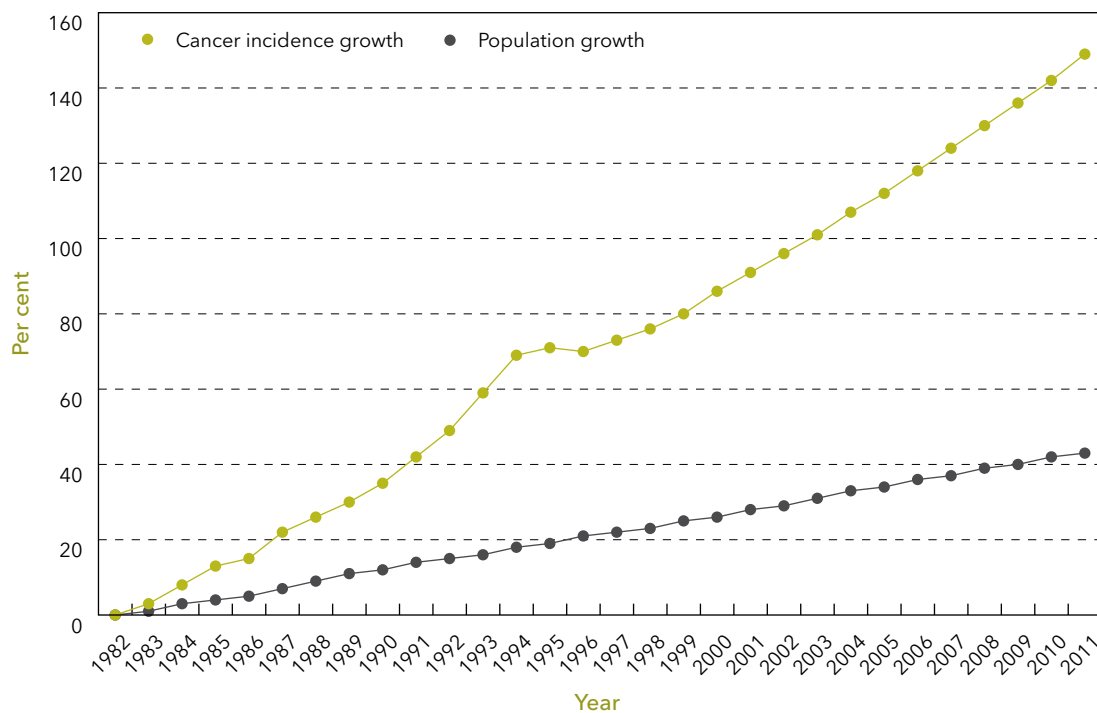
Source: (Department of Human Services 2008b)

NOTE: Australian Institute of Heath and Welfare Cancer Incidence Projections expressed in percentage growth terms with base year 1981 (2002–2011 are all projections)

Health literacy

Health literacy has been defined as an individual's overall capacity to obtain, process and understand basic health information and services needed to make appropriate health decisions (Institute of Medicine 2004). For example, the ability to analyse food purchases, plan exercise regimes, understand health and safety warnings, and navigate care options. Health literacy is dependant on social and individual factors.

This definition recognises the social context of health decision making, based on the interaction of the individual's skills with health contexts and broad social and cultural factors at home, at work and in the community.

Without clear information and an understanding of the information's importance, people are more likely to miss necessary medical tests, end up in emergency departments more often, and have a harder time managing conditions such as diabetes or high blood pressure.

British studies have found that the greater the health literacy of an individual, the greater the likelihood of eating at least five portions of fruit and vegetables a day, of being a non-smoker and of having good self-rated health; and high literacy is associated with understanding the symptoms of diabetes and the ability to control blood sugar (von Wagner et al. 2007; von Wagner et al. 2009).

Similarly a recent US review of the relationship between low health literacy and health outcomes found that low health literacy was consistently associated with more hospitalisations; greater use of emergency care; lower receipt of mammography screening and influenza vaccine; poorer ability to demonstrate taking medications appropriately; poorer ability to interpret labels and health messages; and, among elderly persons, poorer overall health status and higher mortality rates (Berkman et al. 2011).

In 2006 the Adult Literacy and Life Skills Survey measured the literacy of adults aged 15–74 years, including their health literacy. Skill levels ranged from level 1 (lowest) through to level 5 (highest) (see Figure A5). Skill level 3 is regarded as the minimum required to allow individuals to meet the complex demands of everyday life.

Figure A5: Health literacy across the Australian population, 2006
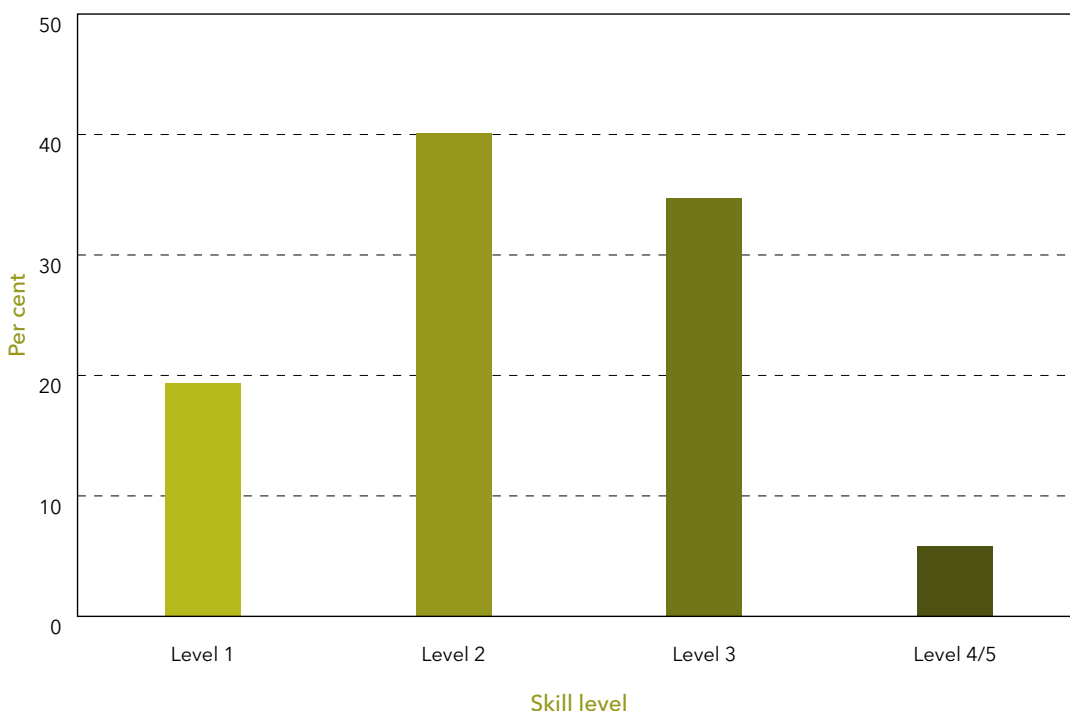
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Abbreviations

ABS	Australian Bureau of Statistics
AHMC	Australian Health Ministers' Conference
COAG	Council of Australian Governments
CVD	cardiovascular disease
HACC	Home and Community Care
MAV	Municipal Association of Victoria
MCH	maternal and child health
MPHWP	municipal public health and wellbeing plan
NBS	Newborn Screening Program
NGO	non-government organisation
NHMRC	National Health and Medical Research Council
NPAPH	National Partnership Agreement on Preventive Health
PCP	Primary Care Partnership
SARS	severe acute respiratory syndrome
STI	sexually transmissible infection
WHO	World Health Organization

Glossary

Chronic and complex conditions	A condition is considered chronic when it lasts for more than six months, has a significant impact on a person's life, and requires ongoing supervision by a health professional. Examples include asthma, cancer, cardiovascular disease, diabetes mellitus, mental health conditions, arthritis and musculoskeletal conditions. People with complex care needs have multiple health, functional and/or social issues and are at risk of functional decline and/or hospital admission.
Community-based services and settings	Health and wellbeing services and service locations (which may include care in the home) designed to meet a community's needs locally, that is, close to where people live.
Configuration of the health system	Denotes how health services are organised to deliver desired outcomes.
Continuum of care	The collective term for all components of care in the health system, including the following. **Health protection** – government actions to help the whole state's population (as opposed to individuals to whom the remaining seven components pertain), for example, in relation to preparing the community for emergencies, protection against communicable diseases, and the protection of environmental health. **Health promotion** – services that help people make decisions about actions and behaviour that lead to good health. **Illness prevention** – services that help people make decisions about actions and behaviour that help prevent illness. **Primary care** – occurs at a person's first point of contact with the medical or healthcare system. There are two types of primary care: – primary medical care is the care you receive at the first point of contact with the medical system, most often with a GP – primary healthcare is the care received at the first point of contact with the healthcare system, for example, when visiting a physiotherapist about a sore back. It is traditionally delivered in community health centres or through private allied health providers. **Secondary care** – the care received when primary care is not enough. Secondary care is more technical, intensive or complex than primary care. **Tertiary care** – care that is more technical, intensive and/or complex than secondary care. **Quaternary care** – the next step up again in technicality, intensiveness and/or complexity of care; it is highly specialised and operates at a statewide level; for example, trauma care and some organ transplants. **Rehabilitation** – services patients access to get back on their feet after ill-health. **End-of-life care** – care given to a dying person.

Coordinated care	'The deliberate organization of individual care activities between two or more participants (including the individual receiving treatment) involved in a person's care to facilitate the appropriate delivery of health care services. Organizing care involves the marshalling of personnel and other resources needed to carry out all required individual care activities, and is often managed by the exchange of information among participants responsible for different aspects of care' (McDonald et al. 2007).
Determinants of health	Broadly defined as the structures and conditions that shape daily life such as: income, employment and housing; access to healthcare, schools and education; conditions of work and leisure; and the state of housing, neighbourhoods and the environment. In short, they are the social, economic, environmental and cultural factors that affect health status (Commission of Social Determinants of Health 2008). Focusing on the determinants of health recognises that interactions influencing health and wellbeing are complex, and that individual choices may not lead to long-term changes in population health status.
Early intervention	Denotes an act of intervening, interfering or interceding with the intent of modifying the outcome either early in a person's life course or early in the progression of a disease.
e-health technology	Electronic tools and resources used in healthcare including electronic medical records, remote monitoring, telehealth and bedside clinical decision support.
Evidence, as in 'evidence-based' and 'evidence-informed'	Accumulated knowledge from practice, experience and research. Often used in the context of decision making. Decisions wherever possible should be based on evidence and not primarily motivated by other considerations (such as past practice or political expediency).
Healthcare	Services aimed at the prevention, diagnosis and treatment of disease, illness, injury and other physical and mental impairments. The healthcare system is focused on the wellbeing of individuals; in contrast, the field of public health (see 'Public health') focuses on the wellbeing of populations.
Health literacy	An individual's ability to read (or otherwise apprehend), understand and use healthcare information to make decisions about their health and follow instructions for treatment.
Health promotion	Any combination of legislative, educational and environmental supports for voluntary actions and conditions of living that are conducive to health.
Health protection	Describes the role of protecting the community (or any part of the community) against hazards of communicable disease, food, water or the environment, including emergency planning and response.
Knowledge-focused	An emphasis on knowledge and information (see also 'Evidence').
Knowledge management	How information and knowledge is managed – that is, collected, stored, analysed, shared and used.

Patient pathway	A picture or model of the procedures and administrative processes that a person experiences when moving through the healthcare system.
People-focused or people-centred	An emphasis on individuals (people, carers and their family members). Often contrasted with 'system-focused' or 'service-focused', and used to denote the importance of designing care and delivery of care primarily around the needs and experiences of people, not of the system or services.
Prevention	**Primary prevention** – activities that aim to prevent health problems in whole populations before they occur (reduce incidence), for example, tobacco control regulation, health promotion campaigns, fluoridation and immunisation.
	Secondary prevention – population-based activities that aim to identify precursors to, and early signs of, illness when treatment can be most effective and supported by clear referral pathways, for example, using screening programs to test a healthy but high-risk populations to identify those who have a disease but do not yet have any symptoms.
	Early intervention – efforts that are aimed at responding to early signs of disease and preventing worsening of the disease so that people stay as well as possible, for example, opportunistic testing for impaired glucose tolerance in people at risk of diabetes and working with those people to better manage their glucose levels (along with managing lifestyle risk factors).
Provider, as in health provider or service provider	An individual who or organisation that provides services related to health and wellbeing.
Primary healthcare	See 'Continuum of care'.
Primary medical care	See 'Continuum of care'.
Private health sector	Comprises health and wellbeing services primarily funded by individuals through insurance payments, and managed by organisations that are independent of government (for example, churches and for-profit companies).
Public health sector	Comprises health and wellbeing services primarily funded by citizens through the taxation system, and managed by or on behalf of government.
Public health	What we, as a society, do collectively to assure the conditions in which people can be healthy. Public health focuses on prevention, promotion and protection rather than on treatment (see 'Healthcare'), on populations rather than individuals, and on the factors and behaviour that cause illness and injury.
Wellbeing	Term reflecting a subjective view of wellness that is more than the absence of disease or illness. Wellbeing incorporates broader concepts such as better living conditions, improved quality of life and community connectedness. The inclusion of the term wellbeing in the Public Health and Wellbeing Act reflects this broader view of health.

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