BACKGROUND PAPER

Supporting document for the joint policy statement on health promotion and illness prevention

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Please note – there may be some further modifications to this paper to ensure consistency with the final Health Promotion and Illness Prevention Policy Statement and in light of feedback received.

Contents

EXECUTIVE SUMMARY

Focus

The background paper draws on existing evidence to explain the importance of health promotion and illness prevention in Australia. It emphasises the need for overarching, strategic leadership for health promotion and illness prevention beyond a focus on specific topics or particular diseases. The background paper supports the joint policy statement in its call to action for Australian governments and key decision makers to prioritise health promotion and illness prevention.

Key messages

A multifaceted, population approach is vital

- Decades of experience and learning indicates that health promotion and illness prevention is achieved most effectively through a whole of systems approach that is targeted at addressing the social determinants of health and shifting the distribution of power and resources towards health equity for all.
- Effective health promotion and illness prevention also requires multifaceted population-wide approaches to reshape the environments in which people live and in which they make choices.
- Reshaping unhealthy environments through a combination of legislative, policy and program responses does more to promote health than campaigns that rely only on efforts to change behaviours.

Health promotion and illness prevention are cost-effective but inadequately funded

- Evidence demonstrates that population health promotion and illness prevention activities are cost-effective and can improve health, while also contributing to social and economic progress. As such, funding for health promotion and illness prevention should be regarded as a worthwhile investment by decision makers in Australia.
- Australia's health policy priorities continue, however, to focus predominately on treating illness. Investment in the promotion of health and the prevention of illness in Australia is lower than the OECD average.
- Current investment is inadequate given the costs associated with chronic disease and the worsening impact that preventable health problems are expected to create in the future.

Stronger leadership is essential

- Current support for health promotion and illness prevention is fragmented at the national and state/territory level. Focus is mainly on specific diseases and individual behaviours, rather than on a more cohesive, integrated and holistic health promotion approach.
- Strengthened national leadership is essential to harness the considerable benefits that will emerge from improved health, wellbeing and equity in Australia.
- Action is required to improve evaluation and reporting, systematise prioritisation, enhance funding effectiveness and strengthen workforce capacity. Broad directions for action in each of these areas are summarised in the background paper.

Limitations

This background paper was developed via a rapid review. The rapid review approach allowed for the gathering of some evidence in what is a very large field, spanning both behavioural and social health promotion and illness prevention. The background paper draws primarily on review papers, evaluations of practice, policy analysis papers and statements from national and global bodies. Given the rapid approach, the review cannot be considered inclusive of all evidence related to health promotion and illness prevention.

Intended audiences

Australian Federal, State/Territory, Local Governments; non-government health and social service agencies; policy makers; program managers; and the media.

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Purpose

This background paper presents evidence regarding the key role of health promotion and illness prevention in contributing to population health, wellbeing and health equity. The background paper informs the recommendations that will be outlined in the joint Public Health Association of Australia (PHAA) and Australian Health Promotion Association (AHPA) policy statement.

The purpose of the joint policy statement is to urge Australian governments and key decision makers in public, private and non-government organisations to prioritise health promotion and illness prevention as part of their strategic activities. Effective prioritisation will necessitate sustained investment in cost-effective activity to harness the future economic and social benefits that will flow from improving health and preventing illness.

Context

This background paper draws from existing academic literature and strategic policy. Although valuable policy documents related to illness prevention and health promotion already exist, recently they have been issue based and/or chronic disease focussed. This background paper focuses more broadly to provide a foundation for united leadership across all aspects of health promotion and illness prevention. The evidence provided in the background paper supports the importance of addressing the determinants of health and wellbeing holistically, through acting to reduce inequities by applying a whole of systems approach.

The background paper and joint policy statement are focussed on Australia, but the supporting evidence includes global literature and learnings. The background paper has been produced via a rapid review of evidence. As such it primarily considers key review papers, evaluations of practice, policy analysis papers and statements from national and global bodies.

The background paper is written within the context of ongoing debates about the meaning and preferred application of related terminology. Such debates, while conceptually important, have the potential to weaken advocacy efforts by disrupting unity among public health advocates. For this reason, explanation of key terms is provided in a supplement to the

background paper to document the agreed understandings upon which the joint policy statement is based (see Supplement 1).

Within this background paper the phrase *'health promotion and illness prevention'* is used in an inclusive manner. It is intended to encompass all associated activities, including but not limited to work to optimise wellbeing, to prevent health problems and to prevent injuries. Further elaboration on the broad range of activities that are involved in the promotion of health and the prevention of illness is provided throughout the background paper.

Critical underpinnings of health promotion and illness prevention

Broad focus with shared foundations

Health promotion and illness prevention activities focus on facilitating changes that will enhance wellbeing and prevent the development of health problems. While health promotion and illness prevention work reflects slightly different foci (see Supplement 1), both approaches arise from the 'new public health' and prioritise:

- strategies that will support health equity and create healthy environments to improve opportunities for healthy living
- involvement of a broad range of partners across sectoral areas and within public, private and non-government organisations
- use of multifaceted approaches, and
- application of a holistic focus to promote all aspects of wellbeing.

Based on the holistic and intersectoral approaches applied, health promotion and illness prevention activity occurs in multiple settings. These include schools, workplaces, neighbourhoods and cities. Health promotion and illness prevention roles are also diverse, and may include a focus on policy development and implementation, program delivery, advocacy or research and evaluation.

Population focus is powerful

Some forms of health promotion and illness prevention activity are focussed on individuals (see Supplement 1). There is, however, wide and increasing recognition of the power of broader interventions that are targeted at populations rather than individuals, and which seek to change the

Supporting individuals to access secondary and tertiary illness prevention services and to make healthy choices is important. However, the focus of this paper and the joint policy statement is on populations, and systems level interventions to create healthy environments. Without healthy environments, opportunities for healthy choices are restricted.

environments in which people live.[1-3] Action at the population level can shift the distribution of power and resources towards good health and health equity for all.[1] Population strategies seek to address the social determinants that influence health, wellbeing and equity.

Social determinants of health are integral

Abundant evidence shows that health, wellbeing and equity are strongly influenced by the socioeconomic, political and cultural environments that people are exposed to.[1 4-7] The factors that influence and shape the distribution of socioeconomic, political and cultural resources are now widely recognised in research and policy as social determinants of health (SDH).[1 8-10] The SDH include education, food, housing, stigma/discrimination, social relationships, social exclusion, transport, employment, the natural and built environments and gender.[1 11-16] As emphasised by the WHO Commission on Social Determinants of Health,[1] the SDH also include the distribution of power, money and resources, which influence conditions of everyday life.

Modifying the SDH makes health possible through the creation of environments that are conducive to wellbeing.[1] For example, a policy and legislative focus on protecting the natural environment will assist in minimising and/or preventing climate change. Addressing climate change will, in turn, avert or minimise the many associated human health impacts, including heat-related disorders, malnutrition, poverty and mental health problems.[17 18] Adopting a focus on SDH also directs attention to the need to further social justice.

Target the health equity gradient

Differences in health status between population groups caused by *avoidable and unfair* exposures to detrimental socioeconomic, political and/or cultural conditions are recognised as health inequities.[1 19] Health inequities manifest as a social gradient in health, which runs from the top to the bottom of the socioeconomic spectrum.[1] Along this gradient it is apparent that those with greatest access to resources have the best health outcomes. This is a global phenomenon and it means that health inequities affect most people in a society- *not only the very poor.*[1]

The unequal distribution of health compromising experiences and conditions is not a natural or inevitable phenomenon.[1] It is instead the result of disadvantages that are driven by resource-poor social environments and the policies, programs and economic arrangements that shape such environments. It is the task of health promotion and illness prevention activities to tackle these issues. Strategies used to do this at a population level include

advocacy for the creation and implementation of healthy public policy and legislation, and adoption of a whole of systems approach to understanding and acting to achieve health equity improvements for all Australians.

Focus on achieving healthy public policy via whole of systems approach

The environments in which we grow, live and work are multifaceted and cannot be shaped solely by governments or the health system.[19] As such, the evidence on population health promotion and illness prevention directs attention to the role of all systems in affecting health and health equity- this includes systems implemented by Australian governments (federal, state/territory and local) but also the actions (or inactions) of industry and other non-government entities.[20]

In addition, the current evidence makes clear that many sectors outside of the traditional boundaries of the health system shape the SDH, often inadvertently, through their policies and actions.[21 22] This means that to be most effective health promotion and illness prevention activity must be targeted at all aspects of systems across all sectors.[1]

Recognition of the importance of shared responsibility and action is not new. It has guided health promotion efforts for several decades.[20 23-25] Such recognition underpinned the Declaration of Alma-Ata[26] and the Ottawa Charter for Health Promotion,[20] and it led to initial interest in, and ongoing support for, Healthy Cities and Health in All Policies approaches around the world.[27 28] Adding further impetus, and drawing renewed attention to the need to include industry and other non-government partners, the United Nations[8] and its agency the World Health Organisation (WHO)[29] have called for national leadership to understand and address the health effects of all policies and actions across *all* areas of activity. In 2013 an Australian Senate inquiry into Australia's national response to the WHO Commission on Social Determinants of Health[1] recommended consideration of SDH in *all* relevant policy development activities.[30] The importance of such recognition is also reinforced in the United Nation's Sustainable Development Goals,[31] the Shanghai Declaration[32] and the Global Charter on Public Health.[33]

Promoting health and preventing illness requires a whole of system response. This involves the combined efforts of public, private and non-government organisations. It involves all sectors that shape the environments in which people grow, live and work. Improved health cannot be achieved by the health sector alone.

Evidence indicates, however, that *sustained* whole of systems action to address SDH remains elusive.[34-37] Enhancing future whole of systems activity for health is, therefore, vital.

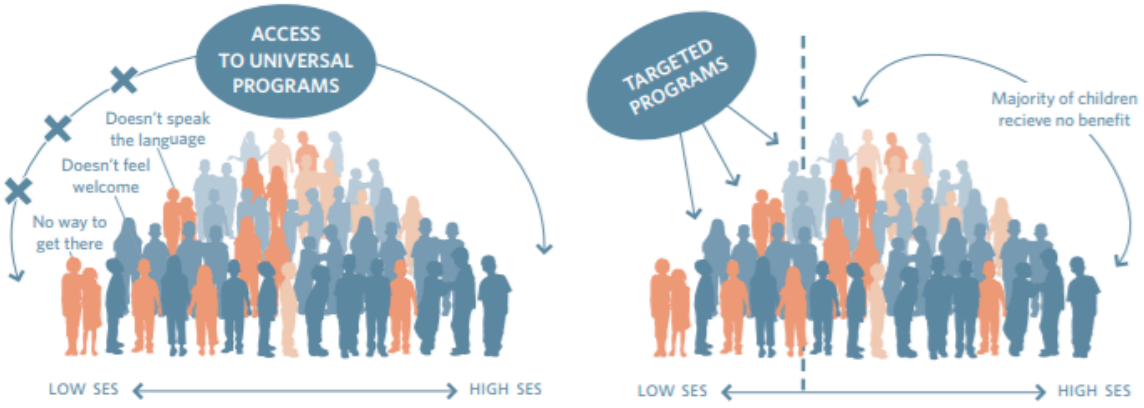
Prioritise proportionate universalism

Effective population health promotion and illness prevention improves health for the whole population, and for particular groups who live in disadvantaged circumstances.

Universal approaches apply to a whole population (e.g. all Australians, all women, all men, all children or all students). This approach is based on the philosophy of equal access, and underpins universal education and health care in Australia. However, evidence suggests that universal access does not provide universal benefit.[2 38 39] This is because universal policies and programs favour those who are already in advantaged positions while failing to *proportionately* improve the circumstances of those living in less advantaged conditions. This maintains (or even widens) health inequities (see Figure 1).

Targeted approaches apply to a prioritised sub-group within a population (see Figure 1). Priority is usually directed to sub-groups who are considered to be exposed to higher risks than the mainstream population based on their characteristics or circumstances, and/or the ways that other individuals and systems may discriminate against them (such as people with low income, poor health status or minority ethnicity).

Figure 1: Universal versus targeted intervention



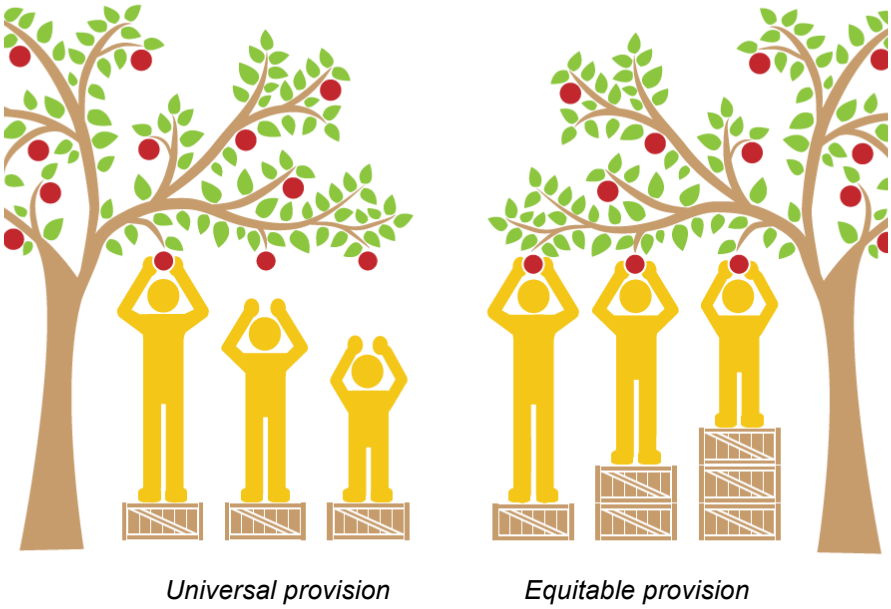
Source: Human Early Learning Partnership (2011)[40]

Evidence shows that targeted approaches may address the consequences of inequities rather than their causes.[2] Furthermore there is a tendency for targeted interventions

intended to address structural causes (particularly within policy) to drift toward an isolated focus on individuals' behaviours and education for individual behaviour change.[41-43] While some focus on supporting healthy living is important, if such activity replaces action to target structural factors then the broader causes of ill health and health inequity will not be addressed.

To overcome the shortcomings of both approaches and to capitalise on their strengths, a blended approach called proportionate universalism has been called for. *Proportionate universalism* involves the implementation of universal interventions that are implemented with a scale and an intensity that is proportionate to the level of need.[38 44] The insensity of implementation and support is determined by the level of disadvantage experienced at different points of the health equity gradient[38] (See Figure 2).

Figure 2: Difference between universal provision and a proportionate universal approach focussed on achieving health equity



Source: Saskatoon Health Region Advancing Health Equity Project (2017)[45]

A multifaceted approach improves effectiveness

Evidence also supports multifaceted health promotion and illness prevention responses, which target all aspects of regulatory mechanisms integrated within a whole of system framework.[20 46 47] The reduction in cigarette smoking in Australia offers a clear example of the effectiveness of a multifaceted approach. It utilised legislative controls (including those that restrict marketing and availability), organisational policy reform (for example smoking bans in workplaces, schools and restaurants) as well as programs that provide additional supports to individuals who smoke or who are at risk of smoking related disease.[48 49]

Why is health promotion and illness prevention important?

Many of the factors that impact negatively on people's health and impede realisation of their full potential can be prevented or delayed through a targeted focus on promoting health and health equity.[1 50 51] Furthermore, effective health promotion and illness prevention work can delay or prevent people moving into higher risk categories for disease and slow the progression of disease or disability once it develops.[52] The potential benefits associated with promoting health and preventing illness are considerable.

Better health, wellbeing and equity will enhance Australia's social and economic progress

A healthy population contributes to the social and economic progress of Australia. The available evidence indicates that improving health across the population is likely to result in the following benefits:

- a decreased prevalence of communicable and non-communicable disease
- an increase in the average number of years that Australians can remain economically and socially productive
- reduced public reliance on welfare, social and health services
- reduced pressure on tertiary health care systems
- decreased demand on health care budgets and a concomitant increase in resources to direct to other priority areas
- lower levels of poverty
- lower rates of crime
- higher rates of business growth and investment, which may result in greater employment opportunities, and
- higher rates of education (primary, secondary and tertiary) completion across the population.[1 46 50 52-54]

Is health promotion and illness prevention cost-effective?

A key question for decision makers relates to cost-effectiveness. Cost effectiveness in this area necessitates an assessment of the human and financial resources expended to create and implement an intervention balanced against the benefits it achieves, including the problems that it averts.[55 56]

The relevant literature provides strong evidence to support the cost-effectiveness of health promotion and illness prevention activity. The evidence comes from controlled trials and well designed, rigorous observational studies. Some health promotion and illness prevention activities have been found to be cost-saving, but most generate flow-on benefits (such as reduced burden on health care) as a pay-off for investment.[49 55-58] Effective health promotion and illness prevention also contributes to national economic and social productivity by increasing the number of years that Australians remain in good health.[52 58 59]

Responses that involve a combination of actions generally produce the greatest benefit and are most cost-effective.[49 57] Evidence to support this has emerged across multiple areas of health promotion and illness prevention practice, including in the areas of smoking cessation, cardiovascular disease prevention, child injury prevention, road trauma prevention, sudden infant death syndrome prevention and HIV/AIDS management and prevention.[49 60 61]

The prevention and control of HIV/AIDS in Australia is considered to have been successful because of strong national leadership, the use of both targeted and universal approaches, sustained effort over time and supportive legislative and policy interventions.[62] The response involved the introduction of national monitoring systems, innovative social marketing campaigns to raise awareness, harm minimisation tactics such as needle exchange programs, implementation of donor screening and blood testing to ensure the safety of blood supply for transfusions, and research to understand risk factors, patterns of transmission and treatment options.[49 62] These strategies have had a significant impact in slowing and containing the transmission of HIV in Australia and in improving the lives of those already infected. The cost of the health promotion and illness prevention response from 1984 to 2010 is estimated to be $607 million.[49] The net benefit is estimated at $2.54 billion.[49]

In terms of singular actions, legislated taxes to reduce consumption of health harming substances are consistently shown to be highly effective.[49] The benefits and cost-effectiveness are even greater when such legislated taxes are supported by marketing

regulation and the availability of healthy alternatives.[56] In contrast, media-based campaigns, particularly when implemented as an isolated strategy without other public health interventions, are shown to be inconsistent in their cost-effectiveness.[63]

Interventions targeted at children are also among those that have strong cost-effective potential. This is because promoting health in childhood can shape health over the life course and there is a longer timeframe for benefits to be realised.[49] The Head Start program in the USA, for example, was implemented in 1965 and included a comprehensive child development program to promote school readiness by providing educational, health, nutritional, social and other support to children from low income families.[64] Overall, evaluations suggest that young people who participated in the program were more likely to complete secondary school, attend college and less likely to engage in criminal activity.[65] Researchers estimate that by the 1980s, Head Start was producing $7 in benefits for every $1 spent on the program.[64]

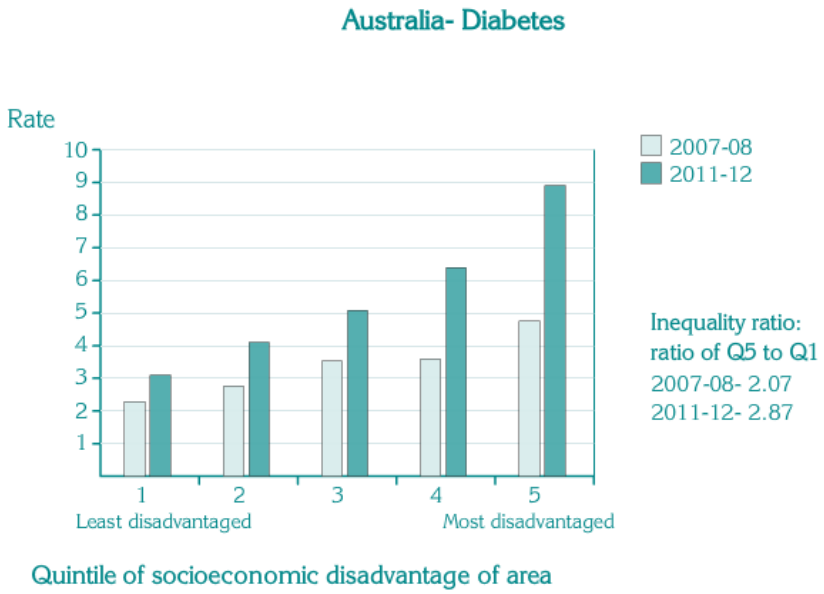
While the benefits of most health promotion and illness prevention activity emerge over decades, there are some interventions that produce benefit over the short term.[43] An example is the protection and promotion of mental health in the workplace via strategies such as supportive workplace conditions that cater to employee needs and circumstances, job-security, equitable staff recognition systems as well as stress reduction strategies. Improved mental health at work can produce immediate returns in the form of reduced staff turn-over, increased productivity and reductions in staff absences.[66-68]

The cost of not investing in future health promotion and illness prevention

The costs associated with not acting to support and facilitate health promotion and illness prevention in the future are considerable. This is due, in particular, to the anticipated increasing burden of chronic health problems and health inequities.

Currently one in two Australians suffer from chronic disease.[58] Chronic disease accounts for approximately 83% of all premature deaths, and 66% of the total disease burden.[58] Chronic disease rates in Australia also follow an equity gradient, which is becoming more inequitable over time. Figure 3 highlights that although the rate of diabetes is increasing in the Australian population overall, it is those in the most disadvantaged circumstances who carry the greatest burden of this increase.

Figure 3: Rate of Type 2 Diabetes in Australia over time



Source: Public Health Information Development Unit (2018)[69]

Note: This graph shows the estimated number of people with type 2 diabetes, expressed as a rate per 100 of population.

Much of the current and future projected burden is preventable, however, through effective health promotion and illness prevention practice, especially policy action.[51] Economic projections indicate that if health gaps along the health equity gradient were closed in Australia 500,000 people could avoid suffering a chronic illness; 170,000 additional Australians could enter the workforce, and annual savings of $4 billion in welfare support payments could be made.[70]

Despite the potential for benefit, Australia's health policy priorities continue to focus predominately on treating illness rather than preventing it. Investment in the prevention of chronic diseases in Australia is much lower than the OECD average.[51] Overall, treating chronic disease costs the Australian community an estimated $27 billion per year, which accounts for more than a third of the Australian national health budget.[58] It is estimated that Australia currently spends just more than $2 billion of health sector budgets on prevention each year, or approximately $89 per person. This expenditure is equivalent to only 1.34% of all health spending and just 0.13% of gross domestic product,[58] which is substantially less than New Zealand, Canada, the USA and the UK.

It is, however, difficult to determine *exactly* how much *total* government expenditure is directed towards health promotion and illness prevention efforts because non-health sector activities are not accounted for as part of the 'illness prevention' budgets of Australian

governments. This situation reflects a siloed approach to thinking and action, where accountability for health problems and credit for health improvements is still not shared across sectors.[51]

What are the barriers to effective and sustained health promotion and illness prevention?

Siloed approaches

The siloed organisation of government, involving both departmental and budgetary silos, can impede the whole of systems action that is required to address the SDH.[54] All sectors have particular goals, and these are often framed as if they are independent of each other, rather than interconnected and integrated across policy areas. This is exacerbated by a general lack of high level (chief executive and ministerial) accountability for facilitating cross-sectoral approaches within government.[71]

To address siloing, those working in the health sector must act as stewards to strengthen capacity for collective action across sectors.[72] Some progress is being made in this area, driven in particular by initiatives based on Health in All Policies principles. Examples include the Healthy Parks, Healthy People approach[73-75] and the numerous healthy planning initiatives that have emerged from the Healthy Cities movement.[76] Sustained attention on providing health stewardship for effective intersectoral action is imperative as part of future health promotion and illness prevention efforts.[72]

Short-termism

There is pressure on governments and decision makers to prioritise short-term needs. A short-term outlook prioritises investment in activities that will produce results quickly, while threatening sustained action on, and investment in, activities that generate benefits over the medium to long-term.[77] Decision makers are also highly responsive to crises; more so than to gradually worsening social conditions and increasing health equity gaps.[78] These factors conflict with the prioritisation of, and sustained investment in, health promotion and illness prevention and can lead to under-funding and withdrawal of funding.[77-80] Short-termism can also make health promotion and illness prevention activity vulnerable to cuts and cancellation when budgets are stretched or when political and corporate imperatives necessitate quick results.[78 81]

Under-funding health promotion and illness prevention or funding it over the short-term only can impede a whole of systems approach. This is because short-term funding generally favours vertical programmes implemented within existing arrangements. Horizontal arrangements that cut across sectors and that involve the development of new collaborations and governance systems usually require longer and more resources to establish and sustain.[39]

A scan of health promotion and illness prevention policy over time suggests that there has been some improvement. While health promotion and illness prevention activity was generally funded annually in the past, some initiatives are now funded for two or three years at a time. Effort to ensure the further sustainability of funding in the future should continue to be prioritised. Adequate and long-term funding linked to defined priorities is essential for the delivery of effective health promotion and illness prevention.[25]

Victim-blaming

The pervasiveness of neoliberal beliefs within Australian society skews attention towards the agency of individuals, and their ability to make healthy choices. This is problematic because it deflects attention from the social, economic and political environments that shape health.[82] [83] Interpreting health problems through a lens of individual responsibility can lead to the blaming of individuals.[82]

The strong emphasis on individual responsibility also makes it difficult to gain support from decision makers for health promotion and illness prevention activities that focus on reshaping the environments in which people live. This can be politically unpopular if people are held responsible for their social and economic situation, and the associated health impacts. A key example of this relates to community resistance to programs that are implemented to support prisoners or people recently released from prison.[84] In addition, blaming individuals for their health problems is disempowering. Disempowerment makes behaviour change more difficult, and therefore hinders health promotion.[82]

Lack of coherence in approaches

As explained in greater detail previously, health problems that stem from the SDH are preventable but they require sustained and multifaceted responses. There are increasing examples of comprehensive and sustained approaches to health promotion and illness prevention (for example in the areas of obesity prevention,[85] tobacco control, and sexual health education) but there is still a long way to go. Inadequate investment leads to

dispersed and sporadic approaches, particularly without coherent national leadership, and these factors are all linked to weak achievements.[46] In addition, frequent reforms and restructuring within governments may compromise partnerships between health and non-health sectors.[71] Fragmented decision making structures and processes across sectors also restrict opportunities for effective planning and implementation.[54]

Sporadic leadership

Overarching national leadership in health promotion and illness prevention waxes and wanes in Australia (as demonstrated by the recent closure of ANPHAP for example). There is a dearth of policy at the federal and state/territory level in Australia that provides overarching direction and support for health promotion and illness prevention beyond specific issues or specific population groups. Where such overarching leadership does exist, it is highly vulnerable to political shifts and funding stress. This was demonstrated recently in South Australia by the retraction of the State's Primary Prevention Plan[60] as part of State withdrawal from health promotion.[80]

Focus on deficit rather than strengths

Where policy does exist it is generally focussed on health *problems* rather than health promotion. While it is important to understand particular problems and the associated epidemiology, the dominant focus on problems can come at the cost of attention on building upon existing strengths through a health promotion framework. The emphasis on problems communicates that there is failure, a helplessness, an area of need.[86] It may also disempower those represented as having the deficit and creates a dependency on external resources and solutions.[87] Another major problem with this approach is that it often comes too late; intervening after the problem is already established rather than working to prevent it.

Some exceptions do exist. However, these are generally offered by health promotion organisations rather than by the governments that have the capacity to control national and state/territory budget allocations. A promising example is the VicHealth Mental Wellbeing Strategy 2015-2019,[88] which displays a clear strengths base approach to optimise population mental health, rather than focussing primarily on mental illness and the associated treatments. Furthermore, there are plans to ensure that future work on the Closing the Gap Strategy at the national level will be strengths based. This will necessitate greater engagement with Aboriginal and Torres Strait Islanders to develop targets that focus on advancement rather than disproportionately emphasising deficits.[89]

What will facilitate health promotion and illness prevention in the future?

This background paper has emphasised the importance of health promotion and illness prevention activity being:

- targeted at shaping environments in ways that are conducive to better health
- undertaken via diverse roles and in multiple settings
- targeted at addressing the social determinants of health and shifting the distribution of power and resources towards health equity for all
- undertaken via a whole of systems approach involving public, private and non-government organisations across all sectors, and
- based on a multifaceted approach, involving a suite of legislative, institutional, policy and program interventions.

To support future practice, actions must also be taken to strengthen leadership, improve evaluation and reporting, systematise prioritisation, enhance funding effectiveness and strengthen workforce development.

Strengthen leadership

- While strong leadership is currently provided by non-government organisations and advocacy groups in Australia this cannot be considered a substitute for cohesive national leadership. Strengthened political leadership at the national level is vital.[33 90]
- A national policy for health promotion and illness prevention is required.
- Introducing a national policy will facilitate a more systematic and comprehensive approach to producing cost-effective improvements in health, reducing inequities and harnessing the associated social and economic benefits. The national policy should emphasise the importance of promoting health, equity and wellbeing via the activities of all sectors. The policy should also advocate shared accountability for health across government, industry and other non-government organisations.

- To protect health promotion and illness prevention when budgets are stretched and when crises develop, health sector leadership must also be strengthened at all levels of government.
- Heath sector leadership can support health promotion and illness prevention by integrating these as key priorities within health sector policy.
- Stronger stewardship for promoting health beyond the health sector is also required.[72] Health in All Policies and Healthy Cities are internationally regarded

approaches that can be used by the health sector to facilitate health promoting activity in non-health sectors.

- Australian governments at all levels could also demonstrate greater valuing of health promotion and illness prevention by implementing integrated governance mechanisms. One strategy involves ensuring health promotion and illness prevention representation on whole of government committees, cabinet committees and on health portfolio executive committees.

- To support implementation of health promotion and illness prevention action across public, private and non-government organisations, a national agency dedicated to wellbeing should also be established in Australia. This agency would be different from a health department in that it would not oversee provision of illness treatment services. Instead it would exist to provide direction, advocacy and investment to support health promotion and illness prevention activity. Funding such an agency would assist in keeping health promotion and illness prevention on the agendas of decision makers to counter short-termism.

Improve evaluation and reporting

- A key function of the national agency could be undertaking and/or advocating for evaluation of health promotion initiatives. Routinely evaluating *all* health promotion initiatives will provide a rigorous evidence base that will assist in identifying the most cost-effective actions.
- Evaluations of cost-effectiveness should include assessments of SDH related costs and benefits.[58] To further support a whole of systems approach, evaluations also need to consider costs and benefits beyond the traditional interests of the health sector.
- Increasing the availability of rigorous evidence about the potential benefits of health promoting activity for non-health sectors may facilitate increased investment. For example, the education sector may be more likely to progress actions to improve the mental health of students if cost saving benefits can be demonstrated in reducing teacher stress and classroom disruption, in addition to the associated health system savings.[54]
- Evaluation research should generate practical, policy relevant recommendations to inform ongoing adaptation and improvement.[57] Reports and recommendations also need to be made publically available so that policy makers, practitioners and other decision makers can learn from and build upon past efforts.

- Accountability for promoting health and preventing illness across all sectors of government must also be increased. A strategy for achieving this is requiring annual reports on the progress being made to reduce health inequities and improve health. This could be organised in a similar to the reporting structure that currently governs the Closing the Gap initiative in Australia.[89]

Systematise prioritisation

- A systematic approach to establishing priorities for health promotion and illness prevention is important. Without prioritisation, efforts tend to become scattered across many areas, sometimes with duplication, and this dilutes effectiveness. Prioritising fewer areas for action allows for increased intensity of effort and improves likelihood of success.
- A national policy for health promotion and illness prevention and a national agency will guide prioritisation.
- Mechanisms for coordinating the range of actors involved in whole of systems responses are also required. Such mechanisms need to provide opportunities for the range of actors involved to gather and agree on priorities for action in systematic ways. In doing so, it is important to recognise that while different actors may have different roles, responsibilities and capacities, working towards common goals is empowering and unifying.
- Established health promotion and illness prevention initiatives that have already proven effective in guiding priority setting at the national and local levels across multiple sectors are Healthy Cities (particularly via the WHO European Healthy Cities Network and the Healthy Cities alliance across Asia and the Pacific) and Health in All Policies. Healthy Cities provides a good example of a multifaceted approach involving action at the policy and local level, seeking structural change, environment modification and community capacity building to promote health.

Enhance funding

- Sustained funding is vital to support effective health promotion and illness prevention[61] and to protect against the vulnerabilities created by political shifts and short-termism.
- Greater flexibility in funding structures is also required. Current, siloed funding structures within government departments restrict co-investment and collaboration on efforts that will produce co-benefits for multiple sectors.[71] This channels money

towards the core business of departments only and introduces a culture of competition between departments. Challenging the predominance of vertical, rigid funding structures will open new opportunities for intersectoral action, and promote greater cooperation around activity that may promote health and prevent illness.[54]

- Reinvestment of money raised from dedicated taxes on health damaging products like tobacco and alcohol, or returns from state-controlled gambling, should be reinvested into health promotion and illness prevention activities.[25] This will assist in protecting against the future burden on health care systems associated with consumption of such products.

Strengthen workforce development

- The Global Charter for Public Health[33] stresses the importance of building public health workforce capacity. This involves workforce planning, supportive systems and infrastructure, standards, accreditation and ongoing training.
- New opportunities for health promotion accreditation are now arising in Australia via the International Union for Health Promotion and Education.
- While it is important to support health promotion professionals, this must be done in a way that avoids reinforcing silos. Therefore, it is also important to build public health capacity in the broader Australian workforce in areas that influence health, such as transport, housing and urban planning.[49] Doing so is necessary to address the SDH but is also important in ensuring that key health promotion objectives (such as local community participation) can be achieved in all sectors.[91]

- A critical component of both workforce development and enhancing leadership is ensuring that those who have policy responsibility for health (at all levels of government) have the skills and knowledge required to value and stimulate health promotion and illness prevention activity.[90] Such skills and knowledge are not necessarily the same as those held by clinicians or economic managers.

Summary

The evidence that has been summarised in this background paper emphasises the importance and potential benefits of valuing and investing in health promotion and illness prevention. Protecting health promotion and illness prevention against the vagaries of political cycles is essential to harness future social and economic benefits. It is clear that promoting health and preventing disease is far more cost-effective than treating illness. It is also clear that improved population health will produce co-benefits that reach far beyond the

health sector. Decision makers across sectors and at all levels of government have the power to improve health and reduce inequities. Now is the time to use that power to strengthen commitment to health promotion and illness prevention, to support cost-effective action, and to harness the considerable savings and population benefits that will result.

SUPPLEMENT 1: EXPLANATION OF KEY TERMS

This supplement explains key terms that are relevant to the Joint Policy Statement, and provides background information about each. The supplement is intended to represent the agreed understandings upon which the joint policy statement is based.

Public health

Public health refers to the study of disease and positive attributes in whole populations.[50] The World Health Organisation defines Public Health as "*the art and science of preventing disease, prolonging life and promoting health through the organized efforts of society*". This distinguishes public health from other roles of the health system because it goes beyond the treatment of individuals to encompass the promotion of health and wellbeing and the prevention of disease, disability and injury.[50 92 93]

There has been a long history of public health development in Australia. The current era is termed the 'new public health' to differentiate it from previous eras where a focus on measures such as sanitation was prominent, and efforts to change individual behaviour dominated.[50] The new public health has been strongly influenced by WHO policies, including the Alma Ata Declaration of Health for All and the Ottawa Charter. The new public health emphasises the need to focus on shaping environments in ways that facilitate healthy behaviours.[50] It emphasises collective responsibility for health through actively encouraging intersectoral action and it directs attention to the health impact of global forces.[50] Both health promotion and illness prevention activities are prioritised within the new public health and are generally orientated towards whole of system action, underpinned by a social justice lens.

Health promotion

Over decades health promotion practice has also evolved, drawing on evidence and experience about what is most effective and by responding to the broader new public health movement.[3 94] The ecological approach to health promotion is supported by the most recent evidence[3] and this model underpins the discussion paper and joint policy statement.

The *ecological approach* acknowledges the reciprocal relationship between the health-related behaviours of individuals and populations and the environments in which they grow, live, work and play.[95] This approach emphasises that behaviour does not occur in a vacuum, but is rather influenced by a combination of environmental exposures, structural determinants and the expression of individual agency.[96] Those implementing an ecological

approach focus on environments at all levels (micro, meso, exo and macro) and implement actions within a range of settings.[95 97] This approach also acknowledges the importance of a comprehensive and multifaceted response to issues, based on efforts to seek change at individual, environmental and systems levels.[96 97]

The ecological approach combines elements of both the biomedical and social approach to health promotion, and builds upon the learnings derived from their application. The *biomedical approach* focuses on risk behaviours and healthy living strategies.[98] It emphasises health education with the intention of changing knowledge, attitudes and skills. The *social approach* to health promotion focusses on addressing the broader determinants of health, including via intersectoral collaboration, and it includes actions to reduce social inequities.[98] The focus is primarily on systems level change, including action to enable equitable access to health care.

The biomedical approach dominated pre-1970s health promotion efforts,[98] and is still applied under some treatment models. It has been shown to be limited and largely ineffective, however, because it relies on the singular strategy of health education, it generally focuses of people's deficits or risks, and it treats people in isolation of the environments that shape their health and wellbeing, which may even widen health inequities.[43 99-102] The social approach to health promotion gained traction from the mid-1970s onwards[98] as it overcomes some of the shortcomings of the biomedical model. However, the social approach has been criticised for deferring responsibility almost entirely to social structures and denying the power of individual agency.[103]

Adoption of the ecological approach combines the strengths of other approaches by integrating a commitment to health promotion action at the population level, with recognition of individuals' agency and contexts.[96] Ultimately, within the ecological model, health promotion is intended to enable people to increase control over their health via a multifaceted response that will shift the determinants of health in ways that are conducive to wellbeing and health equity.[20 47]

Illness prevention

At its core, illness prevention involves efforts to reduce the likelihood that illness will develop, and to reduce the severity and impact of illness if it occurs. As such, illness prevention (like health promotion) is concentrated on wellbeing. Illness prevention focuses mostly on efforts to prevent decline in wellbeing and this is achieved through a focus on those who are well,

those who are well but at risk, and those who are already experiencing illness. The concept of illness prevention can be broken down into different levels, with different activities at each.

Primordial prevention

This level of prevention has considerable overlap with an ecological approach to health promotion. Primordial prevention activity is intended (like health promotion) to avoid the emergence of risk factors for disease by acting on the social, economic and cultural determinants that may give rise to risk factors.[104] Such action may involve, for example, intervention in the education system to improve literacy outcomes so that students leaving school will not be exposed to the health damaging experiences associated with low literacy levels during adolescence and adulthood (such as unemployment, low income and low self-esteem).

Primary prevention

Primary prevention also has some overlap with population health promotion. Primary prevention is focussed on reducing risk factors for illness and it is implemented before illness develops. Primary prevention may be undertaken through efforts to change environments in ways that reduce or eliminate risks, alter individual behaviours and increase population resistance to disease should an outbreak occur.[105] Examples include literacy programs for adults, legislation mandating the use of seatbelts by car users, introduction of healthy school canteen policy to reduce the number of sugary foods for sale and population immunisation campaigns.[106]

Secondary prevention

Secondary prevention involves action to halt the progression of an illness once it develops and it aims to prevent future long-term complications.[105] This is achieved through early diagnosis, prompt treatment of a disease to slow its progression, and rehabilitation programs to assist people to recover.[106] Examples include routine screening to detect breast cancer in early stages. While secondary prevention is integral, it is largely focussed on individuals, and is outside the scope of this background paper and the joint policy statement.

Tertiary prevention

Tertiary prevention aims to reduce the impact of disease that has advanced beyond its early stages. This is achieved by retraining, re-educating and/or rehabilitating people who have already developed long-term health problems in order to improve their ability to function, their quality of life and their life expectancy.[105] Examples include chronic disease self-management programs for diabetes or physiotherapy to assist patients to walk again after

injury.[106] While tertiary prevention is important, it is largely focussed on individuals, and is outside the scope of this background paper and the joint policy statement.

Summary

The information provided in this supplement to the background paper emphasises the commonalities that underpin health promotion and illness prevention approaches. Population focussed health promotion and illness prevention efforts stem from the new public health. Both are also based on an ecological approach that prioritises changing social, political and economic conditions in ways that are conducive to health, while acknowledging the influence of individual agency and focussing on supporting healthy living. To influence environments, both health promotion and illness prevention efforts rely upon effective intersectoral action, involving key stakeholders across public, private and non-government organisations. Multifaceted approaches are also prioritised, with a combination of strategies most effective in underpinning effective health promotion and public health. Ultimately, both health promotion and illness prevention have a focus on wellbeing at their core- with health promotion prioritising wellbeing optimisation and illness prevention focussing on preventing or delaying wellbeing decline.

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