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Promoting the Health of Australians

A review of infrastructure support for national health advancement
Promoting the Health of Australians

Final Report

A review of infrastructure support for national health advancement

December 1996

National Health and Medical Research Council

NHMRC
Contents

Preface  i
Project Team  ii
Contents  iii
Acknowledgements  vii
Abbreviations used in this report  ix

Promoting the health of Australians: A review of infrastructure support for national health advancement - Terms of Reference  xi

Executive Summary and Recommendations
Part 1: The Review  xv
Part 2: The findings  xxiii
Part 3: Recommendations for action: leadership and direction  xxvi
Part 4: Recommendations for action: an infrastructure for the future  xxx
Part 5: References  xlv

Final Report

Section 1: Background and methods  1
1.1 Background  1
1.2 Methods  2

Section 2: An infrastructure to support national health advancement  5
2.1 An overview of current infrastructure  5
2.2 Components of the current infrastructure  6
2.3 Analysis of the current infrastructure: issues for the future  12
2.4 Improving Australia’s capacity to promote health  14
Section 3: Policy

3.1 The role of policy in promoting health

3.2 An analysis of Australia’s current health policy

3.3 Implications for health policy

3.4 Conclusions

Section 4: A ‘whole of government’ approach to promoting health

4.1 Why is intersectoral action necessary to promote health?

4.2 Factors that influence success

4.3 Opportunities for the future

4.4 Implications for the health sector: building capacity

Section 5: Program planning and delivery structures

5.1 Components of the health sector’s health promotion program planning and delivery system

5.2 Current government program planning and delivery structures for promoting health

5.3 The focus of current programs with national or State/Territory responsibility for health promotion

5.4 Roles and responsibilities of components of the infrastructure for program planning and delivery

5.5 The challenges

Section 6: Prioritisation and financing

6.1 Sources of funds

6.2 The impact of health services funding models on health promotion

6.3 Common models for priority setting in health services

6.4 Building capacity

Section 7: Monitoring and surveillance

7.1 A national health promotion data framework: scope and definitions

7.2 Australian health data collections and their relevance to health promotion

7.3 Priorities for addressing data gaps and developing indicators

7.4 Where to from here

7.5 Filling gaps in the health information system

7.6 Improving the measurements

7.7 Strategies and infrastructure for development of health promotion surveillance and monitoring information
Section 8: Research

8.1 The current research effort 77
8.2 Limitations of the current research effort 78
8.3 Moving the agenda forward 82
8.4 The role of the National Health and Medical Research Council 84

Section 9: Evaluation 87

9.1 A concept of evaluation 87
9.2 Types of health promotion evaluation 87
9.3 Current status of health promotion evaluation activities in Australia 89
9.4 Building the capacity for health promotion evaluation in Australia 90

Section 10: Workforce education, training and development 93

10.1 The current health promotion workforce 93
10.2 Education and training for the health promotion workforce: the current situation 97
10.3 Conclusions 102
10.4 Defining the direction and content of effective workforce development 102
10.5 Delivering effective education and training 104

Appendices
Appendix One: Terms of reference 107
Appendix Two: Contributors 109
Appendix Three: Glossary of terms 113

List of Tables and Figures

Figure 1. Information requirements for health promotion 52
Figure 2. Conceptual framework for health promotion data 53
Figure 3. A schematic illustration of a comprehensive data framework 57

Table 1. Information domains 54
Table 2. Indicative list of indicators for health promotion 62
Table 3. National health targets by frame classification and priority area 64
Table 4. Key elements of best practice for health promotion workforce development 101
Preface

The last 15 years have seen the first components of a national system of infrastructure for promoting health assembled and moved into position in Australia. The Australian Institute of Health and Welfare was established to collect and interpret national health statistics. From the Kerr White Review the nation obtained the Public Health Research and Development Committee of NHMRC and the Public Health Education and Research Program. Following the success of the Commonwealth and States in forging a national approach to AIDS, the Commonwealth launched the National Campaign Against Drug Abuse, the Better Health Program and the National Program for the Prevention of Breast Cancer. The Australian Health Ministers’ Advisory Council was established as a means for the Commonwealth and States to develop a national view of health financing. Following from the Bienenstock Review, the Health Advancement Standing Committee, was created designed to introduce a contemporary health promotion agenda into the policy work of the NHMRC.

Other important initiatives have occurred in the non-government sector and at State level. These have included organisations concerned with advocacy and workforce development such as the Public Health Association and the Australian Association of Health Promotion Professionals, and the health promotion service branches and health promotion foundations, which have become the backbone of Australian health promotion practice.

Despite all of these welcome developments, there still remains much work to be done before Australia has a comprehensive national system to promote the health of the population. The picture is vastly improved, because most of the necessary components exist, yet some are not wired up effectively, a few components are still missing, while others are not yet geared correctly for the task. There are troubling uncertainties about respective roles and responsibilities and even greater lack of clarity in the relationships between components and what mechanisms exist to achieve overall coordination.

The review of infrastructure support for national health advancement has essentially two goals:

• to identify steps needed to make Australia’s infrastructure for national health advancement among the best in the world; and

• to recommend actions to strengthen the capacity of Australia’s health sector to lead, enable, and support action to promote, protect and sustain the health of all Australians.

This final report, with its recommendations, is the realisation of these goals. It represents the end result of the most extensive national consultation ever conducted by the NHMRC. Thousands of individuals contributed through submissions and participation in workshops. The quality of the process and the final result is a tribute to many people, but especially to the abilities and professional dedication of the Project Director, Ms Marilyn Wise and Ms Jennie Lyons. One hopes that in another 15 years, resulting from the directions set embodied in this report, Australia will have a health-promoting health system that will be the model of international best practice.

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Sections 3, 5, 6, 7, 8 and 10 of the report have drawn heavily on the work provided by consultants who were commissioned to prepare papers on specific components of infrastructure support for promoting health. The authors of each of these papers acknowledged separately the people who participated in consultations, in review meetings and who commented on their drafts. However, the Project Team would like to thank the authors of each of the papers. The authors were:

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The Project Team would also like to thank the Project Executive and members of the Health Advancement Standing Committee for their active support of the work and for their individual and collective contributions.

The second stage consultation, conducted in February 1996, was made possible by the support of key people in each of the States and Territories. Mr Chris Fotoff, Ms Angela Gartons, Ms Tess Leopoldo, Ms Jane Hansen and Mr Alan Head, Ms Yvonne Robinson, Ms Teresa Carbonado, Ms Jennifer Nilbers, Ms Wendy Spencer and Ms Roseanne Bullock made the consultation possible. We would like to thank them for their assistance.
Abbreviations used in this report

AAHPP  Australian Association of Health Promotion Professionals
ABS    Australian Bureau of Statistics
ACHA   Australian Community Health Association
AFAO   Australian Federation of AIDS Organisations
AHMAC  Australian Health Ministers’ Advisory Council
AIDS   Acquired Immune Deficiency Syndrome
AIHW   Australian Institute of Health and Welfare
ANCA   Australian National Council on AIDS
CHD    Coronary Heart Disease
COAG   Council of Australian Governments
Commonwealth Commonwealth Department of Health and Family Services
CVD    cardiovascular disease
DALY   disability-adjusted life years
EHIA   environmental and health impact assessment
GATT   General Agreement on Tariffs and Trade
GPEP   General Practice Evaluation Program
HASC   Health Advancement Standing Committee, NHMRC
HEAPS  Health Education and Promotion System
HIV    Human immunodeficiency virus
HPSIG  Health Promotion Special Interest Group
ICD    International Classification of Diseases
ILAP   Integrated Local Area Planning Process
MPH    Master of Public Health
NACAIDS National Advisory Council on AIDS
NBHP   National Better Health Program
NCEPH  National Centre for Epidemiology and Population Health
NHAC   NHMRC National Health Advisory Committee
NHAP   National Health Advancement Program
NHGTs  National health goals and targets
NHMRC  National Health and Medical Research Council
OECD   Organisation for Economic Cooperation and Development
<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
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<tbody>
<tr>
<td>PHA</td>
<td>Public Health Association of Australia</td>
</tr>
<tr>
<td>PHERP</td>
<td>Public Health Education and Research Program</td>
</tr>
<tr>
<td>PHRDG</td>
<td>Public Health Research and Development Committee, NHMRC</td>
</tr>
<tr>
<td>PHWET</td>
<td>Public Health Welfare Education and Training</td>
</tr>
<tr>
<td>QALY</td>
<td>quality-adjusted life year</td>
</tr>
<tr>
<td>QWB</td>
<td>quality of well-being</td>
</tr>
<tr>
<td>RADGAC</td>
<td>Research and Development Grants Advisory Committee</td>
</tr>
<tr>
<td>RHSET</td>
<td>Rural Health Support, Education and Training Program</td>
</tr>
<tr>
<td>SERU</td>
<td>Support, Evaluation and Resource Unit</td>
</tr>
<tr>
<td>STD(s)</td>
<td>sexually transmissible disease(s)</td>
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Promoting the health of Australians: A review of infrastructure support for national health advancement

Terms of reference

The Health Advancement Standing Committee of the National Health and Medical Research Council will undertake a comprehensive review and analysis of past and current health promotion initiatives. This review will inform the preparation of a report by the Committee, detailing a range of options for future health promotion activity in Australia.

1. The Health Advancement Standing Committee will review the current systems within which health promotion occurs, and assess existing health promotion initiatives and evidence-based strategies to develop a detailed plan for the long-term future role of health promotion in Australia. The final report should identify key recommendations for future health promotion activity in all important areas.

   This report should make particular reference to:

2. Improving the infrastructure in support of health promotion in areas such as:
   - data collection and surveillance;
   - research, including recommendations to facilitate the conversion of knowledge gaps to funded national research projects;
   - policy and program planning, including policy and legislative frameworks;
   - health promotion financing models, including reviewing funding and purchasing models to develop a funding strategy for health promotion, and addressing the impact of existing health care financing models on health promotion;
   - program implementation, program administration and coordination, and organizational structures for health promotion planning and delivery;
   - evaluation, including the development of accountability and performance measures (outputs and outcomes), developing proxy criteria for those interventions which may be disadvantaged by the need for 'evidence-based' measures (such as community development strategies), recommendations on systems for evaluating and monitoring of progress against program or health status goals, and/or commissioning baseline measurement of some issues over time to assist with the design of further studies;
   - intersectoral action, that is, activity within and across all relevant sectors (i.e. not only the health sector) to promote healthy public policy;
   - workforce training and education; and
   - information dissemination and uptake.

3. Considering these structural issues in relation to their appropriate application to the range of health promotion issues, such as health/illness/injury concerns, health status inequalities, population groups, environments, and national health goals, targets and strategies.

4. Identifying the roles and responsibilities of all relevant agencies with an interest in health promotion
(including agencies in the non-health sector). This includes: Commonwealth agencies (with particular reference to the Public Health Division of the Commonwealth Department of Health and Family Services, the Australian Institute of Health and Welfare, the National Health and Medical Research Council, and the Australian Health Ministers’ Advisory Council), State and local interests, non-government organisations, academic institutions, and professional groups.

5. Promoting best practice in health promotion and illness and injury prevention, with due regard to the particular needs of various population groups.

6. Ensuring equality of access to appropriate and affordable health promotion information and services.

7. Maximising all Australians' opportunity to participate effectively in decisions affecting their health.

8. The final report should:
   - detail a range of options for future health promotion action in Australia;
   - make specific recommendations in line with the infrastructure issues raised in Term of reference 2 above; and
   - advise on the interaction of these structural issues with current policy frameworks (e.g. national health goals, targets, and implementation strategies and the National Health Policy), and the broader systems within which health promotion activity occurs.

The report will ensure that health promotion models are fully examined and presented as options for future consideration in the context of a national uniform framework for improving the health of all Australians. As such, it will contribute to the transposition of health promotion for an adjunct to primary and acute care, to a legitimate, effective and equal partner in improving population health status.
Executive Summary and Recommendations
Part 1: The Review

1.1 Background

In May 1995 the Health Advancement Standing Committee of the National Health and Medical Research Council was commissioned to undertake a comprehensive review and analysis of past and current health promotion initiatives in Australia, and of the systems that are responsible for directing and implementing action to promote health. The Committee was asked to develop recommendations that would lead to improvements in the quality, range and effectiveness of Australia’s initiatives to promote health.

The review was conducted in several stages. Following broad consultation with many key stakeholders within the health sector and the development of a series of commissioned papers on specific topics, a Discussion Paper was released for public comment in December 1995. Public meetings, meetings with senior members of health departments in each of the States and Territories, and meetings with several State and Territory Health Ministers were held early in 1996. In all, more than 1,000 people participated in the consultations and more than 100 people and organisations commented in writing.

This report presents the findings of the review and the recommendations of the Health Advancement Standing Committee. The review has also included an extensive consultation with Aboriginal and Torres Strait Islander health workers and communities. Some of the findings from this consultation have been included in this document. In addition, a separate, complementary report on the infrastructure support for Aboriginal and Torres Strait Islander health advancement is being published simultaneously. A further complementary report on the infrastructure support required to promote the mental health of Australians will be published in this series mid 1997.

The findings from the review and in particular, its extensive national consultation, have led to the recommendations contained in this report. Overall, there was considerable agreement about the problems or shortfalls that exist in the current system and on the action that is needed to address these. In addition many issues were raised and discussed during the consultation that had not been addressed sufficiently (or at all) in the Discussion Paper. These have now been included.

The Health Advancement Standing Committee is confident that the recommendations represent a national consensus on the actions that are needed to improve the quality and range of programs to promote the health of Australians, and on the actions that are needed to improve the infrastructure to support this.

1.2 Definitions

Public health

Public health is defined as the efforts organised by society to protect, promote and restore the public’s health. It is the combination of sciences, skills and beliefs that are directed to the maintenance and improvement of the health of all people through collective or social actions. This broad definition includes the description of problems, the planning and action taken to address the problems, and evaluation to assess progress and to define outcomes.
Health promotion

Health promotion is the action taken to solve public health problems. It is based on a specific body of knowledge and practice in the areas of planning and acting to address health issues. Defined as ‘a process of enabling people to increase control over the determinants of health and thereby to improve their health’ health promotion is a way of working that ideally:

- involves the population as a whole in the context of their everyday lives, rather than focusing on people at risk of specific diseases;
- focuses on the determinants or causes of health and illness health;
- uses diverse combinations of methods and approaches, such as legislation, development of policy, organisational change, community development and education;
- seeks to involve the public in identifying the problem, defining what needs to be done, in making decisions and in implementing action; and
- is applicable across the continuum of care, as primary, secondary and tertiary prevention.

Health promotion is based on an understanding of the determinants of health (including an understanding of the causes of ill health) and acts to address these.

Outcomes

Australia uses the term ‘health outcome’ where other countries tend to use the term ‘health gain’. A health outcome has been defined as a change in the health of an individual or group of individuals which is attributable to an intervention or a series of interventions. Famous and others also point to the need to distinguish between health outcomes (affected by social, demographic, and economic factors) and health care outcomes (affected specifically by health care interventions).

The results of most health promotion activities are measured in terms of their impact on improvements in the environments that determine the health of populations and individuals, reductions in risk behaviours, and improved access to effective health care services. These have been identified as intermediate outcome?—prerequisites for the achievement of health outcomes. Health promotion outcomes are represented by improvements in the health knowledge and skills of individuals and communities, (including the capability of communities to act collectively) and in strengthened capacity of communities and organisation to promote health.

Determinants of health

The major determinants of human health status are not medical care inputs and utilisation, but cultural, social and economic factors—at both the population and individual levels. Societies, in which there is both a high level and relatively equitable distribution (i.e. narrow range) of wealth enjoy a higher level of health status, as measured by routinely collected data.

At the individual level, one’s immediate social and economic environment and the way that environment interacts with one’s psychological resources and coping skills, has much more to do with the determination of health status than was recognised by early epidemiological studies of chronic disease aetiology.

This knowledge has pointed to the need for increasingly comprehensive interventions to address the determinants of health. The review has found that it will be necessary to add to the current monitoring and surveillance system, research and evaluation funding and training systems, program financing and delivery systems, and the system responsible for training the workforce to enable Australia to address the complex issues that have an impact on the health of the population. It will mean changes in health policy and increasing awareness of the health impact of all public policy.
The role of the health system in intersectoral action

Intersectoral action has been defined as a recognised relationship between part or parts of the health sector and part or parts of another sector, that has been formed to take action on an issue or to achieve health outcomes (or intermediate outcomes) in a way that is more effective, efficient or sustainable than could be achieved by the health sector working alone."

There is growing recognition within the health sector both of the ways in which decisions made by sectors other than health affect the health of the population, and of conditions that influence the likely success of intersectoral action for health.

While the recommendations in this report include some that point to the need to build the nation’s intersectoral effort to promote health, their main focus is on the actions that are required within and by the health sector to enable the health sector to take such action appropriately and effectively.

1.3 A brief overview of the infrastructure* to direct and support action to promote the health of the Australian population

Infrastructure for public health

Early public health initiatives ensured that Australia’s water and food supplies were regulated to protect the health of the public. that there was some control of public working conditions to protect them from occupation-related injury or harm, and that there were organised initiatives to control the spread of communicable diseases such as polio, diphtheria, and whooping cough. The first Public Health Act was adopted in most States in the early 1900s.

Other important initiatives that were aimed at preventing ill-health and promoting health included the Early Childhood Centres, school dental services, district nursing, child guidance and, in the late 1960s, some community mental health programs* and the family planning movement. In 1973 the Community Health Program was established with the express intention of ensuring that all Australians had access to basic health services, and to develop a variety of new ways to deliver those services. The backbone of the program was to be the multidisciplinary health centre responsible for the health of a given area. In many ways the Community Health Program foreshadowed the themes subsequently expressed in the Ottawa Charter for Health Promotion."

Aboriginal community-controlled health services were developed in the early 1970s (initially in urban areas) out of sheer necessity, in order to make primary health care services available to Aboriginal people who were otherwise not receiving any health care until they were seriously ill."

The 1970s also saw the development of the women’s health movement that led to significant changes in the range and focus of health services offered for and by women. In the 1980s concern with the health and safety of the workforce saw a renewed emphasis on occupational health.

However, although many steps were taken to protect and promote the health of the population during the period 1950–1975 for the most part the primary focus of Australia’s health policy and its program delivery structures was on the provision of treatment and care for those who were ill. Acute care medicine and a growing range of diagnostic and therapeutic technologies seemed to offer the greatest potential for improving the health of the population. Relatively limited attention was given to public health policy and in contrast with earlier public health programs, relatively few organised, large-scale initiatives were taken to improve the health of the population as a whole. By the early 1980s in most State and Territory health authorities there was no discrete program responsible for public health and there were no organised approaches to promoting the health of the population. One obvious consequence of this has been a legacy of poor immunisation rates.

* In this report, infrastructure refers to the systems for policy development, monitoring and surveillance, research and evaluation, workforce development, and program delivery that direct and support action to promote, protect, and maintain the health of the population.
It had become clear that the growing investment in health care services was not achieving the expected improvements in the health of populations. Increasing incidence of largely preventable chronic diseases (such as diabetes), growing costs associated with the expanding range of new technologies, and improved understanding of inequalities in the health of populations (despite the expanded health care services and national health insurance) resulted in gradual changes in health policy and program delivery. There was renewed interest in developing policies and programs that were aimed at improving the health of populations, at reducing rates of preventable mortality and morbidity, and at protecting the public’s health.

It was also clear that current health policy was not leading to improvements in the health of population groups who were most disadvantaged, particularly Aboriginal and Torres Strait Islander populations. There had been failure in the fields of policy and administration to give effect to repeated commitments to ‘do something about Aboriginal health’.”

In all, the infrastructure to support action to promote, protect and maintain the health of the population was unequal to the action that was needed. The work of the Better Health Commission was a major step toward developing a more sophisticated system to deal with the more complex health problems that were now facing those administering the health sector. The Commission recommended many actions to strengthen the infrastructure for preventing illness and promoting the health of the population.

Major achievements have included, for example:

- the development of national health goals and targets to provide direction and priority.
- the establishment of the Public Health Division within the Commonwealth Department of Health and Family Services, the National Better Health Program and its successor, the National Health Advancement Program;
- the establishment of a public health program structures in each State and Territory health department;
- the development of designated health promotion program delivery structures at State, area and local levels in some States and Territories;
- enhanced education and training programs in public health and health promotion (through the Public Health Education and Research Program, PHERP) and nutrition in the undergraduate training of doctors and nurses;
- the establishment of the Australian Institute of Health in 1987 (it was renamed the Australian Institute of Health and Welfare in 1992);
- the National Women’s Health Program in 1989;
- the adoption of the National Health Information Agreement in 1992;
- the establishment of the Public Health Research and Development Committee, the Aboriginal and Torres Strait Islander Health Standing Committee, and the Health Advancement Standing Committee by the National Health and Medical Research Council;
- National Occupational Health and Safety legislation;
- the strengthening of professional associations such as the Public Health Association of Australia and the inception of the Australian Association of Health Promotion Professionals, as well as the establishment of Public Health and Health Promotion Committees within some of the Royal Colleges, and the establishment of the Faculty of Public Health Medicine;
- the strengthening of consumer and community input to decision making through organisations such as the Consumers’ Health Forum, the National Health and Medical Research Council and the Community Sector Support Scheme (formerly the Community Organisations Support Program);
- the adoption of a National Health Policy that commits the system to improving health in addition to providing high quality, responsive health care services;
- the development of national, organised approaches to major issues including cervical and breast cancer, HIV/AIDS, and drugs and alcohol; and
• the development of health-specific legislation in areas as diverse as the wearing of seat belts, restriction of smoking, and the redefinition of rape as a crime of violence (sexual assault).

As well, there has been growing understanding within the health sector of the influence of decisions made by other sectors on the health of the population, and increasing commitment to collaborate with other sectors to promote health. This has been most obvious, perhaps, in relation to links between the health and education sectors, and the health and transport sectors, but considerable progress has been made in working with local government, with the environmental sector and with the private sector on some issues.

In some States there have been significant efforts within the health system to develop a culture focused on health outcomes and to devise the tools for measuring health service outcomes.

There has also been growing recognition of the need to bring an economic perspective to the allocation of resources and to examine the incentives (or lack of) for the health system to link its funding and activity to improvements in the health of the population.

In summary, many of the components of a national system to promote, protect and maintain the health of the population are now in place.

The review demonstrated that there had been considerable success in enhancing the policies, program delivery, structures, and information systems that are necessary to support action to promote population health.

The review also highlighted two major population groups for which specific infrastructure development is needed, particularly if inequalities in health are to be adequately addressed. The experience of the National Women’s Health Policy and Program and the HIV/AIDS Program, in particular, demonstrate the achievements that are possible when attention is given to developing an effective infrastructure. In both cases, the effects of these programs in developing both specific interventions and in influencing mainstream responses to need (both in terms of health care services, and in promoting health), serve as examples of what is needed in order to further the health of Aboriginal and Torres Strait Islander populations and some immigrant population groups.

**Infrastructure for promoting Aboriginal and Torres Strait Islander health**

The review of infrastructure for public health revealed the need for infrastructure to oversee the development of services and public health/health promotion for the Aboriginal and Torres Strait Islander populations.

Two recent publications have drawn attention to fundamental problems with infrastructure that continue to inhibit action to improve the health of Aboriginal and Torres Strait Islander populations. The consultation that has been carried out for this review has confirmed the need for a range of initiatives to develop coherent, community-centred, culturally appropriate Aboriginal and Torres Strait Islander health policies, health services, and programs to promote health.

Although the focus of the review is on infrastructure support for health advancement, it is impossible to isolate structures and initiatives to promote the health of Aboriginal people and Torres Strait Islander people from the overall structures that have been established to fund and provide Aboriginal and Torres Strait Islander health services. The current range of agencies involved in planning, funding and delivering programs and services is confused and confusing. Lines of responsibility and accountability are unclear leading to conflict and competition for the limited resources available.

In addition it is clear that improving the health of the Aboriginal and Torres Strait Islander populations will require active effort on the part of all the organisations and people who are engaged in promoting the health of Australians. While community control and community development are the fundamental underpinnings necessary to improving the health of Aboriginal and Torres Strait Islander populations, it is clear that there is a need to build partnerships among all the groups that have a role in promoting the health of Australians. As well, all the structures and programs that are developed to promote the health of Australians must be sensitive to the needs of, and develop the capacity to work effectively with Aboriginal people and Torres Strait Islander people.
Infrastructure for promoting the health of immigrant Australians

As well, the current infrastructure to direct and support initiatives to promote the health of Australians does not account adequately for the needs of immigrant Australians, particularly those from culturally diverse backgrounds. The needs of these groups have been largely overlooked in the development of public health infrastructure in Australia, partly because, using routine measures of health and illness, immigrants have better health than the Australian born population. However, immigrants from some countries experience high rates of specific diseases," while among some immigrant populations the prevalence of behavioural risk factors such as smoking and physical inactivity is high." Immigrants from culturally diverse backgrounds, particularly those newly arrived in Australia, are over-represented among the unemployed and low-paid workforce. The kinds of work available to people with limited English-language literacy tends to mean that a greater proportion of this group is exposed to working conditions that are hazardous." And many immigrant Australians also experience mental health problems that are linked with the process of migration," and a potential loss of a sense of social coherence that increases their risk of mental health problems."" However, routine measures of mortality, in particular, obscure the extent to which the health needs of many immigrants of culturally diverse backgrounds are not being met adequately. Here, as is true of the Aboriginal and Torres Strait Islander populations, the availability of appropriate, sensitive health care services is a fundamental feature of an infrastructure to promote the health of these communities. This is easily overlooked in a review of the infrastructure required to support health advancement among all Australians.

In conclusion

Australia has a proud record in its development of the infrastructure necessary to direct and support action to promote the health of the Australian population. Now that structures and systems are in place it is necessary to ensure their relevance to and focus on the needs of all groups that make up Australia’s socially and culturally diverse population. It is not being suggested, here, that new and separate infrastructure is always necessary—rather, it is important that existing systems and institutions adapt to ensure that the whole population is included. However, particularly in areas of policy and workforce development, specific initiatives are required.

1.4 Improvements in the health of Australians

The review highlighted areas in which there has been considerable success in reducing the prevalence of risk factors (smoking;" high blood pressure"; 
 reducing rates of mortality (cardiovascular disease," motor vehicle crashes")); 
 reducing the transmission of a communicable disease (HIV/AIDS") in improving physical environments within which people live and work." A series of case study reports highlighting major achievements is available in a companion report."

Although it is not possible to attribute success to any single program or element, it is possible to associate the improvements in health with improvements in the infrastructure for promotion health. First, information about patterns of illness and health in population groups has led to better-targeted efforts to promote health and prevent disease. Greater understanding of the underlying determinants of disease and health—behavioural, social, economic, and environmental—resulted in some successful initiatives to work with other sectors to influence determinants of health. Greater investment in the infrastructure for public health and health promotion (including program delivery structures, a skilled workforce, a more relevant research base, and more consistent funding), enabled longer term, more comprehensive programs to be implemented and evaluated.

It is clear, too, that improvements in the diagnosis, treatment, and rehabilitation of people who are at risk of illness or injury (or who are already ill or injured) have also contributed to improvements in health."" In all, experience has demonstrated that comprehensive interventions are needed, using a combination of population approaches aimed at reducing levels of risk across the whole population, and high-risk approaches, carefully targeted to reach those with high levels of risk and those with identified disease. Reflecting this, the
greatest improvements in health have been achieved in those areas in which there has been a sustained response that has engaged many parts of the health sector (clinicians, hospitals, non-government organisations, universities and public health professionals) and community members.

The work of other sectors has been an essential component.

The review highlighted several major areas in which substantial improvements in the health of the population and/or in the environments that determine health have been achieved as a result of efforts organised by society to protect, promote and restore the public's health, using a combination of sciences, skills, beliefs and collective or social actions.4 However, it also highlighted the challenges that remain.

1.5 Future challenges

Reducing inequalities in health

Continuing inequalities in the health of Australians remain a source of major concern.*** The fact that the health of Aboriginal and Torres Strait Islander populations has not improved markedly this century contrasts both with the marked improvements in the health of the indigenous populations of the United States and New Zealand** and in the health of non-indigenous Australians. Across the whole population there are large variations in mortality and morbidity experienced by different groups, much of which cannot be accounted for on biological grounds. It is these avoidable, unfair and just differences that must be the focus of health policy in general and policy directed to promoting health in particular in the future." Maintaining and improving the health of immigrant Australians, particularly those from culturally diverse backgrounds is a further challenge for the future. While overall, immigrants appear to be healthier (or at least experience lower rates of mortality from most causes) there are wide variations in the rates of mortality and morbidity amongst different groups. Unemployment levels among immigrants from culturally diverse backgrounds tend to be higher than among their Australian born counterparts, and overall, new immigrants, at least, tend to be over-represented in low socioeconomic groups.

There is substantial information confirming that Australians with low family income generally have worse health. The prevalence of risk factors such as smoking, risk drinking, overweight or obesity and lack of exercise is greater among low income Australians. They also are less likely to make use of preventive and screening services.5 Socioeconomic factors influence the health of children and adults at all ages. In addition, the social and economic deprivation often experienced by people in low income groups means that they have been less able to respond to health promotion efforts in the past.

Perhaps the greatest challenge over the coming decade is to use the evidence of determinants of inequalities in health to develop intersectoral and whole of government approaches that will reduce both income and health differentials across the Australian population.

Sustaining change

The case studies conducted in the course of this review identified several areas in which Australia has achieved significant success in reducing rates of premature mortality and morbidity. However, in addition to the need to now focus on improving the health of disadvantaged populations and reducing avoidable inequalities in health status, it will also be necessary to ensure that the improvements that have been achieved are sustained.

As an example, between 1968 and 1993, declines in coronary disease death rates among 20–69 year-old Australians resulted in almost 193 000 fewer deaths than would have occurred if the 1967 death rate had prevailed. Similarly, falls in death rates from stroke among 20–69 year-olds have led to almost 60 000 lives 'saved' over the period 1968 to 1993. However, while overall coronary heart disease mortality in Australia continues to decline, results from a recent birth cohort analysis suggest that the rate of decline among younger males may be slowing.17
Trends such as this, together with an increase in the prevalence of smoking among adolescent girls, a much slower decline in the prevalence in smoking among adult women (than men), and high rates of smoking among some immigrant populations and among the indigenous populations are cause for further concern.

There must be a focus on sustaining the positive changes in environments, health services and lifestyles that have been achieved to date.

**Building and disseminating evidence of effectiveness**

While there have been significant achievements in improving the health of the population, there is still much to be done to develop the base of evidence of ‘what works’ in promoting health. The case studies prepared for the review have highlighted the need for comprehensive, integrated approaches that are sustained over time. The challenge is to identify more precisely evidence on effective strategies and the conditions under which they are most likely to succeed.

There is a further challenge to ensure the widespread adoption of effective practice.

**Adding health to life**

The focus of much intervention to solve public health problems has been on preventing or alleviating the effects of disease. However, particularly in relation to mental health, there is evidence of a relationship between high levels of resilience and coping skills, a sense of social cohesion and good health. “The importance of social support and social integration to health (both physical and mental) of individuals and populations is increasingly well supported by evidence,” highlighting the need for effective health promotion to move beyond a focus on reducing behavioural risk factors.

An ongoing challenge in promoting both the physical and mental health of Australians is to extend action to improve people's living and working conditions, and to develop communities' resilience and coping skills to bring health to life.
Part 2: The findings

2.1 If we’ve done so well, what more is needed?

Health promotion, as part of a comprehensive public health approach, will be a keystone to improving health in Australia as we move into the next century. The review and the consultation have made it clear that much remains to be done to prepare for and meet the demands of the future.

The review found that the current infrastructure is characterised by:

- failure to address continuing inequalities in the health status of population subgroups;
- lack of national leadership by the health sector in guiding action to promote health;
- lack of focus on health outcomes and on reducing inequalities in health outcomes;
- lack of a national public health policy to guide the Commonwealth, States and Territories and many other key organisations in setting priorities, allocating resources, and overseeing/reviewing progress;
- lack of incentives for mainstream health services to link their work to improvements in population health outcomes and to actively promote health;
- inadequate research focused on the delivery and effectiveness of interventions;
- lack of a national evaluation framework that enables measurement of inputs to and outputs from health promotion interventions;
- limited knowledge of and skill in promoting health among the public health workforce;
- lack of a system of monitoring and surveillance that includes indicators of determinants of health;
- inefficient program delivery structures that impede the delivery of high quality effective programs;
- barriers within the health sector to the building of partnerships with other sectors, including the private sector; and
- no system for publicly reviewing or accounting for progress.

In all, the review has focused on the system that are in place in Australia to set directions for, deliver and evaluate the efforts organised by society to protect, promote and restore the public’s health.

2.2 Why take a national approach?

Ultimately, decisions about the role and direction of the health sector are made nationally, through the Australian Health Ministers’ Conference and the Parliament. National agreement that it is the responsibility of the sector to lead and guide action to improve the health of the nation is required.

Because many of the decisions that influence the health of the population are made by sectors other than health a ‘whole of government’ approach is needed at all levels of government, including at federal level, if real progress is to be made.

An integrated, national system is needed to direct, support and evaluate the nation’s efforts to promote health. The system must be capable of coordinating the surveillance, research, priority setting, policy development,
program planning and implementation, and evaluation that is required. For Aboriginal and Torres Strait Islander health, national agreement about and management of policy, funding, and delivery systems is considered to be an essential prerequisite for improving health.2,3,4

Uniform laws and regulations, nationally recognised qualifications for the workforce, and national standards for public health practice were viewed by many as essential components of a robust infrastructure.

A system of monitoring and surveillance that collects comparable data from throughout the nation will ensure comparability and consistency of information. Research is necessary to identify effective systems to deliver health promotion programs, or to disseminate better practice, for example. National workforce standards of competence will assist in developing appropriate education and training, and in ensuring that qualifications are recognised nationally. In the area of public policy, particularly in terms of legislation in areas such as blood alcohol limits for drivers, registration of gun owners, and sales of tobacco to minors, nationally consistent laws would improve the effectiveness of program delivery.

A national approach is important to ensure greater equity of action across the country. Programs such as the National Better Health Program, the National Women’s Health Program, or the National Campaign Against Drug Abuse, for example, were developed on a cost-shared basis, thereby ensuring that some action was taken in each of the States and Territories. It is unlikely that this would have been the case without the stimulus of a national program. A national approach, therefore, ensures greater equity in terms of the development of capacity to act.

At the program level, a national approach, such as that developed for the HIV/AIDS Strategy, or the Organised Approach to Cervical Cancer, has been essential to ensure uniform standards of practice are applied nationally, and that each part of the system (including community organisations, the Commonwealth Department of Health and Family Services, the States and Territories, and research organisations) has had a predetermined, clearly defined role. A nationally developed strategy has resulted in more effective program delivery at every point in the system.

Ultimately, it is necessary to be able to define and measure progress as a nation, toward the achievement of improvements in the health of the population, to assess the health effects across the whole population of decisions made by government and the private sector.

A national system does not mean a single organisation exercising central control. It does not mean that greater power would be vested in a single entity such as the Commonwealth Department of Health and Family Services. Nor does it mean that the same programs should be delivered without variation across the whole nation.

It does mean a system in which many different parts have defined goals and roles, and in which each part contributes to agreed outcomes.

2.3 Proposed National Public Health Partnership

In recognition of the need for a more systematic, cohesive national approach to identifying and solving public health problems, the Council of Australian Government (COAG) agreed, in June 1996, that:

Long term arrangements for system-wide reform are to be explored and developed...a significant realignment of roles and responsibilities could flow from this approach, involving both levels of government (Commonwealth and State) in jointly setting objectives, priorities and performance standards and funding the system, with the Commonwealth taking a leadership role in relation to public health standards and health research, and the States primarily responsible for managing and co-ordinating the provision of services and for maintaining relationships to most providers.5

In light of this agreement by COAG, the Australian Health Ministers’ Council endorsed the concept of a National Public Health Partnership. The Partnership will provide a multilateral public health policy framework.
within which specific bilateral public health outcome funding agreements (between the Commonwealth and individual States and Territories) should be negotiated.

It has been proposed that the Partnership Group would consist of senior representation from each of the jurisdictions participating in the formal agreement between the Commonwealth and States/Territories. In addition, it has been proposed that senior representation from National Health and Medical Research Council (NHMRC) and the Australian Institute of Health and Welfare (AIHW) would join the Partnership Group as full members. This Group would then be the point for planning and coordination and provide the leadership for matters of national significance.

The proposed priorities for the Public Health Partnership Work Program address a number of infrastructure issues.

While the objectives, roles and structures of the National Public Health Partnership have not been finalised, it is the view of the Health Advancement Standing Committee that such a partnership would be an important mechanism through which to implement many of the recommendations of the review. Therefore many of the recommendations have been directed specifically towards the work program of the Partnership.

2.4 Role of lead agencies

Wherever possible this report identifies lead agencies—i.e. department, organisation or group that is expected to lead and coordinate action. For the most part, the Australian Health Ministers’ Advisory Council, the Commonwealth and/or the State/Territory health authorities are nominated as lead agencies. It is understood that the National Public Health Partnership will be identifying lead agencies to implement its work program.

However, at the level of program delivery, in particular, there is a potential role for organisations such as the Australian Cancer Society, the National Heart Foundation, the Consumers’ Health Forum, or Diabetes Australia (to name a few).

Lead agencies are nominated to take responsibility for leading action to achieve specific goals and for reviewing and accounting for progress toward these. The goals might be expressed as health goals or targets, or they might be expressed as the development of a specific component of the infrastructure, such as the development of a national dataset related to a particular environment or setting (e.g. air quality, or health care settings).

On the whole, it is expected that lead agencies would be appointed for a defined period, to carry out specific tasks. This is consistent with growing moves by government to contract out program delivery, and would provide greater opportunities for the community and self-help sectors to contribute to such work.

On the other hand, the report recognises the danger of institutionalising the work of such groups, of creating greater fragmentation, and of reducing the implementation of practice that meets the highest standards of quality and effectiveness.
Part 3: Recommendations for action: leadership and direction

3.1 National leadership: commitment to change

Organisations are set up by society to provide services and to solve problems—their core business. The people who work within the organisations act in accordance with the mandate they are given that defines the goals of their organisation, their roles, and the actions (or outcomes) for which they and the organisation will be rewarded. The consultation revealed widespread concern that the rhetoric of the National Health Policy and Better Health Outcomes for Australians is not matched, in general, by the management commitment, consistency of resource allocation, or the performance agreements that govern much of the health system."

The review confirmed that the complex issues that have an impact on the health of the population and the fact that continued growth in health care service provision is becoming unsustainable mean that changes in the focus, culture and practices of the health system are necessary. Experience has demonstrated that such leadership must be provided by those who are responsible for and manage the health sector. Neither the Community Health Program nor the National Better Health Program has been able to overcome its marginalisation within the health care system to provide the leadership that is required.

To bring about the required changes will require active leadership from the Federal and State/Territory Ministers for Health, and opinion leaders within the health sector. There will be a need, too, to build a constituency within the community to support the changes in the focus of health policy and in the balance of health sector investment.

There are many issues yet to be resolved within the health sector itself about ways to ensure equitable and efficient allocation of resources, particularly in relation to health promotion. "Efforts in Oregon, in the USA and in New Zealand" to engage members of the community in making decisions about the allocation of resources for health care services have revealed difficulties that can arise both in terms of process and in terms of outcomes."

At least three States have developed considerable experience in developing mechanisms to engage community members in making decisions about health and health services. South Australia, particularly through its Health and Social Welfare Councils, Boards of Directors of Community Health Services, and Healthy Cities Projects, has developed a significant body of experience in supporting community participation in making decisions about health and health care Services." In Victoria, initiatives such as the Health Issues Centre and the District Health Councils have also reflected a commitment to broader participation by community members in decisions about the health and health services of their communities." Tasmania conducted wide consultation in the preparation of its State health goals and targets."

This experience should be used to guide the further development of strategies to extend public debate about the direction and priorities of the health sector to include discussion of action needed to resolve public health problems (in addition to the current emphasis on the provision of health care services).

It is recommended that:

- the Federal Minister for Health and Family Services deliver a 'Health of the Nation' address to the Australian Parliament biennially;
- the State and Territory Ministers for Health report on the 'health of the population' of their constituencies biennially:
• all Federal and State/Territory Ministers be asked to report on the contribution of their portfolios to the health of the nation; and

• the Commonwealth, States and Territories, through the National Public Health Partnership, develop strategies to extend public debate about the direction and priorities of the health sector to include discussion of action needed to resolve public health problems (in addition to the current emphasis on the provision of health care services).

3.2 National agreement to invest in health

The review highlighted the extent to which current health policy and investment is reactive and focused on the provision of health care services. Ministers for Health are forced to react to ever increasing demands for health care services. A more explicit process for establishing priorities based on assessment of the health outcomes that might be expected from specified interventions within given levels of resources would provide Ministers with a coherent basis upon which to make decisions about where best to allocate funds.”

In 1993/94 Australia invested approximately 3.6 per cent of its Gross Domestic Product in the health sector, annually — more than $30 billion.” In its recent judgements about the success of this investment have been made on the basis of efficiencies in the throughput and outputs of the health care services (e.g. more people diagnosed, treated, or rehabilitated per dollar spent); reductions in waiting lists for elective surgery). However, although Australia has much to be proud of in terms of the range and quality of its health care services, there are significant groups in the population who do not have access to the health services they need, including the preventive services such as cervical screening or immunisation.”

Many people of non-English-speaking background in particular, do not have access to information about services available to them, are not able to use services because they do not have access to interpreters, or because services have been found to be culturally insensitive or inappropriate.” With the exception of services provided through Aboriginal Medical Services, many Aboriginal people and Torres Strait Islander people still do not have ready access to primary health care services, let alone services that are culturally appropriate. While these issues technically fall outside the terms of reference for this review, it is clear that access to health services is of fundamental concern to individuals and communities. There is an essential overlap between the development of effective primary health care services to many communities and the capacity to promote health.

There is also concern that the results of Australia’s initiatives to promote health have not been enjoyed equally by all Australians. In all, the consultation highlighted the need for national agreement to link investment in health (including investments in health services) to improvements in the health of the population (with particular emphasis on reducing inequalities in health) and to establish the mechanisms through which the necessary actions can be taken.

The Australian Health Ministers’ Advisory Council (AHMAC) is responsible for the focus and direction of the health system, and for the results it achieves. AHMAC is comprised of the heads of the Commonwealth, State and Territory health authorities and its role is to set national directions for health policy, resource allocation, and major program areas.

AHMAC has endorsed the concept of a National Public Health Partnership. It is anticipated that the proposed Partnership Group will provide a coordination mechanism for the work of the Partnership and will operate as a subcommittee of AHMAC.

It is recommended that:
• the proposed Partnership group be responsible for development of a national public health policy that would canvass:
  - why health matters to Australia—that health is a resource (for individuals, families and the community at large) and that population health status is a reflection of national pride and quality of life (good health is achieved where healthy people are valued);
Pathways to better health, with particular emphasis on creating social environments conducive to health, in addition to providing personal health care and personal preventive services, support for personal choices for better health, and progress towards safer, healthier and more supportive living and working environments. The focus of such policy must be on reducing inequalities in health so that particular attention is paid to the likely effects of all health policy on the health of the most disadvantaged groups in the population.

- **Partnerships for better health**—partnerships among different sections within the health sector, with policy makers and practitioners from other sectors, with community and non-government organisations, and with individuals;

- **Programs and services** that achieve health advancement drawing on evidence of best practice and conditions for success;

- **Institutional strengthening within the health sector**: building the infrastructure for health promotion and public health; developing the capacity to work intersectorally; and

- **The need for a whole of health sector approach** to focus on improving population (as well as individuals') health.

4. the proposed Partnership Group be responsible, through implementation of its work program, for the development of a National Agreement on Promoting Health. Such an agreement would:

- set out the respective roles and responsibilities of Australia’s major health institutions in promoting health;

- establish a formal, public process to identify criteria for setting priority outcomes to be achieved within defined time periods. The process should engage community, consumer, and self-help groups, Aboriginal people, Torres Strait Islander people, people from culturally backgrounds, in addition to health professionals, and people from sectors other than health.

The criteria should include consideration of equity and social justice (with particular attention to Aboriginal and Torres Strait Islander populations and populations from culturally diverse backgrounds), and community concern as well as epidemiologic criteria such as incidence, prevalence and severity, and economic criteria such as allocative and technical efficiency. They should also seek to ensure that there is investment in interventions whose outcomes are likely to take some time to achieve, in addition to those that are achievable within a shorter time scale;

- select a limited number of priority intermediate and health outcomes based on these criteria. The priorities should be expressed in terms of outcomes using the framework from the revised national health goals and targets as a guide. That is, outcomes would include changes in environments, individual and community-wide health literacy and skills, as well as changes in the prevalence of risk factors and mortality, and reductions in the gap between the health status of the least and most disadvantaged population groups;

- negotiate to establish lead agencies to coordinate and account for progress on each of these;

- establish criteria for allocating resources to implement national strategies; and

- establish a formal, public process to review and report on progress toward the priority national health outcomes.

3.3 **Address determinants of health through a ‘whole of government’ approach**

The complex array of factors that influence the health of populations requires complex solutions, most of which can be implemented only by sectors working together. The health sector has a vital role to play in stimulating,
leading and guiding action to promote the health of the population but it must develop enduring partnerships with other sectors to influence public policy in general, and the practices of other sectors. However, the health sector has had mixed success in working with other sectors to promote health⁶ and the review found widespread agreement that building its capacity to develop partnerships with other organisations and sectors must be a priority for the health sector.

In particular, this means that the Commonwealth and State and Territory health authorities will need to build their capacity to scan the environment to identify opportunities to work with other sectors—that is, issues or outcomes of mutual importance.

When specific issues have been identified, health authorities need to ensure that their planning and management structures are supportive of the development of ongoing relationships with other sectors, that resources (including time) are allocated to maintain the process of working together as well as to carry out the project. And that the different needs of all the organisations in the partnership are understood and met.

**It is recommended that:**

* the following be considered as priorities for inclusion in the National Public Health Partnership Work Program:
  - establish a group that is responsible for identifying opportunities to work at the national level with other sectors to develop and implement healthy public policy;
  - establish an ongoing relationship with the National Aboriginal and Torres Strait Islander Health Council to identify opportunities to work jointly to develop and implement intersectoral action with particular reference to the needs of Aboriginal and Torres Strait Islander communities;
  - commission research and prepare information to use to explain to other sectors why the health sector is interested in working with them;
  - identify mechanisms through which to establish ongoing relationships with other sectors;
  - commission research to identify indicators of the health system’s capacity to work with other sectors;
  - commission a project to evaluate the impact of the use of the Health Impact Assessment model developed for the National Health and Medical Research Council on public policy and programs; and
  - commission a series of ‘futures papers’ highlighting social, demographic, or economic trends that are likely to influence the health of Australia’s population, and/or that are likely to influence capacity to intervene (for example, the use of new communication technology);
* identify opportunities to work with other sectors to develop healthy public policy and programs; and
* develop and implement interventions in collaboration with other sectors whenever it has been demonstrated that this is necessary in order to achieve benefits for each sector.

⁶ Note: The Department of Community Services and Health in Tasmania began implementing health impact assessment in Tasmania in 1996.
Part 4: Recommendations for action: an infrastructure for the future

The review has identified the components of the infrastructure that need to be refined if Australia's public health infrastructure is to be sufficient to direct and support effective interventions to promote health in the future. The components are systems to:

- design and deliver effective interventions;
- ensure the efficiency of programs and their delivery systems;
- conduct and report on the results of monitoring and surveillance;
- initiate, conduct, and disseminate the results of research and evaluation; and
- ensure effective workforce development.

4.1 Improve the quality and effectiveness of programs and their delivery: invest in health promotion program delivery infrastructure

The Commonwealth and all the States and Territories now have included infrastructures to develop and deliver comprehensive health promotion interventions within their public health programs. At local, area and regional levels the States and Territories have adopted different models for the delivery of projects and services for promoting health. However, the primary health care system plays a significant role everywhere, as do major non-government organisations. The Health Promotion Foundations now play a significant role in program delivery in addition to sponsorship of sport, arts, and racing in several States.

The quality and effectiveness of interventions to promote health depends upon there being systems capable of designing and delivering programs at national, State and Territory and local levels. The roles and responsibilities of each level must be delineated clearly, but it is necessary to ensure that at each level the health sector has sufficient capacity to act to solve public health problems in addition to its capacity to identify them. The separation of funding, purchasing and providing functions within the health sector, while offering the opportunity to link the allocation of resources more closely to identified needs, can lead to the erosion of infrastructure if neither funders, nor purchasers, nor providers are responsible for investing in the components of the stable and active infrastructure that is necessary to ensure effective, high quality programs.

Program delivery infrastructure for promoting Aboriginal and Torres Strait Islander health is addressed in greater detail in the companion report. However, it is critical that ongoing partnerships be developed within the health sector among all the areas responsible for Aboriginal and Torres Strait Islander health service and health promotion program delivery, and between these groups and community-controlled Aboriginal health services.

It is recommended that:

- the National Public Health Partnership require that the State and Territory health authorities commit to long-term investment in the infrastructure necessary to promote health at local levels. The investment is necessary to:
- ensure that there is capacity to oversee the establishment of State and Territory priorities and to purchase or initiate effective action to achieve these;
- ensure that the States and Territories and the Commonwealth have ongoing access to high quality technical advice on intervention theory and methods;
- ensure that basic infrastructure such as program planning and delivery systems, information systems, workforce development systems and research and financial reporting are funded separately from projects and on a stable and ongoing basis;
- enable the development of effective intersectoral partnerships to promote health;
- establish standards for the training required by individuals and organisations that engage in promoting health both within and beyond the health sector;
- ensure that the quality interventions and the resources allocated are sufficient to achieve the expected outcomes;
- commission and fund appropriate levels of research and evaluation; and
- ensure that locally-based health services (including hospitals) have the capacity to contribute to the implementation of programs to address State-wide as well as local priority issues. At local level, throughout most of the country, health promotion projects and services are delivered by the primary health care sector (including Divisions of General Practice) and through hospitals. However, to ensure that high quality, effective programs are delivered, it is necessary to ensure that there are formal links between work carried out at local level and that carried out at State and regional levels, and that organisations (such as hospitals, the Divisions of General Practice and community health centres) and staff have a mandate to promote the health of the population as part of their core business; and
- the National Public Health Partnership commit the Commonwealth and State and Territory health authorities to the continuing development of evidence-based policy and practice. (Note: This will require investment in developing the body of evidence for effective health promotion practice and in developing processes for ensuring its dissemination and adoption).

4.2 Delineate roles and responsibilities

The lack of clear delineation of the roles and responsibilities of the many organisations and groups that make up the health sector was considered to be a major cause of ineffectiveness and inefficiency.

The review and consultation highlighted the extent to which it is necessary to define the roles of national, State and Territory and local health authorities in relation to promoting health. The different jurisdictions of national, State and Territory and local authorities are particularly important to define when working with other sectors to develop public policy. In other words, it is necessary to assign responsibility for action in relation to legislation, regulation, policy and program delivery to the appropriate level of jurisdiction.

But even within the health sector, itself, it appears that limited attention has been paid to defining what the Commonwealth, State and Territory and local health authorities (foundations, non-government organisations, professional organisations, etc.) each contributes best to action on specific issues.

It is recommended that:

- the National Public Health Partnership clearly delineate areas for which there should be national responsibility for action, and those for which the Commonwealth Department of Health and Family Services and the States and Territories should be responsible. The delineation of responsibilities should be based on the formal jurisdiction of each and the principle that responsibility for implementation should be as close to the point of intervention as possible. The following roles and responsibilities should be considered:

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* See recommendations on prioritisation and financing

Promoting the Health of Australians — A review of infrastructure support for national health advancement
National responsibilities

- to set strategic direction in collaboration with key stakeholders;
- to establish national health policy;
- that, in collaboration with key stakeholders, nationally agreed minimum standards be established to ensure consistency and comparability in a range of areas:
  - standards of competence for the health promotion workforce;
  - accreditation standards for education and training in health promotion;
  - better practice and clinical (with particular reference to population screening) guidelines;
  - infrastructure for service delivery, particularly at local level; and
  - national dataset — indicators of intermediate outcomes;
- to ensure the development of national infrastructure, including education and training through the Public Health Education and Research Program (with revised terms of reference), research and evaluation (particularly through the National Health and Medical Research Council NHMRC), and monitoring and surveillance;
- identify and provide incentives for additional delivery systems to engage in promoting health (e.g. local government, hospitals, community-controlled health organisations, Divisions of General Practice);
- to ensure that public policy that influences the health of the population is consistent across the nation (e.g. blood alcohol limits for drivers);
- to foster the dissemination and implementation of good practice; and
- to establish a system to review and account for progress.

Commonwealth Department of Health and Family Services responsibilities

- to facilitate the development and application of national public health policy and nationally consistent standards;
- to advocate at national level for public health and contribute to strengthening the public and professional constituency for action to promote the health of the population;
- to fund national intervention programs in accordance with agreements reached with the States and Territories through the National Public Health Partnership;
- to establish and maintain partnerships with other sectors, including the private sector, to influence public policy;
- to review public policy to identify areas that are likely to influence the health of people and society;
- to coordinate the design, delivery, monitoring and evaluation of national programs that so economies of scale can be achieved without compromising effectiveness;
- to facilitate the process of reaching national agreement on program development and delivery and/or joint funding; and
- to conduct, in consultation with a range of partners, Australia's international responsibilities and obligations in public health.

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§ See recommendations on leadership.
¶ See recommendations on workforce development.
State and Territory health authorities’ responsibilities

• to fund programs in accordance with agreements and work programs developed through the National Public Health Partnership;

• to set strategic direction for the State or Territory in collaboration with key stakeholders, including the Health Promotion Foundations in those States and Territories that have them. (Note: It is necessary to establish strategic direction at State and Territory levels in order to account for specific regional or local issues—for example, dengue fever in North Queensland, or the needs of a local group of refugees, or areas of socioeconomic disadvantage);

• to coordinate, review and report on the implementation and outcomes of national and State and Territory programs to promote the health of the population;

• to provide, maintain and develop the infrastructure necessary to promote health, with particular emphasis on research and workforce development;

• to establish and maintain partnerships with other sectors, including the private sector to influence public policy and to deliver effective programs;

• to fund demonstration projects and disseminate the results;

• to facilitate the development and implementation of a State policy and regulatory framework for public health; and

• to review, and report on progress at regular intervals (e.g. through a biennial report on the health of the population to State and Territory parliaments).

Local/area health authorities responsibilities

• to assess the health needs of the local/area population;

• to prepare local/area strategic plans for promoting health that integrate national and State health policy and local need;

• to select priorities for action;

• to establish and maintain partnerships with other sectors, including the private sector, to design and deliver local action to promote health;

• to plan and deliver interventions based on assessment of evidence of good practice;

• to evaluate the quality and impact of interventions;

• to provide incentives and training for all health professionals (including clinicians in hospitals, general practice, and community health) to engage in promoting the health of their clients, patients, and the wider community;

• to provide incentives and training for community members and personnel from sectors other than health to engage in promoting health; and

• to review and account for progress at local/area level.

4.3 Develop organisational structures that are flexible and able to address the full range of health problems

In all States and Territories and in the Commonwealth there are separate, specific program structures responsible for different issues or population groups such as HIV/AIDS, drugs and alcohol, women’s health, Aboriginal and Torres Strait Islander health, etc.—vertical programs. They operate, commonly, with little reference to one another, or to the health promotion or public health programs, particularly at national and State or Territory levels. At local levels, the competing demands of implementing these programs as discrete entities are a source of tension.
The lack of coordination leads to overlap, contradictions (in some cases), and to reduced effectiveness and efficiency. Vertical programming in isolation from any means of integration has meant that different perspectives on a given issue are not considered and programs are developed that do not address the full range of population groups or issues that are necessary, or are not based upon evidence of good practice.

The review has confirmed that there is no single, best organisational structure to design and deliver effective programs to promote health. However, it was widely agreed that it is critical to have designated ‘programs’ within the Commonwealth and State and Territory health authorities that are responsible for the strategic direction and coordination of health promotion. The impetus given to health promotion (and issues such as women’s health) by national, cost-shared programs such as the National Better Health Program was considered critical in all the States and Territories, particularly smaller ones.

Matrix structures adopted by the Commonwealth and State and Territory health authorities appear to be one means by which to overcome the lack of flexibility in the current system by integrating the content expertise (in the vertical program areas) with the methodology of health promotion. There is an obvious need for such structures to include the capacity to collaborate with external agencies both within and beyond the health sector. The matrix structure, like, does not refer to a management structure — rather the matrix is to ensure an integrated approach to selecting and implementing priorities and strategies, drawing on the strengths of all partners, including those within the health sector.93

It is recommended that:

- health authorities adopt matrix structures designed to encourage collaboration among different program areas within their organisations in the development of national strategies in the range of priority areas; and
- the Commonwealth Department of Health and Family Services provide funding to identify indicators of the organisational capacity of the health sector at national, State, and local levels to promote health.

4.4 Develop an organisational culture that encourages community participation

The lack of community involvement in planning and delivering health services and health promotion/public health programs has long been viewed as a source of inequity, inefficiency and ineffectiveness.94,95 This review found this to be most obvious in relation to Aboriginal, Torres Strait Islander and immigrant communities, but included other disadvantaged groups. Members of these communities find that it is common that services and programs are designed without reference to their cultures, languages or living and working conditions. Opportunities to develop interventions that might apply equally across the whole population are missed while programs that have been designed specifically for disadvantaged population groups are rare and under-funded.96

It also highlighted many examples in which services and programs had failed to reach specific population groups because the planners and providers had not known about (or accounted for) the culture, language and/or health needs of the population groups and had not engaged members of those communities in developing programs. The different needs of women and men, for example, clearly need to be accounted for in interventions to promote health.

Finally, it is clear that, if alienation and powerlessness underlie health inequalities, then strategies that engage communities actively and meaningfully to advocate for their own health are an essential component of effective action to promote health.97

It is recommended that:

- any funding agreements developed through the proposed Public Health Outcome Funding Agreements commit the health sector to engaging communities in decision making about the priorities, directions, services and programs to be delivered by the health sector (see recommendations on national agreement to invest in health);
• the National Public Health Partnership commission research to identify organisational structures that have succeeded in actively engaging community members in decision making to influence the priorities, directions, services and programs of the health sector; and

• the Commonwealth Department of Health and Family Services provide continuing and additional funding for the Community Organisations Support Program to encourage and enable communities to participate in decisions about their health and health services. Particular initiatives to engage Aboriginal, Torres Strait Islander, immigrant community organisations, and men in such activities should be encouraged.

4.5 Establish a system to identify and disseminate good practice

A system to ensure the identification and dissemination of “good practice” in promoting health is an essential prerequisite for developing the quality and effectiveness of interventions. Several issues need to be addressed to develop such a system in Australia.

The review found that current criteria for funding research do not give priority to research that focuses on the delivery of effective interventions to promote health, while the lack of consistent, reliable funding for the implementation of health promotion programs has precluded the systematic implementation of effective programs over time, thereby reducing the likelihood of success.

Although there is a growing understanding of the need to identify “good practice” in promoting health there has been no systematic approach to funding research either to identify methodological efficacy (the best type of interventions to apply in given circumstances), or to improve practice quality (applying those interventions in the most effective, efficient way). The review also identified the need for research to identify the most effective and efficient methods of disseminating and encouraging the uptake of good practice in promoting health.

Particular attention needs to be given to defining and disseminating good practice in promoting the health of disadvantaged populations. The companion report on promoting Aboriginal and Torres Strait Islander health, for example, highlights the need to identify and disseminate principles of good practice in promoting the health of indigenous populations. Promoting the health of immigrant populations too will require specific attention.

It is recommended that:

• funding be provided jointly by the Commonwealth, States and Territories to established practitioners and researchers to enable them to contribute to the development of guidelines for good practice in health promotion with particular emphasis on promoting the health of disadvantaged populations;

• the NHMRC consider developing a mechanism to encourage researchers and practitioners to collaborate in preparing proposals and implementing programs; and

• funding be provided jointly by the Commonwealth and the States and Territories to support the Health Promotion Journal of Australia and the Aboriginal and Islander Health Work Journal to enhance their capacity to disseminate information on better practice in health promotion. Some of the specific actions that might be taken by the journals include:
  - conduct courses in writing skills;
  - identify and publish case studies that illustrate principles of good practice; and
  - commission articles based on analysis of data, the literature and current practice in relation to specific issues to guide practice at local and area levels, in particular.

* These journals have been identified, in particular, because their focus is on health promotion practice. There are many other journals that focus on publishing the results of research and evaluation.
4.6 Ensure that links between national, State and Territory policies and programs and local delivery systems are made explicit

Experience with the setting of national priority health goals and targets, and the development of national strategies in areas such as HIV/AIDS and women’s health, has highlighted that the implications for the work of State, local or area health services of national policies such as the priority goals and targets are rarely made explicit. Nor are the overlaps between such policies or programs addressed explicitly. The conflict of the directions of national documents with local needs or programs, the lack of resources attached to many national programs or issues and the need for separate reporting can result in paralysis at local levels. Even if funding is available through national programs, at local levels this can result in a large number of separate contracts, each requiring separate accounting and reporting. Many of the projects funded in this way are short term and the administrative work required for each is out of proportion to the size of the grant and difficult for local services to manage.

At least some of this difficulty would be reduced if locally based health workers were included among the groups developing national policy documents, but it is clearly necessary for worked examples to be included to make the intentions of the policy makers clear to each level of responsibility within the health sector (at least), if not also to community, non-governmental and professional organisations.

It is recommended that:

- all national health policy and strategy documents outline their implications for action at local health service levels; and

- the Commonwealth, States and Territories provide funding for research to develop models of contracting between State and Territory and local/area health services that will enable the most effective and efficient use of funds to promote health. The models should show resources to be shifted between programs. The current agreements being signed between the National Aboriginal Community Controlled Organisations, and the Commonwealth and State and Territory health authorities are examples of an initiative aiming to achieve this.

4.7 Allocate resources more effectively and efficiently

To date, priorities established for intervention to promote health in Australia have been set with only limited reference to the economic principles of technical and allocative efficiency. This review confirmed the need for models of economic evaluation that will be useful tools for policy makers to use to decide how to maximise health gains from scarce resources."

However, the methods of economic evaluation that are available to assess interventions are not well developed. There is a need for mechanisms to guide the redistribution of resources within the health system, so that funding is linked to the interventions that have been found to be the most effective in achieving specified health and/or intermediate outcomes."

While the measures and protocols are being developed it will be necessary to ensure there is continuing and sufficient investment in promoting health. The resources that are committed to promoting health are already limited. As financial pressures on the health system become greater, it will be necessary to ensure that there is continued investment in both the infrastructure and the programs that are necessary to solve public health problems. Promoting health is an emerging area of knowledge and practice. A model of investment that is based on allocating resources only to programs and services of proven effectiveness is likely to stifle innovation unless particular attention is paid to encouraging innovation. Just as there is a need to invest in programs of known effectiveness, there is also a need to invest in innovation, to take risks."

As the health system moves to separate the funding, purchasing and provision of health services it will be particularly necessary to ensure that the infrastructure necessary to support ‘intelligent purchasing’ is in place. The infrastructure includes an information system to identify risk and need; the evidence provided by research and evaluation (and the meta-analysis or synthesis of results); people who are able to interpret and synthesise
the analysis of needs and evidence of costs and effectiveness in order to assess the nature of the interventions that are needed in particular circumstances; and people who are able to deliver interventions effectively.

It is not possible to ‘purchase’ health promotion intelligently without such an infrastructure (just as it would not be possible to purchase appropriate health services e.g. surgery, without an infrastructure that ensures the quality and effectiveness of the service). As Australia moves toward project funding (or to the purchase of ‘products’) in health promotion, there is danger of producing a myopic, short-term, unstable and fragile, poorly trained, poorly informed system of program delivery.

In effect, this highlights the necessity for investment in the capital needed for good health promotion practice—recruitment of well trained, committed, high quality staff in long-term positions; staff development; information systems; administrative support; and well developed community networks. The New Zealand health authorities have identified a series of ‘extra-contractual’ public health strategies that cannot be ‘purchased’ using the same contractual system that has been used to fund specific intervention programs. Examples of such ‘extra-contractual’ strategies are the capacity of the health sector to work with others at the national level to define and develop policy and organisational changes. “In the United Kingdom, too, a distinction is now being made between the infrastructure required to commission interventions and the purchase of programs or ‘products’.” They have identified the need to commission, separately from projects, a range of broad-based supports for product delivery, including intersectoral activity.

This review identified four principles to underpin investment in health promotion—resources should be allocated to achieve:

- technical efficiency;
- allocative efficiency;
- equity; and
- to encourage dynamic practice that continues to foster innovation as well as the widespread adoption of good practice.

The capacity to achieve the outcomes that are the objective of promoting health depends upon:

- information on which to make decisions, and a willingness to make the decisions that are indicated by the information;
- evidence on the level of a program’s cost-effectiveness and its contribution to health and social justice;
- agreement through the policy process about goals and constraints; and
- focus on evidence of need—even where programs are not cost effective, they may be warranted on equity grounds because of an unacceptable level of need in a particular population.

It is recommended that:

- through the National Public Health Partnership, research be commissioned to measure the true size of Australia’s investment in promoting health, including the funding of dedicated programs, activities carried out by the mainstream health system, and the investment by the private sector;
- the proposed Partnership Group commission the development of a framework to identify the information needed to enable Ministers and senior health administrators to make rational decisions about where best to invest health resources in general, and those for promoting health in particular (see also, recommendations on ‘setting priorities’ above). Initially, the level of funding should be determined by a needs-adjusted population formula that should be refined progressively to recognise the distinction between the needs of the whole population and the specific requirements of disadvantaged populations when greater levels of investment may be required to achieve similar outcomes;
- the Commonwealth, States and Territories consider the following principles to set priorities and to allocate funding for interventions to promote health:
- equity and efficiency — that is, the proposed interventions should be judged by the extent to which they achieve technical and allocative efficiency and fulfill the requirements of social justice;
- evidence-based priority setting and funding — which should apply both to the aggregate government budget for promoting health and to the selection of particular interventions;
- investment information on the scale and scope of planning, review and management of action to promote health;
- dynamic adjustment — to encourage innovation and the expansion of more cost-effective programs at the expense of less cost-effective programs, and also to encourage the better performance of existing programs; and
- an assessment of value to money. This will need an initial stage of comparing the results of open competition to all public and private providers, with both a limited form of competition to preferred providers, and an 'internal market' of public service providers;

* the proposed Public Health Outcome-Funding Agreement articulate:
  - evidence of the effectiveness (and, where possible, cost effectiveness) of new interventions is specified together with an outline of the population health need to which the proposed intervention is responding;
  - expected levels of activity and investment are specified;
  - expected outcomes (including intermediate outcomes) and benefits at the population level, are specified;
* through the mechanism offered by the National Public Health Partnership model nationally agreed performance indicators be established that specify the minimum necessary public health and health promotion program infrastructure at State and Territory levels and minimum expected levels of public health and health promotion program delivery.

### 4.8 Create incentives for the health care system to promote health

Current methods of allocating resources within the health sector, including those for promoting health, are usually based on an historical assessment of costs and are flawed. However, there has been no incentive to change this. New funding models and service contracts are needed to provide incentives for health service managers and clinicians to begin incremental change toward investing resources in those programs and services that are likely to result in the greatest improvements in the health of the population, and that will achieve improvements in equity (of opportunity to achieve improved health) and access to services and programs.”

Formal agreements are needed between service providers (an area health service, a community health centre, a hospital or a division of general practice, for example) and the Commonwealth or State or Territory health authority. At the national level, the Medicare Agreement represents such a contract. Eagar has suggested that the 1998 Medicare Agreement should include:

* an incentives program which aims to encourage all health care providers to measure health outcomes as a matter of routine;
* an agreed national view (Commonwealth, State and Territories, providers and consumers) on the optimum way to blend cost-based, needs-based and output-based funding;
* agreed national definitions and recommended standard measurement tools for health status, quality of life and functional status/gain; and
* a nationally funded program for the development of practice guidelines and critical pathways.”
The Australian Health Ministers can also use direct program grants, and future contracts between the Commonwealth and the States and Territories to create incentives for health service providers to allocate resources based on assessment of the potential health gain.

In all, the review highlighted the need to create incentives for the mainstream health system to engage in promoting health. The incentives recommended included changes in contractual arrangements between funding bodies and the organisations that deliver services to require specified levels of activity in promoting health; development and inclusion of relevant standards in existing accreditation processes; changes in the balance of funding to support greater levels of activity; and improved opportunities for health professionals to acquire appropriate knowledge and skills.

It is recommended that:

* the Commonwealth, State and Territory health authorities fund research to assist the Australian Council of Healthcare Standards (ACHS), the Australian Community Health Association, and the Divisions of General Practice to develop indicators that would enable the upgrading of standards for accrediting health care settings for promoting health. The General Practice Service Evaluation and Research Units are a mechanism through which such standards might be developed;

* in collaboration with the Commonwealth and State and Territory health authorities, the accreditation bodies develop a system to reward organisations for meeting (and surpassing) the standards for promoting health;

* through the work program of the National Public Health Partnership, national research be commissioned to identify mechanisms to identify how best to fund and support action to promote health in hospitals;

* through the work program of the National Public Health Partnership, a national experimental trial be commissioned to identify the most effective and efficient incentives to engage general practitioners in promoting health by comparing the effects of fee-for-service and block funding approaches on group practice health promotion outputs and practice cost profiles; and

* through the work program of the National Public Health Partnership, model terms of agreement be developed to guide the States and Territories and area health services, hospitals/community health centres/divisions of general practice. In negotiating these agreements, the broader should take into account:

  - evidence of the effectiveness (and, where possible, cost effectiveness) of new interventions is specified together with an outline of the population health needs to which the proposed intervention is responding;

  - expected levels of activity and investment are specified; and

  - expected outcomes (including intermediate outcomes) at the population level are specified.

4.9 Invest in a more comprehensive national health information system: monitoring and surveillance

The Australian Institute of Health and Welfare (AIHW) and the National Health Information Agreement have been instrumental in the development of a national health information system. The biennial reports on Australia’s health, "and other reports" prepared by the AIHW have provided a wealth of information about the health of the Australian population, and have contributed significantly, to knowledge about determinants of health and about inequalities in health, in particular. Health authorities now accept responsibility for monitoring the impact on health of harmful elements in the social, economic and physical environments."

However, the review and consultation demonstrated that currently:

* the national data collection systems are not sufficiently sensitive to identify the particular needs of the many different population subgroups that make up Australia’s multicultural, multilingual population;
there is very limited national information about the structural determinants of health; and

the system measures progress only in terms of changes in mortality and morbidity, and changes in some behavioural risk factors. Given that the greatest progress in improving health outcomes is likely to come from improvements in the environments, and social structures that determine health and in addition to improving the health literacy and skills and health behaviours of the population, it is necessary that the national health information system be expanded to reflect these.

There was wide recognition of the fact that such changes to the national health information system will require additional funding, particularly to support the development of measures of

- quality of life; and
- environments (physical, social, recreational, organisational etc.)

Existing monitoring and surveillance systems, and the new measures must enable identification of the effects of structural changes on the health of people from specific culturally diverse background population groups and on Aboriginal or Torres Strait Islander people in addition to differentials linked with socioeconomic status and sex.

In all, the need is to develop health intelligence to assist in identifying problems, in setting priorities for action, and to monitor progress. The challenges are to:

- develop an information system that reflects the multiple factors, including the social and environmental structures that determine the health of populations;
- develop an information system that reflects the multicultural composition of Australia's population and that is sensitive to the differences among the different population groups;
- develop nationally agreed measures and indicators that reflect these;
- collect and report on the data in a manner that it enables its use in advocacy for health; and
- increase the extent to which the system is able to account for the actions it has taken and the results achieved.

Local information will still be needed to inform program design, to monitor implementation, and to measure progress. It is likely that information gathered at a local level will be more sensitive to a wider range of needs and problems.

This is particularly, but not exclusively, true of Aboriginal and Torres Strait Islander communities, for whom national information is unlikely to be sufficiently specific to local conditions to guide action without additional, local data.

For both Aboriginal people and Torres Strait Islander people, and for population groups of culturally diverse background, there is often tension between the need for more and better quality data and the need for more, and more effective, intervention programs. It is important that the need for data (and the costs associated with its collection and reporting) not be offset against funding for program design and delivery.

It is recommended that:

- the AIHW be nominated as the lead agency and provided with additional funding to:
  - develop measures of quality of life outcomes at the population level;
  - further develop measures of environmental and social attributes of society that are related to health;
  - develop measures of the resources expended on promoting health;
  - coordinate a national effort, including the Commonwealth and State and Territory health authorities, to collect and report measures of quality of life, health-promoting environmental attributes and resources expended on promoting health in a consistent manner across Australia;
ensure that all national monitoring and surveillance systems be developed to include sufficient sensitivity to identify problems arising in the range of population subgroups that make up the Australian population and to measure progress across the full range of these groups;
- continue to work with Aboriginal and Torres Strait Islander communities to develop a plan to improve all aspects of information about their health and access to health services; and
continue regular national health and risk factor surveys for Aboriginal people and Torres Strait Islander people.

4.10 Expand research to focus on intervention and the evaluation of comprehensive programs

The NHMRC’s Public Health Research and Development Program was widely regarded as having played a critical role in the development of public health research. The consultation confirmed that there is enormous support for the continuation of at least the current level of funding by the NHMRC for public health research. However, the consultation revealed a growing need for research that focuses less on the description of public health problems and more on the methods used to solve the problems including policies and programs. There is also a need to refine the approach to evaluation so that the relationship between the inputs to programs and their outcomes is more clearly defined, and so that there is a framework to measure the breadth of national action. The challenges this presents include the need to change the criteria used to fund research projects, including the need to acknowledge that effective interventions are, increasingly, comprehensive and complex. They do not lend themselves readily to research designs such as randomised controlled trials. New research designs that reflect and inform current good practice are needed.

Promoting health is, by its nature a multidisciplinary, multisectoral activity. One of the key findings of the review has been the need to develop a skilled workforce, able to design and conduct research focused on the delivery of effective programs to promote health. This will require:

- incentives to encourage and support individuals to enter effective research training programs;
- funding that encourages multidisciplinary intervention research;
- funding for research that is related to intervention priorities issues/population groups, in addition to investment in innovative research;
- funding for research on the dissemination of effective practice;
- funding for research to identify indicators that would enable assessment of intermediate outcomes; and
- funding for research to develop and evaluate the effect of economic tools to assist in assessing costs, effectiveness and benefits of given interventions to promote health.

In addition to an extended research and related workforce development program, a further critical component of building a comprehensive, national approach to promoting health will require greater emphasis on evaluation.

The review found that the scientific evaluation of health promotion is now relatively well supported by national and state-based research funding agencies. While there is a need for concentrated effort to attract and train a strong health promotion research community, and for greater focus on intervention research, there is widespread acceptance of the need for well-designed, appropriate evaluation of interventions at all levels. However, there has been only limited commitment across the States and Territories to an organised and systematic approach to the managerial evaluation of action to promote health. This has resulted in there being only very limited knowledge of the inputs (including financial and human resources) to health promotion interventions (across States and Territories and nationally), of the quality of the interventions, or of the efficiency (technical or allocative) of current initiatives.
It is recommended that:

- the NHMRC retain the present level of funding for public health research within the next triennium;
- NHMRC consider ways to increase the level of investment in public health intervention research;
- selection criteria be established for proposals requesting intervention research. These criteria should include:
  - multidisciplinary supervision of research training;
  - evaluation of interventions; and
  - extent to which the research is developed in collaboration with health and community service organisations.
- a Special Incentive Program be established offering at least five scholarships annually for researchers undertaking intervention (mainly multidisciplinary and cooperative research in areas of priority);
- the NHMRC Guidelines for Aboriginal Research continue to be implemented in assessing all proposals for funding in or engaging Aboriginal and Torres Strait Islander populations and communities; and
- through the National Public Health Partnership, agreement be reached on a national evaluation framework to assist in developing an integrated view of the performance of health promotion activities by the Commonwealth and State and Territory health authorities, the health promotion foundations, and major non-government organisations; and
- the capacity of the AIHW be expanded to enable it to undertake responsibility for programmatic evaluation to complement its existing capacity in national surveillance.

4.11 Strengthen the system that is responsible for training the workforce

The consultation reinforced the view that the workforce engaged in promoting health includes a wide range of people working both within and beyond the health sector. There was broad agreement that all those who have a role in promoting health require knowledge and skills to assist them to promote health effectively.

The Public Health Education and Research Program is the cornerstone of formal, postgraduate education in public health in Australia. It has played a vital role in building a skilled public health workforce and it will continue to be vital in the future. However, it is now important to review its terms of reference and to revise these to meet the needs of the public health workforce of the future.

The review and consultation have highlighted the extent to which all health professionals now require skills in promoting health. However, current education and training programs for these groups include only limited content on promoting health and there are no nationally agreed standards of competence for these groups.

People who work in the health sector in clinical and/or community-based roles, people who work in other sectors, and members of the community do not require and, often, are unable to commit to undertaking a full, formal program of study. Nonetheless, they do require (and are demanding) training to assist them to make their work more effective. The review and consultation highlighted the need to develop a national, flexible, accessible network of training opportunities to enable the wide range of individuals and organisations that have roles in promoting health to develop and maintain relevant knowledge and skills.

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* For more detailed discussion of this issue, see complementary report: Promoting the health of Indigenous Australians: A review of infrastructure support for Aboriginal and Torres Strait Islander health advancement. Canberra: National Health and Medical Research Council, 1996.

† See recommendations in Section 4.7 on allocating resources more effectively and efficiently.
The need for culturally appropriate, accessible training and ongoing education was of particular importance to the Aboriginal and Torres Strait Islander communities and organisations consulted. Many Aboriginal Health Workers have had only limited access to training of any kind, few had had access to training in health promotion in particular, and many work in organisations that do not have sufficient funds to allow staff to participate in additional training.

Several barriers to members of disadvantaged groups participating in education and training were identified. Many of these barriers were experienced most acutely by Aboriginal people and Torres Strait Islander people, but many are also experienced by immigrants from countries in which English is not the first language.

In addition to training in the technical skills of health promotion the Aboriginal and Torres Strait Islander consultation highlighted the extent to which training is required by all health professionals about Aboriginal and Torres Strait Islander history and culture, and in ways to build partnerships with the communities to promote health.

There is also a need for a knowledgeable and skilled health promotion research workforce. There are few incentives in place, currently, to encourage young graduates to develop the specialised knowledge and skills that are necessary, or to enable them to develop careers in this area.

The Aboriginal and Torres Strait Islander consultation also highlighted the need for support for indigenous people to be trained in and encouraged to conduct research. As well, the lack of cultural sensitivity of much research among Aboriginal people and Torres Strait Islander people to date has pointed to the need for the development and implementation of training and guidelines for all non-indigenous (and indigenous) people who intend to undertake research in Aboriginal or Torres Strait Islander communities.

In all, the review pointed to the need for a more comprehensive system for workforce development. Formal training such as that offered through the PHERP and other tertiary-based courses, needs to be supplemented with more systematic programs of short courses and on-the-job training.

It is recommended that:

- nationally agreed standards of competence for the specialist health promotion workforce be developed (see roles and responsibilities, above), and that these include standards with reference to working with population groups from different cultures—with particular emphasis on Aboriginal and Torres Strait Islander cultures;
- the National Public Health Partnership support the retention of the Public Health Education and Research Program (PHERP) as an infrastructure funded by the Commonwealth Department of Health and Family Services to ensure a systematic, national approach to the research, provision of expert advice and education and ongoing training of public health professionals;
- the terms of reference of PHERP be revised to ensure that public health education and training courses place greater emphasis on the knowledge and skills required to solve public health problems, advised by the standards of competence;
- additional funding be provided to PHERP to provide incentives for Aboriginal, Torres Strait Islander, and immigrant Australians to undertake formal and ongoing training in public health and health promotion;
- the Commonwealth Department of Health and Family Services, through its funding of PHERP, commission research to identify the ‘undergraduate’ health promotion training needs of major groups of health professionals. Key stakeholders to include in the dialogue should include professional organisations, universities, and consumers;
- the Commonwealth Department of Health and Family Services, through PHERP, fund the development of a national strategy to enable a wide range of individuals and organisations from sectors other than health (and including the community) to participate in training to improve their knowledge of and skills in promoting health; and
- the Commonwealth Department of Health and Family Services, in collaboration with the Department of Employment, Education and Training and the State and Territory health authorities, offer up to ten scholarships annually to members of disadvantaged groups to undertake training in health promotion. The training should be interpreted widely and not refer only to formal postgraduate training.
Part 5: References


9. ibid., p.59.


Promoting the Health of Australians—A review of infrastructure support for national health advancement
73 National Health Strategy. 1993. op. cit., p.82
74 Bartlett B. Lege D. op. cit., p.6–7
80 Holman C. Donovan R. Corti B. Report of the evaluation of the Western Australian Health Promotion Foundation. Western Australia: Department of Public Health and Graduate School of Management, 1994.
81 Health Promotion Journal of Australia 1993;3(1). Complete issue
82 National Health and Medical Research Council. Promoting the health of Aboriginal and Torres Strait Islander health advancement. Draft report. Canberra: National Health and Medical Research Council, 1996.

Promoting the Health of Australians: A review of infrastructure support for national health advancement


93 NSW Health Department. Getting it right: focusing on the outcomes of health services and programs. Sydney: NSW Health Department, 1994.


104 Antonovsky A. 1996. op. cit., p. 16


107 National Health Strategy. Pathways to better health. 1993. op. cit

Final Report
Section 1: Background and methods

1.1 Background

The Health Advancement Standing Committee was commissioned to conduct a review of action needed to improve Australia’s infrastructure support for national health advancement. The Terms of Reference are outlined in Appendix One.

The review included the following steps:

- consultation with key stakeholders in Australia;
- consultation with international experts in health promotion;
- public meetings;
- commissioned papers in the areas of:
  - impact of health policy on health promotion;
  - health promotion program structures;
  - prioritisation and financing;
  - surveillance and monitoring; and
  - education, training and workforce development;
- distribution of a Discussion Paper for review and comment;
- second stage consultation with the States, Territories, and a wide variety of individuals and organisations in a series of public meetings;
- preparation of a Summary Report and Recommendations (included in this document as an Executive Summary).

In all, more than 1 000 people have participated in the consultations conducted in the course of preparing this report. More than 1 000 Aboriginal people and Torres Strait Islander people contributed to the companion report on infrastructure for Aboriginal and Torres Strait Islander health advancement (see below).

Companion Reports

The Health Advancement Standing Committee also commissioned a national consultation on infrastructure support for Aboriginal and Torres Strait Islander health advancement. A Discussion Paper based on the initial consultations was distributed for review and comment and a final Report has been prepared for publication as a companion volume to this document. In addition, case studies of achievements in improving the health of Australians and of effective action to promote the health of indigenous Australians are to be published in two further reports in 1996.

The National Mental Health Working Group also commissioned a project to identify steps needed to improve Australia’s capacity to promote mental health. A report based on the findings of consultation and review is to be published in mid 1997.
1.2 Methods

Consultation with key stakeholders in Australia

The Project Team interviewed key stakeholders in almost all Australian States and Territories. Participants commented on current issues influencing the effectiveness of health promotion in Australia and suggested ways in which further progress might be achieved. These interviews enabled the Project Team to gather as wide a range of views as possible, both on current practice and on directions for the future.

Consultation with international leaders in health promotion

The Project Team met with international leaders in health promotion during the 15th World Conference of the International Union for Health Promotion and Education in Japan. These experts provided advice and information about the supportive infrastructure, funding, and direction of health promotion in their respective countries.

Public meetings

Two public meetings were held during the first round of consultation—the first in the ACT at a joint meeting of the Branches of the Public Health Association of Australia, the Australian Association of Health Promotion Professionals, and the Australian Community Health Association; the second in Cairns, at the 27th Annual Public Health Association of Australia Conference in September, 1995.

Review of the literature and commissioned papers

Five specific papers were commissioned at the beginning of the review. The topics were:
- surveillance and monitoring;
- impact of health policy on health promotion;
- health promotion program structures;
- prioritisation and financing; and
- education, training and workforce development.

Recently published reports on intersectoral action for health and on the dissemination of research findings into health promotion practice were used to highlight achievements to date and issues to be addressed in order to improve Australia’s capacity to promote health. This work was also used to advise the formulation of the recommendations in this report.

Publication of Discussion Paper for review and comment

More than 3,000 copies of the Discussion Paper, published in December 1995, were distributed. More than 120 written comments were received in response.

Meetings with State/Territory health authorities, key non-government organisations, professional associations and community organisations

With the assistance of the State and Territory health authorities, members of the Project Executive visited each State and Territory and held a series of meetings with, wherever possible, the senior executive of the health authorities, and a wide range of key stakeholders from the health, non-government, and community sectors. In two States, the Project Executive met with the Minister for Health.

In addition, a public meeting was held in each State and Territory to which a wide range of people was invited. More than 500 people attended these meetings around the country.
An interactive workshop was held with more than 50 participants at the Eighth National Health Promotion Conference in Sydney in February 1996.

This final Report, the Summary Report and Recommendations, therefore, are based on an extensive consultative process.

The Summary Report and Recommendations are to be published separately. However, they have also been included in this document as an Executive Summary.

REFERENCES


Section 2:
An infrastructure to support national health advancement

2.1 An overview of current infrastructure

Australia’s health sector has gradually built its capacity to promote, protect, and maintain the health of the population. The major components of an infrastructure to prioritise, guide, implement action to promote the health of the population and to assess progress are now in place.

Some of the most important of the components of health infrastructure developed since the turn of the century to identify and solve public health problems include:

- Since colonial days, public health legislation at the State level has regulated sanitation, food, drugs, and infectious diseases. Most States and Territories have updated their Public Health Acts since the mid-1970s;
- the establishment of a Public Health Division within the Commonwealth Department of Health, the National Better Health Program and its successor the National Health Advancement Program;
- public health program structures in each State and Territory Health Department;
- health promotion program structures in each State and Territory Health Department;
- health promotion program delivery structures at regional or local levels in each State and Territory;
- the establishment of the Community Health Program in 1973;
- the establishment of the Australian Institute of Health and Welfare;
- the National Women’s Health Program in 1989;
- the development of the National Aboriginal Health Strategy in 1989;
- the 1993–1998 Medicare Agreements, and complementary legislation enacted by the States committing all States to developing strategies for the implementation of action to achieve goals and targets in priority areas;
- the National Health Information Agreement signed by the Commonwealth, State and Territory health authorities, the Australian Bureau of Statistics, and the Australian Institute of Health and Welfare, came into effect in 1993;
- the development and revision of national health goals and targets and the identification of national priority issues;
- enhanced education and training programs in public health and health promotion (through the Public Health Education and Research Program, PHERP) and inclusion of health public health/health promotion in undergraduate training of doctors, nurses and allied health professionals;
- National Occupational Health and Safety legislation;
• the establishment of the Public Health Research and Development Committee, the Aboriginal and Torres Strait Islander Health Standing Committee, and the Health Advancement Standing Committee by the National Health and Medical Research Council;

• the strengthening of professional associations such as the Public Health Association of Australia, the inception of the Australian Association of Health Promotion Professionals, as well as the establishment of Public Health and Health Promotion Committees within some of the Royal Colleges, and the establishment of the Faculty of Public Health Medicine;

• consumer and community input to decision making through organisations such as the Consumers’ Health Forum, the National Health and Medical Research Council, and the Community Organisations Support Program, and, in some states, explicit goals regarding community participation in health service planning in their legislation;

• the development of national, organised approaches to major issues including cervical and breast cancer, HIV/AIDS, and drugs and alcohol; and

• the development of health-specific legislation in areas as diverse as the wearing of seatbelts, restriction of smoking, and the redefinition of rape as a crime of violence (sexual assault).

These represent, largely, actions taken by governments to build or enable the development of an infrastructure to direct and support action to promote health. However, the consultation highlighted the wide range of community organisations, self-help groups, and non-government organisations that form part of the infrastructure that promotes the health of Australians. This review also confirmed the extent to which sectors other than health have acted in collaboration with the health sector to improve health. Examples include the role of local government in a wide range of activities from the enforcement of environmental health legislation, to preparing municipal health plans; or the leadership of the NSW Roads and Traffic Authority in promoting road safety in NSW; or the support of Departments of School Education for ‘health promoting schools’ initiatives.

The focus of this review has been on the action that is needed by government health authorities at national and State/Territory level, to improve the infrastructure support for national health advancement. This is not to overlook the importance of the roles of other sectors nor of community and non-government organisations. Rather, it is to ensure that the health sector has the capacity to ensure the active engagement of these groups, in particular, in all aspects of action to promote health in Australia.

Section 3 analyses current health policy to identify the extent to which it encourages both the active involvement of communities and individuals, and of sectors other than health, in action to promote health. Section 4 explores the implications for the health sector of a ‘whole of government’ approach to enable action to address the determinants of health.

Section 5 identifies current program delivery structures at national, State, and local levels and points to actions to improve the effectiveness of these, and Section 6 examines principles that might be used to develop criteria for setting priorities for action and for allocating resources. Section 7 identifies the monitoring and surveillance systems needed to support effective action to promote health, and Sections 8 and 9 identify steps to improve the research and evaluation available to support action to promote health. Section 10 explores the issues that need to be addressed to ensure effective workforce development.

2.2 Components of the current infrastructure

There is already a significant infrastructure to support action to identify and to solve public health problems in Australia. However, there has been growing recognition that, in order to enhance the quality, range, and effectiveness of action to promote the health of all Australians, a more comprehensive, systematic effort is needed. Furthermore, as understanding of the determinants of health has expanded, and as knowledge about effectiveness in promoting health has developed, so has the need for infrastructure support to enable this new knowledge to be applied.
National health policy

It is only in relatively recent years that Australia’s health policy has been more explicit in its commitment to action to promote health beyond the provision of health care services.

The Australian Health Ministers’ Advisory Council (AHMAC) was established as a means for the Commonwealth and State and Territory Health Departments to develop a national view of health financing. In the late 1980s, AHMAC ventured cautiously into the area of health promotion, and in 1987 established the Health Targets and Implementation (Health for All) Committee to develop health goals and targets for Australia.oid

The Better Health Commission had identified the need for national commitment to the promotion of better health and recommended a range of actions to improve Australia’s capacity for promoting the health of the population. The National Better Health Program, supported by joint funding from the Commonwealth and the States and Territories, was instrumental in the development of infrastructure for promoting health and demonstrated that it was possible to influence the direction of action to promote the health of Australians.

The revised goals and targets included goals and targets for improvements in social structures and physical environments that would improve health and contribute to the prevention of disease in Australia. The Australian Health Ministers, in adopting the framework within which the revised goals and targets were developed, for the first time gave official sanction to the evidence that the extent to which individuals are able to maintain their health is determined, largely, by factors that are outside their individual control.

The 1993–1998 Medicare Agreements committed the Commonwealth and the States and Territories to acting to improve the health of the population through commitment to four priority issues. The improvements are to be achieved through the provision of accessible, high quality health services and continuity of care, and through the development and implementation of cooperative strategies to reduce major causes of illness and premature death including environmental and lifestyle factors.

The Better Health Outcomes Working Group acknowledged the importance of environments but chose to develop strategies for improving environments within the context of each of the priority ‘disease’ groupings. It acknowledged that the healthy environments concept, in its broadest context, has not been addressed. The four issues selected by the Better Health Outcomes Working Group as priorities for action were all specific diseases or causes of mortality/morbidity. In 1996, the priority issue of diabetes was added.

In all, the review found that there has been growing commitment by the health sector to action to promote health and to the achievement of outcomes measured at the population level. However, it also identified a lack of national leadership for action to address the determinants of health, and a limited (in growing) commitment to working with other sectors in this pursuit.

Investment in promoting health

The proportion of the national health budget committed to health promotion in Australia is approximately 1.5 per cent. While this does not accurately reflect the funding devoted to all health promotion activity (it does not include the work of non-government organisations, the private sector, or the community sector, for example), it is an estimate that is often used as a benchmark.

However, importantly, in the midst of major cost cutting by the Commonwealth, State and Territory health authorities in recent years, the funding available for health promotion has remained fairly constant following an injection of cost-shared funding in support of the National Better Health Program in 1988.

Program delivery structures

National and State/Territory health promotion infrastructure

The Commonwealth Department of Health and Family Services, and the State/Territory health authorities have established designated health promotion program structures and allocated resources both to support the
structures and to design and implement programs. The extent of this commitment and the range of activities for which the programs are responsible varies. Around the country there is increasing commitment to the integration of the public health and health promotion functions and responsibilities. In the Commonwealth and some States and Territories, the generic health promotion infrastructure is far outweighed by the size and resources available to issue-specific infrastructures; in others it is more equal.

The health promotion foundations, established in almost every State and Territory, have contributed to the depth and breadth of action to promote health in Australia, and to research and workforce development. It is the State and Territory health authorities together with the foundations, that have been the backbone of health promotion practice."

In addition to generic health promotion program structures, however, the Commonwealth Department of Health and Family Services and all the States and Territories include issue or population-group specific program structures to oversee and implement action in areas including Aboriginal and Torres Strait Islander health, drugs of dependence (including tobacco), women's health, HIV/AIDS, and mental health. Most of these programs include responsibility for improvements in relevant health services as well as preventive action. The review found that in most cases there has been only limited interaction among the groups responsible for these program areas, and with the primary health care promotion programs.

Following the success of the Commonwealth and States in developing a national approach to the AIDS epidemic, the Commonwealth Department of Health and Family Services launched a series of national health promotion programs, including the National Campaign Against Drug Abuse, the National Better Health Program, the National Program for the Prevention of Breast Cancer, and the National Women's Health Program. Linked with funding (often cost-shared between the Commonwealth and the States and Territories), these national strategies have been influential in directing practice, and in developing coordinated, systematic approaches to the issues. In each case, comprehensive interventions are being implemented, including improvements in access to appropriate health care services (early diagnosis and effective clinical treatment, care and rehabilitation), in addition to action to increase community health literacy, and to mobilise community support to address environmental barriers to participation.

Information support
The Health Education and Promotion System (HEAPS) is a national computerised database and clearing house of health education and programs. HealthWIZ is a social health database that has been established specifically for use in planning community-based programs. A range of commissioned reports has contributed to the information base for health promotion, along with the production of the Social Health Atlas.

The Community Health Program
The Community Health program was established in 1973, with three principal objectives:

• to shift the emphasis of the health care system from the treatment of the prevention of disease;
• to provide an alternative to traditional general medical practice in the delivery of primary health care; and
• to reduce the dependence of the community on institutionalisation.

Implementation varied widely in each of the States and Territories, but a 1986 review found that a coherent program had developed, even without direct Commonwealth involvement. The review also found that, overall, the program had become more conservative in practice than had been intended in 1973, with an essentially illness-focused, paramedical, para-hospital, residual service providing mainly secondary and tertiary prevention?

A 1992 review found that the community health/primary care sector continues to play a significant role in promoting health in Australia. There is an extensive community health infrastructure across urban and rural regions, with staff having considerable knowledge of and experience in working both within the health sector (with Divisions of General Practice, for example), and with other sectors to develop and implement programs and policies at local and regional levels.
At local and regional levels, in particular, the primary health care sector is a significant part of the program delivery infrastructure required. Community health practitioners, general practitioners, non-government and community organisations continue to play significant roles in promoting the health of Australians.

**General Practice**

The last five years has seen the development of Divisions of General Practice—a system that has been designed to enable general practitioners to engage with the wider health system, in part, so that they can more readily contribute to promoting health. Given that 86 per cent of the Australian population visit a general practitioner at least once every 12 months, the frequent and repeated contacts between general practitioners and their clients make this potentially one of the most important actions to have been taken to improve the system for health promotion in Australia in recent years. In addition, the General Practice Evaluation Program (GPEP) has been used to begin to re-direct general practice toward a greater population focus and the measurement and achievement of health outcomes.

**Monitoring and surveillance**

Since 1977–78, the Australian Bureau of Statistics has collected health-related information at five-yearly intervals through the National Health Survey. The Australian Institute of Health and Welfare (AIHW) was established in 1987, and, since 1988, has published biennial reports on aspects of Australia’s health and health services. The National Health Information Agreement that came into effect in 1993 signified a public commitment to a national approach to improve Australia’s health information.” The Agreement has enabled the development of other important elements of the national health information infrastructure—National Health Information Work Program, the National Health Data Dictionary, the National Health Information Development Plan and the National Health Information Model. The AIHW has also prepared specific reports on health differentials, on the health of immigrants in Australia, and on the current national status of Aboriginal and Torres Strait Islander health.23-25

In 1994, the Australian Bureau of Statistics conducted its first National Aboriginal and Torres Strait Islander Survey, which data on self-perceived health status, and access and use of health care services was collected and reported. The 1995–96 National Health Survey has an enhanced sample of Aboriginal and Torres Strait Islander people.23 The AIHW has also recognised the need to continue to improve the information available to Aboriginal people and Torres Strait Islander people about their health status.

The AIHW has also identified people of non-English-speaking backgrounds as priority populations for monitoring the equity objectives of social and health programs, in addition to the information on specific health problems and aspects of lifestyle.23

Several States have collected data to assist in monitoring progress in promoting health. The New South Wales Health Promotion Survey was conducted for the first time in 1994, while the South Australian Cumbus Survey has been carried out regularly during the 1990s. Western Australia has published a report—“The state of health”—documenting its progress in improving the health of the population.24 The health promotion foundation in Western Australia has also published a report on the evaluation of its work.27

The consultation also pointed to the range of information available in sectors other than health that is of significance both identifying priorities for action and in monitoring progress. An example of such work is the Pilot survey of the fitness of Australians conducted by the Department of the Arts, Sport, the Environment and Territories.” The consultation highlighted the potential that exists to draw together data collected in sectors other than health with that which is collected by the health sector to provide a more comprehensive understanding of the relationship between the health and wellbeing of Australians and the determinants of these.

**Research**

The establishment of the Public Health Research and Development Committee of the NHMRC was a major step toward building a body of public health and health promotion research in Australia, and toward developing a skilled public health research workforce. The Bienenstock Review of the NHMRC saw the creation of the
Health Advancement Standing Committee within the NHMRC, which was designed to introduce a contemporary health promotion agenda into the policy work of the organisation. The Committee has prepared a range of publications that provide evidence for future action to improve the range, quality and effectiveness of action to solve specific public health problems.\textsuperscript{92}\textsuperscript{\textsuperscript{14}}

Many of the major non-government organisations (National Heart Foundation, Anti-Cancer Councils, Asthma Foundation, for example) have designated funding specifically for health promotion and public health research. Specific centres, such as the Centre for Health Promotion and Cancer Prevention Research in Queensland have been established to conduct research to support and to evaluate health promotion programs. Universities have expanded their capacity to undertake health promotion research, developing the new methodologies, theoretical constructs, and styles of conducting research that are required by practitioners.

Some States have established health outcomes programs, designed, largely, to develop methods to measure clinical services outcomes. A Cancerone Collaborating Centre has been established to begin to develop systems in Australia to conduct and disseminate the results of meta-analyses to inform clinical practice. An Australian Health Outcomes Clearing House has been established through the AIHW.

**Evaluation**

Poor definition of anticipated outcomes of health promotion activities has long been a stumbling block to progress in health promotion.\textsuperscript{92}\textsuperscript{\textsuperscript{14}} Currently, evidence of success in health promotion is measured in terms of mortality and morbidity. However, it is clear that while health outcomes can be defined as a change in the health of an individual or group which is attributable to an intervention or series of interventions, there are many different outcomes possible depending on the forms of health or medical intervention.\textsuperscript{92}\textsuperscript{\textsuperscript{14}}

Nutbeam suggests that there are three types of outcome that can and should be measured to evaluate the effectiveness of action to solve public health problems—health and social outcomes, intermediate outcomes, and health promotion outcomes:\textsuperscript{93}

Each of these ‘types’ of outcome represents success, depending upon the target group, the type of intervention, and the context within which the intervention is occurring, and the stage of development of the intervention.\textsuperscript{93}

Furthermore, the comprehensive range of strategies required to bring about changes in the health of populations and society requires the development of broader approaches to understanding the changes and their ‘causes’.\textsuperscript{93}

This review has also highlighted the lack of comprehensive information about the ‘inputs’ to promoting health in Australia. Even in an area as well researched as the reduction in the prevalence of smoking, there is only limited information available about the range, scale, quality, and costs of interventions over the last two decades.

**Workforce development**

**Professional preparation**

Several universities throughout the country have offered teaching in health promotion through courses in primary health care and/or community health for many years. However, in the late 1970s there was only one university in Australia offering a degree in Public Health. There were none offering degrees in health promotion. The Public Health Education and Research Program has been instrumental in the expansion of public health teaching in Australia, to the point that there are now many university courses that provide students with knowledge and skills to act to solve public health problems.\textsuperscript{94} Specialist courses have been developed for Aboriginal Health Workers and Aboriginal Health Promotion Officers in some States. There is a growing emphasis on public health in curricula for medical students at many universities, and the professional preparation of many nurses and allied health professionals now includes some focus on promoting health. There is a growing number of teachers participating in tertiary courses on public health and health promotion.
Continuing education: professional associations, conferences, and journals

The Australian Journal of Public Health and its predecessor, Community Health Studies, have contributed to the knowledge and skills of the public health workforce, while the Annual Public Health Association Conference has continued to be an important component of public health workforce development in Australia. The Australian Community Health Association, too, through its conferences, its contributions to the journals, and its representation on all major public health bodies, has played a significant role in shaping the practice of action to promote health at all levels in the health sector.

However, as the workforce engaged in health promotion grew in size, experience, and sophistication, it became clear that additional, more specific interests were not being well served by existing organisations. The growth of the Health Promotion Special Interest Group (HPSIG) within the Public Health Association (PHA), and, more recently, the establishment and growth of the Australian Association of Health Promotion Professionals are examples of this. The National Health Promotion Conference, too, has become an important component of the spectrum of workforce development activities for the wide range of people engaged in health promotion and the Australian Journal of Health Promotion, now in its sixth year of publication, points to a distinctive, although overlapping, with public health, area of interest.

The Aboriginal and Islander Health Worker Journal has played a key role in the professional development of Aboriginal Health Workers in particular and a wide range of health and community personnel working in the area of Aboriginal and Torres Strait Islander health. In addition, as an outcome of a small meeting at the Seventh National Health Promotion Conference in Brisbane, a National Aboriginal and Torres Strait Islander Health Promotion Network was established, comprised of Aboriginal and Torres Strait Islander health personnel who are engaged in or who have an interest in promoting health. The level of interest in this group has been high, and reflects the importance of networks to enable people with shared problems and interests to develop their knowledge and skills.

The Royal Australian College of Physicians has established a Working Group on Health Promotion, and the Queensland Branch of the Australian Medical Association has established a joint committee with the Public Health Association and the Queensland University of Technology's School of Public Health.

Continuing education: short courses, 'on the job' training

There has been a growing number of short courses for health promotion practitioners covering specific health issues, the needs of population groups, or building their generic knowledge and skills. In recent years more structured short-course programs are being developed through the National Centre for Health Promotion at the University of Sydney, and an international summer school at the Queensland University of Technology.

Competency-based standards

Competency-based standards for designated health promotion practitioners have been developed in two States and a third is currently developing its own set.

Structures to provide advice on policy development and technical issues

The Health Advancement Standing Committee and the Aboriginal and Torres Strait Islander Health Standing Committee, NHRMC

The NHMRC was restructured in line with the recommendations of the Bienenstock review in 1993. That review recommended that the functions of the former Health Care Committee and the Public Health Committee be integrated into a comprehensive National Health Advisory Committee (NHAC) and that the membership of that Committee be broadened to reflect the nature of these responsibilities.

NHAC was established in 1994 and in this triennium has been supported by seven standing committees with responsibility for particular aspects of public health, health services, and population health. Two of these committees, in particular — the Aboriginal and Torres Strait Islander Health Services Standing Committee and the Health Advancement Standing Committee — have strengthened the Council's capacity to provide policy and
technical advice in these areas. However, the NHMRC is being restructured upon completion of its current triennial work program in December 1996 and the current standing committees are to be disbanded.

Support for community organisations and representatives to engage in promoting health

The Community Sector Support Scheme (formerly the Community Organisations Support Program) and the Rural Health Support, Education and Training Program (RHSET) are examples of programs developed by the Commonwealth Department of Health and Family Services to support people from organisations outside the formal health sector and those who are geographically isolated to participate in decisions about health service provision and promoting health.

A wide range of organisations has been established in recent years to bring together groups with common interests in specific areas of health promotion or in specific health issues. Examples of these include the Australian Health Promoting Schools Association, the Australian Federation of AIDS Organisations, and the Health Issues Centre in Melbourne.

Many of the major health-related non-government organisations have become increasingly committed to health promotion. Several have developed sophisticated strategic plans to guide this work — the Australian Diabetes Society/Diabetes Australia, the National Heart Foundation, the Australian Cancer Society, and the National Asthma Campaign, for example.

In Victoria and South Australia, in particular, there has been active effort to develop the knowledge and skills of community members to enable them to participate in health service development and in planning and acting to promote health. At local level, throughout the country, community members are widely involved in specific programs to promote health. The Victorian Health Issues Centre and the Consumers Health Forum are two organisations that have played significant roles in expanding the access of community members to the knowledge and skills needed to influence the role and direction of Australia's health sector. Healthy Cities Projects around the country have also placed significant emphasis on providing community members and people from sectors other than health with knowledge and skills in the health area.

2.3 An analysis of the current infrastructure: issues for the future

Looking back to the early 1980s there were almost no components of a national health promotion system. Several States had developed their own health promotion programs, most notably in tobacco control, but nationally there were only the remnants of the Community Health and Aboriginal Advancement Programs from the Whitlam era. There was only limited activity from the Public Health Committees of the NHMRC, although the NHMRC's Research Unit in Epidemiology and Preventive Medicine did enhance research capacity in this area. There was no national health surveillance to speak of, and no evaluation at the national level.

The last two decades then, have seen the gradual development of a significant infrastructure for public health and health promotion in Australia. There have also been significant achievements in improving the health of the Australian population. A companion volume of case studies outlining these is to be published with this review.

However, there are still major issues to address. Amongst these are the need to reduce the inequalities in the health of Australians. Although there are consistent and continuing improvements in the health of affluent Australians, there is a disappointing stagnation in indigenous health; social class gradients persist, and the incidence of some risk factors such as smoking, are actually increasing. Sustaining the achievements in terms of improved health, improving the effectiveness of action to promote health, and ensuring that the focus of action to promote health includes improvements in wellbeing and quality of life are remaining challenges.

In terms of infrastructure itself, the complex web of organisations, practitioners and other interests which comprise the health system frequently gives rise to claims that it lacks cohesion. In fact, it was the commonly held perception that overall, the national effort to promote health is poorly coordinated, fragmented and subject to inefficiencies due to duplication of effort that was a major impetus for initiating this review.
These concerns were echoed by key informants during the review's initial consultation phase. Major elements of concern included:

- Duplication in policy development, leadership and program implementation due to poor articulation and understanding of the roles and responsibilities of the major players, including the Commonwealth, State and Territory government health authorities, the health promotion foundations, and the major non-government organisations.

- There is currently no mechanism with which to deliver health promotion programs in a systematic way across the country (whereas there are organised mechanisms, for example, for breast cancer screening, Divisions of General Practice and access provision to public hospitals).

- The level of consultation and coordination between the Commonwealth and the States and Territories—and, to a lesser extent, between the States and their regional authorities—is inadequate. The lack of State and Territory input into some Commonwealth program initiatives, including even prior knowledge of impending campaigns, contributed to duplication and confusion at the State and Territory level when similar (but not integrated) initiatives were also under way. While acknowledging the consultative approaches adopted by some areas in the Commonwealth Department of Health and Family Services (particularly in relation to HIV/AIDS), informants unanimously articulated the need for better national coordination of campaigns—highlighting tobacco and alcohol programs as particularly problematic areas which warrant attention.

- The vertical program structures at both the Commonwealth and State and Territory levels contribute to duplication and an inconsistent approach to addressing population-based or service delivery issues. Informants suggest that consideration be given to condensing or broadening many of the existing programs to enable more flexible funding arrangements and program structures.

This points to the need for a national system to provide a mandate for and to support action at national, State/Territory and local levels. "This national system must then be capable of coordinating the surveillance, research, priority setting, policy development, program planning and implementation, and evaluation that is required for effective health promotion."

Such national organisation requires:

- unity of purpose with respect to the goals of health promotion;
- delineated roles in the achievement of the goals; and
- the organisations involved to understand and acknowledge the nature of their interdependency.

It must also ensure that there is encouragement for diversity, for local initiative based on local needs and circumstances, and for innovation. These issues are of particular importance where interventions to promote the health of the population have been least successful—among disadvantaged population groups. The need for systematic action to implement effective practice across the population must not overcome or outweigh the need to develop, with the full participation of the communities themselves, effective methods to reduce inequalities in the health of Australians.

The challenges are to:

- extend the successes to date to include the whole population and to sustain the successes that have been achieved;
- work with disadvantaged populations to develop interventions that will result in reduced inequalities in access to the resources that individuals and communities need for health;
- continue to develop and disseminate the body of knowledge and theory that underpin effective practice;
- continue the development of appropriate methodologies for research and evaluation; and
- continue to re-orient the health system to become more health promoting.
2.4  Improving Australia's capacity to promote health

The last two decades have seen the development of many of the elements required to promote health effectively in Australia. Now that many of these structures are in place, and we have more than two decades of experience upon which to build, the goal is to ensure that health promotion takes its place as a cornerstone in the health system.*

This review confirmed the need for:

• policy directions that would provide a stronger mandate to promote health;
• organisational structures that would provide leadership for, set priorities for, and review progress in promoting health;
• principles to guide a funding strategy for action to promote health, including a review of funding and purchasing models;
• the extended range of information needed to identify priorities for action, to identify the most effective strategies for intervention, and to measure progress;
• structures to direct and support program development and delivery at national, State, regional/area and local levels, and delineation of roles and responsibilities;
• action needed by the health sector to build its capacity to work with other sectors to promote health;
• research required to guide and support effective action to promote health;
• structures and mechanisms to analyse, synthesise and disseminate information on effective practice;
• workforce development to ensure the availability of a knowledgeable, skilful workforce;
• a system of evaluation to assess and review progress.

REFERENCES

5 Holman CDJ. Prospects for health promotion in Australia. Address given at the official opening of the National Centre for Health Promotion. Sydney, 10 May, 1995.
6 The National Health Targets and Implementation (Health for All) Committee, 1988. op. cit.
11 ibid., p. 18.
13 Holman, 1995. op. cit.


17 Walker R. Information needs of health promotion in primary health care. Melbourne: La Trobe University, 1995.


27 ibid., p. 204.


29 Hofman CIJ, Donovan RJ, Corti B. Report of the evaluation of the Western Australian Health Promotion Foundation, Western Australia Health Promotion Development and Evaluation Program, Department of Public Health and Graduate School of Management, University of Western Australia, 1994.


37 ibid., p. 59.


45 Holman. 1995. op. cit.


47 Holman, 1995. op. cit.


Section 3: Policy

3.1 The role of policy in promoting health

The term policy is used in many different ways to refer to highly diverse sets of activities or decisions. It can include:

- **goals**: the desired ends to be achieved;
- **plans or proposals**: specified means for achieving the goals;
- **programs**: authorised means for achieving the goals;
- **decisions**: specific actions taken to set goals, develop plans, implement and evaluate programs; and/or
- **effects**: the measurable impacts of programs (intended and unintended; primary and secondary).

Policy is often expressed as **legislation, regulations, or statutes**, for example. Policy appears to be, itself, a process whereby the problems influence the processes designed to solve them; the processes in turn help to explain the programs and policies, and the policies affect what problems emerge in society and get to the agenda of government. Federally structured political systems experience additional and complex phases of the policy process because the authority to decide health policy and the responsibility to carry it out may be divided between levels of government.

Policies can be thought of as providing guidelines for coordinated action across institutional systems. These guidelines can be formal (as in legislation), or informal (as in agreement that this is the usual way of doing things). The meaning, interpretation, and implementation of policy change according to the individuals and organisations involved, and in response to its effects.

Public policy is that for which governments are primarily responsible. Public policies are carried out in the name of the people as a whole, and they affect the public interest.

Policy contributes to action to promote health in three major ways.

**Legitimising action to solve public health problems as a key function of the health sector—health promoting health policy**

Policy is acknowledged worldwide in contemporary management theory and practice as the basis of all planning processes and related activities in the public and private sectors. Policy determines the identification of problems, the selection of priorities, the development of infrastructure for program design and delivery, the collection of data, and the strategies used to solve problems. Australia’s health policy, therefore, is a vital component of the infrastructure needed to ensure effective action to solve public health problems.

Only within the last two decades has Australia’s health policy begun to reflect a concern with active intervention to promote the health of the population, in addition to a commitment to provide high quality, accessible health care services.

The 1993–1998 Medicare Agreements, for the first time linked the major source of funding for health services in the States and Territories with a commitment to action to improve the health of the population (in four priority areas). The Agreements and the subsequent action through the Better Health Outcomes Committee represent a policy shift on the part of the health sector to provide an explicit mandate for a range of activities to improve the health of the population using a combination of actions that include but are not only the provision of effective, efficient health care services.
Health policy can also have a direct impact on the health of individuals and populations. In the course of this review, several examples were identified of health policy that has been developed with the intention of improving people’s access to the resources they need to become and stay healthy. The analysis found that existing policies appeared to identify three pathways by which this goal can be achieved. That is, that the health of populations will improve through the implementation of policies and programs that ensure that individuals and communities:

- have access to relevant, high quality health care services, including personal preventive services;
- have the (individual and collective) capacity to choose healthier and safer ways of living; and
- live, work, and play in safe, healthy, supportive environments

Health policy, to date, where it has been directed toward promoting health, has concentrated more on the first and second of these pathways than on the third. That is, it is possible to identify a great deal of health policy (ad hoc or planned) that is directed to improving people’s access to services, somewhat less policy that is directed toward improving people’s health literacy and skills, and even less, in recent years, that has been directed toward improving environments.

With regard to this last, much of the health advantage enjoyed by many Australians has been the result of earlier public health policies that ensured the provision of clean water, sewage systems, better housing, and improved working conditions. It is also true that for some Australians, particularly Aboriginal people and Torres Strait Island people, health policy must continue to focus on these issues.

As well, decisions made by other sectors often have a profound impact on the health of populations. Increasingly, many of the issues that affect the health of populations are indivisible—that is, they cannot be resolved by one sector working alone.

In these cases, it is vital that health policy acknowledges the need to, and provides a mandate for all parts of the health sector to act with other sectors.

**Policy as an intermediate outcome — healthy public policy**

Policies developed and applied by other sectors influence the health of the population. By working with other sectors, it has been possible to achieve significant improvements in the health of populations. Examples include the introduction and enforcement of legislation requiring motor vehicle drivers and passengers to wear seat belts, or legislation banning smoking on public transport, or that regulates environments to reduce the likelihood of transmission of infectious diseases through the food supply.

The review found major support for action to improve the health sector’s capacity to work with other sectors to develop and implement healthy public policy.

The review also found that the effectiveness of public policy in influencing the health of the population depends upon the extent to which it has public support. To develop and implement healthy public policy requires a process that allows people to be well informed about the issue and possible risks and benefits of intervention, and allows them to participate in a decentralised way as possible in the formulation of policy.

**Policy as a mandate for effective practice**

Policy can be a set of principles that provide a mandate for health workers, for example, to work in particular ways on particular issues. One example of this policy model is that of primary health care. In several States, in particular, this model has underpinned the development and practice of the community health services, allowing for a wide range of activities addressing a range of issues that might otherwise (in a more narrowly focused policy framework) fall outside their area of work.

The Ottawa Charter for Health Promotion, too, is an example of a set of principles that have been influential internationally in guiding action to promote health.
3.2 An analysis of Australia’s current health policy

This review was carried out using more than 40 policy documents published in Australia over the last two decades. It focused on policies that were explicitly directed to better health (although it includes policies directed at achieving more effective intersectoral policy collaboration).

It analysed the work of health policy makers and the role of public health and health promotion practitioners in policy making and implementation.

It focused on the extent to which the pathways and partnerships that have been shown to be necessary to the achievement of improved population health have been encouraged or discouraged by current health policy. The analysis showed that the goals of Australian health policy, as identified by analysis of current policies are:

- access to health care services;
- healthy physical environments;
- improvements in individuals’ health knowledge and skills;
- improvements in the social environment;
- partnerships for better health.

The tasks of health advancement (encompassing health promotion, health protection, disease prevention and improving health care systems) requires the establishment of a series of partnerships:

- among the practitioners and organisations of the personal health care system;
- among practitioners and policy makers in other sectors (production, transport, food, communications, etc); and
- with citizens, as individuals and as members of families and community organisations and as participants in larger social movements.

Legge et al. identified nine policy objectives as a framework against which to assess current health policy. The objectives are:

1. to strengthen the ability of the health care system to deliver improved personal health care, including personal preventive services;
2. to strengthen the ability of the public health and health promotion system to facilitate the delivery of personal preventive services;
3. to support individuals, families, and carers to procure relevant, timely personal health care, including personal preventive services;
4. to ensure that people have access to health-relevant knowledge and skills;
5. to strengthen the ability of the health care system to provide consumers with the information and skills they require to prevent, manage, or treat illness or injury;
6. to strengthen the ability of the health promotion system to ensure that individuals and communities have access to the knowledge and skills they require to become and stay healthy;
7. to collaborate with policy makers in other sectors to develop policies aimed at achieving safer, healthier, more supportive environments;
8. to support individuals and community organisations to contribute to the development of safer, healthier, more supportive environments; and
9. to strengthen the ability of the health system to work with communities and other sectors to achieve safer, healthier, more supportive environments.
Taking each objective in turn, the review identified some of the major health policy initiatives and assessed their effectiveness in relation to their objective.

Several major policy initiatives have been undertaken by the health sector in the last decade in order to improve people’s access to health care services. These include:

- the introduction of universal health insurance through Medicare;
- the Access and Equity Strategy, designed to improve the access of people from non-English-speaking backgrounds;
- the National Aboriginal Health Strategy;
- the National Women’s Health Policy; and
- the Rural Health Strategy.

Policy to improve people’s access to preventive health services has developed both informally and formally. For example, a de facto policy to diagnose and treat high blood pressure has emerged over the last 20 years, in contrast with the organized approaches that have been developed to improve the diagnosis and treatment of cervical and breast cancer. These contrasting methods of policy development and implementation highlight the need to examine both formal and informal policy in order to assess their effects on health improvement.

Several initiatives have been designed to improve the health system’s ability to deliver effective services to promote health. Perhaps the largest of these has been that of the General Practice Demonstration Grants Program, which was designed to improve the ability of general practitioners to plan and deliver health promotion services in their communities.

The Quality Use of Medicines Policy, developed in 1992, the newly published Draft Charter of Consumers’ Health Rights and the The Community Sector Support Scheme (formerly the Community Organisations Support Program) are examples of initiatives that have arisen from health policy directed toward improving people’s health literacy and skills.

The health sector has long been engaged in efforts to assist individuals and communities to improve their health literacy and skills. This has been of particular importance to people in non-English-speaking backgrounds, who, often, do not have access to information through mainstream media and other community outlets. The Health Information and Translations Service in NSW Health was one example of an initiative of this kind, although it has been disbanded recently. Other policy driven initiatives have included the introduction of product labelling for cigarette packets, pharmaceutical packaging and standard stock labelling.

In addition to providing information, the health sector has a long tradition of educating patients, clients and communities using means ranging from conversations conducted with individuals to organising small group education programs, particularly for people with chronic conditions, but also for people at different life stages (for example, women undergoing menopause, or young people who are experiencing depression).

Beyond the confines of the health system, however, there has been a growing level of activity that has been directed toward improving the knowledge and skills of individuals and communities in bringing about health-promoting change in their communities. As knowledge of the conditions for effective health promotion has grown, it has become clearer that community action and advocacy are critical components. The success of the HIV/AIDS strategies has been predicated, in part, on the ability of the gay men’s community to put the issue on the public and political agenda, and to sustain the action required to put effective programs into place at national, state, and local levels.

In this case, health policy was developed, initially, in response to community action but the policy then became a framework for subsequent, planned action across a range of sectors and issues.

In the case of action to reduce smoking, health policy has been less formal, responding to different phases in the development of the intervention programs.
3.3 Implications for health policy

The impact of policy was reviewed using the framework of the nine objectives for health policy outlined above. Looking at each of the nine policy objectives and programs or strategies that have been undertaken to achieve them, it is clear that there has been some significant progress. Health policy has resulted in changes in the health care delivery system, the health promotion system, and in priority issues that have contributed to improvements in population health.

However, it is important to identify ways in which the policy objectives have not been achieved, and to identify the directions that health policy must now take in order to improve the effectiveness of Australia’s health policy in general and health promotion policy in particular.

Reviewing progress to date, therefore, reveals a range of ways in which health policy might be revised.

Ensure that a full range of options for ‘solutions’ is considered when developing policy

The process used to develop the current hypertension control policy has resulted in a strong emphasis on a ‘high risk’ approach. The Commonwealth Department of Health and Family Services estimates annual expenditure on antihypertensives (excluding beta blockers) at $3.16 million in 1993–94, increasing at a rate of 16.8 per cent per annum. The cost in medical benefits is less clear but is likely to be of the same order of magnitude.

Although there is now evidence that a population approach (based on increased physical activity, smoking cessation, and dietary change across the whole population) is likely to contribute to reducing the average level of blood pressure in the population, current blood pressure policy does not actively support these measures. Without a mechanism for formal review of policy, therefore, it is more difficult to bring about change in current policy.

Ensure that all those who are affected by the problem or who must act to resolve it are involved in developing and implementing policy

On the other hand, the national breast screening program highlights some of the benefits of an organised approach to personal prevention including guidelines, quality control, registries and recall capacity. A systematic, system-wide approach has meant that the program has been implemented nationally. Although there have been reports that the implementation in some States has been less than ideal, the program guidelines (policy), set the standards against which practice can be measured.

However, these programs were not developed in collaboration with the National Women’s Health Program, so that their effectiveness has been compromised by lack of sensitivity to a range of issues that affect the likelihood of women attending the screening services.

This tension often occurs when disease prevention programs are conceived in terms of particular diseases or risk factors (immunisation, hypertension, cancer screening) and health promotion programs are conceived primarily in relation to identified populations. Both approaches are necessary elements of any comprehensive policy package.

Ensure that policy includes incentives for health professionals to engage in health promotion

The General Practice Demonstration Grants Program is an example of providing incentives for general practitioners to participate in health promotion activities, enabling them to build structures (Divisions of General Practice), that enable them to participate in the wider public health system.

On the other hand, the remuneration of general practitioners through Medicare is an example of a policy-related barrier to individual GPs undertaking health promotion with their clients.
Ensure that policy builds on existing structures to expand the range of health promotion available in communities

Examples might include:

- encouraging Divisions of General Practice to collaborate with health promotion and public health personnel to develop joint programs;
- supporting the development of regional public health and health promotion units as a source of health and epidemiological data, technical advice in intervening to bring about changes in the health of populations, and public health leadership;
- supporting the role of community health centres as an institutional base from which community oriented project work can be mounted; and
- encouraging work with local government through the wider implementation of municipal public health planning.

Ensure that policy supports mechanisms that enable community members to contribute to policy development, priority setting, and program development

While the analysis of current policy showed some successes in this area, it is clear that it has not yet been well accepted that community involvement (in a range of ways) is a vital component of the success of health promotion action.

Develop policy that extends the range of channels through which people develop their health literacy and skills

Most people acquire knowledge and skills that are relevant to their health independently of health agencies and practitioners. Health-promoting policy, therefore, must support, if not more systematic development of pathways for learning such as:

- formal education;
- mass media;
- institutions of informal and adult learning; and
- channels specific to particular settings of social life, such as diverse community settings.

Ensure that policy supports the health system to deliver effective education to its clients and patients

Well planned and delivered education through the health care system has been shown to have positive effects on the health of people in the care of or in contact with the system.\(^1\)\(^2\)\(^3\)

However, such education tends not to be provided systematically as an integral part of the care offered by the personal health care system.

Policy now needs to:

- support general practitioners to participate in population health programs;\(^4\)
- support community health centres to develop their roles in providing community education at the local level;\(^5\) and
- support hospitals to extend the patient education function?
Ensure that policy makes explicit the need for the health sector to work with other sectors to build healthy public policy

Developing the capacity of the health sector to work with other sectors to develop and implement healthy public policy is a key strategy for promoting health."

The health sector has now had some success in working with others to improve health. There are other areas in which activity has yet to be fully developed:

- promoting the health of the workforce, working in partnership with Worksafe Australia. Such a relationship must be sensitive to the needs of both sectors for different kinds of information, and potentially, different outcomes; and
- the national food and nutrition policy has already been developed, highlighting the importance of the Commonwealth retaining a strong policy capacity.

However, it appears that a major limitation on its implementation is that it is not fully owned by the States where competition for food industry investment impinges more sharply than it does at the national level.

Identify areas in which the Commonwealth must take the lead in developing healthy public policy

The Commonwealth has an integral role to play in fostering the development of and maintaining healthy public policy, through such means as facilitating consultation and the bringing together of key players and sectors on specific issues, or through the use of financial agreements between the Commonwealth and the States. Financial agreements, such as the Medicare Agreements or tax grants, can include either incentives or penalties (or both) to effect a change in policy or service delivery or orientation, for example, by tying financial resources to the achievement of specified outcomes.

This can also be extended to a whole of government approach, of which the current Council of Australian Governments (COAG) process is a prime example. Through COAG, the Commonwealth Government and State and Territory Governments are seeking to rationalise program and service delivery across numerous sectors, including health and community services, with the aim of identifying appropriate roles and responsibilities, reducing duplication, and enhancing the quality and continuity of care. The Commonwealth has a vital role to play in the COAG process, through the contribution of policy and research support, and the provision of funds for demonstration projects to develop innovative approaches to policy and program delivery.

As international efforts continue to reduce trade barriers and regulation, there will be additional need for Commonwealth leadership in policy development. Increasingly health protection is linked to occupation, environment, food and nutrition and pharmaceuticals regulation will be determined at the international level.

Here, the health interest can only be served through agreements with provision for standard setting and monitoring to prevent countries from competing economically on the basis of lower standards. The challenge this poses is critical as many newly industrialising countries have identified similar propositions in the past as unfair restrictions on trade citing aspects of the new General Agreement on Tariffs and Trade (GATT) which effectively favour the industrialised nations. Trans-national companies, too, oppose the development of such standards.

Conduct and support research that will assist other sectors to develop healthy public policy

Road transport planning illustrates a different challenge for health leadership. The health and safety benefits of a strong commitment to public transport and sensibly planned urban development in capital cities are self evident (encompassing injury, pollution, isolation, exercise and ecological sustainability).

Where it is clear that it is only by working intersectorally that health goals can be achieved, it is important that the health sector be able to identify, clearly, why issues that are the responsibility of other sectors are also
important to the health sector. This, in part, means that there is a need for the health sector to develop policy oriented research to identify the issues and to suggest ways in which to resolve these.

This will require the health sector to:

- develop health sector research and policy in those areas in which intersectoral action is clearly necessary, even where this appears to run counter to current government policy;
- develop knowledge linking population health outcomes more clearly to features of physical and social environments;
- develop the knowledge and sophistication of health policy researchers about the issues and concerns of policy makers in other sectors; and
- support moves to build capacity for participation in intersectoral policy collaboration at all levels of government.

The NHMRC’s independence and expertise means that it is well placed to take the lead in this area. By directing considerably more funds to policy-oriented research, including intervention studies, it could provide the data needed to inform other sectors of the influence of their decisions on population health, and of some potential solutions.

**Develop policy to educate and inform communities about the conditions for health**

Community organisations and social movements have demonstrated their importance in tackling environmental health issues (including issues in the social environment), which has been shown to be an effective means of contributing to changes in the health of populations. The Non-Smokers’ Rights Movement, Aboriginal leaders and community controlled organisations, and the Gay Rights Movement are all examples of effective community-based groups/organisations whose advocacy on behalf of their issue or people has proven an essential component of positive changes in their environments.

Health policy is needed to:

- facilitate the access of community organisations to relevant health information;
- provide organisational support for the health sector to work with different settings and sectors;
- build a strong research involvement; and
- support consumer-perspective research.

While it is difficult for governments to provide direct support to organisations that are likely to, at some point, oppose government policy, it is nonetheless in the long-term population health interest to have strong community-based groups advocating for specific issues.

**Ensure that policy provides a mandate for health professionals to work intersectorally, including with communities, to develop safer, healthier, more supportive environments**

It is necessary to define the elements that are required to promote health and provide health services effectively at the local level. One of these elements is a policy that provides a clear mandate for health workers, having identified problems and their causes, to act in collaboration with others to bring about change.

The 1992 NCEPH review of primary health care identified the need for a national primary health care policy and implementation plan and sketched some of the main issues which would need to be addressed in such a policy:

- structures to support primary health care;
- support for consumer and community involvement; and
- a broadening of local government’s role in promoting health.
3.4 Conclusions

Australia has developed and implemented a range of policies that have contributed to improving the health of the population. Much has been learned about working with other sectors to build healthy public policy, and health policy has moved to focus more directly on ways to promote health. At least some of the policy that is necessary to improve the effectiveness of the health promotion industry is now in place, including the National Health Policy. However, it is clear that, in the absence of a national health promotion policy that defines more clearly the role of the health sector in working with others, many opportunities to work with other sectors to promote health are being lost or under-utilised.

Within the health sector, policy has contributed to building infrastructure for promoting health more effectively but there remains a need to strengthen the institutional infrastructure for health policy making and policy implementation. An overarching health promotion policy framework would contribute to the definition and dissemination of best practice in health promotion, and provide a set of standards against which gaps and weaknesses could be more easily identified.

REFERENCES

2 Ibid., p. 6.
Section 4: A 'whole of government' approach to promoting health

4.1 Why is intersectoral action necessary to promote health?

Effective intersectoral action is a recognised relationship between parts or parts of the health sector and parts or parts of another sector; that has been formed to take action on an issue or to achieve health outcomes in a way that is more effective, efficient, or sustainable than could be achieved by the health sector working alone.

The determinants of health mean that the health sector cannot achieve its goal of improving the health of the population by working on its own. The relationship between socioeconomic disadvantage and poor health, the impact of working conditions on the health of the workforce, the impact of unemployment on health, or the effects of colonisation and the denial or trivialisation of its effects on indigenous people, mean that the health sector must work with other sectors to bring about the changes in policies and practices of other sectors that are necessary to improve health. The evaluation of the National Better Health Program, 'the national health goals and targets,' and the National Health Strategy[10] are among many recent Australian reports over the last decade that have found that it is only by working intersectorally that sustainable gains in population health status are likely to be possible. Internationally, too, there has been a growing emphasis on working with other sectors to create the conditions for health (individual and social health). In many ways, this represents the application of the knowledge gained in early public health practice—when changes in the living and working conditions of the population were the object of public health action.

The organisations and key stakeholders consulted for this review strongly endorsed the need to strengthen the health sector's capacity to work with other sectors. Many examples were given of intersectoral action at local and State/Territory levels. At the Commonwealth level, the Ministerial Council on Drug Strategy is one example of sustained, intersectoral action. While it is likely that the health sector needs to work (to varying degrees) with almost all other government sectors to address the range of issues that determine the health of populations, the review emphasised the particular importance of local government and school education, while effective collaboration among the private sector, roads and traffic authorities, the police, local government and the health sector has resulted in sustained, significant reductions in mortality and morbidity associated with road traffic accidents.

However, there are complexities inherent in working across sectors that must be understood and addressed if such work is to expand and succeed. Many people consulted in the course of the review pointed to the potential health gains that can result from working with other sectors. It is important that the health sector focus on building its own capacity to work in this way.

4.2 Factors that influence success

A recent Australian review identified conditions for successful intersectoral action for health. The authors found that the most effective action occurs when organisations (rather than individuals) actively engage in working together. The conditions for success then highlighted the extent to which it will be necessary to build the capacity of the health sector to adapt its own expertise, culture and structures in order to work effectively in this way.
There is a wide range of intersectoral action for health already occurring in Australia. It ranges from activities that are often identified with promoting health through to service delivery where negotiations between health and community services might assist in the care of someone with a health problem in the community. All parts of the health sector already work with people in other sectors with a view to assisting individuals to maintain their health or quality of life, or with a view to developing environmental conditions that are conducive to health in particular communities.

The activity does not always involve working in committees. Rather it might include sharing information, networking, managing cases jointly, jointly sponsored programs, or it might be formal bilateral agreements binding two organisations to work in particular ways for predetermined ends.

**Build a constituency in the community for improving population health**

It will be necessary to obtain community support for investing health resources in action to improve population health, particularly where this means adjusting the current balance of resources within the health budget. It is important that the rationale for working with other sectors is continually promoted within the health sector and the broader community.

**Identify and publicise the reasons that it is essential for the health sector to work with others to achieve its goals—the necessity**

Not all issues require intersectoral action. On occasion it may be necessary only for the health sector to support other sectors in their primary roles—by ensuring safe, secure housing and effective education so that all children are literate when they leave school.

Issues become amenable to intersectoral action only when it is impossible for one sector to address them alone. To work together successfully, organisations must identify and acknowledge their interdependence in resolving a given problem. That is, that neither organisation, working alone, can achieve its goals.

**Take advantage of (or create) opportunities for action**

Organisations find it easier to engage in working intersectorally if the environment within which they operate supports the intended action. Conversely, where there is no broad constituency, organisations find it much more difficult to act. An example is that of mental illness, an issue that is still not well understood in the wider community.

To take advantage of or to create opportunities for intersectoral action, the health sector must:

- inform the community about the relationship of health to factors that are outside the health sector and beyond the capacity of any single individual or organisation to influence;
- build on the opportunities that emerge within the broader environment, such as the Integrated Local Area Planning Process (ILAP) which is being promoted through local government and planning bodies.

**Identify policies and directions being taken by other organisations that address issues relevant to the health sector**

Develop skills in environmental scanning so that the health sector can identify opportunities in the social, economic and economic environments that might be able to be used to further the health agenda.

**Identify (or create) triggers for action**

Organisations are more likely to engage in intersectoral action when there are specific triggers that highlight issues (for example, new prevalence data), that demand action (e.g. a bus accident) or that simply provide the means to act (such as end-of-year funding).

The health sector often creates triggers for action with the release of new information about a health issue (such as Hepatitis C, or a measles outbreak). Conversely, it may also react to external triggers such as deaths from sporting injuries, or community concern about the health effects of sewage pollution on Sydney’s beaches.
For triggers to lead to effective and sustainable action, however, there is a need for:

- ways of controlling or anticipating triggers so that they do not shift focus away from existing activities that need to be completed, or from the long-term goals. (Note, this is most obvious when governments are pressured by lack of hospital beds on specific occasions to divert resources from other activities to reduce waiting lists);
- the use of new triggers for action to build on existing action wherever possible rather than to create a radical new agenda; and
- research to enable assessment of which triggers are best at creating effective and sustainable long-term action.

Build capacity within the health sector:
If the health sector is to work effectively with other sectors to achieve its goals, it will be necessary to develop its capacity to do so.

There are several key steps. The health sector needs to acknowledge that working with other sectors is the only way in which its own organisational goals can be achieved. This means that managers must first recognise the need for and support the action. Working with other sectors requires resources, including considerable time.

Sectors other than health have core business that does not always include a focus on health. This must be understood by the health sector before joint action is proposed. The health sector needs to develop its understanding of the core business, structures and culture of organisations with which it wishes to work to promote health. In addition there is a need to develop long-term relationships with other sectors to enable specific projects to be jointly planned and implemented. There is still much to be learned about working intersectorally to promote health.

4.3 Opportunities for the future

Municipal public health planning and the role of local government

At the local level, Bidmeade recommended that other States follow the Victorian provisions requiring local government to complete municipal public health plans. This was reiterated by the National Health Strategy. The National Centre for Epidemiology and Population Health also argued for the broadening of local government’s role in public health suggesting that local level intersectoral coordination is linked to a statutory obligation (imposed through State legislation) to prepare municipal public health plans.

Municipal public health plans can play a central role in supporting intersectoral collaboration at the local level. They also constitute a vehicle for priority setting and strategy development at the local level.

Local government already plays a key role in promoting health in a whole range of ways. Its responsibility for environmental health, urban planning, and the provision of community and social services, in addition to the provision of some direct health services (e.g. immunisation) means it is a key sector which to establish strong relationships.

The Integrated Local Area Planning (ILAP) process being undertaken by local government is, itself, an effort within the local government sector to introduce a whole of government approach to its roles.

Health impact assessment

The National Health Policy commits the Commonwealth Government and State and Territory Governments to adopting a formal mechanism by December 1995 to ensure that health impact is examined as a part of public policy formulation.
Bidmeade describes the background to the 1988 Victorian legislation which mandated health impact statements. This legislation was never proclaimed, principally for resource reasons (the obligation to fund an inquiry lay with the Health Department rather than the proponent).

A thorough study of the implications of environmental and health impact assessment (EHIA) was carried out in 1994. It proposed a set of broad principles upon which such assessment might be based. EHIA is a potentially powerful vehicle for intersectoral collaboration for ecological sustainability and better health but it is clear that its implementation will not be easy. EHIA would be meaningless if it did not have a capacity to exercise real influence on lines of economic development. This being the case, it is reasonable to expect some opposition with respect to its implementation in all Australian jurisdictions. Ewan et al.13 point to a number of administrative issues which would also need to be worked through.

EHIA presents big challenges to public health research. Being able to predict the health impact of particular developments implies a technical capacity and knowledge base which for many categories of hazard is imperfect and incomplete, particularly in the impact of the social environment on health as well as exposure to material hazards is to be encompassed.

**Health-promoting settings**

Workplaces, schools, hospitals, sporting and recreational facilities, and the home are all settings in which action to promote health has been developing in recent years. In each case, the setting offers the opportunity to influence environments that determine health, and to reach a broad cross-section of the population. The Health Advancement Standing Committee has recently drafted reports outlining the evidence for and potential health gains from working in schools and sporting and recreational facilities, and there is growing interest in and knowledge of effective ways to promote health using settings as the organising principle. However, the review also pointed to the need for sensitivity on the part of the health sector to the core business, cultures and capacities of settings to promote health.

**4.4 Implications for the health sector: building capacity**

To enhance the health sector's capacity to work with other sectors, several steps are recommended.

**Identify opportunities to work with other sectors**

Although it is increasingly obvious that the health sector must work with others to achieve its goals, it is not as obvious to other sectors how the health sector can help them to achieve their goals. It is important that the health sector develop knowledge of the policy interests of other sectors, and define ways in which, by working together, the goals of both might be achieved more effectively and efficiently.

Skills in external scanning and analysis of policy developments in other sectors will be essential in building the capacity of the health sector to work intersectorally. The Commonwealth Department of Health and Family Services and State/Territory health authorities will need to ensure that, within their public health/health promotion program structures, they include capacity to scan the external environment for opportunities to work with other sectors, to identify triggers, and to build the relationships that are required.

**Continue to develop instruments that help to contribute to the developing understanding of the relationship between decisions made in other sectors and their impact on population health**

The EHIA and experience with municipal health planning in Victoria, in particular, are useful bases upon which to build. In both cases, the instruments and the processes of developing them have been important in building both the technical knowledge (within the health sector) and the knowledge about the process of collaborating with other sectors.
Research is needed to identify the needs of other sectors for information that will assist them to consider the likely health impact of their decisions. Research is needed, too, to identify ways in which the joint development of municipal health plans has furthered the interests of both the health sector and of local government.

Evaluation of the process of working intersectorally, and of the outcomes that are achieved will also be necessary. This is of particular importance given that the outcomes of interest are likely to be different for the different sectors involved in any given partnership.

**Initiate training for policy makers and practitioners within the health and other sectors in working intersectorally**

Working intersectorally is an area of emerging research interest. There has been little training available for health professionals (or others) to build their knowledge and skills in this area.

Universities, professional associations, and other training institutions must be encouraged to add courses in this area to begin to build the critical mass of knowledge and skills that will be required.

**Support community organisations to participate in intersectoral action**

There is strong evidence that community participation in the development of policies and programs is a key factor that contributes to their successful implementation. In the area of Aboriginal and Torres Strait Islander health,” and in work with populations from non-English-speaking backgrounds,” it is clear that without such involvement progress is unlikely.

It is vital that there be continuing support for community organisations to participate both in training in this area, and in the processes of intersectoral negotiation.

Currently there are few formal processes that link such groups to the policy development process, and the groups themselves often do not have resources to enable them to contribute actively.

Additional resources should be provided through the The Community Sector Support Scheme (formerly the Community Organisations Support Program) to enrich and strengthen the institutional fabric of the public health and health promotion systems, including consumer and self-help groups as well as professional and peak body supports. A high priority for such additional support would be for the Aboriginal health movement, in particular for Aboriginal health workers and for managers of community-controlled health services.

The health promotion policy system has also been weak in mobilising practical leadership from and participation by health promotion practitioners in policy making and it is weak in consulting effectively with these practitioners.

A comparison of clinical medicine and biomedical research with the Aboriginal and Islander health field illustrates the difference between fields rich with structural support for participation in policy development and a field constituted by isolated agencies, struggling to cope with huge needs but inadequate resources and with almost no resources to support professional development and peak bodies. The tax payer supports a wide range of policy relevant activities in the fields of clinical medicine through significant taxation expenditure in addition to the support provided by pharmaceutical and other supply companies to medical journals and medical conferences.

The Community Sector Support Scheme (formerly the Community Organisations Support Program) provides some support to certain professional organisations (such as the Public Health Association) and to consumer and community involvement at the national level (through the Consumers’ Health Forum) but there is presently very little support provided for consumer and community organisations in health at State and local levels.

*Promoting the Health of Australians — A review of infrastructure support for national health advancement*
REFERENCES


Section 5: Program planning and delivery structures

5.1 Components of the health sector’s health promotion program planning and delivery system

The Minister for Health and Family Services is responsible for reporting to the nation on progress in improving the health of the population. Public funded health authorities at the Commonwealth, State and Territory levels are the organisations responsible for leading action to achieve the nation’s health goals. As part of its core business, therefore, the health sector is responsible not only for ensuring the provision of health care services but also for ensuring that action is taken to identify and solve public health problems and to achieve health gains. The promotion of health in Australia depends greatly upon government support, including infrastructure, money, and a congenial policy environment. For this reason, this review has focused most closely on the role of government health authorities in leading and guiding action to promote health, with particular emphasis on action to improve the range, quality and effectiveness of the action.

The emphasis on the role of government does not overlook the fact that Australia’s health sector includes a wide range of non-government structures with a role in planning, delivering and evaluating interventions to promote the health of the population, of society, and of individuals. (See Section 4). These include a wide range of non-government organisations, the health promotion foundations in most States and Territories, community and consumer organisations, and self-help groups. General practitioners, professional associations, and universities, too, have roles in planning, delivering and evaluating interventions to promote health. Community health centres, hospitals (public and private), and a range of specialised health care services (e.g. early childhood centres, women’s health centres, workers health centres) also contribute. These organisations conduct a range of activities spanning service delivery, research, education and training, community development and program funding.

The review confirmed the finding of the National Health Strategy that even a cursory overview revealed a plethora of organisational and funding arrangements for health promotion, with sometimes bewilderingly complex lines of communication and accountability among the Commonwealth, States and Territories and within each jurisdiction.’ Many people consulted during this review spoke of inefficiencies that occurred as a result of this confusion — different priorities, overlapped or doubling up on program delivery, and continuing lack of progress in reducing inequalities in the health status of some population groups in comparison with others.

5.2 Current government program planning and delivery structures for promoting health

Since the introduction of the National Better Health Program in 1986 the Commonwealth Department of Health and Family Services and each of the State/Territory health authorities has developed a designated health promotion program structure that has been responsible for directing, co-ordinating, and in some cases, delivering, health promotion activity. The extent of the program infrastructure (including the resources allocated to it) has varied considerably from State to State, but broadly speaking, these program areas have been responsible for setting priorities, providing funding, and supporting action to promote health (focused on national and/or state priorities) at State/Territory, Area, regional or local levels.
Over the last decade the health sector has gradually placed greater emphasis on promoting health as an integral part of its core business. This has been reflected in Commonwealth and State and Territory financing agreements, and in the level of funding allocated to specific programs, such as the National Women’s Health Program, HIV/AIDS, the reduction of drug abuse, the Early Detection of Breast Cancer, the National Mental Health Program, and the National Childhood Immunisation Program.

Within some of the Commonwealth’s health services programs, such as the ambulatory care, aged care and disability programs, also, there has been growing emphasis on promoting health. As an example, the General Practice Divisions and Projects Program has, since 1992, funded approximately 100 health promotion and disease prevention projects. A further 200 projects at least have contained a health promotion or disease prevention element. States and Territories are reporting a significant increase in the number of project submissions from Divisions of General Practice for health education and promotion activities.

However, the extent to which there is collaboration amongst the specifically-funded, vertical programs and between these and the designated health promotion program varies considerably from State to State.

At the State/Territory level the community health system has been a major component of the health promotion program delivery structure. In Victoria, South Australia, Tasmania, the ACT, and Queensland, in particular, the community health system, together with community and non-government organisations, has been the mechanism for almost all program delivery. In New South Wales and Western Australia separately-funded designated health promotion programs have been established in each area or regional health service, working in collaboration with the community health system. In all States and Territories, therefore, there is a central, designated program structure that is responsible for setting priorities, for overseeing and, on some issues, implementing action to address these.

In addition, Victoria, South Australia, the ACT, and Western Australia have each established a health promotion foundation funded from a specifically levied tax on tobacco. While the proportional funding allocations differ under each foundation’s legislation, they each provide funds to sporting and arts bodies to replace tobacco sponsorship, as well as providing resources for intervention projects, training and research. The foundations have made a significant contribution, both directly through their sponsorship and project funding activities, and indirectly, through their capacity to influence the policies and activities of the groups to whom they are providing funding.

The legislative roles of the, funds available to, and the access of the foundations to a wide range of organisations and groups beyond the more usual sphere of activity for the formal health authorities is a significant feature of their activity. Through their sponsorships, funding of both small and large organisations to conduct projects, partnerships with other sectors (particularly sports, arts, and industry) and by offering training and support for the people carrying out the work, the foundations’ reach into the community has been extensive and effective.

Queensland and Tasmania have established health promotion councils with funding directly from State budgets. The funding was for projects submitted in response to calls for tenders, usually linked with national and State priorities.

The National Health Strategy found, and this review confirmed, that the programmatic resources available to the States, Territories and Commonwealth were considerable, but that identification of who did what, best, amongst the different institutions may save time, effort and friction. It would also improve the quality, reach and effectiveness of interventions to promote health.

This review confirmed that leadership for action to promote health is the responsibility of the formally-constituted health authorities — Federal, State/Territory. Those people who were consulted confirmed the need for the health sector itself to develop a more systematic process to identify problems, to select priorities, to allocate resources, to guide or deliver action, and to assess progress.
5.3 The focus of current programs with national or State/Territory responsibility for health promotion

The program structures within Commonwealth and State/Territory health authorities that have been designated as accountable for the area of activity defined as health promotion, are funded separately and report separately from the programs that are responsible for the provision of health services, and from those that are responsible for specific issue programs (e.g. drugs and alcohol, or HIV/AIDS).

In an effort to identify the extent to which the formal health promotion structures do work as part of an informal national system, the Health Advancement Standing Committee conducted a brief review of the activities of the designated health promotion program areas. The review found that almost all of the national effort is underpinned by expressed aims of promoting health and reducing health differentials.

There is a considerable degree of fit between the Commonwealth, States and Territories in relation to risk factor reduction, particularly in the areas of food and nutrition, tobacco, and alcohol and other drugs. The national and State/Territory priority health issues were the focus of the majority of the work. Nonetheless, all States and Territories have also worked to ensure that local community issues that fall outside the priority areas can be addressed. The extent to which this tension between national and State/Territory priorities has been resolved varies, and the review revealed considerable concern about this issue.

The 1990s have seen the development in almost all States and Territories and the Commonwealth of specific programs to build the capacity necessary to enable the health system to promote health.

All jurisdictions also included programs (many of which are national cost-shared initiatives and/or focus predominantly on service delivery) that focus on specific population groups—women’s health, child and youth health, migrant/ethnic health, Aboriginal health and, to a lesser extent, older people and rural health.

The brief review demonstrated that there has already been considerable success in developing a more focused approach to promoting the health of the population. However, it also demonstrated the extent to which the work of the designated health promotion program structures is separate from and, often, unrelated to the work of other vertical programs.

The relationship between State/Territory health authorities, the health promotion foundations, non-government and community organisations, too, remains unclear. Although diversity of both programs and providers—critical to the success of the national health promotion effort, the consultation highlighted the need for nationally agreed priorities that are addressed with sufficient resources over sufficient time to achieve health gains.

Many of the Commonwealth’s specific purpose programs have developed largely in a piecemeal fashion—isolated from any coherent policy framework. This has led over time to proliferation, duplication, unnecessary administrative complexity, and even skewed accountability requirements.

This points to the need to develop a clear policy framework, in which the goals and strategies for promoting the health of Australians are clearly articulated. In this way, each program has a clear sense of its role in achieving and delivering those aspects of the system’s effort for which it is responsible, and the connections between the individual programs are clarified.

The current process to develop a National Public Health Partnership is a major step toward the development of a systematic, integrated and consultative approach to program design and implementation.

5.4 Roles and responsibilities of components of the infrastructure for program planning and delivery

Each of the major initiatives taken to improve Australia’s health promotion efforts in recent years has recommended the clearer delineation of roles and responsibilities. There has been some attempt to achieve this and there are examples (such as the National HIV/AIDS Strategy, or the National Approach to Cervical
Cancer) where roles have been better defined. But further progress is required. Throughout this review, there have been calls to reduce duplication, to improve efficiency and effectiveness, to improve the dissemination of information and best practice, and to enable a workable system of accountability for progress to be established.

The first step toward clarifying roles and responsibilities is that of obtaining national agreement that this is necessary. Progress toward improving national cooperation in promoting health has been slow. Nonetheless, the current progress toward the development of a National Public Health Partnership is an encouraging sign of a developing national approach to a range of issues.

Experience to date demonstrates that it is by no means simple to define appropriate roles and responsibilities for all the organisations engaged in health promotion.

As a first step, the Recommendations included in the Executive Summary of this report outline national roles and responsibilities for consideration by the National Public Health Partnership, representing agreement on areas in which the Commonwealth and States/Territories would have joint responsibility.

In addition, responsibilities for the Commonwealth Department of Health and Family Services, the State/Territory health authorities, and other area health authorities are recommended.

However, there are many other components of the infrastructure to plan and deliver effective action to promote health. It is impossible to delineate roles and responsibilities so accurately that there is neither overlap nor gaps. Nonetheless, the consultation revealed some support to begin the process of clarifying roles.

**Health promotion foundations**

Each of the health promotion foundations has adopted a different role, emphasising different aspects of the work of promoting health. Some of these differences are defined by the statutes under which they were established but others are the result of different views on the roles the foundations can and should play in the States and Territories. It would be important for the foundations’ priorities to be linked with their State/Territory priorities.

It is suggested that the health promotion foundations would be responsible for:

- contributing to the establishment of State/Territory priorities for health promotion intervention;
- developing and pilot testing innovative programs (on priority issues or with priority populations) with particular focus on working with other sectors;
- developing and pilot testing innovative programmes with priority populations;
- innovative research that focuses on the delivery of effective health promotion interventions with particular interest in the role of foundations in stimulating and funding action;
- sponsorship and grants for small projects that are linked to building capacity for promoting health in other sectors; and
- replacement of tobacco sponsorship in sport, the arts, and racing and the development of ongoing relationships with these organisations to influence policy and practice in a range of areas other than smoking.

The foundations have a potentially powerful role in building capacity for promoting health in communities, and in other sectors. It appears that ‘small grants’ programs are more successful than large, demonstration style projects in engaging communities and organisations in other sectors in health promotion and in achieving positive outcomes. When the small grants programs include a strong training component, they make a significant contribution to developing a knowledgeable, skilful community-based workforce.

Through their sponsorship activities, in particular, the foundations have developed strong working relationships with other sectors. In Victoria and Western Australia, in particular, initial sponsorship arrangements have been extended to include the implementation of more directly health promoting measures, such as changes in the food supplied at sporting venues, or the introduction of non-smoking policies.
The community health infrastructure

The extensive community health infrastructure across urban and rural Australia provides a strong foundation for the delivery of health promotion programs. With more than 4,600 community health centres across the country, and more than 23,500 staff, community health services are well placed to design and act to promote the health of communities and defined population groups.

In addition, many community health staff have extensive experience and success in working with local government, community and non-government organisations, and with other government sectors to develop interventions to promote health. A growing number of community health services is working with Divisions of General Practice.

In addition to their direct role in promoting health, the community health services also have a significant role to play in contributing to the development of community understanding and support for national and State policies directed to promoting health. Given that community support is an essential part of effective action to promote health, this is, indeed a major role.

With their focus on and knowledge of local community needs, their access to key people in communities, and local organisations, and their ongoing association with the community, the community health services have a key role in promoting health.

The consultation found considerable support for the strengthening of the capacity for health promotion at the local level, in addition to the action recommended at national and State/Territory levels.

General Practice

The significant role of general practitioners in promoting health has been widely recognised and is now being actively supported, largely through the mechanism of the Divisions of General Practice. Grants offered under the GPEP scheme are reflecting considerable levels of activity among general practitioners, making the most of the many opportunities they have to promote health.

The role includes:

- opportunistic health promotion and screening for those diseases where there is evidence that such screening is effective;
- systematic advice, screening, and early intervention based on clinical guidelines for best practice;
- a pro-active, population approach through the opportunity offered by the Divisions to link with other health care providers, and local communities.

The Royal Australian College of General Practitioners plays a significant role through its establishment of national and state-based preventive and community medicine committees that promote the adoption of a preventive orientation to general practice.

In addition, the College publishes Guidelines for Preventive Activities in General Practice, and has engaged in a collaborative research project with the Australian Community Health Association to identify successful models of collaborative practice. It is also engaged in intervention projects to encourage and enable general practitioners to contribute more actively to promoting health.

Non-government organisations

Non-government organisations have key roles in promoting health in Australia. Their focus on specific issues (diabetes, asthma, heart disease, cancer) or on specific population groups (Ethnic Communities Council, People Living with HIV/AIDS, Council on the Ageing), for example, means that they have specific knowledge, experience, and access to individuals and communities that is sometimes more difficult for government organisations to obtain.
In addition, more recently, such organisations have taken more active preventive roles, adding designated health promotion workers to their staff, and to developing strategic plans that direct their work to prevention. There have been encouraging steps to integrate the work of non-government organisations with that of the State and Territory health authorities in some States. However, it is clear that there is need to continue to develop clearer delineation of roles for each.

In addition, where such organisations have overlapping interests (as in the case of smoking), it is important that roles be clarified amongst both non-government organisations, themselves, as well as the State authorities. This will require recognition by government of the particular areas of expertise of the non-government organisations. It is also likely that non-government organisations will require additional funding to support work that contributes to the achievement of national priorities.

As is the case for local government, it is not appropriate for the health sector to decide on roles and responsibilities for non-government organisations independently of the organisations. Rather, the task is to establish where agendas overlap and roles require delineation.

**Professional associations**

A wide range of professional associations has played and continues to play significant roles in promoting the health of the Australian population. The most obvious of these, perhaps, have been the Public Health Association of Australia, the Australian Community Health Association, and the Australian Association of Health Promotion Professionals.

However, the Royal Australasian College of Surgeons, the Royal Australian College of General Practitioners, the Royal Australian College of Physicians, the Dietitians Association of Australia, and the Australian Medical Society on Alcohol and Drugs have all contributed extensively to action to promote health.

The roles of professional associations include:
- workforce development through conferences, training programs, and journals;
- policy development and advocacy; and
- networking and advice to health authorities, training institutions, and other professional groups.

**Universities**

Universities are an integral part of the infrastructure support for promoting the health of Australians. Over and above their roles in teaching and research, universities can:
- advocate for the knowledge-base upon which health promotion is built;
- conduct research and development that links science and practice more closely;
- convert knowledge into policy-relevant advice;
- advise governments on health promotion strategies, plans, programs; and
- carry out education and training as part of a formal workforce development strategy.

Delineating roles and responsibilities will continue to require specific effort on the part of all the constituencies involved in health promotion. It would be ideal if it were possible for the definitions to be clear, for there to be no overlap and for there to be no conflict among those involved. However, it would also be unrealistic to expect this.

The purpose of focusing on role delineation is to highlight the extent to which roles do overlap currently, and to point to the need for all negotiations among the various organisations involved to conclude with clearly defined roles and responsibilities assigned to each. It is likely that this will need to occur on a project-by-project basis.
5.5 The challenges

The challenge for the future is to develop a cohesive system that is capable of identifying and addressing effectively any given public health problem. The system must be able to identify public health problems and to select priorities for action. The people consulted for this review were very clear that the process for selecting priorities at national, State, and local levels, must include strong community voice. The system must then allocate resources to the priority areas. It must then be able to develop and implement comprehensive interventions that are responsive to local conditions. The system must be able to tolerate both consistency (in terms of planning) and diversity in terms of the delivery of intervention.

In addition, it must be possible to review progress and to measure outcomes—health promotion, intermediate and health outcomes."

Further challenges for the future are to develop the health sector’s capacity to reduce inequalities in health, to develop the means to assess the cost-effectiveness of interventions to promote health (and hence to use this information to assist in making decisions about priorities and the allocation of resources), and above all, to strengthen the role of community members in making decisions about actions that are needed by governments, communities and individuals to improve the health and well-being of all Australians.

The consultation identified the need for:

- A policy framework that sets out the health goals of the nation and that provides guidance to all parts of the health sector about roles and responsibilities in relation to achieving these.
- Program structures within government health authorities that provide effective leadership in the development of effective responses to public health problems. Vertical program structures serve important purposes in focusing effort on specific issues across the range of preventive, treatment, rehabilitation and palliative services. However, such structures tend to become rigid and limiting the extent to which their activities are informed by the perspectives of other program areas, and ignore the opportunities for joint action;

In New South Wales and Queensland, in particular, there have been efforts to develop integrated program management systems that incorporate strategic and operational planning, outcome-focused resource management and systematic performance assessment. The Queensland Health model’s appeal lies in its ability to bring together, in different configurations depending upon the issue, the best available advice and experience to address the problem.” It accepts the need for expertise in specific content areas or in working with defined population groups but provides a structure that enables integrated planning;

- Clarification of the roles and responsibilities of the major components of the infrastructure to promote health, both within government health authorities, and in the wider health sector. The recommendations in the Executive Summary outline proposed roles and responsibilities for government health authorities. Suggested roles and responsibilities for other components of the infrastructure for promoting health have been outlined in this and other sections of the report;
- Program structures that can plan and coordinate the delivery of comprehensive responses that address determinants of health with the intention of reducing preventable inequalities in health and in access to the resources that people and communities need to maintain their health and well-being;
- Funding that is linked to the priorities that have been selected at national, State, and local levels;
- Systematic dissemination and application of effective practice;
- Integrated planning but diverse systems for action. This implies the need for effective coordination in addition to recognition of the need for different interventions in different communities, at different times, with different levels of resources.

The National HIV/AIDS Strategy is perhaps the best example of what is possible if planning is integrated and involves the communities most affected, and when delivery is diverse, reflecting the different needs of different audiences in different settings.”
A national system and local systems to review progress. These systems should aim to assist in developing more effective interventions to bring about positive changes in the health of the population.

In all, the program structure for planning and delivering effective health promotion requires extensive refinement in order to develop the systematic, integrated, comprehensive range of actions required.

The current action to develop a National Public Health Partnership is therefore a vital step toward such a system. The review revealed widespread concern that such a systematic response to public health problems will reduce the power of health promotion to address community concerns, and to mobilise social action. On the other hand, it revealed considerable frustration with poorly defined roles and responsibilities, with obvious examples of poorly coordinated (but expensive) interventions, with the lack of funding, and the lack of organisational support to ensure that effective practice is applied.

The challenge is, indeed, to develop program planning and delivery systems that are responsive and that address with the best available expertise (including community expertise) the determinants of the public health problems in Australia today and in the future.

REFERENCES

3. ibid., p.23–26
Section 6: Prioritisation and financing

6.1 Sources of funds

Australia's health services

Finance for Australia's health services comes from three sources:

- State and Territory and local government (24 per cent):
- Commonwealth government (41 per cent); and
- Private expenditure, including individuals, workers' compensation, private health insurance funds and motor vehicle third party, (32 per cent)

The State and Territory governments have some capacity to raise taxation revenue, but the Commonwealth has the principal revenue raising powers. The Constitution provides for the Commonwealth to distribute funds to the States and Territories as general purpose grants or specific purpose grants, and the States and Territories have become dependent on Commonwealth revenue for a significant proportion of their health sector finance.

Additionally, the Commonwealth provides financial rebates for the cost of services provided by medical practitioners, optometrists and pharmacists through the Medicare Benefits Schedule and the Pharmaceutical Benefits Scheme.

Traditionally, the Commonwealth has used specific purpose grants to further policy objectives in specific areas of interest. The Constitution originally allocated responsibility for providing health services to the States, but the Commonwealth has become increasingly involved through constitutional amendments, its greater revenue raising powers, implementing 'national' policy initiatives, and the use of tied grants to influence resource allocation and service delivery.

National health promotion expenditure

It is very difficult to be precise about the source of funds and expenditure in the health promotion and illness prevention field. Reasons include the extent of health promotion activity that takes place outside the health sector, the extent of health promotion activity that takes place within mainstream health care services (by medical practitioners, within hospitals and other health care institutions), and the overlap between expenditure on community health services and health promotion. It is possible, nonetheless, to give a broad picture of funding and expenditure patterns for dedicated health promotion services using the AIHW health expenditure data.

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* The statistical information provided in this section draws on the Health Expenditure Bulletins published by the Australian Institute of Health and Welfare (AIHW), and the Commonwealth and State and Territory budget papers.

b While the AIHW published separate expenditure categories for 'Community Health Services' and 'Health Promotion and Illness Prevention' for bulletins prior to 1993, the two categories were subsequently combined into the composite category 'Community and Public Health'. While it is true many services of a preventive nature are rendered by community health services, and it is difficult to disaggregate them, they also provide a range of health care services (domiciliary care, home nursing, infant health, mental health, physiotherapy, chronic disease management, etc).
Dedicated health promotion expenditure is a very small percentage of total recurrent health care expenditure. Using the new AIHW definition ‘Community and Public Health’, dedicated health promotion activity accounts for approximately four to five per cent of recurrent health sector expenditure, but separation of the community health care and health promotion activities is difficult. Earlier estimates (in 1986/87–1989/90) suggested that health promotion activities alone represented only about one to two per cent of recurrent health expenditure.

The source of funds for ‘Community and Public Health’ expenditure illustrates quite a different pattern from that for health care services expenditure as a whole. There are two key differences:

- the contribution from the private sector is very small at one to four per cent, compared to its 32 per cent share for health care as a whole; and
- the Commonwealth government share (currently 21 per cent) is approximately half what it contributes to health care as a whole (34 per cent).

Both these points require further explanation. The definitions used by the AIHW to categorise private sector expenditure do not include expenditure on individuals on healthy food, fitness/exercise activities, bicycle safety equipment and the like, although such expenditures are likely to be quite considerable.

Similarly, the size of the Commonwealth contribution to health promotion is underplayed by only considering the ‘Community and Public Health’ category in the health expenditure accounts. The Commonwealth contribution to medical services is substantial (80 per cent of total recurrent expenditure on medical services of over $6 billion) and medical practitioners are increasingly providing preventive services. This includes screening, immunisation, counselling and chemoprophylaxis.

It should also be noted that since the beginning of the (General Practice) Divisions and Project Grants Program in 1992, approximately 100 health promotion projects have been funded, and at least a further 200 projects have contained a health promotion element. Such health promotion projects involved funding of approximately $3 million in 1993/94 alone. The Divisions and Project Grants Program is now establishing a Support, Evaluation and Resource Unit (SERU) in health promotion, as one of six SERUs being established to assist with the evaluation of the Program.

The Commonwealth’s health promotion agenda has been moving towards a system-wide emphasis on improving population health outcomes. A major focus for this re-orientation of health service delivery is through Commonwealth and State and Territory financing agreements such as the Medicare Agreement. The Commonwealth’s contribution via dedicated health promotion funding, therefore, may prove to be only a minor part of its overall funding commitment to promoting health.

Commonwealth funding for health promotion

While the AIHW expenditure category ‘Community and Public Health’ is indicative of dedicated health promotion funding, it is not sensitive enough to provide a detailed or accurate picture. Greater precision requires a detailed examination of both the Commonwealth and State and Territory budget papers, and consistent interpretation of what program and expenditure components are included as ‘health promotion’. The former Commonwealth ‘Health Advancement Program’, for example, included a number of sub-programs that had little to do with the provision of health promotion services (for example, Sub-program 1.5 Therapeutic Goods and much of sub-program 1.4 Health Research) and judgement is needed as to whether departmental running costs are included or excluded.

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*While the AIHW analyses the Commonwealth Budget Papers, it relies on Australian Bureau of Statistics (ABS) data for State, Territory and local governments. The ABS uses the Government Purpose Classification and Economic Transaction Framework which is not very sensitive to categories as small as health promotion and illness prevention.*
A number of points stand out from the analysis of the budget papers:

- The Commonwealth has tended to fund health promotion activity directly (i.e. expenditure other than grants to the States and Territories). However, the share of Commonwealth funding for health promotion has been falling in comparison to grants to the States and Territories, particularly in the Health Promotion and Disease Prevention Subprogram (largely due to the increasing significance of transfers to the States for the breast cancer screening program, the National Mental Health Program, and the National Childhood Immunisation Program).

- Commonwealth funding is taken up by a few large programs that will account for 70 per cent of total expenditure in 1995/96 (that is, the National Campaign Against Drug Abuse, Family Planning, HIV/AIDS, the breast cancer screening program, the National Mental Health Program and the National Childhood Immunisation Program).

- The Commonwealth’s direct expenditures are primarily in the areas of research, regulation and initiation of new programs deemed to be of national significance. The Commonwealth has therefore been an important source of new health promotion initiatives.

The role of the Commonwealth Department of Health and Family Services is, however, undergoing significant review, with responsibility for program delivery (of all health services, including health promotion) devolving more explicitly to the States and Territories.

**Dedicated State and Territory health promotion funding**

For the same reasons that apply at the Commonwealth level, it is very difficult to gain an accurate picture of State and Territory funding for health promotion. The lack of consistent definitions of health promotion across the States and Territories means that any analysis of program expenditure patterns using only the budget papers is likely to be inaccurate.

This highlights the urgent need to improve the quantification of our health promotion investment in Commonwealth and State and Territory programs. Expansion to include health promotion investment in mainstream activities (for example, general practice, community health centres, hospitals) would also be highly desirable.

**6.2 The impact of health services funding models on health promotion**

Mainstream medical and hospital services have a potentially important role in health promotion through three main avenues, namely:

- opportunistic health promotion activities which may be carried out in the context of other services, for example, advice on diet or lifestyle, relaxation approaches to sleep disturbance;
- the ongoing management of chronic diseases; and
- organisational responses to health promotion.

The full potential of the health-promoting hospitals effort is still emerging. However, casemix funding models for hospital activity may threaten continued hospital involvement in health promotion and preventive services and activities. Particular concerns about the potentially adverse impact of casemix funding on health promotion relate to:

- its focus on individuals and clinically defined outputs—whereas most health promotion is centred on populations and more diffuse interventions which do not lend themselves well to output measurement in such terms;
- the likelihood that collaboration amongst health practitioners and services could be jeopardised—which, again, threatens a key principle of health promotion action; and

*Promoting the Health of Australians — A review of infrastructure support for national health advancement*
• early discharge from hospital means that there is increased volume and complexity of case load for community health services, which in turn reduces their capacity to devote already limited resources to health promotion.'

A recent Victorian study' found that two thirds of hospital chief executive officers believed that hospital-based preventive programs and outpatient services should only be provided when they are separately funded. Hence, unless hospitals receive separate funding for health promotion and preventive programs, it is unlikely that they will participate in such activities.

Developing incentives for health services to be more health promoting

The re-orientation of all mainstream services to include a greater emphasis on health promotion could result in a significant increase in the quantity of health promotion undertaken by health professionals. There is evidence that such work has significant potential to improve health.

Financial incentives play an important role in encouraging services to expand their health promotion effort. In the context of general practice services, the incentive is that longer services involve a higher fee. However, the existing time bands may be too broad for this to be an effective incentive. Similarly, the Medicare legislative restrictions against screening or asymptomatic individuals may also act as an impediment to preventive activities in general practice.

Financial incentives are also likely to play a significant role in encouraging and enabling community health services and hospitals to engage in greater levels of health promotion activity. There are examples of such incentives being applied—in South Australia, for example.

6.3 Common models for priority setting in health services

There are two separable issues in prioritisation. The first is the process for ranking priorities. The second is the institutional and funding arrangements which maximise the likelihood of priorities being implemented.

There are several common approaches to health services planning that offer a framework for priority setting for health promotion. These include:

• historical decision rules—where funding is based broadly on the previous year’s allocation to program areas and is adjusted up or down, typically in response to changes in health service costs, population base, gross domestic product or budget objectives. This has been—and continues to be—the standard approach to health services planning and de facto priority setting;

• best practice guidelines—which have been prepared, often by health service providers (for example, through consensus conferences or the NHMRC) to attempt to improve the quality of health service delivery;

• needs assessment—such as community-based analyses of health care priorities, epidemiological based assessment of health needs, and disease costing on the basis of burden of illness; and

• health goods and targets—the use of which as a health planning approach has become common in the field of health promotion.'

The last two of these are currently the most popular for deliberate priority and planning exercises.

Needs-based approaches can provide valuable input to health planning, particularly when undertaken with the community and practitioner groups as active partners. However, their value is limited in the absence of information on the benefit and cost of interventions that may address areas of identified need. When taken on their own to establish priorities, the implication is that health resources should be allocated on the basis of size of disease burden or level of community concern. But disease burden or public health significance may bear no relationship to the opportunity for reducing that burden or to the cost effectiveness of achieving health gains.
The needs-based approach is implicit in the regional allocation formula often used for the provision of funds to particular regions. As a starting point for the provision of regional funds, this may be the most appropriate policy, although it is not the theoretically best approach. Ideally, if all current and potential uses were evaluated, the size of the budget for different regions would be automatically determined by decisions about what programs should be offered.

Health goals and targets documents often disregard the reality of resource scarcity (implicitly or explicitly) and the need for prioritisation. Despite this, published health goals and targets have been widely adopted, and they provide the broad strategic directions for many health policy makers and health service providers. However, this is a second best approach for prioritisation, and perhaps best thought of as a temporary technique to be replaced by more rigorous research as this becomes available.

**Priority setting on the basis of economic evaluation**

A number of key assumptions underpin the approach to priority setting derived from economics. Specifically, these are that:

- the community's resources are seen as responsive to unlimited wants and needs — thus, ultimately all health service providers compete for available resources;
- a primary objective is the maximisation of health gain (where health is defined in its broadest sense) — the difficult issue of how to measure health gain does not alter the importance of the objective; and
- issues of equity and access must be explicitly considered, although their attainment is considered separately from the objective of health maximisation — equity and access are perceived as a constraint, or an objective to be traded off against efficiency. *E* 

Economic theory provides a framework for the prioritisation of health services to maximise health gain from limited resources (defined as 'allocative efficiency'). The necessary condition for allocative efficiency is that, at the margin, health output per unit cost is equal for all interventions. If this is not satisfied then, as a matter of logic, it is possible to increase social benefits, by redirecting resources to where the ratio is highest. The equation highlights the centrality of marginal analysis, and the need for evidence on health benefits and cost.

While the theoretical prerequisites for allocative efficiency are clear and logically compelling, implementation is problematic. The measurement of marginal costs and benefits is difficult and the magnitude of the research task for health sector-wide allocative efficiency is daunting. The challenge is to develop a theoretically sound framework that encompasses all pertinent interventions, but which is tractable in terms of research effort required and offers the possibility for a staged analysis.

Examples of economic evaluation models are outlined below.

**Program budgeting with marginal analysis**

The program budgeting with marginal analysis approach is designed primarily to address priority setting within programs. The model requires health service providers (or funders) to classify their services into program streams and then to identify program areas where expansion is likely to result in greatest health gain and others where a reduction in resource use will result in minimal health loss. As an allocative model, it is particularly useful for an individual health service agency or provider determining how best to allocate a given annual budget between competing activities. As a management tool, it has a sound social theoretical base.

**The Oregon experiment**

The Oregon experiment was an ambitious attempt to develop a league table that prioritised health service interventions based on analysis of comparative cost utility. The model was used to develop a priority list of health services provided at public expense in Oregon, USA.

**The macroeconomic evaluation model**

The macroeconomic evaluation model is designed for disease impact costing and resource allocation in the health promotion and illness prevention sector. It is essentially the construction of a ranking index of potential
interventions from a systematic analysis of available databases, and facilitates a broad-based framework for priority setting comprising disease impact assessments, life expectancy analysis, and project appraisal.

The disease-based framework for priority setting

The disease-based framework for priority setting is designed to cover the entire health sector with disease groupings as the context for analysis. It combines analysis of all actual and potential health interventions across the stages of intervention in the disease process from primary prevention through to end stage care and palliation. The approach is able to be implemented at the individual service provider or program level, although it is desirable for research to establish priorities to be reviewed in the first instance at the community level, without regard to current funding rigidities. By taking a whole health sector perspective, it addresses the total level of resourcing to health promotion, relative to other approaches to achieving health gain, and also reviews priorities within the health promotion sector given a predetermined budget.

The health promotion investment portfolio approach

Hawe and Shiell note that service provision based on health outputs and outcomes, casemix funding and program budgeting is inherently conservative, as it reinforces “safe and best” practice within the limits of current knowledge. They propose that health promotion programs be viewed in the same way that one would construct an investment portfolio in order to preserve the proportion of activities about which outputs and outcomes are uncertain but potential is great, that is, the innovative or leading-edge activities in health promotion. Program investments would then range from “blue chip” activities (such as cardiac patient education), through to higher risk programs, where the uncertainty is high but the potential for high levels of health gain is great — community development and intersectoral health action, for example.

Specific conditions relating to program resourcing and evaluation would need to be applied to the higher risk programs. This. they argue, would permit the benefits of the program to be fully realised and the program subsequently to be mainstreamed, or alternatively, if benefits cannot be found, resources may be diverted to other programs. A mechanism such as this is needed to protect within-practice innovation in health promotion, otherwise accountability pressures may lock practitioners and policy makers into a pathway to population health gain that is unacceptably slow and also inequitable.

Conclusion

It is clear from this analysis that implementation of any of these models will need to draw on incomplete evidence. This means that indicative (rather than detailed cost-effectiveness) analysis will need to be conducted initially. This approach is justified on the basis that sound evidence about some types of health promotion activity will be difficult to obtain and best judgement incorporated into a suitable analytical framework is preferred to the alternative option of there being no explicit analysis and decisions relying on implicit judgements.

These models also assume constant review and revision. In the absence of good evidence there is no alternative to a significant increase in research effort if resources are to be allocated to best achieve society’s objectives.

The consultation revealed widespread concern about the processes and criteria used to establish priorities for health promotion (and to allocate funding) at national, State and local levels. The concern centred on the lack of community input to the process, and the lack of well-defined criteria—that might be openly debated and contested.

In addition to the assistance provided by economic principles and theory, there is a need for the processes used to establish priorities to be as transparent and inclusive as possible.

6.4 Building capacity

Richardson et al. note that priority setting and funding for health promotion should be underpinned by the following principles:

- **Equity and efficiency**—that is, health promotion activities should be judged by the extent to which they achieve technical and allocative efficiency and fulfil the requirements of social justice;
Evidence-based priority setting and funding—which should apply both to the aggregate government health promotion budget and to the selection of particular health promotion activities. This will require significant investment to develop the indicators and collect more appropriate information;

- Investment information—available on the scale and scope of health promotion activities for planning, review and management;

- Dynamic adjustment—to encourage innovation and the expansion of more cost-effective programs at the expense of less cost-effective programs, and also to encourage the better performance of existing programs; and

- Testing value for money through contracts for health service agreements—this could be done through open competition to all public and private providers, or through a limited form of competition to preferred providers, or through an ‘internal market’ of public health service providers.”

Evidence and priority setting

Given that a major purpose in health planning and priority setting is to achieve certain social objectives, the actual capacity to achieve this depends upon:

- information on which to make decisions, and a willingness to make the decisions that are indicated by the information;

- evidence on the level of a program’s cost-effectiveness and its contribution to social justice;

- the application of regulation and constraints on programs which are determined as part of the policy process and should include a process of social dialogue between interested parties; and

- a focus on the evidence of ‘need’—everywhere programs are no cost effective, they may be warranted on equity grounds because of an unacceptable level of need in a particular population.

Again, the consultation highlighted the need for direct community involvement in consideration of the evidence upon which priorities are to be based, in establishing the criteria upon which selection is to be made, and as active participants in the process of selection.

Financing

The need for flexibility

There should be significant flexibility in the funding of health promotion activities, with annual budgets negotiated in the light of new evidence concerning program benefits. The most fundamental principle advocated within this proposal is that resource allocation to and within health promotion should be evidence based.

Financing arrangements should make suitable allowance for planning, evaluation, and the development of skills.

Articulation of outputs in funding arrangements

Emphasis needs to be placed on the development of ‘intelligent purchasing’ practices in health promotion and health services generally. That is, decisions underpinning priority setting and resource allocation should be based on evidence and information about expected program benefits, be guided by a formal planning framework, and be based upon some articulation of the outputs expected for the investment.

Priority setting and purchasing for health gain requires the active consideration of the interventions and potential outputs across the range of health promotion endeavour as articulated in Figure 1.

Once identified, such outputs should be articulated in financial agreements and form the basis for financial planning for health promotion activities.

Commonwealth and State and Territory agreements

There should be a health service agreement between the Commonwealth and States and Territories specifying the Commonwealth’s health promotion requirements. Financial compensation should be negotiated within the
broader context of the Commonwealth and State and Territory funding agreements. The formula should not penalise those States or Territories that demonstrate greater fiscal effort in relation to health promotion.

There should be a health service agreement between the States and Territories and their regions, specifying the State or Territory’s (and through them, the Commonwealth’s) health promotion requirements. Funding should exceed the amount strictly needed for the defined programs in order to give regions a capacity to initiate programs and undertake evaluations. Initially the financial transfer should be determined by a needs adjusted population formula. This should be refined progressively to recognise the distinction of needs per se and program requirements of particular populations.

Funding innovation
Funding should be available at all levels of government for experimentation and pilot program implementation. A requirement of such funding should always be that pilot programs are evaluated, and that a means exists for transferring successful programs to broader application and ongoing funding.

Incentives for health services to be health promoting
There should be ‘ring fencing’ of cost-effective health promotion activities within hospitals. This is most easily achieved through a contractual agreement between individual hospitals and the States and Territories or regions. For instance, a contract may nominate specific funding for identifiable health promotion staff or services, but also have a requirement for evidence of a health promotional approach to service delivery within the hospital. Opportunities for hospital initiated health promotion are extremely wide, extending far beyond provision of health education literature. There are many examples involving genuine partnership with the local community and other health service providers within a region.

Health service agreements with hospitals and community health services should specify requirements for health promotion activity and outputs.

Additionally, the application of non-financial incentives should be explored, such as the inclusion of health promotion responsibilities in the duty statements of traditional health care practitioners.

Information requirements
Research is required to improve the quantification of the Australian health promotion investment in dedicated Commonwealth and State and Territory programs. Expansion to include health promotion investment in mainstream activities (for example, general practice, community health centres, hospitals) would also be highly desirable.

Linking funding and accountability
There is a need for more focused accountability with respect to the planning and implementation of health promotion programs and projects, and the funding contract is a key site for strengthening such accountability. However, given the paucity of information in this regard, there is a need for critical studies of the relationships between funding bodies and health promotion program providers with a view to promoting best practice in these relationships. Such studies would be valuable in exploring the potential and limitations of output-based funding in health promotion and the scope for developing more emphasis on investing to optimise health gain.

REFERENCES
2 Health Solutions Pty Ltd. Independent Assessment of Casemix Payment in Victoria—A report to the Casemix Development Program Canberra: Commonwealth Department of Human Services and Health, 1994.
4 ibid.


10 ibid

11 Richardson J et al. 1995, op. cit
Section 7: Monitoring and surveillance

7.1 A national health promotion data framework: scope and definitions

National health information

National health information is information which is either national in coverage or has relevance nationally and relates to:

- the health of the population;
- the determinants of the population’s health, including those in the external environment (physical, biological, social, cultural and economic) and those internal to individuals (such as knowledge, behaviour, disease risk factors);
- health interventions or health services, including health interventions provided directly to individuals and those provided to communities, covering information on the nature of interventions, management, resourcing, accessibility, use and effectiveness; and
- the relationships among these elements.

Monitoring and surveillance data for health promotion

This is defined as the ongoing systematic collection, analysis and interpretation of national or State and Territory population data relevant to the national health promotion effort. Such data are collected at national or State and Territory levels repeatedly over time.

Monitoring is the performance and analysis of routine measurements, aimed at detecting changes in the environment or health status of populations.

Surveillance is ongoing scrutiny, generally using methods distinguished by their practicality, uniformity and, frequently, their rapidity, rather than by complete accuracy. Its main purpose is to detect changes in trend or distribution in order to initiate investigative or control measures.

Monitoring data relate to health, its determinants and to process measures which together provide a set of indicators summarising progress towards the building of a healthy society in relation to areas addressed by health promotion strategies.

Surveillance data are comprehensive health status and risk factor data used for monitoring trends or distributions as a warning system to raise health issues which may need to be addressed by health promotion activities and as a basis for setting priorities for health promotion activities.

A range of information is required for these purposes, as illustrated in Figure 1. What distinguishes the data needed to prioritise, plan, implement and evaluate health promotion programs from monitoring and surveillance data is that they do not need to be collected from national or State and Territory level populations, nor do they need to be collected repeatedly over time.

For example, a well evaluated smoking intervention which identified the most cost-effective type of intervention need only be carried out in a representative sample population, and need not be evaluated (in terms
of outcomes) again, unless other elements of the scientific knowledge base suggest that the results may no longer be applicable.

**Figure 1. Information requirements for health promotion**

National information does not necessarily mean large centralised data collections. The essential characteristics of national information are the nationwide comparability and national relevance of the information collected. In relation to monitoring and surveillance data for health promotion, we expand this definition to include State and Territory level health information.

**Conceptual framework for health promotion data**

The World Health Organization defines health as:

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

Figure 2 presents a conceptual framework for health promotion monitoring and surveillance data. It attempts to identify the major components of health and its determinants and to show their relationships. The framework is intended to assist in identifying and structuring the information relevant to health promotion, to assist in the inventorying of existing data and to identify data gaps and deficiencies.

As such, its purposes are somewhat different to those of an information model, but the major domains identified in it are similar to those in the National Health Information Model, as discussed below.

One of the important dimensions of health status is functional ability, the ability to perform tasks of daily living and to carry out social roles. Disability is defined as a reduction or loss of functional capacity or activity...
resulting from ill health and handicap is defined as the social disadvantage resulting from an impairment and/or a disability, entailing a divergence between individuals’ performance or status and that expected of them by their social groups.

Figure 2. Conceptual framework for health promotion data

The determinants of health include individual characteristics such as biological and genetic factors (inherited physiological and psychological traits as well as inherited risk of disease) and lifestyle and behavioural factors, as well as characteristics of the social, economic and physical environments. The determinants also include risk factors as well as more complex determinants of health such as socioeconomic disadvantages, where causal links are not so well defined. There are many determinants of health where risk factors and risk markers may not have been well identified (such as social environment).

Health promotion activities (shown in the shaded boxes) attempt to improve health and/or to prevent disease either directly through preventive services or via a number of enabling factors:

- health knowledge, attitudes, beliefs and skills;
- health promoting environments; and
- policy, legislation and guidelines.

These factors are not, in themselves, determinants of health but rather the levers which health promotion interventions address in order to modify the determinants of health. Each of these enabling factors can be addressed in a range of settings, as shown at the bottom of Figure 2.
**Inputs, outputs and outcomes**

There is frequently confusion between the inputs into the process of producing health and the outcomes which result.

The *inputs* are the resources — labour force, buildings, equipment, supplies, funds, knowledge and technology — that are put into an intervention. It is important to note that information on cost effectiveness is an important input to priority setting and strategy development. These are shown in the box to the bottom right of Figure 2.

The *process* is the series of actions or events which use the inputs to produce outputs (or outcomes). The shaded box labelled ‘health promotion’ refers to health promotion interventions or processes.

An *output* is a measure of the process. The dictionary definition of output and outcome are almost the same but output is now commonly used to refer to process outputs, such as the numbers of people exposed to a health promotion program or the numbers of screening tests performed.

A *health outcome* is an improvement in health due to a health promotion program or preventive health intervention. The scientific knowledge base has shown that transfer of health information (outputs) can result in improved health determinants, perhaps by changes to behaviour and lifestyle, and hence in improved health (the health outcome).

This framework provides a basis for identifying the basic categories of data for monitoring and surveillance at the population level in relation to health promotion. The information domains identified in Table 1 provide one useful classificatory dimension for documenting health promotion monitoring and surveillance data, data quality and data deficiencies.

<table>
<thead>
<tr>
<th><strong>Table 1: Information domains</strong></th>
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<tbody>
<tr>
<td><strong>Health</strong></td>
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<tr>
<td>— mortality</td>
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<tr>
<td>— health and wellbeing</td>
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<tr>
<td>— morbidity</td>
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<tr>
<td>— disease and risk factor impact (e.g. cost, Quality Adjusted Life Years)</td>
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<tr>
<td><strong>Determinants of health</strong></td>
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<tr>
<td>— lifestyle and behaviour</td>
</tr>
<tr>
<td>— social environment</td>
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<tr>
<td>— economic environment</td>
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<tr>
<td>— physical environment</td>
</tr>
<tr>
<td><strong>Enabling factors</strong></td>
</tr>
<tr>
<td>— health knowledge, attitudes, beliefs</td>
</tr>
<tr>
<td>— healthy public policy (legislation, policy, guidelines, etc.)</td>
</tr>
<tr>
<td>— health promotive environments (products, services, settings)</td>
</tr>
<tr>
<td><strong>Health promotion interventions</strong></td>
</tr>
<tr>
<td>— preventive services (inputs, process)</td>
</tr>
<tr>
<td>— health communication (inputs, process)</td>
</tr>
<tr>
<td>— health protection (inputs, process)</td>
</tr>
<tr>
<td>— community and organisational development</td>
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The AIHW has developed a National Health Information Model which provides a framework for the management of national health information. The model identifies the basic categories of health information, and the key relationships between them.

The model will be the basis for future information and data development work in health information systems and classification systems at Commonwealth, State and Territory levels. It is intended that the model will lead to consistency, and therefore comparability, of data collected from different sources.

**Priority issues and populations**

There have been several efforts to establish national priorities for health promotion in recent years. Additionally, the Commonwealth Department of Health and Family Services and each of the State and Territory health departments have established State or Territory priorities. Many of these priorities have been established in a de facto sense. The priorities include both health issues and population groups, and there has been little effort to integrate these.

A brief review of current priorities (as identified by program area at the national level) identifies the following health issues and population groups:

- Coronary heart disease (NHGT priority area)
- Cancers (NHGT priority area)
- Mental health and mental disorders (NHGT priority area)
- Injury prevention and control (NHGT priority area)
- Maternal and infant health
- HIV/AIDS (National Strategy)
- STD prevention
- Infectious disease surveillance
- Other cardiovascular disease and diabetes
- Asthma (possible future NHGT priority area)
- Disabling musculoskeletal conditions (possible future NHGT priority area)
- Child immunisation
- Tobacco (Health Australia priority)
- Alcohol and other drugs (National Drug Strategy)
- Nutrition (National Nutrition Policy)
- Physical activity and fitness
- Sex and fertility education
- Violent and abusive behaviour
- Occupational health and safety (Worksafe Australia)
- Environmental health
- Food and drug safety (National Food Authority)
- Dental health
- Suicide prevention
- Women’s health (National Women’s Health Policy and Program)
- Aboriginal and Torres Strait Islander Health
A list such as this highlights the volume of data required if the whole range is to be collected in each category for each of these priority issues or populations.

**Priority populations**

Social justice and equity are additional ‘outcomes’ that have been identified as desirable from health promotion programs. In relation to health, inequity is a moral and ethical issue, and refers to differences which are unnecessary and avoidable, as well as being unfair and unjust.

Equity in health service provision can be defined as equal access to available services for equal need, or equal utilisation for equal need. Equal quality of service provision for all is another equity objective. Fairness may be judged within groups (horizontal equity) and between groups (vertical equity). The different population groups between which inequities may occur can be characterised in terms of geographic location, health status, socioeconomic status, education, and language spoken at home, for instance. The equity policy objective is concerned with creating equal opportunities for health and with bringing health differentials among population groups down to the lowest level possible.

Information on equity covers a wide range of issues, including:

- access to knowledge about how to maximise one’s own health potential;
- access to knowledge about what services are available for which health problems, how to obtain the services and which do or do not work;
- accessibility of services, knowledge, environments; and
- use of health services in relation to need.

Priority populations are defined as identifiable populations with significant health disadvantage (for example, Aboriginal people and Torres Strait Islanders) or those who experience problems in obtaining access to knowledge or to services (such as people from culturally diverse backgrounds).

Significant priority populations identified at the 1994 National Health Information Forum were:

- socioeconomically vulnerable people;
- Aboriginal people;
- Torres Strait Islanders;
- people of non-English speaking background;
- refugees;
- homeless people;
- people living in rural and remote areas; and
- males and females (the need for health data to identify gender).

For the purposes of the health promotion data framework, populations defined by their health status (for example, people with disabilities, people with mental disorders) or by age or sex (for instance, women, older people) are not identified as priority populations, but are generally identifiable in the population health data.

Although the focus of this report is on national and State and Territory data, the level of geographic identification in data collections is relevant for assessing the usefulness of data to monitor socioeconomic disadvantage (for which small area may be the only feasible proxy) and regional differentials (rural and remote populations).
Surveillance and monitoring in the context of the framework

The dimensions discussed above may be put together to form a comprehensive framework for discussion of data needs and gaps as shown in Figure 3.

Figure 3. A schematic illustration of a comprehensive data framework

In summary, data relevant for surveillance comprise comprehensive health status and risk factor data used for monitoring trends or distributions. Surveillance indicators tend to be fairly stable and monitored over long-term periods. Data relevant for monitoring include health data and data on the determinants of health, these latter being indicators of progress toward becoming a healthier society.
7.2 Australian health data collections and their relevance to health promotion

The health promotion related data collected in Australia at the national level consists of 85 national or quasi-national datasets which are relevant to monitoring or surveillance of health promotion, of which 51 are continuing collections and 34 were either one-off collections or continuing collections which ceased between 1985 and 1994.

Health

The largest proportion of the collections are in the health category. Most of them focus on mortality, morbidity or risk factors, with only two including substantial data on health and wellbeing (as opposed to ill health and disease).

The greatest number of repeated collections also occur in the health category. While a one-off collection may be useful for establishing baseline information on health promotion issues, data must be collected repeatedly over time to be useful for monitoring or surveillance.

Population surveys

The major surveys in this category are the Australian Bureau of Statistics’ National Health Survey, National Nutrition Survey and Population Survey Monitor and the National Heart Foundation Risk Factor Surveys.

The National Health Survey is conducted every five years. However, the period between surveys is too long for effective use for surveillance. The Population Survey Monitor is a smaller, but more regular survey. It is run quarterly and has been successfully used to provide data for surveillance of population health and risk factor indicators and monitoring for national health goals and targets at a national level.

The National Heart Foundation Risk Factor Prevalence surveys were run on a quasi-national basis with samples drawn from capital cities in each State. They have been largely replaced by the current Australian Bureau of Statistics’ National Health Survey and National Nutrition Survey.

Disease and death registers

State and Territory Registrars collect data on births, deaths and marriages. These data are forwarded to the Australian Bureau of Statistics for coding of the causes of death using the International Classification of Diseases. The deaths dataset includes information on demographic characteristics, cause(s) of death, area of usual residence, occupation, country of birth, length of residence in Australia, marital status and some specified disease entities.

The major disease registers cover cancer and HIV/AIDS. Each State and Territory has a register of all cancer cases and these have been compiled into a national register by the Cancer Statistics Clearing House at the AIHW. This national register covers all cases diagnosed in Australia since 1982.

The National Centre in HIV Epidemiology and Clinical Research compiles a register of all cases of HIV/AIDS in Australia which covers the period from 1980.

Other

Other sources of national data in the health category include:

- hospital morbidity data held by AIHW;
- the AIHW National Perinatal Statistics Unit, which collates information from State and Territory health authorities about mothers and their babies, including statistics on hospital and home births, and data on congenital malformations;
- the AIHW National Injury Surveillance Unit, which collates information about injuries;
- the AIHW Dental Statistics and Research Unit, which collates dental health statistics;
the Australian Bureau of Statistics' current work on linking births, infant deaths and midwifery data to provide an ongoing national linked data source to facilitate research and analysis of events from birth to two years of age;
• the National Mental Health Survey;
• reports of notifiable diseases and virus and selected non-virus laboratory reports;
• sentinel networks of general practitioners, STD clinics and laboratories; and
• Worksafe Australia, which produces information on occupational health and safety.

Determinants of health

There are 24 nationally relevant health promotion related datasets in this category, most of which also fall into the health category described above. The remaining ones include:
• the Australian Market Basket Survey which monitors the pesticide and contaminants present in food and estimates their intake in the diets of Australians;
• the measurement at selected Australian sites of ambient levels of solar ultraviolet radiation;
• the collection of data on the extent to which skin types and clothing of models in fashion magazines and the settings in which they are photographed are consonant with skin cancer prevention; and
• the Australian Bureau of Statistics publication ‘Social indicators, Australia’, which presents a selection of social indicators and other statistics providing a broad background to social issues in Australia.

There are no nationally collected direct measures of the physical environment such as air and water quality. However, there are environmental measures which relate to specific settings such as radiation exposure in the workplace and the home. Of the data collections in this category, 14 are continuing collections.

Enabling factors

There are 12 datasets in this category, of which seven are continuing collections. All 12 data collections relate to health knowledge, attitudes and beliefs. None of the national datasets on the inventory include information on healthy public policy or health promotive environments.

Health promotion interventions

There are 12 datasets in this category. Of these, eight are continuing collections. The Health Education and Promotion System (HEAPS) is unique to this category. It provides information about programs and resources in the field of health promotion and education. Other datasets in this category include collections on fluoridation, cancer screening, immunisation and blood pressure screening.

Expenditure data

Although a detailed discussion of expenditure data is beyond the scope of this report, such data are important in any assessment of Australia’s health promotion activity. There are two aspects to expenditure data. The first is the raw accounting data compiled for projects or programs. A major deficiency in these is the lack of a nationally agreed standard chart of accounts. The second aspect is the difficulty of analysing these data by program, level of government and specific intervention.

Conclusions

The areas best covered by current national data collections are health and determinants of health. These collections focus on ill health with measures of diseases and risk factors that are well understood and easily measured. Recently there has been increasing use of health and well being measures such as the short form 36 (SF36) questionnaire, so future health data collections should have better coverage of this area.
Current data are weakest in the areas of enabling factors and health promotion interventions. Current national data include some information on health knowledge and skills but this coverage is very limited. The data collected on health promotion interventions apart from the HEAPS collection is mainly focused on preventive services in a limited number of disease specific areas.

While this discussion relates to national data, a similar pattern is evident in data currently collected at State and Territory levels.

7.3 Priorities for addressing data gaps and developing indicators

This section summarises priorities for addressing data gaps within the framework outlined above. The priorities have been drawn from those identified in the National Health Information Forum, the AIHW National Health Information Development Plan, the Better Health Outcomes for Australians report, and consultations with a range of experts and organisations.

In order for data collected by systems of monitoring and surveillance to be reliable and relevant, it is necessary to construct meaningful and useful indicators from the data and to collect the data in a standardised way using validated instruments. Some of the issues relating to best practice for the collection of data and construction of indicators are addressed in the following section.

Why have indicators for health promotion monitoring and surveillance?

No single measure of health or health gain is sufficiently comprehensive to include all the different facets of health and health gain following a health promotion activity. This is because of the multi-dimensional character of health, the complexity of health determinants and health promotion interventions, and the lengthy time lags connecting some of these to ultimate health gains.

Health indicators are useful for informing the general public, health practitioners and policy makers about the status of health and about changes in the health and wellbeing of the community. They are also useful for highlighting differences within and between the various groups that make up a community.

What is an indicator?

An indicator is an indirect or partial measure of a complex situation or concept. However, if indicators are measured sequentially over time, they can help to determine direction and speed of change and serve to compare different areas or groups of people at the same moment in time.

As far as possible, an indicator should be:

- **valid** — measure what it is supposed to measure;
- **objective** — the answer should be the same if measured by different people in similar circumstances;
- **sensitive** — sensitive to changes in the situation;
- **specific** — reflect changes only in the situation concerned;
- **useful** — be widely acceptable and meaningful to a wide range of potential users; and
- **measurable** — that is, an indicator is only of use if it can be measured through monitoring and surveillance mechanisms. There are three types of indicators for health promotion monitoring and surveillance:
  - **input indicator** — a measure showing the amount of resources used for a particular health promotion intervention over a specified period of time;
- **output indicator** — a measure showing the product or accomplishment produced by a process or program — this would commonly relate either to a process measure (such as proportion of people screened) or an enabling factor (for instance, changes in knowledge or attitudes); and

- **outcome indicator** — a measure showing intermediate and long-term changes in relation either to health or health determinants for the target population as a result of the interventions.

The primary issues in choosing indicators of progress toward healthy populations and a healthy society are that the indicators need to be:

- normative (this means that process indicators must relate directly to major strategies and the causal link between the process and the outcome must be well established);
- defined in a standard way and able to be measured;
- valid;
- available at national (or quasi-national) or State (or quasi-State) levels; and
- available at repeated intervals.

In this context, the requirement that a causal link be well established may be interpreted flexibly. While it is desirable for this link to be established by rigorous scientific testing, there may be cases where this is not practical or ethical. For example, the long lead times of randomized, controlled trials and the difficulties associated with establishing meaningful control groups at the population level may mean that data should be collected where the weight of informed scientific opinion suggests that it should be collected.

Health indicators can be macro level indicators developed to monitor or how a system (or health service) is performing overall, or micro level indicators to monitor the performance of interventions at local level. In this report, the focus is on macro level indicators at national or State and Territory level and the data needed to support their monitoring over time.

A **macro level health indicator** must be a statistic of direct normative interest which facilitates concise, comprehensive and balanced judgments about the condition or a major aspect of health, about a determinant of health, or about progress towards a healthy society. It should in all cases be subject to the interpretation that, if changes in the desired direction while other things remain equal, then there has been an improvement or people are better off.

Thus indicators of health status are always useable as macro level health indicators, whereas input and output indicators should only be used as macro level health indicators if there is also a body of knowledge (the scientific bases of practice) that identifies a clear link between the input or output indicator and improvements in outcomes. This definition highlights the need for a normative element in input or output indicators.

### Availability of data for monitoring

Monitoring data for an indicator should be available at national or State and Territory levels to measure movements towards the objectives of a health promotion program. In some instances, it may be acceptable to use quasi-national or quasi-State data. For example, while data may not be available at a national level, data may be available from several States and these may be combined to provide a quasi-national picture. Similarly, data from several regions within a State may be combined to produce quasi-State data.

For monitoring the achievement of the objectives of a program, data about the indicators must be available on a comparable basis at repeated time intervals. To maximise the usefulness of health indicators as tools for monitoring how health promotion is performing overall, they need to be relevant to health promotion programs. Indicators are needed that broadly and accurately reflect the performance of health promotion.
A national minimum set of indicators for monitoring and surveillance

Table 2 summarises indicators identified as important for monitoring and surveillance in terms of the framework. These indicators have been drawn from the national health goals and targets development work, from the work of the AIHW and from a number of other recent national reports. Areas where research is needed to develop national indicators are also shown.

<table>
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<tr>
<th>Framework category</th>
<th>Priority area</th>
<th>Indicator</th>
<th>Data available</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mortality</td>
<td></td>
<td>Death rates by cause and external cause</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>General</td>
<td>Perinatal and infant mortality rates</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>Infant health</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Health and wellbeing</td>
<td></td>
<td>Life expectancy</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Disability and handicap prevalence</td>
<td>Yes</td>
</tr>
<tr>
<td>Morbidity</td>
<td>General</td>
<td>Inpatient episodes by diagnosis, ext. cause</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Prevalence of reported conditions</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Incidence of serious disease, disability</td>
<td>No</td>
</tr>
<tr>
<td>Cancer</td>
<td></td>
<td>Cancer incidence</td>
<td>Yes</td>
</tr>
<tr>
<td>Communicable diseases</td>
<td></td>
<td>Notifiable disease incidence</td>
<td>Yes</td>
</tr>
<tr>
<td>Infant health</td>
<td></td>
<td>Other communicable disease incidence</td>
<td>Partly</td>
</tr>
<tr>
<td>Dental health</td>
<td></td>
<td>Congenital malformation rates</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Decayed, missing and filled teeth</td>
<td>Yes</td>
</tr>
<tr>
<td>Risk factors and risk markers</td>
<td></td>
<td>Edentulous</td>
<td>Yes</td>
</tr>
<tr>
<td>General</td>
<td></td>
<td>Overweight and obesity</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Blood pressure</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Serum cholesterol</td>
<td>No</td>
</tr>
<tr>
<td>Infant health</td>
<td></td>
<td>Low birthweight</td>
<td>Yes</td>
</tr>
<tr>
<td>Disease and risk factor impact</td>
<td></td>
<td>Attributable mortality and morbidity</td>
<td>Partly</td>
</tr>
<tr>
<td>All causes</td>
<td></td>
<td>Potential years of life lost</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Disability-adjusted life years lost</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Direct and indirect costs</td>
<td>Partly</td>
</tr>
<tr>
<td>Lifestyle and behaviour</td>
<td>Diet and nutrition</td>
<td>Apparent consumption indicators</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Nutrient intakes</td>
<td>1995 only</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Food habits</td>
<td>No</td>
</tr>
<tr>
<td>Physical activity</td>
<td></td>
<td>Leisure time exercise indicator</td>
<td>Yes</td>
</tr>
<tr>
<td>Tobacco</td>
<td></td>
<td>Smoking prevalence</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Passive smoking</td>
<td>No</td>
</tr>
<tr>
<td>Alcohol</td>
<td></td>
<td>Alcohol intake, risk drinking</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Alcohol-related road accidents</td>
<td>Yes</td>
</tr>
<tr>
<td>Drugs</td>
<td></td>
<td>Use indicators (licit and illicit)</td>
<td>Yes</td>
</tr>
<tr>
<td>Sexual behaviour</td>
<td></td>
<td>Safe sex indicators</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Cancer risk factors</td>
<td>No</td>
</tr>
</tbody>
</table>
Table 2. Indicative list of indicators for health promotion (continued)

<table>
<thead>
<tr>
<th>Lifestyle and behaviour</th>
<th>Total fertility</th>
<th>Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Teenage births</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>Maternal age</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>Induced abortion rate</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td>Use of contraceptives</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>Sterilisation rates</td>
<td>No</td>
</tr>
<tr>
<td>Infant health</td>
<td>Breastfeeding (1,3,6 months)</td>
<td>No</td>
</tr>
</tbody>
</table>

Social, economic and physical environment

| All                      | Research needed to develop indicators | No |

Health knowledge, attitudes and beliefs

| All                      | Research needed to develop indicators | No |

Healthy public policy

| All                      | Research needed to develop indicators | No |

Health promotive environments

| All                      | Research needed to develop indicators | NO |
| Diet and nutrition       | Food accessibility                   | NO |

Health promotion interventions

| Inputs                   | Expenditure on health promotion programs | No |
| Process                  | Indicators for preventive services include: | |
|                         | rates of Pap smear and screening; mammography; immunisation coverage; | |
| Research needed to develop indicators for interventions for health communication and health protection | Yes |

7.4 Where to from here?

Good information has been shown to be vital to effective health promotion. While many important steps have been taken to improve Australia’s health information systems over the last decade, (including the establishment of the AIHW itself), the need now is for a national system of monitoring and surveillance that is capable of guiding Australia’s health promotion effort and of assessing progress toward improving the health of the population.

Sections 7.5 and 7.6 below outline the data development that is required to fill current gaps in the health information system. Section 7.7 outlines strategies and infrastructure needed to continue to build the national health information system so that it supports Australia’s health promotion initiatives.

7.5 Filling gaps in the health information system

Australia’s current health monitoring and surveillance systems reflect the emphasis of the health sector on illness, injury, and disease. The most comprehensive data available are those that focus on causes of mortality and morbidity, followed by data on lifestyles and behavioural risk factors. While these are, and will continue to be, vital indicators of the health of the population, additional information is required.
The health information that is currently available has been sufficient to highlight the impact of social, economic, and physical environments on the health of populations. Environmental health was addressed in the national health goals and targets developed in 1988 and again in 1993. However, as illustrated in Table 3, among the 149 national targets in the four priority national goal and target areas, there is only one target for an environmental determinant of health.

<table>
<thead>
<tr>
<th>Table 3. National health targets by frame classification and priority area</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Frame classification</strong></td>
</tr>
<tr>
<td>--------------------------</td>
</tr>
<tr>
<td><strong>Health</strong></td>
</tr>
<tr>
<td>Mortality</td>
</tr>
<tr>
<td>Health and wellbeing</td>
</tr>
<tr>
<td>Morbidity</td>
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<tr>
<td>Risk factors and risk marker</td>
</tr>
<tr>
<td>Disease and risk factor impact</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td><strong>Determinants of health</strong></td>
</tr>
<tr>
<td>Lifestyle and behaviour</td>
</tr>
<tr>
<td>Social environment</td>
</tr>
<tr>
<td>Economic environment</td>
</tr>
<tr>
<td>Physical environment</td>
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<tr>
<td></td>
</tr>
<tr>
<td><strong>Enabling factors</strong></td>
</tr>
<tr>
<td>Knowledge, attitudes, beliefs</td>
</tr>
<tr>
<td>Healthy public policy</td>
</tr>
<tr>
<td>Health promotive environments</td>
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<tr>
<td></td>
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<tr>
<td><strong>Health promotion interventions</strong></td>
</tr>
<tr>
<td>Preventive services</td>
</tr>
<tr>
<td>Health education</td>
</tr>
<tr>
<td>Health protection</td>
</tr>
<tr>
<td>Information system developement</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Total health promotion related</td>
</tr>
<tr>
<td>Other</td>
</tr>
<tr>
<td>Total Targets</td>
</tr>
</tbody>
</table>

*Promoting the Health of Australians—A review of infrastructure support for national health advancement*
This appears to ignore the fact that each of the four priority goals is likely to be achieved only when improvements in the environments that determine the health of populations have been improved. It demonstrates the importance of the national health information system in pointing out where action is necessary, and in monitoring progress.

At present, the national health information system does not have the capacity to measure the extent of health promotive environments nor to measure progress in improving these. There is only limited national information on levels of health literacy or skills among the population.

**Health promotive environments**

Health promotive environments (schools, workplaces, health care settings, for example) are the focus of an increasing proportion of health promotion interventions. A concerted effort is now needed to identify a key minimum set of indicators for monitoring at the population level to measure progress towards health promotive environments.

The workplace is an example of the need for both the collection of a wider range of information to reflect the influence of work on health, and collaboration among the agencies responsible for the health of the workforce to develop and implement a national information system.

**Data development**

Research and development is needed to identify a minimum set of key indicators for health promotive environments which could be monitored at the national level. An example of an area in which early progress is possible is that of the Department of Health and Family Services, AIHW and Worksafe Australia collaborating to develop suitable indicators to monitor the health of workplace settings, as well as monitoring the health and safety of the workforce.

**Physical environment**

Responsibility for the surveillance of, monitoring of and action to control environmental health problems is diffuse. For instance:

- the National Food Authority is responsible for food safety;
- the Commonwealth Environment Protection Agency is responsible for national guidelines, standards and codes of practice in environmental matters within the Commonwealth jurisdiction; it addresses national air and water quality guidelines, waste minimisation strategies, management of contaminated land sites, development of environmental impact assessment procedures and greenhouse response strategies; and
- the National Environmental Protection Authority has policy making authority in the environmental area.

Each of these agencies collects national environmental information, but there is currently no system to bring together the information to enable monitoring of national environmental indicators relevant to population health.

The physical environment has been largely neglected in the development of national health information. With global population growth and increasing industrialisation, the risks to population health of environmental change will grow. It is important that information be developed on aspects of the environment relevant to health.

Registers of health effects, such as congenital malformations, cancer, and mortality, are useful for surveillance of aspects of health related to the physical environment although the usefulness of these data for detecting emerging environmental health problems is dependent upon the timeliness of the data collection and reporting.

Additionally, national information on air quality is needed to guide policy on control measures to improve air quality. National information on water quality is required to study associations between it and disease in Australia and to provide information to assist in decisions about the need for additional water treatment.
Data development

AIHW should explore the potential to collaborate with other agencies to collate existing data to enable improved surveillance and monitoring of environmental indicators relevant to population health.

Research and development are needed to identify a minimum set of key indicators of physical and chemical environments which could be monitored at the national level.

Social and economic environments

Social and environmental factors are important determinants of population health. Further research is needed to identify social and economic indicators that it would be appropriate to monitor as determinants of health status. Such indicators could include family income, employment status, quality of housing, or presence and degree of overcrowding. Many of these are measured already by agencies other than health. The need is for research to identify more closely the population health effects of these, and to identify appropriate indicators of progress in terms of the health of the population. There should then be a national minimum set of indicators, standards and instruments for use in administrative collections and population surveys.

As an example, healthy family relationships are believed to be of central importance in relation to mental health. Little information is available at population level in this area although some work has been done to identify indicators for social support and loneliness.” But to date no normative indicators have been identified for monitoring progress towards healthy family environments.

Data development

Research is needed to identify key social and economic indicators related to health status. Standard measures to allow national monitoring of progress need to be developed.

Health literacy and skills

While it is clear that there are relationships between levels of literacy and skills and population health, no indicators have yet been developed that could be used to monitor progress at the population level. Further research is needed to validate indicators of key factors causally associated with behaviour change and health gain.

Data development

Research and development are needed to identify priority issues in the relationship between general population knowledge about health, the causes and prevention of disease, self care and the use of health services, to identify a minimum set of key indicators which should be monitored at the national level.

Healthy public policy

Influencing public policy is a key strategy for promoting and protecting the health of the population. The National Health Information Development Plan recommended the establishment of an ongoing inventory of public policy, regulations and legislation aimed at creating environments that are conducive to the improvement and maintenance of health. It also recommended monitoring the extent to which such policies had been implemented.

From such an inventory it would be possible to identify a national minimum set of indicators for monitoring progress towards healthy public policy at a population level. While direct monitoring of public policy may be best done at State or local levels, it is important to have a nationally agreed set of indicators to ensure consistency and to enable national comparisons.

Data development

Develop a minimum set of key indicators for healthy public policy which should be able to be monitored at local, State and national levels.
Risk factors, lifestyle and behaviour

While national information on some potentially modifiable risk factors for major diseases is available from several sources, ongoing national collections such as the National Health Survey do not cover all major risk factors (for instance, blood pressure and blood cholesterol concentration are not measured). Moreover, few national collections are representative of the whole population, include sufficient numbers of people from priority populations (such as Aboriginals, Torres Strait Islanders, people of non-English speaking background), use nationally agreed data collection instruments, include routine validation of subjects’ self reports, or include biological measurements where they are the most accurate and cost-effective measures. These are all important characteristics if the national data collected are to be accurate, comparable across time, and able to address major health policy needs.

Relevant risk factors include food intake, alcohol and tobacco consumption patterns, nutrient status, body weight and composition, exercise patterns, blood pressure and serum cholesterol. There are four national health targets relating to blood pressure and plasma cholesterol and no defined strategy for monitoring these beyond 1995.

Data development

*Develop ongoing surveillance of potentially modifiable, major disease risk factors, including biological measurements where necessary, ensuring adequate coverage of priority populations.*

In 1992 the National Food and Nutrition Policy identified monitoring and surveillance of the food system as one of its four priority objectives. AIHW was funded to prepare a public report on food and nutrition and to develop a strategy to implement a National Food and Nutrition Monitoring Program.5

Data development

*In collaboration with other relevant agencies, including the National Food Authority, the Department of Agriculture, the Australian Bureau of Statistics, a national food and nutrition monitoring system should be developed to:*

- collect standardised data on food and nutrient intake particularly among priority populations; and
- collect more specific information on food expenditure.

*This will require the development of standard questionnaire modules to assess food habits relevant to current dietary recommendations and of standard questions on breastfeeding.*

A program of continuous data collection with a longitudinal component has been adopted in some countries and the efficacy of such an approach should be examined in Australia.

Other sources of data besides health surveys should also be explored for the collection of health and risk factor data such as sentinel practice networks and the routine collection of data during consultations with general practitioners or other health professionals.

Data development

*Current national and State health surveys should be reviewed to explore the feasibility of a continuous national health and risk factor surveillance system.*

The national mental health goals and targets highlight the need for the development of prevalence data for mental illnesses, focusing on depression and schizophrenia. National targets were not set relating to risk factors or determinants of mental illness and the planned National Mental Health Survey will not address significant risk factors among adults in the domains to be surveyed although it is proposed that it will do so for children and young people.” Further research is needed to identify factors that it would be appropriate to monitor as normative indicators of progress towards a “mentally healthy” society.

Data development

*Further research is needed to identify key factors which it would be appropriate to monitor as determinants of mental health status, and then develop agreed national standards and methods for the collection of these indicators.*
A national approach to *immunisation surveillance* is required. The validity of data currently collected periodically by population survey could also be increased by requiring a review of immunisation records and collection of blood for serum antibodies in at least a sample of subjects.

**Data development**

The standardisation, coverage, validity and timeliness of communicable disease and immunisation surveillance data should be improved.

**Mortality and morbidity data development priorities**

Mortality data remain the most comprehensive and completely collected national data relating to health. Some of the current limitations will be addressed with the introduction of ICD10 coding in 1998. In addition, more specific information on factors relating to fatal injury is required.

**Data development**

Modify collections of data relating to measuring morbidity and mortality to include International Classification of Diseases (ICD) codes of cause, place of occurrence and type of activity, where relevant.

Hospital inpatient episode data have been used as a proxy for the incidence of serious morbidity. Some of the limitations of these data are being addressed in several States and Territories by the introduction of unique patient identifiers and record linkages. But other limitations remain, including the sensitivity of the data to the supply of inpatient services, to variations in the institutional arrangements for acute care and in admission policies.

While mortality and hospitalisation data provide useful information on aspects of many diseases, they are of little use in measuring the burden of chronic conditions with low fatality and comparatively infrequent need for hospitalisation but major impact on wellbeing. Examples of such conditions include asthma, diabetes, musculoskeletal conditions, dental conditions and hearing loss. There is currently little or no ongoing collection of data for monitoring the occurrence of these and a number of other important chronic conditions.

Apart from several areas where national disease registers have been established (notably for cancers and congenital malformations), there are few population level sources for disease incidence data. The inclusion of the SF36 instrument in the 1995 National Health Survey is a step towards the collection of information on the severity and consequences of illness conditions in the population.

There are considerable time lags for the compilation of national information from most disease registers. It is essential that these lags be further reduced. The Australian Bureau of Statistics has taken steps to improve the timeliness of national mortality data. Steps are also being taken by others to develop a National Coronial Information System. However the timeliness of mortality data for broad population surveillance could be further improved. One way to do this would be to release a 10 per cent sample of death registrations within three months of the end of the calendar year in which the deaths occurred.

**Data development**

Timeliness of mortality and disease registration data should be improved.

Cardiovascular disease remains the biggest killer of Australians, with a commensurate strain on health resources. The Australian Health Ministers’ Advisory Council has endorsed the establishment of a national monitoring system as an urgent priority, and the Commonwealth Department of Health and Family Services has funded the AIHW to establish a National Centre for the Coordination of Cardiovascular Disease Monitoring.

There are currently no national data on the incidence, prevalence and consequences of mental illness and outcomes of its care. The proposed National Mental Health Survey will provide baseline data on incidence and prevalence of mental illness. However, it is a one-off survey which will provide little information on outcomes of care and no continuing monitoring information.

**Data development**

Standardised information on the incidence, prevalence, and consequences of priority health issues should be developed and collected.
The national communicable diseases surveillance system is in place with an agreed list of notifiable conditions. There is an urgent need to improve the quality and uniformity of surveillance data, to develop the capacity to detect new or non-notifiable conditions (such as the recent outbreak of food-related haemolytic-uraemic syndrome), to improve feedback to data providers, and to develop nationally agreed guidelines for the timeliness of reporting of specific conditions which relate to the urgency of the public health response required.

Data development
Initiatives to improve the standardisation, coverage, validity and timeliness of communicable disease surveillance data should be continued.

Priority populations

Aboriginal people and Torres Strait Islander people
There is an urgent need to improve all aspects of health information on Aboriginal people and Torres Strait Islander peoples.

Funding provided by the Commonwealth Department of Health and Family Services and the Aboriginal and Torres Strait Islander Commission has enabled the AIHW and the Australian Bureau of Statistics to maintain a National Aboriginal and Torres Strait Islander Health and Welfare Information Unit within the Bureau’s Darwin office for two years. Beyond this there will be a need to ensure continued funding for a national centre to coordinate the improvement and reporting of national information for indigenous people. Given the relative lack of progress in improving Aboriginal health information over the last decade, the National Health Information Development Plan has recommended development of a national plan to improve information about indigenous health and health services. Such a plan must be developed in consultation with Aboriginal people and Torres Strait Islander people.

The 1994 National Aboriginal and Torres Strait Islander Survey is an important advance in collection of information about Aboriginal and Torres Strait Islander peoples and should be repeated at regular intervals.

Data development
The AIHW should work with Aboriginal and Torres Strait Islander communities to develop a plan to improve all aspects of information about their health and access to health services. Regular national health and risk factor surveys for Aboriginal and Torres Strait Islander peoples should be continued.

Current mortality data collections, hospital inpatient data collections and other collections such as cancer registry data and notifiable disease data need to be examined to determine the completeness of Aboriginal and Torres Strait Islander identification in these systems and steps taken to address problems identified.

Data development
Further efforts are urgently required to ensure the accurate and complete identification of Aboriginal and Torres Strait Islander peoples in all health information systems and vital statistics collections.

Aboriginal and Torres Strait Islander populations experience some specific conditions, several of which are very disabling but of low fatality. Information about the prevalence of these and about the outcomes of treatment is required.

Data development
Strategies should be developed for monitoring the incidence, prevalence and outcomes of conditions of particular importance to Aboriginal and Torres Strait Islander peoples’ health, such as rheumatic heart disease, diabetes, end stage renal failure, trachoma and oitis media.

The methodology used by the National Aboriginal and Torres Strait Islander Survey means that the information cannot be readily compared with that available for other Australians.
With over-sampling of Aboriginal and Torres Strait Islander people in population health surveys, agreement on the definition of Aboriginal and Torres Strait Islander status for health data collection purposes, and its universal recording in surveys and vital statistics collections, reporting of results specific to Aboriginal and Torres Strait Islander people is becoming increasingly practicable. The level of disaggregation and quality of the data used in this process should be scientifically defensible, so that if numbers are low reporting may only be appropriate at a State or national level.

Data development
Report specifically on Aboriginal and Torres Strait Islander peoples in health related surveys and collections

People of non-English-speaking background

Data development
The value of language spoken at home (or preferred language) as indicators of inequalities in health and disadvantage in access to health services should be further explored.

Socioeconomically vulnerable people

Socioeconomic status and its link with health status is not sufficiently well defined or understood to allow the construction of simple, easily measured, comprehensive indicators.

Family income adjusted for family composition is possibly the best single indicator of socioeconomic status, but it is rarely included in administrative collections. Employment status (whether a person is employed or not) and occupation are important indicators of socioeconomic status and important determinants of health in their own right. But are only applicable to working age adults. Quality of housing, and presence and degree of overcrowding, may also be useable as indicators of socioeconomic disadvantage, but have generally not been addressed in health surveys or administrative collections.

Less directly, but also less invasively, location of residence when combined with social indicators measured at the Census can be very useful as a socioeconomic indicator."

Population surveys such as the Australian Bureau of Statistics’ National Health Survey generally include a comprehensive range of socioeconomic information, including education level, income, employment status and occupation. Administrative collections rarely include any of these indicators of socioeconomic disadvantage. The vital statistics collections include occupation, but this is not collected in a form that provides data of sufficient accuracy or reliability for use in identifying socioeconomic disadvantage. Disease registers generally collect only limited information on socioeconomic status.

Data development
There is an urgent need to develop agreed national means of identifying broad population groups in terms of socioeconomic disadvantage using simple and readily collected data items, and to implement these, either in the collection of, or the analysis and reporting of, national health data collections.

The AIHW should collaborate with other agencies to standardise the collection of socioeconomic indicators in national surveys and registration collections.

Geographically defined sub-populations

All surveillance and monitoring data should be collected in such a way that it is useful for local area health promotion activity. Often this will take the form of benchmark information for comparison with locally collected data. However, large scale surveys and other large scale data collections such as disease registers should include geographical identification so that data for local areas can be extracted.

This classification requires the development of a stable, mappable small area classification system. Ideally such a system would be based on absolute geographical references to maximise its comparability with other systems.


Data development

The capacity to undertake small area analysis should be improved by ensuring adequate sample sizes in population surveys and by developing and implementing a stable, relevant, mappable small area classification.

7.6 Improving the measurements

Health and quality of life

Measurement of population health status and health outcomes must include quality of life, level of physical, mental, social and occupational functioning and other, broader aspects of wellbeing.

Increasingly, there is a desire to place measures of single health dimensions into a broader health context. Several multi-dimensional measures of health have been developed. Of these, the Medical Outcomes Study Shortform 36 (SF36) appears to be most widely used. In Australia, the SF36 has been included in several health surveys including the 1995 National Health Survey.

It would clearly be useful to have a single index of health, not only to compare outcomes of different interventions, but also to measure changes in health in the same way that economic indices are used to measure changes in the economy.

Attempts to construct a global measure have included the Quality of Well-Being (QWB) Scale and the quality-adjusted life year (QALY)—a method for adding years of life in different health states —and have typically been used to measure and compare the benefits of medical interventions.

The question 'in general, would you say that your health is excellent, very good, good, fair or poor' has been included in a large number of national health surveys and has been shown to be an accurate indicator of people's health status. At the minimum, it should be included in all health and risk factor surveys.

An alternative approach to developing global indicators of population health has been to extend the concept of life expectancy to health states other than 'alive'. Such health expectancies are now widely used to monitor the evolution of population health. They are a potentially powerful tool for monitoring population health. However, there is a need to develop and agree on standardised measures of health states (for instance, disability) which can be collected consistently over time and related to clinical criteria, before these indicators can be sensibly used.

Widespread interest in health outcomes has led to proliferation of instruments for their measurement. Clinically specific measures are required to enable comparison of health outcomes across the country. Generic outcome measures are required if the health gains from interventions directed to different diseases in different populations are to be assessed. Such measures would reduce the need to collect information on clinically specific outcome measures.

Data development

Research is needed to develop standardised generic health status measurement instruments, and to develop agreed indicators based on data collected with such instruments.

Disease and risk factor impact

The traditional reliance on mortality data and hospital admission data for measuring the impact of disease can produce a misleading indication of the impact of chronic disease, particularly those which do not result in either hospitalisation or death until the disease is far advanced.

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* Nottingham Health Profile. 38 items measuring 6 health dimensions.
* Sickness Impact Profile. 136 items measuring 12 health dimensions.
* McMaster Health Questionnaire. 88 items measuring 3 dimensions.
* Medical Outcomes Short Form 36. 36 items measuring 8 dimensions.
Additionally, infectious disease surveillance to date has focused on measuring incidence, and not on finding ways to reduce the burden of disease as measured more broadly by disability and quality of life.

The World Bank’s Global Burden of Disease project developed a measure of the burden of disease expressed in the form of Disability Adjusted Life Years (DALYs). This measure consists of two components: loss of years of life due to premature mortality and years of life spent with various forms of disability.

The application of burden of disease methodology to Australian data may provide useful indicators of disease impact that would assist in setting priorities for the focus of health promotion interventions.

Health expenditure, service utilisation and other data can be used to estimate the direct and indirect costs of diseases, risk factors and health determinants. Such a methodology could be extended to produce a systematic national chart of accounts for health.

**Data development**

The World Bank DALY methodology and Australian data should be reviewed and an Australian approach to estimating the burden of diseases which utilise available data developed. Disease and risk factor costing should be extended to develop a national chart of accounts for health.

**Health promotion interventions**

National information about the provision of health promotion programs, their focus and target populations, their geographic distribution, and cost is minimal in comparison with information on treatment services. Such information is required to assess the adequacy of provision of these services and to assess their effectiveness. The development of a nationally agreed classification of health promotion programs will be a critical first step.

**Data development**

Standardised information on the provision and use of health promotion services by the general population and priority populations should be developed and collected.

For health promotion, as in all areas of health services research, cost-effectiveness of individual programs are required to augment information on health outcomes.

In addition, information on total expenditure on health promotion area is needed to evaluate whether the macro priorities for health expenditure are appropriate.

Work began in 1996 under the auspice of the National Health Information Agreement to standardise definitions for health expenditure. Two categories were proposed in the public health area—population health services and preventive health services.

**Data development**

Expenditure data for health promotion programs according to nationally standardised categories need to be developed and collected.

**Intersectoral collaboration**

Working intersectorally to promote health has many implications for the development of a national health information system. Just as it is necessary to collaborate with other sectors at the point of intervention, it is also necessary to collaborate when developing appropriate systems to collect data and report on progress.

This requires a two stage process. First, appropriate data collections must be developed. These data will typically be collected outside the health sector and their primary purpose may not necessarily be directly health related. Second, appropriate indicators for health promotion must be developed. Both these stages will require considerable negotiation with other sectors.

**Data development**

Relationships with other agencies need to be established to enable the collection of data relevant to both the health and other sectors, and to report on progress in ways that are beneficial to all those sectors involved.
7.7 Strategies and infrastructure for development of health promotion surveillance and monitoring information

**Surveillance data**

Surveillance data for health promotion does not differ from that required for general health surveillance. Hence, strategies for its development are the same as those for general health data.

The AIHW recommends that such data be developed via the National Health Information Agreement and regular National Health Information Forums.

A key element is the National Health Data Dictionary. This is a mechanism for reaching agreement on standard definitions and data collection protocols for health information. The Data Dictionary for institutional care was first published by the AIHW in 1993.

Surveillance data should be collected on a long-term basis. They consist of data with well understood relationships to health status and well validated measurement and collection techniques. However, even these data should be routinely reviewed.

Little information is currently available on the cost and extent of use of particular national health data collections. A key recommendation of the 1994 Forum was to establish an ongoing mechanism for reviewing the cost and quality of data collections. One way to achieve this would be to include this review function as part of the continuing work program of State and Territory health authorities and the AIHW with a view to having these bodies make recommendations to future Forum meetings.

**Monitoring data**

Monitoring data collections should arise from new or existing health strategies or targets. The Commonwealth and State and Territory governments already set targets for improving health in specific areas. Any program initiated to achieve the targets should include development of indicators for inclusion in a monitoring system.

National forums and a national agreement have proved successful for prioritising the collection of general health data. It is therefore recommended that an analogous process be used in relation to the inclusion of new indicators relevant to health promotion.

Such forums should also review the monitoring data collections. Monitoring data should be collected on a short to medium-term basis and reviewed regularly in light of changed priorities.

An important part of this process should be the use and, where necessary, the development of standard data definitions and collection protocols to ensure that surveillance, monitoring and evaluation data are comparable. The further development of the National Health Data Dictionary is the most useful mechanism to ensure this.

One characteristic of monitoring data for health promotion is that the link between health promotion activities and health outcomes is not always well understood and the measurement of the associated indicators is not always straightforward. Hence, another important part of this process should be continuing work to develop new indicators and to examine the scientific basis for the link between (a) indicators and the promotion activity they measure, and (b) health promotion activity and health outcomes.

**Information development structures for health promotion**

Health promotion surveillance data should be developed as part of general health surveillance. It is recommended that responsibility for health promotion monitoring be incorporated into existing structures.

Integrating health promotion into existing structures has the advantage of eliminating duplication and making health promotion part of mainstream health data collection. While there is a risk that health promotion priorities would be overlooked, it is considered essential that the monitoring and surveillance systems become more relevant to improving the health of the population and hence, that the population health requirements be
included within mainstream data collection.

Two main structures are considered appropriate. The first is the structure recommended for surveillance data — the National Health Information Agreement and regular National Health Information Forums. These already address many of the relevant issues and could easily be extended to consideration of such data.

The other existing structure is that established to oversee progress towards national health goals and targets — the AHMAC Better Health Outcomes Overseeing Committee. This committee already addresses issues involved in data collection for monitoring goals and targets strategies and its brief could be extended to the broader area of health promotion within priority areas identified by the National Health Information Forums.

**New methods of information collection**

New methods of data collection need to be explored to support health promotion surveillance and monitoring. These include:

- **sentinel surveillance networks** — which are currently mainly used for identifying outbreaks of infectious diseases — work should be done to explore their use for other aspects of health promotion including determinants of health and enabling factors;

- **data collection from service providers** — networks of service providers such as the Divisions of General Practice should be explored as a source of monitoring data — this would need to be collected in a standardised way so that it could be aggregated to State and Territory or national level;

- **data collection through institutional settings** — such as schools or workplaces — issues to be explored here include whether such data should be incorporated into routine administrative collections or collected on the basis of a sample survey;

- **development of a minimum national data set for collection from Aboriginal-controlled medical services**;

- **use of new technologies for data capture**; and

- **rolling health and riskfactor surveys** — piloting of such new methods is required to ensure that the planned information developments are workable, achieve the results required and have no unintended consequences — while pilot testing is an obvious requirement, it is often not carried out and must, therefore, be given greater prominence.

**Better use of existing data**

**National definitions and standards**

Many health data are collected in one State or Territory only. Although many of these address topics relevant to health promotion monitoring and surveillance, lack of agreed definitions, standards and instruments seriously limits the usefulness of these collections for developing quasi-national monitoring and surveillance indicators. There is an urgent need for the development and implementation of nationally agreed classifications (including small areas, health promotion programs and expenditure categories) and nationally agreed standards for survey instruments, methods and indicators relevant to health promotion monitoring and surveillance.

The National Health Information Agreement has initiated a process of national development of data items and definitions, and many groups are developing indicators and minimum datasets. These efforts have been largely confined to treatment services and institutional health care and there is a need to extend them to address health status, the determinants of health, and health promotion inputs and processes.

Many collections of national health data are made from data generated as a by-product of processes designed primarily to produce information for the day-to-day administration of health services. There is a need, now, for national guidelines or standards for compiling administratively-by-product data generally, and for ensuring their quality.

Far more deliberate and conscious coordination of State and Territory health data collections is required, together with agreement on the basic indicators that should be monitored.
Intersectoral links
Many sites for health promotion are not within the health sector. In these areas, surveillance and monitoring data would often be best collected by groups in the non-health sector. The use of such data would require the development and implementation of standard definitions and collection instruments which meet the needs of both health promotion and the non-health sector.

Better access to data
The National Health Information Forum is preparing a regulatory framework which reflects and responds to contemporary attitudes to information access and achieves an appropriate balance between the public interest in information and its use, and the privacy of individuals and organisations.

Linkage of data collections
Data from separate surveillance systems are rarely linked. Currently there is no national or coordinated approach to health record linkage in Australia. Record linkage has been developed to only a limited extent in Australia because of the lack of a clearly documented justification, concerns about invasion of privacy and scepticism about its feasibility and cost effectiveness. These issues must be addressed if it is to be advanced.

Revision of current data collections
Both surveillance and monitoring data should be continually reviewed for relevance and cost effectiveness.

Training in the use of surveillance and monitoring data
The efficient application of data for policy analysis, guiding priority setting decisions, and in policy and program development and evaluation is reliant upon practitioners, policy makers and other users being skilled in effective data management.

This may require the introduction of biostatistics and data analysis courses as part of tertiary training for health promotion workers and policy advisers, and the development of standard protocols for the analysis of surveillance and monitoring data. There is a particular need for data analysts who have an understanding of the potential applications of data in the workplace, and how to make data useful for policy makers, planners, managers and practitioners — in ways which do not raise privacy concerns. This requires well developed skills in interpreting disparate pieces of information and transferring the knowledge in user friendly and practical ways.

REFERENCES
4. Armstrong B. Report to the Western Australian Health Promotion Foundation on priorities for health promotion activities and policies and procedures for the funding of research relevant to health promotion. Unpublished. 1991.
8. ibid.


Section 8: Research

8.1 The current research effort

The Public Health Association of Australia (PHA) estimated the extent of public health research funding to be $54.39 million in 1992–93.

However, the PHA also noted that the range of funding bodies and reporting processes make it difficult to quantify the true extent of Australia’s public health research effort. Without a consistent reporting framework it is difficult to describe the different types of public health research funding, the level of training and the broad strategic directions of this research, even before its contribution is evaluated.

Funding for health promotion research is provided by government agencies, health promotion foundations, issue-specific non-government organisations, and private trusts and foundations. These agencies fund research projects and programs, commissioned research, core-funded research centres, training opportunities, scholarships and visiting fellowships.

Public sector

In the area of public health, the Commonwealth Department of Health and Family Services provides funding for research projects, scholarships, fellowships, traineeships, public health research training, and commissioned research. The most important sources of such funding are: Research and Development Grants Advisory Committee (RADGAC) (with its important emphasis on developing practitioner-focused research), the National Health and Medical Research Council’s medical research and public health special initiatives, the Research into Drug Abuse Program, the National Health Advancement Program, (Commonwealth AIDS Research Grants (CARG), several Public Health Research and Development Committee (PHRDC) initiatives, the National Drug Strategy, and the World Health Organization Fellowships in health promotion and disease prevention. Some health promotion-related research is funded through health services programs, such as the General Practice Evaluation Program and the Medicare Incentives Program.

Approximately 63 per cent of Commonwealth research funds go to universities. This reflects the highly competitive research funding environment and assessment processes which assess project proposals using the criteria of scientific merit, public health relevance and the researchers’ capacity to conduct the project. These criteria tend to favour well-established research teams with strong academic credentials.

In addition to the provision of research grants, the Department funds several core research organisations, such as the National Drug and Alcohol Research Centre (Sydney), National Centre for Research into the Prevention of Drug Abuse (Perth), National Centre in HIV Social Research, National Centres in HIV Epidemiology and Clinical Research, and the NHMRC-funded Centre for Health Program Evaluation (Melbourne).

The Public Health Education and Research Program (PHERP) supports public health training and research development through the provision of funds to academic centres of public health. Additionally, PHERP provides specialty funds to several institutions for specific initiatives in Aboriginal health, communicable disease and venereology, public health and community nutrition, research and training in health promotion practice, environmental health, and health economics.

While not funded by the Department directly, several national centres focusing on health promotion research and practice have also been established within some PHERP-funded universities. These include the National Centre for Health Promotion (University of Sydney), the Centre for Health Promotion Research (Curtin University) and the Centre for Public Health Research (Queensland University of Technology).
Several State-based research initiatives are also under way. In New South Wales, for example, the Hunter Centre for Health Advancement has been established. Additionally, the New South Wales Health Department has recently initiated a review of its research and development activities with the aim of enhancing its social health research efforts. This action represents a particularly positive step towards shifting the balance of the New South Wales Health Department’s research activities from a focus on biomedical research toward a focus on population health research.

**Non-government and private sector**

The non-government sector is an important source of funds for health promotion research and training. Some of the health promotion foundations have established research centres. The Victorian Health Promotion Foundation, for example, funds four centres of excellence—the Centre for Adolescent Health, the Centre for the Study of Mothers and Children’s Health, the Centre for the Study of Sexually Transmitted Diseases, and the Centre for Health Program Evaluation. In addition, the major foundations fund a range of research projects relevant to health promotion.

Other non-government agencies such as the National Heart Foundation, the State-based Anti-Cancer Councils, the Asthma Foundation, the AIDS Trust of Australia and the Sudden Infant Death Research Foundation, also fund considerable research relevant to health promotion in their area of special interest. As is true of government research funding, the balance between biomedical research and epidemiological and health promotion research is beginning to shift toward the latter.

Pharmaceutical companies and other private trusts and foundations such as the Clive and Vera Ramaciotti Foundation also provide funds for research.

**Community health sector**

A particularly important focus on building skills in community-based social research methodology is provided by centres such as the South Australian Community Health Research Unit (Flinders University), the Centre for Development and Innovation in Health (Melbourne), and the health-care consumer focused Health Issues Centre (also in Melbourne). Similar initiatives include the research work of the Consumers’ Health Forum in providing training opportunities in basic research skills and methodologies for health consumer groups.

Several community health centres have clearly demonstrated their leadership in developing practitioner and community-based research skills. The Parks Community Health Centre (Adelaide) has a strong commitment to professional development for staff, through the provision of financial support and study leave for postgraduate research studies, and also in building research relationships with Adelaide universities. Another insightful initiative was provided some years ago by the Victorian Springvale Community Health Centre, which employed two researchers as part of its permanent staff, to assist the centre’s practitioners and local community to develop research of relevance to their community.

**8.2 Limitations of the current research effort**

While the above overview suggests an impressive health promotion and public health research effort in Australia, it is limited by the type(s) of research currently funded, the utilisation of research findings, and the lack of evaluation measures to adequately inform health promotion program development.

**Issues in research methodology**

**What should be the subject of investigation?**

The extent to which health promotion research funding should focus on investigator led research or on national priorities has been the subject of debate within the scientific community. Traditionally, funding bodies have favoured investigator led research. However, it is clear that the current system is leading to significant gaps in knowledge in areas that have been accorded national priority. The National Health Strategy pointed to the fact
that it had been necessary to earmark funding for research related to the prevention of HIV/AIDS, drug use and injury prevention in order to ensure that the intervention programs were based on sound information.\textsuperscript{1}

In order to ensure that research is available to guide the development of effective health promotion, it will be necessary to develop a research agenda that is linked to national priorities to balance the current program that favours investigator initiated research. A predetermined research agenda, linked to national priorities, would require changes in the criteria used by Commonwealth research-funding programs and that of the PHRDC.

**Evidence required for effective health promotion**

There has been considerable debate about the type and quality of evidence required to initiate and guide effective health promotion. To date, much of Australia's public health agenda has been driven by descriptive epidemiological evidence on patterns of disease and injury among the population, and on patterns of risk. This has been (and will continue to be) an effective but is now being used to identify problems and to assess progress.

However, a range of additional information is also required to guide the development of effective health promotion, to guide the dissemination of best practice in health promotion, and to assist in making decisions about resource allocation for health promotion. Research is needed to define local needs, to identify priority populations, to guide program development and implementation, and to define appropriate outcomes.

As it becomes more necessary to account for achievements in terms of both effectiveness and cost-effectiveness, it will be necessary to develop more cost-effective methods to evaluate program outcomes, including evaluation of the cost effectiveness.

Reductionist models of research do not provide the full range of evidence required by health promotion. Rather, a full range of theories and methodologies is required, drawing on a range of disciplines. The research agenda must broaden to allow the development of understanding of the relationship between environments and health, and between the health of society and the health of individuals. The reductionist model, with its emphasis on specific conditions or diseases, has led to research that is focused overwhelmingly on individuals and interventions that are designed to assist individuals to change their behaviour.

Over the next decade, it will be necessary to develop appropriate methodologies to enable research that supports the full range of action necessary to promote health. This will mean, for example, re-examining the role of accepted experimental studies such as randomised controlled trials in relation to the reality of health promotion interventions that are designed to bring about changes in whole organisations, or across whole communities. The National Health Strategy argued that there can be no single dominant methodological perspective on research design and program evaluation for health promotion, since the basic research inputs to inform health promotion policy and practice need to encompass analysis of causality, the potential scope of desirable intervention content, and understanding of community needs. Research is also needed to establish an appropriate theoretical base to guide the development of an intervention (including individual, organisational, and community change theories and management practices).\textsuperscript{1}

Again, it will be necessary to ensure that scientific excellence remains a criterion for the granting of research funds. However, it is vital that a wider theoretical base and an expanded range of outcome indicators be included among the criteria for research funding.

**Types of health indicators in research**

Much of the current research effort produces information about the impact of behaviour change and personal skills on reducing health problems, or focuses on health status in clinical or morbidity-related terms. The National Health Strategy noted that this probably reflected the existing strengths in behavioural research in Australia, and the relative infancy in the understanding of the other intermediate health outcomes in health promotion research.\textsuperscript{1}

In many cases, the impact of problems has been defined, but the causes and extent of problems themselves remain unclear. There is often a strong imperative to act because of the serious impact of the problems. However, for policy and program design, research must identify the range of risk factors and social and environmental determinants. There is a distinct paucity of information available on the broader influences on
health needed to fully appreciate disease patterns and the impact of behavioural, structural, social, economic and environmental factors. In order to facilitate effective health promotion practice, research is needed using the perspectives and methods of the full range of disciplines including epidemiology, social sciences, behavioural sciences, political science, environmental science, etc. As well, there is a need for applied research that focuses on the effective delivery of programs, and on the dissemination of best practice.

**Developing practice relevant research**

In addition to the need to focus on integrated health promotion research methodology, it is also important to consider how the research findings can be converted into policy and practice relevant advice. Catford refers to this as the *science of delivery* rather than just the *science of discovery.*

**Intervention research**

Health promotion is practice focused and dependent upon a comprehensive range of integrated intervention points. However, it is argued that popular research design and measurement methods do not match the complexity of the interventions. Thus, intervention research, which is related to the social, economic and behavioural influences on health and its enhancement, is an increasingly important link in the chain of events leading to a successful national health effort.

Examples of such gaps include rigorous studies of interventions which focus on community-wide change, the identification of reliable indicators of positive changes in healthy public policy or legislation focused interventions, or the exploration of the potential for health-promoting settings such as schools, workplaces, and health care facilities.

A systematic approach is needed to initiate research that will inform the total health promotion effort. That is, research that focuses on priorities such as reducing differences in population health status, that investigates the impact of a range of strategies on promoting health (for example, community participation and public policy), and that identifies valid, reliable indicators of health-promoting environments. Most important is the need for the development of methodologies that will enable measurement of the inter-relationship between a mix of strategies and their impact on the social and environmental determinants of health.

**Developing effective methods of promoting the health of vulnerable population groups**

There is a lack of information on effective strategies for working with vulnerable groups. We know little about the comparative worth of intervention strategies across population groups, or the mechanisms which underlie the association between the various forms of social disadvantage and health. The development of research methods for use with vulnerable or at-risk population groups is also critical in order to develop programs and strategies to effectively alleviate inequities in health.

**Looking towards the future**

Research is also needed to begin to identify issues that will arise in the future. That is, we should consciously consider the likely major social and environmental issues facing society in the next decade or two, such as the impacts on health of an ageing population or degradation of the physical environment.

Where possible, emerging health issues should be anticipated, and the implications of these considered in terms of research priorities, workforce development, policy, program planning and services delivery.

**Encouraging the dissemination of innovation**

It is argued that the active dissemination of new research findings is an essential step in the promulgation of best practice. Yet cost-effective programs are not always adopted as widely as the evidence suggests they should be."

King et al. note that more research is needed in order to make research and programs ready for dissemination, and also to investigate the most effective methods to use in disseminating health promotion programs and research results. Furthermore, there is a need to provide feedback to researchers on practice, and to change the incentives and rewards for researchers, through such means as auditing the outcomes of research and taking account of these factors in the funding of further research."
Green suggests that ‘the rule of thumb’ governing the readiness of practitioners to adopt or apply the results of research and development appears to be the degree to which they have been consulted and involved in the formulation of the study.17

Participatory research
Green et al. note that, for health promotion, participatory research appears to be more effective than approaches where the investigators remain at arm’s length and have exclusive control, in that it helps to make the research questions more relevant to the community, the methods more acceptable, and the results more meaningful to them.18

In this context, ‘participatory research’ is defined as ‘the active involvement of, and often control by, those people who would be among the objects or beneficiaries of the research’, with the roles of participants including defining the questions, controlling the process, and interpreting the findings (ideally as originators, proponents and executors of the research).19

It has been suggested that practitioners’ perceived barriers to participating in research include professional territorialism, a lack of training in research skills, poor access to human resources, and a poor understanding of and misconceptions about research grant processes.20

Consideration needs to be given to the development of strategies that increase the opportunities for collaborative interaction between researchers and practitioners, and also to facilitating greater community and consumer oriented research, through joint research, community-directed research, and the development of research opportunities and support for community groups.

Research evaluation to inform policy and program development
The transfer of research evaluation findings into the development or revision of policy and programs raises several problems, in terms of both the applicability of the outcomes, and the availability of and access to those outcomes.

For instance:

- Research and practice-based projects which are reliant on grant funding often do not have the funding (or the skills) available to undertake evaluation. As a result, much information which could provide valuable input to program design and planning is simply not captured or, when it is, its quality may be compromised;
- Next, the research which is undertaken often does not have commonly agreed baselines or consistent frameworks and definitions, so that the ability to compare and contrast outcomes and impacts is, at best, limited;
- Current research and evaluation tends to concentrate on the outcomes or impacts with relatively little analysis of the effectiveness or otherwise of the processes employed. There is only limited strategic analysis of programs and projects to determine not only what is successful, but also how these successes have been achieved; and
- Finally, the mechanisms for sharing this information are seen to be inadequate in terms of its relevance, comprehensiveness, and currency.

Conclusion
Underpinning the issues raised in this section is that health promotion efforts may be compromised by both a lack of adequate funding and the need for more strategic training of researchers in health promotion. These shortcomings in the structures impact upon the quality of research produced.

For effective health promotion research, the areas which need to be addressed most urgently are:

- funding resource levels which reflect the size of the task, the potential rewards, and the long-term commitments required; and
- the transfer of knowledge from research to all participants involved in the research process.
Addressing the information gaps

From this analysis, it is clear that we currently have a limited understanding of the scale or scope of our health promotion program effort. Research is required, particularly in terms of:

- the contribution of program efforts to health gain (for example, in tobacco, drugs, etc.);
- the source and expenditure of health promotion program funds;
- the effectiveness of various modes of delivery (for example, national, State and Territory, regional, general practice, community health services, foundations, non-government organisations, etc.); and
- the effectiveness of various approaches (such as mass media, environmental support, etc.).

8.3 Moving the agenda forward

A strong health promotion research effort will be highly dependent upon the existence of strategic leadership and vision, a clear sense of priorities and objectives, supportive organisational structures and a well trained workforce. Additionally, the research funding should be directed towards the development of depth, and range across problem solving in service delivery, methodological excellence and curiosity-driven research?

Supports are now required to facilitate the much needed interaction between social and behavioural research, epidemiology, policy development and practice in order to:

- broaden the type of research conducted in both subject matter and research methodology;
- expand the network of researchers involved;
- improve the working relationships between researchers, practitioners and communities; and
- create infrastructure for the long-term development of health promotion research.

Research framework

The review found that a research framework is needed to guide the development of Australia's health promotion research effort and assist in:

- fostering the development of high quality research across the spectrum of the framework provided by the Ottawa Charter for Health Promotion;
- facilitating the development of practice-focused research in health promotion through collaborative research opportunities between researchers, practitioners, policy makers and communities;
- enhancing the transfer of new information into practice in a deliberate and systematic way;
- developing and maintaining health promotion research training opportunities; and
- developing a national strategy for the research and development effort required to promote health in Australia.

Foster the development of high quality health promotion research

The NHMRC has a key role in fostering the development of high quality applications in health promotion intervention research across the totality of health promotion effort through the establishment of targeted research program initiatives in areas of greatest need. Funding that is ring-fenced for a specified period was viewed as being essential to ensure that this change occurs and is sustained.

The consultation highlighted the importance of the public health research and training opportunities that had been provided by the PHRDC, and there was strong support for the retention of the PHRDC as a consequence. In addition, the review found support for the addition of sufficient science expertise on relevant research committees and review processes to enable the development of appropriate health promotion research.
It was emphasised that Commonwealth, State and Territory health authorities should have in place a clearly articulated research strategy to guide the commissioning of research. Such a strategy would target the development and improvement of standards for commissioned research in terms of methodology, outcome measures and performance indicators, and identify mechanisms to facilitate the transfer of research outcomes into departmental policy and programs in an integrated way.

The consultation advised that formal mechanisms be explored to facilitate the integration of NHMRC research findings and advice into Commonwealth health policy initiatives, and to ensure that the Commonwealth’s policy objectives and priority health issues are conveyed to the NHMRC to facilitate the direction of research effort into areas of need.

**Facilitate the development of practice-focused research in health promotion**

It was suggested that the Australian Association of Health Promotion Professionals and the Public Health Association of Australia consider holding one-day workshops in conjunction with their annual conferences, focusing on translating recent research theory and outcomes into practice.

**Provide support for new initiatives**

Other suggestions focused on the role of the Commonwealth, proposing that the Commonwealth and the NHMRC develop model programs of collaboration that match academic training to the needs of those working in health promotion policy development and practice.

It was also suggested that the Commonwealth, through the Community Sector Support Scheme (formerly the Community Organisations Support Program) provide targeted funding to facilitate the development of research training for community groups and opportunities for collaborative research with health consumers and communities.

**Research grant funding processes**

The consultation found strong support for actions by research funding providers to initiate processes to maximise the potential for transferring research findings into practice by ensuring that the grant selection criteria include:

- consideration of the policy and practice relevance of all research applications;
- the applicant’s intended processes for reporting and disseminating the results in a manner appropriate to practitioners; and
- demonstration of collaborative research design and project management between academic researchers, practitioners and communities (as appropriate).

Initiatives are also needed to encourage research traineeships and formal practice-based research and project placements, and appropriate mechanisms for promoting and disseminating the results of their funded research effort and work in progress in major priority areas.

**Develop and maintain health promotion research training opportunities**

Career development awards and training award initiatives to foster health promotion research training opportunities were further suggestions.

**Develop the research skills of non-researchers**

To develop the research skills of non-researchers, guidelines and a practical manual or resource kit to assist in the development of joint research initiatives were suggested as methods that might be used to enhance practice-based research initiatives.

The model provided by the General Practice Evaluation Program is one mechanism through which the Commonwealth provides resources for developing research effort and skills and building the constituency for evidence-based practice in health promotion. Specific initiatives might include the establishment of a technical...
advisory group to provide assistance to applicants and grant recipients in developing research applications and research methodology, and avenues for highlighting research findings and work in progress through regular conferences and newsletters.

**Develop a system-wide approach to organisational learning**

In establishing appropriate standards for assessing the quality of health promotion interventions, it was considered to be important that the process of review be linked to system-wide organisational learning. This will require the development of stronger links between the health services research function in health promotion and the practitioners in the field.

Providing increased support for a more active field of practitioner-based research (appropriately supported by career researchers) would contribute to a reconceptualising of the reporting function from simply one of accountability to being part of a wider process of system-wide organisational learning.

One line of activity which would help to strengthen the capacity of the health sector to participate in such collaborations would be for the NHMRC to commission policy studies or reviews on issues of overlapping interest (for example, health aspects of urban planning, health aspects of urban transport policy, aspects of the work and health relationship which are not considered through Worksafe Australia, the cultural barriers to moving to healthier and more economically suitable lifestyle habits, etc.). Such studies could contribute to more effective intersectoral collaboration at the State Territory and local government levels.

More focused studies are needed with respect to structures and arrangements for intersectoral collaboration at the national level including intersectoral consultative fora, cross portfolio policy statements and strategies and bilateral cross portfolio collaborations.

**Develop a national strategy for the research and development effort for promoting health in Australia**

There is a need for a national strategy to support and guide Australia’s health promotion research effort. To this end, a recent recommendation of the Public Health Association is adopted: that the NHMRC’s Public Health Research and Development Committee, in conjunction with the National Health Advisory Committee, support a project to develop and consolidate a framework to quantify and document Australia’s public health research performance and to highlight priority areas for future funding. This should be based on a systematic framework which links research expenditure with Australia’s health goals and targets.”

8.4 **The role of the National Health and Medical Research Council**

The current triennial work program of the NHMRC will end in December 1995. The Council is to be restructured, and both the Committees highlighted below will be disbanded at the end of the triennium. Nonetheless, the roles that they have played have been significant and it is considered important that the functions be included in the work program for the next triennium.

**Best practice: Health Advancement Standing Committee**

The NHMRC demonstrated its commitment to health promotion with the establishment of the Health Advancement Standing Committee. The Committee’s role was to contribute to the development of a national approach to health advancement through work in several areas. Its role included the identification of significant gaps in knowledge and priorities for research in health promotion, the identification of measurements of the health of individuals and society that should be included in national systems of surveillance, and the provision of advice on the administrative and legislative options to improve the health of Australians.

The Committee’s work, in addition to the conduct of this review, focused on identifying best practice in health promotive environments (schools, sport and recreational settings,) in community-based interventions, and in...
preventive health services. It has also published a review of the literature on the dissemination of best practice in health promotion.

The Health Advancement Standing Committee has been an important mechanism through which to develop evidence for and to disseminate information about best practice in health promotion. The Committee added important dimensions to the range of advice the NHMRC can provide to policy makers about promoting the health of the population. It demonstrated the importance of developing an independent body of knowledge and expertise on the advancement of health that can contribute to policy development, to research, and to the development of effective systems of surveillance and monitoring.

Research: Public Health Research and Development Committee

The Public Health Research and Development Committee was established to ensure that research of relevance to promoting the health of the population was developed and funded. Section 7 in this report has identified the strengths and weaknesses of this approach. The role of the Committee in developing the research base for health promotion has been outlined in that section.

However, this review has found that, in addition to the need for high quality public health research, there is a need for research on the delivery of health promotion, to develop knowledge of 'conditions for success' and to identify effective means of disseminating best practice. This would mean extending the range of research methodologies that are considered to contribute to scientific understanding.

REFERENCES

2. ibid
4. ibid., p. 66
5. ibid., p. 69
6. ibid., p. 67-68
7. Catford J. Personal communication.
11. ibid., p. 27
14. ibid.
17. Public Health Association of Australia, 1994. op. cit

Promoting the Health of Australians — A review of infrastructure support for national health advancement
Section 9: Evaluation

9.1 A concept of evaluation

Evaluation is the act or process of judging the value or amount of something. In the context of health promotion, evaluation may refer to the act or process of ascertaining the degree to which a set of health promotion activities either achieve their objective(s) or otherwise meet one or more standards of practice. Thus, evaluation is a specialised form of research in which the object of research is a health promotion program, project or activity, and the facts discovered by the investigation are used to ascertain the level of performance. An important corollary of this definition is that predetermined objectives or standards of practice for health promotion are necessary for meaningful evaluation to be possible.

Evaluation is of increasing significance in the field of health promotion. Given the preoccupation of OECD governments with improving the effectiveness and efficiency with which public expenditures are applied, the consideration of ‘value for money’ from resources invested into health promotion has become the primary criterion against which existing programs must be defended and new programs must be advocated. Moves towards evidence-based practice in medicine and output-based funding of health and human services signal the emergence of an operating environment in which the ability to prove the intended service outputs for given inputs of resources is of increasing importance. Governments are demanding accountability from the health promotion community and this means that evaluation should receive careful attention. It is unnecessary, however, for all health promotion activities to be evaluated to the same degree.

9.2 Types of health promotion evaluation

One useful framework for evaluation specifically related to health promotion is that of the US National Academy of Sciences. Coyle et al. delineated three types of intervention evaluation: formative, process, and outcome evaluation. They recommended a fourth type—efficacy evaluation—for population or media-based interventions in particular. These four types of research are designed to answer the four questions:

- What intervention types, message strategies and materials would work best (formative)?
- Could the program actually make a difference if implemented under ideal conditions (efficacy)?
- Was the program implemented as planned (process)?
- What impact, if any, did the program have (outcome)?

Formative evaluation: What is likely to work best?

Formative evaluation is carried out prior to or in connection with the different components of a program in order to formulate and improve the program during its course. It is concerned with pre-testing of materials, piloting strategies, target group clarification, and other evidence with respect to potential effectiveness before initiation, continuation or wider development.

Efficacy evaluation: Can the program make a difference?

Efficacy testing is designed to measure whether a campaign could work if it was implemented optimally, but under ‘real world’ rather than laboratory conditions. It is similar to the ‘test marketing’ carried out by
commercial marketers in selected geographical markets. Efficacy trials also can be used to further refine strategies and message materials before wider deployment of the program.

**Process evaluation: Was the program delivered as proposed?**

Process evaluation is carried out on the components of a program either during or at the end of the intervention. The questions these measures are designed to answer relate to whom the program was delivered, and how and how well the various components were implemented. While health promotive environmental change may be construed as an outcome in its own right, it may be more appropriate to include the achievement of environmental change in process evaluation.

**Outcome evaluation: Did the program make a difference?**

Outcome measures are designed to assess whether, and the degree to which, the program achieved its aims. Outcome objectives can be long-term biological outcomes, intermediate behavioural changes, or more immediate short-term psychological effects such as changes in awareness, knowledge and attitudes (sometimes referred to as ‘impact’ measures).

**Scientific/managerial evaluation**

This is an important distinction in one that has implications for future directions in health promotion in Australia. The principal motivation for scientific evaluation is to create new knowledge which may be generalised to other similar programs or projects, whereas managerial evaluation is principally concerned with accounting for the empirical performance of a specific program or project. However, scientific and managerial evaluation are not mutually exclusive.

**Overview**

Several prerequisites are needed to support an effective system of evaluation. Excellence in evaluation tends to flow from excellence in program design. Health promotion programs which have clearly articulated objectives or standards of performance lend themselves readily to evaluation, provided that the achievement of objectives or standards is measurable in a way that reflects on program performance. Too often the objectives of health promotion programs are couched in terms that are unrealistic for the level of resources and duration of the program or so broad as to preclude the attribution of causality to program effects.

The level of evaluation — formative, efficacy, process, or outcome — must be matched appropriately to the activity to be evaluated. Well-established activities with a high degree of prior credibility of efficacy require only a managerial approach to evaluation usually at the process and/or impact levels. Outcome evaluation is unnecessary where adequate scientific evidence of efficacy already exists. Effectiveness in a specific context may be inferred provided that process and/or impact performance are adequate. Moreover, the level of evaluation in terms of the inclusion of impact evaluation versus process evaluation alone, and the extent and sophistication of managerial evaluation activities, should be related appropriately to the cost of the program. A comparatively inexpensive program in a proven area of activity should require only a minimum of evaluation resources, which in the least resourced situation may consist of no more than simple verification that the program was delivered in accordance with its scientifically defensible design (that is, program fidelity). A more expensive program requires more rigorous evaluation.

Both large and small programs that involve the use of innovative and unproven health promotion activities should be subjected to scientific evaluation and demand a larger investment of evaluation resources than would be the case if only managerial evaluation was required. Scientific evaluation should generally be done by experts qualified in health promotion research, whereas managerial evaluation activities are appropriately the responsibility of health promotion managers and practitioners. In both instances, specific skills and knowledge are required, separated only by a distinction in the degree of expertise.
9.3 Current status of health promotion evaluation activities in Australia

Scientific evaluation of health promotion in Australia is supported mainly by national and State and Territory-based research funding agencies such as the PHRDC, a number of Commonwealth Department of Health and Family Services research grant schemes, the National Heart Foundation and member organisations of the Australian Cancer Society, the health promotion foundations and, to a limited extent, State and Territory health departments. In the main, the objects and methods of evaluation, especially at national level, are investigator driven and the mix of evaluation activities is determined principally by the interests of investigators and the merit of their proposals. This field of evaluation equates more or less with ‘health promotion intervention research’ and should be viewed as Australia’s contribution to an international effort to advance knowledge of the efficacy, effectiveness and cost effectiveness of health promotion services.

Although there has been progress in the area of evaluation of action to promote health, it remains a difficult and challenging craft. Lack of agreement on and/or lack of acknowledgement of the outcomes that are most likely to be achieved by health promotion and lack of instruments to enable measurement, have also hampered the development of systematic evaluation.

Scientific evaluation of health promotion has been marked by several positive trends in Australia, occasioned by the injection of additional resources through PHRDC, PHERP and the health promotion foundations, and by the increased attention given to multidisciplinary paradigms of evaluation, mixed qualitative/quantitative systems of data collection and analysis, experimental designs and the consideration of costs as well as effectiveness. However, these developments are still in their infancy. In addition to the technical issues that must be confronted is the evaluation of health promotion, a limiting factor identified is the consultations is the supply of researchers capable of designing and implementing advanced scientific evaluations.

Evidence of an organised and systematic approach to the managerial evaluation of health promotion in Australia is seen mainly at State and Territory level. However, the commitment has been quite variable across the State and Territories, being dependent of the sequestration of resources for evaluation undertaken by specifically designated internal or external groups. Core campaign-driven programs such as those concerned with tobacco control, alcohol education, nutrition education, sun protection and physical activity have received the most attention. Several high-profile Commonwealth programs such as the National HIV Strategy, the National Drug Strategy and the National Women’s Cancer Prevention programs have been subjected to ad hoc evaluations by external consultants. Managerial evaluation of health promotion is the regional and local levels has not been a strong feature of the Australian health system, with most local evaluation occurring as the result of projects supported by special funds (for example, to pilot an innovative program) and/or a requirement for an account of performance. The rigour of these evaluations has usually been found to be insufficient to produce knowledge that can be generalised.

In summary, a comprehensive system for the evaluation of the national health promotion effort in Australia is non-existent. Patchy systems of evaluation exist at State and Territory level, but their coverage is limited and variable across States and Territories, although interest and expertise is growing. At local level, ongoing activities are seldom subjected to managerial evaluation, whereas new activities are evaluated managerially when scientific evaluation is what is actually required. The directions of scientific evaluation show early promise, but as yet there is insufficient common ground between scientific and managerial interests and an insufficient supply of highly qualified investigators. Evaluation skills in the general health promotion workforce remain underdeveloped.
9.4 Building the capacity for health promotion evaluation in Australia

The review identified several steps that are needed to strengthen the national system of evaluation of health promotion in Australia.

A strong health promotion research community

A highly qualified critical mass of health promotion researchers is needed in Australia to enhance the national capacity to undertake scientific evaluations and to synthesise the state of international knowledge concerning evidenced-based practice, so that a clearer distinction may be drawn between situations in which scientific and managerial evaluation are required (in other words, what we know works and what we do not know). Increased doctoral level research training opportunities are required to produce a breed of health promotion investigator that operates from a multidisciplinary base (involving epidemiology, behavioural science, health economics and other social sciences), is well versed in quantitative and qualitative research methods and that can work closely with program managers in the design and implementation of interventions. Such individuals should be available to undertake scientific evaluations, to advise service agencies on the state of knowledge of evidence-based practice and to educate the general health promotion workforce about managerial evaluation principles.

Linking scientific and managerial evaluation

Great benefits flow when health promotion managers and scientists work cooperatively to evaluate costly and innovative programs in a way that contributes to the international state of knowledge. Australia’s system of research and service delivery present structural barriers that discourage these crucial links. Service delivery agencies view the cost of successful evaluation as an academic luxury that is unnecessary to program delivery and, therefore, alien to the purpose of funding. Moreover, experimental and other rigorous designs may complicate program implementation to a degree that is beyond the service agency’s commitment.

Research funding agencies question the need to pay for the evaluation of the activities of a major service delivery institution, because they believe that evaluation should be part of the manager’s responsibility in delivering their programs. Neither group appear to appreciate the potential for synergy between the service delivery and academic research sectors in supporting high quality scientific evaluations of new health promotion services (thus creating knowledge of evidenced-based practice), ensuring that new knowledge created by researchers is relevant to practice (thus facilitating dissemination of research findings) and assisting in the development of evaluation skills within the general health promotion workforce. A shift is required so that greater priority is given by service delivery agencies to trial of large new programs that are to be scientifically evaluated and greater priority is given by research funding agencies to research proposals that involve scientific evaluation of new programs to be introduced in the service sector.

Popularisation of evaluation knowledge and skills

The knowledge and skills necessary to undertake process and impact evaluations of health promotion programs for managerial purposes should be universal in health promotion managers and highly prevalent among practitioners at all levels in the system. Present deficiencies are most marked at the regional and local levels and this requires rectification. The network of PHERP-funded Centres for Public Health provides an ideal system through which to organise and deliver a national program of continuing education designed to build the capacity of the health promotion workforce to enact a greater commitment to managerial evaluation. The acquisition of postgraduate education at master’s or postgraduate diploma levels makes an important contribution to meeting these needs, especially in the case of health promotion managers, but even more relevant to the general health promotion workforce are opportunities to attend short courses and workshops on evaluation, preferably at a geographically accessible location.
A national evaluation framework

It is clear that both scientific and managerial evaluation of health promotion must occur at the national, State and Territory and local levels, but particular attention here is focused on improvements at national level. The development of national goals, targets and strategies in Better Health Outcomes for Australians offers a quasi-programmatic structure and a set of high level objectives that could serve as a framework for evaluation, but the corresponding systems of data collection, analysis and reporting are not yet available. The AIHW has been responsible for important developments in national health information, although it may be argued that much remains to be achieved in the provision of an adequate national information system for health promotion. The biennial report on Australia’s Health is (appropriately) long on description and short on interpretive analysis of the achievement of national health objectives (only six pages were devoted to this in the 1994 edition). What is falling through the gap between national health goals and targets and national health information is a process of evaluation that adopts an integrated view of the performance of health promotion activities of the Commonwealth and State and Territory health departments and foundations and the major non-government organisations.

One important step in building a more cohesive, national approach to evaluation would be to enhance the role of the AIHW to give the Institute a capacity for programmatic evaluation to complement its existing capacity in national surveillance. This would require new resources and a shift in the focus of the Institute away from large and continuous national data collections and towards an involvement in multiple smaller and more specialised datasets that reflect on the performance of health promotion programs.

It was also suggested that, through the mechanism of the National Public Health Partnership, national capacity for programmatic evaluation be extended. This would require new resources, national agreement and objectives, with lead agencies of the States and Territories (depending on the issue) being responsible for delivery. This would then be the basis for an annual or biennial report tabled in the Australian Parliament by the Federal Health Minister concerning the performance of the health promotion effort in Australia.

REFERENCE

Section 10:
Workforce education, training and development

10.1 The current health promotion workforce

Who is in the health promotion workforce?

The composition of the health promotion workforce and the knowledge and skills it requires have been considered in many reports in recent years. There is continuing contention around the extent to which health promotion is a special area of knowledge and expertise or whether it is part of everybody’s business. Within the health sector, a particularly contentious issue is that of the ‘professionalisation’ of health promotion.

It is true that the whole population has a role in promoting health. However, in order to provide effective workforce development, narrower definitions are required. Specific groups which form the workforce should be delineated, and the different characteristics and roles of each and hence their needs for different education and training, identified.

Historically the health promotion workforce has been viewed as being part of the public health workforce, but the maturation and progression of health promotion philosophy and theory, increased focus by the health sector on health promotion and the development of a significant health promotion infrastructure have resulted in the development of a more specialised health promotion workforce. Several reports have also called attention to the range of health professionals who promote health as part of their role. Alexiou et al. indicate that there is also a need to strengthen the education for non-public health professionals in those aspects of health promotion and public health they can positively affect the outcome.

This review therefore focuses upon three major groups to define workforce development needs—designated health promotion practitioners, health professionals whose roles include health promotion, and people in sectors other than health whose roles include promoting health.

Because no comprehensive study of the health promotion workforce in Australia has been conducted, the Public Health Workforce Education and Training Study (PHWETS) has been used as a source of information on the characteristics of the health promotion workforce. That data has been supplemented with information obtained specifically for the Health Australia review.

The PHWET study found that eight per cent of the respondents (n=85) identified their main occupation as health promotion and an additional 352 respondents also devoted some of their working time to health promotion. More than half the health promotion practitioners in that study worked for government health agencies, while a further 30 per cent worked for non-government or voluntary organisations. In all, more than 400 people work in government health services in designated health promotion positions throughout Australia. There are no accurate data on the number of designated health promotion positions in non-government or voluntary agencies. The qualifications and experience required for these positions varies widely, as do the terms of employment and the salaries.

The PHWET study found that one in two people working in the public health field had done so for less than five years. This confirmed findings from two smaller studies of the health promotion workforce in New South Wales.

There is only limited information about the size of the health promotion workforce, particularly when the broadest definition of the workforce is used. Within the health sector, however, the field is relatively small and most people appear to have been in their positions for relatively short periods.
Knowledge and skills of the health promotion workforce

The increasing emphasis of the health sector on improving population health has placed an emphasis on the need for more effective and specific preparation of health promotion practitioners? In Australia, the focus on achieving national health goals and targets has highlighted the need for workforce development for both the designated health promotion workforce and for all those who have a role in promoting health.

Some States have begun to define standards of competence for the designated health promotion workforce. While these competencies are not the exclusive domain of health promotion practitioners, the level of training, experience and range of competencies that health promotion professionals require are notable.

St Leger et al. in consultation with a range of practitioners, identified several elements of best practice in health promotion program development. Programs must have:

- a specified evaluation component;
- demonstrated commitment to addressing issues on the basis of improving equity in health status;
- used multiple strategies;
- engaged other relevant sectors;
- been based on consultation with their target groups;
- specified needs and priorities;
- been well planned;
- demonstrated cost effectiveness;
- been designed so that the effects can be sustained;
- been adequately funded and supported.

These are the parameters that define the range of knowledge and skills required by the health promotion workforce. There has been no comprehensive study in Australia of the health promotion workforce to measure knowledge and skills in accordance with these standards; nor has there been an audit of the training programs available to the health promotion workforce to identify the extent to which they prepare the workforce to achieve the levels of competence outlined in the standards, or to develop programs that meet these standards of best practice.

Qualifications and perceived training needs of the health promotion workforce

In the absence of a comprehensive, national study of the qualifications and training needs of the whole of the health promotion workforce, it is possible to comment only on those people who work in designated health promotion roles, usually within the public health sector of government. This is an important caveat, given the wide range of people outside that group who are also engaged in promoting health.

Most people in designated health promotion roles have tertiary qualifications. Many are professionals who adapted their knowledge and skills to work in health promotion or public health, for example nurses, psychologists, journalists or teachers.

The Public Health Workforce Education and Training Study identified the qualifications of some of the designated health promotion workers and the perceived training needs.

- 91.5 per cent of the health promoters who responded possessed at least a bachelor's degree;
- 6.9 per cent of the health promotion respondents had a health promotion qualification;
- 18.8 per cent of the health promotion respondents were undertaking an academic course at the time of the survey;
• 58.8 per cent indicated that they had participated in or intended to participate in continuing education activities this year with a high percentage of this continuing education focused on the behavioural sciences; and

• 97.6 per cent indicated ‘some competence’ or that they felt ‘very competent’ in their job.

The findings suggest that the health promotion workforce is highly qualified but 70.3 per cent of the respondents indicated a need for additional training.

Many respondents identified barriers to participating in such training. Lack of time, no relief from duties, no study leave, distance and funding were identified as significant barriers to attending training. People also felt that they lacked information about courses, and that there were few relevant or appropriate courses.

The implications for workforce development of the national health goals and targets

The national health goals and targets delineate a specific national agenda for measuring improvements in the health of Australians. National goals and targets have been agreed to in four priority areas: cardiovascular disease, cancers, injury, and mental health.

The marked difference in the content for each of the priority areas highlights one of the dilemmas for health promotion workforce development. Each is a complex issue in itself. requiring high levels of specialist knowledge. On the other hand, there are many common determinants of these diseases. One of the negative consequences of selecting four disease groupings as priority issues is that of ignoring the many common determinants that these conditions have in common. Effective workforce development, it seems, must concentrate on developing generic health promotion knowledge and skills, in addition to those that are specific to an area of interest.

A synthesis of the workforce development implications of each of the four priority national health goals and targets highlights the need for:

- political commitment to and national leadership for promoting the health of the population, with particular emphasis on the four priority areas;
- professional preparation and continuing education for health professionals to meet practice in their clinical roles;
- professional preparation and continuing education in health promotion for all health professionals, including medical, nursing, and allied health professionals;
- the development of incentives for key groups such as general practitioners and community-based health professionals to engage in effective health promotion practice;
- effective methods for disseminating new knowledge and skills both in the areas of clinical practice, and health promotion;
- identification of opportunities to collaborate with other sectors and of workforce development needs in other sectors;
- links between the allocation of resources and the achievement of potential health gains;
- research on the competencies and organisational support required to ensure effective health promotion practice;
- research on the optimal composition of teams delivering effective health promotion programs;
- networks of people engaged in work on similar issues or in similar settings;
- access to specialised as well as generic continuing education;
- access to flexible, relevant education and training; and
- access to timely, relevant information.

Promoting the Health of Australians — A review of infrastructure support for national health advancement
The analysis of the workforce development issues arising from the four priority national health goals and targets reveals that the immense specialist knowledge required by those working in each of the priority areas means that most members of the workforce identify their needs in terms of improving their content knowledge. No attention is given to identifying the determinants of these conditions (at the population level). However, each identifies the need for a range of professionals and sectors to be engaged in the process of achieving the relevant goals and targets, and each identifies the need for professional preparation and continuing education to improve both clinical and health promotion practice.

In addition, each identifies the need for an infrastructure that supports the development of the workforce and the implementation of the best practice that is taught through the various formal and informal processes that comprise workforce development.

Conclusions

There has been a rapid development of the Australian health promotion workforce over the past 15 years, with personnel being drawn from many different professions. Health promotion has become a professional specialty and a component of every health worker's role.

The designated health promotion workforce appears to be highly qualified and committed to ongoing professional development. However, the diversity of qualifications, the lack of clearly defined roles and responsibilities, the lack of organisational support, short-term contracts and the consequent high levels of mobility of the workforce have meant that overall knowledge, skills and experience in health promotion in many cases, have not matched the demands of the work. In addition, the ways in which priorities for health promotion have been set, and the requirements of funding bodies (both research and intervention funding) have meant that greater emphasis has been placed on innovative practice than on the identification and systematic implementation of best practice.

As the focus of the work of the health sector moves toward health outcomes, there will be an increasing need for the designated health promotion workforce to collaborate with other specialists within the health sector, and with organisations outside the health sector to define needs, plan and implement programs, and to evaluate their effects. In addition, although greater numbers of health professionals are being encouraged to include health promotion in their roles, concomitant workforce development strategies have not been established. Many health professionals are committed to the work but have had neither the professional preparation nor the continuing education that they require. Many also work without sufficient resources or organisational support.

As the health sector moves to establish partnerships with other sectors it will be vital that the training needs of workers in other sectors be identified — they may or may not be identical to those of health professionals.

Finally, it will be essential to continue to define the professional preparation and continuing education needs of the health promotion workforce. At present there is no nationally agreed set of competency-based standards, no mechanism for regularly reviewing needs, and no mechanism for disseminating information on these to training institutions.

It is clear that workforce development is required by the whole range of individuals and organisations working to promote the health of Australians. A range of professional preparation and training needs must be met, they must be offered through a range of flexible, accessible mechanisms, and attention must be given to the organisational support required by the workforce if it is to be able to improve the effectiveness of its health promotion effort.
10.2 Education and training for the health promotion workforce: the current situation

Workforce development includes a broad range of formal and informal activities that are designed to develop the knowledge and skills of the workforce and to encourage and enable effective practice. It also includes the organisational development that is required if individuals are to be able to put their knowledge and skills into practice.

The context for workforce development in Australia

Several broader initiatives have precipitated an accelerated national agenda for health promotion workforce development. Health care needs in Australia are changing, and the demands on health professionals, providers and managers are increasing. Public accountability, managerial efficiency, quality assurance and a focus on outcomes are now central concerns. Accompanying these changes is an increasing emphasis on illness prevention, health promotion and community participation in health care. All health professions (and many other professionals) have been affected by these changes.26-27

Changes in higher education

In addition to major changes affecting the delivery and focus of health services, there has been a series of dramatic changes in the higher education sector.

In 1984, the Australian government initiated a series of major changes in the delivery of tertiary education. The changes are still unfolding, with universities being asked to deliver marketable programs and courses using the rapidly developing new technologies that are making it possible to provide opportunities for multi-mode delivery of programs, augmenting the classical teacher/student relationship with off-campus delivery modes including video conferencing, audiographics and delivery through Internet. These changes have been accompanied by modernisation of university management, a focus on quality outcomes, performance measures, strategic approaches and planning.29

Increasing technology has facilitated the possibility of joint university sponsorship of degrees, twinning of research opportunities and joint student intake.

The National Training Agenda

Broader microeconomic reforms within the Australian economy have led to the creation of a National Training Agenda in 1989.27 This training reform initiative was designed to develop an effective, efficient, responsive and coherent national vocational educational and training system.28

The primary component of the National Training Board’s agenda is the formulation and adoption of competency-based standards for occupations. “Workforce competencies are statements which identify the specific skills, knowledge and behaviour required to perform the roles and responsibilities within an organisation.”29

In Australia and internationally there is considerable debate about the role of competency-based standards for health promotion.” However, despite the divergence of opinion, several projects have defined the skills and competencies required of health promotion practitioners.

Education and training currently available for the health promotion workforce

The development of an effective workforce is the result of professional preparation, continuing education, and on-the-job training and support. The mechanisms through which these occur include formal accredited courses, non-accredited courses, distance learning, on-the-job training, and self-directed learning.” Conferences, newsletters, professional journals, and a range of informal communication channels also contribute.
The last decade has seen a significant increase in the range of education and training for the health promotion workforce—both the designated workforce and the other major workforce groups. In 1993, there were 21 tertiary institutions in Australia offering specialist health promotion courses. The Public Health Education and Research Program has played a significant role in extending the range of tertiary level courses in public health and health promotion. However, in 1993 PHERP-funded courses accounted for only 22.1 per cent of all enrolments in Master of Public Health courses. PHERP graduates, more than any other graduates, believed that their courses had met their expectations.

Following its last review, the PHERP also provided funds for three years to expand the range and flexibility of training in health promotion in Australia. The funds went to the Department of Public Health and Community Medicine at the University of Sydney. The National Better Health Program led to significant progress in relation to the education and training of health and health-related professionals and in the development of new courses in line with health promotion priorities.

The National Health Promotion Conference, and an increasing range of short courses and seminars or symposia are being offered through professional associations such as the Australian Association of Health Promotion Professionals and the Public Health Association, and through the National Centre for Health Promotion, the Queensland University of Technology’s Centre for Public Health, and the Curtin University Centre for Health Promotion Research. The health promotion foundations, too, have contributed to building the knowledge and skills of the health promotion workforce, particularly that portion of the workforce working in other sectors.

A large proportion of workforce development is conducted outside formal training institutions. As people spend 98 to 99 per cent of their work time on the job and only one to two per cent in formal training, most learning must occur on the job. It is vital that attention be given to methods for ensuring effective on-the-job training.

For health professionals other than designated health promotion officers, the range of professional preparatory courses in health promotion appears to be limited and patchy. Some undergraduate courses for nurses and allied health professionals now include health promotion, and some medical training courses include aspects of public health practice but it is by no means viewed as a critical part of the training.

However, in recognition of a growing interest in disease prevention and health promotion amongst doctors, in particular, the Royal Australasian College of Physicians has established a Working Group on Health Promotion, and the Queensland Branch of the Australian Medical Association has established a Public Health Committee in partnership with the Queensland University of Technology and Queensland Health. The Faculty of Public Health Physicians has included some training in health promotion on its agenda. The Royal College of General Practitioners has also included some training in health promotion on its members.

There is a growing range of courses for Aboriginal Health Workers offering training in health promotion. The Northern Territory, in particular, has developed an accredited training program in health promotion for Aboriginal health workers.

In all there is a wide range of both formal and informal arrangements for health promotion education, training and development activities in Australia. In each of the States and Territories there appears to be a plethora of training options related to health promotion. Several States have also developed (or are developing) broader strategies that provide direction and a supportive organisational environment for health promotion workforce development.

Conclusions

Current information about the specific requirements of the health promotion workforce is very limited. The PHWET Study has contributed some information, but it is limited in relation to the health promotion workforce. The Health Australia review found that the health promotion workforce undertakes a lot of training but there is no information about the quality of this training and there appears to be no systematic ongoing education available for the health promotion workforce.

In addition, it appears that only limited attention has been given to the workforce development needs of the health promotion workforce in specific populations. The training needs of Aboriginal and Torres Strait Islander...
health promotion practitioners and communities, for example, are not being well addressed by current professional preparation and continuing education programs.

In addition to the research requirements identified elsewhere in this report, specific research on the workforce, its education and training needs, and on methods and systems for delivery of education and training is required. Research is required to:

- specify the characteristics and training needs of the various groups that make up the health promotion workforce;
- identify current levels of knowledge, skills, and qualifications of the health promotion workforce;
- identify expected levels of knowledge, skills, and qualifications of the health promotion workforce;
- identify current professional preparation and continuing education (including on-the-job) options available for each of these groups;
- identify the career paths of the health promotion workforce and the structural issues that influence these;
- assess the content and quality of current training options for the health promotion workforce; and
- assess the accessibility of current training options for the health promotion workforce.

A workforce development strategy

Although there is considerable education and training activity occurring, there is limited strategic planning and minimal amount of coordination of this activity.

The profusion of training and professional development opportunities has not been led by a national workforce development strategy. At present there is no national group responsible for identifying the future directions to be taken by the health promotion workforce, for speaking with employees about their requirements, for consulting the community and other sectors about their requirements of the health promotion workforce, or about their own training requirements. There is no systematic assessment of the quality of the training courses, and there appear to be few formal links between those who provide the training and education (both formal and informal) and those who are its users.

The Canadians have found, for example, that skills and tools are lacking for community development, analysing policy and collaborating with other sectors. “In keeping with international recognition of the need for training in leadership and management skills in industry,” there is a need for the public health and health promotion workforce to develop such skills. To date there has been little investment in Australia in the area of public health leadership development.

The quality and range of formal education and training in health promotion and public health

The PHWET study found that a major policy question relates to whether public health education and research funding should continue to support established centres of excellence or whether funds should be targeted towards a broader range of programs, which facilitate differing types of skills and specialisation in public health.

There is growing demand for more flexible education, accessible to students who are geographically isolated or whose limited time requires them to look for alternatives to classroom-based education. New technologies appear to offer opportunities to expand the education and training to reach a wider audience. These will require the development of appropriate teaching methods and, for some universities, re-orientation of current styles of education.

Short courses appear to play a significant role in the development of the health promotion workforce. In a rapidly emerging field such courses offer the opportunity to disseminate new information, to top up knowledge on specific issues, and to build networks of people with shared interests.
Orientation to public health and health promotion

The sizeable annual entry of people into the health promotion workforce, from a range of occupational backgrounds, the multi-functional roles to be played and the differing levels of skill and knowledge to be required of many of them call for early exposure to a relatively broad orientation to the public health field in general and health promotion in particular.67

On-the-job training

Ninety-five per cent of training takes place on the job. However, limited attention has been given to this in terms of workforce development for health promotion.

A range of actions is required, including the development of specific job descriptions with performance indicators that enable assessment of learning needs and levels of performance. This, in turn, requires health promotion managers to have sufficient knowledge and skills to supervise staff in this way, to assess performance and to develop guided training opportunities for staff. These opportunities should, where possible, be structured within the job.

To support such training, people require access to information, and to structured learning experiences as well as to formal training.

Information about education and training in health promotion for health professionals

There is a dearth of information about training in health promotion for health professionals. Given the growing importance of these groups in promoting health, it will be vital to increase knowledge of what is currently available, and to identify directions for the future. The size and reach of the health workforce makes it a potentially powerful tool for promoting the health of the population if its full power can be harnessed appropriately.

A first step toward improving the range and quality of training in health promotion available to health professionals will be to identify what is currently available, who is being reached, and to assess the quality of the training.

Information about education and training in health promotion for people working in other sectors

In addition, the training options available for people working in other sectors appear to be limited both in reach and quality. Again, more information is required before it is possible to identify training needs.

Mechanism for reviewing the needs of the health promotion workforce and for influencing postgraduate courses

Until recently there has been only limited connection between the requirements of employers of the public health and health promotion workforce, and training institutions. The PHERP review conducted in 1994 suggested some steps to overcome this gap, and the MPIH Accreditation Program that has been established under the auspice of PHERP is another important initiative that is attempting to link the needs of the workforce more closely to the training offered.

The structure of postgraduate courses, their staffing and the content of subjects offered in them should be systematically reviewed in the light of the actual functions of public health personnel and the current public health knowledge and skills base.
Mechanism for reviewing the needs of the health promotion workforce and for establishing relevant, accessible short courses

Increasing the range of and access to short courses provided by graduate public health programs and alternative sources is of particular importance to some groups within the health promotion workforce, including those who live and work in rural and remote areas, and those who work with vulnerable population groups. The courses should be developed with the workforce, and delivered using methods that enable them to undertake study when it is most relevant.

The National Centre for Health Promotion, the Centre for Public Health at Queensland University of Technology and the Curtin Centre for Health Promotion Research and Training are beginning to extend the range and flexibility of short courses available, but further development is necessary if all members of the health promotion workforce are to receive effective training.

Elements of best practice in health promotion workforce development

The consultation conducted for this review included discussion of best practice in health promotion workforce development. The key elements that were identified are outlined in the table below.

Best practice in workforce development for health promotion, therefore, is that which is linked with national health promotion policy and priorities; which is developed in close collaboration with its recipients; which is supported by organisational structures and processes; which is delivered using methods that are relevant and appropriate to the needs of participants; which is formal and informal; and which can demonstrate its effectiveness.

### Table 4. Key elements of best practice for health promotion workforce development

<table>
<thead>
<tr>
<th>Element</th>
<th>Description</th>
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<tbody>
<tr>
<td>Quality practice</td>
<td>Equitable, accessible, relevant - definitive practice focus with courses designed specifically for the workforce, multi-sectoral and multi-level training opportunities; culturally appropriate; accountable.</td>
</tr>
<tr>
<td>Infrastructure available and organisational capacity for workforce development</td>
<td>National health promotion policy with explicit reference to workforce development as a framework; agency and management recognition and support; capacity of the organisation to facilitate and manage workforce development.</td>
</tr>
<tr>
<td>Resources that are sufficient to ensure sustainability</td>
<td>Funding models that facilitate sustainability; adequate ongoing funding; appropriate resourcing both human and material; efficient and cost-effective programs.</td>
</tr>
<tr>
<td>Nationally agreed competencies defining knowledge and skills</td>
<td>Based on nationally delineated health promotion competencies; produces measurable changes in knowledge and skills; based on future health promotion practice as well as contemporary needs.</td>
</tr>
<tr>
<td>An effective process for delivery</td>
<td>Using multiple strategies, relevant technologies and flexible modes of delivery; acknowledging and reinforcing incidental learning opportunities; acknowledging other sources of learning beyond formal training such as mentoring, apprenticeships; uses principles of adult learning; involves participants in planning; multidisciplinary; cross-cultural training opportunities; recognition of prior learning;</td>
</tr>
<tr>
<td>A style of delivery that is matched to the needs of the workforce and to the demands of the content</td>
<td>Use of the range of opportunities both formal and incidental available in the workplace; need for coordination between providers.</td>
</tr>
</tbody>
</table>
10.3 Conclusions

Contemporary health promotion practice utilises a wide range of approaches and represents ‘a mediating strategy between people and their environments, combining personal choice with social responsibility for health to create a healthier future’ (Ottawa Charter, WHO, 1986). National developments in health promotion, coupled with an advancing maturity in philosophy and theory have led to the development of a more specialised health promotion workforce. However, given the evident complexity of the workforce, in particular its multidisciplinary nature, there are inherent difficulties in estimating its nature, size and composition. The health promotion workforce is highly qualified, usually with a primary degree in a health or education-related field and committed to the need for additional training.

Organisational capacity emerges as a major influence on health promotion workforce development. It is likely to be a potential support or barrier to the development and implementation of educational and training opportunities. Management, understanding and experience of health promotion are factors influencing health workers’ education and training opportunities. The non-government health sector’s lack of resources, expertise and commitment to health promotion influences the extent of workforce development strategies in this sector.

The central objective of health promotion workforce development should be the creation of a highly skilled, flexible and adaptable workforce, increasing collaboration between tertiary institutions, health and education systems at national and State and Territory levels and professional associations will be required to achieve this.

Using the elements of best practice as a guide, the following actions are needed:

- development of a national policy on health promotion that reinforces the need for a national system for health promotion workforce development;
- national agreement on the standards of competence for health workers engaged in health promotion practice across the spectrum from promotion to illness/ injury prevention;
- incentives to ensure managerial support for health promotion workforce development;
- equitable access to education and training that is relevant and community based and that utilises the most effective educational methods;
- nationally agreed quality control mechanisms and continuous improvement of education and training programs;
- workforce development to be linked to national, State and local health promotion priorities;
- funding to enable non-government, community and voluntary organisations to participate in training and development opportunities; and
- funds designated for training, education and development.

10.4 Defining the direction and content of effective workforce development

Ensuring that education and training is relevant, of high quality, and accessible

To ensure that workforce development initiatives are effective, it is necessary to have clearly defined goals and standards of performance. A system is required to review performance against these standards. A mechanism is then required to ensure that the findings of the review are incorporated into newly defined goals and standards.
National leadership: a health promotion workforce development strategy

A national workforce development strategy that is based on a national public health policy is required. It is recommended that a joint Working Party be established comprised of representatives of the Commonwealth Department of Health and Family Services, the NHMRC, the AHW, and the Commonwealth Department of Employment. Education, Training and Youth Affairs, universities, and professional associations. The role of the joint Working Party would be to develop and oversee the implementation of a national health promotion workforce strategy.

The Public Health Education and Research Program, the Rural Health Support, Education and Training Program, and the Indigenous Workforce Agency are examples of programs already established within the Commonwealth Department of Health and Family Services with responsibility for improving the knowledge and skills of parts of the health promotion workforce. The National HIV/AIDS Strategy has also included a range of workforce development initiatives, and a project to identify health promotion standards of competence for HIV/AIDS educators is currently under way. These programs should be drawn into the development of the national workforce development strategy.

Considering the needs of the whole of the health promotion workforce, the strategy would establish goals for training and identify the key elements of best practice in health promotion workforce development, including the content or focus of the education or training.

The strategy should then identify the range of methods and mechanisms that can be used to develop the knowledge and skills of the workforce including, in addition to formal education and training, mentoring, short courses, supervision, and apprenticeships. It should identify the major organisations and institutions responsible for delivering education and training. The strategy would also delineate the roles and responsibilities of the major organisations and institutions.

The strategy would include indicators of progress, allowing the joint Working Party to review and report on progress, and to recommend changes in the content of education and training and in the systems for delivery.

Linking workforce development to the implementation of best practice in health promotion and to the achievement of national, State and local priorities

As knowledge grows about the effectiveness of health promotion in particular settings or among specific population groups, or in achieving particular outcomes, it is necessary to ensure that new knowledge is applied to practice as quickly as possible. At present in health promotion, as in other areas of emerging knowledge in the health sector, the transfer of new knowledge into practice tends to be slow and unsystematic. A particular issue is that of the need to identify best practice in improving the health of Aboriginal and Torres Strait Islander communities (and other vulnerable populations), and to link these findings with education and training.

While national priority goals and targets have been identified and strategies for implementation have begun to be developed in the States and Territories, it is not clear that the implications for workforce development have been identified.

State and Territory workforce development strategies are also required. These should engage the institutions and organisations that provide training (including professional organisations, publishers of journals and newsletters, universities and colleges) in collaboration with the State and Territory health authorities to develop curricula and/or short courses, to identify other means of informing or educating the workforce, and to coordinate the delivery of programs or activities.

At State and Territory level, a mechanism is needed to review systematically progress in workforce development, to oversee the implementation of quality improvement systems for workforce education and training, and to recommend changes and new directions.

Conferences, seminars, workshops, and journals continue to be effective methods of informing the workforce of new developments in health promotion practice. New technology is now enabling people to network more directly, to share knowledge and experience.
Ensuring that development of the health promotion workforce is supported and sustained

Organisations that require health professionals to integrate health promotion into their roles should ensure that they have opportunities to undertake appropriate training.

The Australian Council on Healthcare Standards should be invited to develop an accreditation system for the health promotion carried out by hospitals. This will then complement the Community Health Accreditation and Standards Program that provides this for the community health sector.

All national health policies (for example, the National Aboriginal Health Strategy, National Women’s Health Strategy, the National Rural Health Policy), should include specific components that specify the workforce development requirements necessary for its implementation.

10.5 Delivering effective education and training

Formal agreements among the sectors responsible for developing a knowledgeable, skilful health promotion workforce

A formal tripartite relationship is required between the sectors responsible for defining the development needs of and providing the education, training or support required by an effective health promotion workforce. The PHERP arrangement is an example of this, but the Rural Health Education and Training Program is another example of a joint initiative taken by the Commonwealth Department of Health and Family Services to support workforce development among rural populations.

Improved education and training initiatives for health professionals

All health professionals should receive education in health promotion as part of their core preparatory training. This will require the Departments of Employment, Education, Training and Youth Affairs and Health and Family Services to work with relevant professional organisations and tertiary institutions to develop relevant curricula and professional accreditation criteria.

Education and training for members of vulnerable population groups

Specific provision will be needed to encourage and support members of vulnerable populations to enter the health workforce in general, to enter the health promotion workforce in particular, and to work in their communities on health promotion projects. In the short term, this is likely to mean the development of specific education, training and development programs for health workers who are members of vulnerable populations.

Funding should be allocated specifically to facilitate access to education, training and development opportunities for health workers working with vulnerable population groups. Further, there should be national coordination of training opportunities so that these ongoing initiatives are developed from introductory programs to advanced education and training programs.

Aboriginal health*

Aboriginal and Torres Strait Islander health workers must be included in all education and in-service training programs about health promotion.

The new joint initiatives being taken by the Department of Health and Family Services with the Department of Employment, Education and Training with respect to the Aboriginal and Torres Strait Islander health workforce

* consideration of the Aboriginal and Torres Strait Islander health promotion workforce has been separated due to specific national workforce developments.
(such as the Indigenous Workforce Agency) should be publicised widely within the health promotion community.

There is need for ongoing collaboration between Aboriginal and Torres Strait Islander health organisations, with community members, and with relevant professional organisations to define the education and training needs of the Aboriginal and Torres Strait Islander health promotion workforce, to identify appropriate methods for delivery, and to review and comment on progress.

The national competencies being developed for indigenous health workers in this instance should be used to assess the effectiveness of education and training programs, with a view to ensuring the integration of indigenous health workers into the mainstream health promotion workforce.

**Gaps in current education and training**

Cross-cultural training for mainstream health workers about the health needs and concerns of vulnerable groups, particularly indigenous people, should be an integral part of the orientation of all health promotion specialists and health professionals who undertake health promotion. In particular, the training must emphasise the need for working in partnership with Aboriginal people and Torres Strait Islander people.

All professional preparation courses for health professionals should include, in their core curricula, courses on indigenous people's health status, their holistic view of health and of the need to work in partnership with indigenous communities to develop solutions to the problems that the communities themselves define.

At present there are few courses available that have been developed specifically for people from sectors other than health who have roles in health promotion. Such courses will need to be developed in collaboration with the other sectors to ensure their relevance and accessibility.

**REFERENCES**

15. NSW Health Department. 1988. op. cit.
18. NSW Health Department. 1994. op cit


26. Recent trends and current issues in Australian higher education (conference paper, 1993). In addition Employment projections for various occupations from 1991–2001 has also included as an Appendix to this Occasional Paper from DEET.


30. NSW Health Department. 1994. op cit.


37. ibid., p 24


42. Commonwealth Department of Human Services and Health, 1995. op cit


Promoting the Health of Australians—A review of infrastructure support for national health advancement
Appendix 1: Terms of reference

The NHMRC Health Advancement Standing Committee (HASC) will undertake a comprehensive review and analysis of past and current health promotion initiatives. This review will inform the preparation of a report by the Committee detailing a range of options for future health promotion activity in Australia.

1. The HASC will review the current systems within which health promotion occurs, and assess existing health promotion initiatives and evidence-based strategies to develop a detailed plan for the long-term future role of health promotion in Australia. The final report should identify key recommendations for future health promotion activity in all important areas.

This report should make particular reference to:

2. Improving the infrastructure in support of health promotion in areas such as:
   - data collection and surveillance;
   - research, including recommendations to facilitate the conversion of knowledge gaps to funded national research projects;
   - policy and program planning, including policy and legislative frameworks;
   - health promotion financing models, including reviewing funding and purchasing models to develop a funding strategy for health promotion, and addressing the impact of existing health care financing models on health promotion;
   - program implementation, program administration and coordination, and organisational structures for health promotion planning and delivery;
   - evaluation, including the development of accountability and performance measures (outputs and outcomes), developing proxy criteria for those interventions which may be disadvantaged by the need for ‘evidence-based’ measures (such as community development strategies), recommendations on systems for evaluating and monitoring of progress against program or health status goals, and/or commissioning baseline measurement of some issues over time to assist with the design of future studies;
   - intersectoral action, that is, activity within and across all relevant sectors (i.e. not only the health sector) to promote healthy public policy;
   - workforce training and education; and
   - information dissemination and uptake.

3. Considering these structural issues in relation to their appropriate application to the range of health promotion issues, such as health/illness/injury concerns, health status inequalities, population groups, environments, and national health goals, targets and strategies.

4. Identifying the roles and responsibilities of all relevant agencies with an interest in health promotion (including agencies in the non-health sector). This includes: Commonwealth agencies (with particular reference to the Public Health Division of the Commonwealth Department of Health and Family Services, the Australian Institute of Health and Welfare, the National Health and Medical Research Council, and the Australian Health Ministers’ Advisory Council), State and local interests, non-government organisations, academic institutions, and professional groups.
5. Promoting best practice in health promotion and illness and injury prevention, with due regard to the particular needs of various population groups.

6. Ensuring equality of access to appropriate and affordable health promotion information and services.

7. Maximising all Australians’ opportunity to participate effectively in decisions affecting their health.

8. The final report should:
   - detail a range of options for future health promotion action in Australia;
   - make specific recommendations in line with the infrastructural issues raised in Term of reference 2 above; and
   - advise on the integration of these structural issues with current policy frameworks (e.g., national health goals, targets, and implementation strategies and the National Health Policy), and the broader systems within which health promotion activity occurs.

The report will ensure that health promotion models are fully examined and presented as options for future consideration in the context of a national uniform framework for improving the health of all Australians. As such, it will contribute to the transposition of health promotion from an adjunct to primary and acute care, to a legitimate, effective and equal partner in improving population health status.
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The consultation process for the Health Australia Review took place during the period July 1995 to September 1996. The following list of names, titles and organisation details were current during the period of consultation.

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Promoting the health of Australians—A review of the infrastructure supporting national health advancement.
Promoting the health of Australians—A review of the infrastructure support for national health advancement
Written responses to the Discussion Paper were received from:

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Promoting the health of Australians—A review of the infrastructure support for national health advancement
Appendix 3: Glossary of terms

There is no universal language of health promotion and health policy. However, to assist readers who may be unfamiliar with the terms used frequently in this report, the following are some of the most commonly cited definitions.

**Cochrane Collaboration**
An international organisation of health professionals and consumers, which aims to prepare and maintain systematic reviews of the effectiveness of health care interventions and disseminate them broadly to influence decisions about health care provision and practice.\(^1\)

**Evaluation**
The systematic assessment of the relevance, adequacy, progress, efficiency, effectiveness, and impact of a health program.\(^2\)

**Health advancement**
The improvement of population health, and especially the prevention of illness and injury, through such means as the development of health promotive environments, implementation of community-based interventions and provision of preventive health services. It is a generic term which is not aligned with any one particular philosophy or approach to public health or health promotion. Rather, it encompasses all relevant philosophies and activities.

**Health outcome**
A change in the health of an individual, a group of people or population, which is attributable to an intervention or a series of interventions.\(^3\)

**Health promotion**
Encompasses all those activities that seek to make life safer and enable individuals to more easily choose health and behave in health-preserving and health-enhancing ways. That is, health promotion is the process of enabling people to increase control over, and to improve, their health.\(^4\)

The mix of policies, methods and activities undertaken by governments, health professionals and community members to change the determinants of health and disease in order to improve health.\(^5\)

The combination of educational and environmental support for actions and conditions of living conducive to health.\(^6\)

**Monitoring**
The continuous follow-up of activities to ensure that they are proceeding according to plan.\(^7\)

The performance and analysis of routine measurement, aimed at detecting changes in the environment of health status of populations.\(^8\)

**Prevention—primary**
The promotion of health by personal and community-wide efforts, for example, improving nutritional status, physical fitness, and emotional wellbeing, immunising against infectious diseases, and making the environment safe.

**Prevention—secondary**
Measures available to individuals and populations for the early detection and prompt and effective intervention to correct departures from good health.
Prevention—tertiary

Measures available to reduce impairments and disabilities, minimise suffering caused by existing departures from good health, and to promote patients’ adjustments to irremediable conditions. This extends the concept of prevention into the field of rehabilitation. 55

Primary health care

Primary health care:

- is based on the application of the relevant results of social, biomedical and health services research and public health experience;
- addresses the main health problems in the community, providing promotive, preventive, curative and rehabilitative services accordingly;
- involves all related sectors and aspects of national and community development, and demands the coordinated efforts of all those sectors;
- promotes maximum community and individual self reliance and participation in the planning, organisation, operation and control of primary health care;
- fosters comprehensive health care for all, giving priority to those most in need; and
- relies on a range of suitably trained practitioners to work as a health team and to respond to the expressed health needs of the community. 56

A level of care provided by the health system: the first point of contact.

A health systems policy model: a framework for thinking about health system problems and possible initiatives. The norms of primary health care may be described in terms of four basic principles. These are:

- collaborative networking;
- consumer and community involvement;
- a balancing of health care priorities between micro and immediate needs on the one hand and macro and longer term aspects on the other; and
- partnership with the secondary and tertiary sectors. 57

Public health

One of the efforts organised by society to protect, promote, and restore the people’s health. It is a combination of the health of all the people through the collective or social actions. The programs, services, and institutions involved emphasise the prevention of disease and the health needs of the population as a whole. Public health activities change with changing technology and social values, but the goals remain the same: to reduce the amount of disease, premature death, and disease produced discomfort and disability in the population. Public health is thus a social institution, a discipline, and a practice. 58

The science and art of preventing disease, prolonging life and promoting health through the organised efforts of society. 59

Surveillance

Ongoing scrutiny, generally using methods distinguished by their practicability, uniformity, and frequently their rapidity, rather than by complete accuracy. Its main purpose is to detect changes in trend or distribution in order to initiate investigative or control measures. 60
REFERENCES


8. World Health Organization. 1984


13. Last JM. op. cit


15. Last JM. op. cit

*Promoting the Health of Australians — A review of infrastructure support for national health advancement*
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